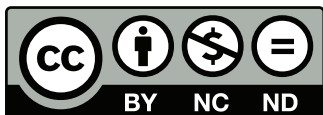


The stigma of problem gambling: Causes, characteristics and consequences

**Nerilee Hing, Alex Russell, Elaine Nuske, and
Sally Gainsbury**

Centre for Gambling Education & Research,
Southern Cross University

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Victorian Responsible Gambling Foundation

Level 6, 14-20 Blackwood Street
North Melbourne, Victoria, 3051
PO Box 2156
Royal Melbourne Hospital
Victoria, 3050
Tel +61 3 9452 2600
Fax +61 3 9452 2660
ABN: 72 253 301 291

[Our vision: A Victoria free from gambling-related harm](#)

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Executive summary

Research aims and objectives

The aims of this study were to determine the nature, relative intensity and process of stigma creation for problem gambling in the Victorian adult community, and to analyse how this stigma is perceived and experienced by different groups in Victoria, how it may impede treatment and interventions amongst first-time and relapsed help-seekers, and how it influences recovery from problem gambling.

Specifically, the objectives of the study were to:

1. Determine the nature of problem gambling, as perceived by the Victorian adult community.
2. Analyse the process of stigma creation for problem gambling in the Victorian adult community.
3. Determine the relative intensity of any stigma the Victorian adult community associates with problem gambling.
4. Determine how stigma associated with problem gambling is perceived and experienced by different groups in Victoria.
5. Determine how significant stigma is as an impediment to treatment or interventions for problem gambling and how recovery from problem gambling is impacted by stigma.
6. Analyse how stigma impacts people with gambling problems seeking treatment for the first time, compared to those seeking treatment after a relapse.

Methodology

Four stages of research were conducted to address the study objectives, with a full explanation provided in Chapter Three of this report:

Stage 1: Literature review. A comprehensive literature review was conducted to inform the subsequent project stages, drawing on Australian and international literature relevant to problem gambling stigma and to the stigma associated with mental health disorders.

Stage 2: Victorian Adult Survey. This stage was conducted to inform Research Objectives 1-4. To measure public stigma around problem gambling, a survey was conducted with 2,000 adult residents of Victoria, with weighting according to population norms enabling results to be highly representative of the Victorian adult population. Based on responses to vignettes of problem gambling and other mental and physical health conditions (for comparison), this survey determined the perceived dimensions of problem gambling, the process of stigma creation, and whether the perceived nature and intensity of stigma varied amongst respondents with different socio-demographic characteristics, level of gambling involvement, problem gambling severity, and level of contact with the stigmatised population. Including vignettes of other mental and physical health conditions in the survey also allowed the relative intensity of the public stigma associated with problem gambling to be ascertained.

Stage 3: Survey of People with Gambling Problems. This stage of the study informed Research Objectives 4-6 by examining the experiences of and responses to public stigma amongst those with the stigmatising condition – that is, people with gambling problems. To capture the quantifiable elements of the experience of problem gambling stigma, we surveyed 203 Australian adults who had experienced having a gambling problem in the preceding three years. This survey investigated their perceptions of public stigma, devaluation and discriminatory experiences, coping mechanisms used, impacts on self-stigma and their use of interventions including professional help, non-professional help and self-help. Statistical comparisons were drawn between respondents with different levels of problem gambling severity, different psychological and socio-demographic characteristics, and between those who have experienced relapse and those who have not.

Stage 4: Qualitative in-depth studies. To capture the depth and complexity associated with the perceptions, experiences and effects of problem gambling stigma, this stage involved in-depth interviews with 44 people with recent experience of a gambling problem and with nine counsellors providing gambling help to Victorians. This stage informed Research Objectives 4-6. Using interpretive phenomenological analysis and thematic analysis, these interviews provided a rich understanding of the perceived source, nature and intensity of stigma associated with problem gambling, affective responses to that stigma, perceived devaluation and discrimination by those facing this stigma, and actual experiences of stigmatising behaviours. This qualitative analysis also yielded a deep understanding of the coping mechanisms used when faced with this stigma, and the impact of this stigma on help-seeking, treatment and recovery. The interviews with the nine counsellors provided valuable insights into the influence of stigma on help-seeking behaviour and recovery, and how concerns for self-stigma are incorporated into treatment, including in relation to relapse.

Results

The key results from this study are summarised below. Full results for each stage are contained in Chapters Four to Seven. Chapter Eight integrates the results from the various research stages and discusses them in relation to previous research, and their implications for stigma-reduction and for further research.

Public stigma

Public stigma is the reaction of society to those with a stigmatising condition and the formation of negative attitudes towards the stigmatised population (Corrigan, 2004; Corrigan & Shapiro, 2010).

- The Victorian Adult Survey found that problem gambling is believed to be quite a noticeable condition, highly disruptive across several life domains, and caused mainly by a reaction to stressful life circumstances. However, problem gambling was not perceived as particularly dangerous to others (in terms of violence) and most respondents believed that it is possible to recover from problem gambling. Problem gambling was generally believed to be an addiction, but there was limited recognition that it is also a mental health condition.
- The Victorian Adult Survey respondents tended to stereotype 'problem gamblers' as impulsive, irresponsible, greedy, irrational, anti-social, untrustworthy, unproductive, and foolish. The stereotypes attached to 'problem gamblers' highlight that the public generally assigns blame for the problem to the individuals affected.

- While moderately willing to socialise with 'problem gamblers' in incidental ways, there was overall unwillingness to enter into closer and more enduring relationships, such as marrying into the family. Respondents were more likely to pity a person with gambling problems than to feel anger and fear, although a substantial minority reported feeling annoyed, apprehensive, angry or uncomfortable. Public devaluation and discrimination against people with gambling problems were apparent in areas including personal relationships, employment and trust.
- Respondents who desired greater social distance from people with gambling problems were more likely to attribute problem gambling to the person's own bad character, to consider it to be less recoverable and more perilous, to feel less pity and more anger and fear, to hold more negative stereotypical views, and to endorse greater status loss and discrimination.
- The stigma attached to problem gambling by the Victorian adult community was higher than for sub-clinical worries and recreational gambling, but lower than for alcohol use disorder and schizophrenia.
- Demographic groups less likely to stigmatise people with gambling problems, as measured by their willingness to socialise with them, were females, those who speak English at home, those who are more progressive, and those who have had higher levels of contact with problem gambling and more gambling involvement themselves.
- Demographic groups more likely to stigmatise people with gambling problems, as measured by beliefs that problem gambling would result in loss of status loss and discrimination, were males, those with higher educational levels, people who are more progressive, those who place importance on religion, non-problem gamblers, and those with lower levels of gambling involvement.

Perceived stigma

Perceived stigma is the belief that others have passed judgment and hold stigmatising thoughts and ideas about a stigmatising condition (Barney Griffiths, Jorm, & Christensen, 2006).

- Respondents to the Survey of People with Gambling Problems believed that problem gambling is more publicly stigmatised than alcoholism, obesity, schizophrenia, depression, cancer, bankruptcy and recreational gambling, but is not more stigmatised than drug addiction.
- Respondents to the Survey of People with Gambling Problems also perceived problem gambling to be more stigmatised than it actually is (as measured by the Victorian Adult Survey). They thought that this stigma is largely due to a public belief that problem gambling is a person's own fault due to failures of character such as lack of self-control, low intelligence, dishonesty and selfishness.
- Respondents to the Survey of People with Gambling Problems perceived the public to attach a range of negative stereotypes to, and desire social distance from, 'problem gamblers' and expected anger-related responses more than fear or pity. The interviews with gamblers confirmed these results.
- Most problem gambler participants in the survey and interviews perceived being negatively judged by others because of their gambling, although direct experiences of demeaning and discriminatory behaviours were rare because most had not widely disclosed their gambling problem. Expectations and fear of being devalued and discriminated against were strong deterrents to problem disclosure and help-seeking.

Self-stigma

Self-stigma occurs when individuals with a stigmatised condition internalise and apply negative societal conceptions to themselves, resulting in diminished self-esteem, self-efficacy and perceived social worth (Corrigan, 2004; Watson, Corrigan, Larson, & Sells, 2007).

- The Survey of People with Gambling Problems and interviews with gamblers indicated that the damaging impact on self-image of having a gambling problem was highly evident, and manifested as lower self-esteem and reduced self-efficacy in resolving the problem.
- Self-stigmatising beliefs included feeling disappointed in themselves, ashamed, embarrassed, guilty, stupid, weak, a failure, that they are entirely to blame, and that they are worse than people who can control their gambling.
- Whether public stigma causes self-stigmatising beliefs could not be ascertained from our cross-sectional surveys. Interviewees discussed that these beliefs emanated both from self-judgment and from what they perceived others to think – or would think if they disclosed their gambling problem.
- The strength and breadth of self-stigmatising beliefs suggest that efforts to lower self-stigma and reconstruct an unspoiled identity are a critical part of recovery from problem gambling.
- Females, those whose most problematic gambling form is EGMs, and respondents with higher levels of psychological distress were more likely to report self-stigma, suggesting that female EGM players with gambling problems may be particularly susceptible to self-stigmatising beliefs.
- Those reporting higher levels of public self-consciousness, social anxiety, psychological distress, and PGSI scores, and those with lower self-esteem, were more likely to report perceived or experienced stigma. Thus, various psychological characteristics are associated with varying levels of reported stigma, but causal directions are unclear.
- These results also indicate that perceived and experienced stigma increases as problem gambling intensifies, imposing a double burden on people with gambling problems.

Coping with stigma

- Secrecy was the main mechanism used to cope with stigma, by over four-fifths of respondents, meaning that significant others were typically unaware of a loved one's gambling problem. This secrecy was grounded in fear: fear of rejection, fear of shame, fear of being labelled 'a problem gambler', and of being stereotyped, judged, demeaned and discriminated against.
- There was more limited use of other coping mechanisms, including withdrawal, cognitive distancing, educating, challenging and substance use.

Help-seeking, recovery and stigma

- Fear of disclosing a gambling problem meant that self-help was most commonly used, followed by support from family and friends. However, disclosing a gambling problem to significant others was anticipated to lead to feelings of inadequacy and stupidity, although some respondents reported receiving more supportive responses than anticipated. Others experienced blame, anger, contempt and criticism.
- Shame and fear of being exposed as 'a problem gambler' were the major deterrents to self-exclusion from land-based gambling venues, due to the public stigma attached to having their

photos visible to venue staff, which risked gossip that would expose their gambling problem, humiliate them, put their jobs at risk, and ruin their lives. Online exclusion was generally believed to be far less shameful than excluding from land-based venues due to the ability to do this remotely.

- Stigma did not deter use of anonymous online and telephone help, but some participants reported limited benefits as they spoke with different counsellors each time they contacted these services.
- Some participants had attended counselling in spite of their fears of being stigmatised, typically once their problem and its impacts were so severe that they overrode the stigma barrier. Others were confident that counsellors would not be judgmental, although a few had encountered instances of professional stigma.
- Those who had not attended treatment noted that they would find the experience stigmatising, were worried that the counsellor would be judgmental, or were concerned that attending counselling would itself cause stigma.
- Counsellors emphasised the fear that clients have to overcome to attend counselling: fear of the unknown, that they may be judged as weak and irresponsible, that they may not be heard and supported, that they may not be able to trust the professionals they approach, and that they may not succeed with treatment.
- Mixed views were apparent in relation to stigma arising from the 'gamble responsibly' message and other public education campaigns for problem gambling. Participants variously considered that these messages lower stigma by increasing awareness about problem gambling; others felt they had no effect because the messages are tokenistic and have no educational value; and some felt that the messages increase stigma because they depict people with gambling problems as liars, untrustworthy, irresponsible and losers.
- Some counsellors strongly considered the 'gamble responsibly' message to add to problem gambling stigma, by conveying that people were personally at fault for having a gambling problem because they were irresponsible, which added further blame for their perceived failings.
- Perceived and experienced stigma were compared between those who had and had not sought each of 11 different types of help. Where differences were observed, those who had sought help had higher scores on the various stigma scales compared to those who had not sought help. However, the causal direction of these relationships is unclear. Increased perceived and experienced stigma may underpin a greater need for help. Alternatively, the experience of help-seeking may compound feelings of stigma.
- Many gambler participants believed that stigma can motivate behaviour change, while several others thought that there are no positive elements to stigma as it creates a sense of hopelessness and failure for people experiencing problem gambling.
- There was no significant difference between those who had and had not overcome their gambling problem at some point on any of the stigma measures. Most of those who had overcome their problem had done so only temporarily, as evidenced by relapse. The effect of stigma on long-term recovery remains unknown.
- The counsellors reported that dealing with self-stigma is considered a vital part of treatment for problem gambling. In fact, the counsellors generally noted that reducing clients' self-stigma is one of their first goals.

Relapse and stigma

- Episodes of relapse were reported to worsen self-stigma, eliciting feelings of self-loathing, lower self-esteem, reduced self-efficacy and shame. Survey respondents who had relapsed had significantly higher levels of self-stigma compared to those who had not relapsed. While causal directions cannot be verified, it is likely that relapse increases self-stigma amongst those with gambling problems.
- Effects of relapse on help-seeking were variable, with some participants too ashamed to return to counselling, while others did return as they were determined to overcome the problem. The survey found that nearly one-half of those who had sought help both before and after relapsing reported that seeking help was more embarrassing for them after relapsing, while about one-third found it neither more or less embarrassing, and one-fifth found it less embarrassing.
- There was no significant interaction between any of the stigma-related scales and seeking help from 11 different sources between those who had relapsed and those who had not. Therefore, while stigma appears to have an effect on different forms of help-seeking, these effects did not differ between those who had and had not relapsed into gambling problems.
- Counsellors reported that they explained to clients very early in their treatment that relapse is a common experience so as to normalise it and encourage treatment adherence.
- Relapse appears to increase self-stigma and lower self-esteem and self-efficacy; thus preparing clients for relapse and incorporating stigma-reduction strategies into treatment after relapse appear to be highly important components of therapy.

Limitations of the findings

Key limitations are listed below but should be read in conjunction with the fuller discussion provided in Chapter Eight.

- The Victorian Adult Survey sample was recruited as a panel through a market research company which may have introduced some sample bias. Nevertheless, data were then weighted to be highly representative of the Victorian adult population.
- Both the Victorian Adult Survey and the Survey of People with Gambling Problems were conducted online, which restricted respondents to those with Internet access.
- Most of the key measures in the Victorian Adult Survey were based on responses to vignettes. While this is a commonly used method in stigma research, the results are dependent on how accurately each vignette captured the condition or behaviour it aimed to represent.
- All vignettes in the Victorian Adult Survey included only a male protagonist; therefore the results for public stigma may not generalise to women with gambling problems. This was necessary to control for unnecessary variance between vignettes and to limit survey length. The decision to have a male rather than female protagonist was based on the higher prevalence of problem gambling amongst males in the Victorian population.
- The Survey of People with Gambling Problems recruited only respondents who had acknowledged a gambling problem, as meaningful questions and responses could only be gained from them. The results may not generalise to people who are in denial about having a gambling problem.

- The sample for the Survey of People with Gambling Problems was not representative of the broader population of people with gambling problems. Given the low prevalence of problem gambling in the population, gaining a representative sample was not considered feasible.
- Similarly, the interview sample of gamblers was not intended to be representative of the population of people with gambling problems, and was also recruited on a convenience basis. In-depth qualitative research aims to provide detailed insights and capture the range of experiences, rather than provide representative data.
- Counsellors from multi-cultural and culturally-specific services were overrepresented in the sample interviewed. While this allowed insights into some cultural aspects of stigma, the ethnic groups represented were too diverse to be able to draw firm conclusions about any one cultural group. Results from the counsellor interviews were used mostly to help triangulate findings from the other project stages, and to gain insights into how stigma is incorporated into treatment.
- Any research into stigma may be subject to social desirability bias. To minimise this potential, we used measures that have been previously used in stigma research wherever possible, including those that ask respondents what 'most people' think, tacitly giving them permission to express highly stigmatising attitudes (Link & Cullen, 1983).

Strengths of the findings

A precondition for effective stigma-reduction interventions is to arrive at a valid model for the stigma of the condition being examined (Schomerus et al., 2011). This study has contributed to a deeper understanding of problem gambling stigma by explicating numerous facets of its public stigmatisation and the perceived and self-stigma experienced by people with gambling problems, and has therefore helped in advancing the development of such a model. This study represents the first comprehensive examination of the stigma associated with problem gambling, and the first research to examine public stigma using a general population sample. The study also included a detailed examination of perceived and self-stigma amongst people with gambling problems, and is the first to do so using quantitative methods.

The findings of this study can inform stigma-reduction efforts in relation to problem gambling, such as public education campaigns, increasing community contact with people with gambling problems, challenging labelling and negative stereotypes by conveying more positive images of people with gambling problems, reducing professional stigma, and increasing options for anonymous forms of help and for early intervention. However, because stigma reduction interventions were not a specific focus of this study, we have not explicitly explored them in this report.¹ This study also identifies numerous avenues for further research to better understand the causes, characteristics and consequences of problem gambling stigma, and how it can be reduced.

¹ Our original grant application included an examination of stigma-reduction strategies for problem gambling. However, this stage was not funded.

Conclusions by objective

Objective 1: Determine the nature of problem gambling, as perceived by the Victorian adult community.

Problem gambling is perceived as quite noticeable, highly disruptive, and caused mainly by a reaction to stressful life circumstances, but to be a condition from which people can recover and one which is not particularly dangerous to others.

Objective 2: Analyse the process of stigma creation for problem gambling in the Victorian adult community.

A process of labelling, stereotyping, separating, emotional reactions, and status loss and discrimination was apparent in the creation of problem gambling stigma. Negative stereotypes, a degree of social distance, pity rather than anger and fear, and devaluation and discrimination in areas including personal relationships, employment and trust, were apparent towards people with gambling problems.

Objective 3: Determine the relative intensity of any stigma the Victorian adult community associates with problem gambling.

The stigma attached to problem gambling by the Victorian adult community was higher than for sub-clinical worries and recreational gambling, but lower than for alcohol use disorder and schizophrenia.

Objective 4a: Determine how stigma associated with problem gambling is perceived by different groups in Victoria.

Demographic groups less likely to stigmatise people with gambling problems, as measured by their willingness to socialise with them, were females, those who speak English at home, those who are more progressive, and those who have had higher levels of contact with problem gambling and more gambling involvement themselves. Demographic groups more likely to stigmatise people with gambling problems, as measured by beliefs that problem gambling would result in loss of status loss and discrimination, were males, those with higher educational levels, people who are more progressive, those who place importance on religion, non-problem gamblers, and those with lower levels of gambling involvement.

Objective 4b: Determine how stigma associated with problem gambling is experienced by different groups in Victoria.

People who have recently experienced a gambling problem consider 'problem gamblers' to be highly stigmatised – to be labelled by their condition, negatively stereotyped, to attract social distancing and anger-related responses, and to be devalued and discriminated against. This perceived stigma appears to commonly result in self-stigma, lower self-esteem and reduced self-efficacy. Self-stigma was highest amongst females, those whose most problematic gambling form is EGMs, and those reporting higher levels of public self-consciousness, social anxiety, psychological distress and problem gambling severity, and those with lower self-esteem.

Objective 5: Determine how significant stigma is as an impediment to treatment or interventions for problem gambling and how recovery from problem gambling is impacted by stigma.

Secrecy was the main mechanism used to cope with stigma, thus impeding use of help and recovery from problem gambling. Fear of disclosing a gambling problem meant that self-help was most commonly used. Stigma was a strong deterrent to disclosing the problem to significant others and self-exclusion from land-based venues, but less so for professional counselling. Stigma did not deter use of anonymous online and telephone help. Counsellors reported that dealing with self-stigma is a vital part of treatment for and recovery from problem gambling.

Objective 6: Analyse how stigma impacts people with gambling problems seeking treatment for the first time, compared to those seeking treatment after a relapse.

Episodes of relapse were reported to worsen self-stigma. Seeking help was reported as more embarrassing after relapsing, with some participants too ashamed to return to counselling, while others returned as they were determined to overcome the problem. However, no significant differences were found in help-seeking between respondents who had relapsed and those who had not. Preparing clients for relapse and incorporating stigma-reduction strategies into treatment after relapse appear to be highly important components of therapy.

Chapter One: Background to the study

1.1 Introduction

Gambling is a popular, socially accepted, and normalised activity in many countries, including Australia. However problem gambling, characterised by impaired control and harmful consequences, appears to be highly stigmatised.² This stigma can lead to deep shame amongst people experiencing problem gambling, deter problem acknowledgement and disclosure, discourage or delay help-seeking, and lead to reluctance to enter into and adhere to treatment. Despite these negative effects, very little research has examined the relationship between problem gambling and stigma. To help to address this gap in knowledge, this study examined the characteristics, causes, and consequences of this stigma to deepen understanding of how and why problem gambling is stigmatised, and how this stigmatisation impacts on people with gambling problems. Given the infancy of research specifically into the stigma associated with problem gambling, this study drew on concepts, theories and methodologies from the mental health literature to inform its design.

Stigma has been defined as a social process which occurs when individuals are devalued or discredited in a particular social context because of a perceived negative attribute, behaviour or social identity which disqualifies them from full social acceptance (Goffman, 1963; Crocker, Major, & Steele, 1998). Stigma can be considered from two main perspectives. **Public stigma** is the reaction of society to those with a stigmatising condition and the formation of negative attitudes towards the stigmatised population (Corrigan, 2004; Corrigan & Shapiro, 2010). Public stigma is formed through a process of judgment and labelling, where people are defined by their condition or problem, and as a group are assigned a range of negative stereotypes; this results in a division between those who are considered 'normal' and those who are not, leading to the devaluation of the stigmatised individual or group (Link & Cullen, 1990; Link, Yang, Phelan, & Collins, 2004). Although responses to **perceived public stigma** vary, some individuals may internalise these stigmatising attitudes and attributes as **self-stigma**, resulting in diminished self-esteem, self-efficacy and perceived social worth (Corrigan, 2004; Corrigan, Watson, & Barr, 2006; Watson et al., 2007). Internalisation of the stigma associated with problem gambling can manifest as feelings of shame, embarrassment, guilt, stupidity, weakness and low self-esteem (Carroll, Rodgers, Davidson, & Sims, 2013). Whether stigma is directly experienced or only perceived, these internalised beliefs diminish self-perceptions of social worth and can result in withdrawal from social support, rejection of help, and negative outcome expectancies (Corrigan, Markowitz, Watson, Rowan, & Kubiak, 2003; Scambler, 1998).

This chapter sets out the study's aims and objectives, provides an overview of its main stages, and outlines the structure of this research report. The study was conducted by researchers from the Centre for Gambling Education and Research at Southern Cross University over two years between mid-2013 and mid-2015. It was funded by the Victorian Responsible Gambling Foundation under its Grants for Gambling Research Program 2013 (Round 5).

² We have opted to use the term 'problem gambling' in this report as this was the accepted term in Australia at the commencement of the study and remains the most widely understood term to describe behaviour that is 'characterised by difficulties in limiting money and/or time spent on gambling which leads to adverse consequences for the gambler, others, or for the community' (Neal, Delfabbro & O'Neil, 2005). The DSM-V now uses the term 'disordered gambling' (American Psychiatric Association, 2013). In recognising the stigma associated with the term 'problem gambler', we have restricted its use to describe survey participants scoring 8+ on the Problem Gambling Severity Index (PGSI) as this is the official nomenclature used for this categorisation (Ferris & Wynne, 2001).

1.2 Research aims and objectives

The aims of this study were to determine the nature, relative intensity and process of stigma creation for problem gambling in the Victorian adult community, and to analyse how this stigma is perceived and experienced by different groups in Victoria, how it may impede treatment and interventions amongst first-time and relapsed help-seekers, and how it influences recovery from problem gambling.

Specifically, the objectives of the study were to:

1. Determine the nature of problem gambling, as perceived by the Victorian adult community.
2. Analyse the process of stigma creation for problem gambling in the Victorian adult community.
3. Determine the relative intensity of any stigma the Victorian adult community associates with problem gambling.
4. Determine how stigma associated with problem gambling is perceived and experienced by different groups in Victoria.
5. Determine how significant stigma is as an impediment to treatment or interventions for problem gambling and how recovery from problem gambling is impacted by stigma.
6. Analyse how stigma impacts people with gambling problems seeking treatment for the first time, compared to those seeking treatment after a relapse.

1.3 Overview of research stages

Four stages of research were conducted to address the study objectives:

Stage 1: Literature review. A comprehensive literature review was conducted to inform the subsequent project stages, drawing on Australian and international literature relevant to problem gambling stigma and to the stigma associated with mental health disorders.

Stage 2: Victorian Adult Survey. This stage was conducted to inform Research Objectives 1-4. To measure public stigma around problem gambling, a survey was conducted with 2,000 adult residents of Victoria, with weighting according to population norms enabling results to be highly representative of the Victorian adult population. Based on responses to vignettes of problem gambling and other mental and physical health conditions (for comparison), this survey determined the perceived dimensions of problem gambling, the process of stigma creation, and whether the perceived nature and intensity of stigma varied amongst respondents with different socio-demographic characteristics, level of gambling involvement, problem gambling severity, and level of contact with the stigmatised population. Including vignettes of other mental and physical health conditions in the survey also allowed the relative intensity of public stigma associated with problem gambling to be ascertained.

Stage 3: Survey of People with Gambling Problems. This stage of the study informed Research Objectives 4-6 by examining the experiences of and responses to public stigma amongst those with the stigmatising condition – that is, people with gambling problems. To capture the quantifiable elements of the experience of problem gambling stigma, we surveyed 203 Australian adults who had experienced having a gambling problem in the preceding three years. This survey investigated their perceptions of public stigma, devaluation and discriminatory experiences, coping mechanisms used,

impacts on self-stigma and their use of interventions including professional help, non-professional help and self-help. Statistical comparisons were drawn between respondents with different levels of problem gambling severity, different psychological and socio-demographic characteristics, and between those who have experienced relapse and those who have not.

Stage 4: Qualitative in-depth studies. To capture the depth and complexity associated with the perceptions, experiences and effects of problem gambling stigma, this stage involved in-depth interviews with 44 people with recent experience of a gambling problem and with nine counsellors providing gambling help to Victorians. This stage informed Research Objectives 4-6. Using interpretive phenomenological analysis and thematic analysis, these interviews provided a rich understanding of the perceived source, nature and intensity of stigma associated with problem gambling, affective responses to that stigma, perceived devaluation and discrimination by those facing this stigma, and actual experiences of stigmatising behaviours. This qualitative analysis also yielded a deep understanding of the coping mechanisms used when faced with this stigma, and the impact of this stigma on help-seeking, treatment and recovery. The interviews with the nine counsellors provided valuable insights into the influence of stigma on help-seeking behaviour and recovery, and how concerns for self-stigma are incorporated into treatment, including in relation to relapse.

1.4 Report structure

This report is structured into eight chapters. The literature review in Chapter Two considers concepts, theories and research findings to contextualise the study and inform its design. Chapter Three explains the research methods utilised for each stage. Chapter Four presents results of the Victorian Adult Survey, while Chapter Five presents results of the Survey of People with Gambling Problems. Chapters Six and Seven present analyses of the interviews with gamblers and counsellors, respectively. Finally, Chapter Eight draws together the study's findings in relation to each of the research objectives and discusses them in terms of the extant literature. Limitations and implications of the findings are also presented.

Chapter Two: Literature review

2.1 Introduction

In Australia, about two-thirds of adults gamble at least once a year, but 0.6% of the adult population meets criteria for problem gambling, and 18.6% of gamblers experience some negative consequences from their gambling (Gainsbury, Russell, Hing et al., 2014). Non-problem gambling is relatively normalised, although some research has found that Australian adults hold generally unfavourable attitudes towards it (Donaldson et al., 2015). In contrast, problem gambling attracts considerable public stigma; and this public stigma may be perceived and/or internalised as self-stigma by individuals experiencing problem gambling (Hing, Holdsworth, Tiyce, & Breen, 2014).

The most prominent effect of this stigma appears to be low rates of help-seeking for gambling problems, including from professional treatment services, peer support groups, and family and friends, as well as via self-exclusion and self-help measures (Delfabbro, 2012; Hing, Nuske, & Gainsbury, 2012; Hing, Tolchard, Nuske, Holdsworth, & Tiyce, 2014). Thus, stigma reduction measures, informed by research evidence and understandings, are needed to improve the utilisation of help services and other interventions to enhance recovery from problem gambling. However, very little research has previously investigated problem gambling stigma. At the time of writing, only five peer reviewed publications had specifically investigated aspects of problem gambling stigma (Dhillon, Horch, & Hodgins, 2011; Feldman & Crandall, 2007; Hing, Holdsworth et al., 2014; Horch & Hodgins, 2008, 2013), along with a government commissioned report (Carroll et al., 2013) and an unpublished PhD thesis (Anderson, 2014).

In contrast, a much larger body of research has examined stigma in relation to other mental health conditions, largely catalysed by Goffman's seminal book on social stigma, *Notes on the Management of a Spoiled Identity* (1963). Stigma is now widely recognised as one of the greatest challenges facing mental health (Horch & Hodgins, 2008; Hinshaw, 2006; Stuart, 2011). The Diagnostic and Statistical Manual of Mental Disorders (DSM-V; American Psychiatric Association, 2013) classifies gambling disorder as a behavioural addiction. Thus, research investigating the relationship between mental health (including addiction) and stigma can provide some insights into the stigma associated with problem gambling, as well as concepts, theories and methodologies to inform related research.

This chapter reviews the literature on stigma and problem gambling, while also drawing on related constructs and findings from the mental health literature. It examines problem gambling stigma from both the perspective of society (public stigma) and from the perspective of people experiencing problem gambling (perceived and self-stigma). Impacts of stigma on people with gambling problems are examined, as well as individual differences in how stigma is projected and experienced, and the stigma that can be experienced by significant others.

2.2 What is stigma?

Stigma occurs when individuals are devalued or discredited in a particular social context because of a perceived negative attribute, behaviour or social identity which acts to disqualify them from full social acceptance (Goffman, 1963; Crocker, Major, & Steele, 1998). Thus, stigma has been defined as a social process by which an attribute, behaviour or reputation causes an individual to be discredited by

society (Goffman, 1963). Research has differentiated between two main types of stigma: public stigma and self-stigma. These two facets of stigma are now considered within the context of problem gambling, drawing on concepts and theories from the mental health literature. Additionally, perceived stigma, professional stigma and courtesy stigma are briefly examined.

2.3 Public stigma

Public stigma is the reaction of society to those with a stigmatising condition and the formation of negative attitudes towards the stigmatised population (Corrigan, 2004; Corrigan & Shapiro, 2010). This process involves the judgment and labelling of certain people according to the perceived presence of a negative attribute, resulting in the devaluing of the individual and the assumption of moral failure; individuals are either discredited if their stigmatising condition is known, or discreditable if it remains hidden but at risk of being revealed (Goffman, 1963). In this way, a division is formed between those who are perceived as being 'normal' and those who are not, reinforcing a barrier between 'us' and 'them' (Rusch, Angermeyer, & Corrigan, 2005).

2.3.1 Explanations of public stigma

Two main theories have been proposed to explain why it is that mental illness attracts public stigmatisation: attribution theory (Weiner, 1986) and the danger appraisal hypothesis (Corrigan et al., 2003).

Attribution theory, proposed by Weiner and colleagues, explains that the perceived causality of outcomes for an individual determines emotional responses to that person, expectations about the person's future, and intended or actual actions towards them (Weiner, 1986; Weiner, Perry, & Magnusson, 1988). In the context of stigma, attribution theory proposes that the perceived cause of the stigmatising condition determines affective responses towards the stigmatised person, expectations of future recovery, and a variety of behavioural responses (Weiner et al., 1988). Thus, external attributions of the cause of a stigmatising condition (e.g., genetic cause, accident) should elicit pity and helping behaviours, while internal attributions (e.g., poor choices, lack of self-control) can be expected to result in anger and punishing behaviours. In experimental research (Weiner et al., 1988), the onset of physically based stigmas were perceived as uncontrollable and elicited pity, no anger, and helping intentions; in contrast, the onset of mental-behavioral stigmas were perceived as controllable, and elicited little pity, much anger, and intentions to neglect or ignore. Thus, the perceived origin of a stigmatising condition is thought to be a major determinant of the level of public stigma it attracts.

The danger appraisal hypothesis, as proposed by Corrigan and colleagues (2003), extended attribution theory to explain a fear response to a stigmatising condition. The hypothesis is based on the notion that the appraisal of a situation results in an emotional response; specifically that the perception of dangerousness operates by increasing fear and eliciting a greater desire for social distance from an individual with the stigmatising attribute. Further, empirical research has found that perceptions of dangerousness affect emotional and behavioural responses independently of the perceived causality of the condition (Corrigan et al., 2003). Thus, a condition perceived as dangerous will elicit a fear and avoidance response.

2.3.2 Dimensions of stigmatising conditions

Attribution theory and the danger appraisal hypothesis suggest it is the perceived nature or characteristics of a condition that determine its public stigmatisation. Further, in order to effectively combat problem gambling stigma, it is necessary to understand the perceived attributes that contribute to its public stigmatisation. Jones et al. (1984) proposed six dimensions which contribute to the formation of stigma: origin, peril, course, concealability, disruptiveness and aesthetics. Later empirical research (Feldman & Crandall, 2007) found that only three dimensions were essential in accounting for social rejection as measured by social distance: personal responsibility for the illness (origin), dangerousness (peril), and rarity of the illness. These dimensions are discussed in relation to problem gambling.

Origin

Consistent with attribution theory (Weiner, 1986), greater stigma is attributed to a condition when its origin is believed to be due to an individual's own actions, as opposed to biology or accident. Studies have found that people experiencing mental illness are judged more harshly than those with a physical disability, with the former judged as having higher levels of personal responsibility for their condition and being less worthy of pity than the latter (Corrigan et al., 2003; Piner & Kahle, 1984; Socall & Holtgraves, 1992; Weiner et al., 1988). Studies have also reported addictions to be more negatively perceived than other mental illnesses (Corrigan et al., 2005; Link, Cullen, Struening, Shrout, & Dohrenwend, 1989; Martin, Pescosolido, & Tuch, 2000). This is likely because individuals with addictive disorders are perceived by the public to be more blameworthy for their disorder, as well as more dangerous, compared to people with other mental illnesses (Angermeyer & Dietrich, 2006).

In a study by Horch and Hodgins (2008), participants (249 undergraduate university students) rated vignettes describing five health conditions (schizophrenia, alcohol dependence, problem gambling, cancer, and a no diagnosis control) on a social distance scale. Participants reported wanting a significantly greater social distance from the protagonist in the problem gambling vignette, compared to those in the cancer and no diagnosis control vignettes. However, there was no difference in participants' ratings of desired social distance from those with problem gambling, alcohol dependence, and schizophrenia, which supports earlier findings that mental health disorders are viewed differently to physical illnesses or disabilities (Weiner et al., 1988). Participants considered stressful life circumstances and 'bad character' as the main origins of gambling problems (as opposed to the alternate options of chemical imbalances in the brain, upbringing, God's will, and genetic factors). Dhillon et al. (2011) also found that stressful life circumstances were perceived by another sample of university students (N = 114) as the main cause of problem gambling, when also presented with vignettes. Further, a study assessing the relative public stigmatisation of 40 mental health conditions (Feldman & Crandall, 2007) found that pathological gambling was the 13th most stigmatised mental illness by 281 university student participants, with 'personal responsibility' being one of three dimensions predicting this stigmatisation. A qualitative study (Carroll et al., 2013) found that EGM gamblers viewed problem gambling as largely an individual's own fault, being due to their lack of self-control, lack of guilt, risk-taking propensity, ignorance of the odds of winning, and having unrealistic beliefs about winning. These studies provide some important insights into reasons why 'problem gamblers' are stigmatised. However, their small samples and use of university students in quantitative studies limits the extent to which the results can be generalised to wider populations (Gainsbury & Blaszczynski, 2011; Gainsbury, Russell, & Blaszczynski, 2014).

Peril

Consistent with the danger appraisal hypothesis, peril is a dimension of a condition which can lead to stigmatisation based on a perception of dangerousness (Corrigan et al., 2003; Feldman & Crandall, 2007). However, while fear of dangerousness has been identified in response to other mental health

conditions (Corrigan et al., 2003), research has found that people experiencing problem gambling are not rated as particularly dangerous. Participants in Horch and Hodgins' (2008) study rated the protagonist in the problem gambling vignette to be 'somewhat unlikely to be violent', while nearly equal numbers of participants in Dhillon et al.'s (2011) study rated the protagonist as 'somewhat likely' and 'somewhat unlikely' to do something violent to other people. Nevertheless, both studies found that those who perceived greater likelihood of violence desired greater social distance from the protagonist. While Feldman and Crandall (2007) did not report specific characteristics of problem gambling which led to its relatively high stigmatisation amongst 40 mental health conditions, they did find that perceived dangerousness was one of three dimensions predicting stigmatisation of mental illness.

Course

The course dimension has been found to be an influential factor in public stigma, depending upon whether the condition is viewed as reversible or not, with irreversible conditions tending to be being more stigmatised (Jones et al., 1984). However, stigmatised physical conditions are typically viewed to be irreversible while stigmatised mental health conditions are generally considered reversible (Weiner et al., 1988). This confounds the relationship between the course dimension and public stigma, given that mental health conditions are generally more stigmatised than physical conditions. Further, since recovery is common among people with gambling problems (Abbott, Williams, & Volberg, 2004; Slutske, Blaszczyński, & Martin, 2009), it is possible that the course dimension may not play as important a role, however, in the formation of problem gambling stigma as other dimensions. Research is required however, to confirm that the public is in fact aware of the true course of gambling problems. If the public perceives that most people do not recover from problem gambling, this perception may strengthen the public stigmatisation of problem gambling.

Concealability, rarity, disruptiveness and aesthetics

Concealability appears to be relevant to understanding the public stigma associated with problem gambling, given that people often report hiding a gambling problem due to shame, embarrassment and fear of being stigmatised (Hing et al., 2012; Hodgins & el-Guebaly, 2000). That is, people typically maintain secrecy about their gambling problem to avoid negative judgments by others. Concealability may also be related to perceived rarity if the public perceives that problem gambling is less common than it is, due to its hidden nature. Rare conditions are stigmatised more than common conditions (Feldman & Crandall, 2007), so the silence that appears to surround problem gambling may increase its public stigmatisation. Carroll et al. (2013) found that some gambling counsellors in their study reported that clients sometimes felt that they had a unique flaw, emphasising the hidden nature of problem gambling. However, the role of concealability and rarity in the formation of public stigma has not previously been investigated in relation to problem gambling. Similarly, the dimensions of aesthetics and disruptiveness have not yet been applied in problem gambling stigma research, although the disruption caused by problem gambling to the lives of gamblers and significant others is well documented (Holdsworth, Nuske, Tiyce, & Hing, 2013). Thus, further research is needed to clarify the role of these dimensions in the formation of problem gambling stigma.

2.3.3 The process of public stigma creation

To understand how public stigma is formed, research needs to illuminate how it is that society comes to assign and stigmatise negative attributes amongst people with gambling problems. Thus, it is necessary to understand the process by which stigma is created. Various cognitive, emotional and behavioural components have been identified as elements in the process of public stigma formation. According to Corrigan (2000), stereotyping (based upon a cognitive knowledge structure), prejudice

(resulting from the combination of cognitive and emotional response to the stereotypes formed), and discrimination (behavioural consequence that follows from prejudice) explain the process of stigma formation. Similarly, Link et al. (2004) have proposed five distinct elements in the process of public stigma creation: labelling, stereotyping, separating, emotional reactions, and status loss and discrimination. Each of these factors is discussed below, and in relation where possible to problem gambling.

Labelling

Moderate levels of gambling are generally viewed as being socially acceptable in many countries. In contrast, excessive gambling is not as well received or tolerated. Individuals engaging in heavy or harmful gambling have been labelled as 'compulsive', 'addicted' and 'pathological' (Campbell, 2003; Campbell & Smith, 2003). It may be that the classification of problem gambling as a mental disorder in the DSM, first as an impulse control disorder (pathological gambling) and more recently as an addiction (gambling disorder), has worsened its public stigma. In agreement with the most recent diagnostic classification, the general public tends to view excessive gambling as an addiction (56%), or as a disease/illness (38%) (Cunningham, Cordingley, Hodgins, & Toneatto, 2011). Thus, the labels which the general population applies to problem gambling are largely consistent with the medicalisation of the condition and its DSM classification.

Nevertheless, regardless of the accuracy of labels, Scheff (1966) argues that labelling an individual's behaviours as 'mental illness' triggers stereotypes and social rejection. Labelling emphasises difference and implies a separation of 'us' from 'them', leading to the understanding that 'they' are fundamentally different from 'us' (Rusch et al., 2005). In many mental health cases, a label applied to someone can eventually be used to define them. For example, it is common to refer to someone as 'a schizophrenic' rather than as someone who 'has schizophrenia' (Link & Phelan, 2001; Rusch et al., 2005). In a similar way, referring to someone as 'a problem gambler' creates a stronger sense of stigma than referring to someone 'with a gambling problem'. In this way, labelling and the language that people use can be powerful sources of stigma. A recent study found that, even though gambling is a normal part of Australian culture, distinctions are made between 'responsible gamblers' and 'problem gamblers', with the latter viewed as possessing negative personality traits such as an addictive personality or a lack of self-control that set them apart from 'responsible gamblers' (Carroll et al., 2013). This same study concluded that the 'gamble responsibly' message contributes to stigma by placing the onus on individuals to control their gambling, despite the inherent risks of using gambling products.

Stereotyping

Stereotypes are efficient ways of categorising and organising information about different social groups, based upon collective opinions about the members of a group (Rusch et al., 2005). They allow individuals to apply beliefs about a particular social group to someone they perceive to be a member of that group (Judd & Park, 1993). Descriptions of the stereotypical attributes which people associate with 'problem gamblers' include them being greedy, unproductive, compulsive, deviant and neglectful of responsibilities (Bloch, 1951; McMillen, 1996; Rosecrance, 1985; Smith & Preston, 1984). More recently, a study found that the most common stereotypes associated with 'problem gamblers' are that they are compulsive, impulsive, desperate, irresponsible, risk-taking, depressed, greedy, irrational, antisocial, and aggressive (Horch & Hodgins, 2013). In this way, it is not just the act of labelling a person as 'a problem gambler' or 'a gambling addict' which is the main cause of stigmatisation, but rather the negative stereotypes which are attached to these labels.

Separating

Once labels have been applied to individuals, and stereotypes formed based on those labels, members of these stigmatised social groups are often categorised as 'them', resulting in social distancing from (the more powerful) 'us'. All studies investigating the public stigma of problem gambling have used a social distancing scale as the primary dependent variable (Dhillon et al., 2011; Feldman & Crandall, 2007; Horch & Hodgins, 2008). As noted earlier, Horch and Hodgins (2008) found that problem gambling prompted desire for greater social distance than did cancer and a non diagnosis control, and similar social distance to alcohol dependency and schizophrenia; while Feldman and Crandall (2007) found that pathological gambling attracted the 13th highest stigmatisation amongst 40 mental health conditions, when measured on social distance. This social distancing can result in loss of social acceptance and social isolation, and ultimately devaluation, status loss and discrimination (Link et al., 2004).

A further negative consequence of labelling is evident when people with gambling problems avoid being classified as 'a problem gambler' by denying their issues and justifying their actions, as found in a sample of French and Finnish gamblers (Majamaki & Poysti, 2012), ostensibly as a way to separate themselves from the stigma attached to the label of 'problem gambler'. Similarly, professional gamblers, including those with gambling problems, have been found to verbally distance themselves from other heavy (but non-professional) gamblers (Istrate, 2011; Radburn & Horsley, 2011). Moderate risk gamblers in a recent Australian study also considered that 'problem gamblers' were other people who had extreme gambling problems (Carroll et al., 2013). In this way, separation not only creates social distance between groups, but can also be a major barrier for individuals to accept and admit that they have a gambling problem. Effects of stigma on problem gambling acknowledgement and help-seeking are discussed later in this chapter.

Emotional reactions

Link et al. (2004) argue that the labelling of human differences, the linking of these differences to negative stereotypes, and social distancing from the stigmatised group or person are likely to be accompanied by emotions such as anger, irritation, anxiety, pity or fear in the stigmatiser. These emotional responses may be conveyed to the target of stigma (intentionally or unintentionally), thus emphasising difference. These emotions also affect subsequent behaviours towards the stigmatised group or individual (such as helping behaviours versus punishing behaviours), and are thought to be shaped by perceptions of the origin of the stigmatised condition. Sympathy and pity are more likely to be extended when the cause of the condition is perceived to be outside of the individual's control; in contrast, irritation and anger are more likely when the condition is perceived to be the person's own fault (Jones et al., 1984; Weiner, 1986; Weiner et al., 1988). Anxiety, apprehension and fear can be expected when the condition is perceived as dangerous (Corrigan & Miller, 2004).

Given that problem gambling is largely perceived as an individual's own fault, with much of the blame being attributed to a person's own failings (Carroll et al., 2013; Horch & Hodgins, 2008), irritation and anger and lack of sympathy and pity may be typical emotional responses, accompanied by punishing behaviours such as blame, rejection and withholding of support. However, these are speculations, given that little research has specifically examined emotional responses to problem gambling, and their role in its public stigmatisation. Horch and Hodgins' (2008) study provides some preliminary insights; the student participants attributed high levels of personal responsibility to the person portrayed in the problem gambling vignette, felt both anger and pity towards him equally, and expressed fear and desire for separation.

Status loss and discrimination

Central to the process of public stigmatisation is the issue of power. Link & Phelan (2001, p. 367) maintain that:

Stigmatization is entirely contingent on access to social, economic and political power that allows the identification of differentness, the construction of stereotypes, the separation of labeled persons into distinct categories and the full execution of disapproval, rejection, exclusion and discrimination.

Thus, the process of public stigmatisation provides the rationale for powerful actors to devalue and discriminate against stigmatised people. According to Rusch et al. (2005), the main consequences of stigma for those experiencing mental health conditions include devaluation and discrimination in interpersonal interactions, structural discrimination whereby they are restricted of opportunities, and avoiding treatment-seeking due to fear of stigma. Additional specific consequences which have been identified include social isolation (Livingston & Boyd, 2010), less likelihood of being hired by an employer (Bordieri & Drehmer, 1986), fewer housing and employment opportunities (Corrigan, 1999), disturbed family relations, and diminished quality of life (Sartorius & Schulze, 2005).

Concerns about devaluation and discrimination appear to be keenly felt by people with gambling problems, who report maintaining secrecy about their problem due to fear of being negatively judged and discriminated against by those around them (Carroll et al., 2013; Hing et al., 2012; Nuske & Hing, 2013). Thus, gaming venue staff have been found to be unwilling to disclose a gambling problem due to fear of job loss or being blamed for any cash shortfalls at work (Hing & Gainsbury, 2013). Disclosure of problem gambling to housing service providers has been reported to jeopardise opportunities for assistance (Antonetti & Horn, 2001). Counsellors in Carroll et al.'s (2013) study reported that the legal system and bankruptcy laws treat people with gambling problems more harshly than people with alcohol disorder or other addictions. However, little is known about discrimination against individuals experiencing problem gambling, including both direct and structural discrimination.

2.4 Perceived stigma

Perceived stigma is the belief that others have passed judgment and hold stigmatising thoughts and ideas about a stigmatising condition (Barney et al., 2006). One study of over 80,000 participants across 16 countries concluded that perceived stigma is frequently and strongly associated with mental disorders worldwide (Alonso et al., 2008). Whether accurate or not, these beliefs have been associated with negative outcomes when held by people with the stigmatising attribute, although causal directions are unclear. Perceived stigma associated with mental illness has been found to be associated with lower self-esteem, lower adherence to treatment, poorer social adjustment, decreased quality of life, higher work and role limitation, and higher social limitation (Alonso et al., 2009; Link, Struening, Neese-Todd, Asmussen, & Phelan, 2001; Perlick et al., 2001; Pyne et al., 2004; Sirey et al., 2001a, 2001b).

However, individuals have been found to differ in the extent to which perceived stigma affects them, with research supporting that not all people experience perceived stigma in the same way. This difference in reactions among publicly stigmatised individuals has been called 'the paradox of self-stigma and mental illness' (Corrigan & Watson, 2002b). While some people react to stigma with anger, other people are indifferent, and some individuals may internalise these negative attributes as self-stigma (discussed later). For example, some people with mental illnesses experience diminished self-esteem as a result of stigma (Link, Cullen, Mirotnik, & Struening, 1992; Link et al., 1989; Wright, Gronfein, & Owens, 2000). However, other studies have found that, despite an awareness of negative

attitudes, stigmatised individuals do not necessarily have lower levels of self-esteem (Hayward & Bright, 1997). Furthermore, some individuals within stigmatised groups actually feel empowered and have higher levels of self-esteem (Hoelter, 1983). As Corrigan and Watson (2002b) explain, if people feel that the negative attitudes towards a group specifically apply to them, they will as a result have diminished self-esteem. However, if they do not identify with the stigmatised group or the associated negative attributes, or think that claims about the group are illegitimate, they will not have a lowered self-esteem but instead feel indifferent or perhaps angry. In this way, reaction to stigma may be dependent upon an individual's perception of the stigmatising message (Rusch et al., 2005). Although research has not yet examined individual differences in how stigma is perceived by those with gambling problems, clinicians should be mindful of how the effects of stigma may vary from person to person.

In relation to gambling, Carroll et al. (2013) found that their problem gambling participants invariably expected others to think badly of them if they disclosed their gambling problem, and that these expectations instilled a sense of fear that discouraged them from seeking help. Participants expressed a fear of being judged by treatment providers, a fear of being labelled as 'a problem gambler', and fear of others finding out that they were attending problem gambling treatment. Similarly, Nuske and Hing (2013), in a narrative analysis of interviews with people in recovery from problem gambling, identified a common fear of being judged by others that delayed problem disclosure to family and friends. Many felt that they would have sought help earlier if societal stigma of problem gambling had been lower. Many interviewees also noted that when they finally sought professional help, the non-judgmental attitude of their counsellor was critical in their recovery. As discussed later, numerous studies have found that problem gambling is typically kept hidden until crisis point, because people expect to be judged negatively. Thus, perceived stigma appears to be very high amongst people with gambling problems. In fact, having a gambling disorder has been described as more shameful than having an alcohol or drug dependence (Carroll et al., 2013). Nonetheless, individual differences may exist in how stigma is perceived and this is a worthy avenue for future research.

2.5 Self stigma

Self-stigma occurs when individuals with a stigmatised condition internalise and apply negative societal conceptions to themselves, resulting in diminished self-esteem, self-efficacy and perceived social worth (Corrigan, 2004; Watson et al., 2007). Self-stigma arises when people with a stigmatising attribute turn societal prejudice against themselves, come to believe the negative stereotypes and apply them internally (Corrigan & Watson, 2002b; Scambler, 1998). This internalisation of stigmatising social attitudes manifests as feelings of shame, embarrassment, guilt, stupidity, weakness and low self-esteem (Carroll et al., 2013). Whether stigma is directly experienced or only perceived, these internalised beliefs diminish self-perceptions of social worth and can result in withdrawal from social support, rejection of help, and negative outcome expectancies (Corrigan et al., 2003; Scambler, 1998).

In one study that illuminated some of the psychological effects of self-stigma, 30 interviewees who self-identified as having a gambling problem rarely used the word 'stigma' in relation to their own feelings; instead, 'shame' was by far the most commonly used term to describe their own emotions (Carroll et al., 2013). Other terms used were embarrassed, weak, stupid, guilty, disappointed, and remorseful. These feelings appear to reflect loss of self-esteem and perceived social worth, as found in research examining the self-stigma of other mental health conditions (Corrigan, 2004; Watson et al., 2007). However, additional research is needed to better understand the psychological effects of self-stigma for people with gambling problems, including whether it compounds already high rates of

comorbid disorders such as depression, anxiety, and substance abuse (Kessler et al., 2008; Petry, Stinson, & Grant, 2005; Thomas & Jackson, 2008).

A further issue for consideration is whether the shame that commonly accompanies a gambling problem is always an internalisation of public stigma as self-stigma, or whether shame instead occurs because an individual's behaviour violates his or her own internal values. Carroll et al. (2013) raise this question and identify conflicting views in the literature about whether the source of shame is primarily external or internal. Research is needed to address this question in relation to problem gambling stigma.

2.6 Impacts of stigma on people who feel stigmatised

2.6.1 Coping mechanisms

Stigma results in behaviour modifications to cope with a 'spoiled identity' (Goffman, 1963, p. 3). A spoiled social identity (as a result of public stigma) can adversely impact on subjective identity (which may become self-stigmatised), posing challenges about what stigmatised people think about themselves and prompting concerns about whether and how much to disclose their situation to others (Goffman, 1963). People's desire to manage their identity by hiding shameful problems or characteristics, in order to protect themselves from being shunned by society and significant others, explains why many individuals keep a gambling problem hidden (Carroll et al., 2013). Secrecy through hiding the attribute or condition from others is a common coping mechanism to deal with stigma (Link et al., 2002). Other coping mechanisms include: withdrawal from social interactions and social support; educating others about the problem as a means of justification; challenging to confront prejudice and discrimination; and cognitive distancing from the stigmatised group (Link et al., 2004). In this way, many of the difficulties which are faced by individuals with mental illnesses are worsened through needing to cope with projections or perceptions of societal stigma.

Hing, Holdsworth et al. (2014) suggest that secrecy and, to a lesser extent, withdrawal and distancing appear the most common ways of coping with the stigma of problem gambling. These coping mechanisms are discussed further below in reviewing how stigma impacts on problem gambling acknowledgement, help-seeking, and treatment. This discussion provides substantial evidence that coping through maintaining secrecy about a gambling problem is very common and delays and deters help-seeking. Evidence of withdrawal is also apparent, with many people expressing a desire to solve their gambling problem alone without seeking social support. Cognitive distancing occurs when people deny a gambling problem and, as discussed earlier, can be accompanied by attempts to justify heavy gambling and by the 'othering' of those with gambling problems (Carroll et al., 2013; Istrate, 2011; Majamaki & Poysti, 2012; Radburn & Horsley, 2011). Problem denial is also discussed further below.

While there is little evidence of challenging behaviours to cope with problem gambling stigma, some initiatives have encouraged people who have experienced problem gambling to assist in educating the public about the problem. While these initiatives have typically been initiated to raise awareness and understanding of problem gambling in the community, assist other people experiencing gambling problems, and/or reduce public stigma associated with problem gambling, they have also been found to have therapeutic benefits for those doing the educating. For example, participants in a Consumer Voice project articulated the healing power of being able to tell their gambling stories, which enabled them to regain self-esteem and their sense of self, to transition from a problem saturated story to a problem free story, and to therefore reconstruct their identity in a positive way (Nuske & Hing, 2013).

2.6.2 Stigma and problem gambling acknowledgement

People may be reluctant to acknowledge a gambling problem for fear of self-identifying as 'a problem gambler', as this is likely to contradict their desired self-concept and erode dignity and self-worth. Self-worth appears to be a basic human need (Becker, 1962), and managing or avoiding a discreditable identity involves creating, presenting and maintaining a personal identity that supports the self-concept (Snow & Anderson, 1987). Thus, assertion of a contrary identity to 'problem gambler', even to the self, is a strategy used to retain self-worth. As such, denial amongst those with a gambling problem appears common (Hing et al., 2012; Suurvali, Cordingley, Hodgins, & Cunningham, 2009).

A further strategy to minimise damaging psychological and social effects is to 'pass' by hiding or withholding information about the stigmatising condition (Goffman, 1963). Fear of being judged and stereotyped according to a stigmatised social category presents a major obstacle to disclosure. Carroll et al.'s study (2013) involved interviews with 21 clients who had sought help for problem gambling. They expressed feelings of deep shame, embarrassment and guilt about their gambling problem, and substantial fear of exposure and of the consequences of that exposure. Hiding the problem, even from themselves, was the most commonly used strategy to cope with stigma. Further, several studies have documented that significant others are often shocked to learn of a loved one's gambling problem, not least because the problem had been concealed for so long (Holdsworth et al., 2013; Patford, 2007, 2008, 2009). These studies have also documented the considerable efforts that people make to hide evidence of a gambling problem.

2.6.3 Stigma and help-seeking for problem gambling

Stigma also presents a barrier to finding out about available help, and to building the confidence to actually seek help (Carroll et al., 2013). Several studies have identified stigma-related concerns as a major barrier to treatment-seeking for problem gambling (Gainsbury, Hing, & Suhonen, 2014; Hodgins & el-Guebaly, 2000; McMillen, Marshall, Murphy, Lorenzen, & Waugh, 2004; Pulford et al., 2009a; Rockloff & Schofield, 2004; Tavares, Martins, Zilberman, & el-Guebaly, 2002). These concerns have been variously expressed as pride, shame and denial (Pulford et al., 2009a), shame/secretcy (Tavares et al., 2002), stigma (Rockloff & Schofield, 2004), shame for themselves and family, and wanting to solve the problem alone (Gainsbury, Hing et al., 2014). Nevertheless, relationships between these constructs and stigma remains unclear. A review of Australasian research concluded that shame and embarrassment, and a false hope in the ability to regain control or win back losses, were the primary obstacles to accessing professional gambling help (Delfabbro, 2012). Similarly, a review of 19 studies in five countries found that gamblers most commonly reported wishing to handle the problem alone, shame/embarrassment/stigma, and unwillingness to admit to the problem as barriers to treatment-seeking (Suurvali et al., 2009).

Stigma also appears to discourage help-seeking from other sources. Cooper (2001, 2004) identified stigma to be such an important barrier that it prevented patients attending Gamblers Anonymous groups. Similarly, Hing, Tolchard, Nuske, Holdsworth, & Tiyce (2014) and Hing and Nuske (2013) have found stigma to be a key barrier preventing many individuals with problem gambling from self-excluding from gambling venues. Hing et al. (2012) also found that shame and embarrassment prevented seeking support and assistance for a gambling problem from significant others. As a result, many individuals with problem gambling try to resolve the issue on their own, to avoid disclosing to anyone (Evans & Delfabbro, 2005; Hing et al., 2012). Such strong reluctance to disclose a gambling

problem means that most individuals initially using self-help measures to try to resolve the problem on their own (Hing et al., 2012).

Help-seeking rates for problem gambling are low and when people do reach out for help, they are typically at crisis point (Cunningham, 2005; Hing et al., 2012; Delfabbro, 2012). A review of research conducted with treatment-seeking gamblers (Suurvali, Hodgins & Cunningham, 2010) found that motivators for help-seeking related mainly to experienced or imminent harmful consequences. Most common were financial and relationship problems, followed by negative emotions including 'hitting rock bottom', work/legal difficulties and physical health concerns. Financial problems are the most common reason for seeking gambling help (Gainsbury, Hing et al., 2014; Ledgerwood et al., 2013; Pulford et al., 2009b). An Australian study found that individuals were unlikely to seek help unless their financial position was so severe that they were unable to pay household bills, were pawning personal possessions, and were experiencing declining psychological and physical health (Evans & Delfabbro, 2005). Over half (51%) of another Australian sample of individuals with problem gambling cited 'hitting rock bottom' as the main reason for seeking help (New Focus, 2005), also reflecting unwillingness to act until problems are acute. A review of Australasian research concluded that the shame and embarrassment associated with seeking help means that treatment-seeking is typically crisis-driven, such as when prompted by a suicide attempt, court charges, arrests, impending financial ruin, or relationship conflicts (Delfabbro, 2012). Thus, it appears that help-seeking is a last resort for most people when the situation is so acute that it overshadows shame and stigma. This may include the shame associated with having a gambling problem, the self-stigma of admitting the problem (even to oneself), fear of public stigma once the problem is disclosed, and the stigma associated with attending treatment. The last of these issues is discussed further below.

2.6.4 Stigma and treatment entry and adherence

Substantial stigma is attached to seeking and attending treatment, and this stigma is the most cited reason for avoiding professional help for mental health problems (Corrigan, 2004). To engage in treatment is to admit to needing help, which may be perceived by self and others as indicating weakness and acknowledging failure; in fact, the accompanying feelings of inferiority and incompetence may be considered worse than enduring the mental health problem itself (Vogel, Wade, & Haake, 2006). Specifically within the addiction literature, even once individuals overcome this barrier and gain access to treatment, they have been found to remain stigmatised while undergoing rehabilitation and even after completing effective treatment (Kreek, 2011). Such reports have come from substance abuse populations such as methamphetamine users (Semple, Grant, & Patterson, 2005), intravenous drug users, and antidepressant users (Luoma et al., 2007).

Corrigan (2004) explains that many people fail to participate, or to participate fully, in mental health treatment to evade the damaging label of mental illness, which lowers self-esteem through self-stigma and undermines social opportunities through the stereotyping, prejudices and discrimination accompanying public stigma. He contends that label-avoidance is the most significant way in which stigma impedes treatment. This is consistent with labelling theory (Scheff, 1966), which proposes that the self-identity and behaviour of people are influenced by the terms used to classify or describe them. Several researchers have criticised the pathologising of problem gambling as deficit or disease (Castellani, 2000; Cosgrove, 2008; Reith, 2007; Reith & Dobbie, 2013; Rosecrance, 1985), which heightens the subsequent stigma of being classified and labelled as having an illness which needs to be treated and cured. However, little research has investigated the role of stigma in adherence to problem gambling treatment.

The World Health Organisation (2012 cited in Anderson, 2014) notes that stigma is also the main reason for early termination of treatment by clients with mental illness and addiction. Relapse may also prompt cessation of a treatment program, given that it is typically accompanied by feelings of failure, humiliation, shame and embarrassment (Petry, 2005). Clients may cease treatment rather than disclose that they have 'failed' their therapy and therapist (Dunn, Delfabbro, & Harvey, 2011). While relapse prevention strategies appear to be common and beneficial inclusions in problem gambling treatment (George & Murali, 2005; Oakes et al., 2012), efforts to destigmatise relapse may not be. Dunn et al. (2011, p. 25) advocate for early, open discussions between practitioners and clients 'about the possibility, but not the definite fatality, of relapse during therapy'. Given that relapse is a common experience amongst recovering problem gamblers (Smith et al., 2013), destigmatising relapse appears important to maximise client retention in treatment programs.

2.6.5 Accommodating stigma during treatment

Reduction of self-stigma is an important component of treatment, given the considerable self-stigma that problem gambling clients are likely to present with. Recovery from addiction is thought to require identity reconstruction and management in order to reinstate an unspoiled old identity or to establish a new non-addict identity (Koski-Jannes, 2002; McIntosh & McKeganey, 2000). In examining how individuals recover from problem gambling, Reith and Dobbie (2012) found that shifting concepts of self-identity and reshaping of self were integral to the process, as also found by Nuske and Hing (2013). Thus, Dunn et al. (2011) advocate for problem gambling therapists to assess and address client embarrassment, shame and fears about stigma during early stages of treatment. Strategies aimed at reducing self-stigma for mental illness have either endeavoured to alter clients' self-stigmatising beliefs or, more commonly, tried to enhance skills for coping with self-stigma through improving self-esteem, empowerment and help-seeking behavior (Mittal, Sullivan, Chekuri, Allee, & Corrigan, 2012). However, little is known about use of self-stigma reduction strategies during treatment for problem gambling.

Additionally, minimal research has investigated how therapists and clients navigate and address stigma during treatment. Anderson's (2014) unpublished PhD thesis is an exception. He interviewed six gambling counsellors and six clients, with particular emphasis on how the latter managed their identity when faced with stigmatising attitudes and behaviours during the treatment itself. Anderson (2014) points out that effective treatment assumes that clients engage in open and frank discussions with therapists, and that therapists convey accepting, non-judgmental, safe and non-stigmatising attitudes. However, he found that some treatment providers conveyed stereotypical views about people with gambling problems, attached labels that clients considered inappropriate, or conveyed negative attitudes and expectations. These attitudes and behaviours reflect a professional stigma which has also been found in services catering to other mental health issues (Angermeyer, Matschinger, & Schomerus, 2013; Griffiths, 2011). Clients in Anderson's study (2014) adopted, challenged, or resisted certain descriptions and classifications of their stigmatised status and, in some cases, limited their disclosure to counsellors or ceased treatment. These findings align with research revealing that stigmatising attitudes of mental health practitioners can influence treatment outcomes (Griffiths, 2011; Flanagan, Miller, & Davidson, 2009; Schulze, 2007; Wahl, 1999; Wahl & Aroesty-Cohen, 2010). They also emphasise the need for practitioners to be sensitive to stigmatised populations in the language and approaches used during treatment.

2.7 Differences in stigma

Both the experiences of stigma, as well as judgments which are passed on stigmatised groups or individuals, may vary according to factors of gender, culture and other socio-demographic characteristics. The potential influence of these socio-demographic factors is discussed below, but there is little direct research evidence to draw definitive conclusions.

2.7.1 Gender

Although women in Australia gamble just as frequently as men (Delfabbro, 2012), women are thought to be more vulnerable to stigmatisation for engaging in gambling because gambling is more commonly accepted as being part of male culture. This prejudice appears to be heightened for problem gambling. Women have been judged as irresponsible, unrespectable, incompetent and selfish for displaying problem gambling behaviours (Casey, 2006; Holdsworth, Hing, & Breen, 2012; Piquette-Tomei, Normal, Dwyer, & McCaslin, 2008). A significant barrier which has deterred women from seeking help for a gambling problem is the potential shame of being viewed as not fulfilling the stereotypical female role of home-maker and nurturer (Brown, Johnson, Jackson, & Wynn, 1999). As a result of such attitudes, women who experience gambling problems have been found to feel intense guilt and shame about their gambling (McMillen et al., 2004; Piquette-Tomei et al., 2008).

Examining problem gambling and gender differences from another perspective, it has been suggested that women are more tolerant and accepting of those with stigmatised conditions (Schnittker, 2000). However, while males have been found to have more stigmatising attitudes towards depression compared to women, no consistent gender differences have been found for beliefs in the dangerousness component of stigma, nor in desired social distance (BeyondBlue, 2015). In relation to problem gambling, Horsch and Hodgins (2008) found no gender differences in desired social distance amongst their sample of university students. At present, it is difficult to draw conclusions about the effect of gender on stigmatising attitudes held by the general public.

2.7.2 Culture

Culture is another basis upon which the nature and intensity of stigmatisation may differ. For example, BeyondBlue (2015) notes that there are major cross-national and cross-ethnic differences in the (public) stigma-related components of perceived dangerousness and desire for social distance in relation to depression. Only one study appears to have directly investigated cultural differences in the public stigmatisation of problem gambling, albeit restricted to a university student sample. Dhillon et al. (2011) compared problem gambling among East Asian and Caucasian groups and found that East Asian participants stigmatised problem gambling more so than did the Caucasian participants. Further, the East Asian participants stigmatised East Asian individuals with gambling problems more so than they stigmatised Caucasian individuals with gambling problems. These findings suggest that culture may play a significant role in the formation of stigma, with some cultures being more judgmental of problem gambling than others. They also highlight that problem gambling by people from particular cultures may be more stigmatised than others.

No research has directly examined how problem gambling stigma is perceived or self-stigmatised by different cultural groups. However, studies of attitudes to help-seeking provide some insights into how people from different cultural groups may experience shame and stigma associated with problem gambling. For example, Tse, Wong, and Kim (2004) found that Asian people feel deep shame and feelings of failure if they lose more money gambling than they can afford, as it may jeopardise their family's financial situation. Chinese people often avoid seeking help outside of the family unit to avoid shame and further conflict, and deal with debt by selling valuables or by borrowing money from family (Scull, Butler, & Mutzleburg, 2003). Among Greek people within Australia, pride, rather than shame, has been identified as a major barrier to admitting to having a gambling problem; however the fear of being recognised and bringing disgrace upon the whole family deters them from seeking help (Scull et al., 2003). Studies examining problem gambling among Indigenous Australians have found that denial of having a gambling problem and reluctance to seek help stem from stigma and feelings of shame (Breen, Hing, & Gordon, 2010; Breen, Hing, Gordon, & Holdsworth, 2013). These findings suggest

that shame and embarrassment are commonly experienced responses to having a gambling problem, across different cultures, and that this deters help-seeking. However, further research is required to enable definitive conclusions about the role of culture in public, perceived and self-stigma.

2.7.3 Other socio-demographic characteristics

Other socio-demographic characteristics have been proposed as contributing to the presence of stigma. Koenig (2009) argued that less stigma is applied to wealthy people who engage in excessive gambling, as they are better able to sustain their losses than someone of a low socio-economic class. Other researchers have noted historical class differences in the stigmatisation of gambling and excessive gambling (Caldwell, 1972; Hing, 2000; McMillen, 1996; O'Hara, 1988). Furthermore, people of a lower socio economic status have reported avoiding using mental health services for fear of family reactions, which may be the result of less education (Sirey et al., 2001a). Research has also found that older people are more judgmental of those with a gambling disorder than younger people (Rockloff & Schofield, 2004), as well as being more judgmental of those with mental health issues in general (Link et al., 2004), including for depression (BeyondBlue, 2015). However, little research evidence exists to determine the influence of socio-demographic characteristics on problem gambling stigma.

2.8 Stigma and significant others of people with gambling problems

Stigma may not only affect people with a gambling problem, but also those around them. Stigma has been found to contribute negatively to the quality of life of those with mental illnesses, as well as reducing the quality of life for their relatives, community and service providers (Sartorius & Schulze, 2005). This has been labelled as 'courtesy stigma', that is, the prejudice extended to people simply because of their association with someone who has a mental illness (Goffman, 1963). A number of studies have revealed that between one-quarter and one-half of family members believe that their relationship with a mentally ill person should be kept secret (Ohaeri & Fido, 2001; Phelan et al., 1998). Just as stigma and discrimination lead mentally ill individuals to deny or hide their disorder, family members are afraid of exposing their relationship for fear of shame (Corrigan, Watson, & Miller, 2006). Furthermore, family stigma may vary according to the individual's role, that is, as parent, spouse, sibling or child (Corrigan & Miller, 2004). Research has found that spouses and parents, particularly mothers, are often blamed for a mental illness within the family (Struening et al., 2001). Siblings and spouses are also often blamed for failure to help a mentally ill person remain on their treatment plan and subsequently for their relapse (Greenberg, Kim, & Greenley, 1997; Weiner 1995). The general finding, however, is that the family member who is most associated with the person with mental illness experiences most courtesy discrimination, as they are seen to have greater responsibility for the person's current condition (Phelan et al., 1998).

Research with family members of people with a gambling problem has also found that they experience deep associated shame. For example, one study of 48 Australian family members who had contacted a gambling helpline about a loved one's gambling problem found that two of the strongest barriers which had delayed their contact were feeling ashamed for themselves or their family, and wanting to solve the problem on their own (Hing, Tiyce, Holdsworth, & Nuske, 2013). Other studies have similarly found that the silence that often surrounds problem gambling extends to significant others, especially partners, with embarrassment, guilt and shame being powerful barriers to help-seeking by significant

others, leaving them isolated and unsupported and with lowered self-esteem and self-efficacy (Bellringer, Pulford, Abbott, DeSouza, & Clarke, 2008; Holdsworth et al., 2013; Krishnan & Orford, 2002; McMillen et al., 2004; Patford, 2007, 2008, 2009; Valentine & Hughes, 2010). These effects may limit the ability of significant others to cope with their loved one's gambling problem, as well as limit the support they can provide. Because people with gambling problems most commonly turn to their spouses, families and friends for help before engaging with people outside of their direct network (Clarke, Abbott, DeSouza, & Bellringer, 2007; Hing et al., 2012), the impact of stigma on significant others may also undermine support and recovery for those with gambling problems. Research is needed to inform stigma reduction efforts for significant others affected by the 'courtesy stigma' associated with problem gambling.

2.9 Chapter summary

Problem gambling appears to attract high levels of public stigma, similar to other mental health disorders and addictive behaviours. Consistent with attribution theory, the main dimension fuelling this public stigma arguably appears to be perceived origin, with problem gambling generally considered to be an individual's own fault and a failure of character. Through a process of labelling, people with gambling problems may come to be defined by their problem, and as a group are assigned a range of negative stereotypes including being irresponsible, impulsive, compulsive and greedy. Differences between 'us' and 'them' can then be accentuated through a process of separating or social distancing, which reflects a loss of social acceptance. Emotional responses then ensue, such as anger, irritation, anxiety, pity or fear, which can provide a rationale for devaluing and discriminatory behavioural responses.

People experiencing problem gambling are likely to perceive this negative public stigma. While individual differences may exist in how this stigma is perceived and the effects that it has, perceived stigma for other mental disorders has been associated with a range of negative outcomes, suggesting that this is also likely to occur for problem gambling. In fact, perceived stigma appears to be very high amongst people with gambling problems, resulting in strong reticence to expose their problem, due to fear of being judged, fear of being rejected, and fear of being labelled 'a problem gambler'.

Some people may also internalise perceived stigma as self-stigma. Self-stigma occurs when people apply the negative societal conceptions to themselves and believe the negative public stereotypes, resulting in diminished self-esteem, self-efficacy and perceived social worth. While people with gambling problems tend to report experiencing deep shame, as well as feeling embarrassed, weak, stupid, guilty, disappointed and remorseful, little research has investigated the psychological effects of self-stigma for people with gambling problems.

Stigma typically results in behaviour modifications to cope with a spoiled identity. The most frequently used coping mechanism for problem gambling stigma appears to be secrecy, although there is also evidence of withdrawal, cognitive distancing and educating behaviours. Problem denial is common because it helps people to retain their dignity and self-worth by avoiding self-identifying as 'a problem gambler'. However, even once self-acknowledgement of a gambling problem occurs, many people keep it hidden, which further deters or delays help-seeking. Numerous studies confirm that shame and stigma are the major barriers to seeking help for problem gambling, until the situation becomes so acute that it overrides these barriers. Thus, those seeking help (whether through professional treatment, self-exclusion or other interventions) are typically at crisis point. Attending treatment can be stigmatising in itself, adding a further barrier to help-seeking, and also to treatment adherence. Relapse appears to potentially add a further layer of shame.

Treatment needs to address both the gambling problem and the self-stigma that many clients bring to therapy, as well as destigmatise relapse to encourage clients to continue treatment. Recovery can require reducing self-stigma through strategies to build self-esteem and empowerment so that a person's previous unspoilt identity can be reinstated or a new unspoilt identity can be established. Treatment providers therefore need to be sensitive to the self-stigmatising beliefs of clients in the language and approaches they use during treatment.

Public stigma, perceived stigma and self-stigma are likely to vary amongst different socio-demographic groups. Women and certain cultural groups are thought to be more likely to attract a greater public stigma for having a gambling problem. The stigma levelled against people with gambling problems may also vary amongst socio-demographic groups. However, there has been inadequate research to draw any firm conclusions about socio-demographic differences in relation to problem gambling stigma.

Stigma may not only affect those with a gambling problem, but also their significant others. This 'courtesy stigma' has been found to impede disclosure and help-seeking by significant others due to the shame, embarrassment and guilt that they can feel. Significant others are therefore often left isolated and unsupported and with lowered self-esteem and self-efficacy, hindering their ability to support their loved one with a gambling problem who often turns to them for help. In this way, the stigma experienced by significant others can also undermine support and recovery for those with gambling problems.

Overall, research into the stigma associated with problem gambling is in its infancy. This process of stigma formation has been examined in relation to problem gambling only in a small number of studies. While these studies have provided useful insights, their small university student samples mean that further research is needed to better understand the public stigmatisation of problem gambling. No peer reviewed studies have directly investigated how problem gambling stigma is perceived or becomes self-stigmatising amongst those experiencing problem gambling, although one study prepared for a government agency has provided valuable insights. Research to date has provided useful preliminary findings; however there is still much to understand about the relationship between problem gambling and stigma. These preliminary findings, along with concepts and theories from the mental health literature, have informed the research design for the current study, as explained in the next chapter of this report.

Chapter Three: Research methods

3.1 Introduction

This chapter explains the research methods for each empirical stage of the study: the Victorian Adult Survey (Stage 2), the Survey of People with Gambling Problems (Stage 3), and qualitative interviews with people who have recently experienced a gambling problem and with gambling counsellors (Stage 4). Approval for all stages of the project was obtained from Southern Cross University Human Research Ethics Committee (ECN: 13-148).

A mixed methods approach was used in this study to both quantitatively measure public stigma and self-stigma, and to qualitatively explore the meanings and understandings of people experiencing stigma. Key methods recommended for doing this are through the use of vignettes, behavioural measures, and in-depth qualitative interviews (Link et al., 2004).

Figure 3.1 shows the research model used to frame this study. The model shows each empirical stage of the methodology, the associated research objectives, key constructs measured and the relationships explored between them. The methodology for each research stage is now explained in more detail.

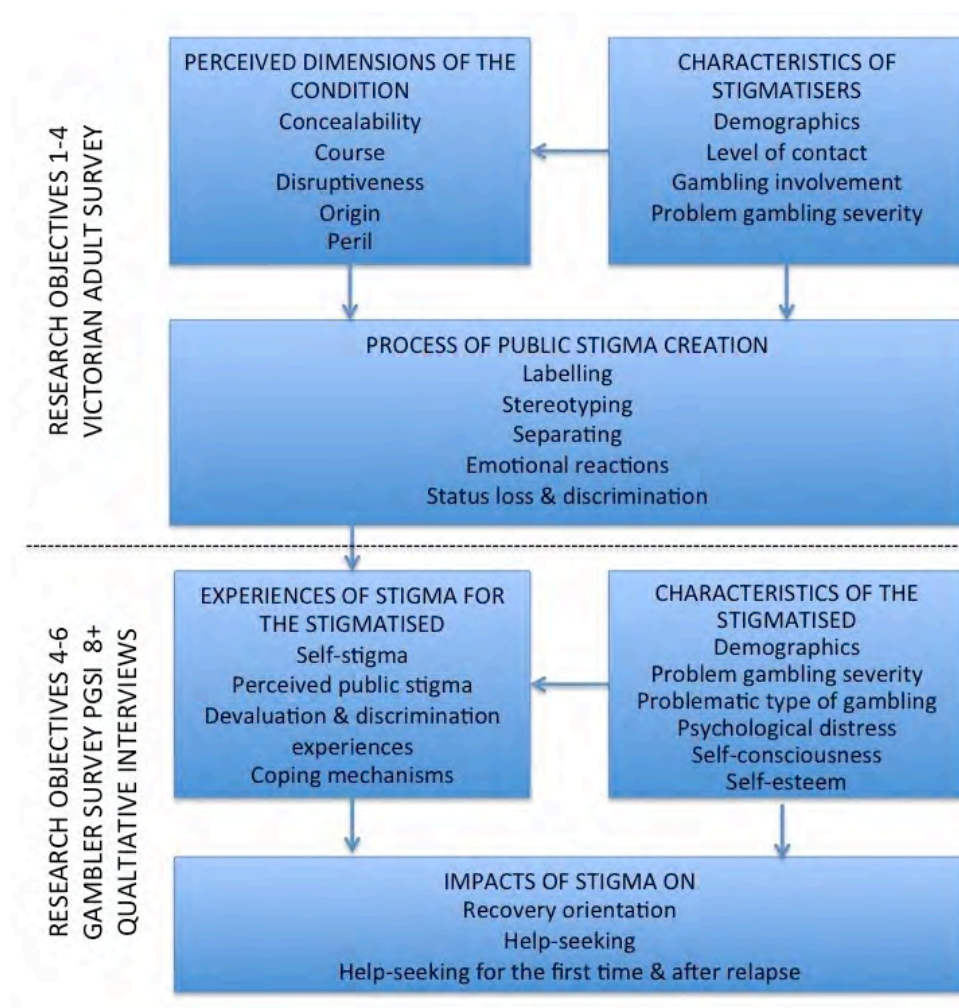


Figure 3.1 – Research model

3.2 Methods for Stage 2

The Victorian Adult Survey was conducted to measure public stigma around problem gambling. It was conducted with N = 2,000 adult residents of Victoria, with weighting according to population norms enabling results to be highly representative of the Victorian adult population.

3.2.1 Recruitment and sampling

A sample of 2,000 Victorian adults was recruited via a series of online panels obtained by a market research company (Qualtrics). Respondents were recruited according to quotas based on the 2011 Census (ABS, 2011). These quotas were: sex, age (in cohorts, see Table 3.1) and location of residence. The location of residence quota was based on postcodes and respondents were split into Greater Melbourne and the Rest of Victoria.

A total of 3,895 respondents started the survey and 3,539 completed the survey. As part of their regular panel recruitment methodology, Qualtrics examined the responses of the 3,539 participants (e.g., using catch questions, or looking for respondents who tick the same response option for all questions) and excluded where necessary to ensure the required total of 2,000 responses were 'good completions'. The responses from these 2,000 respondents are analysed in Chapter 4.

Young, male respondents from Melbourne were slightly difficult to recruit, so the quotas were relaxed towards the end of the survey period to ensure that 2,000 respondents were recruited as per our agreement with Qualtrics. In order to correct for these slight differences between the sample and the population (based on the Census), the responses were weighted.

3.2.2 Weighting

Some cells were slightly under- or over-represented in the final sample and thus the sample was weighted against the 2011 Census based on a crosstabulation of age cohorts (18-29, 30-39, 40-49, 50-59, 60-64 and 65+), gender (male/female), and location of residence (Greater Melbourne/the Rest of Victoria).

The data were crosstabulated from the 2011 Census (eligible Victorians only) and from the sample. Each of the 24 cells (6 age cells x 2 gender cells x 2 location cells) in the sample were compared to the population statistics using the following formula:

$$\text{Cell weight} = \frac{(\text{size of cell in Census})/(\text{number of eligible Victorians in Census})}{(\text{size of cell in online survey sample})/(\text{sample size of online survey sample})}$$

The sample was then weighted using these weights and the demographic crosstabulation was once again compared to the Census. Weights were once again calculated according to the formula above and these were multiplied by the weights from the first iteration to form a more accurate weight. After this second iteration, any further iterations made very little difference and the procedure was deemed to have converged. Table 3.1 indicates the proportion of each cell from the 2011 Census, from the raw sample data before weighting and from the weighted sample.

The largest weight used was 2.20 and the smallest was 0.62, indicating that there were no extreme weights in use and that the effects of this weighting were quite mild. The use of weighting can lead to results where the number of respondents fluctuates slightly due to rounding in the addition of weighted cases. For example, the total N for the weighted sample in the following table is 1,998, but in other analyses is 2,000. This is not considered to be a concern.

Table 3.1 – Demographics from the 2011 Census in Victoria and equivalent demographics from the sample data before and after weighting

Gender	Location	Age	2011 Census		Sample data (unweighted)		Sample data (weighted)	
			N	%	N	%	N	%
Male	Melbourne	18-29	363,711	8.8	220	11.0	175	8.8
Male	Melbourne	30-39	296,463	7.2	137	6.9	143	7.2
Male	Melbourne	40-49	282,012	6.8	142	7.1	136	6.8
Male	Melbourne	50-59	234,910	5.7	79	4.0	114	5.7
Male	Melbourne	60-64	98,524	2.4	47	2.4	47	2.4
Male	Melbourne	65+	235,333	5.7	141	7.1	113	5.7
Male	Rest of Vic	18-29	90,044	2.2	20	1.0	44	2.2
Male	Rest of Vic	30-39	73,802	1.8	19	1.0	35	1.8
Male	Rest of Vic	40-49	89,127	2.2	28	1.4	43	2.2
Male	Rest of Vic	50-59	92,711	2.2	56	2.8	45	2.3
Male	Rest of Vic	60-64	44,483	1.1	23	1.2	22	1.1
Male	Rest of Vic	65+	108,860	2.6	69	3.5	52	2.6
Female	Melbourne	18-29	358,314	8.7	153	7.7	173	8.7
Female	Melbourne	30-39	304,981	7.4	149	7.5	148	7.4
Female	Melbourne	40-49	296,359	7.2	141	7.1	143	7.2
Female	Melbourne	50-59	247,364	6.0	114	5.7	120	6.0
Female	Melbourne	60-64	105,543	2.5	39	2.0	51	2.6
Female	Melbourne	65+	289,151	7.0	95	4.8	139	7.0
Female	Rest of Vic	18-29	88,719	2.1	43	2.2	43	2.2
Female	Rest of Vic	30-39	78,749	1.9	59	3.0	38	1.9
Female	Rest of Vic	40-49	94,865	2.3	57	2.9	46	2.3
Female	Rest of Vic	50-59	95,673	2.3	75	3.8	46	2.3
Female	Rest of Vic	60-64	44,912	1.1	33	1.7	21	1.1
Female	Rest of Vic	65+	127,671	3.1	61	3.1	61	3.1
Total			4,142,281	100.0	2,000	100.0	1,998	100.0

3.2.3 Procedure

The survey was completed online on the Qualtrics engine between 13 and 30 March 2014. An informed consent preamble was included on the first page that emphasised the voluntary, anonymous and confidential nature of the survey. The survey concluded with contact details of the Gambling Helpline and Gambling Help Online.

After completing the demographics questions, participants answered three repeated sets of questions based on Jones et al.'s (1984) dimensions of stigma and Link et al.'s (1999) process of stigma in regards to three vignettes. All participants answered questions about a problem gambling vignette and a sub-clinical control vignette (minor non-specified psychological distress). Participants were also randomly allocated to completing the same questions about a person with alcohol use disorder, a person with schizophrenia, or a person who gambles without apparent problems. Participants then ranked the three protagonists in the vignettes they viewed in terms of who had the most/least value to society. Next, participants answered a set of questions explicitly measuring their stigma-related

attitudes towards problem gambling. Finally, all participants completed questions regarding their exposure to problem gambling, their gambling participation, and their own problem gambling risk status.

3.2.4 Measures

The following measures were used in the Victorian Adult Survey which incorporated use of vignettes. Appendix A contains the survey questionnaire.

Vignettes

The five vignettes used were modelled around those used by Horch and Hodgins (2008) and/or Link et al. (1999), with the exception of the sub-clinical gambling vignette which was created for use in the current study. The sub-clinical gambling vignette was included to control for whether any detected stigma towards problem gambling in the current study was linked to gambling generally, as opposed to problem gambling specifically. Vignettes were modified from their original forms to (a) standardise the time frames of the vignettes (i.e., over the last year), (b) reduce cues that other people have already made value judgments of the protagonists, (c) keep ethnicity and education level constant by having the first line simply read 'X is a man who lives in your community' and (d) be more inclusive of DSM-5 criteria for each condition. The sub-clinical control vignette was also made less negative than that used by Horch and Hodgins (2008) to reduce Type II error caused by reduced ability to detect differences in the stigmatisation of people with gambling problems versus people with 'normal' sub-clinical worries and problems (referred to in Chapter 4 as sub-clinical distress). Note that the name Peter was used for the rotating vignette – that is, no respondent saw two vignettes where the protagonist was named Peter.

The final vignettes displayed for participants were as follows:

1. Problem gambling (adapted from Horch & Hodgins, 2008)

Dan is a man who lives in your community. During the last twelve months, he has started to gamble more than his usual amount of money. He has even noticed that he needs to gamble much more than he used to in order to get the same feeling of excitement. Several times, he has tried to cut down, or stop gambling, but he can't. Each time he has tried to cut down, he became agitated and couldn't sleep, so he gambled again. He is often preoccupied by thoughts of gambling and gambles more to try to recover his losses. Dan has also lied to his family and friends about the extent of his gambling.

2. Alcohol use disorder (adapted from Link et al., 1999)

Peter is a man who lives in your community. During the last year Peter has started to drink more than his usual amount of alcohol. In fact, he has noticed that he needs to drink twice as much as he used to in order to get the same effect. Several times, he has tried to cut down, or stop drinking, but he can't. Each time he has tried to cut down, he became very agitated, sweaty and he couldn't sleep, so he took another drink.

3. Schizophrenia (adapted from Link et al., 1999)

Peter is a man who lives in your community. Up until a year ago, life was pretty okay for Peter. But then, things started to change. He thought that people around him were making disapproving comments and talking behind his back. Peter was convinced that people were spying on him and that

they could hear what he was thinking. Peter lost his drive to participate in his usual work and family activities and retreated to his home, eventually spending most of his day in his room. Peter was hearing voices even though no one else was around. These voices told him what to do and what to think. He has been living this way for six months.

4. Sub-clinical gambling control (developed for this study)

Peter is a man who lives in your community. During the last year, Peter has started to gamble occasionally. He usually bets the same amount of money and never bets more than he intends. He stops gambling when he is losing and doesn't lose very much money. He often goes long periods without gambling and does other leisure activities instead. He doesn't find he misses gambling and he doesn't think about gambling while he is away from it. Peter's family and friends know that he sometimes gambles.

5. Sub-clinical distress control (adapted from Horch & Hodgins, 2008)

John is a man who lives in your community. During the last year, life has been pretty okay for John. Most of the time he is pretty content, although he sometimes feels worried, a little sad, or has trouble sleeping at night. When things go wrong, he can usually handle the situation pretty well, although sometimes things bother him more than they should and he gets a bit down or annoyed. Nevertheless, most of the time he manages to keep his emotions under control and he is getting along pretty well.

Vignette questions

1. The nature of the condition

To measure the perceived nature of problem gambling, and enable comparisons with the other vignette conditions, the following dimensions were measured for the condition in each vignette.

Concealability

Because an existing measure of perceived concealability of a condition from the stigmatiser's point of view could not be located, concealability was measured with a single question measured on a 5-point Likert scale: 'How noticeable would X's situation be to his family and friends if he hadn't told them about it?'. Response options were: 'Not at all noticeable' (0), 'Somewhat noticeable' (1), 'Moderately noticeable' (2), 'Very noticeable' (3) and 'Extremely noticeable' (4).

Course

Because an existing measure of perceived course of a condition from the stigmatiser's point of view could not be located, we measured course with a single question measured on a 5-point Likert scale: 'How strongly do you agree or disagree that people can recover from X's situation?'. Response options were 'Strongly disagree' (0), 'Disagree' (1), 'Neither agree nor disagree' (2), 'Agree' (3) and 'Strongly agree' (4)

Disruptiveness

A short measure of disruptiveness was created based on three questions from the *Key Informants Questionnaire* (KIQ). The KIQ was developed by a World Health Organisation (WHO) taskforce, originally used in a WHO Collaborative Study (Wig et al., 1980) and validated in subsequent studies (e.g., Alem, Jacobsson, Araya, Kebede, & Kullgren, 1999; Khandelwal & Workner, 1986; Whyte, 1991). Participants rated on a 5-point Likert scale how seriously they believed the situation of the

protagonist would affect his ability to (a) live independently, (b) be in a serious relationship and (c) work or study.³ Response options were 'Not at all' (0), 'A small amount' (1), 'A moderate amount' (2), 'A large amount' (3) and 'An extreme amount' (4).

Peril

We included Horch and Hodgins' (2008) *Perceived Dangerousness Item* that asked 'How likely is it that X would do something violent to other people?'. We also included another question: 'How likely is it that X would do something violent to himself?'. For both questions, responses were rated on a 5-point Likert scale. Response options were 'Extremely unlikely' (0), 'Unlikely' (1), 'Neither likely nor unlikely' (2), 'Likely' (3) and 'Extremely likely' (4).

Origin

Perceived origin of the condition was measured with the *Perceived Causes Scale* (Link et al., 1999) which measures six commonly perceived causes of mental illness. Extensive research indicates that differences in belief in these perceived causes are predictive of stigmatising attitudes towards mental illness (Reavley & Jorm, 2014; Rusch, Todd, Bodenhausen, & Corrigan, 2010). Participants rated the likelihood that the protagonist's condition was due to each possible cause on a 5-point Likert scale. Response options were 'Extremely unlikely' (0), 'Unlikely' (1), 'Neither unlikely nor likely' (2), 'Likely' (3) and 'Extremely likely' (4). For example, 'How likely do you think it is that X's situation is caused by his bad character?'.

2. The process of public stigma creation

To measure elements in the process of stigma creation in relation to problem gambling and the other vignette conditions, the following measures were used.

Labelling

Participants were asked whether they thought the protagonist qualified to fit a certain label. For example, 'Do you think X has a mental illness?' The response options were 'Yes', 'Unsure', or 'No'. Six relevant labels were selected that could apply to all conditions so as to not alert the participant that we were examining gambling specifically. If a participant indicated that they believed the protagonist had 'a diagnosable condition', an open ended question was included to gain qualitative information about what condition the participant believed the protagonist had. Respondents were told that their opinion of whether or not the person in the vignette had a diagnosable condition did not depend on whether they had any clinical training.

Stereotyping

Ten relevant stereotypes were measured based on a literature review into common stereotypes associated with problem gambling (Hing, Holdsworth et al., 2014, Horch & Hodgins, 2013). Stereotyping was measured on a 7-point semantic differential scale whereby participants selected

³ Two questions from the original KIQ were excluded as they were deemed too general and, thus, obsolete: 'In your opinion, how serious is X's situation?' and 'Do you think X's situation will improve or get worse?' Two of the remaining questions were modified. 'How seriously do you think X's situation will affect his ability to live at home?' was changed to 'How seriously do you think X's situation will affect his ability to live independently?'. 'How seriously do you think X's situation will affect his ability to become or stay married?' was changed to 'How seriously do you think X's situation will affect his ability to be in a serious relationship?'. These questions were changed because (a) 'living at home' could refer to living with his parents or living independently (as opposed to in a hospital or in-patient care) and in the case of (b) in contemporary Australia, many people are in de facto relationships so this question was reworded to be more inclusive.

where they felt the protagonist in each vignette sat between two antonyms e.g. 'Rational' – 'Irrational'. Response options were coded from 0 to 7 with higher scores indicating greater endorsement of the negative stereotype.

Separating

As used by Horch and Hodgins (2008), we measured separating with the *Social Distance Scale* (Martin et al., 2000) which is comprised of six items measured on a 5-point Likert scale. Response options were 'Definitely unwilling' (0), 'Unwilling' (1), 'Neither willing nor unwilling' (2), 'Willing' (3) and 'Definitely willing' (4). Past studies have determined reliability for these items to be excellent ($\alpha = .87$) (Horch & Hodgins, 2008).⁴

Emotional reactions

Following from Angermeyer and Matschinger (1996), the survey measured three emotional reactions to the protagonist described in each vignette: fear, anger and pity. Research validates that these are the most relevant three emotions when measuring emotional reactions of the public towards people with mental illness (von dem Knesebeck, Angermeyer, Lüdecke, & Kofahl, 2013; Angermeyer, Holzinger, & Matschinger, 2010). Participants were asked how much they agreed with nine statements (three statements for each emotional grouping) about what their emotional reactions to the protagonist would be if they met him in real life. For example, 'X would scare me'. Agreement with the question was rated 5-point Likert scale. Response options were 'Strongly disagree' (0), 'Disagree' (1), 'Neither agree nor disagree' (2), 'Agree' (3) and 'Strongly agree' (4).

Status Loss and Discrimination

Status loss and discrimination was measured with an adapted form of the *Perceived Devaluation-Discrimination Scale* (Link, 1987) which is based on modified labelling theory and assesses respondents' perceptions of what most other people believe. Asking respondents what 'most people' think is intended to reduce social desirability bias, tacitly giving them permission to express highly stigmatising attitudes (Link & Cullen, 1983). The scale has been demonstrated to have good internal consistency ($\alpha = >.70$ across different samples) (Link, 1987) and construct validity (Link et al., 2004). Participants indicated their strength of agreement to 12 statements on a 5-point Likert scale. Response options were 'Strongly Disagree' (0), 'Disagree' (1), 'Neither agree nor disagree' (2), 'Agree' (3) and 'Strongly Agree' (4).⁵

3. Global questions

Two global questions were asked to gather more direct assessments of public stigma associated with problem gambling.

Global stigma question

Participants were asked to rank the protagonists of the three vignettes they viewed in order from the 'most valuable to society' to the 'least valuable to society'. This question was included so as to force

⁴ Two wording changes were made for use in the current study. How willing would you be to... 'Live next door' was changed to 'Move next door' in recognition that one does not always have control over who lives next door and, thus, cannot be 'willing'. 'Start working closely at work or study' was changed to 'Start working closely with X on a project' so as to include collaborating in contexts outside of work and study.

⁵ This measure was developed with regard to patients with mental disorders and, thus, had to be modified for use in the current study. For example, 'Most employers would hire a mental patient if he was qualified for the job' became 'Most employers would hire X if he was qualified for the job.'

participants to directly (as opposed to indirectly through comparing vignette scores) rank the protagonists in terms of perceived value to society.

Direct questions

Participants also answered 13 questions measured on a 5-point Likert scale that were included to directly assess attitudes towards problem gambling. Each question provided a more direct measure of each of the constructs already measured in the vignettes section. For example, 'I would look down on a problem gambler' represented status loss and discrimination.

Individual differences variables

Several individual difference variables were measured to enable comparisons between different groups in the Victorian community.

1. Demographics

Participants reported age, gender, language spoken at home, how many years they had lived in Australia, household income, highest educational level, location/postcode, religion/religiosity and political affiliation/orientation. Most demographic questions were based on Census questions and previous studies of gambling (e.g., Hing, Gainsbury et al., 2014). Religion and religiosity were measured by asking participants what religion they identified as belonging to and how important they considered religion/spirituality to be to them on a 7-point semantic differential scale from 'Not at all important' (0) to 'Extremely important' (6). Political affiliation was measured by (a) asking participants what political party they mostly aligned themselves with and (b) where they would place themselves on a 7-point scale of political orientation. Response options were 'Very progressive' (-3), 'Progressive' (-2), 'Slightly progressive' (-1) 'Neutral', (0) 'Slightly conservative' (1), 'Conservative' (2) and 'Very conservative' (3).

2. Exposure to problem gambling

Exposure to problem gambling was measured by a modified 'problem gambling' version of the *Level of Contact Report* (Holmes, Corrigan, Williams, Canar, & Kubiak, 1999). Participants answered 'Yes' or 'No' to 12 questions that represented differing levels of contact with problem gambling, e.g., 'I have had a job that includes providing treatment to people with a gambling problem'. Situations were rank ordered with higher values indicating greater contact; the measure is scored by taking the highest rank score endorsed (Horch & Hodgins, 2008).⁶

3. Gambling involvement

Gambling involvement was measured with a modified version of the *Involvement in Gambling Checklist* (Horch & Hodgins, 2008). Participants were asked the frequency that they engaged in eight different forms of gambling in the last 12 months on a 5-point frequency scale. Response options were

⁶ Further modifications were (a) the tense of the questions was changed to include previous contact i.e., 'I have had X contact' as opposed to 'I have X contact', (b) 'persons' was replaced with 'people' and (c) the question 'I have had a job that includes providing treatment/services to people with a gambling problem' was modified to be 'I have had a job that includes providing treatment to people with a gambling problem' because of its overlap with the question 'I have had a job that includes providing services to people with a gambling problem'.

'Never' (0), 'Monthly or less' (1), '2-4 times a month' (2), '2-4 times a week' (3) and '5 or more times a week' (4).⁷

4. Problem gambling status

Problem gambling status was measured by the Problem Gambling Severity Index (PGSI; Ferris & Wynne, 2001). The PGSI is a widely used and validated measure of problem gambling status. The PGSI was developed specifically for use in estimating the prevalence of problem gambling at the population level and is the preferred measure for prevalence studies in Australia and possibly world-wide, due to the scale's excellent reliability, dimensionality, external/criterion validation, item variability, practicality, applicability and comparability (Holtgraves, 2009; McMillen & Wenzel, 2006; Orford, Wardle, Griffiths, Sproston, & Erens, 2010). The PGSI consists of nine questions with response categories scored as 'Never' = 0, 'Sometimes' = 1, 'Most of the time' = 2 and 'Almost always' = 3. These are summed for a score between 0 and 27, where 0 = non-problem gambler; 1 or 2 = low risk gambler; 3 to 7 = moderate risk gambler; and 8 or more = problem gambler.

3.2.5 Design and randomisation

All respondents saw three vignettes from the pool of five vignettes. All respondents saw the problem gambling vignette as well as the sub-clinical distress vignette. The third vignette was randomly allocated from: alcohol use disorder ($n = 672$), schizophrenia ($n = 633$) and sub-clinical gambling ($n = 695$).⁸

A second level of randomisation was that, once the respondents were allocated to see a particular third vignette, the order in which they saw the vignettes was randomised. Finally, the order of the questions for each scale was also randomised.

3.2.6 Scale reliability and analysis

All scales were checked for reliability. The lowest Cronbach's alpha was 0.65 for the pity subscale for the schizophrenia vignette, due to the 'I would feel the need to help him' item. The same item reduced reliability for the pity subscale in the alcohol vignette (Cronbach's alpha = 0.73) and problem gambling vignette (Cronbach's alpha = 0.75), but these alphas were considered to be acceptable. Removing that item increased Cronbach's alpha slightly, but meant that the vignettes could not be compared unless this was done for all vignettes. Since the reliability was not unacceptably low, the item was retained. All other scales displayed acceptable levels of reliability for each vignette. While Cronbach's alpha is sensitive to the number of items in the scale, we believe its use here is justified.

⁷ Several categories in the original scale were condensed e.g. 'sport betting with a bookie' and 'sports pools (workplace, friends, others)' were condensed into 'sporting events'.

⁸ In any procedure such as this, it is possible that random allocation to a condition may result in carryover effects. Thus, those allocated to different conditions were compared based on their ratings for the common vignettes. Some differences were found between respondents who saw different third vignettes. For example, those who saw the sub-clinical gambling vignette rated the problem gambling condition as slightly more noticeable ($M = 2.33$) compared to those who saw the schizophrenia vignette ($M = 2.12$) and the alcohol vignette ($M = 2.10$). However, where differences were present, it was not always the same set of respondents that was different to the others, so the randomisation did not appear to have a systematic effect. Furthermore, the effect sizes for these differences were small ($\eta^2 = 0.01$), so these differences were considered to only be significant due to the large sample size and were most likely not meaningful. Thus, the randomisation between the third vignettes was considered to be successful.

Exploratory factor analyses were conducted on the emotional reactions scale to determine whether the pity, anger and fear subscales were separate factors in these data. For all scales, the pity questions were identified as a unique factor. For all but the schizophrenia scale, the fear and anger subscales did not separate into different factors. However, they did for the schizophrenia scale. In order to facilitate comparisons between scales, the three factors (pity, anger and fear) were computed as the mean of the relevant three items in the scale.

Scales were coded differently in the survey engine, so that some were coded as -2 to +2, and some as 0 to 4. For consistency, all scales were (re)coded so that their response options were coded from 0 to 4 (or to 6 in the case of the stereotyping scale). The anchors for these scales differed and are included in notes under the relevant tables in Chapter 4 with the mean and SD for each vignette. Medians were also analysed but the results were very similar to those of the means and are thus not reported. Table 3.2 summarises the scales used.

Table 3.2 – Summary of scales and what their scores mean

Scale	Higher score means that the respondent believes that...
Concealability	The situation in the vignette is more noticeable (less concealable).
Course	People can recover from the situation in the vignette.
Disruptiveness	The situation in the vignette is more disruptive.
Origins	The situation in the vignette is likely to be due to each of the six origins surveyed.
Peril to others	The person in the vignette is likely to harm others.
Peril to self	The person in the vignette is likely to harm themselves.
Emotions – pity	They would want to help (or feel sorry for) the person in the vignette.
Emotions – anger	They would feel anger towards the person in the vignette.
Emotions – fear	They would be fearful of the person in the vignette.
Stereotyping	They have more negative views (e.g., deviant, untrustworthy, foolish) of the person in the vignette.
Separating	They would be willing to socialise with (retain less social distance from) the person in the vignette.
Status loss and discrimination	The person in the vignette would lose social status or be discriminated against because of their situation.

Note: All scales range from 0-4, except for stereotyping which ranges from 0-6.

3.2.7 Statistical comparisons between vignettes

Due to the randomisation of the third vignette, repeated measures statistical comparisons between problem gambling and, for example, schizophrenia were based on different respondents, compared to the comparison between problem gambling and, for example, alcohol use disorder. The statistics presented in the tables for problem gambling and sub-clinical distress were based on the whole sample, but the comparisons between problem gambling and, for example, schizophrenia were based on the problem gambling statistics for those who answered the schizophrenia questions. Thus, if a keen reader were to attempt to confirm the statistical analyses reported here by hand based on the statistics presented in the table, they may reach a slightly different result. However, given that any differences between the results for the common vignettes were minimal for the groups of participants who saw the different third vignettes (see above), we believe that this made no discernable difference to any of the results.

Comparisons between the vignettes on each of the questions and scales were based on repeated measures parametric analyses. Planned comparisons between the problem gambling vignette and all

other vignettes were conducted after omnibus tests using contrasts. As these contrasts were independent of each other, type I error correction was deemed to be unnecessary.

Analyses of scores based on single Likert scales are often conducted using non-parametric statistical tests. These tests were conducted and were found to mirror results from the parametric tests. We chose to report the parametric tests because the means are more informative than medians and so that there was consistency in the tests used for single-item Likert scales and scales based on multiple items.

Effect sizes are reported throughout, with the exception of correlations, as correlation coefficients also serve as effect sizes.

3.3 Methods for Stage 3

The Survey of People with Gambling Problems was conducted to collect data on the experiences of and responses to public stigma amongst those with the stigmatising condition – that is, people with gambling problems. The research team was acutely aware that this survey could be considered confronting and distressing for some respondents. We therefore worked closely with the Chair of Southern Cross University's Human Research Ethics Committee, as well as the Victorian Responsible Gambling Foundation, to ensure that the survey instrument minimised risk for participants. This was done by a) pilot testing the survey with a small number of former and current problem gamblers to ensure that the survey instrument minimised risk, b) advising in the informed consent preamble that some questions were confronting and challenging, and that the survey was voluntary, anonymous and confidential, and c) providing the following text in large font on the bottom of each page of the survey:

Remember, you may stop your participation at any time during the survey if you find it too uncomfortable or distressing. If you need crisis support, call Lifeline now on 13 11 14. If gambling is a problem for you, you can contact the Gambling Helpline: 1800 858 858 or the Gambling Help Online: <http://www.gamblinghelponline.org.au/>

3.3.1 Recruitment and sampling

The original plan was to survey a sample of Victorian residents scoring PGSI 3+. However, this criterion was changed to PGSI 8+ when designing the survey instrument, because it became evident that meaningful questions and responses could only be gained from respondents who had self-acknowledged a gambling problem. That is, it was considered inappropriate and potentially insulting to ask people about stigma they had experienced in relation to their gambling problem if they had not self-acknowledged this. Thus, with the permission of the Victorian Responsible Gambling Foundation, we sampled only people scoring PGSI 8+ and extended the sampling frame to residents in Australia to ensure we could gain the targeted number of responses. The recruitment email was also clear that we were recruiting people 'who have experienced a gambling problem'.

Thus, the eligibility criteria for completing the Stage 3 survey were having met PGSI criteria for problem gambling (PGSI 8+) within the previous three years, living in Australia and aged over 18 years. Recruitment emails were sent to 395 eligible people on a database developed by the CGER of previous survey respondents who had consented to receive invitations to participate in future research. Thirty-six emails bounced back, and 117 completed responses were received for a response rate of 32.6% from this population. Google advertisements were used from 5 June to 28 July 2014 and

gained an additional 86 responses. A total of 203 completed responses were received. Respondents received a \$20 shopping voucher for completing the survey.

3.3.2 Respondents

A total of 351 respondents started the survey, with 203 completing all questions (completion rate = 57.8%), exceeding the original target of 100-200 respondents. Median completion time was 27.5 minutes.

3.3.3 Measures

The following measures were used in the Survey of People with Gambling Problems. Appendix B contains the survey questionnaire.

1. Demographics

Participants reported age, gender, language spoken at home, how many years they had lived in Australia, annual household income, highest educational level, postcode, religion, religiosity and political affiliation. These items were measured in the same way as for the Stage 2 survey.

2. Self-stigma

Themes from Carroll et al. (2013) were analysed to create 19 questions measuring participants' negative emotional reactions to their gambling. Participants rated how strongly they agreed or disagreed that their gambling has made them feel, for example, 'Ashamed'. Response options were 'Strongly disagree' (-2), 'Disagree' (-1), 'Neither agree nor disagree' (0), 'Agree' (1) and 'Strongly agree' (2). Thus, higher scores on this scale indicate higher levels of negative emotions. Cronbach's alpha for the *Self-Stigma Scale* in this sample was 0.95.

3. Perceived public stigma associated with problem gambling

Perceived relative public stigma of problem gambling

To examine participants' perceptions of how much problem gambling is publicly stigmatised relative to other conditions, relative stigma was measured by asking participants how much stigma they think *most people* attach to a variety of commonly stigmatised conditions. The conditions were problem gambling, schizophrenia, depression, alcoholism, bankruptcy, cancer, obesity, and drug addiction. Recreational gambling was also included as a control variable. Response options were 'None' (0), 'A small amount' (1), 'A moderate amount' (2), 'A large amount' (3) and 'An extreme amount' (4).

Perceived characteristics the public associates with problem gamblers

Two sets of questions were used. The first set of questions, the *Perceived Stereotyping Scale* included same list of 11 stereotypes as included in Stage 2 with the addition of five extra stereotypes derived from Carroll et al. (2013). Participants indicated how much they thought that *most people* believed each listed characteristic applied to problem gamblers on a 7-point semantic differential scale. Response options were coded from 1 to 7 with higher scores indicating greater endorsement of the negative stereotype. Cronbach's alpha for this scale in this sample was 0.89.

The second question contained an additional 13 items based on themes identified in Carroll et al. (2013). Participants rated how strongly they agreed or disagreed that *most people* think XXXX about problem gamblers, e.g., that gamblers have no concern for their families. Response options were

'Strongly disagree' (-2), 'Disagree' (-1), 'Neither agree nor disagree' (0), 'Agree' (1) and 'Strongly agree' (2). Cronbach's alpha for the *Perceived Characteristics of Problem Gamblers Scale* in this sample was 0.82.

Perceived public attitudes about the dimensions and process of stigma creation

Participants answered the Direct Questions from Stage 2, which were single-item measures of the dimensions of stigma (concealability, course, disruptiveness, origin, peril), and the process of stigma creation (labelling, stereotyping, separating, emotional reactions, and status loss and discrimination), in relation to problem gambling. These questions were modified to ask 'How strongly do you think MOST PEOPLE would do the following?', e.g., 'Think that being a problem gambler disrupts the person's life.' Response options were 'Strongly disagree' (-2), 'Disagree' (-1), 'Neither agree nor disagree' (0), 'Agree' (1) and 'Strongly agree' (2).

4. Experiences of devaluation and discrimination because of problem gambling

Devaluation

Devaluation was measured by nine items adapted from Kessler, Mickelson, & Williams (1999) measuring general devaluation experiences due to their gambling. Respondents were asked: 'How often have you experienced each of the following because someone *thought* you had a gambling problem?', e.g., 'Treated as if you are inferior'. Responses options were 'Never' (0), 'Rarely' (1), 'Sometimes' (2) and 'Often' (3). Thus, higher scores indicate higher levels of experienced devaluation. Cronbach's alpha for the *Devaluation Scale* in this sample was 0.93.

Discrimination

Discrimination was measured by 13 items adapted from Kessler et al. (1999). Respondents were asked: 'Have you ever been discriminated against in the following ways because people thought you had a gambling problem?', e.g., 'Fired from a job'. Response options were 'Yes' (1) and 'No' (0). Higher scores on this scale thus indicate higher levels of discrimination. Cronbach's alpha for the *Discrimination Scale* in this sample was 0.79.

If participants selected 'Yes' to any of the items, they were also asked 'Did the person explicitly stated that their actions or decision was due to your gambling?'. Response options were 'Yes, in all cases' (2), 'Yes, in some cases' (1) and 'No, not in any cases' (0).

5. Coping with perceived stigma about problem gambling

Coping orientation

Six different coping approaches (secrecy, withdrawal, educating, challenging, distancing, substance use), loosely based on Link et al.'s *Measures of Coping Orientation* (2002), were measured. Two questions were asked to measure each coping approach. Participants were asked how strongly they agreed or disagreed with statements such as 'You have hidden evidence of your gambling from others'. Response options were 'Strongly disagree' (-2), 'Disagree' (-1), 'Neither agree nor disagree' (0), 'Agree' (1) and 'Strongly agree' (2).

The following coping approach subscales displayed acceptable reliability and were thus retained: secrecy (Spearman-Brown = 0.769), educating (Spearman-Brown = 0.654), and distancing (Spearman-Brown = 0.682). The substance use subscale displayed poor reliability and thus alcohol use, illicit drug use and cigarette use were analysed separately. Reliability for withdrawal (Spearman-Brown = 0.434) and challenging (Spearman-Brown = 0.327) were low and thus one item was chosen

from each subscale for use in additional analyses. These were 'You avoid people who have negative opinions about problem gamblers' for withdrawal and 'When someone stigmatises or discriminates against problem gamblers you let them know you disagree with them' for challenging.

Fear of disclosure of own gambling

Themes from Carroll et al. (2013) were analysed to create 13 questions measuring participants' fear of disclosing a gambling problem. Participants rated how afraid they were of, e.g., their friends finding out. Response options were 'Not at all afraid' (0), 'A little bit afraid' (1), 'Somewhat afraid' (2), 'Very afraid' (3) and 'Extremely afraid' (4). Thus, higher scores on this scale indicate higher fear of disclosure. Cronbach's alpha for the *Fear of Disclosure Scale* in this sample was 0.92.

Actual disclosure of own gambling

Participants answered 13 questions regarding whether different people/groups were aware of how much they have gambled. Response options on a 4-point scale were 'They don't know I gamble' (0), 'They think I gamble less than I actually do' (1), 'They know I gamble as much as I actually do' (2), 'They think I gamble more than I actually do' (3). Participants could select 'Not applicable' if the target person/group was not applicable to them (e.g., 'children' if they did not have children).

6. Impacts of stigma on help-seeking

Impacts on seeking professional help

Self-stigma of seeking professional help was measured with four questions taken from Vogel et al.'s (2006) measure of self-stigma. The four items chosen were those that had the highest factor loadings on their confirmatory factor analysis. Participants were asked whether going to a therapist for psychological help with a gambling problem would make them feel (a) Unintelligent (b) Inadequate, (c) More self-confident and (d) More empowered. Response options were 'Strongly disagree' (-2), 'Disagree' (-1), 'Neither agree nor disagree' (0), 'Agree' (1) and 'Strongly agree' (2). The latter two questions were reverse-coded, with higher scores thus indicating higher levels of self-stigma. Cronbach's alpha for the *Self-Stigma of Seeking Professional Help Scale* was 0.78.

Impacts on seeking self-exclusion

Self-stigma of seeking self-exclusion was measured with the same questions as self-stigma of seeking professional help except participants were asked how self-excluding from a gambling venue would make them feel. Scoring was as for self-stigma of seeking professional help and Cronbach's alpha for the *Self-Stigma of Seeking Self-Exclusion Scale* was 0.85.

Impacts on seeking non-professional help

Self-stigma of seeking non-professional help was measured with the same four questions except participants were asked how seeking help from their family and/or friends for a gambling problem would make them feel. Scoring was as for self-stigma of seeking professional help and Cronbach's alpha for the *Self-Stigma of Seeking Non-Professional Help Scale* was 0.83.

7. Impacts of stigma on help-seeking before and after any relapse

Whether ever regained control over gambling

Participants were asked if they had ever felt they had successfully overcome a gambling problem or regained control over their gambling. Response options were 'Yes' (1) and 'No' (0). Respondents selecting 'No' skipped to the questions on 'help-seeking without recovery and relapse' (below).

Whether ever relapsed

Participants who reported they had overcome, or regained control over, gambling were asked if they had ever relapsed back into having a gambling problem. Response options were 'Yes' (1) and 'No' (0). Respondents selecting 'No' skipped to the questions on 'help-seeking without recovery and relapse' (below).

Help-seeking before and/or after relapse

Participants who reported relapse were asked whether they sought help before or after relapse from a list of 11 different sources of help. Response options were 'Never' (0), 'Before Relapsing' (1) and 'After relapsing' (2), with multiple responses allowed for the last two options.

Thus, there were three possible groups of respondents: those who had not overcome their gambling problem, those who had overcome their gambling problem and had not relapsed, and those who had overcome their gambling problem and had relapsed. Respondents in the former two groups were considered to not be relapsed gamblers and respondents in the latter group were considered to be relapsed gamblers. In total there were 113 (56.8%) individuals who had not relapsed and 86 (43.2%) individuals who had relapsed in the sample.

Whether help-seeking was more or less embarrassing after relapse

Participants who reported using at least one form of help both before and after relapse were asked whether they found it more or less embarrassing to seek help after relapse. Response options were 'Much more embarrassing' (-2), 'Somewhat more embarrassing' (-1), 'Equally embarrassing' (0), 'Somewhat less embarrassing' (1) and 'Much less embarrassing' (2).

Help-seeking without recovery and relapse

Participants who reported that they had never experienced relapse recorded whether they had ever sought help from the same list of 11 sources of help. Response options were 'Yes' (1) and 'No' (0).

8. Impacts of stigma on recovery orientation

The impact of stigma on participants' recovery orientation was measured using 14 questions from the *Personal Vision of Recovery Questionnaire* (Ensfield et al., 1998) that was adapted for problem gambling. Participants were asked whether other people's views about problem gambling increased or decreased, e.g., their confidence and hope that they can control their gambling. Response options were 'Greatly decreased' (-2), 'Decreased' (-1), 'Neither increased nor decreased' (0), 'Increased' (1) and 'Greatly increased' (2). Cronbach's alpha for the *Impacts of Stigma on Recovery Orientation Scale* was 0.89.

9. Psychological Measures

Problem Gambling

As in Stage 2, level of problem gambling was measured by the *PGSI*. Cronbach's alpha for the *PGSI* in this sample was 0.91. Participants were also asked what type of gambling had caused them the most problems from nine options (including 'Other: Please specify').

Self-esteem

Self-esteem was measured with the 10-question *Rosenberg Self-Esteem Scale* (Rosenberg, 1965) which is a widely used and well validated measure of self-esteem (Schmitt & Allik, 2005). Participants were asked how strongly they agreed or disagreed with 10 statements regarding their attitudes towards themselves, e.g., 'I feel that I have a number of good qualities'. Response options were 'Strongly disagree' (-2), 'Disagree' (-1), 'Neither agree nor disagree' (0), 'Agree' (1) and 'Strongly agree' (2). Cronbach's alpha for the *Self-Esteem Scale* was 0.87.

Psychological distress

Psychological distress was measured with the *Kessler-6* (K-6), which is a well-validated, reliable measure of psychological distress (Kessler et al., 2002). Participants were asked six questions about how often they felt a particular way in the last four weeks. These six questions encompass nervousness, hopelessness, restlessness, depression, worthlessness and that everything is an effort. Response options were 'All of the time' (4), 'Most of the time' (3), 'Some of the time' (2), 'A little of the time' (1) and 'None of the time' (0). A sum of the scores on all six items was calculated to give an index of psychological distress. Despite the widespread use of the *K-6*, no clear optimal scoring standards are available (Kessler, Green, Gruber, Sampson, et al., 2010). The most commonly used thresholds based on validation studies were therefore used in this study: scores of 0-12 indicating no psychological distress, and scores of 13+ indicating mild to high levels of psychological distress (referred to here as high psychological distress for brevity). Cronbach's alpha for the *K-6* was 0.92.

Self-consciousness

Self-consciousness was measured with the public self-consciousness and social anxiety sub-scales of the Scheier and Carver (1985) *Self-Consciousness Scale* (SCS-R). The SCS-R is a widely used and well-validated measure of self-consciousness (see Cramer, 2000). Participants answered seven items about public self-consciousness and six items about social anxiety that were recorded on a 4-point scale. Response options were 'Not like me at all' (0), 'A little like me' (1), 'Somewhat like me' (2), 'A lot like me' (3). Cronbach's alpha for the *Public Self-Consciousness Subscale* was 0.83 and for the *Social Anxiety Subscale* was 0.82.

3.4 Methods for Stage 4

Stage 4 involved in-depth interviews with 44 participants with recent experience of a gambling problem, and with nine gambling counsellors working in Victoria.

3.4.1 Approach

The overall research design for Stage 4 incorporated a qualitative approach which sought to interpret, understand and explain the meanings of participants' experiences (Neuman, 2007). Qualitative methods were considered the most appropriate approach in this instance because they yield rich in-depth data about the participants' experiences of problem gambling, and how problem gambling and help-seeking behaviour have been affected by stigma and the accompanying discrimination commonly directed toward stigmatised people (Link et al., 2004).

As a qualitative approach considered suitable for researching under-represented or marginalised groups of people (Creswell, 2007), phenomenology was employed to generate rich and thick descriptions through in-depth interviews (Geertz 1983). Phenomenology is the study of shared meanings of experiences of a phenomenon for a range of people (Creswell, 2007). It involves understanding the meaningful concrete relations implicit in original descriptions of experiencing the phenomenon (Moustakas, 1994). The researcher gathers data as lengthy interviews describing the shared participants' experiences and then reduces these data to a central meaning, or 'essence' of the experience. Highly structured interview questions are not used extensively because the purpose is to explore participants' views of what is important rather than to look at what the researchers believe is important (Smith, Jarman, & Osborn, 1999). A rich study keeps asking and answering questions like when, why, how, and under what circumstances the phenomenon occurs (Rubin & Rubin, 1995).

3.4.2 Recruitment and sampling

Phenomenological studies require smaller rather than larger sample sizes as it is the in-depth quality rather than quantity of data that encourages insightful analyses to be developed (Larkin & Thompson, 2012). Our targets were to interview up to 45 people with recent experience of having a serious gambling problem, and up to 10 gambling counsellors.

Participants in the gambler interviews were recruited through the Stage 3 survey. A question at the end of the survey asked respondents if they would be willing to participate in a telephone interview about stigma associated with gambling problems and, if so, to forward their first name and their telephone number to a CGER email address. In total, 58 survey respondents agreed to a telephone interview and provide their telephone number. Amongst these 58 respondents, 44 interviews were achieved with the remainder being non-contactable despite multiple attempts.

To recruit the counsellors, we first emailed all Gambler's Help agencies in Victoria to request for one or more of their counsellors to participate in the study. Many of these agencies were reticent to participate without approval from the VRGF. The VRGF therefore emailed all counselling agencies to provide this approval and to encourage them to participate. After telephoning each agency, we interviewed nine counsellors from Gambler's Help agencies.

3.4.3 Procedure

All gamblers and counsellors who we recruited were sent a Participant Information Sheet, Informed Consent Form and the list of interview questions. All interviews were conducted by telephone at a mutually convenient time. Two clinical psychologists conducted the interviews with gamblers, while members of the research team conducted the interviews with counsellors. Interviews lasted 30-60 minutes and were digitally recorded and later transcribed by a professional transcription company, ready for analysis.

3.4.4 Interview schedules

Interviews with both gamblers and counsellors were semi-structured. The interview schedule for gamblers is contained in Appendix C and covered the following areas:

- Background, including basic demographic data, how long their gambling had been problematic, and types of gambling causing most problems.
- Meaning of stigma to the participant.
- Self stigma/internalised stigma, focusing on their own feelings about having a gambling problem.
- Public/perceived stigma, focusing on how problem gamblers are viewed by others.
- Their reactions to public/perceived stigma, focusing on the participant's own experiences of how the stigmatising attitudes and behaviours of others make them feel.
- Stigma and help-seeking, focusing on how stigma may have affected the participant's efforts to seek support and help for their gambling.
- Stigma and relapse and recovery, focusing on how stigma may have impacted on recovery and how relapse may have attracted stigma and impacted on willingness to seek help and support.
- Stigma reduction, focusing on whether there are any beneficial effects of stigma and how stigma associated with problem gambling might be reduced.
- Any other comments.

The interview schedule for the counsellors is contained in Appendix D and covered the following areas:

- Meaning of stigma to the counsellor
- Perceptions and experiences of their clients in relation to: how they feel they are viewed by others because of their gambling; if clients discuss feeling stigmatised; effects of stigma on clients' acknowledgement of having a gambling problem; effects of stigma on clients' willingness to seek treatment, self-exclusion, join peer support groups, and seek support from family and friends; and impacts of stigma on recovery and on help-seeking after relapse.
- Professional views of counsellors in relation to: the nature and intensity of public stigma towards problem gamblers; how consideration of stigma is incorporated into their approach to treatment; whether stigma affects treatment and recovery, as well as treatment after relapse; whether some problem gamblers are more stigmatised than others; how stigma associated with problem gambling might be reduced; and effects of public health messages on problem gambling stigma.
- Any other comments.

3.4.5 Data analysis

Data analysis consisted of interpretative phenomenological analysis (IPA), which is a framework for analysing qualitative research data to bring about deep insights and understandings into how individuals make sense of a phenomenon (Smith et al., 1999). The aim of IPA is to explore in detail how participants make sense of their personal and social world, and the meanings and perceptions they place on their particular experiences. Themes are identified from the participants' accounts, and connections between themes are made in order to group them in a meaningful way. This information is then written up, with an emphasis on anchoring the participants' accounts of the phenomenon in the research, thus providing meaningful insights (Smith et al., 1999).

3.5 Chapter summary

This chapter has presented the research model for this study and explained the methodology used for each of the three stages of empirical research. The first of these stages entailed a survey of 2,000 adults from the Victorian community, weighted to be as representative as possible of the Victorian adult population. Its focus was on measuring aspects related to the public stigmatisation of problem gambling. Stage 2 surveyed 203 Australian gamblers who had recently scored 8+ on the PGSI. Its focus was on measuring perceived and self-stigma and its impacts on coping orientation, help-seeking and recovery from problem gambling. Research methods were also explained for Stage 4, which involved interviews with 44 people with recent experience of problem gambling and with nine gambling counsellors from Victoria.

The next chapter is the first of four results chapters. It presents results from the Victorian Adult Survey.

Chapter Four: Results from the Victorian Adult Survey

4.1 Introduction

This chapter presents results from the Victorian Adult Survey which was conducted to inform Research Objectives 1-4. Chapter Three explains the sample and methods used for this survey. In summary, 2,000 general population Victorian respondents were recruited according to age, gender and location quotas from the 2011 Census, with the data weighted to be representative of the Victorian adult population on these variables.

The survey contained vignettes about five conditions: problem gambling, non-problem gambling (here referred to as 'sub-clinical gambling'), sub-clinical distress, alcohol use disorder and schizophrenia. Respondents rated these vignettes on scales that were designed to capture the perceived nature of these conditions according to five dimensions: concealability, course, disruptiveness, peril and origin. They also rated the vignettes on measures designed to capture elements in the process of stigma creation: labelling, stereotyping, separating, emotional reactions, and status loss and discrimination. Individual difference variables were also measured amongst respondents, including demographics, exposure to gambling, gambling involvement and problem gambling status.

To inform Objective 1 (to determine the nature of problem gambling, as perceived by the Victorian adult community), this chapter first presents the survey results on the perceived dimensions of problem gambling. Ratings of these dimensions are also compared to those for the other vignettes. To inform research Objective 2 (to analyse the process of stigma creation for problem gambling in the Victorian adult community), results are then presented for each element in the process of stigma creation, before being compared to those for the other vignettes. These comparisons help to understand how problem gambling is perceived and stigmatised relative to these other conditions (Objective 3). The results are then analysed by the individual difference variables to inform research Objective 4: to determine how stigma associated with problem gambling is perceived and experienced by different groups in Victoria. To improve the readability of the report, some detailed statistics and individual statistical comparisons are presented in tables in Appendix E.

4.2 Demographic characteristics of the sample

The sample was weighted on the variables of gender, age (in cohorts) and residential location. Thus, after weighting, these variables are representative of the Victorian population according to the 2011 Census (Table 4.1). Most respondents spoke English at home (91.7%) and respondents were fairly evenly spread across levels of education. In terms of political affiliation, most reported voting for either of the two major parties (Liberal/National and Labor, with a relatively even split between these), followed by The Greens (14.6% of those who reported their political affiliation) and other (8.7%). Approximately 37.7% reported a progressive political orientation, 37.0% considered themselves neutral and 25.2% reported a conservative orientation. Approximately 60% of respondents reported some religious affiliation, with most of these reporting affiliation with a Christian religion. Almost 40% of those who answered the question reported not being religious. Table 4.1 indicates the spread of

how important the respondents believed religion to be in their lives. Household income is also reported in Table 4.1.

Table 4.1 – (Weighted) demographic information of the sample

Gender*	Weighted N	Weighted %
Male	970	48.5
Female	1,030	51.5
<i>Total</i>	<i>2,000</i>	<i>100.0</i>
Age*	Weighted N	Weighted %
18-29	435	21.8
30-39	364	18.2
40-49	368	18.4
50-59	325	16.2
60-64	141	7.1
65+	366	18.3
<i>Total</i>	<i>2,000</i>	<i>100.0</i>
Location of residence	Weighted N	Weighted %
Greater Melbourne	1,504	75.2
Rest of Victoria	497	24.8
<i>Total</i>	<i>2,000</i>	<i>100.0</i>
Main language spoken at home	Weighted N	Weighted %
English	1,833	91.7
Language other than English	167#	8.3
<i>Total</i>	<i>2,000</i>	<i>100.0</i>
Level of education	Weighted N	Weighted %
Postgraduate qualifications	329	16.4
A university or college degree	590	29.5
A trade, technical certificate or diploma	487	24.4
Year 12 or equivalent	407	20.4
Year 10 or below	186	9.3
<i>Total</i>	<i>2,000</i>	<i>100.0</i>
Income bracket	Weighted N	Weighted %
Under \$20,000	167	8.3
\$20,000 - \$39,999	318	15.9
\$40,000 - \$59,999	214	15.7
\$60,000 - \$79,999	287	14.3
\$80,000 - \$99,999	263	13.2
\$100,000 - \$119,999	205	10.3
\$120,000 - \$139,999	118	5.9
\$140,000 - \$159,999	120	6.0
\$160,000 - \$179,999	57	2.9
\$180,000 - \$199,999	52	2.6
Over \$200,000	98	4.9
<i>Total</i>	<i>2,000</i>	<i>100.0</i>

Table 4.1 – (Weighted) demographic information of the sample (cont.)

Political affiliation	Weighted N	Weighted %	Weighted valid %[^]
Liberal/National Party	624	31.2	38.7
Labor Party	612	30.6	38.0
The Greens	236	11.8	14.6
Other	140	7.0	8.7
Prefer not to answer	389	19.4	-
<i>Total</i>	<i>2,000</i>	<i>100.0</i>	<i>100.0</i>
Political orientation	Weighted N	Weighted %	Collapsed %
Extremely progressive	65	3.2	Progressive: 37.7
Progressive	404	20.2	
Slightly progressive	286	14.3	
Neutral	741	37.0	Neutral: 37.0
Slightly conservative	291	14.5	Conservative: 25.2
Conservative	192	9.6	
Extremely conservative	22	1.1	
<i>Total</i>	<i>2,000</i>	<i>100.0</i>	<i>100.0</i>
Religious affiliation	Weighted N	Weighted %	Weighted valid %^{\$}
Protestant/Anglican	319	15.9	16.5
Catholic	417	20.9	21.6
Other Christian	210	10.5	10.9
Buddhism	45	2.2	2.3
Hinduism	45	2.3	2.3
Islam	32	1.6	1.7
Judaism	39	2.0	2.0
Other religion	70	3.5	3.6
No religion	755	37.8	39.1
Prefer not to say	68	3.4	-
<i>Total</i>	<i>2,000</i>	<i>100.0</i>	<i>100.0</i>
Importance of religion^{&}	Weighted N	Weighted %	
Not at all important	491	24.6	
2	308	15.4	
3	190	9.5	
4	304	15.2	
5	257	12.8	
6	215	10.7	
Extremely important	236	11.8	
<i>Total</i>	<i>2,000</i>	<i>100.0</i>	

Note: Variables marked with * were used for weighting. Unweighted data is presented in Table 3.1. Mean age = 46.0 (*SD* = 16.7), median = 45.0. # Most common responses were Cantonese, Hindi and Mandarin (*n* = 11 for each), followed by Greek, Indonesian and Russian (*n* = 9 each), Tamil (*n* = 8) and Italian, Polish and Vietnamese (*n* = 7 each), with smaller numbers of other languages. ^ Valid % for political affiliation is based on *n* = 1,612 (i.e. total *N* when 'prefer not to answer' is treated as a missing value). \$ Valid % for religious affiliation is based on *n* = 1,932 (i.e. total *N* when 'prefer not to answer' is treated as a missing value). & Note: No anchors were used on the points between the extremes of the scale.

4.3 The perceived nature of problem gambling

To help address Objective 1, to understand how the nature of problem gambling is perceived by the Victorian adult community, this section analyses how respondents answered each question assessing the dimensions of problem gambling, in response to the problem gambling vignette. Means and standard deviations for these questions are presented in Appendix E.

4.3.1 Concealability

The concealability scale was a single item scale where respondents were asked to rate whether they believed problem gambling, as described in the vignette, is a noticeable condition. The vast majority (95.2%) stated that it was at least somewhat noticeable, with 41.7% stating that it was a very or extremely noticeable condition (Figure 4.1).

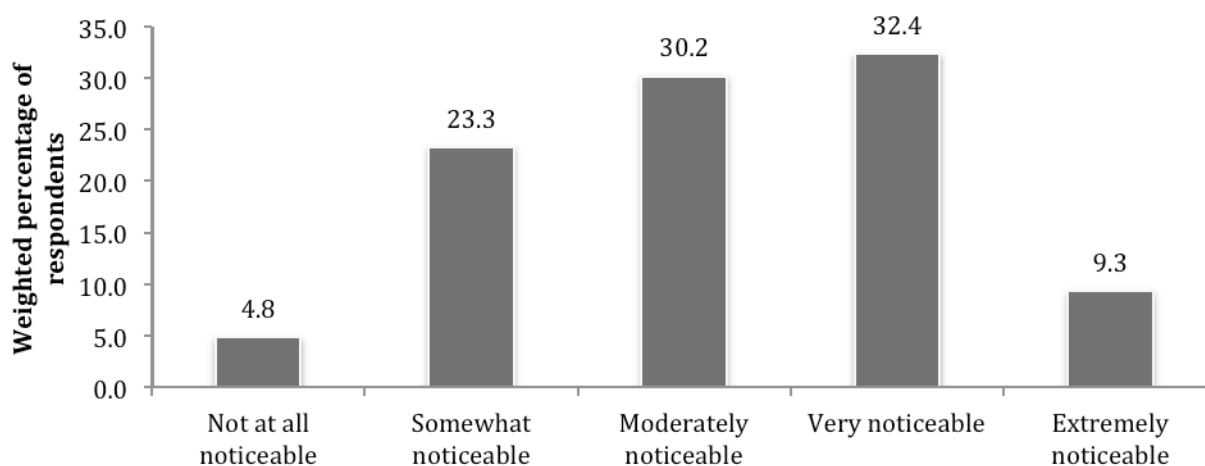


Figure 4.1 – Concealability: Weighted percentage of respondents across each response to 'How noticeable would Dan's situation be to his family and friends if he hadn't told them about it?'

4.3.2 Course

The course scale was a single item scale where respondents were asked whether they believed people can recover from the situation, in this case problem gambling. As illustrated in Figure 4.2, the majority (81.6%) indicated some level of agreement with this statement.

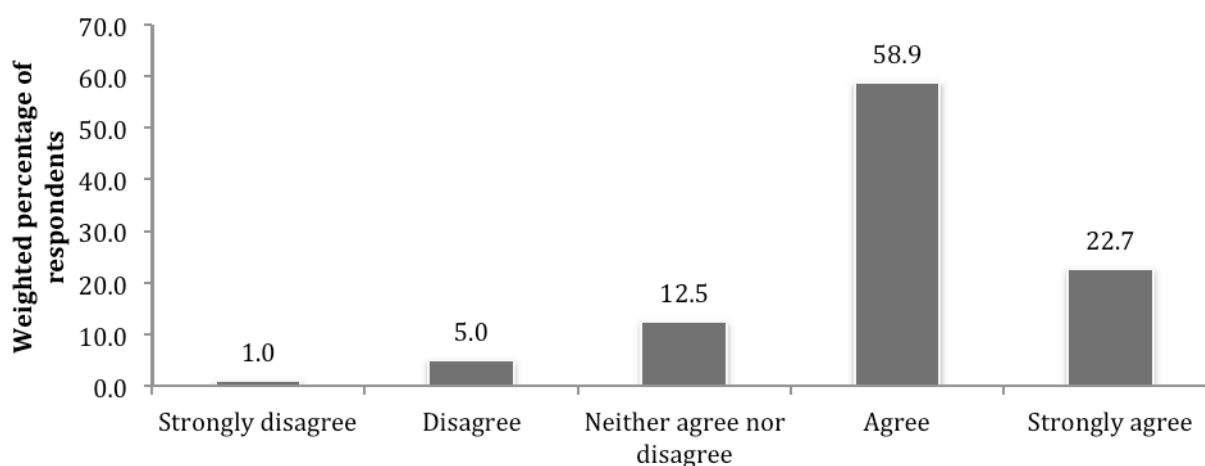


Figure 4.2 – Course: Weighted percentage of respondents who replied with each response to 'How strongly do you agree or disagree that people can recover from Dan's situation?'

4.3.3 Disruptiveness

The disruptiveness scale consisted of three items, as indicated in Figure 4.3. Most respondents indicated that problem gambling would have at least a large effect on work or study, on ability to live independently and on ability to be in a serious relationship.

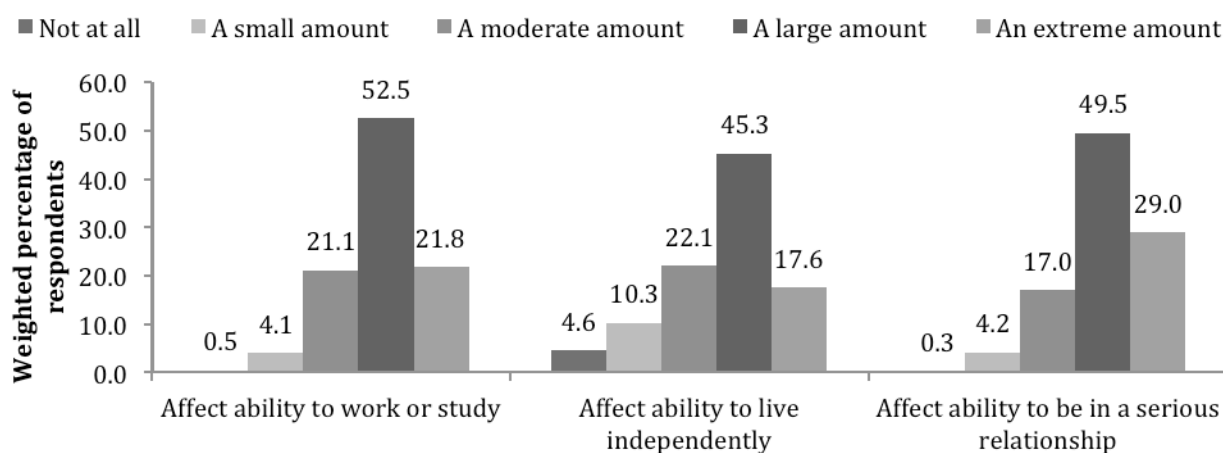


Figure 4.3 – Disruptiveness: Weighted percentage of respondents who replied with each response to 'How much do you think Dan's situation will affect his ability to work or study/live independently/be in a serious relationship?'

4.3.4 Peril to others and to self

Respondents were asked how likely they thought it was that the person in the problem gambling vignette would do something violent to other people due to their condition. Overall, 22.9% thought that it was likely or very likely that the protagonist would cause this type of peril to others, but 42.1% thought that this was unlikely or very unlikely (Figure 4.4).

However, when asked if the protagonist was likely to do something violent to himself, the responses were reversed, with 41.9% indicating that it was at least likely that the person would harm himself, compared to 22.3% indicating that this was unlikely or very unlikely (Figure 4.5). Thus, while there was some belief that the protagonist would be violent to others, there was a stronger belief that he would be violent to himself.

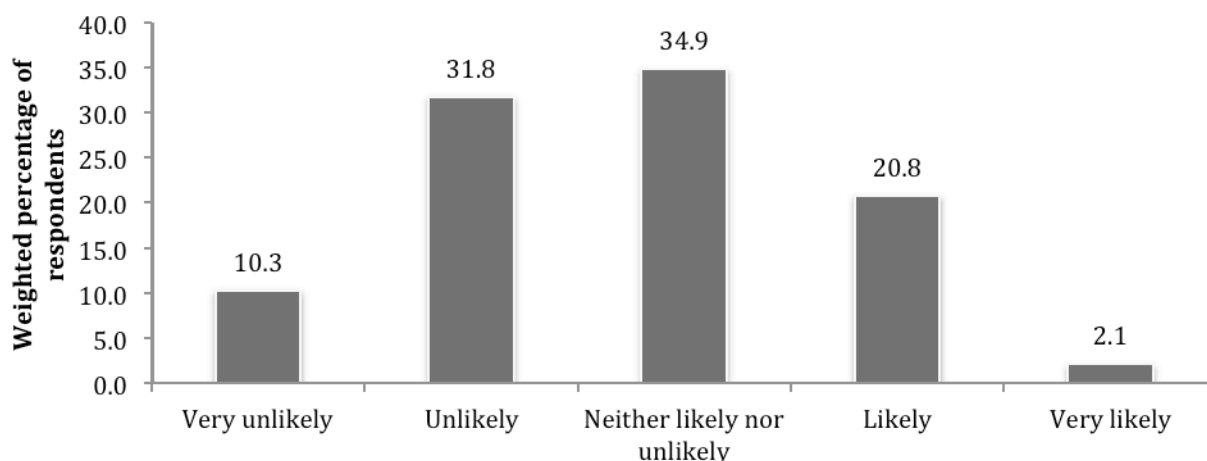


Figure 4.4 – Peril to others: Weighted percentage of respondents who replied with each response to 'How likely is it that Dan would do something violent to other people?'

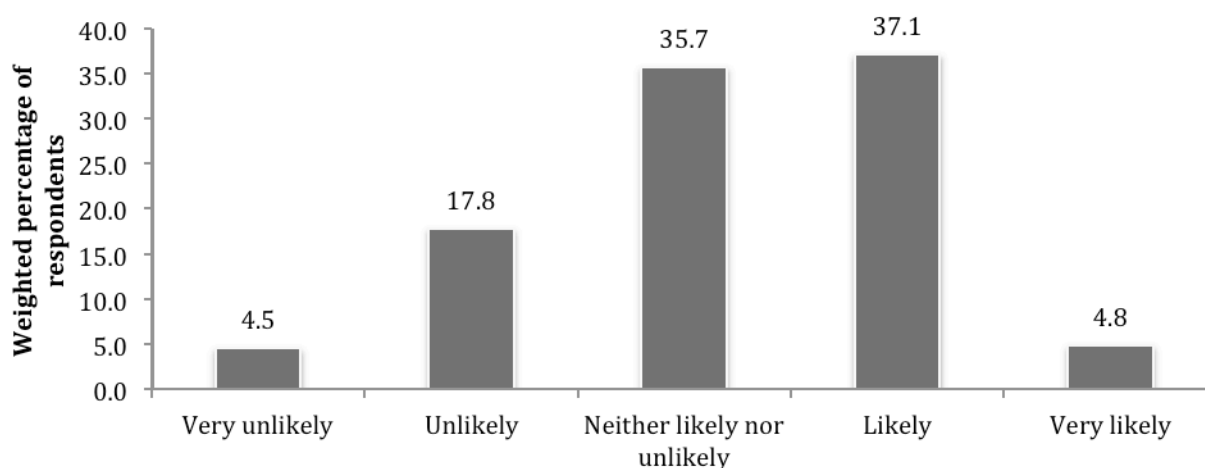


Figure 4.5 – Peril to self: Weighted percentage of respondents who replied with each response to 'How likely is it that Dan would do something violent to himself?'

4.3.5 Origin

Respondents were asked whether they thought each of six items was the possible origin of the condition described in the vignette. Most respondents believed that the condition in the problem gambling vignette was likely to be due to stressful circumstances, but unlikely to be due to the person's bad character, or to God's will. Responses for the other items (chemical imbalance in the brain, genetic or inherited problem, and the way he was raised) were more mixed (Figure 4.6).

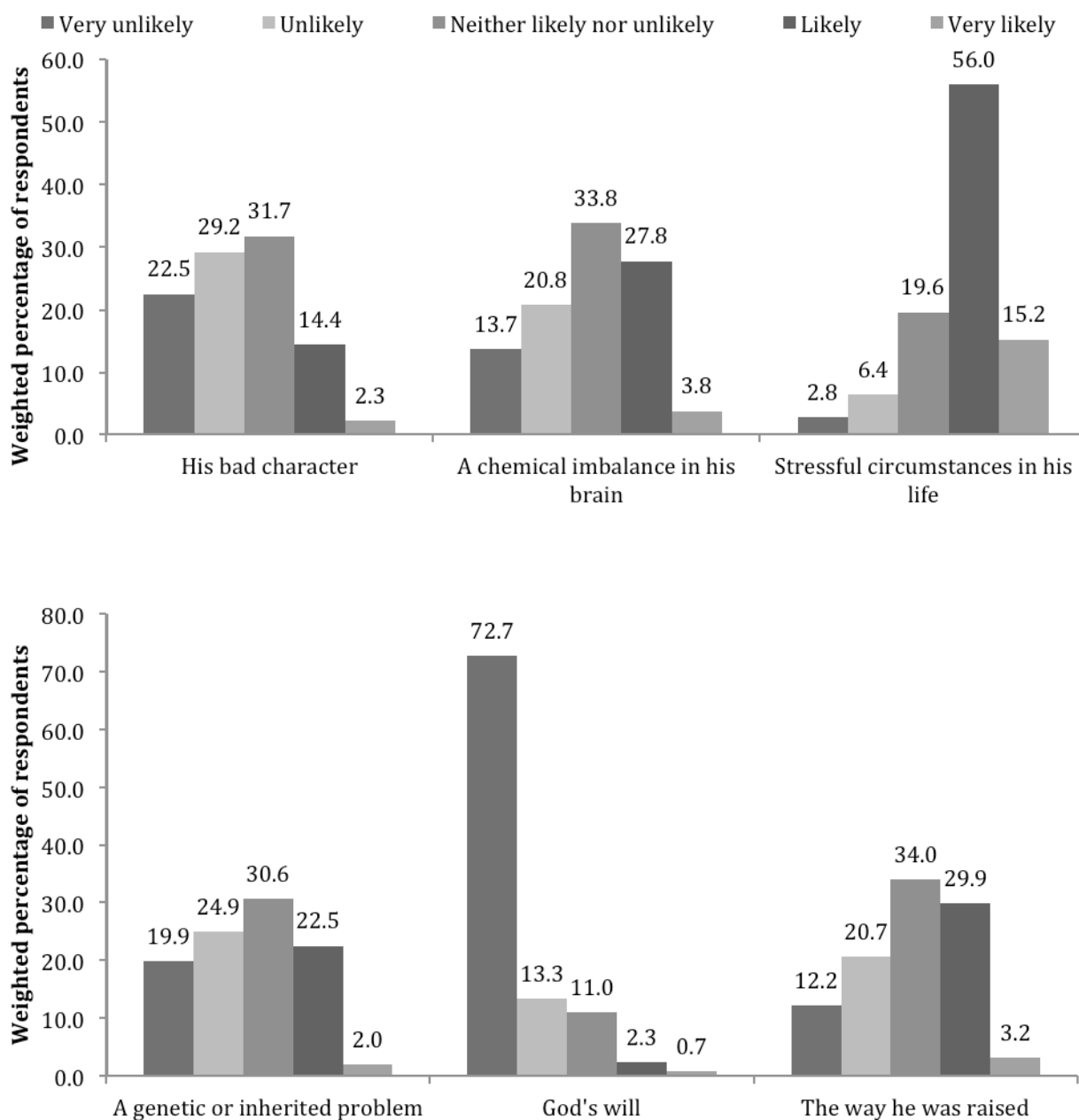


Figure 4.6 – Origin: Weighted percentage of respondents who replied with each response to 'How likely do you think it is that Dan's situation is caused by ...'

4.4 The process of stigma creation for problem gambling

This section helps to address Objective 2, to analyse the process of stigma creation for problem gambling in the Victorian adult community. It analyses how respondents answered each of the questions measuring elements in the process of stigma creation for the problem gambling vignette.⁹ Means and standard deviations for these items are presented in Appendix E.

4.4.1 Labelling

Respondents were asked whether they believed that the person in the problem gambling vignette had any of five conditions and they could respond no, unsure or yes to each item individually. The vast majority believed that the person in the problem gambling vignette had an addiction and slightly more than half believed that this was a diagnosable condition (respondents were told that this last option was based on their opinion, regardless of whether they had had any clinical training). Respondents did not believe that the person in the problem gambling vignette had a physical health disorder and responses were mixed for mental health disorder and disease or illness (Figure 4.7).

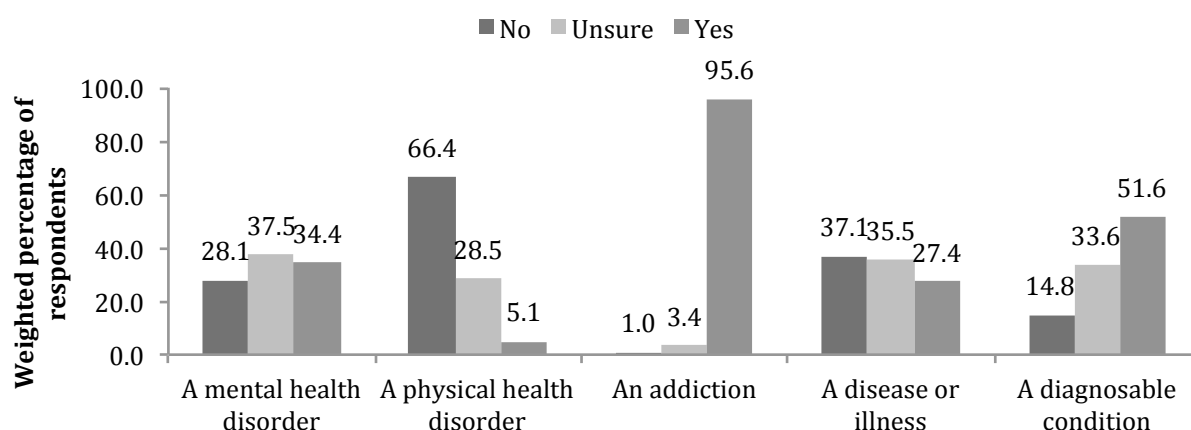


Figure 4.7 – Weighted percentage of respondents indicating their level of agreement to ‘Based on his situation as described, do you think Dan has...’.

4.4.2 Stereotyping

Respondents were asked ten questions about stereotyping and responded on 7-point Likert scales, with the anchors shown in Figure 4.8 at the extremes of each scale. No other anchors were used for midpoints on the scale. The more negative responses were on the right hand side of each scale.

Figure 4.8 shows that, for most of the dichotomies, respondents tended to respond towards the negative side. That is, most respondents indicated that they thought that the person in the problem gambling vignette tended to be impulsive, irresponsible, greedy, irrational, anti-social, untrustworthy, unproductive, and foolish. Responses were more mixed for the normal-deviant and moral-immoral dichotomies. The words ‘deviant’ and ‘immoral’ may be too strong for the feelings that the problem gambling vignette evoked in respondents.

⁹ As the results are presented in isolation, they should be interpreted with caution. For example, one of the items in the status loss and discrimination scale is ‘Hire X to take care of their children’. The subject in all vignettes was male (as a form of constancy control) and thus some people who disagreed with this item may have disagreed because they would not hire a male person to look after their children.

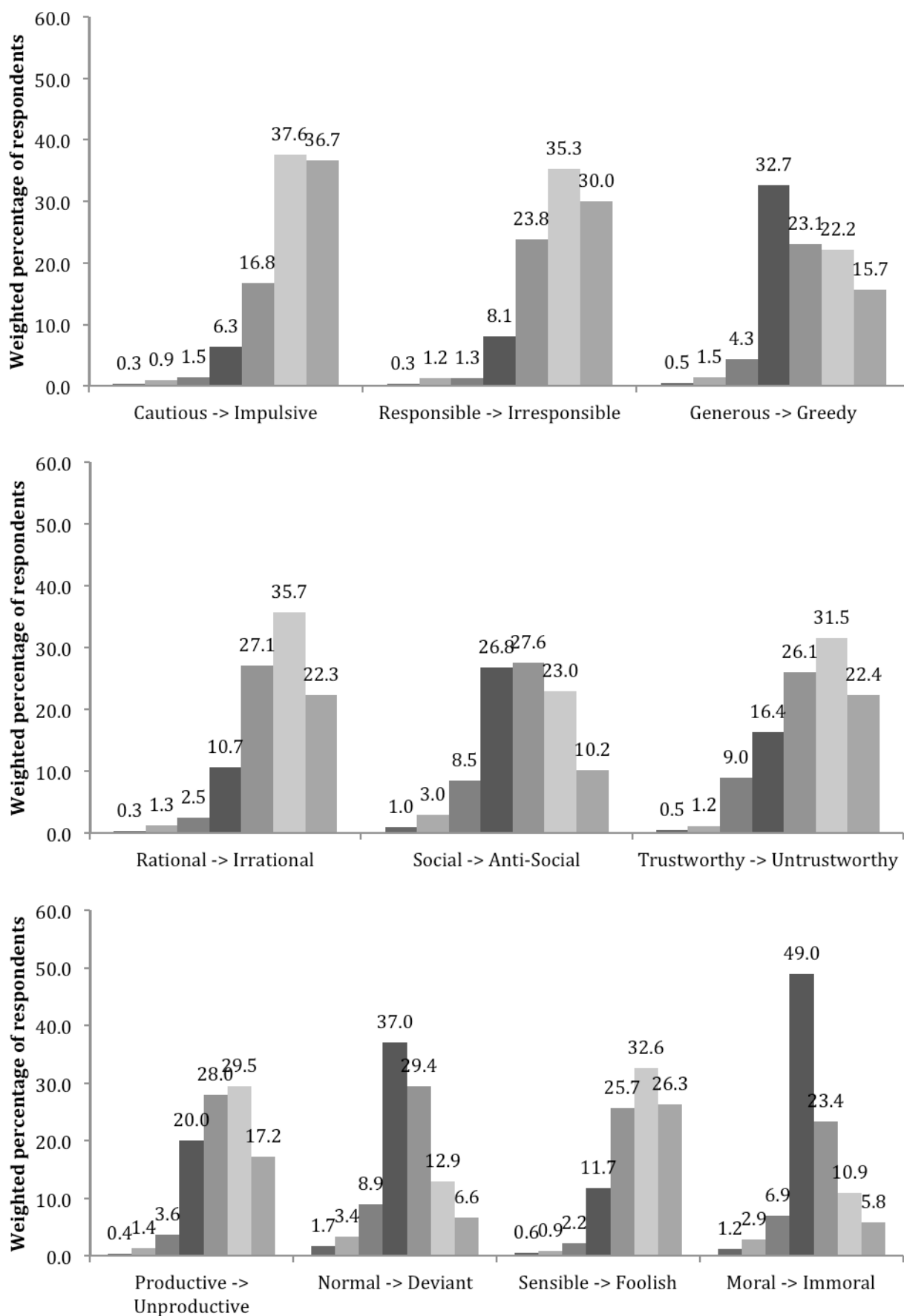


Figure 4.8 – Stereotyping: Weighted percentage of respondents who replied with each response to 'Please rate the extent to which you believe each attribute applies to Dan'

4.4.3 Separating

Respondents were asked six questions to assess their degree of willingness to socialise with the person in the problem gambling vignette (Figure 4.9). Responses were mixed for most items, with similar levels of willingness and unwillingness in the sample for most items. The exception was for 'Have Dan marry into your family', with 73.4% of respondents exhibiting some level of unwillingness for this to occur.

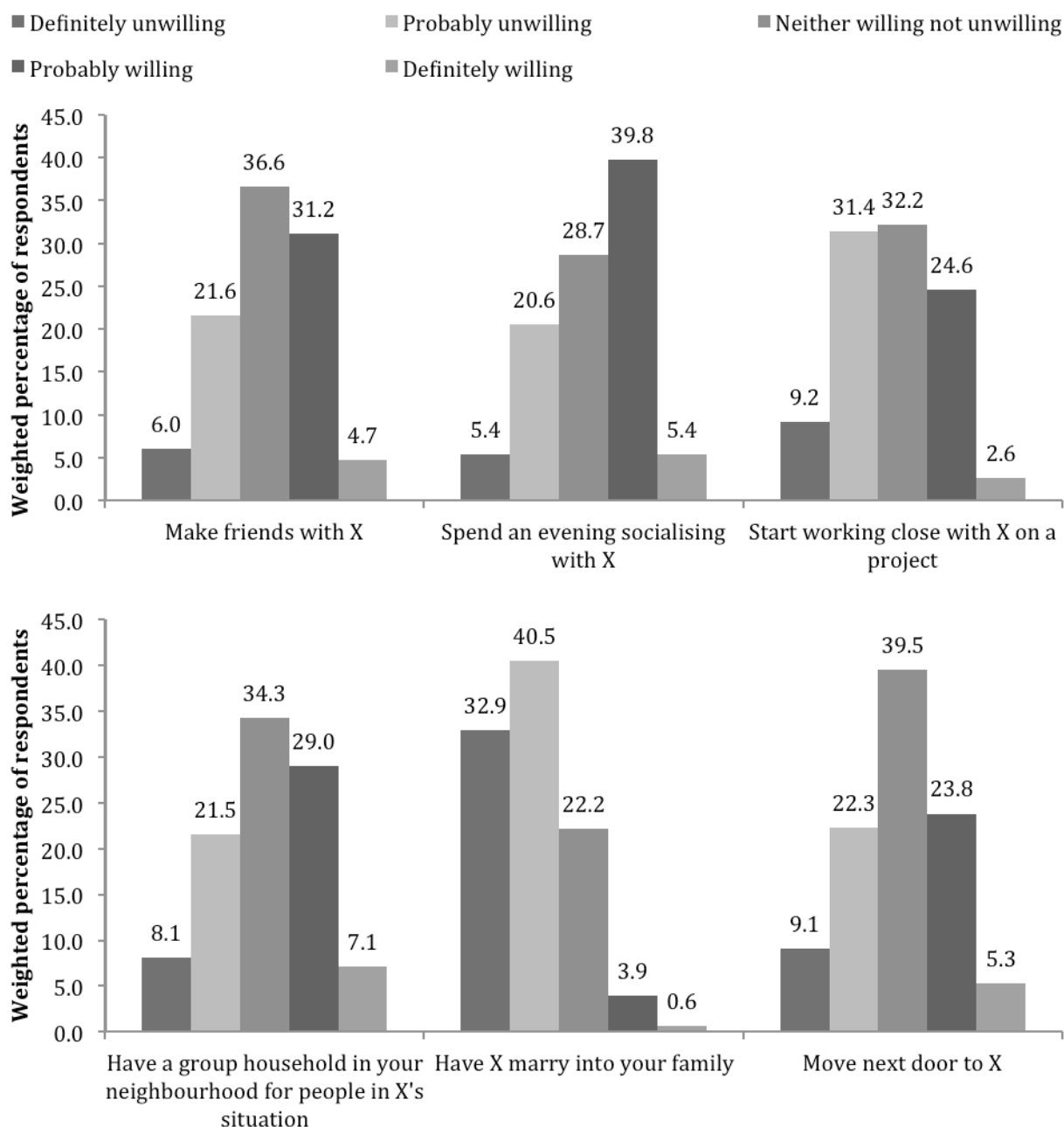


Figure 4.9 – Separating: Weighted percentage of respondents who replied with each response 'If you were aware of Dan's situation, how willing would you be to...'

4.4.4 Emotional reactions: pity, anger and fear

Respondents were asked nine questions about their emotional reactions towards the person in the problem gambling vignette. These questions were separated into three subscales: pity, anger, and fear.

More than half of the respondents agreed or strongly agreed that they would feel sorry for the person, would feel sympathy towards the person and would feel the need to help the person (Figure 4.10). In terms of the anger questions, 60.6% stated that they disagreed that they would feel disgust towards the person, while responses were mixed for annoyance or anger (Figure 4.11), indicating that 'disgust' may be too strong a word, but that there is some level of anger towards people in this situation. For the fear questions, 61.4% of respondents stated that they would not be scared by a person in this situation, but responses were more mixed for 'he would make me feel uncomfortable' and 'he would make me feel apprehensive' (Figure 4.12). This indicates that, like 'disgust', 'scare' appears to be too strong a word for their emotions, but that there was some level of discomfort and apprehension about people in similar situations as the person in the problem gambling vignette.

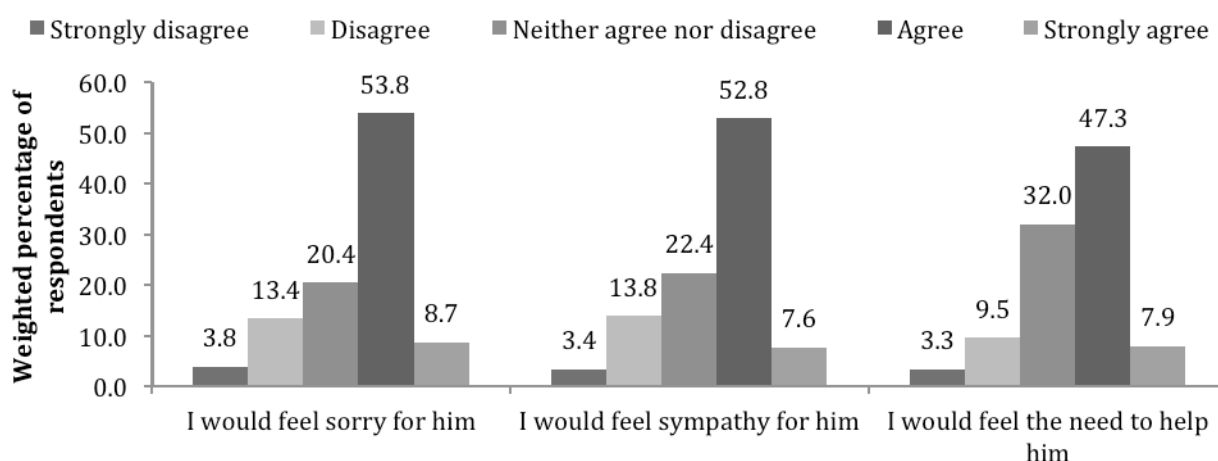


Figure 4.10 – Pity: Weighted percentage of respondents who replied with each response to 'If you were aware of Dan's situation, to what extent do you think you would feel each of the following emotions towards him?'

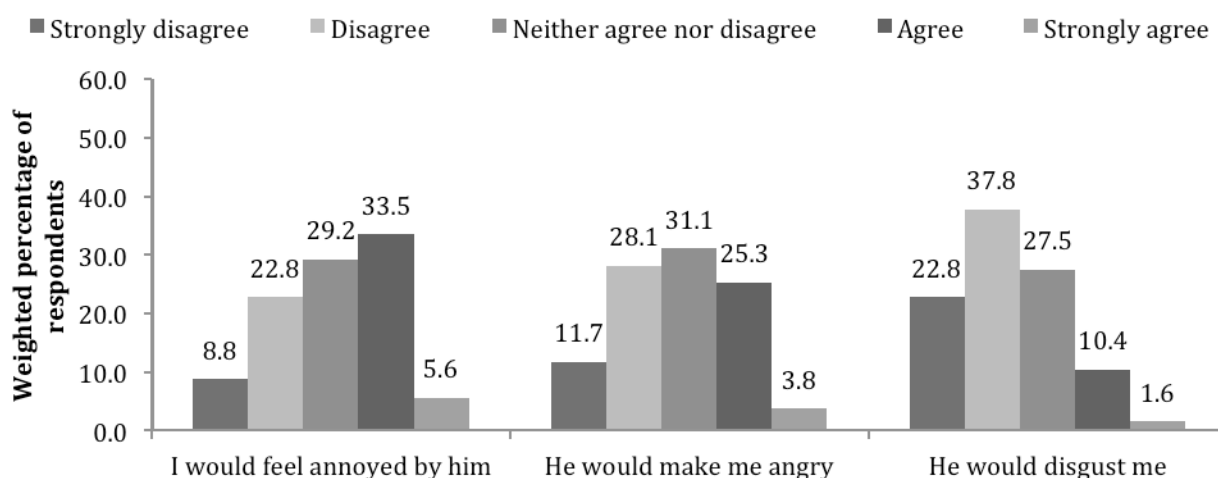


Figure 4.11 – Anger: Weighted percentage of respondents who replied with each response to 'If you were aware of Dan's situation, to what extent do you think you would feel each of the following emotions towards him?'

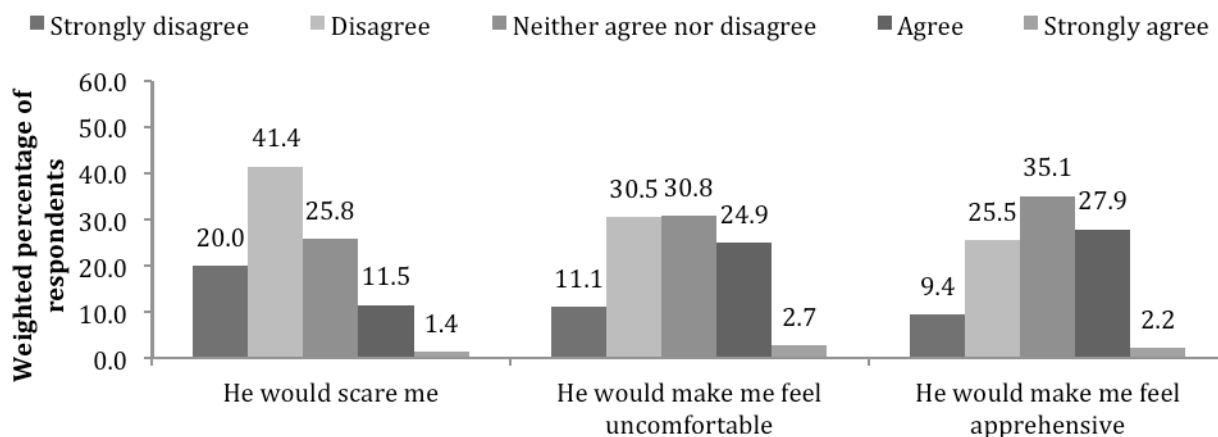


Figure 4.12 – Fear: Weighted percentage of respondents who replied with each response to 'If you were aware of Dan's situation, to what extent do you think you would feel each of the following emotions towards him?'

4.4.5 Status loss and discrimination

Respondents were asked to rate 12 items on scales from strongly disagree to strongly agree. These items were combined (with some items reverse scored) into the status loss and discrimination scale.

More than half of the respondents disagreed that most people would accept the person in the problem gambling vignette as a teacher of children in a public school. More than half also disagreed that most people would hire the person in the problem gambling vignette to take care of their children. Similarly, more than half agreed that most people would pass over the person in favour of another applicant in an employment situation.

More than two-thirds of the respondents agreed that most women would be reluctant to date the person in the problem gambling vignette. Approximately two-thirds disagreed that most people would believe the person to be just as trustworthy as the average citizen.

More than half disagreed that most people would think less of the person in the problem gambling vignette for seeking help, with one in five respondents agreeing that most people would think less of the person for doing so.

Responses were more varied on the other items, indicating some disagreement amongst the sample (Figure 4.13).

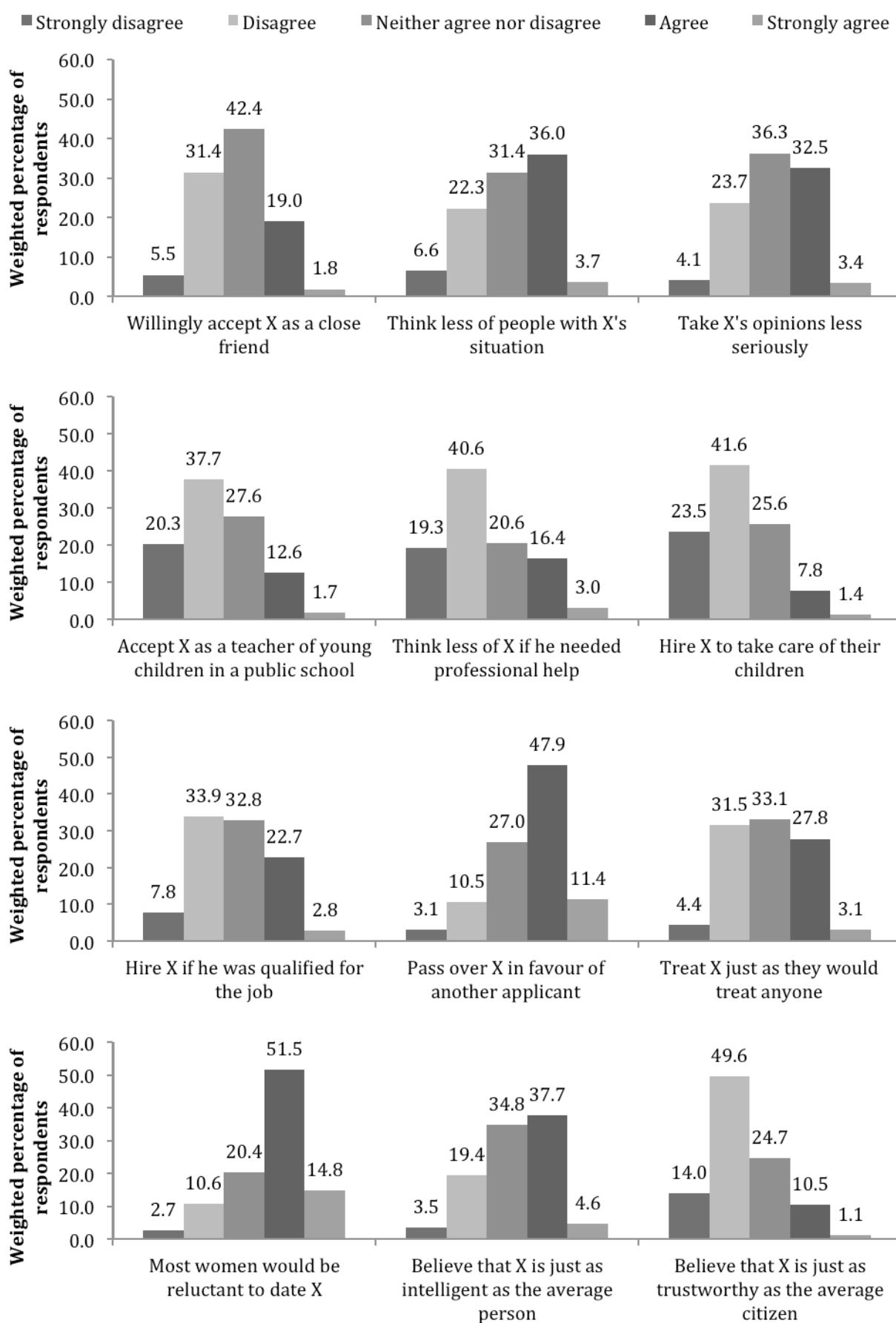


Figure 4.13 – Status loss and discrimination: Weighted percentage of respondents who replied with each response to 'If they were aware of Dan's situation, most people would...'.¹

4.5 Relationships between scales for the problem gambling vignette

To identify any relationships between dimensions perceived to characterise the nature of problem gambling and elements in the process of stigma creation, correlations between scales were examined. While most scales were correlated with each other, many correlations were significant due purely to the sample size. To focus on stronger relationships, the interpretations below refer only to correlations that are stronger than ± 0.2 . This value was chosen based on a common interpretation that a Spearman's rho coefficient between -0.19 and $+0.19$ is 'very weak', although we acknowledge that this value is arbitrary. All statistically significant correlation coefficients are shown in Table 4.2 and their directions are summarised in Table 4.3. Given that a number of measures were correlated with each other, we considered attempting to reduce them through an exploratory factor analysis. However, as one focus of this report was on understanding the different facets of stigma individually, we considered that a factor analysis would mask important detail.

Respondents who rated the situation of the person in the problem gambling vignette as more disruptive were also significantly more likely to rate it as more noticeable. Higher perceived levels of disruption and noticeability were also related to higher levels of perceived peril to others. Higher levels of peril to self were related to higher levels of peril to others and higher levels of disruption.

Anger and fear were correlated with each other, such that those who felt more fear towards the protagonist in the vignette also reported feeling more anger. Higher levels of fear and anger were related to higher scores on peril to others, while higher levels of fear were also related to higher scores on peril to self. Those who reported higher levels of fear or anger were also significantly more likely to disagree that the person in the problem gambling vignette can recover from their condition.

The stereotyping and status loss and discrimination scales were also related, with those with more negative stereotypical views about the person in the problem gambling vignette also believing that this person would lose social status or be discriminated against because of their situation. Those with more negative stereotypical views or the belief that the person in the problem gambling vignette would be discriminated against were also more likely to believe that their situation is disruptive, poses peril to others and to themselves, and they were also more likely to feel anger and fear.

Higher scores on the separating scale indicate that the respondent would be willing to socialise with the person in the problem gambling vignette. Those with higher separating scores were more likely to believe that the person in the problem gambling vignette can recover from their situation and were less likely to believe that the person could be perilous to others. Those with higher separating scores were significantly more likely to feel pity for the person in the problem gambling vignette and less likely to feel fear or anger. Higher separating scores were also related to less negative stereotypical views about the person in the problem gambling vignette and to lower scores on the status loss and discrimination scale.

In terms of origin, those who believed that the situation of the person in the problem gambling vignette is due to the person's own bad character were more likely to feel that they caused peril to others and were more likely to feel anger, fear and have negative stereotypical views. They were also significantly less likely to want to socialise with the person.

Those who believed that the situation of the person in the problem gambling vignette is caused by stressful life circumstances were more likely to feel pity towards him, while those who believed that it was due to a genetic or inherited problem were also likely to respond that the situation was due to a chemical imbalance in the brain.

Those who believed that the situation of the person in the problem gambling vignette originated in the way that the person was raised, or in God's will, were significantly more likely to feel the individual caused peril to others, to fear them, to also blame it on their own bad character as well as to blame problem gambling on a genetic or inherited problem.

Table 4.2 – Relationships between scales for the problem gambling vignette

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Concealability (1)																
Course (2)	-.09**															
Disruptiveness (3)	.31**	n.s.														
Peril to others (4)	.22**	-.13**	.28**													
Peril to self (5)	.15**	n.s.	.34**	.50**												
Pity (6)	n.s.	.10**	.17**	n.s.	.14**											
Anger (7)	.18**	-.21**	.16**	.32**	.17**	-.19**										
Fear (8)	.18**	-.24**	.18**	.41**	.27**	n.s.	.60**									
Stereotyping (9)	.18**	n.s.	.37**	.28**	.26**	-.06*	.34**	.28**								
Separating (10)	-.15**	.23**	-.18**	-.30**	-.14**	.30**	-.39**	-.41**	-.38**							
Status loss & discrimination (11)	.06*	-.09**	.24**	.21**	.20**	n.s.	.20**	.26**	.31**	-.38**						
Origin: His bad character (12)	.15**	-.12**	.13**	.35**	.18**	-.11**	.39**	.37**	.27**	-.30**	.11**					
Origin: Chemical imbalance in brain (13)	.07*	-.08*	.09**	.16**	.16**	.18**	n.s.	.15**	n.s.	n.s.	.10**	.10**				
Origin: Stressful circumstances in life (14)	.05*	.09**	.18**	.08**	.18**	.25**	n.s.	.06*	.12**	.05*	.11**	.05*	.16**			
Origin: Genetic or inherited problem (15)	n.s.	-.14**	n.s.	.11**	.12**	.13**	.07*	.16**	n.s.	n.s.	.07*	.16**	.48**	.08*		
Origin: God's will (16)	.10**	-.16**	n.s.	.20**	.09**	n.s.	.18**	.20**	-.07*	n.s.	-.07*	.30**	.15**	n.s.	.21**	
Origin: The way he was raised (17)	.06*	-.07*	.11**	.21**	.13**	.06*	.17**	.21**	.11**	-.09**	.15**	.33**	.19**	.17**	.30**	.15**

Note: * indicates a correlation that is statistically significant at the 0.05 level. ** indicates a correlation that is statistically significant at the 0.001 level. All correlation coefficients were calculated using Spearman's rho. Correlations in bold are interpreted in the preceding text.

Table 4.3 – Summary of direction of relationships between scales for the problem gambling vignette**Table 4.11b – Summary of direction of relationship between scales for the problem gambling vignette**

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Concealability (1)																
Course (2)	–															
Disruptiveness (3)	+															
Peril to others (4)	+	–	+													
Peril to self (5)	+		+	+												
Pity (6)		+	+		+											
Anger (7)	+	–	+	+	+	–										
Fear (8)	+	–	+	+	+		+									
Stereotyping (9)	+		+	+	+	–	+	+								
Separating (10)	–	+	–	–	–	+	–	–	–							
Status loss & discrimination (11)	+	–	+	+	+		+	+	+	–						
Origin: His bad character (12)	+	–	+	+	+	–	+	+	+	–	+					
Origin: Chemical imbalance in brain (13)	+	–	+	+	+	+		+			+	+				
Origin: Stressful circumstances in life (14)	+	+	+	+	+	+		+	+	+	+	+	+			
Origin: Genetic or inherited problem (15)		–		+	+	+	+	+			+	+	+	+		
Origin: God's will (16)	+	–		+	+		+	+	–		–	+	+		+	
Origin: The way he was raised (17)	+	–	+	+	+	+	+	+	+	–	+	+	+	+	+	+

Note: A green + indicates a significant positive relationship, while a red – indicates a significant negative relationship.

4.6 The perceived nature of problem gambling compared to other conditions

This section helps to address Objective 3, to determine the relative intensity of any stigma the Victorian adult community associates with problem gambling. It compares responses for the problem gambling vignette to each of the other four vignettes individually on all scales measuring the nature (dimensions) of the condition. A summary of means and SDs for all vignettes is presented in Appendix E, along with all statistical results for each comparison.

4.6.1 Concealability

Table 4.4 indicates the mean concealability score for each of the five vignettes. The situation of the person in the problem gambling vignette was rated as significantly less concealable (more noticeable) than the sub-clinical distress and sub-clinical gambling vignettes, but significantly more concealable (less noticeable) than alcohol use disorder and schizophrenia.

Table 4.4 – Concealability statistics for each of the five vignettes

	Problem gambling	Sub-clinical distress	Alcohol use disorder	Schizophrenia	Sub-clinical gambling
Mean	2.18	0.93	2.62	2.97	0.89
SD	1.04	0.93	0.95	1.01	0.99

4.6.2 Course

Table 4.5 indicates that, on average, respondents believed that people with sub-clinical distress or sub-clinical gambling were significantly more likely to be able to recover than the person in the problem gambling vignette. The person in the schizophrenia vignette was rated as significantly less likely to recover from his condition than the person in the problem gambling vignette. There was no significant difference between alcohol use disorder and problem gambling in this respect.

Table 4.5 – Course statistics for each of the five vignettes

	Problem gambling	Sub-clinical distress	Alcohol use disorder	Schizophrenia	Sub-clinical gambling
Mean	0.97	1.11	1.05	0.62	1.13
SD	0.80	0.75	0.72	0.83	0.82

4.6.3 Disruptiveness

On average, the situation of the person in the schizophrenia vignette was the only condition rated as being significantly more disruptive than the situation of the person in the problem gambling vignette. The situation of person in the problem gambling vignette was rated as being significantly more disruptive than alcohol use disorder, sub-clinical distress and sub-clinical gambling (Table 4.6).

Table 4.6 – Disruptiveness statistics for each of the five vignettes

	Problem gambling	Sub-clinical distress	Alcohol use disorder	Schizophrenia	Sub-clinical gambling
Mean	2.85	1.31	2.67	3.21	0.53
SD	0.73	0.85	0.75	0.70	0.82

4.6.4 Peril to others and to self

The situation of the person in the problem gambling vignette was rated as being significantly more perilous than the sub-clinical distress and sub-clinical gambling conditions, but significantly less perilous than alcohol use disorder and schizophrenia, both in terms of peril to others and peril to the person with the condition (Tables 4.7 and 4.8).

Table 4.7 – Peril to others statistics for each of the five vignettes

	Problem gambling	Sub-clinical distress	Alcohol use disorder	Schizophrenia	Sub-clinical gambling
Mean	1.72	1.05	2.48	2.43	0.53
SD	0.97	0.93	0.82	0.89	0.79

Table 4.8 – Peril to self statistics for each of the five vignettes

	Problem gambling	Sub-clinical distress	Alcohol use disorder	Schizophrenia	Sub-clinical gambling
Mean	2.20	1.55	2.41	2.81	0.59
SD	0.94	1.03	0.83	0.76	0.84

4.6.5 Origin

Respondents were significantly more likely to attribute the problem gambling condition in the vignette to bad character than they were for sub-clinical distress, sub-clinical gambling or schizophrenia, with no significant difference for alcohol disorder.

However, they were significantly less likely to attribute the problem gambling situation to a chemical imbalance in the brain compared to all other vignettes with the exception of sub-clinical gambling, where the result was reversed.

The respondents rated the problem gambling condition as significantly less likely to be due to stressful circumstances compared to alcohol use disorder or sub-clinical distress, but more so than sub-clinical gambling.

Furthermore, the problem gambling condition in the vignette was rated as significantly less likely to have its origin in genetic or inherited problems compared to sub-clinical distress, alcohol use disorder or schizophrenia, but more so than sub-clinical gambling.

In terms of God's will, the ratings in general were quite low, with most respondents stating that this was a very unlikely origin. However, the problem gambling condition presented was still rated as being significantly less likely to be due to God's will compared to sub-clinical distress or schizophrenia, with no significant differences when compared to alcohol use disorder or sub-clinical gambling.

The problem gambling condition in the vignette was rated as being significantly more likely to be due to the way the person was raised compared to sub-clinical distress, schizophrenia and sub-clinical gambling, but less likely to originate in this way compared to alcohol use disorder. A summary of the origin statistics is reported in Table 4.9.

Table 4.9 – Origin statistics for each of the five vignettes

Origin	Statistic	Problem gambling	Sub-clinical distress	Alcohol use disorder	Schizophrenia	Sub-clinical gambling
His bad character	Mean	1.45	0.78	1.42	0.81	0.71
	SD	1.06	0.91	1.08	0.90	0.92
A chemical imbalance in the brain	Mean	1.87	2.10	2.22	3.24	0.84
	SD	1.08	1.14	1.02	0.86	0.98
Stressful circumstances in his life	Mean	2.74	3.07	2.99	2.78	1.54
	SD	0.89	0.76	0.74	0.92	1.21
A genetic or inherited problem	Mean	1.62	1.85	2.07	2.56	0.87
	SD	1.10	1.10	1.05	0.98	1.01
God's will	Mean	0.45	0.54	0.46	0.49	0.45
	SD	0.83	0.90	0.81	0.90	0.86
The way he was raised	Mean	1.91	1.81	2.23	1.34	1.60
	SD	1.05	1.09	0.97	1.09	1.24

4.6.6 Summary of scale comparisons (dimensions of each condition)

Table 4.10 summarises results from the preceding analyses comparing the perceived dimensions of problem gambling compared to each of the other vignettes.

Table 4.10 – Summary of results from statistical comparisons between the problem gambling vignette and other vignettes

Scale	Sub-clinical distress	Alcohol use disorder	Schizophrenia	Sub-clinical gambling
Concealability (higher = more noticeable)	↓	↑	↑	↓
Course	↑		↓	↑
Disruptiveness	↓	↓	↑	↓
Peril to others	↓	↑	↑	↓
Peril to self	↓	↑	↑	↓
Origin: His bad character	↓		↓	↓
Origin: Chemical imbalance in the brain	↑	↑	↑	↓
Origin: Stressful circumstances in his life	↑	↑		↓
Origin: Genetic or inherited problem	↑	↑	↑	↓
Origin: God's will	↑		↑	
Origin: The way he was raised	↓	↑	↓	↓

↑ indicates that that vignette was significantly higher on the relevant scale compared to the problem gambling vignette, while ↓ indicates that the vignette is significantly lower than the problem gambling vignette on the relevant scale. Any lack of arrows for vignettes other than the problem gambling vignette indicates no significant difference.

4.7 The process of stigma creation for problem gambling compared to the other conditions

This section also helps to address Objective 3. It compares responses for the problem gambling vignette to each of the other four vignettes individually on all scales measuring the process of stigma creation for each condition. A summary of means and SDs for all vignettes is presented in Appendix E, along with all statistical results for each comparison.

4.7.1 Labelling

Respondents labelled the situations in all vignettes in different ways to that in the problem gambling vignette in terms of each of the labels in Table 4.11. However, some of these differences are relatively small. For example, the differences in percentages between problem gambling and sub-clinical distress for 'a physical health disorder' are not particularly large.

The problem gambling condition was significantly more likely to be considered a mental health disorder compared to sub-clinical gambling, but less so than schizophrenia. The problem gambling condition was also more likely to be seen as a physical health disorder compared to sub-clinical gambling, but less so than alcohol use disorder. The problem gambling and alcohol use disorder conditions were both more likely to be considered addictions compared to all other vignettes. Problem gambling was more likely to be considered a disease or illness compared to sub-clinical gambling, but less likely compared to alcohol use disorder or schizophrenia. Finally, problem gambling was more likely to be considered a diagnosable condition compared to sub-clinical gambling and distress, but less likely than alcohol use disorder or schizophrenia. The results for these analyses are presented in Appendix E.

Table 4.11 – Percentage of respondents answering each labelling question with each option for each of the five vignettes

Do you think X has:	Response	Problem gambling	Sub-clinical distress	Alcohol use disorder	Schizophrenia	Sub-clinical gambling
A mental health disorder	No	28.1	35.0	30.3	2.0	85.9
	Unsure	37.5	31.5	42.5	6.9	12.3
	Yes	34.4	33.4	27.3	91.1	1.8
A physical health disorder	No	66.4	63.2	32.9	50.9	89.6
	Unsure	28.5	30.5	36.7	40.6	9.5
	Yes	5.1	6.2	30.4	8.5	0.9
An addiction	No	1.0	75.0	1.0	52.6	65.8
	Unsure	3.4	21.6	7.5	41.8	20.5
	Yes	95.6	3.4	91.5	5.6	13.7
A disease or illness	No	37.1	46.8	26.2	11.2	85.0
	Unsure	35.5	33.4	35.1	25.0	12.5
	Yes	27.4	19.8	38.7	63.8	2.6
A diagnosable condition*	No	14.8	25.2	9.3	2.1	74.6
	Unsure	33.6	30.3	29.0	12.8	19.3
	Yes	51.6	44.5	61.7	85.1	6.1

*Note: For this question, respondents were informed that 'This is your opinion regardless of whether you have clinical training'.

Open-ended responses on labelling

Respondents were asked what condition they thought the person in each vignette had. The questions were open-ended and the responses were categorised, with the full results presented in Tables E8 to E12 in Appendix E. Table 4.12 identifies the most common response for each vignette. The majority of respondents who gave a response for each vignette were correct in terms of which condition the vignette was designed to represent, indicating that the vignettes served their purposes.

Table 4.12 - Open-ended responses for what condition the respondents believed was present in each vignette

Vignette	Most common response	N	%	Valid %
Problem gambling	Gambling (addiction)	665	33.3	73.6
Sub-clinical distress	Distress (115 said mild or slight distress, 94 also said anxiety with distress)	612	30.6	71.2
Alcohol disorder	Alcohol (addiction)	371	55.2	92.1
Schizophrenia	Schizophrenia (13 also mentioned distress, 22 also mentioned bipolar, 37 also mentioned paranoia, 6 also mentioned psychosis)	312	49.3	62.4
Sub-clinical gambling	Gambling addiction (4 stated 'minor')	20	2.9	51.3

Note: Valid % is based on those who gave a firm response and does not take into account the 'unsure/don't know' responses or those who did not give a response.

4.7.2 Stereotyping

Higher scores on this scale related to a more negative stereotypical view. The problem gambling vignette was rated as significantly higher on this scale than all of the other vignettes (Table 4.13). However, the stereotypes chosen for this scale were based on common stereotypes towards people experiencing problem gambling as found in the literature. Thus, this particular result may be due to the choice of scale items.

Table 4.13 – Stereotyping statistics for each of the five vignettes

	Problem gambling	Sub-clinical distress	Alcohol use disorder	Schizophrenia	Sub-clinical gambling
Mean	4.28	2.15	3.80	3.78	1.95
SD	0.81	0.94	0.81	0.83	1.19

Note: Higher scores indicate more negative stereotypes.

4.7.3 Separating

Respondents were significantly more likely to distance themselves from the person in the problem gambling vignette compared to those in the sub-clinical distress and sub-clinical gambling vignettes. However, respondents less likely to distance themselves from the person in the problem gambling vignette compared to those in the alcohol disorder and schizophrenia vignettes (Table 4.14).

Table 4.14 – Separating statistics for each of the five vignettes

	Problem gambling	Sub-clinical distress	Alcohol use disorder	Schizophrenia	Sub-clinical gambling
Mean	1.84	2.64	1.66	1.78	2.74
SD	0.74	0.70	0.76	0.85	0.80

Note: Lower scores indicate more desired separation from people with the condition.

4.7.4 Emotional reactions: pity, anger, fear

Respondents were significantly more likely to pity the person in the problem gambling vignette than the person with sub-clinical distress or sub-clinical gambling but less likely to pity the person in the problem gambling vignette compared to the person in the schizophrenia vignette, with no significant difference between alcohol use disorder and problem gambling (Table 4.15).

Table 4.15 – Pity emotions statistics for each of the five vignettes

	Problem gambling	Sub-clinical distress	Alcohol use disorder	Schizophrenia	Sub-clinical gambling
Mean	2.48	2.42	2.44	2.85	1.06
SD	0.76	0.82	0.72	3.00	0.92

Respondents were significantly more likely to feel anger towards the person in the problem gambling vignette than towards the person with sub-clinical distress, sub-clinical gambling, and schizophrenia. There was no significant difference in terms of anger towards the person in the problem gambling or alcohol use disorder vignettes (Table 4.16).

Table 4.16 – Anger emotions statistics for each of the five vignettes

	Problem gambling	Sub-clinical distress	Alcohol use disorder	Schizophrenia	Sub-clinical gambling
Mean	1.72	0.72	1.74	1.05	0.66
SD	0.87	0.70	0.86	0.78	0.79

Respondents were significantly more likely to fear the person in the alcohol disorder and schizophrenia vignettes compared to the person in the problem gambling vignette, but were less likely to fear a person with sub-clinical distress or sub-clinical gambling (Table 4.17).

Table 4.17 – Fearful emotions statistics for each of the five vignettes

	Problem gambling	Sub-clinical distress	Alcohol use disorder	Schizophrenia	Sub-clinical gambling
Mean	1.66	0.95	2.07	2.25	0.67
SD	0.84	0.79	0.88	0.89	0.79

4.7.5 Status loss and discrimination

Respondents rated the alcohol disorder and schizophrenia as significantly more likely to result in status loss to the individual than problem gambling, but rated problem gambling as significantly more likely to result in status loss than sub-clinical distress and sub-clinical gambling. See Table 4.18.

Table 4.18 – Status loss and discrimination statistics for each of the five vignettes

	Problem gambling	Sub-clinical distress	Alcohol use disorder	Schizophrenia	Sub-clinical gambling
Mean	2.26	1.39	2.35	2.46	1.14
SD	0.57	0.62	0.53	0.63	0.64

Note: Higher scores indicate more status loss/discrimination.

4.7.6 Summary of scale comparisons (process of stigma creation)

Table 4.19 summarises results from the analyses comparing elements in the process of stigma creation for problem gambling compared to each of the other vignettes.

Table 4.19 – Summary of results from statistical comparisons between the problem gambling vignette and other vignettes

Scale	Sub-clinical distress	Alcohol use disorder	Schizophrenia	Sub-clinical gambling
Stereotyping	↓	↓	↓	↓
Separating	↑	↓	↓	↑
Emotional reactions: Pity	↓		↑	↓
Emotional reactions: Anger	↓		↓	↓
Emotional reactions: Fear	↓	↑	↑	↓
Status loss and discrimination	↓	↑	↑	↓

↑ indicates that that vignette was significantly higher on the relevant scale compared to the problem gambling vignette, while ↓ indicates that the vignette is significantly lower than the problem gambling vignette on the relevant scale. Any lack of arrows for vignettes other than the problem gambling vignette indicates no significant difference.

4.7.7 Global stigma question: ‘Value to society’

Respondents were asked to rate the ‘value to society’ of the person in each of the three vignettes that they had seen. The person in the problem gambling vignette was rated as less valuable than those in the sub-clinical distress and sub-clinical gambling vignettes, but slightly more valuable than those in the alcohol use disorder and schizophrenia vignettes (Tables 4.20-4.22).

Table 4.20 – Rankings of vignettes in terms of value to society (n and %) – problem gambling, sub-clinical distress and alcohol use disorder

Vignette	Most value		Middle value		Least value	
	N	%	N	%	N	%
Problem gambling	25	3.7	378	55.6	277	40.7
Sub-clinical distress	617	90.7	26	3.9	37	5.4
Alcohol use disorder	37	5.5	276	40.6	367	53.9

Table 4.21 – Rankings of vignettes in terms of value to society (n and %) – problem gambling, sub-clinical distress and schizophrenia

Vignette	Most value		Middle value		Least value	
	N	%	N	%	N	%
Problem gambling	47	7.4	394	62.5	190	30.1
Sub-clinical distress	554	87.9	47	7.4	29	4.6
Schizophrenia	29	4.7	189	30.0	412	65.3

Table 4.22 – Rankings of vignettes in terms of value to society (n and %) – problem gambling, sub-clinical distress and sub-clinical gambler

Vignette	Most value		Middle value		Least value	
	N	%	N	%	N	%
Problem gambling	27	3.9	43	6.2	620	89.9
Sub-clinical distress	294	42.5	354	51.4	42	6.1
Sub-clinical gambler	369	53.5	293	42.4	28	4.0

4.8 Who stigmatises people with gambling problems? Differences between groups

This section helps to address Objective 4, to determine how stigma associated with problem gambling is perceived and experienced by different groups in Victoria. In order to understand who was more likely to stigmatise people experiencing gambling problems, demographic variables were included in a linear regression analysis. Regression analysis was used as it can account for overlap between the demographic variables. Bivariate analyses, that do not take into account overlap between the demographic variables, are reported in Tables E13 to E22 in Appendix E.

Two potential dependent variables were chosen as they were significant dependent variables for many of the demographic variables: separating and status loss and discrimination. Separating was also used for a similar purpose by Horch and Hodgins (2008).

All demographic variables were considered for conclusion. Two of the predictors (political affiliation and religion) had missing values, as respondents were allowed to skip these questions if they wished. The variables were related to two other variables (progressive/conservative and importance of religion scales), which were included in their place. There were no other missing values.

Thus the following predictors were included in the analysis: gender (reference = male), age (in years), metro/rural residence (reference = metro), number of years in Australia (in years), language spoken at home (English vs non-English, with English as reference), level of education (dummy-coded with Year 10 or below as reference), progressive/conservative scale, importance of religion scale, income (in brackets), PGSI (dummy-coded with non-problem gamblers as reference), gambling exposure scale and gambling involvement scale. All variables were initially tested for multicollinearity by examining tolerance statistics. Tolerance for “years in Australia” was correlated with age. Once this was removed, all of the independent variables were relatively independent, with the lowest scores amongst the education dummy variables (~0.3) due to relatively small correlations amongst themselves (also around 0.3) and not with any of the other predictors. No other tolerance statistics were below 0.6. Thus the model was considered to be acceptable from this regard. All assumptions were checked for both models and were not found to have been violated.

Both models were statistically significant, accounting for 4.6% of the variance in the separating scale ($F(16,1983) = 6.01, p < 0.001$) and 4.6% of variance in the status loss and discrimination scale ($F(16,1983) = 5.98, p < 0.001$).

For the separating scale, higher scores represent a greater willingness to socialise with problem gamblers. As shown in Table 4.23, the following demographic groups were significantly more willing to socialise with problem gamblers, when controlling for all other variables in the model: females, those who speak English at home, those who are more progressive and those who have higher levels of gambling exposure and involvement.

Table 4.23 – Regression coefficients for the separating scale.

Coefficient	Unstandardised coefficient	Std. Error	Standardised coefficient	t	p	95% CI lower bound	95% CI upper bound
Gender (ref male)	0.076	0.034	0.051	2.249	0.025	0.010	0.142
Age (in years)	-0.001	0.001	-0.017	-0.696	0.487	-0.003	0.001
Metro/rural residence (ref metro)	0.026	0.039	0.015	0.672	0.501	-0.050	0.102
English at home (ref yes)	-0.312	0.062	-0.116	-5.058	<0.001	-0.433	-0.191
Education (ref Year 10)							
Year 12 or equiv	-0.039	0.067	-0.021	-0.583	0.560	-0.169	0.092
Trade, technical cert or diploma	-0.011	0.065	-0.006	-0.169	0.866	-0.138	0.116
University or college degree	-0.039	0.066	-0.024	-0.598	0.550	-0.168	0.089
Postgraduate qualification	-0.077	0.072	-0.038	-1.076	0.282	-0.217	0.063
Progressive/conservative	-0.039	0.013	-0.070	-3.073	0.002	-0.064	-0.014
Importance of religion	0.003	0.008	0.008	0.329	0.742	-0.013	0.019
Income (in brackets)	0.001	0.007	0.003	0.110	0.912	-0.012	0.014
PGSI (ref non-problem)							
Low risk	0.005	0.054	0.002	0.086	0.931	-0.101	0.111
Moderate risk	0.023	0.069	0.008	0.337	0.736	-0.111	0.158
Problem gambler	0.162	0.097	0.046	1.669	0.095	-0.028	0.353
Gambling exposure	0.012	0.005	0.064	2.733	0.006	0.003	0.021
Gambling involvement	0.022	0.006	0.095	3.504	<0.001	0.010	0.034

For the status loss and discrimination scale, higher scores refer to the belief that a problem gambler would lose social status. Those who thought this were more likely to be male, to have a trade or technical certificate or diploma or a university or college degree (compared to year 10 education), to be progressive, to place importance on religion, to be non-problem gamblers (compared to moderate risk gamblers) and to have lower levels of gambling involvement (Table 4.24).

Thus, the results in Tables 4.23 and 4.24 suggest that these are some of the predictors that explain some unique variance in these particular scales.

Table 4.24 – Regression coefficients for the status loss and discrimination scale.

Coefficient	Unstandardised coefficient	Std. Error	Standardised coefficient	t	p	95% CI lower bound	95% CI upper bound
Gender (ref male)	-0.078	0.026	-0.068	-3.018	0.003	-0.128	-0.027
Age (in years)	<0.001	0.001	0.007	0.312	0.755	-0.001	0.002
Metro/rural residence (ref metro)	-0.017	0.030	-0.013	-0.570	0.569	-0.075	0.041
English at home (ref yes)	0.083	0.047	0.040	1.758	0.079	-0.010	0.175
Education (ref Year 10)							
Year 12 or equiv	0.079	0.051	0.056	1.554	0.120	-0.021	0.179
Trade, technical cert or diploma	0.153	0.049	0.116	3.106	0.002	0.057	0.250
University or college degree	0.105	0.050	0.084	2.094	0.036	0.007	0.204
Postgraduate qualification	0.083	0.055	0.054	1.513	0.130	-0.025	0.190
Progressive/conservative	-0.023	0.010	-0.055	-2.389	0.017	-0.042	-0.004
Importance of religion	0.014	0.006	0.051	2.214	0.027	0.002	0.026
Income (in brackets)	0.008	0.005	0.038	1.590	0.112	-0.002	0.018
PGSI (ref non-problem)							
Low risk	-0.074	0.041	-0.041	-1.793	0.073	-0.155	0.007
Moderate risk	-0.155	0.052	-0.068	-2.958	0.003	-0.258	-0.052
Problem gambler	-0.111	0.074	-0.041	-1.486	0.137	-0.257	0.035
Gambling exposure	<0.001	0.003	0.003	0.124	0.902	-0.006	0.007
Gambling involvement	-0.022	0.005	-0.126	-4.632	<0.001	-0.031	-0.013

The multivariate regressions reported above take into account the relationship between each independent variable (e.g. gender) and each outcome, *while controlling for all of the other variables in the model*. As such, the model accounts for some overlap between the predictors, but also presents the relationship between each independent variable and outcome in the context of the other variables in the model. These analyses have also been conducted as bivariate analyses, which are reported in Appendix E.

Table 4.25 – Summary of comparison between bivariate and multivariate results

Independent variable	Separating		Status loss and discrimination	
	Bivariate	Multivariate	Bivariate	Multivariate
Gender		*	*	*
Age				
Years in Australia	*		*	
Metro/rural residence				
English spoken at home	*	*	*	
Education	*		*	*
Progressive/conservative	*	*	*	*
Importance of religion				*
Income				
PGSI	*		*	*
Gambling exposure	*	*		
Gambling involvement	8	*	*	*

Note: An asterisk (*) indicates that the relationship between the independent and dependent variables was significant in the bivariate and multivariate analyses.

4.9 Chapter summary

A total of 2,000 general population respondents from Victoria completed a survey that canvassed their opinions on problem gambling in relation to other conditions, including schizophrenia, alcohol use disorder, sub-clinical distress and sub-clinical (non-problem) gambling.

In general, problem gambling was thought to be at least somewhat noticeable (not very concealable), disruptive and perilous, but that people could recover from the condition. Most commonly, the origin of the problem gambling was considered to be due to stressful life circumstances rather than other causes such as upbringing, genetic reasons, a chemical imbalance in the brain, or the person's bad character.

People with gambling problems tended to be seen as impulsive, irresponsible, greedy, irrational, untrustworthy, unproductive, and foolish. However, many respondents were still willing to socialise with a person with gambling problems, although were less willing to have a person with gambling problems marry into their family. Most respondents reported that they would feel sorry for a person with gambling problems, and would feel pity towards them, with some anger and some fear. Gambling problems were mostly attributed to addiction rather than physical or mental health disorders.

Comparisons were drawn between responses to each of the vignettes to understand how the nature of problem gambling is perceived, relative to the other vignettes examined. Compared to both the sub-clinical gambling and sub-clinical distress conditions, problem gambling was perceived as less concealable, less recoverable, more disruptive, more perilous, and more likely due to bad character or upbringing. Compared to the alcohol use disorder condition, problem gambling was perceived as more concealable, just as recoverable, less perilous, less likely to be caused by a chemical imbalance in the brain, stressful life circumstance and genetic problems, but just as likely to be caused by bad character. Compared to the schizophrenia condition, problem gambling was perceived as more concealable, more recoverable, less disruptive, less perilous, more likely to be due to bad character and upbringing, and less likely to be caused by a chemical imbalance in the brain, a genetic problem, or God's will.

While results varied slightly for the different scales measuring elements of the process of stigma creation, in general, problem gambling was more stigmatised than sub-clinical distress and sub-clinical gambling. Compared to the sub-clinical gambling and sub-clinical distress conditions, problem gambling attracted more social distancing (separating), higher levels of pity, anger and fear, and higher levels of status loss and discrimination. These results suggest that it is not necessarily gambling *per se* that is stigmatised, but problem gambling in particular, which was characterised in the vignette by gambling more than usual, particularly to gain the same feeling of excitement, being unable to cut down or stop their gambling, as well as chasing losses and lying to family and friends about the extent of their gambling.

In general, problem gambling was somewhat less stigmatised than the alcohol use disorder condition and less stigmatised than the schizophrenia condition. Compared to the alcohol use disorder condition, problem gambling attracted less social distancing, less fear and less status loss and discrimination, and about the same levels of pity and anger. Compared to the schizophrenia condition, problem gambling attracted less social distancing, less pity and fear, more anger, and less status loss and discrimination.

Numerous scales measured different aspects of stigma, but for the purposes of clarity and brevity, different demographic and behavioural groups of respondents were compared on two of the scales: separating and status loss and discrimination. The following demographic groups were significantly more willing to socialise with problem gamblers, when controlling for all other variables in the model:

females, those who speak English at home, those who are more progressive and those who have higher levels of gambling exposure and involvement. Those who thought a problem gambler would lose social status were more likely to be male, to have a trade or technical certificate or diploma or a university or college degree (compared to year 10 education), to be progressive, to place importance on religion, to be non-problem gamblers (compared to moderate risk gamblers) and to have lower levels of gambling involvement.

Chapter Five: Results from the Survey of People with Gambling Problems

5.1 Introduction

The preceding chapter focused on the nature and relative intensity of public stigma associated with problem gambling, presenting the results of a survey of the general Victorian adult community. This chapter presents results from the Survey of People with Gambling Problems to understand problem gambling-related stigma from the perspective of people who have recently experienced a serious gambling problem.

The methods for this chapter are described in Chapter Three. In summary, 203 respondents who had scored PGSI 8+ in the preceding three years completed numerous survey questions. These questions related to self-stigma, their perceptions of the public stigma associated with problem gambling, their experiences of devaluation and discrimination because of problem gambling, their coping orientation, disclosure of their gambling problem, and impacts of stigma on help-seeking (including after relapse) and on recovery orientation. Problem gambling severity, self-esteem, psychological distress, self-consciousness and demographics were also measured.

The analyses in this chapter help to inform Research Objectives 4-6. To inform Objective 4 (to determine how stigma associated with problem gambling is perceived and experienced by different groups in Victoria), overall results are first presented and comparisons are then drawn between various demographic and behavioural groups in terms of their experience of stigma. To inform Objective 5 (to determine how significant stigma is as an impediment to treatment or interventions for problem gambling and how recovery from problem gambling is impacted by stigma), results are presented about the impact of self-stigma and stigma from others on help-seeking behaviour and on recovery orientation. To inform Objective 6 (to analyse how stigma impacts people with gambling problems seeking treatment for the first time, compared to those seeking treatment after a relapse), those who had relapsed were compared to those who had not relapsed on measures of stigma and help-seeking.

5.2 Sample demographics

The sample was predominantly male (66.5%) with a mean age of 40.9 years ($SD = 13.9$). Respondents had lived in Australia for 36.1 years on average ($SD = 15.4$). Most of the sample (91.6%) reported speaking English as their main language at home. Respondents were drawn from all states and the ACT. Table 5.1 summarises the demographic characteristics of the sample.

Table 5.1 – Demographic characteristics of the sample

State/Territory	N	%
Australian Capital Territory	5	2.5
New South Wales	76	37.4
Victoria	45	22.2
Queensland	43	21.2
South Australia	15	7.4
Western Australia	14	6.9
Tasmania	4	2.0
<i>Missing</i>	1	0.5
Highest level of education	N	%
Postgraduate qualifications	14	6.9
A university or college degree	41	20.2
A trade, technical certificate or diploma	61	30.0
Year 12 or equivalent	50	24.6
Year 10 or below	37	18.2
Importance of religion	N	%
1 = Not at all important	67	33.0
2	28	13.8
3	16	7.9
4	36	17.7
5	27	13.3
6	7	3.4
7 = Very important	22	10.8

Table 5.1 – Demographic characteristics of the sample (cont.)

Religion	N	%	Valid %
Catholic	45	22.2	23.6
Protestant/Anglican	26	12.8	13.6
Other Christian	20	9.9	10.5
Buddhism	3	1.5	1.6
Hinduism	3	1.5	1.6
Islam	1	0.5	0.5
Judaism	1	0.5	0.5
Other religion	5	2.5	2.6
No religion	87	42.9	45.5
<i>Prefer not to say</i>	12	5.9	-
Income bracket	N	%	Valid %
Less than \$20,000	24	11.8	14.0
\$20,000 - \$39,999	26	12.8	15.2
\$40,000 - \$59,999	34	16.7	19.9
\$60,000 - \$79,999	24	11.8	14.0
\$80,000 - \$99,999	22	10.8	12.9
\$100,000 - \$119,999	9	4.4	5.3
\$120,000 - \$139,999	13	6.4	7.6
\$140,000 - \$159,999	5	2.5	2.9
\$160,000 - \$179,999	6	3.0	3.5
\$180,000 - \$199,999	3	1.5	1.8
More than \$200,000	5	2.5	2.9
<i>Prefer not to say</i>	32	15.8	-

5.3 Self-stigma

This section is the first of several (Section 5.3 to Section 5.6) that help to address Objective 4, to determine how stigma associated with problem gambling is perceived and experienced by different groups in Victoria.

Respondents were asked 19 questions measuring negative emotional reactions to their gambling problem. The most common feelings respondents reported were: disappointed in yourself, ashamed, embarrassed, guilty, stupid, weak, a failure, shocked at yourself, lack of willpower, that there is something wrong with you, that you should be able to fix it on your own, that you are entirely to blame, and that they are worse than people who can control their gambling (Figure 5.1).

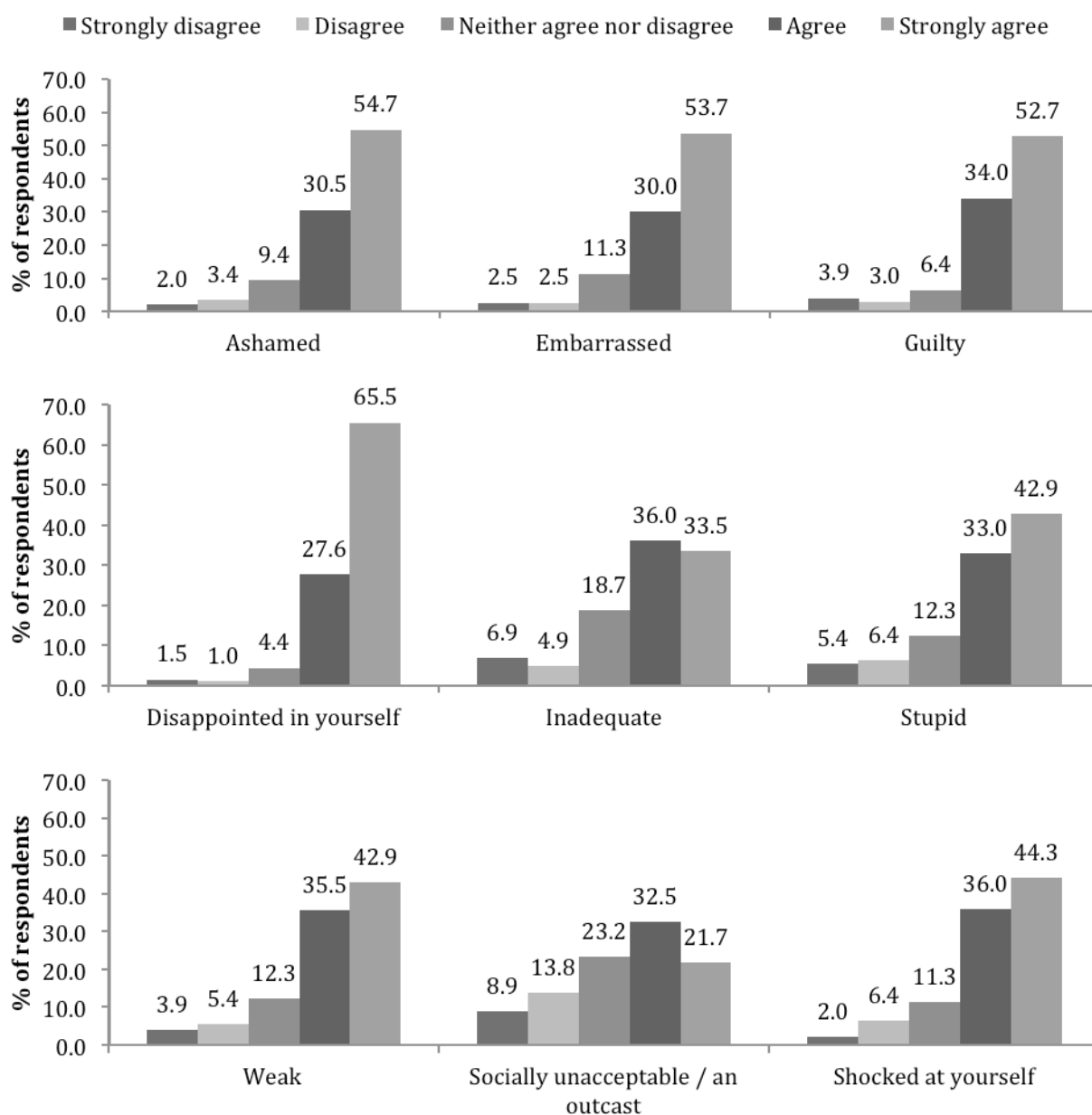


Figure 5.1 – Responses to items on the Self-stigma scale. Respondents indicated their level of agreement with each item regarding how they felt about themselves in relation to their gambling behaviour

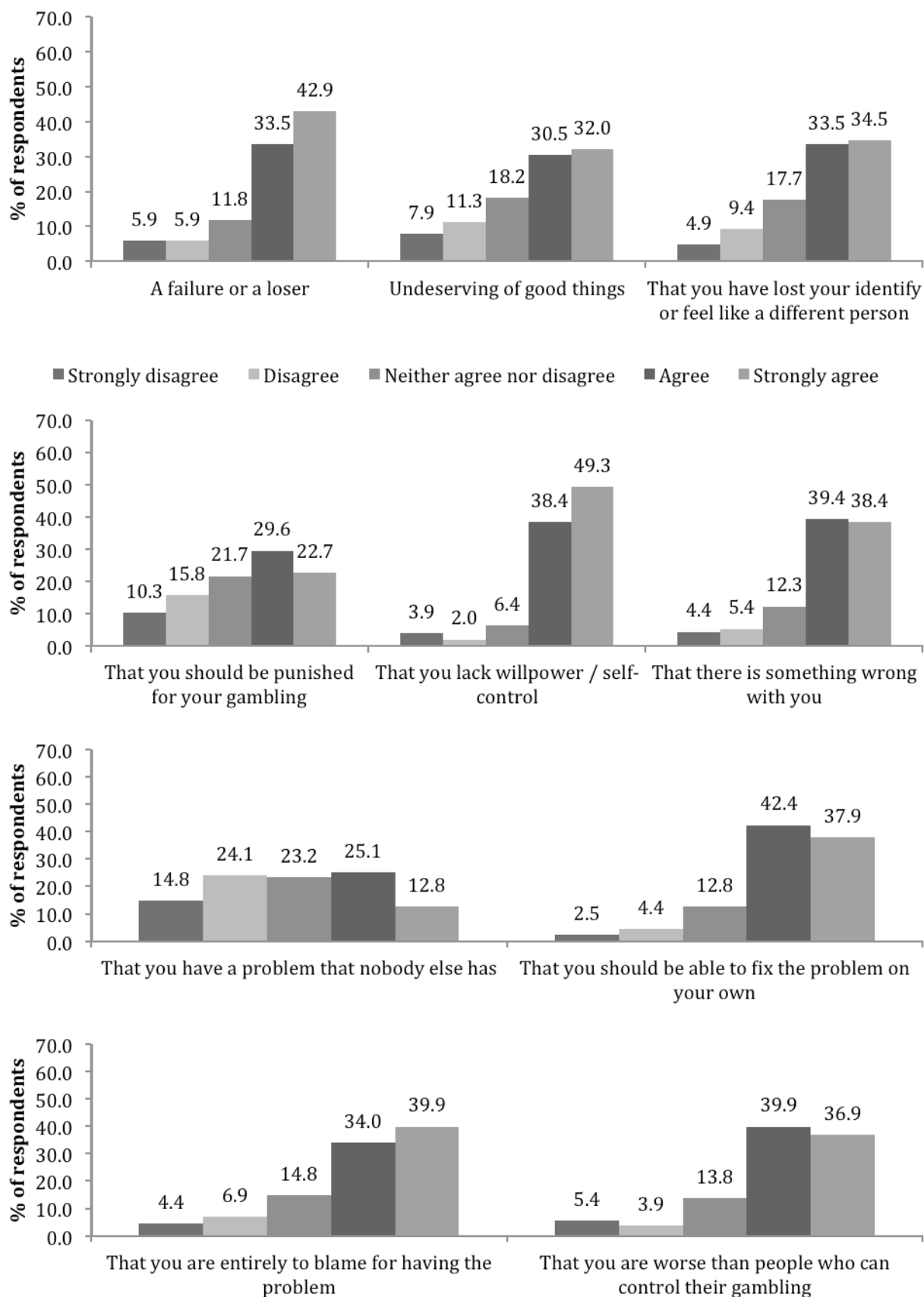


Figure 5.1 (cont'd) – Responses to items on the Self-stigma scale. Respondents indicated their level of agreement with each item regarding how they felt about themselves in relation to their gambling behaviour

5.4 Perceived public stigma associated with problem gambling

5.4.1 Perceived relative public stigma of problem gambling

Respondents were asked to rate how much stigma they think that *most people* attach to nine conditions. The conditions that the sample saw as the most stigmatised by the general public were: drug addiction, problem gambling, alcoholism, and obesity, whereas other conditions such as recreational gambling and cancer were generally perceived to attract less public stigma (Figure 5.2).

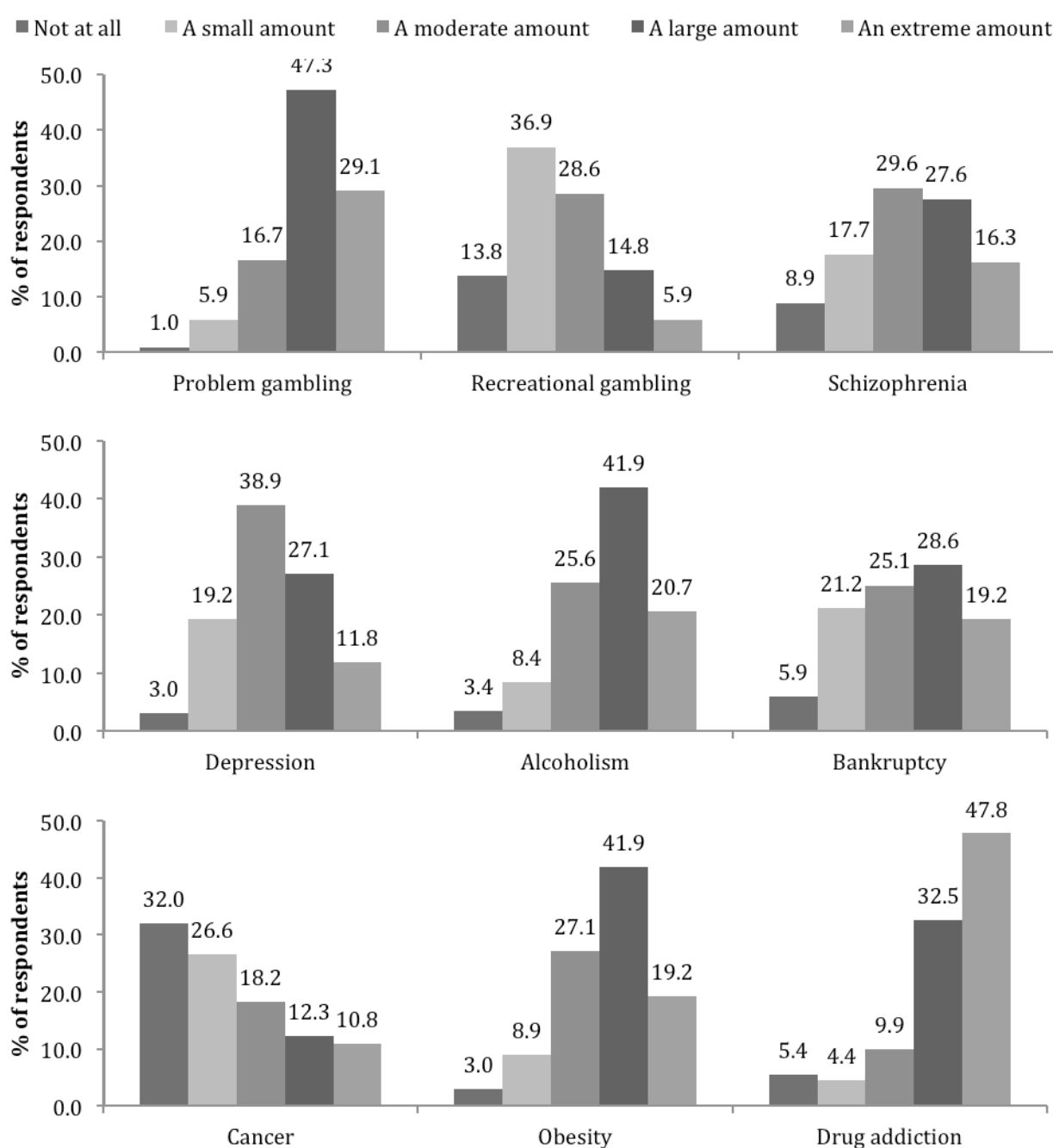


Figure 5.2 – Respondents' perception of 'how much' stigma is attached, by the public, to a variety of commonly stigmatised conditions (Perceived relative public stigma)

The mean, standard deviation and median rating for each condition are presented in Table 5.2. Repeated measures comparisons were conducted using both parametric (paired samples *t*-test). These analyses compared the perceived public stigma of problem gambling to each of the other conditions individually.

Parametric analyses indicated that respondents believed that problem gambling is significantly more stigmatised compared to all other conditions except for drug addiction, where this latter comparison was not statistically significant. Statistical results are presented in Table 5.2.

Table 5.2 – Statistical results for comparison of perceived stigma of problem gambling compared to perceived stigma of other conditions

Condition	Mean	SD	Median	Parametric statistics		
				<i>t</i> (202)	<i>p</i>	<i>d</i>
Problem gambling	2.98	0.89	3.00			
Recreational gambling	1.62	1.08	1.00	17.00	< 0.001	2.39
Schizophrenia	2.25	1.19	2.00	7.37	< 0.001	1.04
Depression	2.26	1.00	2.00	8.88	< 0.001	1.25
Alcoholism	2.68	1.01	3.00	3.86	< 0.001	0.54
Bankruptcy	2.34	1.18	2.00	7.32	< 0.001	1.03
Cancer	1.43	1.34	1.00	13.01	< 0.001	1.83
Obesity	2.66	0.99	3.00	3.92	< 0.001	0.55
Drug addiction	3.13	1.11	3.00	-1.76	0.081	-

Note: The statistics compare each condition to the problem gambling condition.

The response options were 'none' (0), 'a small amount' (1), 'a moderate amount' (2), 'a large amount' (3) and 'an extreme amount' (4).

5.4.2 Perceived characteristics the public associates with problem gamblers

Two sets of questions asked respondents about the characteristics they believe the general public applies to problem gamblers. For the first question which contained common stereotypes associated with problem gamblers, most participants responded towards the more negative sides of all scales (Figure 5.3).

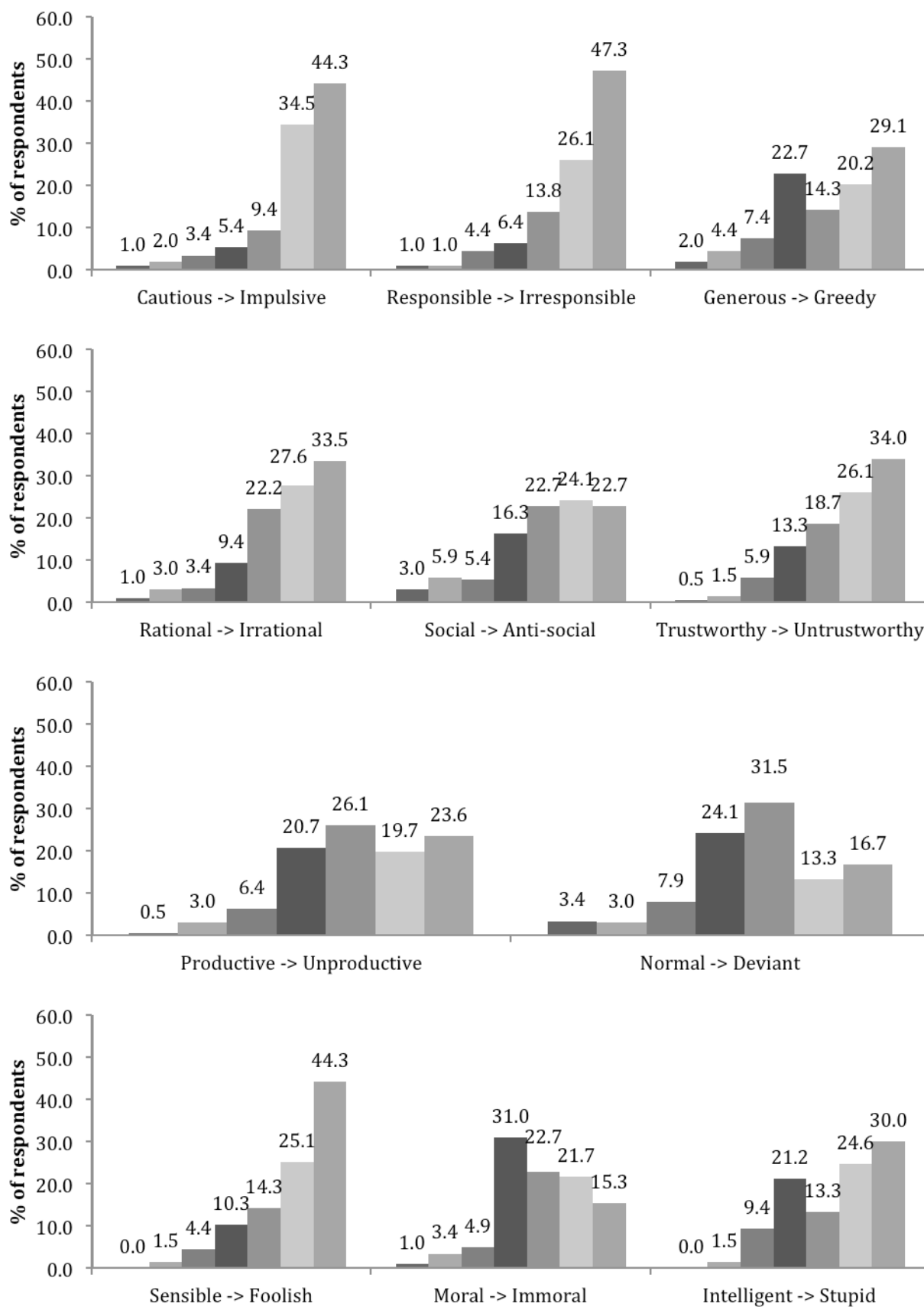


Figure 5.3 – Participants' rating of how much they thought most people believe each stereotype applies to problem gamblers. Response options ranged from 1-7, where higher scores indicated greater agreement with the stereotype (Perceived Stereotyping Scale),

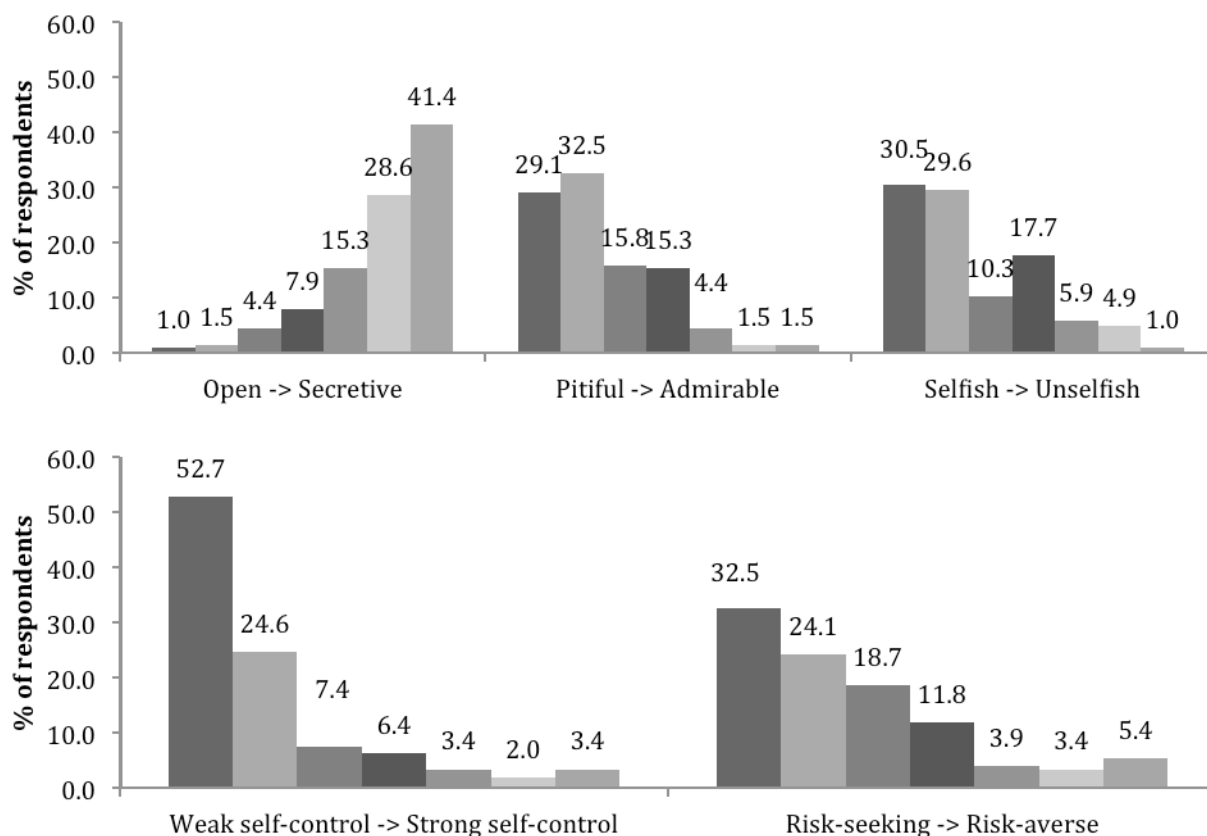


Figure 5.3 (cont'd) – Participants' rating of how much they thought most people believe each stereotype applies to problem gamblers. Response options ranged from 1-7, where higher scores indicated greater agreement with the stereotype (Perceived Stereotyping Scale),

Respondents were also asked how they thought others perceived problem gamblers in terms of the characteristics in Figure 5.4. Most respondents agreed with almost all statements, with the exception of 'feel no guilt' and 'low socio-economic status'.

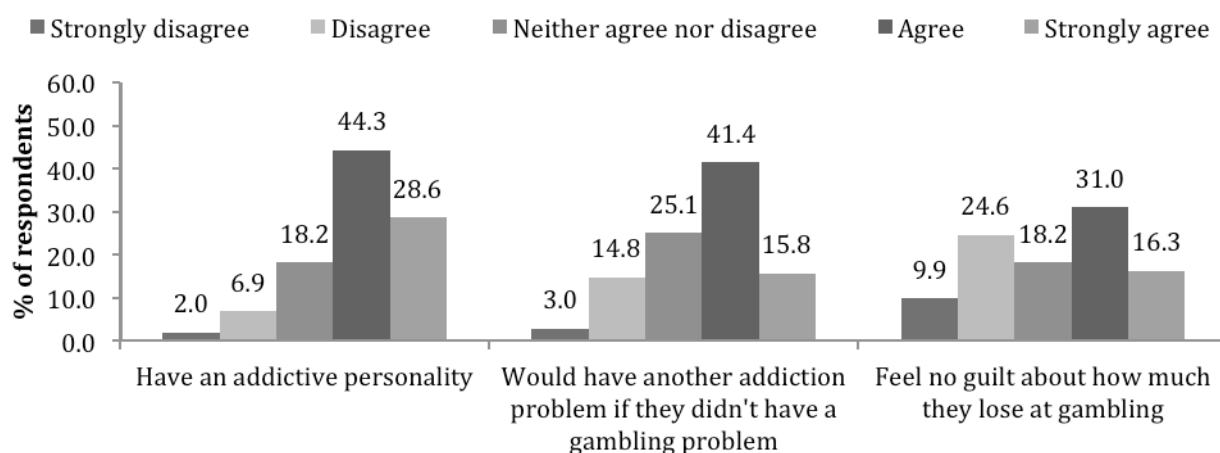


Figure 5.4 – Participants' level of agreement that most people believe each characteristic applies to problem gamblers. (Perceived Characteristics of Problem Gamblers Scale)

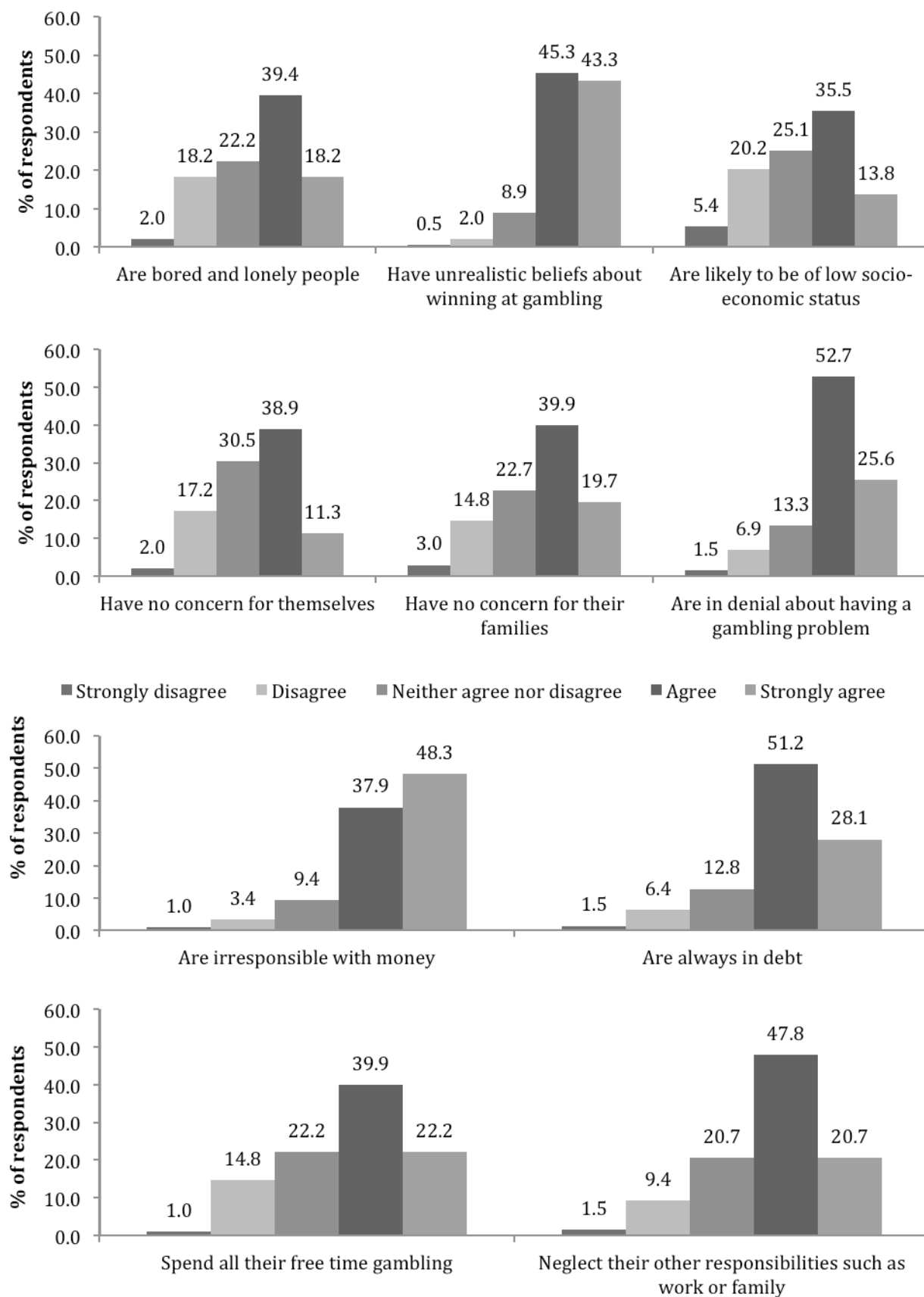


Figure 5.4 (cont'd) – Participants' level of agreement that most people believe each characteristic applies to problem gamblers. (Perceived Characteristics of Problem Gamblers Scale)

5.4.3 Perceived public attitudes about the dimensions of problem gambling

Respondents were asked what most people think about problem gamblers in terms of five dimensions that are thought to influence public stigma. Most respondents agreed that the general public thinks that people can recover from being a problem gambler (course), that being a problem gambler disrupts the person's life (disruptiveness), and that becoming a problem gambler is the person's own fault (origin). However, respondents were more divided about whether most people would notice if a close friend was a problem gambler (concealability), and disagreed on average that most people think that problem gamblers are likely to do something violent to other people (peril) (Figure 5.5).

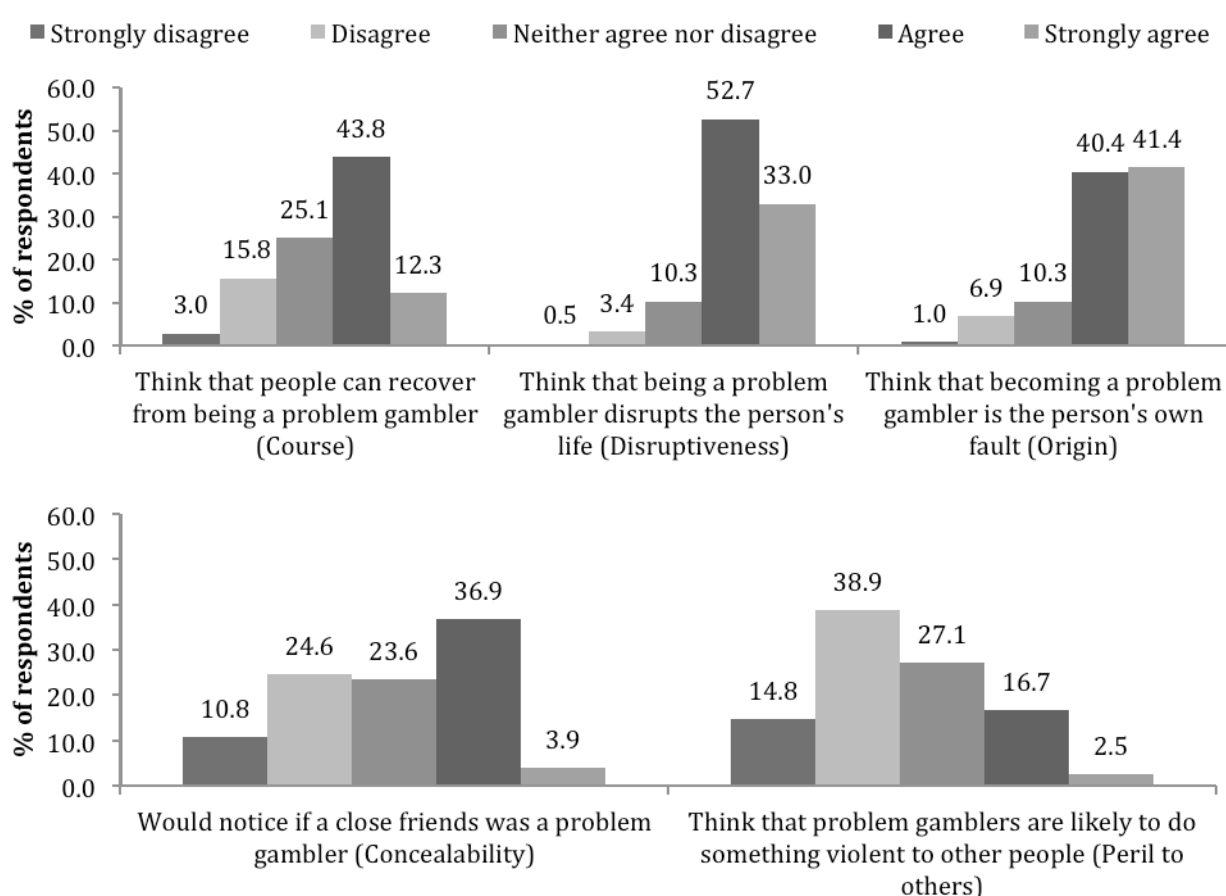


Figure 5.5 – Respondents' perceptions of the general public's thoughts on different dimensions of public stigma surrounding problem gamblers

5.4.4 Perceived public attitudes about elements in the process of stigma creation

In terms of the process of stigma creation, most respondents agreed that the general public thinks that problem gamblers are addicts (labelling), considers them irresponsible (stereotyping), would feel anger towards problem gamblers (emotional reactions), and would look down upon problem gamblers (status loss and discrimination). However, respondents were more divided about whether the general public thinks that problem gamblers are mentally ill (labelling), would not want to interact with a problem gambler (separating), would be afraid of a problem gambler (emotional reactions), and would feel sorry for a problem gambler (emotional reactions) (Figure 5.6).

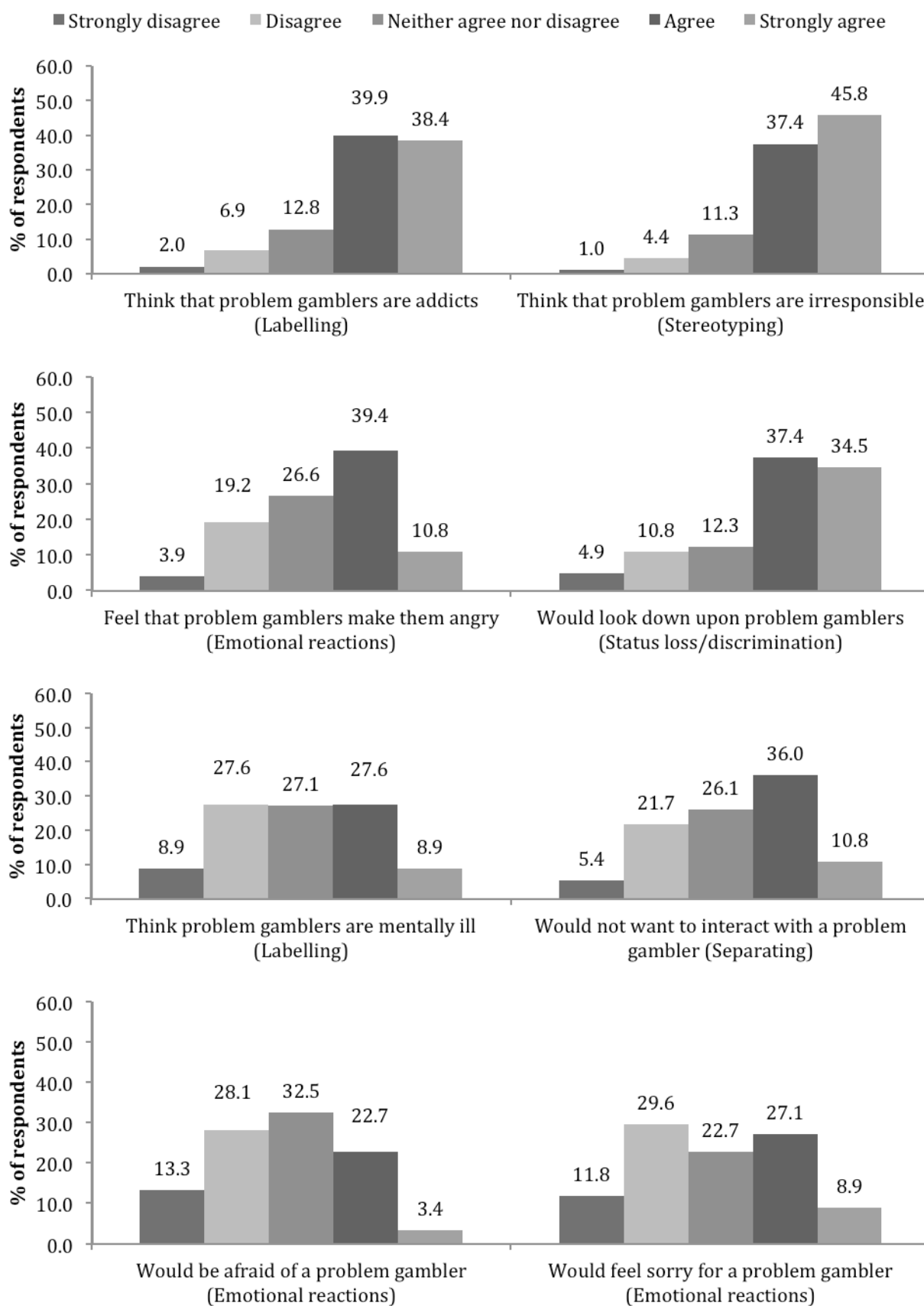


Figure 5.6 – Respondents' perceptions of the general public's thoughts on the process of stigma creation about problem gamblers (Creation of public stigma)

5.4.5 Comparisons with Stage 2 results

Respondents' perceptions of public attitudes about the dimensions of problem gambling and elements in the process of stigma creation were compared to the relevant Stage 2 survey responses from 2,000 Victorian adults. In both the Stage 2 and Stage 3 surveys, we asked single questions that were related to the scales from Stage 2 pertaining to the dimensions of stigma and the process of stigma creation. For example, the single item related to the concealability scale was 'I would notice if a close friend was a problem gambler' (in Stage 2) or 'Most people would notice if a close friend was a problem gambler' (in Stage 3). In both surveys, response options were 'Strongly disagree' (-2), 'Disagree' (-1), 'Neither agree nor disagree' (0), 'Agree' (1) and 'Strongly agree' (2).¹⁰

Confidence intervals were used to compare the results from Stage 2 to Stage 3. If a mean for an item from one stage does not fall within the confidence interval for the same item from the other stage, then the results may be considered statistically significantly different. In this case, as the confidence intervals were different widths, we required that the mean from *both* stages fell outside of the confidence interval from the other stage in order to be considered as statistically significant.

Significant differences are indicated in Table 5.3, with higher scores indicating more agreement with the item. The Stage 3 respondents (who had recently experienced having a gambling problem) significantly underestimated how much the general population thought that problem gambling was noticeable, recoverable, and how disruptive the general population thought problem gambling was. Stage 3 respondents significantly overestimated how much the general population thinks that problem gambling is the gambler's own fault, how much fear and anger the general population feels towards problem gamblers, how irresponsible the general population feels that problem gamblers are, how much the general population would like to avoid problem gamblers, and how much the general population would look down upon problem gamblers.

¹⁰ Using Stage 2 data, the single item questions were compared to their scales to determine whether there was some relationship between the single items and the scales. All were significantly correlated with their scale, although some of the correlations were relatively low (< 0.3). However, these correlations indicated that the single items were at least somewhat related to the scales and could be used in their place. These correlations are in Appendix F.

Table 5.3 – Comparison of Direct Questions on dimensions of stigma and process of stigma creation from Stage 2 and Stage 3

Construct	Item	Stage 2			Stage 3		
		Mean	95% CI Lower	95% CI Upper	Mean	95% CI Lower	95% CI Upper
Concealability	I would notice if a close friend was a problem gambler	0.46*	0.42	0.49	-0.02	-0.17	0.14
Course	People can recover from being a problem gambler	1.13*	1.10	1.16	0.47	0.33	0.61
Disruptiveness	Being a problem gambler disrupts the person's life	1.41*	1.38	1.44	1.14	1.04	1.25
Origin	Becoming a problem gambler is the person's own fault	0.10	0.05	0.14	1.14*	1.01	1.27
Peril to others	Problem gamblers are likely to do something violent to other people	-0.38	-0.42	-0.34	-0.47	-0.61	-0.33
Emotions: fear	I would be afraid of a problem gambler	-0.50	-0.55	-0.46	-0.25*	-0.40	-0.10
Emotions: anger	Problem gamblers make me angry	-0.22	-0.26	-0.17	0.34*	0.20	0.48
Emotions: pity	I would feel sorry for a problem gambler	0.56	0.51	0.60	-0.08	-0.25	0.08
Labelling: addiction	Problem gamblers are addicts	1.26*	1.23	1.29	1.06	0.92	1.20
Labelling: mentally ill	Problem gamblers are mentally ill	0.13	0.09	0.17	0.00	-0.16	0.16
Stereotyping	Problem gamblers are irresponsible	0.62	0.58	0.66	1.23*	1.10	1.35
Separating	I would not want to interact with a problem gambler	-0.15	-0.19	-0.10	0.25*	0.10	0.40
Status loss and discrimination	I would look down upon problem gamblers	-0.38	-0.42	-0.34	0.86*	0.70	1.02

Note: * Indicates a significantly higher mean in a row, with higher scores indicating greater agreement with the item.

5.5 Devaluation and discrimination because of problem gambling

5.5.1 Devaluation

Respondents were asked the frequency of experiencing nine potentially devaluing experiences because people thought they had a gambling problem. More than half of the respondents reported at least occasionally experiencing being treated as inferior, as not smart, less politely, with less respect, as if they were dishonest, and being insulted or called names because others thought they had a gambling problem (Figure 5.7). More than half of the respondents reported never experiencing worse service, threatening or harassing behaviour, or being treated as if others were afraid of them because others thought they had a gambling problem.

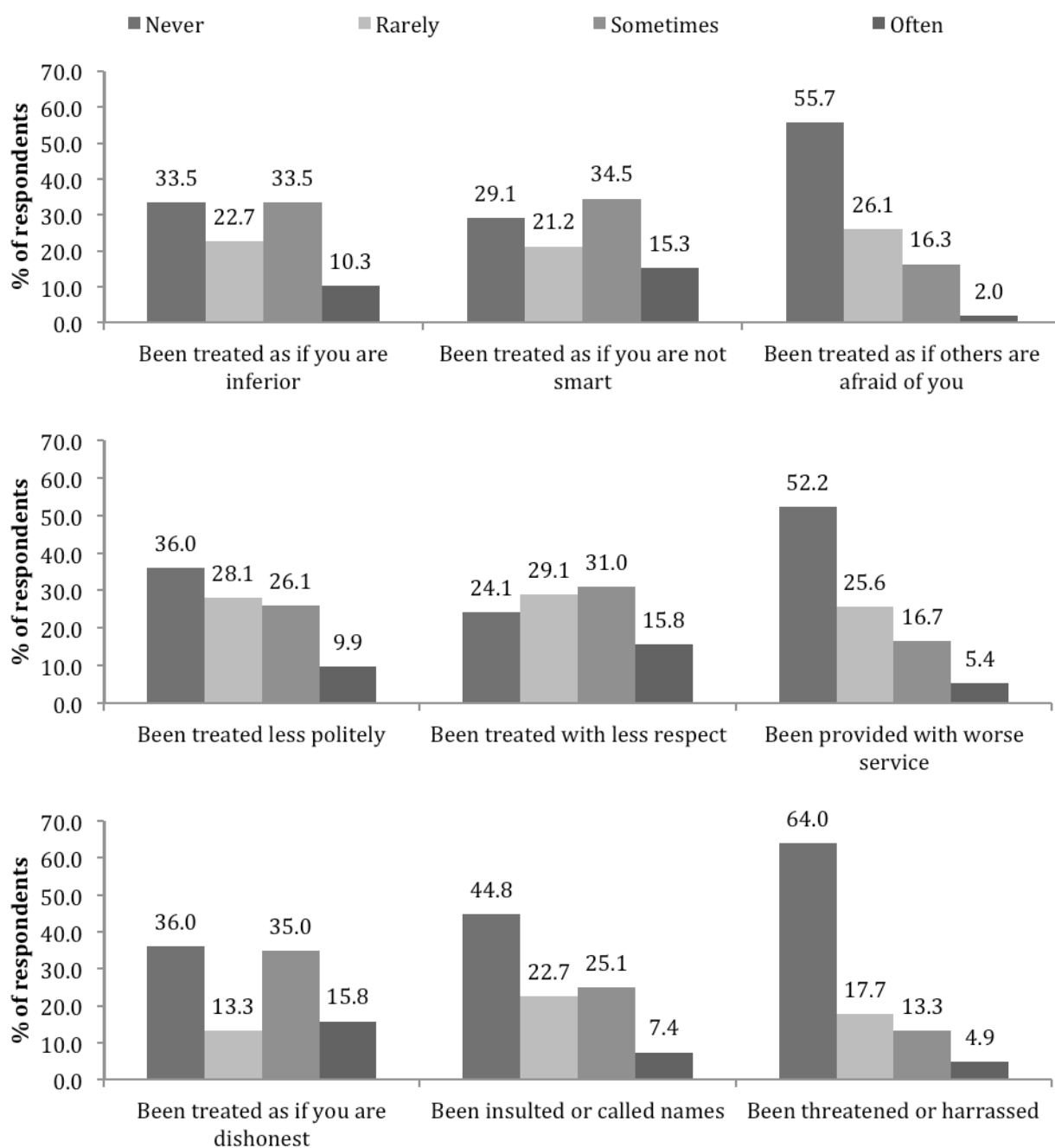


Figure 5.7 – Frequency ratings for each item in response to 'How often have you experienced each of the following because someone thought you had a gambling problem?' (Devaluation Scale)

5.5.2 Discrimination

Respondents were asked whether they had ever experienced any of 13 discriminatory actions because people thought they had a gambling problem. Of all of the items in Figure 5.8 relating to discrimination, the most commonly reported item was being denied a bank loan because others thought they had a gambling problem (23.1%). For all other items, less than 10% of respondents reported experiencing that discrimination.

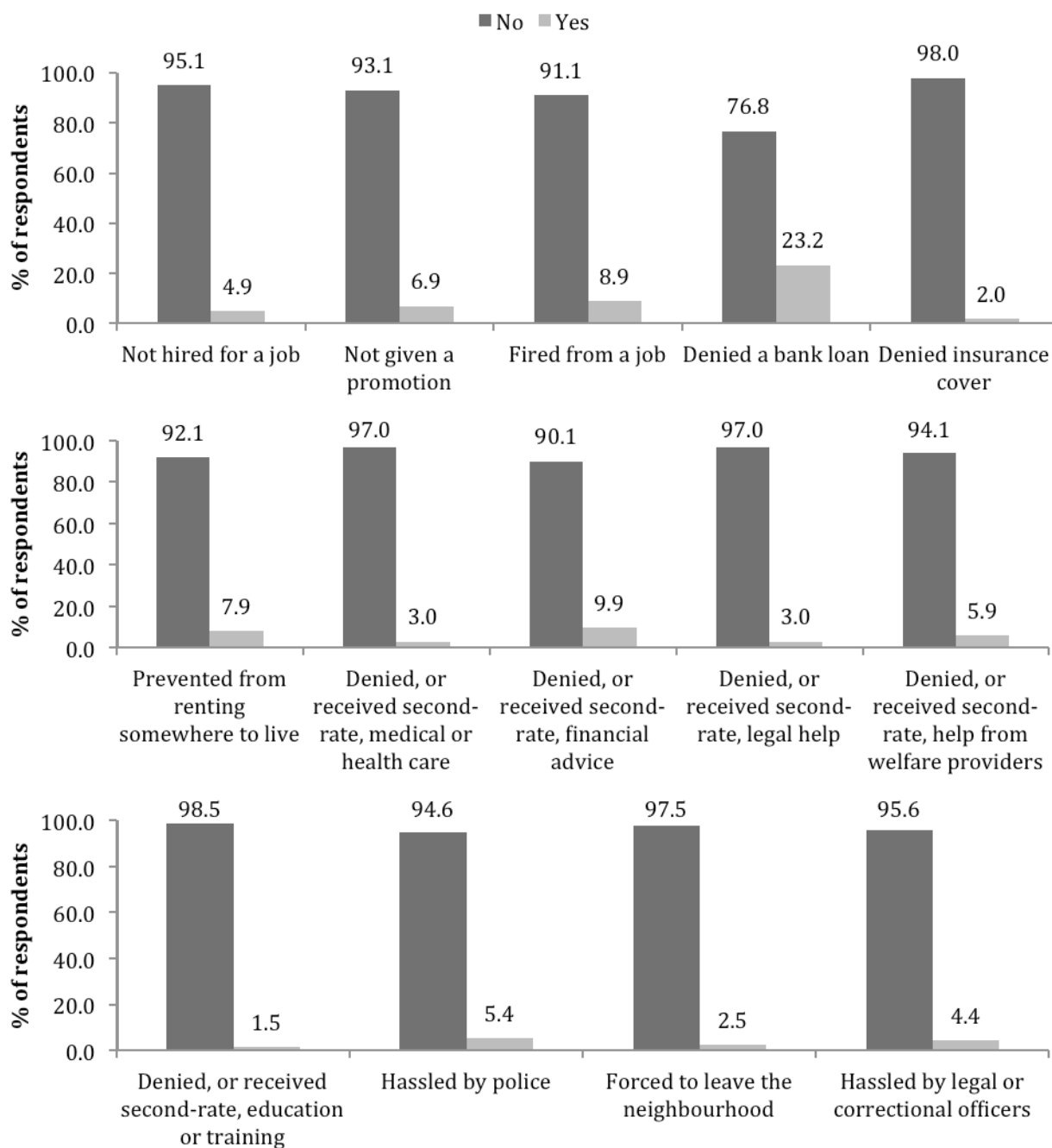
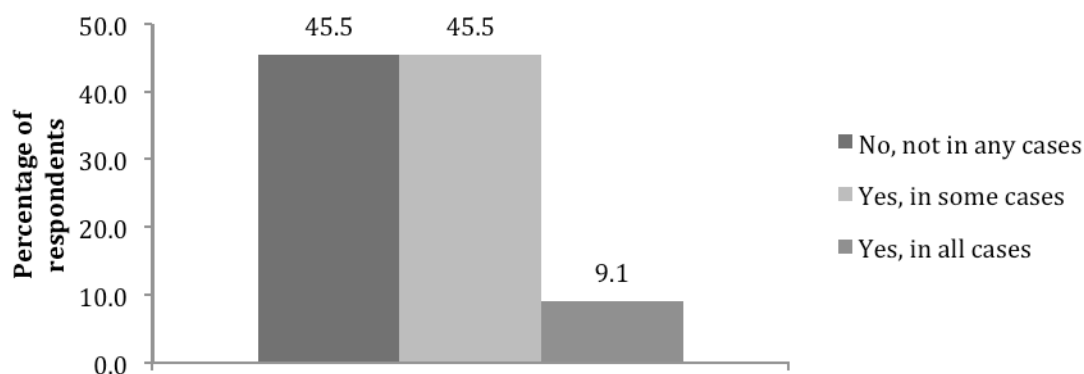


Figure 5.8 – Responses to items on the Discrimination Scale asking whether the respondent had experienced that form of discrimination because people thought they had a gambling problem.

Of those who had experienced any of the discriminatory actions reported in Figure 5.8, more than half reported that they had been told that the action was specifically due to their gambling in at least some cases (Figure 5.9).



Figure

Figure 5.9 – Proportion of respondents who had experienced discrimination who were explicitly told that it was due to their gambling. Note: 126 respondents were not asked this question as they had not experienced any of the items in Figure 5.8.

5.6 Coping with perceived stigma about problem gambling

5.6.1 Coping orientation

Respondents were asked 13 questions to ascertain which of six potential coping orientations they most used. Most respondents reported hiding evidence of their gambling from others or lying about their gambling, whereas most disagreed with participating in education efforts, taking illicit drugs or smoking to help deal with their feelings of embarrassment about their gambling problem (Figure 5.10). Thus, secrecy was the main coping mechanism used, with little reported use of withdrawal, educating, challenging, distancing and substance use.

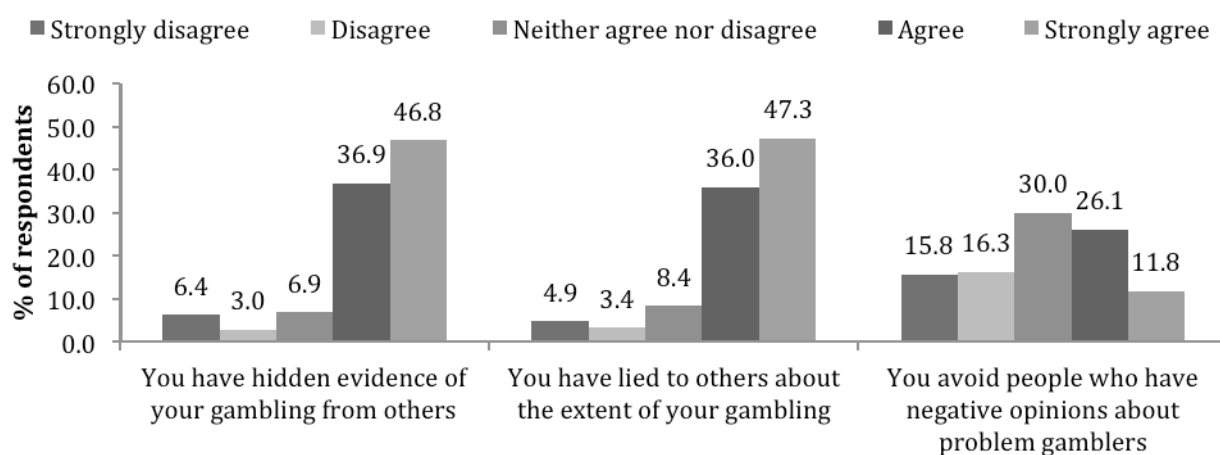


Figure 5.10 – Responses indicating the level of agreement that the respondent employs the various coping methods described (Coping orientation)

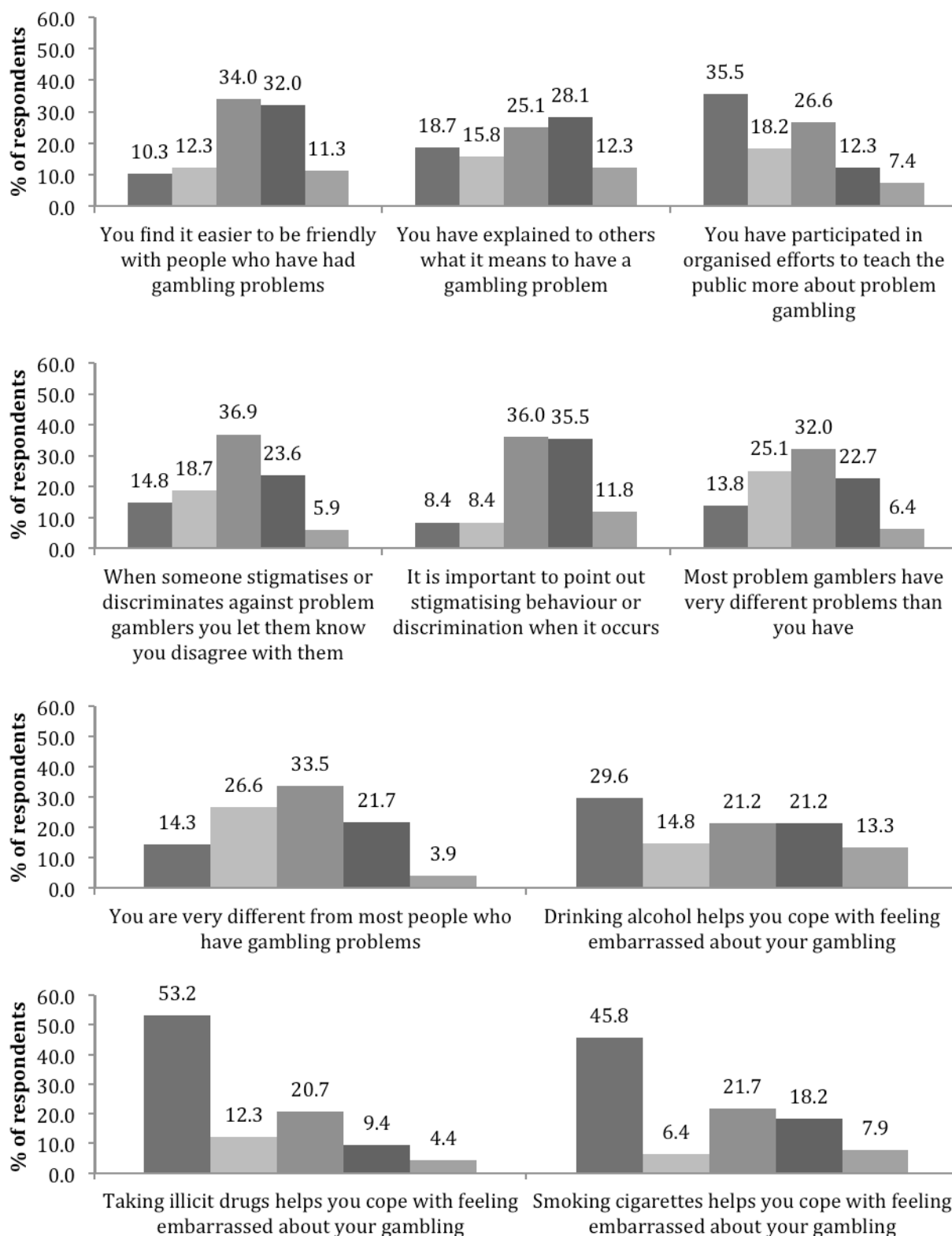


Figure 5.10 (cont'd) – Responses indicating the level of agreement that the respondent employs the various coping methods described (Coping orientation)

5.6.2 Fear of disclosure of own gambling

Participants rated how afraid they were of 13 aspects relating to disclosing their gambling problem. Respondents were most afraid about embarrassing their family (92% at least a little bit afraid), being

exposed as a person with a gambling problem (91%), being labelled a problem gambler (90%), their friends finding out (89%) other family members finding out (89%), doing damage to their employment or career (85%), and their partner or spouse finding out (77%) (Figure 5.11). Respondents were least afraid of people such as police, legal or correctional officers, gambling counsellors, other health professionals, welfare providers, gaming venue staff and other patrons in the gaming venue finding out about their gambling problem.

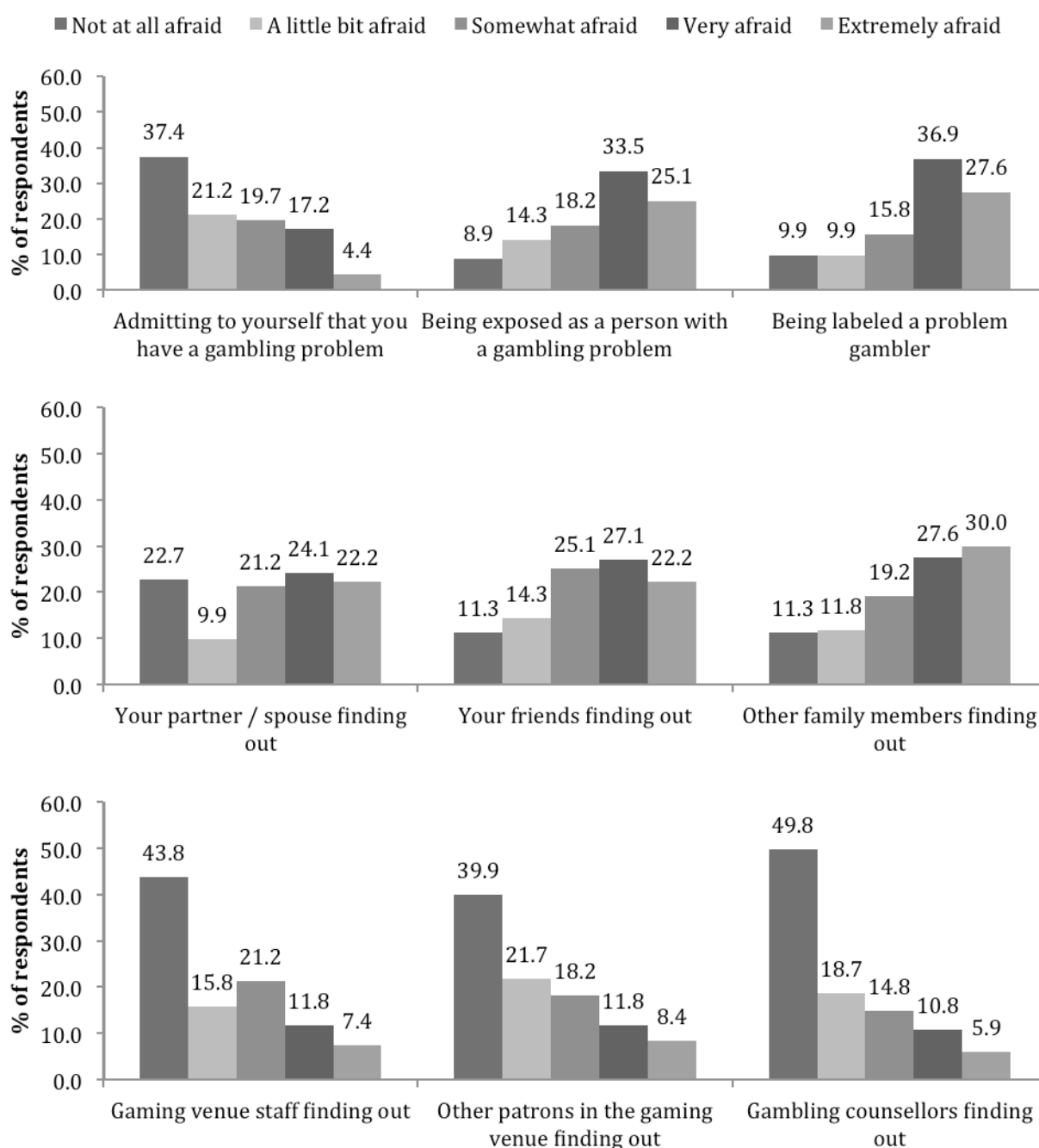


Figure 5.11 – Respondents' rating of fear concerning disclosure of their gambling problem in different settings or with different people (Fear of Disclosure Scale)

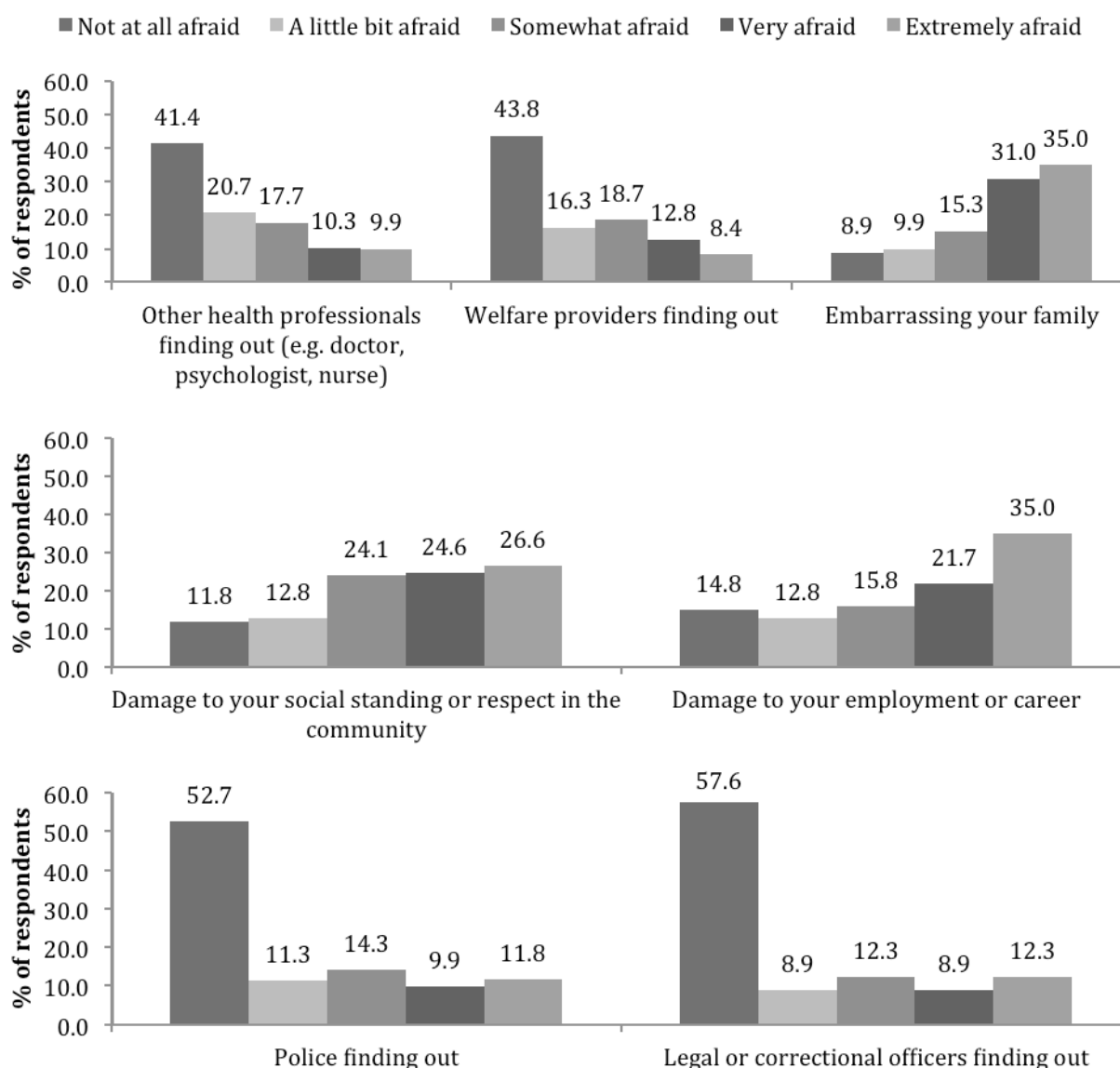


Figure 5.11 (cont'd) – Respondents' rating of fear concerning disclosure of their gambling problem in different settings or with different people (Fear of Disclosure Scale)

5.6.3 Actual disclosure of own gambling

Respondents were asked how much the people around them knew about their gambling. For at least half of the respondents, the following people did not know that the respondent gambled at all: their children, their employer and work colleagues, their doctor/other health professionals, welfare or other service providers they are in contact with, and other organisations they are in contact with (Figure 5.12). Small proportions of respondents indicated that others knew that they gamble as much as they do. Third parties most likely to know the true extent of the respondent's gambling were gaming venue personnel where the respondent gambled (45.3%), and friends they gamble with (31.5%), followed by parents (19.2%), partner/spouse (18.7%), and friends they don't gamble with (17.7%).

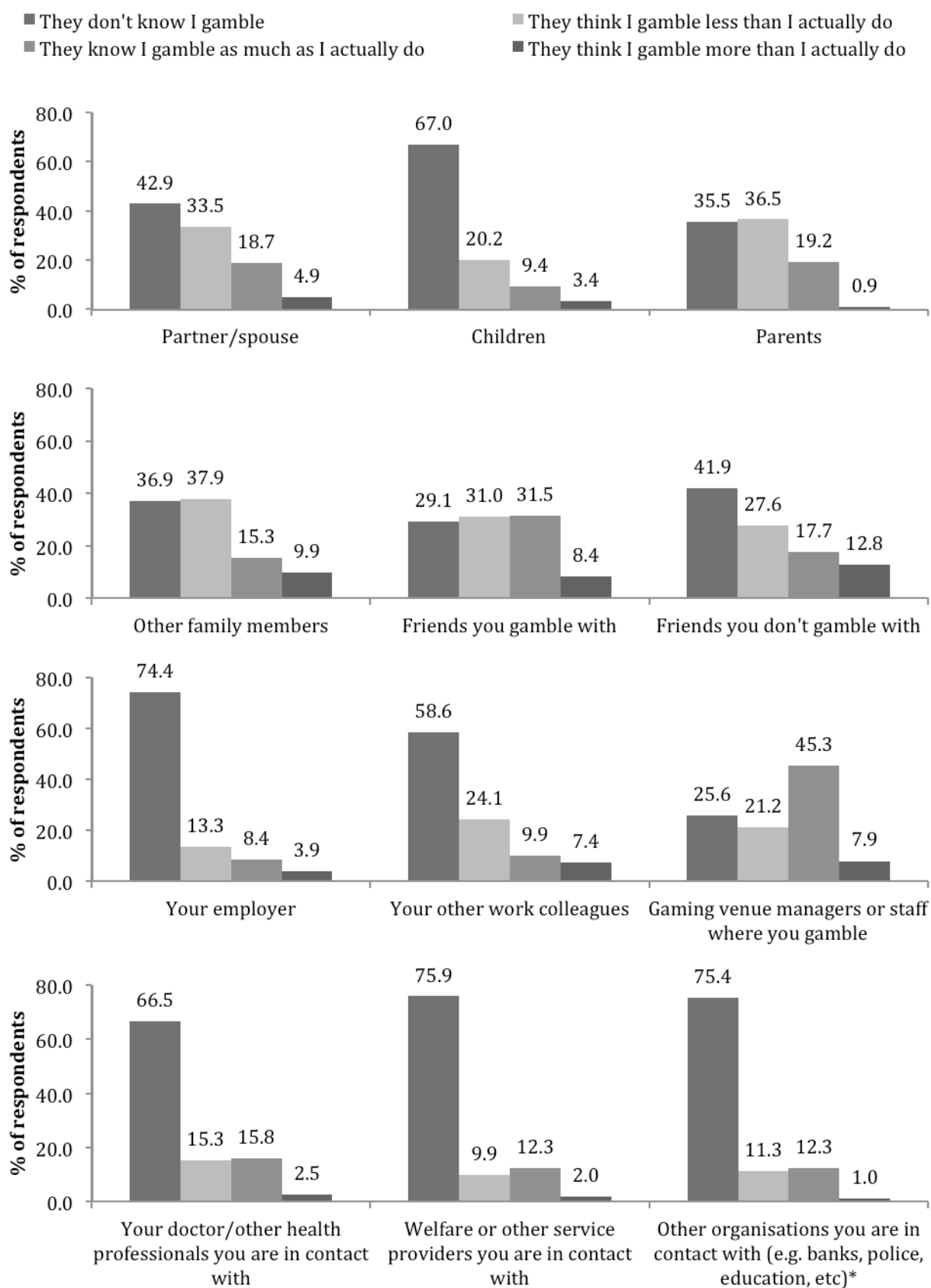


Figure 5.12 – Participants' indication of different groups' or peoples' awareness of how much they actually gamble (Actual disclosure of gambling)

Note: * The full list for this question was: banks, housing providers, insurance companies, police, legal professionals, correctional officers, education and training providers, etc.

5.7 Impacts of stigma on help-seeking

5.7.1 Self-stigma of seeking help

When asked how they would feel about seeking help from a therapist, self-excluding, or seeking help from family or friends, responses were generally split across agreement and disagreement for all four items. Seeking help from a therapist and self-excluding were anticipated to lead to feelings of empowerment by more than half of the sample, while seeking help from family and friends was anticipated by most respondents to lead to feelings of stupidity and inadequacy (Figures 5.13-5.15).

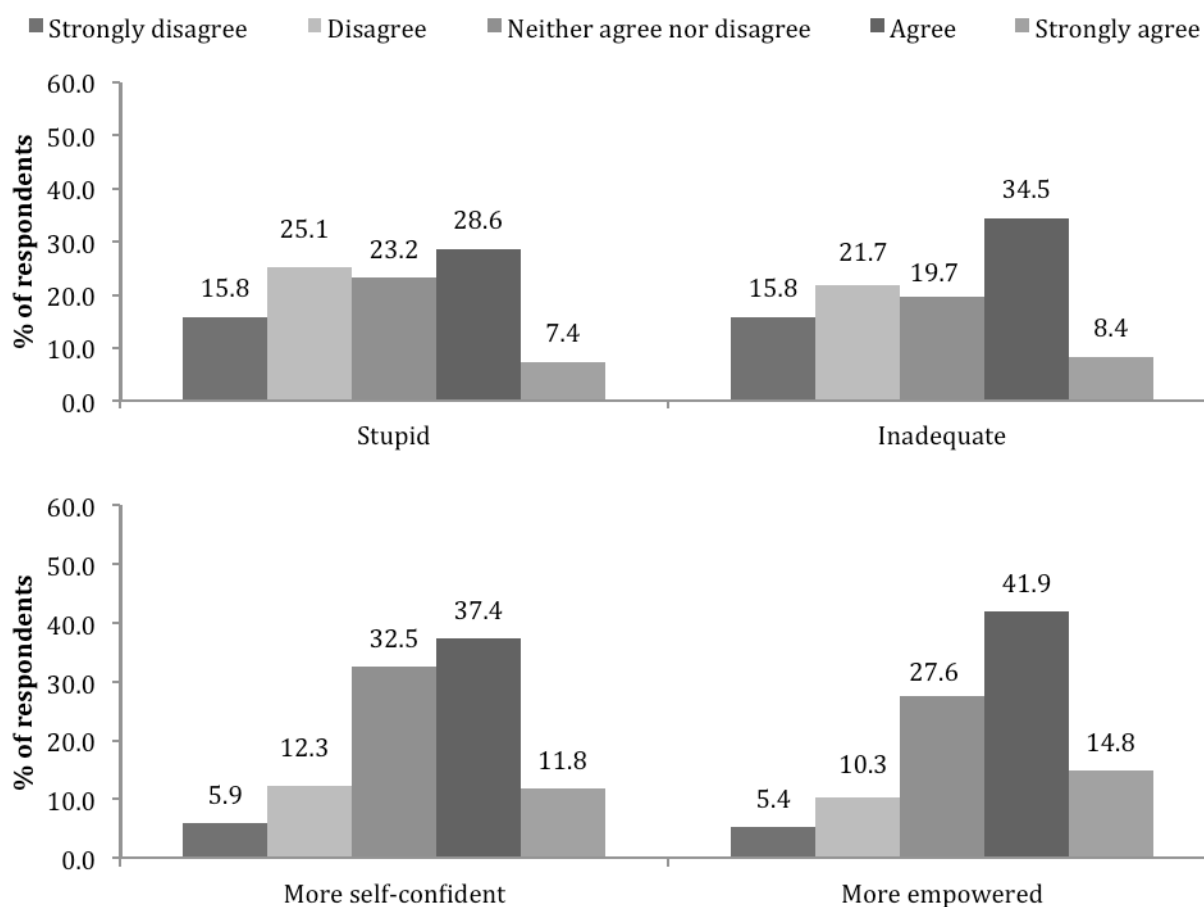


Figure 5.13 – Responses to items in response to 'Going to a therapist for psychological help would make you feel...' (Self-Stigma of Seeking Professional Help Scale)



Figure 5.14 – Responses to items in response to 'Self-excluding from a gambling venue for a gambling problem would make you feel...' (Self-Stigma of Seeking Self-Exclusion Scale)

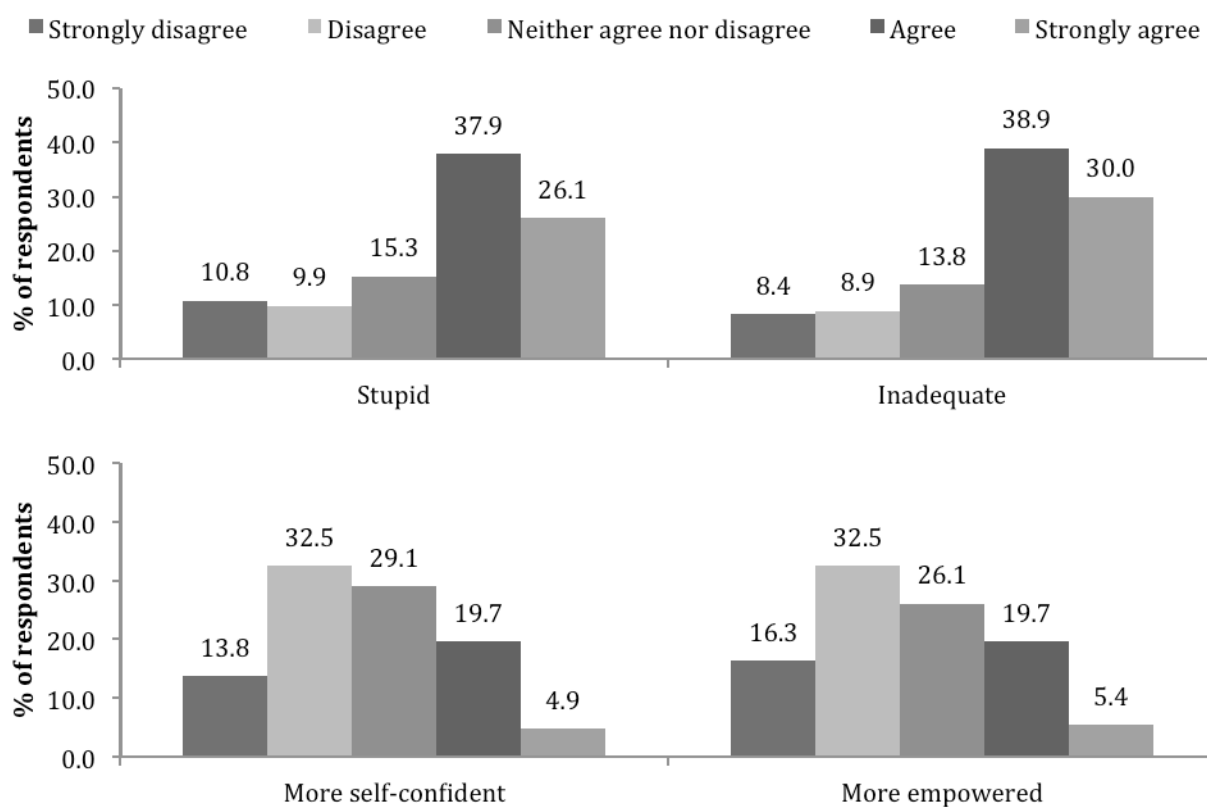


Figure 5.15 – Responses to items in response to 'Seeking help from family or friends for a gambling problem would make you feel...' (Self-Stigma of Seeking Non-Professional Help Scale)

5.7.2 Help-seeking before and after relapse

Respondents were asked whether they had ever felt that they had overcome a gambling problem or regained control of their gambling, with 53.3% saying that they felt that they had and 46.7% stating that they felt that they had not. Of those who felt that they had, 81.1% reported relapsing back into having a gambling problem, while 18.9% reported that they had not relapsed.

Respondents who had relapsed were asked whether they had sought help from 11 possible sources 'never', 'before relapsing' or 'after relapsing', with multiple responses possible for the last two options. The most common forms of help sought were self-help, help from family or friends, and help from specialist gambling counsellors. The least common forms were residential treatment programs, online support groups or discussion boards, and face-to-face support groups (Figure 5.16). This help-seeking often occurred before a relapse into gambling problems, but many sought help after such a relapse, particularly from more formal modes, family or friends, or self-help strategies.

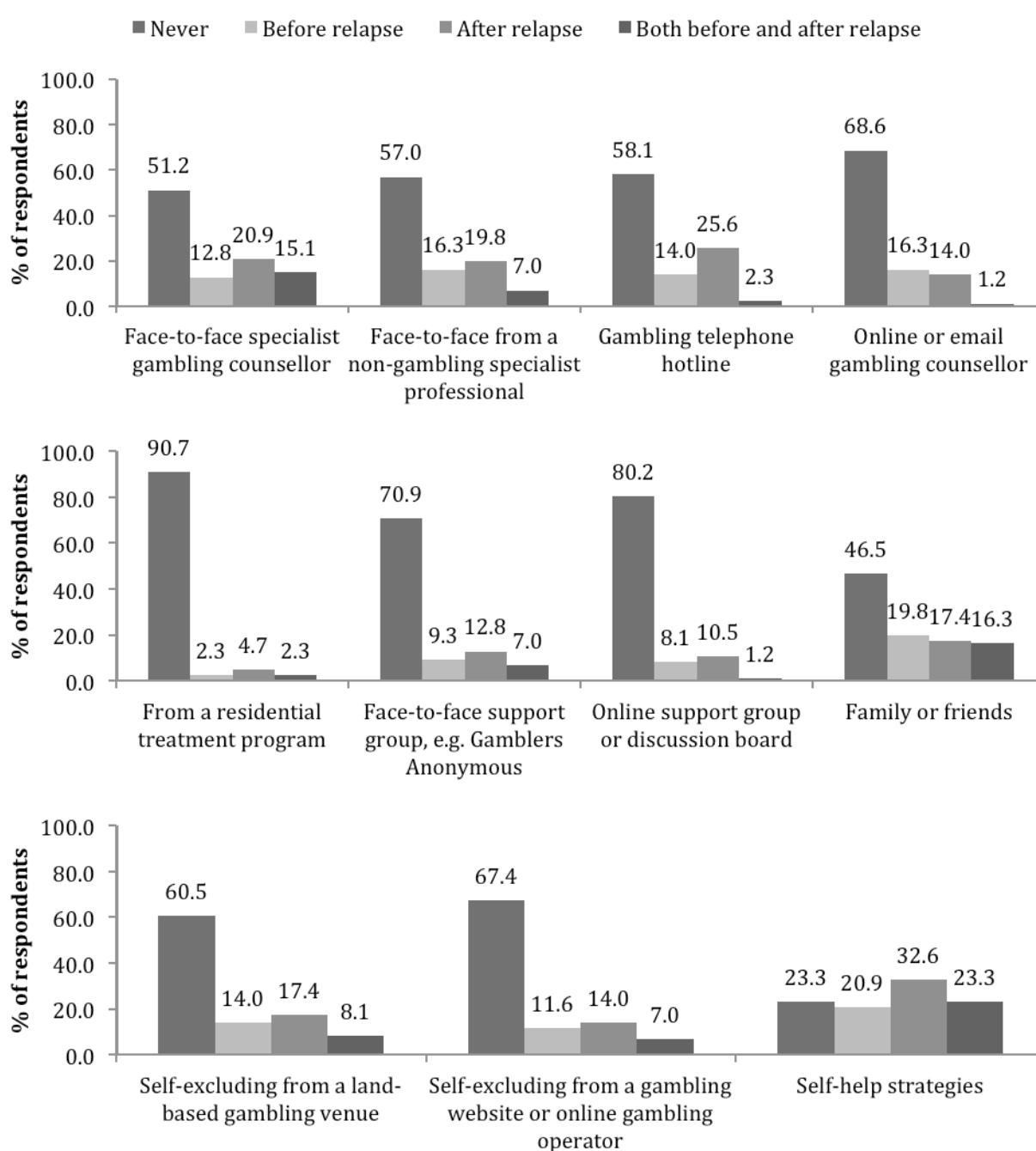
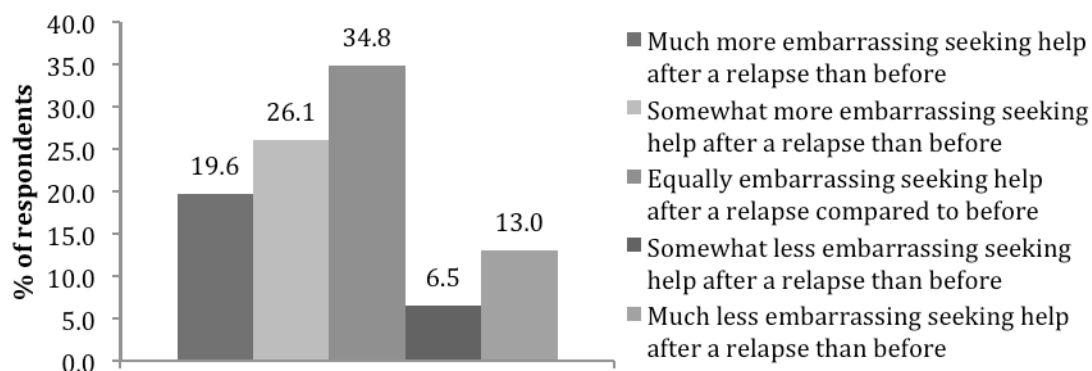


Figure 5.16 – Responses to questions about help-seeking before and/or after relapse

Over two-fifths (45.7%) of those who had relapsed and sought help both before and after relapsing reported that seeking help was more embarrassing for them after relapsing. Relatively few respondents reported that seeking help after a relapse was less embarrassing than seeking help before a relapse (Figure 5.17).



Figure

Figure 5.17 – Responses to whether help-seeking was more or less embarrassing after relapse

5.7.3 Help-seeking without relapse

Of those who had not experienced regaining control and then relapsing, the most common forms of help sought were self-help, help from family or friends, self-excluding from a land-based gambling venue, or face-to-face help from a non-gambling specialist professional. Relatively few of this group reported seeking help from a residential treatment program or from face-to-face support groups (Figure 5.18).

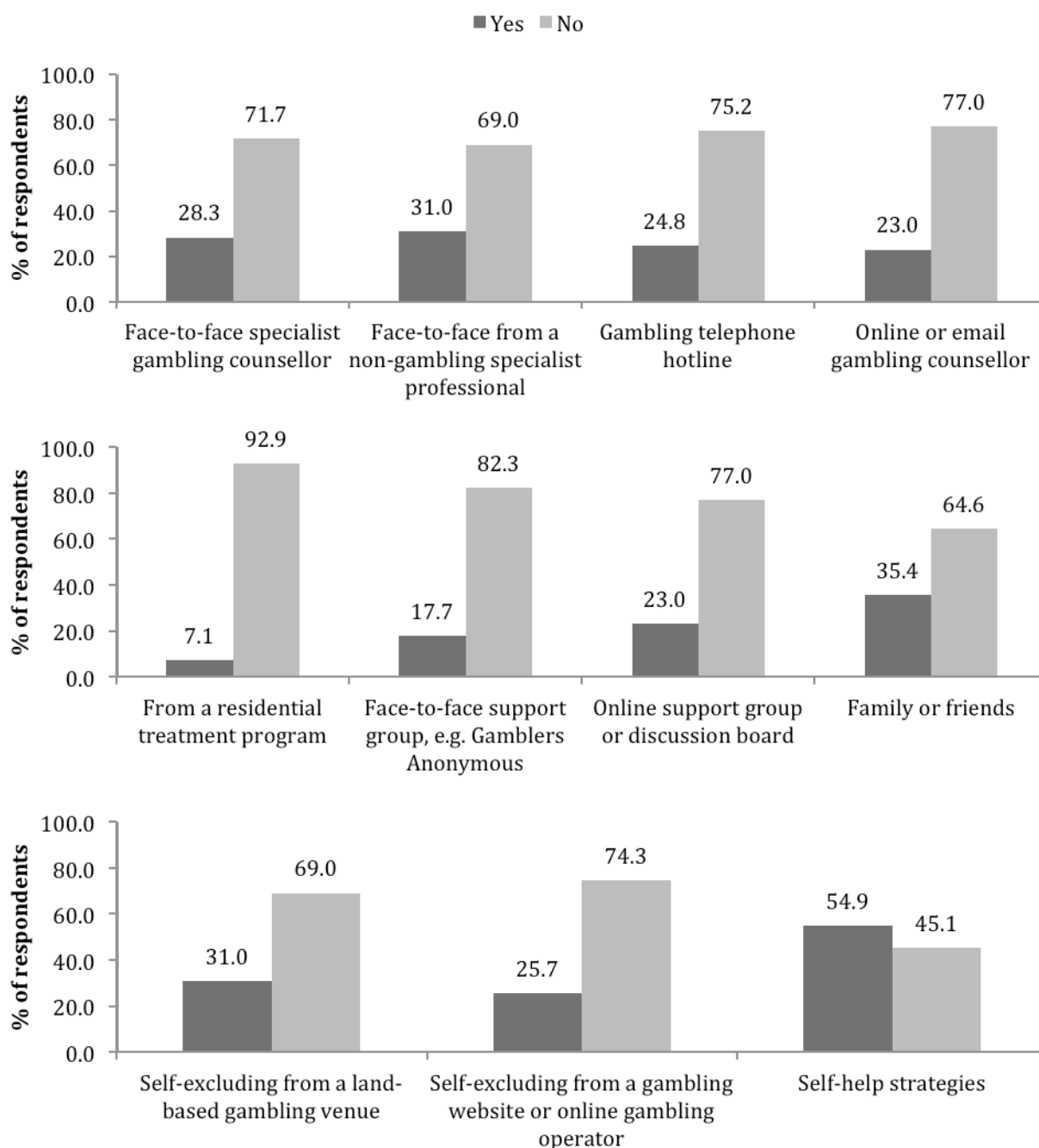


Figure 5.18 – Responses to questions about help-seeking without recovery and relapse (n = 113)

5.8 Impacts of stigma on recovery orientation

Participants were asked whether other people's views about problem gambling increased or decreased their likelihood of undertaking certain actions reflecting a personal vision of recovery. Most respondents reported that these views had little influence on the eight behaviours in Figure 19. Of those who did report that the views of others had an influence on their recovery-oriented behaviours, more respondents reported an increase rather than a decrease in most of the behaviours, with the exception of participating in face-to-face support groups and asking family and friends for help with their gambling. Similarly, most reported that the views of others did not have an effect on their coping behaviours, although those who did report an influence reported increases in their ability to engage in these behaviours due to the views of others (Figure 5.19).

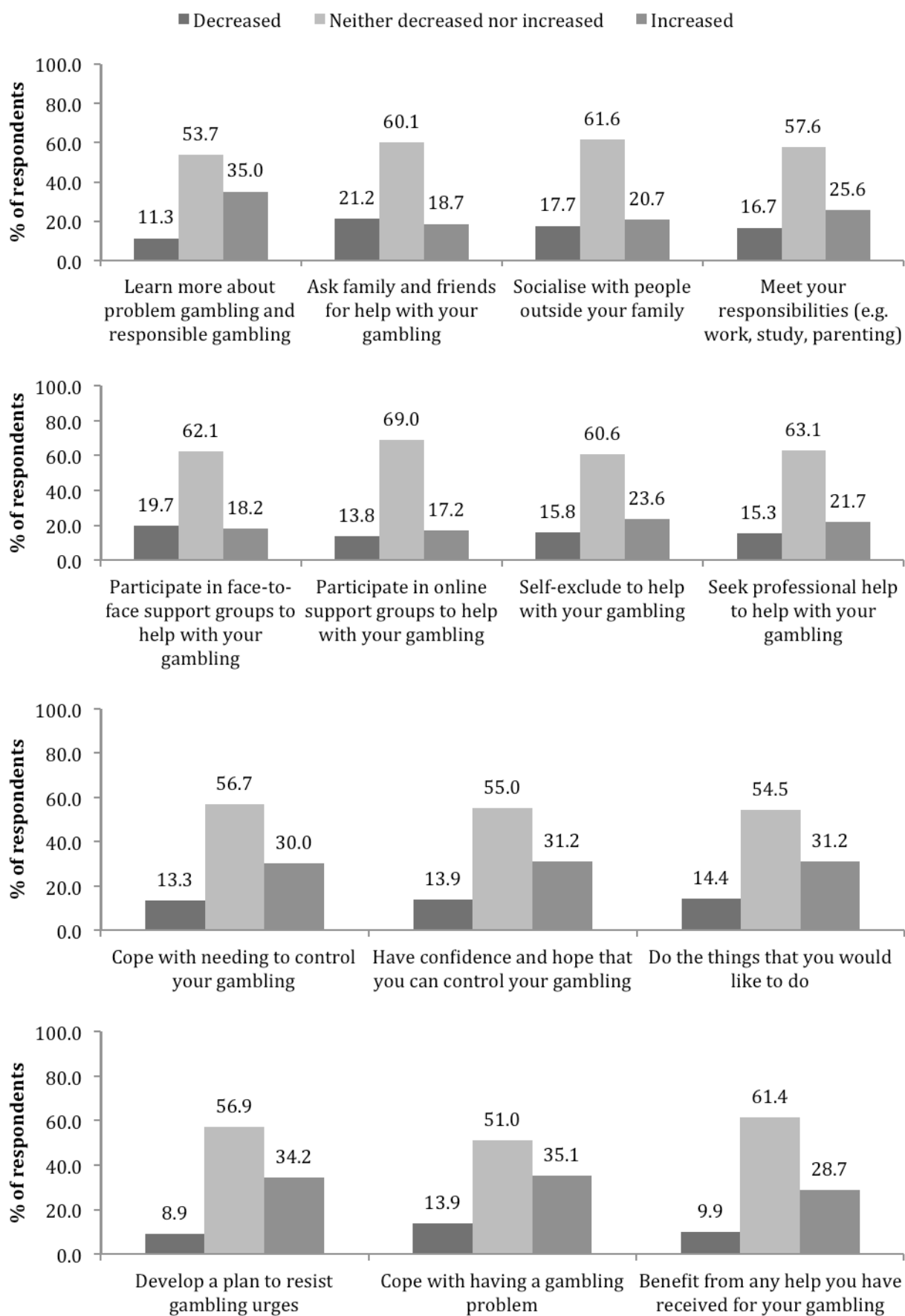


Figure 5.19 – Item responses considering the impact of other people's view of their problem gambling influencing their level of each recovery behaviour (Impacts of Stigma on Recovery Orientation Scale)

5.9 How stigma associated with problem gambling is perceived and experienced by different groups

Objective 4 of this study was to determine how stigma associated with problem gambling is perceived and experienced by different groups in Victoria. Further analyses are presented in this and the following section to help address this objective.

Four scales were used as dependent variables to conduct these analyses. The Perceived Stereotyping Scale was used as a measure of perceived public stigma, while the Devaluation Scale, Discrimination Scale and Self-Stigma Scale were all used as measures of experienced stigma.

5.9.1 Comparisons of perceived and experienced stigma by demographic variables

In order to understand who was more likely to report stigma, demographic variables were included in a regression analysis. Regression analysis was used as it can account for overlap between the demographic variables. Bivariate analyses, that do not take into account overlap between the demographic variables, are reported in Tables F14 to F18 in Appendix F.

The following variables were considered for inclusion: gender (male and female), age (in years), main language spoken at home (English or other), religion (none, Christian or “other” – see note beneath Tables 5.4 to 5.7 for details) and combined pre-tax annual household income (in \$20,000 brackets). A total of 32 respondents did not report their income (as it was not a forced response question), so this variable was removed from the regressions. It is worth noting the income was not a significant predictor of any of the stigma measures. A further 12 people did not report their religion; however this variable was retained as it was significantly correlated with some of the stigma scales in bivariate analyses (Appendix F).

While regression can account for some overlap between variables, too much overlap (known as multicollinearity) can violate the assumptions of this type of analysis. Thus, an initial linear regression was run in order to test for tolerance amongst the variables. Tolerance is a measure of relative independence of the predictor variables. No issues with tolerance were detected (~ 0.3). No other tolerance statistics were below 0.8. Thus the model was considered to be acceptable from this regard. All assumptions were checked for both models and were not found to have been violated.

Thus the following variables were included in each linear regression: gender (male as reference group), age (in years), main language spoken at home (English as the reference group) and religion (none as the reference group).

Perceived stereotyping

The model accounted for 9.6% of the variance in perceived stereotyping ($F(5,185) = 3.94, p = 0.002$), with gender and religion as significant predictors. Females were significantly more likely to report perceived stereotyping, as were those who reported affiliations with religions other than Christianity (Table 5.4).

Table 5.4 – Regression coefficients for demographics predictors of perceived stereotyping

Coefficient	Unstd coeff	Std. Error	Std coeff	<i>t</i>	<i>p</i>	95% CI lower bound	95% CI upper bound
Gender (ref male)	.450	.150	.222	3.013	0.003	0.155	0.745
Age (in years)	-0.001	0.005	-0.021	-0.274	0.784	-0.012	0.009
English at home (ref yes)	0.274	0.245	0.081	1.122	0.263	-0.208	0.757
Religion^ (ref other)							
Christian	-0.761	0.283	-0.396	-2.692	0.008	-1.319	-0.203
None	-0.766	0.284	-0.398	-2.699	0.008	-1.326	-0.206

Note: ^ 'Christian' here refers to anyone identifying as Catholic, Protestant/Anglican or 'other Christian', while 'Other' refers to anyone identifying their religion as Buddhism, Hinduism, Islam, Judaism or 'other religion'.

Devaluation

The model accounted for 2.9% of the variance in devaluation, which was not significant ($F(5,185) = 1.11$, $p = 0.356$). None of the predictors were significant within the model (Table 5.5).

Table 5.5 – Regression coefficients for demographics predictors of devaluation

Coefficient	Unstd coeff	Std. Error	Std coeff	<i>t</i>	<i>p</i>	95% CI lower bound	95% CI upper bound
Gender (ref male)	-0.042	0.124	-0.026	-0.336	0.737	-0.285	0.202
Age (in years)	-0.008	0.004	-0.144	-1.821	0.070	-0.017	0.001
English at home (ref yes)	0.144	0.202	0.053	0.71	0.479	-0.256	0.543
Religion^ (ref none)							
Christian	-0.075	0.234	-0.049	-0.322	0.748	-0.537	0.386
Other	-0.140	0.235	-0.091	-0.598	0.551	-0.603	0.323

Note: ^ 'Christian' here refers to anyone identifying as Catholic, Protestant/Anglican or 'other Christian', while 'Other' refers to anyone identifying their religion as Buddhism, Hinduism, Islam, Judaism or 'other religion'.

Discrimination

The model accounted for 3.1% of the variance in discrimination, which was not significant ($F(5,185) = 1.17$, $p = 0.324$). None of the predictors were significant within the model (Table 5.6).

Table 5.6 – Regression coefficients for demographics predictors of discrimination

Coefficient	Unstd coeff	Std. Error	Std coeff	<i>t</i>	<i>p</i>	95% CI lower bound	95% CI upper bound
Gender (ref male)	-0.002	0.019	-0.006	-0.081	0.935	-0.039	0.036
Age (in years)	-0.001	0.001	-0.112	-1.422	0.157	-0.002	0.000
English at home (ref yes)	-0.002	0.031	-0.004	-0.051	0.960	-0.063	0.060
Religion^ (ref none)							
Christian	0.007	0.036	0.031	0.202	0.841	-0.064	0.078
Other	0.032	0.036	0.136	0.890	0.375	-0.039	0.103

Note: ^ 'Christian' here refers to anyone identifying as Catholic, Protestant/Anglican or 'other Christian', while 'Other' refers to anyone identifying their religion as Buddhism, Hinduism, Islam, Judaism or 'other religion'.

Self-stigma

The model accounted for 5.7% of the variance in self-stigma, which was not significant ($F(5,185) = 2.25, p = 0.051$). However, gender was a significant predictor within the model, with females significantly more likely to report self-stigma than males (Table 5.7). No other predictors were significant.

Table 5.7 – Regression coefficients for demographics predictors of self-stigma

Coefficient	Unstd coeff	Std. Error	Std coeff	<i>t</i>	<i>p</i>	95% CI lower bound	95% CI upper bound
Gender (ref male)	0.329	0.123	0.203	2.687	0.008	0.088	0.571
Age (in years)	0.002	0.004	0.035	0.443	0.658	-0.007	0.011
English at home (ref yes)	0.163	0.201	0.060	0.812	0.418	-0.233	0.559
Religion ^a (ref none)							
Christian	-0.101	0.232	-0.066	-0.437	0.662	-0.559	0.356
Other	-0.192	0.233	-0.124	-0.826	0.41	-0.651	0.267

Note: ^a 'Christian' here refers to anyone identifying as Catholic, Protestant/Anglican or 'other Christian', while 'Other' refers to anyone identifying their religion as Buddhism, Hinduism, Islam, Judaism or 'other religion'.

The multivariate regressions reported above take into account the relationship between each independent variable (e.g. gender) and each outcome, while controlling for all of the other variables in the model. As such, the model accounts for some overlap between the predictors, but also presents the relationship between each independent variable and outcome in the context of the other variables in the model. These analyses have also been conducted as bivariate analyses, which are reported in Appendix F.

Table 5.8 – summary of comparison between bivariate and multivariate results

Independent variable	Perceived Stereotyping		Devaluation		Discrimination		Self-Stigma	
	Bi- variate	Multi- variate	Bi- variate	Multi- variate	Bi- variate	Multi- variate	Bi- variate	Multi- variate
Gender	*	*					*	*
Age			*		*			
State								
English spoken at home								
Religion	*	*						

Note: An asterisk (*) indicates that the relationship between the independent and dependent variables was significant in the bivariate and multivariate analyses.

5.9.2 Comparisons of perceived and experienced stigma by psychological variables

Problem gambling severity (PGSI)

The mean PGSI score for the sample was 15.31 ($SD = 6.87$) and the median was 16.00, indicating high levels of problem gambling, consistent with the recruitment strategy.

Responses to the PGSI items are presented in Appendix F and indicate that more than two-thirds of respondents had experienced each of the PGSI items at least some of the time in the last 12 months, with more than half experiencing most items most of the time with the exception of: borrowing or selling anything to get money to gamble, and being criticised by others about their gambling.

As most (87.2%) respondents scored as being problem gamblers during the previous 12 months, PGSI scores were treated as an ordinal variable, rather than using PGSI groups, when examining relationships with perceived and experienced stigma.¹¹ Relationships between PGSI scores and the four scales of perceived and experienced stigma were assessed using nonparametric (Spearman's) correlations.

Those with higher PGSI scores tended to have higher scores on the Perceived Stereotyping Scale (Spearman's $\rho = 0.173$, $p = 0.013$), the Devaluation Scale (Spearman's $\rho = 0.247$, $p < 0.001$), the Discrimination Scale (Spearman's $\rho = 0.390$, $p < 0.001$) and the Self-Stigma Scale (Spearman's $\rho = 0.468$, $p < 0.001$).

All relationships between the PGSI and perceived and experienced stigma remained significant when controlling for age and gender, with the exception of the perceived stereotyping scale ($p = 0.211$).

Most problematic gambling form

Respondents were asked to report the form of gambling that had caused them the most gambling-related problems (Figure 5.20). EGMs were the most common answer ($n = 108$, 53.8%). Betting on horse or dog races was the next most common ($n = 32$, 16.1%), followed by sports betting ($n = 28$, 14.1%). All other forms were selected by a small number of respondents and these respondents were combined into the 'other' category ($n = 35$, 17.2%) for further analysis.

¹¹ Respondents had all scored PGSI 8+ in the previous 3 years, but not necessarily in the previous 12 months.

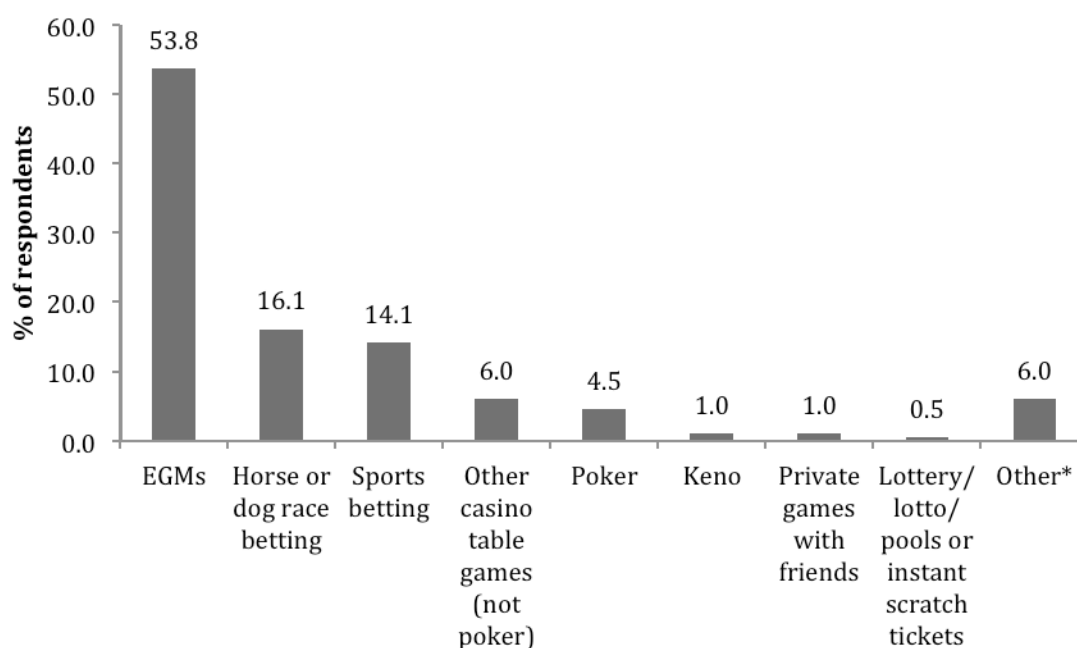


Figure 5.20 – Responses to question about most problematic type of gambling

Note: Of the seven 'other' responses, three indicated a combination of EGMs and sports betting, two indicated EGMs online or as an app on their tablet, one indicated online gaming casinos and one indicated foreign currency.

Differences between the groups were observed for perceived stereotyping and self-stigma. Those with EGMs as their most problematic form reported higher levels of perceived stereotyping and self-stigma than those with horse and dog race betting as their most problematic form, while no other differences were observed between groups on these measures. No significant differences were observed between the groups for the Devaluation or Discrimination Scales. (Table 5.9)

These relationships did not change in statistical significance when controlling for age and gender.

Table 5.9 – Comparisons between those with different most problematic forms of gambling on perceived and experienced stigma scales

Scale	EGMs		Horse and dog race betting		Sports betting		Other		Statistic
	Mean	SD	Mean	SD	Mean	SD	Mean	SD	
Perceived Stereotyping	5.73 _a	0.92	4.94 _b	0.83	5.22 _{ab}	0.80	5.27 _{ab}	1.19	$F(3,199) = 7.13$, $p < 0.001$
Devaluation	1.06	0.82	0.86	0.56	1.18	0.85	1.00	0.79	$F(3,199) = 0.93$, $p = 0.425$
Discrimination	0.06	0.14	0.06	0.08	0.08	0.16	0.06	0.09	$F(3,199) = 0.14$, $p = 0.935$
Self-Stigma	1.16 _a	0.63	0.64 _b	0.70	0.83 _{ab}	0.65	0.74 _{ab}	1.12	$F(3,199) = 5.76$, $p = 0.001$

Note: 'Other' here refers to those who reported any of the following forms as their most problematic: lottery/lotto/pools tickets; poker at a casino, hotel, club or online; keno; private games with friends for money; other (specified in a text box) or other casino table games (not including poker). Subscripts (_{a,b}) denote significant differences between the groups where they were detected. Groups with the same subscript do not differ significantly from each other.

Psychological distress (Kessler 6)

Of the 203 respondents in the sample, 115 (56.7%) were classified as having none or low psychological distress, while the remaining 88 (43.3%) were classified as having high psychological distress. Responses for each item on the Kessler 6 scale are presented in Appendix F and indicate that these feelings of psychological distress are present at least some of the time for the majority of respondents in the sample.

The Kessler 6 was further analysed in two ways. First, respondents were split into those characterised as having high psychological distress and those without, as explained in Chapter Three. These two groups were then compared on each of the four scales used to measure perceived and experienced stigma (Table 5.10). Those with high psychological distress reported higher levels of perceived stereotyping and self-stigma compared to those without high levels of psychological distress. No significant differences were observed in terms of devaluation or discrimination.

These relationships did not change in statistical significance when controlling for age and gender.

Table 5.10 – Kessler 6 comparisons on perceived and experienced stigma scales

Scale	Not high psychological distress		High psychological distress		Statistic
	Mean	SD	Mean	SD	
Perceived Stereotyping	5.32	0.96	5.63*	0.99	$t(201) = 2.25, p = 0.026$
Devaluation	1.01	0.85	1.06	0.68	$t(201) = 0.38, p = 0.704$
Discrimination	0.06	0.14	0.07	0.10	$t(201) = 0.37, p = 0.714$
Self-Stigma	0.75	0.83	1.24*	0.58	$t(201) = 4.70, p < 0.001$

Note: * indicates the significantly higher mean.

Secondly, raw scores from the Kessler 6 scale were also compared to the four perceived and experienced stigma scales using non-parametric (Spearman's) correlations. Those with higher scores on the Kessler 6 scale tended to report significantly higher levels of perceived stereotyping (Spearman's $\rho = 0.165, p = 0.019$), discrimination (Spearman's $\rho = 0.157, p = 0.026$) and self-stigma (Spearman's $\rho = 0.432, p < 0.001$). No relationship was observed between Kessler 6 scores and the devaluation scores (Spearman's $\rho = 0.123, p = 0.079$).

Public self-consciousness

The mean score on the six items used to calculate the self-consciousness scale was 1.80 ($SD = 0.71$), with a median of 1.83, where 0 on the original items represented 'not at all like me', 1 was 'a little like me', 2 was 'somewhat like me' and 3 was 'a lot like me'.

Respondents with higher levels of public self-consciousness were significantly more likely to report more devaluation and discrimination (Table 5.11). They were also significantly more likely to self-stigmatise compared to those with lower levels of public self-consciousness. No relationship was observed between public self-consciousness and perceived stereotyping.

When controlling for age and gender, the relationship between public self-consciousness and discrimination was no longer significant ($p = 0.071$), but the results for perceived stereotyping, discrimination and self-stigma remained unchanged.

Table 5.11 – Results from linear regressions predicting perceived and experienced stigma scales with Public Self-Consciousness Scale scores

Scale	Linear term				
	<i>b</i>	<i>SEb</i>	β	<i>t</i>	<i>p</i>
Perceived Stereotyping	0.001	0.016	0.003	0.05	0.964
Devaluation	0.026	0.013	0.140	2.01	0.046
Discrimination	0.006	0.002	0.191	2.76	0.006
Self-Stigma	0.038	0.012	0.213	3.09	0.002

Social anxiety

The mean score on the six items used to calculate the self-consciousness scale was 1.62 ($SD = 0.77$), with a median of 1.67, where 0 on the original items represented 'not at all like me', 1 was 'a little like me', 2 was 'somewhat like me' and 3 was 'a lot like me'.

Higher levels of social anxiety were correlated with significantly higher levels of devaluation and self-stigma, while no such relationship was observed between social anxiety and either perceived stereotyping or discrimination (Table 5.12).

The relationship between social anxiety and each of the outcomes reported below did not change when controlling for age and gender.

Table 5.12 – Results from linear regressions predicting perceived and experienced stigma scales with Social Anxiety Scale scores

Scale	Linear term				
	<i>b</i>	<i>SEb</i>	β	<i>t</i>	<i>p</i>
Perceived Stereotyping	0.018	0.015	0.083	1.19	0.237
Devaluation	0.036	0.012	0.214	3.10	0.002
Discrimination	0.002	0.002	0.066	0.94	0.350
Self-Stigma	0.041	0.012	0.245	3.59	< 0.001

Self-esteem

Scores on the self-esteem scale ranged from -1.90 to 1.90 (strongly disagree = -2 and strongly agree = 2). Mean score was -0.17 ($SD = 0.77$) and median score was -0.20. Histograms of the responses to individual items are presented in Appendix F. Most respondents reported being at least somewhat dissatisfied with themselves, feeling useless, wishing they could have more respect for themselves, that at times they think they are no good at all, that they are a failure, and that they do not have much to be proud of. However, most respondents also reported feeling that they have a number of good qualities, that they are able to do things as well as most other people, and that they feel that they are of worth, at least equal with others.

Higher levels of self-esteem were associated with lower levels of perceived stereotyping, lower levels of devaluation and lower levels of self-stigma (see Table 5.13). The relationship between self-esteem and perceived stereotyping also had a quadratic component to it (Figure 5.21). That is, lower levels of self-esteem are associated with higher levels of perceived stereotyping *to a point*, after which changes in self-esteem do not appear to predict perceived stereotyping.

When controlling for age and gender, the (linear) relationship between self-esteem and perceived stereotyping was no longer significant ($p = 0.143$), nor was the relationship between self-esteem and

devaluation ($p = 0.054$). The relationships between self-esteem and discrimination, as well as self-stigma, remained unchanged when controlling for age and gender.

Table 5.13 – Results from linear regressions predicting perceived and experienced stigma scales with Self-Esteem Scale scores

Scale	Predictor coefficients				
	<i>b</i>	<i>SEb</i>	β	<i>t</i>	<i>p</i>
Perceived Stereotyping (linear)	-0.226	0.093	-0.177	2.44	0.016
Perceived Stereotyping (quadratic)	0.174	0.081	0.156	2.14	0.033
Devaluation (linear)	-0.142	0.071	-0.140	2.01	0.046
Discrimination (linear)	-0.021	0.011	-0.132	1.89	0.060
Self-Stigma (linear)	-0.479	0.062	-0.478	7.72	< 0.001

Note: The quadratic self-esteem terms were non-significant predictors for the Devaluation, Discrimination and Self-Stigma Scales and are not reported here.

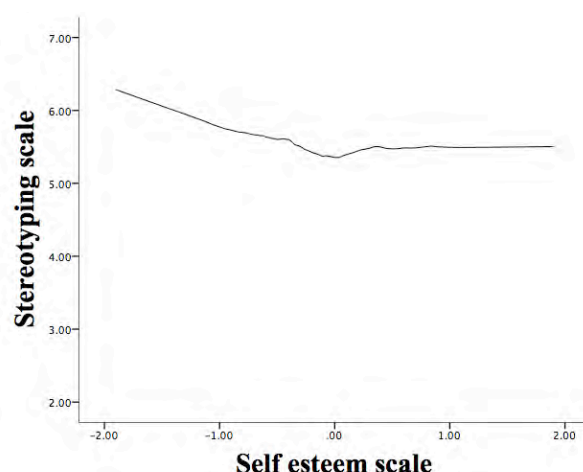


Figure 5.21 – Relationship between scores on the Self-Esteem and Perceived Stereotyping Scales¹²

5.9.3 Summary of comparisons of perceived and experienced stigma

Those reporting higher perceived stereotyping were more likely to: be female, report a religion other than Christianity, have higher PGSI scores, list EGMs as their most problematic gambling form, have higher levels of psychological distress due to their gambling, and have lower levels of self-esteem.

Higher levels of devaluation were reported amongst respondents with higher PGSI scores, those with higher social anxiety scores and those with lower self-esteem.

Higher levels of discrimination were reported by those with higher levels of public self-consciousness.

Higher self-stigma scores were reported amongst females, those with higher PGSI scores, those listing EGMs as their most problematic form, those with higher levels of psychological distress, those with higher self-consciousness and social anxiety, and those with lower self-esteem.

¹² The line in Figure 5.21 is a loess line, which is a line of best fit that does not require the a priori specification of the nature of the relationship between the IV and DV (Jacoby, 2000). It is the line of best fit if it does not have to be linear and is useful for determining the nature of polynomial relationships.

5.10 Relationships between stigma and overcoming gambling problems, relapse and help-seeking

Objective 5 of this study was to determine how significant stigma is as an impediment to treatment or interventions for problem gambling and how recovery from problem gambling is impacted by stigma. Analyses are presented in this section to help address this objective.

The same four measures of stigma were utilised for analyses in this section: Perceived Stereotyping Scale, Devaluation Scale, Discrimination Scale, and Self-Stigma Scale. Independent samples t-tests were conducted to compare those who had and had not overcome their gambling problem at some point, had and had not relapsed, and had and had not sought each of 11 forms of help in terms of their reported stigma.

5.10.1 Overcoming gambling problems and relapse

There was no significant difference between those who had and had not overcome their gambling problem at some point, on any of the four stigma measures (Table 5.14).

However, those who had relapsed after overcoming their gambling problem reported significantly higher levels of self-stigma compared to those who had not relapsed. Those who had not relapsed did not report significantly different levels on any of the other stigma measures compared to those who had relapsed (Table 5.15).

Table 5.14 – Comparisons on perceived and experienced stigma scales between those who felt that they had or had not overcome their gambling problem

Overcame gambling problems?	No		Yes		Statistic
Scale	Mean	SD	Mean	SD	
Perceived Stereotyping	5.49	0.93	5.43	1.03	$t(197) = 0.40, p = 0.688$
Devaluation	1.03	0.82	1.07	0.76	$t(197) = 0.35, p = 0.730$
Discrimination	0.07	0.13	0.06	0.12	$t(197) = 0.68, p = 0.498$
Self-Stigma	1.06	0.59	0.97	0.76	$t(197) = 0.94, p = 0.351$

Table 5.15 – Comparisons on perceived and experienced stigma scales between those who had relapsed and those who had not relapsed

Relapsed?	No		Yes		Statistic
Scale	Mean	SD	Mean	SD	
Perceived Stereotyping	5.43	1.03	5.43	1.04	$t(197) = 0.02, p = 0.985$
Devaluation	0.98	0.90	1.09	0.72	$t(197) = 0.55, p = 0.584$
Discrimination	0.02	0.07	0.07	0.13	$t(197) = 1.58, p = 0.118$
Self-Stigma	0.42	1.06	1.09*	0.62	$t(197) = 3.77, p < 0.001$

Note: * indicates the significantly higher mean.

5.10.2 Help-seeking

Tables 5.16- 5.26 show results of statistical testing for relationships between the four stigma measures and help-seeking from 11 sources of help.

Perceived stereotyping was related to self-help and seeking help through a gambling telephone hotline, with those who had sought these types of help reporting higher levels of perceived stereotyping.

Level of devaluation was related to all of the help-seeking measures except for self-exclusion from land-based or online gambling operations and self-help measures. That is, those who reported seeking professional or semi-professional help, or help from their family or friends, reported significantly higher levels of devaluation compared to those who had not sought these types of help.

Discrimination was not related to any of the help-seeking measures. Self-stigma was related to four of the help-seeking measures: seeking help from a gambling telephone hotline, seeking help from a face-to-face support group such as Gamblers Anonymous or Pokies Anonymous, seeking help from family or friends and self-help. In all cases, those with higher levels of self-stigma reported seeking help from these sources. However, given the number of comparisons and possible overlap of results, these results would not be significant if a Bonferroni correction was applied and should thus be treated with caution.

Table 5.16 – Comparisons on perceived and experienced stigma scales between those who had or had not sought help from a face-to-face specialist gambling counsellor

Sought help	No		Yes		Statistic
Scale	Mean	SD	Mean	SD	
Perceived Stereotyping	5.44	0.96	5.49	1.03	$t(197) = 0.35, p = 0.728$
Devaluation	0.90	0.77	1.29*	0.75	$t(197) = 3.50, p = 0.001$
Discrimination	0.06	0.13	0.07	0.12	$t(197) = 0.06, p = 0.954$
Self-Stigma	0.98	0.68	1.07	0.71	$t(197) = 0.88, p = 0.380$

Note: * indicates the significantly higher mean.

Table 5.17 – Comparisons on perceived and experienced stigma scales between those who had or had not sought help from a face-to-face non-gambling specialist professional

Sought help	No		Yes		Statistic
Scale	Mean	SD	Mean	SD	
Perceived Stereotyping	5.43	1.00	5.52	0.95	$t(197) = 0.65, p = 0.515$
Devaluation	0.86	0.74	1.38*	0.75	$t(197) = 4.75, p < 0.001$
Discrimination	0.06	0.12	0.08	0.13	$t(197) = 1.05, p = 0.295$
Self-Stigma	0.93	0.71	1.15*	0.64	$t(197) = 2.16, p = 0.032$

Note: * indicates the significantly higher mean.

Table 5.18 – Comparisons on perceived and experienced stigma scales between those who had or had not sought help from a gambling telephone hotline

Sought help	No		Yes		Statistic
Scale	Mean	SD	Mean	SD	
Perceived Stereotyping	5.33	1.05	5.73*	0.77	$t(197) = 2.69, p = 0.008$
Devaluation	0.94	0.77	1.27*	0.78	$t(197) = 2.78, p = 0.006$
Discrimination	0.06	0.12	0.08	0.14	$t(197) = 1.45, p = 0.148$
Self-Stigma	0.92	0.71	1.19*	0.62	$t(197) = 2.58, p = 0.011$

Note: * indicates the significantly higher mean.

Table 5.19 – Comparisons on perceived and experienced stigma scales between those who had or had not sought help from online or e-mail gambling counselling

Sought help	No		Yes		Statistic
Scale	Mean	SD	Mean	SD	
Perceived Stereotyping	5.45	1.02	5.50	0.89	$t(197) = 0.36, p = 0.720$
Devaluation	0.93	0.76	1.39*	0.74	$t(197) = 3.83, p < 0.001$
Discrimination	0.06	0.12	0.08	0.13	$t(197) = 0.71, p = 0.479$
Self-Stigma	0.96	0.71	1.13	0.61	$t(197) = 1.53, p = 0.128$

Note: * indicates the significantly higher mean.

Table 5.20 – Comparisons on perceived and experienced stigma scales between those who had or had not sought help from a residential treatment program

Sought help	No		Yes		Statistic
Scale	Mean	SD	Mean	SD	
Perceived Stereotyping	5.47	0.98	5.37	1.08	$t(197) = 0.36, p = 0.719$
Devaluation	1.00	0.77	1.63*	0.68	$t(197) = 3.18, p = 0.002$
Discrimination	0.06	0.11	0.14	0.24	$t(15.53) = 1.39, p = 0.185$
Self-Stigma	1.02	0.70	0.93	0.58	$t(197) = 0.48, p = 0.635$

Note: * indicates the significantly higher mean.

Table 5.21 – Comparisons on perceived and experienced stigma scales between those who had or had not sought help from a face-to-face support group such as Gamblers Anonymous

Sought help	No		Yes		Statistic
Scale	Mean	SD	Mean	SD	
Perceived Stereotyping	5.43	0.91	5.56	1.20	$t(197) = 0.79, p = 0.431$
Devaluation	0.93	0.78	1.46*	0.66	$t(197) = 4.16, p < 0.001$
Discrimination	0.06	0.11	0.10	0.16	$t(197) = 1.95, p = 0.053$
Self-Stigma	0.95	0.70	1.20*	0.60	$t(197) = 2.11, p = 0.036$

Note: * indicates the significantly higher mean.

Table 5.22 – Comparisons on perceived and experienced stigma scales between those who had or had not sought help from an online support group or discussion board

Sought help	No		Yes		Statistic
Scale	Mean	SD	Mean	SD	
Perceived Stereotyping	5.45	0.97	5.49	1.06	$t(197) = 0.19, p = 0.847$
Devaluation	0.96	0.77	1.37*	0.74	$t(197) = 3.07, p = 0.002$
Discrimination	0.06	0.11	0.09	0.16	$t(197) = 1.46, p = 0.145$
Self-Stigma	0.98	0.70	1.12	0.65	$t(197) = 1.22, p = 0.226$

Note: * indicates the significantly higher mean.

Table 5.23 – Comparisons on perceived and experienced stigma scales between those who had or had not sought help from family or friends

Sought help	No		Yes		Statistic
Scale	Mean	SD	Mean	SD	
Perceived Stereotyping	5.40	0.96	5.54	1.01	$t(197) = 0.98, p = 0.330$
Devaluation	0.81	0.73	1.36*	0.74	$t(197) = 5.19, p < 0.001$
Discrimination	0.06	0.13	0.07	0.13	$t(197) = 0.55, p = 0.583$
Self-Stigma	0.92	0.72	1.13*	0.63	$t(197) = 2.11, p = 0.036$

Note: * indicates the significantly higher mean.

Table 5.24 – Comparisons on perceived and experienced stigma scales between those who had or had not sought help by self-excluding from a land-based gambling venue

Sought help	No		Yes		Statistic
Scale	Mean	SD	Mean	SD	
Perceived Stereotyping	5.43	0.92	5.52	1.09	$t(197) = 0.64, p = 0.522$
Devaluation	0.97	0.75	1.19	0.82	$t(197) = 1.89, p = 0.061$
Discrimination	0.07	0.13	0.05	0.13	$t(197) = 1.00, p = 0.321$
Self-Stigma	0.96	0.73	1.11	0.59	$t(197) = 1.52, p = 0.129$

Table 5.25 – Comparisons on perceived and experienced stigma scales between those who had or had not sought help by self-excluding from a gambling website or online gambling operator

Sought help	No		Yes		Statistic
Scale	Mean	SD	Mean	SD	
Perceived Stereotyping	5.49	1.01	5.39	0.93	$t(197) = 0.68, p = 0.501$
Devaluation	1.04	0.77	1.06	0.81	$t(197) = 0.17, p = 0.863$
Discrimination	0.07	0.13	0.06	0.13	$t(197) = 0.08, p = 0.940$
Self-Stigma	0.98	0.74	1.08	0.56	$t(197) = 0.87, p = 0.385$

Table 5.26 – Comparisons on perceived and experienced stigma scales between those who had or had not sought help from self-help strategies

Sought help	No		Yes		Statistic
Scale	Mean	SD	Mean	SD	
Perceived Stereotyping	5.17	0.92	5.62*	0.99	$t(197) = 3.17, p = 0.002$
Devaluation	0.91	0.80	1.13	0.76	$t(197) = 1.89, p = 0.060$
Discrimination	0.06	0.11	0.07	0.13	$t(197) = 0.64, p = 0.525$
Self-Stigma	0.85	0.74	1.10*	0.64	$t(197) = 2.53, p = 0.012$

Note: * indicates the significantly higher mean.

5.11 Relationships between help-seeking, relapse and stigma

Objective 6 of this study was to analyse how stigma impacts people with gambling problems seeking treatment for the first time, compared to those seeking treatment after a relapse. Analyses to inform this objective were conducted and are presented in this section.

Two questions were asked to determine whether a respondent had relapsed. The first questioned whether respondents had ever felt they 'had successfully overcome their gambling problem or regained control of their gambling', with the second question asked only of those who responded 'Yes'. This second question asked whether respondents had 'ever relapsed into having a gambling problem. Relapse means that your gambling got worse again after a period of improvement'.

Thus, there were three possible groups of respondents: those who had not overcome their gambling problem, those who had overcome their gambling problem and had not relapsed, and those who had overcome their gambling problem and had relapsed. Respondents in the former two groups were considered to not be relapsed gamblers and respondents in the latter group were considered to be relapsed gamblers. Thus, in total there were 113 (56.8%) individuals who had not relapsed and 86 (43.2%) individuals who had relapsed in the sample.

In order to determine whether stigma was differentially related to help-seeking for those who had relapsed or not, two-way ANOVAs were conducted. For these analyses, help-seeking (no or yes, with each form run in a separate ANOVA) and relapse (no or yes) were the independent variables, while the four stigma scales (perceived stereotyping, devaluation, discrimination and self-stigma, with each run in a separate ANOVA) were the dependent variable. The interaction terms were the main analysis of interest. The results are reported in Appendix F.

The only significant interactions were related to the discrimination scale and all were non-significant once a Bonferroni correction was applied. Thus, while stigma may have an effect on different forms of help-seeking, these effects do not appear to be different for those who have and have not relapsed into gambling problems.

5.12 Chapter summary

A total of 203 respondents who were identified as recently having a serious gambling problem (PGSI 8+) completed a survey canvassing their beliefs about how the general public stigmatises problem gambling, how they self-stigmatise, whether they have experienced stigma, whether they have disclosed their gambling problems to others, and whether their experiences of stigma have had an effect on their help-seeking and recovery. These respondents were recruited from a database of gamblers held by the CGER, along with online advertising.

In terms of self-stigma, most respondents reported feeling ashamed, embarrassed, guilty, disappointed in themselves, inadequate, stupid, weak, socially unacceptable, shocked at themselves, a failure or loser, undeserving of good things, and that they have lost their own identity or feel like a different person. Most reported that they felt they should be punished for their gambling and that there is something wrong with them, including lacking willpower, and that they are worse than people who can control their gambling. Most felt like they were to blame for having the problem and that they should be able to fix the problem on their own, indicating the types of thoughts that they have about

themselves and their situation. However, many reported that they were not alone in having a gambling problem.

Most respondents reported that they thought the general population probably thought they were impulsive, irresponsible, irrational, anti-social, greedy, untrustworthy, unproductive, and deviant, along with foolish, immoral, stupid, secretive, pitiful, selfish, weak, and risk-seeking. In general, respondents rated problem gambling as one of the most stigmatised conditions, with stigma levels as high as those for drug addiction, but higher than all other conditions surveyed including: recreational (non-problem) gambling, schizophrenia, depression, alcohol use disorder, bankruptcy, cancer, and obesity. These results contrast with those seen in Chapter Four, where the general public was found to stigmatise problem gambling less than alcohol use disorder and schizophrenia, indicating that the perceptions of public stigma related to problem gambling amongst those with gambling problems may be exaggerated.

The gamblers' answers to direct questions on stigma were compared to those in the general population sample from Chapter Four. In general, respondents in the gambler sample significantly underestimated public perceptions of how noticeable, recoverable, and disruptive the general population rated problem gambling to be. They significantly overestimated how much the general population thought that problem gambling is the person's own fault, the fear and anger the general population feels towards problem gamblers, how much the general population looks down on problem gamblers, how much the general population would like to avoid problem gamblers, and how irresponsible the general population feels people with gambling problems to be.

The respondents were also asked about their own thoughts of other people with gambling problems. Most respondents appeared to stigmatise other problem gamblers, including thinking that they are addicts, and are irresponsible, but that they can recover.

When asked about their experiences of stigma related to their condition, most respondents reported some form of stigmatisation, including being treated as if they were inferior, with less respect, less politely and as if they are not smart, or are dishonest. However, most reported that they had not experienced any actual discrimination, such as not being given a promotion or being denied a promotion or a job. The most common form of discrimination reported was being denied a bank loan (23.2%). Those who reported that they had experienced discrimination due to their gambling problems were specifically asked if they had been told that this was due to their gambling, with 45.5% reporting that they had not been told this.

Respondents were asked about their coping mechanisms and the most (>80%) commonly reported answers were hiding evidence of their gambling problems, or lying about the extent of their gambling. These results were related to the next questions about fear of disclosure of their gambling, with most reporting at least some fear of others finding out about their gambling. In particular, most kept their gambling from their children, their employer and other work colleagues and most of those who did disclose that they gambled reported that these people think that they gamble less than they actually do.

Respondents were asked about how they would feel about seeking help for their gambling problems. Many reported that seeking help from a therapist or via self-exclusion would make them feel more self-confident or empowered, but also somewhat stupid and inadequate. However, when asked about seeking help from family and friends for a gambling problem, respondents were less likely to feel self-confident and empowered, and more likely to report feeling stupid and inadequate.

Most had never sought help, with the exception of seeking help from family and friends or self-help. Commonly, this help seeking occurred after a relapse. When asked if the views of others had changed

their likelihood of seeking help, including using self-help strategies, most reported that the views of others neither increased or decreased the likelihood of them seeking help.

Comparisons were then made between different demographic and behavioural groups in terms of experiences of stigma based on four scales of experienced stigma: perceived stereotyping, devaluation, discrimination and self-stigma.

Females were more likely to report perceived stereotyping and self-stigma. Those aligned with religions other than Christianity were significantly more likely to report perceived stereotyping. Those whose most problematic form was EGMs were most likely to report perceived stereotyping and self-stigma, as were those with higher levels of psychological distress. Higher levels of public self-consciousness were related to higher levels of devaluation, discrimination and self-stigma, while higher levels of social anxiety were related to higher levels of devaluation and self-stigma. Higher levels of self-esteem were related to lower levels of stereotyping (to a point), devaluation and self-stigma. Those with higher scores on the PGSI were more likely to report higher perceived stereotyping, devaluation, discrimination and self-stigma.

The mean scores on the perceived stereotyping, devaluation, discrimination and self-stigma scales were compared for those who had and had not sought each form of help. In general, where differences were observed, those who had sought each type of help had higher scores on the various stigma scales compared to those who had not sought help. However, while stigma may have an effect on different forms of help-seeking, these effects did not differ between those who have and have not relapsed into gambling problems.

In general, it appears that people with gambling problems overestimate the stigma that is directed towards them by the general public. They self-stigmatise to a large extent and may be somewhat reluctant to seek help due to feeling of inadequacy and stupidity. Those who do seek help have generally experienced more stigma, independent of the severity of their gambling problems.

Chapter Six: Results from interviews with people who have recently experienced a gambling problem

6.1 Introduction

This chapter presents results from interviews with 44 people with recent experience of having a gambling problem. They were interviewed to provide first-hand perspectives on the stigma of problem gambling and how it had affected feelings and behaviours associated with their gambling problem. The results inform Objectives 4-6 of this study.

After gaining participant consent, interviews were conducted by telephone by three experienced interviewers with clinical/counselling qualifications, using a semi-structured interview guide (Appendix C). Participants were asked to provide basic demographic and gambling information including their age and ethnicity, type of gambling causing most problems, and how long they had been experiencing gambling problems. They were questioned about the meaning they attached to the term 'stigma'; self-stigma associated with having a gambling problem; how problem gamblers are viewed by others (perceptions of public stigma); their reactions to public stigma; how stigma has affected their help-seeking, recovery and possible relapse; and to provide suggestions for reducing stigma.

An interpretive approach to data analysis was used, with thematic analysis providing the foundation to identify, analyse and report themes emerging from the data. The following analysis provides rich data from the individual stories told by participants. As is appropriate with qualitative research, numbers of responses are not reported here, but the use of 'most', 'about half' and 'a few' are used to indicate the strength and range of responses. Quotations from individual responses are notated with an identifying number, gender and age range (e.g., 25, M, 55-64)

6.2 Participant characteristics

Twenty eight of the 44 participants were male and 16 were female, with their age breakdown by gender shown in Table 6.1. About two-fifths of participants were aged less than 35 years, and the remainder aged 35 years or over. Twenty-three participants described their ethnicity as Australian, with the remainder from a range of ethnic backgrounds, including Indian, English, Serbian, Greek, and Asian.

Table 6.1. Age and sex of participants

Age	Male	Female	Total
18-24	6	0	6
25-34	9	4	13
35-44	7	0	7
45-54	3	5	8
55-64	3	4	7
65 or over	0	3	3
Total	28	16	44

Amongst the male participants, the most prevalent gambling forms causing them problems were EGMs and horse race betting, with online sports betting also frequently mentioned. Two men gambled on casino games and one gambled mainly at online-casinos. Many male participants discussed having problems with multiple types of gambling. Seven of the male participants had been experiencing problems with their gambling for less than 2 years, eight for between 2 to 9 years, two for 10 years, five for 11 to 19 years, and six for more than 20 years.

The female participants showed a distinct difference in demographics in that the majority were aged over 44 years. The female participants predominantly reported EGMs as their main problematic gambling activity, with all except one using land-based venues and only one gambling online on EGMs. One woman reported problems with gambling on horse races at race tracks and online. Three women had experienced problems with their gambling for less than 2 years; seven for between 2 and 9 years; two for 10 years; and three for more than 20 years (one unknown). Fifteen of the female participants described their ethnicity as Australian and one was of Greek ethnicity.

Overall, the main gender differences in the sample were that female participants tended to be older; males were more likely to have problems with horses and sports betting, and women with EGMs; and women tended to have experienced gambling problems for a longer period of time.

6.3 Meanings of stigma to participants

When asked what the term 'stigma' means to them, most participants described stigma as a negative judgment made by the community, most typically about a group of people or the behaviour of individuals. Stigma was seen to result in a stereotype or label directed at individuals or groups, by people without a clear knowledge of the issues surrounding the behaviour.

Thus, stigma was seen as:

... judgments that people make about a person who does certain things or doesn't do certain things, and they apply that as a label, if you like, to that person (25, M, 55-64).

In relation to problem gambling, these opinions or judgments generally were associated with weakness, lack of self-control and being a worthless or bad person. For example:

I think stigma means sort of a bias that comes with someone forming their opinion on something. So even before you know about something, you might have a stigma against it to prevent you from having a fair and unbiased opinion (31, M, 25-34).

Stigma was also described as an image of people, created by the community that sets others apart and at a higher level than problem gamblers. For some participants, the stigma of problem gambling meant that most people did not want to associate with them due to their perceived weakness and stupidity.

6.4 Self-stigma

6.4.1 Feelings associated with having a gambling problem

When participants were asked how it felt to have a gambling problem, the impact of their gambling on their self-image was striking. Most used words such as weak, stupid, worthless, bad, ashamed, and embarrassed. Emotions such as anger and annoyance (at themselves) as well as guilt dominated. Others reported feeling surprised, disgusted, defeated, debilitated, isolated, scared, incomplete, restricted, trapped, anxious, saddened, and being generally uneasy. Experiences of loss of dignity and crying inside were also mentioned by one participant. Lack of self-control and the effect on self-esteem were vividly described in the following quotes from participants:

I think I've got every aspect of my life, apart from that, I'm well and truly in control of – but to have the lack of control with gambling – it's sort of like gas that leaks I suppose (4, M, 35-44).

I feel less of a person that I can't control something (2, M, 35-44).

Sick, ashamed, angry and guilty (8, F, 55-64).

Participants were asked if these emotions were a result of perceptions, comments, or behaviours of others, or alternatively about how they viewed themselves. This was a complex issue, with many discussing that they viewed themselves in this way, but that what they perceived others to think compounded these feelings.

A few specifically considered these emotions as emanating from within themselves. For example, one participant explained that:

It made me feel bad about myself because I knew that it was silly and I knew that it was pointless (14, M, 45-54).

A few didn't seem to care what others thought about them, but even then there was some element of doubt in saying this, as one person expressed:

It was just more about correcting a weakness, I don't really worry too much about the criticism – but I guess you are dealing with that at some point (36, M, 55-64).

Many participants were more concerned about how others saw them (particularly family and friends), or would see them if they disclosed their gambling problem. One participant explained that:

A lot of it is to do with how others perceive you and what you think they think of you because of it (9, M, 18-24).

One participant was very aware of what he thought that others saw in him when he said:

It makes you think that they're looking at you and seeing that weakness and perhaps that's all they're ever going to see after that and they're never going to be able to see you as successful or well-rounded and everything else (4, M, 35-44).

However he did continue to comment on how, by hiding his problem gambling, he avoided criticism:

So a lot of the time I don't actually think about what others think about me because I can hide it, keep it to myself. It's probably just me judging me, rather than them judging me (4, M, 35-44).

Some participants described how the source of their feelings had changed. For example, one participant explained that:

It used to be about others but now it's how I perceive myself, because after a while I thought 'Oh, what they think doesn't matter', but I can't get away from what I feel about myself (48, F, 65+).

The secretive nature of their problem gambling behaviour meant that most participants did not actually receive direct judgment or stigmatisation from those around them. Thus, in answering this question they alluded mostly to their own feelings of shame or weakness, whilst acknowledging that they felt that others thought badly of them, or would do so if they disclosed their gambling problem. In many cases, participants were unable to verify whether their felt stigma was real as they did not disclose their problems to others. However, strong feelings of self-stigma were very apparent.

6.4.2 Effects on physical and mental health and self-esteem

Many participants reported that how they felt about their gambling and their self-stigma of having a gambling problem had affected their mental and physical health. For most, mental health issues such as depression and anxiety had arisen. The vast majority also felt that their self-esteem had been affected. A few participants indicated that their self-esteem was still intact, although they continued to have episodes of depression associated with their gambling. About half of the sample described how only their physical health had been affected, including their eating habits, other addictions such as smoking, and general ill-health. About half said that both their physical and mental health had suffered. Some illustrative quotes are:

It's weird. I can go really good all day and just exercise and then if I decide I'm going go to the club that night, then I feel that when I come home I will binge on chocolate or whatever else, because my self-esteem just – I've got none. So with that, I have put on weight (48, F, 65+).

I feel sick in the stomach. I dry retch because I'm that sick (8, F, 55-64).

Makes me feel very depressed. You know, it lowers my self-esteem (46, F, 45-54).

A few considered that their gambling did not affect their health at all, such as one who said:

It never affected me physically at all. And, mentally, I've sort of a bit of a 'screw you' attitude or do whatever I like. It's my money (36, M, 55-64).

6.5 Perceptions of public stigma

6.5.1 How participants view other people with gambling problems

When participants were asked how they view other people with gambling problems, the most common feelings described were pity, sympathy, sadness, and a general feeling of being sorry for them. There was a strong sense of empathy, with acknowledgement that they themselves were just like these other people. About half used judgmental statements, saying there was something wrong with them; many considered them weak, that their behaviour affected other people, and used descriptors including shit, disgust, selfish, stupid and untrustworthy. In general however, they acknowledged that what they felt about other people with gambling problems reflected directly what they felt about themselves, even though this judgment was negative:

I suppose I feel pity and sadness, knowing what it's about and, yeah, I don't judge them. But, yeah, I try to sympathise with them 'cause generally there's something else going on that leads to it (33, M, 25-34).

I can see people just like me (43, M, 45-54).

I think negatively, as well. And you know, I think that they have— you know, they should be able to stop but there's something wrong with them. You know, that they look bad—that they're bad to do that, stupid, irresponsible. I feel pity for them (46, F, 45-54).

A few recognised that their feelings have changed over time, as they themselves moved from being in control of their gambling to viewing themselves as 'problem gamblers'. One explained:

Sorry for them – I used to think a problem gambler – it was their own fault and what they thought they were doing, and why on earth didn't they just stop it and how could they possibly do what they were doing to themselves and for their family and others? That view has changed as a result of my own experiences. I am now understanding that it's not necessarily something that's within control. So I have a great deal of sympathy (25, M, 55-64).

However, a few participants cognitively distanced themselves from people with more severe problem gambling. For example:

Well there's different types isn't there. There's the ones that lose everything, can't put food on the table and the types who put their families – and then I guess there's ones like me who personally, it doesn't matter if I can't eat, but I would never do that (2, M 35-44).

6.5.2 How others are thought to view people with gambling problems

Many participants expressed that they thought people without gambling problems view those with gambling problems in a highly negative light, using descriptors such as stupid, foolish, weak, untrustworthy, secretive, losers, self-indulgent, lacking self-control, irresponsible, pathetic, desperate, lacking intelligence, and no hopers. A few also said that other people saw people experiencing problem gambling as coming from low socio-economic backgrounds and one maintained that others consider them to be the 'scum of the earth' (41, M 18-24). One participant from an ethnic minority background contended that:

If someone is a gambler, nobody will like to give his girl for marriage (40, M, 25-34).

He also felt that nobody wants to be friends with a problem gambler. Another participant contended:

It is a stereotype that problem gamblers are incapable of being a normal human (33, M, 25-34).

These strong emotions are exemplified in the following quotes:

They either can't be bothered with you or they just think you are an idiot (48, F, 65+).

I think they think they're silly. I think they think they don't have any brains. I think they think that they're just wasting their time in the venue. I think they don't want to make friends with them. They keep their distance from problem gamblers (8, F, 55-64).

They think they're thieves. They're liars. They have no life. They have no family (16, M, 18-24).

I think they really look down on them. I think they look at them as lower citizens maybe (4, M 35-44).

When asked about whether 'people view problem gamblers differently than they view non-problem gamblers', some different opinions emerged. A few said there would be no perceived difference. Thus, one person said 'I think they put us all in the same pot' (8, F, 55-64). Many however considered that other people see gamblers with problems differently to non-problem gamblers, with comments that the former were considered less trustworthy, were from lower socio-economic backgrounds, and had less self-control and lower self-esteem. One participant contended that, within the general community, the sense is that 'you either love it or you hate it [gambling]' (33, M, 25-34). The issue of fun was

mentioned by one person, who felt that others see people with gambling problems as not gambling for fun, wasting money and having no self-control.

6.5.3 Who stigmatises people with gambling problems?

When asked 'who stigmatises problem gamblers', most participants nominated the community in general, family and friends, and the media. A few nominated gambling venues, non-gamblers and, interestingly, other people with gambling problems. These perceived sources of stigma are expanded upon below.

General community attitudes were blamed extensively. As one person commented, 'I think it is just community attitudes more than anything' (43, M 45-54). A lack of understanding was identified as the cause of stigmatisation by the general community:

I think it's really just those people that don't gamble, don't understand that it is an addiction. So they're the ones that stigmatise them. They could be anyone. They might be at work or family or whatever. But if they don't understand it, so it's an addiction and they can't – well, they tend to put a stigma on it rather than understand the problem (33, M, 25-34).

Family and friends were often seen as stigmatising problem gambling, thus making it hard for participants to disclose their behaviour; however, others found family and friends very supportive and non-judgmental. This is expanded upon later in this chapter.

A few participants saw the media as falsely glamorising gambling. In addition, the media was considered to put gambling 'in your face', thus causing problems (6, M, 35-44). Attitudes toward the media varied, with about half the participants considering that it presented a very biased picture of people with gambling problems, whereas a few concentrated their comments on how the media promoted gambling as a good thing.

Interestingly, one participant considered the media to now have an unbiased approach to reporting addiction in general, and that media attitudes had changed from demonising addicts to a more cautious approach:

I don't think that the media necessarily does, I think the media stays pretty wary not to – they don't go after problematic bad people. They still don't, even when it's someone famous in the media recently. It's still very much on the side of it these days. A lot has changed, like the addiction and depression and stuff like how the media deals with it (31, M, 25-34).

Another participant wondered about how venue staff viewed patrons experiencing problem gambling:

They see you regularly. They watch you and see your money. Of course they are not gonna tell you anything different because they're getting the money into the venues. Honestly – I mean I've never heard from any of them of course, but it does make me wonder how they're thinking. Are they thinking, 'Oh my God, look at that person how much they're spending. Don't they have a life?' I do wonder in the back of their minds if they do laugh and think about it. But then obviously I've never heard it out loud. There would be some probably that would be like that (50, F, 25-34).

One other comment reflected powerfully on how staff in venues were thought to stigmatise people with gambling problems, although a few felt no stigmatisation from venue staff:

I think people in the venues, who work in the venues ... a lot of them probably think that we're just a bunch of losers and they tolerate us because it's their pay check and that's probably what

they're told by the owners to be nice, but I think they probably think 'how self-indulgent are they?' (39, F, 55-64).

Competition between gamblers was blamed as creating an atmosphere of stigmatisation amongst 'problem gamblers' themselves. One explained:

I think other problem gamblers probably do stigmatise each other because it gets a bit competitive out there sometimes ... We're never particularly happy if somebody else wins and we don't [win]. That they win on the race and we don't [win] and they're happy to show you their slip and whatever. So, I would think problem gamblers themselves are probably quite possibly the worst in terms of stigmatising others (14, M, 45-54).

6.6 Reactions to perceived public stigma

6.6.1 Feeling judged and/or discriminated against

More than half of the participants had felt judged by others because of their gambling. A few participants were able to describe actual experiences, but most could talk only about a general feeling or fear of being judged. Of those who did not feel they had been judged, many said that this was due to no one knowing of their gambling behaviour.

Participants who had a general impression of being judged made statements like:

When I'm not there, they say something else (21, M, 35-44).

Another comment indicated that, although nothing had been said, the participant still felt judgment:

... because of the way I feel, I often feel people maybe are watching me ... that's only my own feelings, it's not that anyone has said anything to me (43, M 45-54).

Others also felt strongly that they were watched and judged by patrons, staff, family and friends in gambling venues even though these judgments were not verbalised:

Mainly when I'm inside playing and if I'm up. If I was up two grand or something like that ... You throw 50 after 50 in, and there's a little old lady betting 25 cents next to you, and she's watching you, betting \$50 a hit, so – yeah. She's definitely judging you (16, M, 18-24).

Only the one time I remember – I was a regular at a particular place and obviously, I'd continually lost there. So I went one time, right, and the staff – they were like – they act like they're better than you. It felt like they're acting like they're better than me because – yeah – I lose money and they look at me like that – they look down on you. And so, when they're going to serve me, like for a drink and that, it's not happily or anything like that. It's just like – 'oh, just hurry up. Get it and go'... I didn't go back after that actually because you're having to deal mentally, to try to win your money back without having to deal with people thinking you're below them (51, M, 35-44).

After acknowledging that his gambling was problematic, one person felt constantly under scrutiny:

Yeah. It's surprising how much people really even noticed or cared. Like I know, a few years ago when I started to come to terms with it I would not use the ATM in the pub because in my mind, I was ashamed with that kind of stigma of keeping going back to the ATM, and people would see me so I would sneak across the road, to a different ATM (31, M, 25-34).

Some more concrete examples of judgment were provided by other participants. At times, a few had heard comments like ‘just a no hoper, he’s no good, he’s got no money, he can’t come out for a beer’ (16, M, 18-24), and ‘you’re just a lonely pokie lady’ (46, F, 45-54). Others related:

Sometimes, my sister says – because my brother-in-law and I ... put in ten dollars each on a Saturday and have a bet. Sometimes, I’ll have a bet on a Sunday, and she goes, ‘Well T doesn’t – T’s her husband – ‘T doesn’t find the need to bet on a Sunday.’ So she’s kind of having a go at me, why am I having a bet on a Sunday? (12, M, 35-44).

Yeah, I’ve been judged because somebody will want me to go out for dinner with them, have a girls’ day out with them and I’ll say, ‘Oh no, I’m busy’ and [they say] ‘Yeah, yeah busy at the club’. Yeah so that’s how I feel I’m being judged. Or if they don’t say it ... I know what they’re thinking, or I think I know what they’re thinking (8, F, 55-64).

A few participants shared their experiences of direct discrimination because of their gambling problem:

Well, this was the most embarrassing thing that happened to me. When I self-excluded myself from one of the clubs, my girlfriend’s husband was a security guy who’d go and pick the money up. And they must have photos up in the office, and she said to me, ‘So and so saw your photo in the office of the club that you self-excluded yourself from.’ And I just felt like – I just felt terrible. But he shouldn’t have even mentioned that because that’s a privacy issue. So I was really not happy about that. I rang up the club and I felt that they should not have those photos on show for people to come in from outside to be seeing ... And I felt in that case, I was being discriminated against because I felt that they didn’t care (48, F, 65+).

When I had a debt agreement to get everything sorted and been paid off, I couldn’t get phones. ... even though ... phones and things were always paid because I’d direct debited all my bills. ... [But] I couldn’t get anything. So that part sucked. I’m trying to explain it to people that you can’t get anything (52, F, 25-34).

Following an experience of judgment, many participants said they felt angry, defeated, inadequate, surprised, or just terrible. A few, however, maintained that they did not care as they were thick skinned or tough or ‘I simply laughed it off’ (36, M 55-64).

6.6.2 Reactions of people to whom problem gambling was disclosed

About half of the participants had not disclosed their gambling to others. Amongst those who had, about half encountered supportive reactions, but others had received negative reactions, with others’ comments about wasting money or doing something better with life being common. One person recalled how her family had responded to her:

Well, I thought they’d support me but they haven’t ... I’ll say, ‘Look, I enjoy going to the club’, and then I can see the look of disdain in their faces. You know, can’t you do something better like clean your house instead of spending all the time at [the club]? (8, F, 55-64).

Another was distressed at his friends’ responses:

Like being looked down on, almost as if it was criminal. You know what I mean? As if what I was doing, even though I wasn’t harming anyone but myself, was a criminal – Well, that’s how they – I perceived them to look at me ... For example, my best friend ... when I opened up to him about it, he reacted really angrily because he felt like I was wasting my life and my money and my current situation with my family. And I thought he would’ve been more sympathetic to my situation, but he reacted angrily to me. It shocked me!’ (51, M, 35-44).

Some participants, however, were surprised to encounter more positive and supportive reactions from family and friends than they had expected when they disclosed their problem:

My whole family pretty reacted positively to it in their way; like some people didn't understand but they stood by me anyway, so really, the fear and the stigma that was attached was unfounded in my case after that (9, M, 18-24).

6.6.3 Which groups are most stigmatised?

Four groups of 'problem gamblers' stood out to participants as being more stigmatised than others: older people, women (EGM players), gamblers from low socio-economic backgrounds, and specific cultural groups (Asians, Indigenous peoples, Greeks, Italians, Middle Eastern nationalities, Russians and Polynesians were mentioned). Young people were also mentioned as being stigmatised as were big gamblers, and finally Baby Boomers. Most participants nominated a range of the above groups, indicating that stigmatisation is perceived to occur across many groups of people with gambling problems.

The Asian folks are really, I think, more stigmatised ... I think it's like racism ... so are criticised for their gambling habits (39, F, 55-64).

A lot of the younger guys, the under 25's and also the pensioners (51, M, 35-44).

It's probably more acceptable in the male community ... women who play the pokies and that kind of thing, it's the lowest form (46, F, 45-54).

6.6.4 Are the views of others unfair or fair?

Participants were asked if they thought the views of others about 'problem gamblers' were fair or unfair and if they had ever agreed with or challenged others' criticism or judgments about people with gambling problems.

About half the participants thought that most negative comments about people with gambling problems were accurate. One explained how she thought that they just wasted their money:

Agreed. That the money could be put to better use. That you know, the machines are always going to win, that sort of thing. Yeah, just the lack of self control. The time wasting. Just those things, I think (29, F, 55-64).

A few were more cautious in their response, indicating that some comments people made were accurate while others were not:

I think they're accurate to an extent – I think to just assume that someone can just stop without help; I don't think that that's fair to expect people to snap out of it. But then I also think it's fair to say that it's silly and we should stop (9, M, 18-24).

However, many considered that negative comments were typically made without a good understanding of the nature of problem gambling. For example, one participant explained: 'I don't think you can have an accurate judgment unless you really know about the problem of someone' (43, M 45-54). Thus, comments like just snap out of it were deemed unfair.

One person felt that all gamblers were grouped together and he resented this stereotyping:

I essentially agree with a lot of them. However some which generalise gambling into like one category and it's like them all ... I generally disagree with that because I know that I'm a good person (41, M 18-24).

Many interviewees felt that the judgments levelled at people experiencing problem gambling were unfair, even though comments about their behaviour may be accurate. One explained:

Well I know they're accurate, but I think it's unfair. Who are they to judge? What I do is wrong but what they do might be morally wrong, might be, you know, don't point the finger at me unless you point it at yourself. 'You gamble too much.' 'You waste your money.' 'You're stupid.' 'If you had half a brain, you'd live your life right.' Things like that (8, F, 55-64).

However, most participants agreed that problem gambling was a bad thing, that it negatively affected many people other than themselves, and that they should stop gambling so much. However, many had not discussed problem gambling in public nor entered into conversations with others about their views of those experiencing gambling problems. For example, one shared:

No. I tend to sort of shy away and keep out of it. It's too close to home (46, F, 45-54).

6.7 Effects of stigma on help-seeking behaviour

Perceived public stigma and self-stigma were powerful contributors to limiting help-seeking behaviour. All participants acknowledged that they had a problem with gambling, but about half said they would not admit it to others and thus would not seek help. The stigma they felt or perceived impacted upon their willingness to talk to others, and could also compromise their resolve to overcome their problem. However, about half were determined to overcome problem gambling regardless of what others thought of them or how they viewed themselves. Nevertheless, a few participants admitted that they did not want to stop gambling even though it was causing them problems. Effects of stigma on help-seeking are detailed below in relation to different sources of help.

6.7.1 Willingness to tell family and friends

About half of the participants had told family and/or friends about their gambling problem. All expressed embarrassment and shame at doing this, but many received support from the people they told, despite their fears of rejection. Many had been surprised at how supportive significant others had been:

I think they would be very proud of me to bring it up. Yeah. They know they just have to sort of help me with that, put me down without patronising me (19, M, 55-64).

I thought my parents would be really angry and judgmental because they're very religious but when I did tell them, they were nothing but supportive and they got me help with a counsellor and just stood by me. (9, M, 18-24).

My wife... her judgment was pretty emotional, and that took ... quite a lot of work for both of us, to work through that. My children have not judged me at all I think is a fair statement, and the friends that I've communicated this to, have also – I mean, they were surprised, completely surprised that I would be in that situation (25, M, 55-64).

However, some participants received negative reactions when they disclosed a gambling problem, with comments like 'he thought I was stupid playing the pokies' (32, F, 45-54) or 'it's all in the genes,

you'll end up like your grandfather' (28, M, 25-34). Another related that 'I've had friends tell me I was selfish for gambling 'cause I should be spending my money on my son, for instance' (5, M, 18-24). Another conceded that his 'family judged me, but had every right to' (35, M, 35-44).

Others recalled delaying disclosure, such as one interviewee who related how ashamed he felt:

It took a long time for me to actually come forward and kind of admit that I had a problem. Yeah. It obviously took a long time to get over that. The shame, as you say, there's the shame of it. And just to be able to come out and say it (27, M, 25-34).

About half the participants felt unable to tell family due to fear of rejection, feeling it was too shameful and that no-one would understand. For example:

I don't tell them anything and I have a million and one excuses of where the money went or why I've got, how I got this, and why this is not paid. So it's basically being devious because I don't want them to look at me and think – I don't even want their pity, you know, I just want them to think of me, same as others would be (48, F, 65+).

Amongst the half of participants who had not told family and friends, many feared a bad reaction. Conversely, a few felt that their family would be supportive if they disclosed their problem, but they still felt unable to do so at that point. Others did not reveal the extent of their gambling to family and friends, while some significant others appeared to purposefully ignore the gambling problem due to their own embarrassment and shame:

I think they're ashamed ... I think they turn a blind eye and just, you know ... ignore that there's a problem. I haven't had one family member say, 'Don't you think you're betting too much? Do you think you should do something about it?' I think they're ashamed and it's a taboo subject (8, F, 55-64).

6.7.2 Willingness to self-exclude

More than half of the participants had never self-excluded from land-based venues or online gambling sites. Amongst this group, most admitted that shame had prevented them from doing so. The remainder had other reasons, such as not wanting to stop gambling completely, having too many venues nearby, not feeling the problem was severe enough, or not knowing about self-exclusion.

Amongst the participants who had self-excluded, a few found that it had been a powerful and positive experience, explaining that they felt they were taking back control over their life, and that stigma did not enter into their thoughts. Some felt able to self-exclude online as this was more anonymous, but found they were unable to do this in land-based venues due to feelings of humiliation, shame, embarrassment, fear of being recognised and judged, and a general sense of their own weakness. Some participants shared the following:

Honestly, there's no way I could go into a pub or club or anything there and self-exclude. I'd be too embarrassed (5, M, 18-24).

I'm a police officer. So I can't self-exclude — because I have to go — like some of the places we go. We go out for dinner as a family and I can't have my picture and my name on a board. No way in hell (52, F, 25-34).

I'm from a small town. People would have found out that I'd done that, so I guess the reason why I didn't do it was because I didn't want people to find out about it (9, M, 18-24).

One person resisted self-exclusion due to embarrassment and because it would mean admitting to himself that he had a gambling problem. However, he finally excluded himself from local venues, but still found it very shameful:

One of the things my wife wanted me to do was to self-exclude. For more than a year after it came out, I saw that as a sign of failure and it was an admission that I was not strong enough and not good enough and not the sort of person I wanted to be. That surely the goodness I can stop this without having to be prevented from going somewhere and having that sort of potential embarrassment. So I actually held back from that for more than a year after that came out and certainly I didn't do it during the period I was gambling ... I did in the end. And that was a pretty traumatic experience to be honest (25, M, 55-64).

Self-excluding online was considered easier than in land-based venues because of greater anonymity, less embarrassment, and because online exclusion can be viewed as barring from websites rather than a public pronouncement of having a gambling problem. These views are indicated in the quotes below:

I felt good because I felt I was taking some action, because I wasn't capable at that point of dealing with it without barring myself. I felt pretty good every time I did it – online (36, M, 55-64).

In a venue - If I'd have done that ... I would have felt that that I would have let myself down by not being able to deal with it myself ... when you do this online business, you're not going to go to the public and say, 'Oh, I'm barred from...'. Ultimately, I've just barred myself from these websites (36, M 55-64).

6.7.3 Willingness to join peer support groups

Very few participants had joined peer support groups. A few explained that this was due to a fear of being judged or patronised by other group members or a sense of self failure. However, most felt that such groups were simply not for them, due to reasons other than a sense of shame. Some described how they were not very sociable, or they had no groups nearby. Some of the remaining participants had joined online support groups, but also expressed that they would not attend face-to-face meetings due to concerns about being stigmatised by group members or of someone seeing them on their way to the group. Some expressed how they saw the need to attend as a weakness within themselves as it reflected a lack of self-control and an admittance of their gambling problem. These sentiments are expressed in some illustrative quotes below:

I've thought of it many times, of going, but I don't know ... I guess I have this fear of being patronised (19, M, 55-64).

I didn't want to join. It's like, you know, it's not just admitting to yourself, it's admitting to the world and then everyone is going to look at you different and you don't want that (48, F, 65+).

I'd feel like a failure, a loser (46, F, 45-54).

Nevertheless, a few participants were considering joining peer support groups and expected they would be understanding, such as one who said:

I think they would really be supportive. I assume, because that's how I think I would be if I were in one and they'd all been through a similar sort of thing. So I guess you'd have to know the pain and the suffering that someone's been through, you can empathise with them (9, M, 18-24).

6.7.4 Willingness to seek counselling

About half the participants had received formal counselling, with a few more thinking about it at the time of their interview. A few had received counselling for non-gambling related issues. A minority also recalled that, in the past, the stigma they felt had stopped them reaching out for help, but that they were now engaged in formal counselling. Willingness to undergo counselling was sometimes apparent in spite of stigma, and for others based on their confidence that counsellors would not be judgmental. Some indicative quotes were:

I haven't really felt that that affects going to see a counsellor because generally, once you get to that point, you need to talk to someone, and the stigma doesn't really bother you (33, M, 25-34).

No, no, I think it is their job ... they would be compassionate (2, M, 35-44).

Of the remaining participants, those who had not engaged in counselling, a few felt that they did not need it. Most did not consider the reason for avoiding counselling to be related to stigma. However, a few commented that they would find the experience stigmatising, were worried that the counsellor would be judgmental, or were concerned that attending counselling would itself cause stigma. For example:

I think the counsellor would be laying down the law of what I should and shouldn't do (19, M, 55-64).

And then I know they'd be kind and supportive and they're there to help you, but everybody is judgmental in some way whether they realise they do it or not (1, F, 25-34).

I'd get ostracised at work (52, F, 25-34).

It makes you feel like you have a worse problem than you do (41, M 18-24).

A few participants who had received counselling were not returning as they had felt judged and criticised by their counsellor. One contended:

The counsellor is just waiting for me to fall out of line, and then it'll be no stopping her (8, F, 55-64).

6.7.5 Willingness to seek other online or telephone support

About half the participants had sought help via online or telephone support services and many of these participants had used both services. A few had participated in the '100 day challenge' and many felt that the success stories from recovering problem gamblers were of particular help:

It's sort of made me feel that I was on their path or way of life (11, M , 18-24).

The other half of the sample had varied reasons for not using online or telephone support. These included lack of awareness of the services, feeling it would be too impersonal, the service wanting to include a partner in the session which the participant did not want to do, or feeling that they did not need that type of help. For example, one said:

I'm at that stage now where I don't need this help at the moment (41, M, 18-24).

Half of those using online support services found them helpful. In contrast, only a few who had used telephone support reported this as helpful because they had to speak to different counsellors each time they called or they felt that the counsellors were not suggesting anything new. One explained that:

There is only so much they can do ... then they tell you to seek self-exclusion and do this and you say you have already done that (48, F, 65+).

However, there was no indication that participants felt judged or stigmatised by either the online or telephone services they used.

6.8 Effects of stigma on relapse and recovery

Even though many participants considered that stigma had impacted on their help-seeking behaviour, many considered that it had not overall affected their recovery from problem gambling or the likelihood of them relapsing. Many participants had experienced relapse, although a few had not, including one who had never having stopped gambling.

One reason that so many interviewees did not see stigma as affecting their recovery or the likelihood of relapse was the secrecy surrounding their gambling. If no one knew they gambled, then there was no stigma attached to not being able to control it. One explained:

You don't want people to know that you've got an issue, so you keep it a secret (54, M, 25-34).

Those who did feel the impact of stigma noted specifically that this was an internal feeling, the 'defeatist attitude that gets into you' (28, M, 25-34), or due to a fear of admitting and disclosing their problem. One shared:

I feel it made it a lot harder to get started [on recovery]. I don't know whether that was due to real external stigma or it's just my rejection. But I did struggle for months, maybe even a year, to actually talk to other people about it. And that was definitely... my perception of the stigma (50, F, 25-34).

6.9 Effects of relapse on stigma and help-seeking

While stigma was generally not seen as contributing to relapse, relapse appeared to worsen the stigma felt or perceived by many participants. Many participants had relapsed at some point, with about half of them feeling that the subsequent stigma attached was then worse or different. Relapse was accompanied by feelings of self-loathing, listening to others telling them not to do that again, and finding it even more embarrassing to admit to family, friends and counsellors that they had failed to stop gambling. Some participants did not disclose their relapse to others. These sentiments are expressed in the following quotes:

Once I sort of made the decision to quit, any relapses are sort of incredibly depressing either way they go, like regardless of whether I win money or lose money. Yeah, it's definitely the conscious association of that, of the stigma and that I'm doing something I don't want to do. It's very different once you relapse (31, M, 25-34).

Yeah. It's harder too. It's a struggle because you just don't feel confident enough to be raising the issues, you relapsed, and all that. You sort of – I think it was stupid that you relapsed. So it was more predicament and you go 'Oh, I really don't wanna be a joke or I don't wanna look like an idiot so I'm just gonna shut my mouth and hope it goes away' (50, F, 25-34).

A few participants who had been receiving counselling told how they were embarrassed to return to their counsellor following relapse. For example, one said:

To go back to her now, I'd be so embarrassed ... I'm thinking that she's gonna be disappointed in me (48, F, 65+).

However, a few participants who had relapsed felt no difference in any associated stigma and seemed to internalise the reasons behind the relapse as their own fault, feeling annoyance and frustration at themselves but renewed determination to address their problem, such as one who said:

It didn't depress me. I was disappointed in myself and then I would make this determination that I'm gonna fix it. But as I since learned, you know when you're ready to do something about it and have managed not to sin with the drinking again. You can tell yourself as many times as you like, for the drinking, but until you're ready, until in your mind you're ready, you won't do anything about it (36, M, 55-64).

Some participants also felt that society expected them to relapse so, while stigma continued to affect them, it was no different than before the relapse. One explained:

I think people probably expect it in a way, because if you probably have that label of gambling addict then you went so long, then you relapsed, then people would be like 'Oh they're a gambling addict what do you expect?' kinda thing. (1, F, 25-34).

Only one participant felt that the change in attitudes following relapse was positive in regard to how others saw him:

If anything, it was more of a positive thing. People will tell, 'Yeah. You tried. You can do it again. Just keep on trying.' (15, M, 25-34).

6.10 Stigma and public health messages

Participants were asked: 'Do you think public health messages about problem gambling, such as television ads, billboards, online materials, raise or lower the associated stigma?' Views on stigma and public health messages were evenly spread, with about one-third of participants feeling that these messages lower stigma, one-third considering that they increase stigma, and one-third feeling that the messages have no impact on stigma. A few participants had not seen any of these messages.

The main reason that messages were perceived to lower stigma was because they raised public awareness of problem gambling, with one participant specifically commenting this was a slow but useful process. Reasons for feeling that the messages had no effect on stigma were that most people would not see them as having any relevance for them or their family, or because the messages were considered 'tokenistic' on the part of advertisers.

However, some strong feelings were expressed by the participants who felt that these messages increased stigma, with many feeling that problem gamblers were ridiculed and portrayed in negative ways in the advertisements. Some commented:

All because you see people on TV they say, 'Oh, I gambled away my house and I gambled away this and I gambled away that', and people can go, 'gambling is a really bad thing.' (48, F, 65+).

I can't remember if it was in the newspaper or a sign, it was like if you're keeping your gambling a secret, you have a problem and it showed a guy there looked pretty depressed, and I guess people would see that and associate people with problem gambling as liars or untrustworthy (13, M, 18-24).

6.11 Stigma reduction

Very few participants could suggest ways that stigma associated with problem gambling could be reduced, but those who could suggested more advertising, with more variety. Some felt that families should be targeted more in the advertising, and that more personal stories from gamblers should be available for the general public to see. It was suggested that gamblers could be more open and honest with their problem and this would create a less judgmental attitude within the community. A few suggested that advertising should emphasise that problem gambling is not a choice, but is the result of a 'condition' or 'addiction'. One person felt that having counsellors more readily available in venues would reduce stigmatisation. This range of views is captured in the following quotes:

Not targeting the actual gambler, but the message is targeting the people that are affected by gambling (6, M, 35-44).

I think somehow recognising that people who do unfortunate things, like steal money or leaving children in a car, or whatever else it might be – yes, they've done things that are not good. We can't change that. We can't hide from that, but somehow recognise that it's being driven by a force that's perhaps outside that person's control (25, M, 55-64).

Advertisements in non-gambling places that are saying to people, 'If you know someone, instead of judging them, help them (12, M, 35-44).

Even getting some stories out there to people who have been through and went back with gambling and how they had recovered, possibly putting positive messages out there. It would be helpful (33, M, 25-34).

6.12 Is stigma beneficial or harmful?

The interviewees were asked : 'Do you think that the stigma associated with problem gambling can possibly have any beneficial effects or do you think it's harmful?' Responses to this questions were varied.

A few participants thought that stigma could motivate people with gambling problems to seek help and prove they weren't such 'losers'. One explained:

So people might think, 'Well I don't want to be stigmatised. I don't want to be an outsider. I don't want to be shunned by society. I don't want people to think of me as a loser or whatever. I'll do something about it.' (14, M, 45-54).

About half the participants felt that the stigmatisation of problem gambling had both good and bad elements, at times motivating people to address their gambling problem, but overall creating a sense of shame and embarrassment that hindered help-seeking, despite their need for support. This was especially evident for those experiencing relapse. Indicative quotes included:

Like it's a good deterrent for people. But once you are addicted, then, you know ... you need to have support and not be judged (46, F, 45-54).

I think it can have a beneficial effect because ... if you can overcome the problem it makes you a stronger person. And you – by achieving success in not gambling – you feel a lot better about yourself and you realise that you do have the necessary qualities to overcome those problems. But then, you know, if you relapse, well that all goes downhill again for a little while (29, F, 55-64).

Even though stigma may motivate help-seeking, one participant felt the process was riddled with guilt and was thus a negative force:

Probably just harmful. It guilts you into trying to be something be better and trying to do something about it, which is probably not the way. You should probably come to that realisation yourself through other methods, not by being guilted into feeling bad about it even though you know it is the wrong thing. You've got to realise in other ways, I think. So it's probably more harmful (2, M, 35-44).

Slightly less than half of the participants felt that there were no positive elements to stigma as it created a sense of hopelessness and failure for people experiencing problem gambling. For example:

I think it's harmful, incredibly harmful. If it wasn't, if it didn't have so much stigma attached to it, possibly more people might think about that they might have a problem, but because of the stigma that I believe is attached to it, it pushes your subconscious, pushes you further into denial (39, F, 55-64).

6.13 Chapter summary

Amongst the 44 participants, the meaning of stigma was interpreted as a general negative judgment on groups or individuals made by community, family, friends, venue staff and the media, and that was based on an unjustified opinion. Participants felt strongly that they were stigmatised and judged by those around them and that this was unfair. It was difficult for them to articulate if this sense of being judged emanated from their own self-stigma or was the result of outside influences, as the two were very closely associated. In general, participants acknowledged that problem gambling was bad and for some, this translated into a sense that they themselves were bad.

Only a few interviewees were able to share specific examples of discrimination or of hearing judgmental comments from those around them, perhaps because many had not disclosed their gambling problem due to fear of this criticism. However, once they did disclose their problem to family and friends, many participants expressed surprise that many others did not overtly judge them and instead supported their efforts to change. Nevertheless, most participants considered that others did stigmatise people with gambling problems in general, as they had heard critical and demeaning comments from many sources, including family and friends.

This sense of being stigmatised impacted strongly on participants' help-seeking behaviour. While stigma was considered to sometimes motivate help-seeking, most often it deterred participants from disclosing their problem and from seeking support from significant others, peer support groups, or through self-exclusion from land-based venues. Stigma did not appear to be such a powerful deterrent to seeking counselling, as most participants expected that counsellors would be non-judgmental and compassionate, although a few participants noted a stigma attached to actually needing and seeking counselling – and the self-stigma of admitting to themselves that they needed counselling.

Self-stigma and perceived stigma from others also impacted on participants' feelings and behaviours following relapse. Relapse was a common experience, and most often accompanied by self-loathing, additional reticence to tell significant others, and a deterrent for some to returning to their counsellor. In contrast, a few participants felt unconcerned about what others said and dismissed any thought of being stigmatised. Even though stigma did affect help seeking in many ways, there was a strong message from those interviewed that they recognised their problem, that they were extremely troubled by it, and were determined to overcome it. Overall, the participants did not consider that public health messages help to reduce stigma; indeed they often expressed how it intensified public stigma and

thus the shame experienced by people with gambling problems. Very few were able to offer suggestions for stigma reduction strategies.

Some participants saw stigma as a motivating force, driving them to show others that they were not the 'losers' that they had been labelled. Overall, however, stigma was seen as harmful and unfair, and as creating an environment where people experiencing problem gambling hid their gambling for fear of criticism, found their self-esteem and health deteriorating, and were reluctant to seek help.

Chapter Seven: Results from interviews with gambling counsellors

7.1 Introduction

This chapter presents the results from interviews with nine gambling counsellors from a range of gambling help agencies in Victoria, including both culturally specific and non-culturally specific services. The counsellors shared both client experiences and their own professional views on stigma associated with problem gambling and its perceived impacts on clients' emotions, behaviours, treatment and recovery. The results inform research Objectives 4-6 of this study.

After gaining individual consent, telephone interviews were conducted by two research team members with experience in interviewing gambling counsellors, using a semi-structured interview guide (Appendix D). The counsellors were first asked to describe what stigma means to them. Focusing on client experiences, they were then asked how their clients feel they are viewed by others because of their gambling; whether clients talk about feeling stigmatised; and whether and how any feelings of stigma have affected clients' acknowledgement of their gambling problem, help-seeking behaviour, recovery and relapse. The counsellors were also asked about how they incorporate stigma-related issues into treatment, and how stigma interacts with relapse and recovery. Suggestions for stigma reduction strategies were also gathered.

Interviews were analysed using a combination of thematic analysis and interpretative phenomenological analysis. Major themes supported by minor themes were extracted and are reported in this chapter. To guarantee confidentiality and anonymity, each interviewee was assigned a code, labelled as: C (counsellor), M or F (gender), and a participant number beginning at 1. These codes are attached to quotations presented in this chapter.

7.2 Participant characteristics

Of the nine interviewees, seven were female and two were male. The length of time that they had been working in gambling help services ranged from two to 15 years. All were gambling counsellors, except for one male participant whose primary role was as a peer support worker. Most worked in services that were not culturally-specific, although all participants worked with clients from a wide range of ethnic backgrounds.

7.3 Meanings of stigma to participants

Counsellors were asked to describe what they thought stigma is. Their responses indicated that stigma was perceived to be comprised of two important components. The first was self-stigma, which manifested as shame and embarrassment felt by clients themselves. The second was public stigma, that is being labelled by others with a shameful and negative condition that was considered to be socially unacceptable.

7.3.1 Self-stigma

Self-stigma was perceived as a personal or culturally embedded barrier preventing people from sharing a problem which, for them, is out of control and interferes with their day to day functioning. Thus, problem gambling is a personal issue, not shared but instead kept hidden because it interferes with gamblers' lives. According to the counsellors, clients expressed humiliation and even horror that they were in a gambling crisis. However, they did not always understand how this crisis had occurred. In fact, some clients could not describe their compulsive behaviour and motivations leading to problem gambling because it was often outside their previously acceptable life and acceptable moral values. The secrecy, lying and deception associated with their gambling problem was reinforced with relapse after they had made decisions to abstain from gambling. Negative stereotypes, self-imposed stigma and feelings of being a loser were recycled in this event. One counsellor summarised the self-stigma of problem gambling as follows:

... because of shame or stigma many people postpone asking for help. And usually they ask for help when they're in a crisis ... after being caught with gambling ... they say they feel ashamed ... stupid ... they are so angry at themselves that they can't control it ... it's their words, they call it hopeless, helpless. They can't control it and they say, 'Why others can control it? Why me? Why I can't control it? I am angry.' (C,F,8)

Feelings of self-stigma were created and compounded, counsellors said, when people make a judgement about themselves and often end up being their own worst enemy. One counsellor noted that, especially when clients hold a respected position in society, they are expected to have more knowledge about and control over gambling compared to others. This was especially said to be the case for those with a religious background who perceive they should present as being a fit and proper community person. Clients with strong faith and links to church groups are reportedly more affected by self-stigma due to problem gambling than others. They are also reportedly very concerned about public stigma; that their religious congregation will think less of them if they reveal they have a gambling problem. As one counsellor observed:

Instead of speaking up trying to get help, it's better off to sort of sit with it and keep it to yourself (C,M,6)

Thus, some people decide that it is not appropriate for them to be known as 'a problem gambler', and self-stigma was seen by some counsellors as stronger for this group than for some others.

A few counsellors also noted that people with low resilience seem to feel and accept stigma more easily than those with high resilience. When a person is caught up with problem gambling and its underlying shame, then it is like they have a broken identity, one with very low self-esteem and even paranoia that can make it difficult to be truthful, even to counsellors. One counsellor explained:

I'll put it in context of ... suicide that you have to have the courage to ask the questions and have the truth put there because ... I often say, a gambler is as good a liar as a heroin addict. They know how to lie and they've been lying to me ... and every time ... I don't know if that's the truth or not, because it is so shameful for them, which is just terrible (C,F,1).

Thus, as explained in more detail later, treatment consists in part of building clients' trust, restoring their self-esteem and resilience, and teaching them coping mechanisms to deal with self-stigma and fear, as well as with their gambling problems.

7.3.2 Public stigma

Public stigma was perceived by counsellors as negative community attitudes towards people with gambling problems, problems best kept hidden. The counsellors considered that perception and judgment by others with very limited information about problem gambling often led to labelling 'problem gamblers' as losers due to their unacceptable and problematic behaviour. Thus, people with gambling problems are often unwilling to speak up and identify their issues because of the stigma and shame they perceive or experience within their social settings. An expectation of damaging social opinion and public misunderstanding meant that some clients told others that their problems were due to drug taking, used pseudonyms for gambling, pretended counsellors were friends they were catching up with in cafes, and refused self-exclusion as their photos would be seen by staff in local gaming venues. Gossip, stereotyping, and ignorance reportedly contributed to isolation, low self-esteem, and humiliation for clients, adding to their self-stigma. Community perceptions about people with gambling problems being able to just stop gambling at any time compounded the stigma reportedly felt by gamblers. External stigma and negative community attitudes were explained simply by one counsellor:

Viewed very negatively ... why don't you just stop? There's a lack of understanding (C,F,2).

Other responses reflected this public disbelief and incredulity that people could become so trapped in problem gambling cycles:

It doesn't make sense that a so-called educated or rational person can do that and keep doing it and bring such distress to the family home or to their work or community' (C,F,1).

Counsellors explained that their clients are often people who have been successful in most other ventures they had attempted. For example, one young man had 'massive accomplishments' (C,F,4) in sports, was at the top level in his work, with many social outlets and friends, but could not control his gambling. The counsellor could not even leave messages on his phone because he was so concerned other people would discover his gambling. He particularly did not want his workplace to know; he was worried about the public shame of not being seen as trustworthy and with that, potentially reduced job prospects. According to this counsellor, secrecy due to fear of public stigma intensified his feelings of self-stigma.

Some counsellors saw the public stigma associated with problem gambling as being similar to that associated with other conditions, such as alcohol and drug misuse and mental illness. However, other counsellors felt that society generally did not understand problem gambling as well as it understood these other problems. One contended that:

I think that it's not recognised or acknowledged in the community as a health issue as much as drug and alcohol is ... not seen in the same light ... that leaves a huge stigma associated with it (C,F,3).

7.4 Effects of stigma on problem acknowledgement and help-seeking

7.4.1 Effects of stigma on problem gambling acknowledgement

The counsellors were asked whether clients talked about feeling stigmatised because of their gambling and how this may affect their acknowledgement of having a gambling problem. Counsellors reported that some clients took time to realise that they were experiencing gambling-related problems. This was often because clients felt that the next win would provide enough money to release them

from their immediate problems. This win would take away the embarrassment and shame, normal life would return and all would be well again. However when problems escalated, some clients found it difficult to understand that their situation was not temporary. They also found this hard to describe to others. One client told his wife that he was using the illegal drug ice as a gambit so that she could understand his behaviour and his request for help. One counsellor explained it this way:

The cycle of change ... it takes quite some time for some people or most people to realise when something has sneaked up on you, which most addictions sneak up on people. One moment it is fine and they're able to cope ... and ... there's that denial process that people go through ... 'I'm a person who can manage and control my life and people see me as that person. And if I ever admit to myself that this is as out of hand ... I might not be even to look at myself in the mirror.' (C,F,4).

By the time clients needed to explain their problem behaviour, their previous visions, hopes and values had been overturned or called into question by their gambling. However, they often had a limited grasp of their condition, their motivations and subsequent behaviour. These limitations also applied to clients being able to articulate their experiences and problems. An insightful description of this combination was provided, which also relays the self-stigma commonly felt by clients when they realise they have a gambling problem:

By the time they get here they're in high crisis ... secretive ... have no idea how to explain to the family ... They don't have a language for it ... don't understand ... very difficult for them to say what's happening and what their actual behaviour is ... feelings of shame, feeling embarrassed, disgraced, just horrified at themselves ... What is going on? How did I get here? How did all this come about? ... just such unawareness and a lack of words ... quite often ... I'm feeding some language for them ... I have to work fairly hard to draw issues out and have an understanding of where has gambling turned into such a horrific problem for them. (C,F,1).

7.4.2 Effects of stigma on seeking counselling

The counsellors were asked: 'How have client experiences of any stigma or shame affected their decision to seek treatment?' Most counsellors agreed that clients experienced a stage of denial before reaching a crisis point which became a catalyst for seeking help. Counsellors often referred to this crisis point as 'hitting rock bottom', or by one counsellor as 'bombs exploding' (C,M,6). It was generally such a significant event that the barriers of self-stigma and shame were overpowered, sometimes opening the way for clients to seek help. However before that, self-stigma delayed or prevented many people from seeking help. One interviewee expressed it like this:

Shame ... always having seen themselves as responsible with their money or with their decisions or their expenses, being able to manage money ... gambling and losing control of the gambling ... not being a responsible person ... I think it adds to the shame and feeling really bad ... they are rock bottom or sometimes they've done a suicide attempt. It is usually a crisis that brings them in ... the stigma ... stands in the way ... it delays ... and then [they] usually cry with relief after some sessions, that we are not making a judgment. (C,F,7)

Clients' reluctance to seek help was underpinned by fear. This included fear of the unknown, fear that they may be judged as being weak and irresponsible, fear that they may not be heard and supported, fear that they may not be able to trust the professionals they approach, and fear that they may not succeed. A lack of power and control over their gambling activities usually lowered self-esteem and deepened shame for the client. One counsellor discussed a case that highlighted some of these issues (C,F,8). The client was so ashamed about his gambling problems that he did not want to tell his family. He had been calling the gambler's helpline almost daily because he was too embarrassed to

see a counsellor face-to-face. Eventually he attended counselling for a few weeks; however, he always wore sunglasses. Later he brought his wife along. She was very supportive and understanding. But due to shame he could not bare his face in the room. Sunglasses were a symbol of hiding his fears. In general, clients would rather talk on the phone or research the topic online first, because stigma delays them from asking for help in person for as long as possible (C,F,8).

Some counsellors suggested that client motivations to seek help for gambling-related problems reflected the nature and intensity of stigma being experienced by them, although this depended on the individual client. For instance one counsellor said it was very hard for clients to 'come through their door' (C,F,2). Some clients did not know whether they would be able to walk across the threshold, it was such a big step for them to acknowledge their problems and seek help. Stigma was a barrier to their accessing gambling help but counsellors saw motivations reducing this barrier coming mainly from the gamblers' own needs, from that of their partner, their family or society. The extent of financial pressures and the impacts caused by problem gambling were being unravelled when they arrived. Thus, motivations might be threatening or supportive, but seemed to be the force behind their help-seeking and thus potentially dealing with stigma and its effects.

Thus, to their own detriment, one dominant desire of people with gambling problems is for anonymity and confidentiality, and stigma can prevent them from approaching professional services (and other types of help). However, if they reach out for help then some of their issues can be resolved, although it often takes them people a long time to approach these services, to overcome the stigma barrier. One counsellor explained this as follows:

So they are extremely cautious when they approach you ... when such clients approach us, it's almost like I'm being tested as a counsellor to preserve the privacy or confidentiality ... And it's a make or break situation in those cases because, if you aren't able to explain it properly, you end up losing the client (C,F,9).

7.4.3 Effects of stigma on seeking counselling after relapse

All counsellors recognised that relapse into problem gambling was a normal part of the help-seeking and recovery process. Counsellors explained to clients very early that relapse was common and provided education on how to deal with relapse. In the counsellors' explanations for how stigma impacts on relapse, differences emerged for several gambler groups.

One group, predominantly men, came to counselling mostly to get help with reducing their escalating financial problems. As one interviewee explained:

They cannot juggle and struggle anymore with their credit cards. They're just at rock bottom (C,F,5).

Once their financial affairs were reviewed and re-arranged, these clients often did not return for counselling until they needed more help with their recurring financial difficulties. They hid their gambling problems, wanting quick solutions and a swift escape. They were unwilling to delve into any underlying issues contributing to their gambling problems. Relapse often followed, as this counsellor observed:

They try to help themselves but they're not going through with recovery ... then I see them with the same issues back again (C,F,5).

Thus, ignoring the causes of problem gambling and only treating the symptoms, appeared to facilitate relapse amongst this first group.

A second group was comprised of clients who were receiving gambling counselling, experienced a relapse, and returned for counselling almost immediately and then regularly. This group seemed to recognise that relapse was an ordinary part of recovery and that the counsellor was not going to treat them like 'some lunatic or mentally unstable person' (C,F,4). Counsellor information normalising gambling relapse seemed to have prepared these gamblers, as this response indicates:

I normalise it in the context of counselling then encourage them to keep coming ... [use] that relapse as a learning experience ... help the client to understand that the emotions ... like an unconscious process ... keep repeating (C,F,8).

Thus, this second group of people appeared much less afraid or embarrassed to return for counselling sessions than a third group, who were extremely reluctant to return for counselling because they were so ashamed of their relapse. As time passed, they felt more guilt for letting down the counsellor assisting them. With growing self-reproach and reducing self-esteem, their counselling stalled and often ceased. Self-stigma attached to a gambling relapse seemed to grow when the length of time between counselling sessions grew, as this comment suggests:

If it's been a couple of months - six months, there's more shame (C,F,3).

7.4.4 Effects of stigma on seeking help from family and friends

Counsellors were asked about any stigmatisation their clients reported experienced from family and friends, and whether this affects clients' willingness to reach out for, or be offered, support from significant others. Their responses indicated that some families supported problem gambling members; however some did not, while others changed their attitudes and support over time.

The counsellors reported that clients were generally unwilling to reveal their problems to family and friends due to their own self-stigma, and the potential public stigma associated with such revelations. Problems remained hidden until there was no choice but to tell others, such as when rent went unpaid, emergency food was needed, or a child's birthday was overlooked. Once revealed, family and friends were initially shocked, distressed and then they were embarrassed, according to the counsellors. Significant others often did not understand the issue and did not know what to do about it, testifying to the silence around problem gambling. One counsellor summarised these client experiences as follows:

They feel ashamed ... let their family down ... let their kids down. Definitely, they feel ashamed because when they keep the gambling as a secret initially, they have control over that stigma ... when eventually they reveal the problem ... they lose that control ... they feel scared because they don't have control, how the family will react because the family reactions can be different, depends on the family, depends on the story ... it's all beyond them ... some of them say it's a relief ... If the family is supportive, it's a huge relief. But others are ... scared to tell the partner because of the fear of consequences (C,F,8).

Supportive families and friends tended to rally behind the gambler to help. They encouraged attendance at counselling and support groups, and often avoided socialising at venues with gambling facilities. However, their support was stretched when the depth and complexity of gambling problems were exposed. Knowledge about the client's problem gambling was kept close within the family or group, not shared publicly with others due to embarrassment and potential stigma. Some families worried that they had enabled such out of control gambling. This was especially the case when the client had been a successful person in many aspects of life, but had this secret gambling problem that none of them had recognised. It was almost as if family members were living with a dual personality, one of whom they did not know. However, most gamblers reported to counsellors that help and

encouragement from family and friends was a major factor in their recovery process. They felt they could not manage without this care.

However, over time and with repeated relapses, some families and friends became physically, emotionally and psychologically drained. They tired of the secrecy of supporting a gambler with problems. Some restricted the gambler's access to money or refused to go near gambling venues. One counsellor related how, after taking the family jewels, one gambler was completely rejected by his hurt and mortified siblings. They had lost so much, endured as much as they could, and this was the final incident. They did not understand why he could not 'just stop gambling because he was a normal person' (C,M,6). Broken relationships were a sign of increasing frustration and deteriorating trust with gambling relapses. As time dragged on and recovery seemed impossible, some friendships also failed. Problem gambling and subsequent stigma eroded relationships for some people, imposing a double shame: shame about having a gambling problem and then shame of being rejected by family and friends.

7.4.5 Effects of stigma on willingness to self-exclude

Counsellors were asked whether stigma had affected their clients' decisions to self-exclude or not from gambling venues. Most counsellors reported that clients did not want to self-exclude due to the public stigma attached to having their photos available and visible to venue staff. One explained:

It's the shame factor ... sort of like you're stealing from a shop ... your face or your picture is posted on the wall and everybody knows that you're not allowed or you're banned. It's very hard to swallow something like that (C,F,6).

At a personal level, choosing self-exclusion meant actually admitting that their gambling was out of control, thus adding to clients' self-stigma. The counsellors also pointed out that self-exclusion did not ensure that clients understood why they had a gambling problem. Counselling was also required to understand the underlying issues and risks contributing to clients' gambling problems. For instance, one client likened being excluded to the loss and grief he felt at the death of his mother. With counselling he began to understand why gambling had become an integral part of his life (C,F,5). Other clients chose not to self-exclude as they would then face greater risks with alternative online gambling, so for them, self-exclusion was not a viable option (C,F,3). The counsellors generally felt that identifying personal issues and risks was as important, if not more important, than self-exclusion for individuals.

At a community level, clients were fearful of self-exclusion, of being publicly 'outed' (C,F,7) as a person with a gambling problem. Most clients felt that the gossip linked to exposing their gambling problem would ruin their lives, humiliate them before their friends, and put their jobs at risk. Fear of public stigma appeared to be more intense in smaller communities where everyone knew everyone else.

In spite of these deterrents to self-exclusion, two counsellors said that self-exclusion acted as a safety net and helped some clients stay away from gambling venues. They suggested that self-exclusion was like locking the door on gambling, especially when security cameras monitored the gaming room. Self-exclusion contracts banned their clients from gambling and simultaneously deterred them from breaching exclusion orders, even stopping some from stealing in order to gamble. Nevertheless, a few counsellors mentioned clients who used disguises to breach their exclusion orders.

7.4.6 Effects of stigma on willingness to attend peer support groups

Two different views were expressed by the counsellors about peer support groups for problem gamblers. A negative view was that fear of public stigma prevents the creation of support groups. People will be seen attending group meetings and knowledge about their gambling problems will become public, as illustrated in the following comment:

We don't have any groups up here because of the fear factor. There was one but I don't think it's running all that well because of the fear and the stigma. But over the history, a lot of the time it doesn't work because they're too embarrassed to step out (C,F,2).

In contrast, a positive view was that peer support groups are welcome because the general community does not understand problem gambling. The congregating of others who have had similar problem gambling experiences helps some clients to cope with the stigma linked to their problem, as seen here:

It is more of just a group of people getting together and supporting one another. It's not as formal or official or run by anyone with the qualification. It's just people that have had a problem getting together and supporting one another. So it's more of their own support network as opposed to a proper GA group (C,F,3).

7.5 How concerns for stigma are incorporated into treatment

Counsellors reported using a variety of treatments to assist their clients, but most were based on cognitive behaviour therapy, exposure therapy, narrative therapy and motivational interviewing. One starting point is discussing how the brain works, the client's risky gambling behaviour, and behaviour patterns that encourage clients to return repeatedly to out of control gambling. This counselling approach reportedly removes stigma and focuses only on thinking patterns and behaviour. Some clients are heavily immersed in grief and trauma and deal with this by gambling to escape from negative mood states. Counsellors may talk about the time before gambling became a problem and then discuss how the problem has developed. This activity tends to help clients identify their problematic gambling patterns and emphasises the importance of changing those patterns.

One of the first goals of counsellors is reportedly to work with clients to reduce self-stigma, allowing understanding, forgiveness, healing and recovery to follow. Initially clients are in denial. With time, clients were said to mostly go through the stages of change in addressing their gambling problems. To get 'near the underlying shame that's been there for 20 or 30 years' (C,F,1), they need understanding, acceptance and trust that recovery is indeed possible. Thus, counsellors reported finding ways to explore self-stigma and the uncomfortable feelings accompanying it. They reported trying to create a safe space to talk about stigma in a way that normalises it. Questions asked will be about triggers for stigma and what it means for them because clients may not understand stigma themselves. So by getting clients to tell their story, then choosing to focus on one or two statements, trying to change their thinking about the disgrace and shame they feel about having a gambling problem, clients may begin to realise that they are not hopeless or worthless. Potentially clients may begin to think and behave differently. Motivational interviewing checks the insights that clients have in admitting they have a problem and how ready they are to make a change. Counselling helps to empower clients to understand and alter their shameful feelings. Counsellors explained that this needs to happen before change can occur, with self-esteem and trust being re-built.

Stigma also plays a very important role in the time needed for treatment and recovery, as it often impedes the client being completely honest and open with the counsellor. One interviewee explained this thus:

Stigma does play a huge factor, because to start off ... it is the deciding factor whether they would seek help and once they seek help, it's a question of how much are you gonna be open about in the session? Often times, stigma interferes to such an extent that counsellors don't get the full picture 'til about the sixth or seventh session where there are a lot of these other things coming out ... which ideally, if they were motivated to seek help, they would've revealed in the first two sessions (C,F,9).

The interviewee who worked in a peer support program staffed by people who had experienced gambling problems themselves, intimated that talking with people with similar problems helped to lower feelings of stigma and facilitate trust, openness and honesty. He explained their telephone support service as a first step towards treatment and recovery:

The uniqueness about a peer support program, realistically is the fact that you're speaking with individuals that have ... been through the experience ... you can really make that connection with them ... you can bring a bit of trust within that phone call ... they still feel judged or stigmatised ... I think it's the key to make a real connection, like a sort of understanding of the emotions, the feelings you're going through ... telling them of the instances and [your] own life experiences ... they can really sort of understand that (C,M,6).

7.6 How concerns for stigma after relapse are incorporated into treatment

Relapse is a common experience, so counsellors reported that they generally talk about relapse early in the first few sessions with clients to normalise it, to maintain a good relationship with clients, and to keep them in long-term counselling working towards recovery. Given that clients have overcome high barriers for their first session, one reason for them to stop counselling is the shame they may feel if they think they cannot continue. This may mean feeling even more hopeless. So, as part of the normalisation process, counsellors explain the change cycle and relapses in that cycle. They discuss relapse, the causes and behaviours, a return to counselling and what learning might result from each relapse episode. A client-centred approach may be needed when clients feel a great deal of shame. This approach includes paraphrasing, reflective listening and similar approaches to identify distorted thought processes. But if the shame is contributing to high suicidal ideation, then pragmatic problem solving would be needed.

In the case of an actual relapse, if the client returns, counsellors reported that they would conduct a major assessment of events leading up to the relapse to analyse what happened. This provides an opportunity to manage any further episodes of relapse differently and to explore future ways of gaining control over gambling. By using relapse as a learning experience, some clients develop strategies with counsellors to help manage gambling triggers, to feel comfortable, accept themselves, and move to a higher level of confidence in gaining some control over their gambling. Counsellors suggested that, as confidence is slowly restored, clients are reminded of positive aspects of their lives, even if the recent past is mostly negative; that they had 'just lost that person for a while' (C,F,4) and now need to regain that earlier self-esteem and integrate more in society. An example was provided by one counsellor:

I've seen how they change ... for instance, a year before seeing one client, it was like very isolated, gambling, gambling and with a very good position at work. But it didn't matter because

all the money went anyway so she's feeling bad all the time. And I encouraged her to join this Dare to Connect program and she went. And even though she relapsed, she came back to me and ... I say, 'Well, do you know that this is part of [recovery]?' ... I've seen her different. She was more confident. She feels a bit happier than what she was (C,F,5).

Stigma was said to take an interesting shift after relapse. Either the counsellor is seen as the one person who has accepted the client, or the counsellor is seen as forming part of the circle of stigma with family and friends. So clients may face similar, if not higher, barriers to attending counselling after relapse than they faced when they first presented for treatment. Clients feel guilty for failing their counsellors and others, their self-esteem falls and they felt like 'losers' again, compounding their self-stigma. One interviewee articulated how clients, after a relapse, would think:

'How am I gonna get back to her after she has been through this process with me? ... I have to get back to her and tell her that I have relapsed ... This is one other person that I have let down' ... the shame of having to admit that, after whatever number of sessions ... they feel weak (C,F,9).

Shame and humiliation mean that clients do not always want to return for more counselling after a relapse, especially if they have been doing well beforehand. It reportedly depends on how desperate they become and whether the counsellor has conducted their initial sessions and preparation thoroughly. Clients who do not return for counselling may give up and accept their self-stigmatising beliefs of being a failure, rationalising this as expressed below by one of the interviewees:

'Oh. I've tried and it didn't work. It's almost like destiny has told me that this is how I am going to be. This is my life ... It's my fault'. They find it very hard to pick themselves up again. They burden themselves with guilt. Felt stigma becomes even further embedded into their being (C,M,6).

Relapse can also attract further public stigmatisation. The old saying 'once a gambler, always a gambler' seems to confirm the public stigma that gamblers can never recover or ever be trusted; if there is money lying around, they will steal it (C,F,7). One client who had spent a year in jail for gambling-related offences (stolen money from company accounts) found it intolerable when she came out. She had a police record, everybody knew why, and although she wanted to return to her home town it was impossible to re-establish herself. She moved away (C,F,7).

7.7 Cultural differences in client stigma

A note of caution: Please be aware that many analyses of cultural differences in this section are based on responses from a single participant.

A few of the gambling counsellors interviewed provided assistance to people from various cultural backgrounds and had noticed some differences in their experiences with stigma. Some cultures mentioned included Indigenous Australians, Middle Eastern, Chinese, African, Indian, Italian, Balkan, Serbian, Bosnian, Croatian and Macedonian cultures.

For Indigenous Australians, shame is reportedly amplified when money spent on gambling is not available to meet cultural obligations. For instance, if gamblers need to attend a funeral and associated 'sorry business' and do not have any money, they will ask their family and extended family for a loan. Culturally, extended families are expected to support anyone in need. In turn, a traditional reciprocal obligation is created. However, families know that gamblers often avoid their traditional reciprocal obligations. So the gambler is ashamed of not having funeral money, embarrassed in

having to ask for money, and humiliated that expected reciprocity is unmet. This accumulation of shame for Aboriginal gamblers adds to the self-stigma associated with having a gambling problem.

For people from the Middle East, attending gambling counselling was reported as both shameful and isolating. Thus, they try to keep their problems hidden while seeking quick solutions. They may try to help themselves, but do not always complete programs of professional help through to recovery. Therefore, some of these clients return to counselling with the same issues and problems at a later time and the whole process is repeated. The shame and stigma is repeated as well. Further, gambling is not acceptable or allowed in the Muslim religion. One counsellor reported that, for one Muslim client, 'when his friends found out he was gambling, there was discrimination in that regard because it was against the culture' (C,F,2).

For Chinese people, the stigma associated with problem gambling was reported as highly important within the circle of family and friends. The Chinese family name is held in very high regard and anything that detracts from or taints the family name is better hidden than exposed. If a problem becomes public knowledge, then the person causing the problem will likely be shunned, something similar to expulsion. Some gamblers would be very hesitant to reveal their problem for fear of the consequences, of being 'thrown out to sea' (C,M,6). This fear and shame greatly deters them from seeking assistance and professional help. However, this does not mean that all people with gambling problems are shunned, with support from Chinese family and friends sometimes being made available to those struggling to control their gambling.

In the Macedonian culture, 'keeping up appearances' (C,F,8) was reported to be very important. Initially, the person experiencing gambling problems would tell their partner, trying to resolve the situation within the immediate family. Even brothers and sisters would not be told. The couple would normally try to support each other, but if the gambling escalates then usually the partner would typically reach out for help, sending the gambler to counselling. All of the family would reportedly then get counselling. For Macedonians, the gambler is blamed first; then the problem is considered failure as a family. According to the interviews, there would be gossip and critique by others and the family would be stigmatised within that culture.

A few counsellors explained that many recent migrants have a background of trauma from being in detention or in war zones or due to intergenerational suffering. In general, many CALD people have experienced trauma in their life, including war, unrest and intergenerational suffering. For instance, most Balkan families are affected by pain and distress because every 30-40 years, there has been another war. So it is impossible for people from the Balkans to not be affected by trauma (C,F,8). Even though they might do well after initially settling in Australia, experiencing life in a new country, unhappiness at having to leave their own country and depression may lead some migrants to want a temporary escape. Some may get caught up in gambling, chase losses and lose control of their gambling, and then feel depressed and like a failure, which may prompt attendance at counselling. In counselling, depressed people generally say that gambling gives them a boost, a mood lift and instant fix. Some counsellors reported that migrants are attracted to gambling, but it can get out of control, so a cycle of shame and distress is established.

A case study describing a gambler with an African background explained aspects of migration, gambling and CALD community ties. The husband had a gambling problem and his wife provided loving support. But she could not tell her family because she thought they would regard him as a 'bad person' (C,F,7). She was worried about him being stigmatised. Major shame affected both partners because of the struggle they had experienced in getting to Australia and becoming residents, which was a very expensive and demanding process. His gambling jeopardised their lives, running up major debts and also risking their relationship. He expressed deep shame about wasting their money. In addition, he held a very strong position as a leader in their community, helping financially-deprived

community members, some of whom could not pay for the medical clearances they needed for residency approvals. He wanted to lend them money, but as he told the counsellor '\$600 I would just throw it out in one sitting' (C,F,7). His gambling problem therefore became a major problem for himself, his wife and for their community, yet the couple kept it hidden. Stigma associated with problem gambling was compounding the negative impacts of his gambling problem on his life, relationships and community work.

7.8 Stigma reduction strategies

Stigma reduction strategies suggested by counsellors included training for health and welfare professionals in general and related fields, widespread community education, and public awareness campaigns.

Counsellors proposed that the topic of problem gambling be included in staff training sessions for alcohol, drugs, and mental health problems, so that a wide cross-section of health and welfare professionals gain an understanding of the depth of gambling-related issues including stigma. Their exposure to gambling-related problems and to the use of common screens and tools to detect gambling problems would assist them in understanding client needs. Training would raise the awareness of staff of the need to screen for gambling problems when other client concerns were resolved, but when they were still experiencing issues of grief, loss of connection, and shame. Such a training strategy would need a top-down approach, prioritised and funded by government, to ensure that it was available to all health and welfare professionals. Some counsellors had experienced a bottom-up approach for other health and welfare issues, and observed that barriers of time, availability, lack of back-up workers, and no incentives often meant well-meaning strategies failed because of competing training courses and no higher authority pressing for their continuance.

The interviewees also noted that widespread community education provided to schools, community organisations and other relevant groups would open discussions about gambling, signs of potential problems, prevention and treatment. This education would help in reducing stigma attached to problem gambling, because similar education has already proved to be effective for depression, suicide, smoking, and drink driving. One counsellor noted that the publicity surrounding mental illnesses such as bipolar disorder, which opened up dialogue, provided information, educated society and created awareness about mental illness, had diminished the associated stigma. Another counsellor suggested that similar campaigns for suicide prevention had been promising especially as they emphasised the grief and loss of connection felt by clients, and the sad outcomes for their partners and families. As the nature of the disorder had been revealed to the public, so the intensity of public stigma had been reduced. In fact, one counsellor commented that gambling was about 10 years behind other societal issues in regards to community education (C,F,1).

To assist community education initiatives, some counsellors felt that provision of up-to-date audio-visual and interactive media tools would help them explain different types of gambling. They were particularly concerned about online gambling, the easy movement between websites, availability of gambling apps and sports betting. According to some interviewees, key audiences would benefit from education to view problem gambling not as something shameful, unlawful or bad, but as something that needs understanding. Deeper understanding in the community sector might open pathways for clients to feel more secure in discussing a gambling problem.

The counsellors also argued that public awareness campaigns about gambling and its potential problems help to normalise problem gambling. They felt that it is currently very hard for people to seek help for problem gambling as they feel stigmatised, that they are the only ones with the problem.

However, when people see gambling problems highlighted in the media, a connection can be made: 'maybe that's similar to me, maybe I can do something about that' (C,M,6). With knowledge and public awareness, people should feel less isolated and ashamed and to be more motivated to take action about reducing their gambling problems.

The interviewees were also asked whether they thought that public health messages about problem gambling, such as 'gamble responsibly', affect its stigmatisation. There was some divergence of views. Some counsellors saw the responsible gambling message as positive, guiding people towards the goal of controlled gambling. Controlled gambling was perceived as a more appropriate goal than gambling abstinence for some clients, as it signalled that they want to learn to manage their own gambling with help from others. Additionally, the stigma associated with a manageable problem is seen as less shameful than that associated with an out of control condition. One counsellor explained how some of her clients viewed the responsible gambling message:

... clients prefer the responsible gambling message as opposed to no gambling ... They want to see that it is still accepted. They've just got out of control ... 'Cause I think that they see it more as a positive thing ... it's okay to gamble as long as you do it responsibly, they don't see their behaviour in such negative downward spiral thing. They'd say, 'It is okay. It's got out of control. I just need to get it back in control,' as opposed to 'This is totally bad and against what everyone's saying.' It's more to say to the client that we will support you regardless of whether you want to stop or control ... if you said, 'Stop gambling,' they would go, 'Well, I don't wanna stop. I won't seek help, because they want me to stop and I don't wanna stop' ... it's more open ... more supportive for us to say, 'Look, we're willing to work with what your needs are' ... coming from a client view (C,F,3).

Other counsellors saw the message of responsible gambling as having negative consequences. Gamblers with little control over their gambling are already struggling with that issue. Responsible gambling messages may add further responsibility to their failings, entrenching a stigmatising condition, because the implication is that: 'you are responsible because you have a problem' (C,M,6). This becomes a double burden and can add to the fear barrier that people with gambling problems already face in seeking help. One counsellor suggested that people experiencing problem gambling already feel so irresponsible that it is important to add educational clarity and value to the responsible gambling message. The message could include advice about keeping gambling safe, being aware of time spent gambling, financial planning, budgeting to reduce debts, and being mindful about relationships. Not only should this reduce stigma associated with problem gambling, it would encourage gamblers to think about connections between themselves and others that have gone astray because of their gambling.

7.9 Chapter summary

This chapter has analysed interviews with nine gambling counsellors based in Victoria. Overall, the counsellors recognised that stigma associated with problem gambling manifests as both the self-stigma typically experienced by people with a severe gambling problem and public stigma emanating from families, friends, acquaintances and society. Stigma was considered to be more strongly felt by those with a respected position in society, as well as by clients with low resilience.

The counsellors' accounts of their clients' experiences confirmed that internalised self-stigmatising beliefs, and public stigma demonstrated as ignorance and labelling, deter or delay people from exposing a gambling problem and seeking help. Clients are often naïve or in denial about the development of their gambling problem and hide its impacts due to shame, embarrassment and fear

of consequences, including stigma. Help-seeking from counselling agencies is usually triggered by a crisis which overpowers the barrier of stigma, or by a relapse after having made decisions to cease gambling. The counsellors reported that clients were generally unwilling to reveal their problems to family and friends due to their own self-stigma, and the potential public stigma associated with such revelations. Once the problem was disclosed, some families were supportive, others were not, and family support sometimes dwindled over time if the problem was not quickly resolved. Most counsellors reported that clients did not want to self-exclude due to the public stigma attached to having their photos available and visible to venue staff. Thus, exclusion was seen to exacerbate stigma as a wider circle of people were informed about the gambler's problems. The counsellors had mixed views about peer support groups. Some felt that fear of public stigma associated with attending such groups deterred their formation. Other counsellors felt that peer support groups helped some gamblers, but not those who feared public shame from attending meetings.

One of the first treatment goals of counsellors is reportedly to work with clients to reduce self-stigma, enabling understanding, forgiveness, healing and recovery to follow. Trust between client and counsellor may take time to establish, with clients often struggling to overcome their self-stigma so they can be completely honest and open about their gambling. Because relapse is common and may compound feelings of hopelessness, failure and self-stigma, counsellors reported that they generally discuss relapse in the first few sessions with clients, to normalise it, reduce the associated self-stigma if relapse occurs, and to encourage the client to continue with counselling. This was said to be very important, because stigma can take an interesting shift after relapse; either the client sees the counsellor as the one person who accepts them, or they see the counsellor as forming part of the circle of stigma with family and friends. Counsellors use a range of treatment approaches to both address self-stigma and the gambling problem, and to reduce stigma associated with a return to treatment after relapse.

Some insights were provided into how problem gambling stigma is felt and experienced by different cultural groups, although these results must be considered as very preliminary, being based on small numbers. Cultural practices, attitudes to counselling, religious beliefs, the importance of the family, keeping up appearances, and migrant experiences of trauma were all reported as factors that influence self-stigma and public stigma, and consequently help-seeking behaviour.

Stigma reduction strategies advocated by the counsellors included compulsory training for relevant professional staff, community education and public awareness campaigns.

Chapter Eight: Discussion of results

8.1 Introduction

This study has examined the stigma associated with problem gambling from the perspectives of the general Victorian community, those experiencing problem gambling, and counsellors providing treatment for people with a gambling problem. Four stages of research were conducted: a literature review, the Victorian Adult Survey, the Survey of People with Gambling Problems, and interviews with 44 people with recent experience of a gambling problem and with nine counsellors providing gambling help to Victorians. This chapter addresses each of the six research objectives by integrating key findings from these stages and considering them in relation to previous research. Limitations of the findings are also discussed.

8.2 Findings relating to Objective 1: The perceived nature of problem gambling

Various explanations of public stigma suggest that the perceived characteristics of a condition largely determine whether and how it is publicly stigmatised (Corrigan et al., 2003; Weiner, 1986; Weiner et al., 1988). Therefore, Objective 1 of this study was to determine the nature of problem gambling, as perceived by the Victorian adult community. To address Objective 1, the Victorian Adult Survey measured various dimensions of problem gambling (through use of vignettes) which are thought to contribute to the formation of public stigma: concealability, disruptiveness, peril, origin and course (Jones et al., 1984). For comparative purposes, these dimensions were also measured in relation to vignettes depicting alcohol use disorder, schizophrenia, sub-clinical distress (normal subclinical worries), and sub-clinical (non-problematic) gambling.

In relation to the concealability dimension (Jones et al., 1984), the Victorian Adult Survey found that the vast majority of respondents (95%) considered problem gambling to be at least a 'somewhat noticeable' condition to family and friends, even if they had not been told about the person's gambling problem, which includes a substantial minority considering it would be 'very noticeable' (32%) and nearly one-in-ten believing it would be 'extremely noticeable' (9%). This finding was unexpected, given that many people report surprise and shock when informed about a partner's or other family member's gambling problem (Grant Kalischuck, 2010; Holdsworth et al., 2013; Patford, 2007, 2008, 2009).¹³ Our Survey of People with Gambling Problems found that only about one-in-five respondents reported that their parents (19%), partner/spouse (19%), and friends they don't gamble with (18%) knew that they gambled as much as they did. These findings appear to reflect a public underestimation of the secrecy that typically accompanies problem gambling and the efforts that those affected often make to keep their gambling problem hidden (Hing et al., 2012; Hodgins & el-Guebaly, 2000). The public may expect the presence of a gambling problem in a significant other to be more obvious than it actually is, which may then limit their capacity to provide assistance and support. At a broader level, this public underestimation of the hidden nature of problem gambling is likely to be accompanied by a public underestimation of the prevalence of gambling problems in the population. Raising public awareness

¹³ The unexpected finding on concealability may be a result of the portrayal of problem gambling using a vignette.

of the signs and symptoms of problem gambling may increase people's capacity to recognise and respond to gambling problems amongst family and friends.

In relation to the disruptiveness dimension (Jones et al., 1984), a substantial majority of respondents to the Victorian Adult Survey considered that problem gambling leads to at least large disruptions to work or study (74%), ability to live independently (63%), and ability to be in a serious relationship (79%). These findings reflect public recognition of the well-documented impacts that problem gambling typically has across numerous life domains (Delfabbro, 2012; Productivity Commission, 2010). However, while problem gambling was viewed as highly disruptive, it was not perceived to be particularly perilous to others. Less than one-quarter (23%) of respondents believed that people with gambling problems are likely to be violent to others, although a larger proportion (42%) believed that they are likely to do something violent to themselves. Dhillon et al. (2011) and Horch and Hodgins (2008) also found some public ambivalence about whether people with gambling problems are perceived as dangerous to others or not. Together, these findings suggest that the danger appraisal hypothesis, where conditions that are perceived as posing more peril to others are more highly stigmatised (Corrigan et al., 2003), is unlikely to fully explain the public stigmatisation of problem gambling.

An alternative explanation for public stigma is provided by attribution theory (Weiner, 1986; Weiner et al., 1988), which proposes that the perceived origin of a condition largely explains how much it is stigmatised; conditions perceived as a person's own fault are more highly stigmatised than those which are perceived as uncontrollable, such as due to accident or biology. In relation to the origin dimension (Jones et al., 1984), over two-thirds of Victorian Adult Survey respondents (71%) considered that problem gambling is likely to be due to stressful circumstances in the person's life. This finding is consistent with the only two previous studies to have measured aspects of the public stigma of problem gambling (Dhillon et al., 2011; Horch & Hodgins, 2008). However, these studies found that bad character is also a commonly perceived contributing factor to development of problem gambling, whereas only 17% of our survey respondents attributed problem gambling to this cause. In our Victorian Adult Survey, the second most endorsed contributing factor was the way the person was raised (33%), followed by a chemical imbalance in the brain (32%). Only a minority of respondents attributed the origin of problem gambling to a genetic or inherited problem (25%) or to God's will (3%). Thus, our survey respondents tended to consider problem gambling as due mainly to how a person reacts to their life situation, and to a lesser extent to their upbringing, rather than to more uncontrollable biological causes. Additionally, over four-fifths of our survey respondents (82%) considered that people can recover from problem gambling, also reflecting a public perception that problem gambling is at least somewhat controllable. In this way, attribution theory (Weiner, 1986) may help to explain why problem gambling is stigmatised as it appears to be perceived as due to personal shortcomings.

Further insights into the perceived nature of problem gambling can be gained by comparing the perceived dimensions of problem gambling to those of the other conditions presented to respondents in vignettes. Compared to both the sub-clinical gambling and sub-clinical distress conditions, problem gambling was perceived as more noticeable, less recoverable, more disruptive, more perilous, and more likely due to bad character or upbringing. Thus, respondents generally distinguished the nature of problem gambling as being different to that of normal subclinical worries and non-problematic gambling, and they perceived problem gambling to be more conspicuous, troublesome and dangerous, and caused at least in part by personal and contextual factors. That respondents perceived the dimensions of problem gambling differently to those of subclinical (non-problematic) gambling confirms that the public makes a distinction between the nature of recreational gambling and the nature of problem gambling.

Compared to the schizophrenia condition as presented in the Victorian Adult Survey, problem gambling was perceived as less noticeable, more recoverable, less disruptive, less perilous, and less likely to be caused by a chemical imbalance in the brain, by a genetic problem, or by God's will. However, compared to schizophrenia, problem gambling was believed to be more likely to be due to bad character and upbringing. These findings suggest that, even though the effects of problem gambling are perceived as less severe than those of schizophrenia, problem gambling is perceived as a developed condition in reaction to life events rather than a predisposed condition which is beyond any personal control. This finding aligns with previous observations that addictions tend to be more negatively perceived than other mental illnesses (Corrigan et al., 2005; Link et al., 1989; Martin et al., 2000) because individuals with addictive disorders are perceived by the public to be more blameworthy for their disorder (Angermeyer & Dietrich, 2006). This contention was also supported by our finding that problem gambling was perceived to be just as likely to be caused by bad character as was alcohol use disorder, and just as recoverable. However, compared to the alcohol use disorder condition, problem gambling was perceived as less noticeable, less perilous to others, and less likely to be caused by a chemical imbalance in the brain, by stressful life circumstance and by genetic problems. The physical effects of heavy alcohol consumption and their behavioural consequences likely explain why alcohol use disorder was perceived as more noticeable and dangerous to others, compared to problem gambling.

Other similarities in how the five vignette conditions were perceived are informative, particularly in relation to perceived origin. In alignment with previous research (Horch & Hodgins, 2008), stressful life circumstances were perceived as the main cause of problem gambling, alcohol disorder and sub-clinical distress, while a chemical disorder in the brain was considered the main cause of schizophrenia. Thus, problem gambling, alcohol dependence and normal subclinical worries were perceived as due mainly to a reaction to one's life situation, in contrast to a biological explanation for schizophrenia. Interestingly, upbringing, along with stressful life circumstances, were believed to be the major contributors to sub-clinical (non-problematic) gambling. This finding suggests that socialisation into gambling while growing up is viewed as largely shaping a person's gambling behaviour.

8.3 Findings relating to Objective 2: The process of public stigma creation for problem gambling

Understanding how, and how much, the public stigmatises a condition or attribute requires examining the process of stigma creation to identify cognitive, emotional and behavioural responses (Corrigan, 2000). Thus, Objective 2 was to analyse the process of stigma creation for problem gambling in the Victorian adult community. Link et al. (2004) have proposed five distinct elements in the process of public stigma creation: labelling, stereotyping, separating, emotional reactions, and status loss and discrimination. Each of these elements was measured in the Victorian Adult Survey (through vignettes), with results discussed below.

Related to labelling, most respondents agreed that problem gambling is an addiction (96%) and a diagnosable condition (52%), but only about one-third of respondents (34%) agreed that it is a mental health condition. In Ontario, Cunningham et al. (2011) found that the general public tends to also view excessive gambling as an addiction (56% agreed), with the next most common conception being a disease or illness (38%), or a habit (32%). The view of problem gambling as an addiction appears to be more widely held in Victoria than in Ontario, although reasons for this are unclear but could be related to different cultural perspectives. Of interest in Victoria is the apparent limited understanding that an addiction is a mental health condition. Alcohol and other addictions have also been found to be

severely stigmatised mental disorders, with people experiencing addiction frequently not regarded as mentally ill and instead considered to have a voluntary condition for which they are held personally responsible (Schomerus et al., 2011).

Reflecting negative stereotyping, most respondents to the Victorian Adult Survey thought that people with gambling problems tended to be impulsive, irresponsible, greedy, irrational, anti-social, untrustworthy, unproductive, and foolish. These results confirm previous research finding that a range of negative stereotypes are attached to people with gambling problems (Carroll et al., 2013; Horch & Hodgins, 2013). In terms of separating (or social distance), respondents were ambivalent overall about socialising with people experiencing problem gambling, although almost three-quarters (73%) expressed some unwillingness for them to marry into their family. While there were similar levels of willingness and unwillingness to socialise in more incidental ways (e.g., spend an evening socialising with them, start working with them closely on a project), these results indicate an overall unwillingness to enter into closer and more enduring relationships. Previous studies have also found that problem gambling elicits a reasonably strong desire for social distance (Dhillon et al., 2011; Feldman & Crandall, 2007; Horch & Hodgins, 2008).

In terms of emotional reactions, respondents were more likely to pity a person with gambling problems than to feel anger and fear emotions. Most respondents reported they would feel sorry for the person (63%), sympathy towards them (60%) or the need to help them (55%). This finding was unexpected, given that pity and sympathy are more common when the origin of a condition is believed to be outside of an individual's control (such as due to accident or biology) (Weiner, 1986; Weiner et al., 1988). Anger and irritation are more likely when the condition is believed to be the person's own fault, while anxiety, apprehension and fear can be expected when the condition is perceived as dangerous (Corrigan et al., 2004; Jones et al., 1984; Weiner, 1986; Weiner et al., 1988). Thus, it was expected that anger-related emotions would be most common. However, only about two-fifths of the survey respondents reported they would feel annoyed (39%), and around three-in-ten reported they would feel apprehensive (30%), angry (29%) or uncomfortable (28%). These results nevertheless reflect some anger and fear emotions amongst substantial minorities of respondents. Those who felt anger or fear emotions were more likely to believe that problem gambling was perilous to others and were less likely to believe that people can recover from problem gambling. Thus, perceptions of danger to others and that problem gambling is more permanent than transitory were associated with more negative emotional responses. Nonetheless, even more positive emotions such as sympathy can emphasise difference and therefore contribute to loss of social acceptance, social isolation, and devaluation and discrimination (Link et al., 2004).

Perceived status loss and discrimination against people with gambling problems were apparent. About two-thirds of survey respondents agreed that most women would be reluctant to date someone with a gambling problem (66%), and a similar proportion disagreed that most people would hire the person to take care of their children (65%) or consider them to be just as trustworthy as the average citizen (64%). More than half of the respondents disagreed that most people would accept people with gambling problems as a teacher of children in a public school (58%) and a similar proportion agreed that most people would pass over people with gambling problems in favour of another job applicant (59%). These findings indicate that problem gambling, if disclosed, is expected by the public to lead to discriminatory attitudes and actions in several life domains, similar to other stigmatised conditions including mental illness (Penn & Wykes, 2003), alcoholism (Schomerus et al., 2011), HIV/AIDS (Simbayi et al., 2007), illicit drug use (Ahern, Stuber, & Galea, 2007), and obesity (Puhl & Brownell, 2002).

As expected, several of the above elements in the process of stigma formation were interrelated, and were also related to some perceived dimensions of problem gambling. Respondents who desired greater social distance from people with gambling problems (as measured through the vignette) were

more likely to attribute problem gambling to the person's own bad character, to consider it to be less recoverable and more perilous, to feel less pity and more anger and fear emotions, to hold more negative stereotypical views, and to endorse greater status loss and discrimination. Horch and Hodgins (2008) also found that respondents who perceived disordered gamblers as dangerous desired greater social distance than respondents who did not. Together, these findings lend support to the applicability of both attribution theory (Weiner, 1986) and the danger appraisal hypothesis (Corrigan et al., 2003) in explaining the public stigmatisation of problem gambling. However, attribution theory may have greater applicability to problem gambling stigma than the danger appraisal hypothesis, given low ratings of peril to others associated with problem gambling. These findings also suggest that reducing the public stigma of problem gambling may benefit from public education that people with gambling problems are not necessarily of bad character, that people can and do recover from problem gambling, that people with gambling problems are unlikely to be violent to others, and that commonly held beliefs about 'problem gamblers' may constitute misinformed stereotypes. As Schomerus et al. (2011, p. 110) point out, 'individuals have a right to be judged by their personal behaviour, not by the stereotypes attached to a diagnostic label'.

8.4 Findings relating to Objective 3: The relative intensity of the public stigma of problem gambling

Objective 3 was to determine the relative intensity of any stigma that the Victorian adult community associates with problem gambling. To address this objective, the stigmatisation of problem gambling was compared to that for the other vignette conditions in the Victorian Adult Survey by considering results on the Social Distancing (separating), Emotional Reactions, and Status Loss and Discrimination Scales.

Overall, problem gambling was more stigmatised than the sub-clinical distress and sub-clinical gambling conditions, with the problem gambling condition attracting more social distancing (separating), higher levels of pity, anger and fear, and higher levels of status loss and discrimination. Horch and Hodgins (2008) also found that problem gambling was more stigmatised than their no-diagnosis control condition. Thus, the current findings confirm their conclusion that problem gambling is a stigmatised condition. While Horch and Hodgins (2008) based this conclusion on a measure of social distance, the current study also found that problem gambling attracts stronger emotional responses and greater status loss and discrimination than the sub-clinical conditions. This indicates that the public stigma of problem gambling is reflected not just in public cognitions, but also in emotional and behavioural responses. This finding implies that public stigma reduction efforts may need to focus on all of these domains.

The current results also indicate that problem gambling is more stigmatised than gambling *per se*. Amongst all five conditions included as vignettes in the Victorian Adult Survey, subclinical (non-problematic) gambling elicited the least desire for social distance, the least pity, anger and fear, and the least status loss and discrimination. This finding lends support to the contention that the growth of commercialised recreational gambling has 'freed the gambler from moral stigma' (Binde, 2005, p. 470), with non-problematic gambling now typically viewed as a socially acceptable form of leisure (Campbell & Smith, 2003). However, Reith (2007) argues that the liberalisation and deregulation of commercial gambling has also been accompanied by rising expectations for self-regulation by gamblers themselves. She observes that there are now increasing demands for gamblers to be responsible, rational, reasoned consumers who exercise self-control, with responsible consumption regarded as both contributing to individual and social health and demonstrating moral wellbeing. Thus, consumers are both the site of gambling problems and their resolution (Reith, 2007, 2008). This recent

emphasis on the responsibility of the individual player, along with the conceptualisation of impaired control over gambling as a disease or pathology (American Psychiatric Association, 2000), has been argued to increase its stigmatisation (Conrad & Schneider, 1980; Cosgrove, 2008; Reith, 2003, 2007, 2008; Rosecrance, 1985). While the current study cannot draw related conclusions about this from the Victorian Adult Survey, its findings demonstrate that problem gambling is indeed publicly stigmatised, and much more so than recreational gambling. This presents a paradox that has been highlighted in the alcohol literature (Schomerus et al., 2011). While gambling and even heavy gambling have been found to facilitate social inclusion and even status in some circles (e.g., Gordon & Chapman, 2014; Sproston, Brook, Hing & Gainsbury, 2015), problem gambling attracts stigma and social exclusion. Thus, by the time an individual encounters stigma about their gambling, their problem is likely to be quite severe, as has been found in alcohol research (Schomerus et al., 2011).

Overall however, problem gambling was somewhat less stigmatised than alcohol use disorder, with problem gambling attracting less social distancing, less fear, about the same levels of pity and anger, and less status loss and discrimination. Problem gambling was also less stigmatised than schizophrenia, with problem gambling attracting less social distancing, less pity and fear, more anger, and less status loss and discrimination. The lesser intensity of public stigma directed towards problem gambling, compared to alcohol use disorder and schizophrenia, appear to at least partially reflect the higher perceived dangerousness of the two latter conditions, which elicited more fear and social distancing, in alignment with the danger appraisal hypothesis (Corrigan et al., 2003). Horch and Hodgins (2008) also found that dangerousness ratings were highest for the alcohol dependence and schizophrenia conditions (compared to disordered gambling, cancer and no-diagnosis control conditions) and that respondents who perceived individuals with a particular condition to be dangerous desired greater social distance. Overall however, they found that 'disordered gambling' was more stigmatised than cancer, but equally as stigmatised as alcohol dependence and schizophrenia. These results may differ from those from the Victorian Adult Survey because of the very different samples in the two studies and also because stigma may be strongly influenced by culture.

A global question asking survey respondents to rate the 'value to society' of people with each of the tested conditions (as portrayed through vignettes) also confirmed the relative stigma of problem gambling. The person in the problem gambling vignette was rated as less valuable than those in the sub-clinical distress and sub-clinical gambling vignettes, but slightly more valuable than those in the alcohol use disorder and schizophrenia vignettes. Feldman and Crandall (2007) found that pathological gambling was the 13th most stigmatised mental health condition (from 40 conditions) when measured on desired social distance. Consistent with the current study, they found it to be less stigmatised than alcohol dependence (rated 10th). In contrast however, they found that pathological gambling was more stigmatised than paranoid schizophrenia (rated 20th). This different relative stigmatisation of problem gambling and schizophrenia to that found in the current study may be due to the use of student samples by Feldman and Crandall (2007), their use of case histories instead of vignettes, and cultural differences.

8.5 Findings relating to Objective 4(a): Variations in public stigma by respondent characteristics

Objective 4 was to determine how stigma associated with problem gambling is perceived and experienced by different groups in Victoria. This section focuses on how public stigmatisation of problem gambling varied by demographic and gambling-related characteristics of respondents to the Victorian Adult Survey. Two stigma-related scales were utilised in these analyses: separating (social distancing), and status loss and discrimination.

Overall, males were more likely to stigmatise people with problem gambling, being less willing than females to socialise with people with gambling problems and more likely to endorse higher levels of status loss and discrimination. No effects were found for age. Respondents with higher levels of education and who placed more importance on religion endorsed higher levels of status loss and discrimination, while greater social distance was desired by more conservative people. In contrast, Horch and Hodgins (2008) found no effects for political orientation and religiosity on social distance scores for disordered gambling. As Jorm and colleagues point out in their reviews of the public stigmatisation of mental disorders, it is difficult to generalise about the level and type of stigmatising attitudes held by different population groups due to the complexity of stigma, and the varying approaches to its measurement (Jorm & Oh, 2009; Jorm, Reavley, & Ross, 2012). Differences between the current results and those found by Horch and Hodgins (2008) may be due to this complexity, as well as the very different samples surveyed.

A more consistent result was found for ethnicity. In the current study, respondents who spoke a language other than English at home, were more likely to stigmatise people with problem gambling, in terms of social distancing. Horch and Hodgins (2008) also found that ethnicity was a significant predictor of social distance for disordered gambling, with Europeans desiring less social distance from disordered gamblers than non-Europeans. These findings align with Dhillon et al. (2011) who specifically investigated cultural influences on problem gambling stigma. East Asian Canadians were found to stigmatise problem gambling more than Caucasian Canadians did. Further, East Asian participants desired more social distance when the protagonist in the problem gambling vignette was depicted as an East Asian individual, than when the protagonist was depicted as a Caucasian individual. However, this study involved only a relatively small sample of university students. Nevertheless these studies by Hodgins and colleagues, along with the current results, suggest that public stigma appears to be influenced by ethnicity. Similar results have been found for other mental health disorders. For example, major cross-national and cross-ethnic differences in perceived dangerousness and desire for social distance have been observed in relation to depression (BeyondBlue, 2015). Further research is needed to identify how judgments about problem gambling might vary by cultural group in order to inform stigma reduction efforts in multi-cultural societies including Australia. Such research may also inform ways to lower stigma-related barriers to help-seeking amongst different cultural groups.

In terms of gambling behaviour, non-problem gamblers, those with less exposure to problem gambling (level of contact), and those with less personal gambling involvement (through their own gambling activities) were significantly more likely to stigmatise people with problem gambling. These findings are consistent with a familiarity effect, whereby contact with a stigmatising condition has been found to lead to less desired social distance from people with the condition (Link & Cullen, 1986; Link et al., 2004; Penn et al., 1994). Thus, one strategy purported to reduce stigma is interpersonal contact with people with the stigmatising attribute in an attempt to dispel inaccurate and negative beliefs and stereotypes (Couture & Penn, 2003). A review of the relevant literature concluded that both retrospective and prospective contact tends to reduce stigmatising views of people with mental illness (Couture & Penn, 2003). However, although interpersonal contact with members of a stigmatised group tends to influence whether a person will stigmatise that particular condition (Link & Cullen, 1986; Link et al., 2004), level of contact with disordered gambling had no effect on desired social distance in Horch and Hodgins' (2008) study. Nevertheless, our current findings suggest that increasing interpersonal contact between the community and people with gambling problems may be a promising strategy to help reduce the stigma of problem gambling.

8.6 Findings relating to Objective 4(b): How people with gambling problems experience stigma

As noted above, Objective 4 was to determine how stigma associated with problem gambling is perceived and experienced by different groups in Victoria. This section focuses on how people with gambling problems experience related stigma, including their perceptions of public stigma, their self-stigmatisation, how perceived and experienced stigma varied by respondent characteristics, and how they cope with stigma. Data informing this discussion are drawn from the Survey of People with Gambling Problems (N = 203), interviews with 44 people with recent experience of having a gambling problem, and interviews with nine counsellors providing gambling help in Victoria.

8.6.1 Perceived stigma

Perceived stigma, or the belief that others have passed judgment and hold stigmatising thoughts about them and the stigmatising condition, has generally been associated with negative outcomes, regardless of whether or not these perceptions are accurate (Alonso et al., 2009; Barney et al., 2006). Thus, perceptions of public stigma were sought from people with recent experience of having a gambling problem, as well as from gambling counsellors.

The survey results confirmed a strong belief amongst people with gambling problems that problem gambling is highly stigmatised. In fact, survey respondents believed that problem gambling is significantly more stigmatised compared to all other conditions/issues they were asked about (including alcoholism, obesity, schizophrenia, depression, cancer, bankruptcy, recreational gambling), except for drug addiction. Thus, contrary to findings from the Victorian Adult Survey, respondents to the Survey of People with Gambling Problems believed that problem gambling is more publicly stigmatised than alcoholism and schizophrenia. Most counsellors considered the public stigma associated with problem gambling to be similar to that associated with substance misuse and mental illness, with other counsellors believing that problem gambling is more stigmatised because it was less well understood as a health issue.

That participants perceived an acute public stigma attached to problem gambling was also confirmed when they were asked how they perceive others to view 'problem gamblers'. The gambler interviewees overwhelmingly considered that the public views 'problem gamblers' in a highly negative light. They used strongly emotive descriptors including 'stupid', 'foolish', 'weak', 'untrustworthy', 'secretive', 'losers', 'self-indulgent', 'lacking self-control', 'irresponsible', 'pathetic', 'desperate', 'lacking intelligence', and 'no hopers'. These terms suggest a belief that others view 'problem gamblers' as being entirely to blame for their own situation due to failures of character such as lack of control, low intelligence, dishonesty and selfishness. The vast majority of respondents to the Survey of People with Gambling Problems (82%) also agreed that the general public thinks that 'becoming a problem gambler is the person's own fault'. A lack of understanding of the origin and nature of problem gambling was discussed by both the gamblers and counsellors as a source of stigmatisation in the general community. Some interviewees, including both gamblers and counsellors, relayed a belief that others thought that problem gambling could be cured by just abstaining from gambling which was simply a matter of self-control. This limited understanding had even been experienced by some gamblers themselves who, once they had developed a gambling problem, had changed their view from considering individuals as blameworthy for their problem to a more sympathetic perspective. This finding suggests that greater understanding of the nature of problem gambling may lead to more tolerant attitudes, consistent with a familiarity effect (Couture & Penn, 2003; Link & Cullen, 1986; Link et al., 2004; Penn et al., 1994).

The interviewees' beliefs in the public characterisation of people with gambling problems also reflect stereotypes attached to the label of 'problem gambler'. Labelling an individual as 'a problem gambler' has been argued to trigger stereotypes and social rejection (Castellani, 2000; Cosgrove, 2008; Reith, 2007; Reith & Dobbie, 2013), with similar stereotypes found in this and previous studies (Carroll et al., 2013; Horsch & Hodgins, 2012). For example, the counsellors felt that society tends to stereotype all 'problem gamblers' as losers, while most survey respondents tended to think they are characterised as impulsive, irresponsible, untrustworthy, irrational, foolish, stupid, secretive, pitiful, selfish, risk-seeking, and having weak self-control. Survey respondents also tended to agree that the public perceives 'problem gamblers' to have an addictive personality, that they would have another addiction if they didn't have a gambling problem, and that they are bored and lonely people who have unrealistic beliefs about winning at gambling, have no concern for and neglect their families, are in denial about having a gambling problem, are irresponsible with money and always in debt, and spend all their free time gambling. These beliefs largely align with those found by Carroll et al. (2013) in their qualitative study of people with gambling problems and how they are viewed by regular EGM gamblers.

Some interviewees in the current study alluded to the labelling and stereotyping process in expressing how they feared that they were now completely socially defined by their gambling problem; others were resentful that being viewed as 'a problem gambler' obscured their good and 'normal' qualities. Labelling also emphasises difference and implies a separation from 'them', who are perceived as fundamentally different from 'us' (Rusch et al., 2005). Reflecting this separating component during stigma formation (Link et al., 2004), the interviewees recognised that people generally prefer to maintain some social distance from individuals experiencing problem gambling, which reportedly limited friendships and other social interactions for some interviewees. Survey responses also demonstrated a perception of desired social distance, with nearly half of respondents (47%) agreeing that people do 'not want to interact with a problem gambler' compared to a little over one-quarter who disagreed with this statement (27%). Thus, survey respondents tended to view having a gambling problem as a socially isolating experience.

Link et al. (2004) argue that the process of labelling, stereotyping and social distancing is likely to be accompanied by emotional responses that affect subsequent behaviours towards the stigmatised group (such as helping versus punishing behaviours). About half the interviewees had not disclosed their gambling problem to others and so had not experienced others' emotional responses directly. Amongst the rest, about half encountered supportive reactions, but others received negative and judgmental responses, with comments about being stupid and selfish, wasting money, or needing to do something better with life being common. Irritation, contempt, anger and blame were apparent in responses recalled by some interviewees. The fear of negative responses deterred many participants from revealing their gambling problem. This was confirmed in the survey, where half the respondents felt that 'most people feel that problem gamblers make them angry' (50%), compared to only a little over one-third (36%) who expected that 'most people would feel sorry for a problem gambler' and about one-quarter (26%) who expected that 'most people would be afraid of a problem gambler'. Some interviewees, however, were surprised to encounter more positive, supportive and sympathetic reactions from family and friends than they had expected when they disclosed their problem. The counsellors confirmed the variable support received from family and friends. Some significant others were not supportive, while other clients' families rallied to encourage them to access professional help and to avoid gambling; however, this support sometimes waned if the problem was not resolved quickly as families tired of the secrecy, distrust, and financial and emotional drain. Families were said to also keep their loved one's gambling problems hidden, due to embarrassment and potential stigma.

Public stigmatisation also provides a rationale for devaluing and discriminating against stigmatised people (Link et al., 2001; Rusch et al., 2005). While many interviewees reported avoiding judgment through hiding their problem, more than half had perceived they were being judged by others because of their gambling. A few interviewees were able to describe actual experiences, but most could talk

only about a general impression or fear, such as some who felt that they were being watched and judged by family, friends, and patrons and staff in gambling venues. Some interviewees related more personal experiences of feeling belittled when hearing demeaning comments. Perceived loss of status, whether real or imagined, was keenly felt by some interviewees, and reflected in survey findings that nearly two-thirds (72%) expected that 'most people would look down upon problem gamblers'. More than half of the survey respondents reported at least sometimes experiencing being treated as inferior, as not smart, less politely, with less respect, as if they were dishonest, and being insulted or called names because others thought they had a gambling problem. Actual examples of discrimination were rare as most interviewees had not widely disclosed their gambling problem; similarly, only a small proportion of survey respondents reported experiencing any discriminatory actions towards them because of a gambling problem. However, following an experience of judgment or discrimination, many interviewees recalled feeling angry, defeated, inadequate, surprised or just terrible. A few, however, maintained that they did not care; in contrast, some participants appeared to internalise perceived stigma as self-stigma. These results suggest that an expectation and fear of being devalued and discriminated against were very real for participants and were strong deterrents to problem disclosure. Problem acknowledgement and help-seeking rates might improve only when people with gambling problems believe that problem disclosure will not be accompanied by demeaning and judgmental attitudes that lower self-worth and dignity and discredit their identity (Snow & Anderson, 1987).

It is interesting to compare perceived stigma as measured in the Survey of People with Gambling Problems to public stigma as measured in the Victorian Adult Survey. This comparison revealed that people with gambling problems significantly underestimated how much the general public thought that problem gambling was noticeable, recoverable and disruptive. They also significantly overestimated how much the general public thinks that problem gambling is the gambler's own fault, how much fear and anger the general public feels towards problem gamblers, how irresponsible the general public feels that problem gamblers are, how much the general public would like to avoid problem gamblers, and how much the general public would look down upon problem gamblers. These results suggest that the gambler respondents perceived problem gambling to be more stigmatised than it actually is. Given that stigma is a major barrier to problem disclosure and help-seeking (Gainsbury, Hing et al., 2014; Hing et al., 2012; Hodgins & el-Guebaly, 2000; Pulford et al., 2009a; Rockloff & Schofield, 2004; Tavares et al., 2002), gamblers themselves may benefit from knowing that the public holds a more sympathetic view of their problem than they appear to perceive. Nonetheless, as noted above, perceived stigma can be damaging regardless of whether it accurately reflects the nature and level of public stigma or not, particularly when it is internalised as self-stigma.

8.6.2 Self-stigma

Self-stigma occurs when people with a stigmatising attribute believe and internalise negative public prejudices and stereotypes, leading to diminished self-esteem, self-efficacy and perceived social worth (Corrigan & Watson, 2002a; Corrigan, Watson, & Barr, 2006; Scambler, 1998). Thus, perceived public stigma can result in a spoiled social identity which may adversely impact on subjective identity; the resulting self-stigma then affects what stigmatised people think about themselves (Goffman, 1963).

When interviewees were asked how having a gambling problem made them feel, the damaging impact on their self-image was striking. Most interviewees described feeling 'weak', 'stupid', 'worthless', 'bad', 'ashamed' and 'embarrassed'. Emotions such as anger and annoyance (at themselves), as well as guilt, dominated. Feeling 'surprised', 'disgusted', 'scared', 'incomplete', 'anxious', 'saddened' and 'uneasy', and experiences of loss of dignity and 'crying inside' were also mentioned. It was clear that the vast majority of interviewees felt that their self-esteem had been affected. For some, the stress

and depression associated with feeling badly about their gambling had manifested as physical health problems. Self-descriptions of feeling 'defeated', 'debilitated', 'isolated', 'restricted' and 'trapped' reflected participants' feelings of eroded self-efficacy in relation to resolving their gambling problem. The counsellors also confirmed the deep self-stigma that their problem gambling clients typically feel, often becoming their own worst enemies. They also noted that this self-stigma was often worse for people who have been successful in other aspects of their lives, and for community and religious leaders, who had even greater fear of public humiliation and a greater desire for secrecy.

Self-stigmatising beliefs amongst research participants were also confirmed by the survey findings. When asked how they felt about themselves in relation to their gambling, the most common feelings endorsed were: disappointed in yourself, ashamed, embarrassed, guilty, stupid, weak, a failure, shocked at yourself, lack of willpower, that there is something wrong with you, that you should be able to fix it on your own, that you are entirely to blame, and that they are worse than people who can control their gambling. Many of these cognitions and emotions aligned with the publicly perceived dimensions and stereotypes associated with problem gambling, as found in the Victorian Adult Survey. However, whether these public perceptions were a causal factor in the self-stigmatising beliefs of our gambler participants cannot be ascertained from our cross-sectional surveys. Nevertheless, the strength and breadth of self-stigmatising beliefs held suggests that efforts to lower self-stigma and reconstruct an unspoiled identity are a critical part of recovery from problem gambling, as proposed by others (Dunn et al., 2011; Nuske & Hing, 2013; Reith & Dobbie, 2012), and as also found for other mental health disorders (Koski-Jannes, 2002; McIntosh & McKeganey, 2000; Mittal et al., 2012).

Carroll et al. (2013) questioned whether the shame that typically accompanies problem gambling is always an internalisation of public stigma as self-stigma (Carroll et al., 2013). It is perhaps telling that the emotion most strongly endorsed by respondents to the Survey of People with Gambling Problems was 'disappointed in yourself' (93% agreed), while feeling 'shocked at yourself' was also highly endorsed (80%). These results suggest that developing problem gambling violates many people's internal values and desired self-concept, regardless of public perceptions. To try to untangle this relationship, interviewees were asked if their negative feelings about having a gambling problem were due to perceptions, comments or behaviours of others, or due to how they viewed themselves. This was a complex issue that warrants further research, with many discussing that they viewed themselves in this way, but that what they perceived others to think compounded these feelings. A few interviewees either specifically considered these emotions as emanating from self-judgment or did not seem to care what others think. In contrast, many interviewees were more concerned about how others saw them (particularly family and friends), or would see them if they disclosed their problem.

As discussed further below, the secretive nature of their problem meant that most gambler participants did not receive direct judgment or stigmatisation from those around them. While a few interviewees considered that their gambling did not affect their physical or mental wellbeing at all, reflecting an absence of self-stigma, strong feelings of self-stigma were very apparent for most interviewees and survey respondents, and confirmed by the counsellors as being typical amongst clients. Further research is needed to investigate the effect of self-stigma on mental and physical health, particularly on co-morbid disorders that commonly accompany problem gambling, including depression, anxiety and substance dependence (Kessler et al., 2008; Petry et al., 2005; Thomas & Jackson, 2008).

8.6.3 Variations in perceived and experienced stigma by respondent characteristics

Four stigma-related scales from the Survey of People with Gambling Problems were used to determine whether perceived and experienced stigma varied according to the demographic and psychological characteristics of respondents: the Perceived Stereotyping Scale, Devaluation Scale, Discrimination Scale and Self-Stigma Scale.

Females were more likely to report perceived stereotyping and self-stigma, as were those whose most problematic form was EGMs and respondents with higher levels of psychological distress. These results may reflect the popularity of EGM gambling amongst women to escape negative mood states (Balodis, Thomas & Moore, 2014; Grant & Kim, 2002; Schull, 2002; Thomas, 1998; Thomas & Moore, 2003), but a tendency to feel stereotyped and to internalise stigmatising beliefs if their EGM play is problematic. In alignment with this contention, female EGM players were one group whom the interviewees felt to be particularly stigmatised (as 'lonely pokie ladies') for their gambling. Younger survey respondents were more likely than older respondents to report devaluation and discrimination, and again they were a group thought to be more stigmatised than others by the gambler interviewees.

Several psychological variables were related to perceived and experienced stigma, although with some variations across results for the four stigma-related scales. In general, survey respondents reporting higher levels of public self-consciousness, social anxiety, psychological distress and PGSI scores, and those with lower self-esteem, were more likely to report perceived or experienced stigma. The counsellors also suggested that people with low resilience tended to internalise stigma more than those with greater resilience. Thus, it appears that various psychological characteristics of individuals are associated with varying levels of reported stigma, but causal directions are unclear. For example, researchers have reported that self-stigma leads to lower self-esteem and perceived self-worth (Corrigan, 2004; Corrigan et al., 2003; Watson et al., 2007; Scambler, 1998). However, it is also possible that lower self-esteem and perceived self-worth lead to higher sensitivity to stigmatising attitudes, emotions and behaviours by others.

Of interest is that respondents with higher scores on the PGSI were more likely to report higher stigmatisation on all four scales: perceived stereotyping, devaluation, discrimination and self-stigma. These results suggest that perceived and self-stigma increase in tandem with the severity of a gambling problem. Thus, not only is the development of problem gambling accompanied by a range of well-documented negative impacts (Delfabbro, 2012; Productivity Commission, 2010), it also appears to be accompanied by increased levels of perceived and self-stigma. Stigma therefore presents an additional burden for people with gambling problems.

8.6.4 Coping with stigma

Coping with a 'spoiled identity' typically necessitates behaviour modifications (Goffman, 1963, p. 3). Secrecy is a common coping mechanism to deal with stigma (Link et al., 2002), and was the most apparent strategy used by our interviewees, in alignment with previous research (Carroll et al., 2013; Hing, Holdsworth et al., 2014). The counsellors also discussed the lengths to which clients often went to hide evidence of their gambling problem from others, for fear of public misunderstanding and damaging social judgment. The Survey of People with Gambling Problems also confirmed that secrecy was the main coping mechanism used by our gambler participants. Over four-fifths of respondents reported they had hidden evidence of their gambling from others (83%), and/or had lied to others about the extent of their gambling (83%). Less than one-fifth of respondents indicated that

significant others knew that they gambled as much as they did, including parents (19%), partner/spouse (19%), and friends they don't gamble with (18%).

Reasons for the widespread use of secrecy as a coping mechanism appeared to be grounded in fear, as also found in previous studies (Carroll et al., 2013; Hing et al., 2012; Nuske & Hing, 2013). About half of the interviewees said they had not, and would not, admit their gambling problem to others due to fear of rejection, feeling it was too shameful and because no-one would understand. Others recalled delaying disclosure due to shame, and due to fear of being labelled and stereotyped in ways which would erode their desired self-concept, dignity and self-worth. Other participants did not reveal the full extent of their gambling to family and friends. The counsellors reported that most of their clients were unwilling to tell significant others about their gambling until the impacts were so obvious and severe that they had no choice. Fear of the consequences of disclosing their problem was said to be the major deterrent. The survey confirmed the range of fears held about problem disclosure. Respondents were most afraid about embarrassing their family (92% at least a little bit afraid), being exposed as a person with a gambling problem (91%), being labelled a problem gambler (90%), their friends finding out (89%), other family members finding out (89%), doing damage to their employment or career (85%), and their partner or spouse finding out (77%). Thus, encouraging higher rates of problem gambling disclosure would appear to need strategies that lower the widespread fears about shame, stereotyping, prejudice and discrimination held by people with gambling problems.

Only a minority of respondents reported using withdrawal, educating, challenging, distancing and substance use as specific coping mechanisms. The most endorsed of these strategies were feeling it is important to point out stigmatising behaviour or discrimination when it occurs (47%, related to challenging), finding it easier to be friends with people who have had a gambling problem (43%, withdrawal), and explaining to others what it means to have a gambling problem (40%, educating). The least endorsed were participating in organised activities to teach the public more about problem gambling (20%, educating), and taking illicit drugs to cope with feeling embarrassed about their gambling (14%, substance use). The interviews also revealed minimal evidence of use of other forms of coping, such as withdrawal, educating, and challenging (Link et al., 2002). However, cognitive distancing was evident in delays in problem acknowledgement and avoidance of help services as these actions would confirm the presence of a gambling problem to self and others. Other studies have found evidence of cognitive distancing from 'other people who have gambling problems' as a mechanism for coping with the stigma of problem gambling (Carroll et al., 2013; Istrate, 2011; Majamaki & Poysti, 2012; Radburn & Horsley, 2011). A little over one-quarter of our survey respondents endorsed using cognitive distancing strategies, including feeling that 'most problem gamblers have very different problems than you have' (29%) and feeling 'you are very different from most people who have gambling problems' (26%).

8.7 Findings relating to Objective 5: Stigma, help-seeking and recovery

Objective 5 was to determine how significant stigma is as an impediment to treatment or interventions for problem gambling and how recovery from problem gambling is impacted by stigma. Data informing this discussion are drawn from the Survey of People with Gambling Problems and the gambler and counsellor interviews.

8.7.1 Help seeking from various sources

The most common forms of help used by survey respondents who had not experienced a relapse were self-help (55%), help from family or friends (35%), self-excluding from a land-based gambling venue (31%), and face-to-face help from a non-gambling specialist professional (31%) or specialist gambling counsellor (28%). Non-face-to-face interventions were used by around one-quarter of these respondents, including self-excluding from an online gambling website or operator (26%), telephone helpline (24%), online or email gambling counsellor (23%), and an online support group or discussion board (23%). Relatively few of this group reported seeking help from a residential treatment program or from face-to-face support groups.

Help-seeking rates were higher amongst survey respondents who had relapsed: self-help (77%), help from family or friends (54%), self-excluding from a land-based gambling venue (40%), and face-to-face help from a non-gambling specialist professional (43%) or specialist gambling counsellor (49%). Use of non-face-to-face interventions was also generally higher amongst relapsed compared to non-relapsed respondents: self-excluding from an online gambling website or operator (33%), telephone helpline (42%), online or email gambling counsellor (31%), and an online support group or discussion board (20%). About one-in-three had attended a face-to-face support group, but only around one-in-ten had attended a residential treatment program.

The popular use of self-help, followed by support from significant others, aligns with previous research that has found self-help to be the first type of help typically used, followed by help from family and friends (Hing et al., 2012).

8.7.2 Feelings of shame and stigma associated with help-seeking

As noted earlier, about one-half of the interviewees had disclosed their gambling problem to family and/or friends and all expressed embarrassment and shame at doing so. The survey results confirmed this, with seeking help from family and friends anticipated by around two-thirds of respondents to lead to feelings of stupidity (64%) and inadequacy (69%). Nevertheless, family and friends were the most used form of help after self-help. In contrast, feeling of empowerment were anticipated by most respondents to arise from seeking help from a therapist (57%) and self-excluding (51%), even though these sources of help were used by fewer respondents. These discrepant results might be explained by some respondents interpreting the survey question in terms of how they would feel *after* they had sought that type of help. Regardless, that such a large proportion of respondents expected to feel stupid and inadequate if they disclosed their problem to significant others, and that only one-third had done so, attests to the feelings of shame and stigma expected. The counsellors also relayed how clients often struggled to articulate and explain their behaviour to significant others as they were usually in high crisis by the time they did so, after hopes of winning their way out of their problem had been dashed. This suggests that public education may be warranted to assist others to effectively support a loved one with a gambling problem without compounding feelings of self-stigma. The likelihood of improvements in self-esteem and feelings of self-worth might also be promoted to encourage further use of self-exclusion, therapy and other interventions.

The interviews also revealed further insights into barriers to seeking different types of help. More than half of the interviewees had self-excluded, with some finding it to be an empowering experience while others found it to be shameful. Online exclusion was generally believed to be far less shameful than excluding from land-based venues due to the ability to do this remotely; thus, researchers have advocated for remote self-exclusion to be available from land-based venues as well as from online gambling websites (Gainsbury, 2010; Hing, Tolchard et al., 2014). Many interviewees who had not

self-excluded cited shame as the major deterrent, as well documented in other studies of self-exclusion (Hing & Nuske, 2012; Hing, Nuske, Tolchard, & Russell, 2014; Hing, Tolchard et al., 2014). This finding was confirmed by the counsellors, most of whom reported that clients avoided self-exclusion due to the public stigma attached to having their photos visible to venue staff, which risked gossip that would expose their gambling problem, humiliate them, put their jobs at risk, and ruin their lives.

Shame, unwillingness to admit a gambling problem, feeling like a failure, and fear of being judged and patronised deterred some interviewees from joining self-help groups, as also found previously (Cooper, 2001, 2004), although most were simply not attracted to such groups. Some counsellors also pointed out that clients were fearful of being seen attending group meetings so that attempts by agencies to establish these groups had sometimes faltered. Other counsellors, however, saw benefits in peer support groups to help clients cope with self-stigma through engaging with others with similar experiences. Online and telephone help were more popular, used by about half of our gambler interviewees, with no indication that shame or stigma was either a deterrent to use or experienced because of use. This finding aligns with Cooper's (2004) research and advocacy for further provision of anonymous support which enables participation in help-oriented activities without disclosing personal information, and helps advancement towards seeking more formal treatment. However, some of our participants found that online and telephone counselling had limited benefits as they spoke with a different counsellor each time they contacted these services and were therefore not in an ongoing program of treatment.

About one-half of the interviewees had attended counselling, with some being willing in spite of their fears of being stigmatised and others because they were confident that counsellors would not be judgmental. Of those who had not attended counselling, some noted that they would find the experience stigmatising, were worried that the counsellor would be judgmental, or were concerned that attending counselling would itself cause stigma. A few participants who had undergone counselling had indeed felt judged and criticised by their counsellor, with instances of this professional stigma documented in other gambling research (Anderson, 2014). Other researchers have noted that stigma is the major deterrent to help-seeking and treatment adherence for mental illness because it requires problem acknowledgement to self and others, may be seen as a sign of weakness or failure, and attracts a label of mentally ill along with expectations of associated stereotyping, devaluation and discrimination (Anderson, 2014; Corrigan, 2004; Vogel et al., 2006). Interviews with counsellors also emphasised the fear that clients have to overcome to attend counselling: fear of the unknown, fear that they may be judged as weak and irresponsible, fear that they may not be heard and supported, fear that they may not be able to trust the professionals they approach, and fear that they may not succeed with treatment. Thus, clients tended to wait until their gambling problem became so severe that it overrode the stigma barrier to attending treatment. These findings suggest that help-seeking and adherence rates might be improved through public education about the non-judgmental role of counsellors, by demystifying the counselling process, through avoidance of professional stigma by therapists, and through promoting treatment attendance as an act of strength rather than weakness.

Another intervention discussed with gamblers and counsellors in interviews was the 'gamble responsibly' message that is promoted in public health messages and required in gambling industry advertisements, along with other public education campaigns around problem gambling. Mixed views were found amongst our gambler interviewees. Some felt that these messages reduce stigma by increasing awareness about problem gambling; others felt they had no effect because the messages are tokenistic and have no educational value; and some felt that the messages increase stigma because they depict people with gambling problems as liars, untrustworthy, irresponsible and losers. Counsellors were also divided in their views. Some considered the responsible gambling message as positive, guiding people towards the goal of controlled gambling which may be preferred and considered more achievable than abstinence; these counsellors also thought that the message helped

to lower stigma because it suggested that gambling is potentially controllable and 'recoverable' (Jones et al., 1984). In contrast, other counsellors considered the message to add to problem gambling stigma, by conveying that people were personally at fault for having a gambling problem because they were irresponsible, which added further stigma to their perceived failings. Thus, some counsellors felt that the 'gamble responsibly' message imposed a double burden on people with gambling problems. This latter view aligns with findings from Carroll et al.'s (2013) study of problem gambling stigma and also with concerns raised in other literature (Reith, 2007, 2008). Further research is needed to determine the effect of public health messages about responsible gambling and problem gambling on public, perceived and self-stigma.

8.7.3 Statistical relationships between stigma and help seeking

Statistical analyses were undertaken on the data from the Survey of People with Gambling Problems to identify any relationships between help-seeking and stigma. Four measures of stigma were utilised: the Perceived Stereotyping Scale, Devaluation Scale, Discrimination Scale, and Self-Stigma Scale. These scales were compared amongst those who had and had not used 11 different types of help.

Perceived stereotyping was significantly higher amongst respondents who had used self-help and a telephone helpline (compared to those not using these types of help). Devaluation was significantly higher amongst those who had sought any type of help, except for self-help and self-exclusion from land-based or online gambling operations. Discrimination was not related to any of the help-seeking measures. Self-stigma was significantly higher amongst those who had sought help from a telephone helpline, face-to-face support group, family or friends, and self-help. Thus, where differences were observed, those who had sought each type of help had higher scores on the various stigma scales compared to those who had not sought help.

It is difficult to further interpret these results as the causal direction of these relationships is unclear. For example, do higher levels of devaluation and self-stigma amongst those seeking numerous types of help underpin a stronger need for help? Does stigma in fact encourage help-seeking? Or does the experience of help-seeking lower people's self-worth and self-esteem? The possibility that stigma may have some benefits is raised below. Clearly, however, further research is needed to identify causal directions between perceived and self-stigma and help-seeking from various sources.

8.7.4 Could stigma have some benefits?

As explained above, results from the Survey of People with Gambling Problems revealed that those who had sought each of the 11 types of help examined had higher scores on the various stigma scales compared to those who had not sought help. This finding raises the possibility that stigma may in fact promote help-seeking through increasing a desire to address a problem that is considered socially unacceptable and a source of shame. Several researchers have discussed whether stigma represents a rational strategy for encouraging adherence to social norms and improving public health, particularly where the stigmatised behaviour is presented as deviant but voluntary, as occurs with addictions (Bayer, 2008; Burris, 2008; Phelan, Link, & Dovidio, 2008; Schomerus et al., 2011). However, in relation to alcohol dependence, Schomerus et al. (2011) argue that stigma is a dysfunctional way of achieving these aims as it increases secrecy and lowers self-efficacy amongst those affected; this hinders help-seeking and therefore prolongs and exacerbates the course of the condition.

A few of our gambler interviewees felt that the stigmatisation of problem gambling encourages people to want to change. About half felt that it has both good and bad elements, at times motivating people to address their gambling problem to prove that they are not failures, but overall creating a sense of shame and embarrassment that hinders help-seeking, despite their need for support. Slightly less than half of the interviewees felt that there are no positive elements to stigma as it creates a sense of hopelessness and failure for people experiencing problem gambling. There is little doubt that stigma delayed and deterred help-seeking amongst our research participants, and numerous studies have found people tend to resist help-seeking due to shame until their gambling problems become severe (Cunningham, 2005; Hing et al., 2012; Delfabbro, 2012). Clearly, further research is needed to determine if stigma has a role in encouraging help-seeking and if and how it might be harnessed to promote earlier and more widespread uptake of help.

8.7.5 Statistical relationships between stigma and recovery

Nearly nine-in ten respondents in the Survey of People with Gambling Problems met criteria for past-year problem gambling when measured on the PGSI, with the remainder experiencing having a gambling problem in the preceding few years. Thus, recovery was not measured in the survey, given the recency of the respondents' gambling problems, high rates of relapse that are typical in the first few years of change, and the difficulties of reliably ascertaining recovered gambler status (Battersby et al. 2010; Nower & Blaszczynski, 2008; Williams, West, & Simpson, 2012). However, respondents were asked whether they had ever felt that they had overcome a gambling problem or regained control of their gambling. A little over half (53%) said that they had (with the vast majority of these later relapsing), with the remainder (47%) stating that they had not. There was no significant difference between those who had and had not overcome their gambling problem at some point on any of the four stigma measures (perceived stereotyping, devaluation, discrimination, and self-stigma). Thus, stigma does not appear to be related to overcoming a gambling problem, at least on a temporary basis. This was confirmed in the interviews, with most interviewees considering that stigma had not affected their recovery (to date) from problem gambling. However, further research is needed to ascertain whether stigma is related to lasting recovery from problem gambling.

8.7.6 Incorporating stigma into therapy

The interviews with counsellors revealed that dealing with self-stigma is considered a vital part of treatment for problem gambling. In fact, the counsellors generally noted that reducing clients' self-stigma is one of their first goals. Before change can occur and in order to progress towards recovery, counsellors explained, clients need to trust that recovery is possible, which in turn requires understanding, forgiveness and healing, and rebuilding self-esteem and self-efficacy. Thus, the counsellors reported that they try to create a safe space to discuss clients' feeling of shame and disgrace, to normalise it, to teach coping mechanisms to deal with self-stigma and fear, and then to empower clients to understand and alter their self-stigmatising beliefs away from feeling hopeless or worthless. Eventually, clients may begin to think and behave differently, although the counsellors reported that it may take many sessions before some clients can overcome their self-stigma sufficiently to be open and honest with their counsellor. Their self-stigma, as reflected in deep shame, low self-esteem, low resilience and even paranoia, can make it difficult to be truthful, even to counsellors. Interestingly, an interviewee who worked in a peer support program staffed by people who have previously experienced a gambling problem, maintained that having a shared experience of problem gambling helped to lower the self-stigma experienced by clients. Overall, in alignment with the mental health literature, the gambling counsellors interviewed endeavoured to alter clients' self-

stigmatising beliefs and tried to enhance skills for coping with self-stigma through improving self-esteem, empowerment and help-seeking behavior (Mittal et al., 2012).

8.8 Findings relating to Objective 6: Stigma and relapse

Objective 6 was to analyse how stigma impacts people with gambling problems seeking treatment for the first time compared to those seeking treatment after a relapse. Data from the Survey of People with Gambling Problems and the gambler and counsellor interviews inform discussion of related findings.

8.8.1 Self-stigma after relapse

Episodes of relapse were reported to worsen self-stigma. Many interviewees had relapsed at some point, and this was accompanied by feelings of self-loathing, listening to others telling them not to do it again, and finding it even more shameful to admit that they had failed to control their gambling. Relapse also appears to encourage more secrecy, with some interviewees not disclosing a relapse to others. The counsellors interviewed also considered relapse to compound self-stigma as clients tended to recycle negative stereotypes, self-imposed stigma, and feelings of being a failure. These findings were supported by the survey results; those who had relapsed reported significantly higher levels of self-stigma compared to those who had not relapsed. While causal directions cannot be verified, it appears likely that relapse contributes to increased self-stigma amongst those with gambling problems.

8.8.2 The impact of stigma on help-seeking after relapse

As discussed earlier, stigma-related issues have been reported to be major barriers to help-seeking, both in the current and in previous research (Delfabbro, 2012; Hing, Holdsworth et al., 2014). However, the current study found variable results for the impact of stigma on help-seeking after relapse. A few interviewees were too ashamed to continue with their counselling after relapse, confirming previous findings that relapse-induced feelings of failure, humiliation and shame may deter completion of a treatment program for problem gambling (Dunn et al., 2011; Petry, 2005). This was confirmed in the interviews with gambling counsellors, who reported that some clients were extremely reluctant to return for counselling because they were so ashamed of their relapse and felt that they had failed their counsellor and their treatment program. Self-reproach was said to increase and self-esteem was thought to decline as these clients delayed or ceased their counselling. Relapse could therefore increase self-stigma and deter further treatment, particularly if clients felt that their counsellor was part of a circle of stigma with family and friends, rather than someone who was non-judgmental and accepting. Nevertheless, many participants returned to counselling after treatment and were still determined to beat the problem, despite feeling angry, disappointed and frustrated with themselves. While relapse might also increase self-stigma amongst this group, the counsellors confirmed that those who returned to counselling almost immediately after relapse appeared to recognise that relapse is a normal part of recovery from problem gambling.

These differing reported effects of relapse on help-seeking were also highlighted by a survey finding that nearly one-half (46%) of those who had sought help both before and after relapsing reported that seeking help was more embarrassing for them after relapsing, while about one-third (35%) found it

neither more or less embarrassing, and one-fifth (20%) found it less embarrassing. When rates of seeking help from 11 different sources was examined amongst survey respondents who had relapsed, the proportion seeking face-to-face help from a professional treatment provider, from a telephone helpline, a residential treatment program, a face-to-face or online peer support group, land-based and online self-exclusion, and through self-help increased. However, the proportion seeking help from an online or email counsellor and from family and friends marginally declined.

Thus, any stigma associated with relapse did not appear to have a consistent effect on overall help-seeking amongst the sample of respondents to the Survey of People with Gambling Problems. There was no significant interaction between any of the four stigma-related scales (perceived stereotyping, devaluation, discrimination and self-stigma) and seeking help from 11 different sources between those who had relapsed and those who had not. Therefore, while stigma appears to have an effect on different forms of help-seeking, these effects did not differ between those who had and had not relapsed into gambling problems.

8.8.3 Incorporating stigma into therapy after relapse

Willingness to return to counselling after relapse may depend on how prepared the client is to accept that relapse is a common occurrence and not necessarily an indication of their long-term recovery prospects. Counsellors reported that they explained to clients very early in their treatment that relapse is a common experience so as to normalise it and encourage treatment adherence. This typically involved discussing the causes and behaviours associated with relapse, the importance of returning to counselling afterwards, and what learning might result from each relapse episode. As such, the counsellors interviewed appeared to recognise the importance of early, frank discussions about relapse with clients, as advocated in the literature (Dunn et al., 2011). Counsellors also reported that they would assess with clients the events leading up to the relapse to analyse what happened, and explore additional opportunities to better manage both their gambling and any further relapses. This might include clients developing strategies with their counsellor to help them to resist gambling triggers, to gain more confidence in gaining control over their gambling, and to move towards greater self-acceptance. Incorporating relapse prevention strategies into problem gambling therapy appears to be a common and beneficial practice (George & Murali, 2005; Oakes et al., 2012). The counsellors generally reported that their therapy also includes strategies to assist clients in regaining their self-esteem after relapse so that their self-stigma would not be compounded. This appeared to be vital for some clients who were said to view a relapse as confirmation that they were a failure, thereby further internalising their self-stigmatising beliefs. As discussed earlier, reduction of self-stigma is an important component of therapy to help clients rebuild an unspoiled identity (Dunn et al., 2011; Koski-Jannes, 2002; McIntosh & McKeganey, 2000; Reith & Dobbie, 2012). Relapse potentially increases self-stigma and lowers self-esteem and self-efficacy; thus preparing clients for relapse and incorporating stigma-reduction strategies into treatment after relapse appear to be highly important components of therapy.

8.9 Limitations of the study

Having discussed the key findings from this study, it is important to highlight their limitations.

The Victorian Adult Survey sample was recruited as a panel through a market research company. Members of survey panels may differ from non-members in unknown ways. For example, respondents in purchased panels agree to participate in return for remuneration which may introduce sample bias.

Nevertheless, survey panels have the advantages of lower cost, higher response rates and more reliable data due to survey completeness (Behrend, Sharek, Meade & Wiebe, 2011; Göritz, Reinhold & Batinic, 2000). Recruitment of respondents for this survey through a purchased research panel also meant that quotas for age, gender and location could be targeted, and data were then weighted to be highly representative of the Victorian adult population. In reality, a panel was the only way that a sizeable and highly representative sample of the Victorian adult population could be recruited within the project budget; however, it is acknowledged that a truly random population survey may have yielded some different results. Nevertheless, even if a CATI survey was affordable for this project, it may have not been representative, given that fewer young people have a landline telephone. Moreover, a random digit dialling mobile phone survey could not have been restricted to Victorian residents.

Both the Victorian Adult Survey and the Survey of People with Gambling Problems were conducted online. Disadvantages of online surveys include restriction to Internet users, although 82.3% of Australians were Internet users in 2013 with this proportion increasing each year (World Bank, 2014). Nevertheless, provision of both surveys in online format only may have introduced some bias. In particular, people with gambling problems who are in severe financial crisis may be unlikely to have access to the Internet.

Most of the key measures in the Victorian Adult Survey were based on responses to vignettes. While this is a commonly used method in stigma research (Link et al., 1999; Link et al., 2004), including for problem gambling (Horch & Hodgins, 2008; Dhillon et al., 2011), the results are highly dependent on how accurately each vignette captures the condition or behaviour it aims to represent. To optimise the accuracy of vignettes, these were modelled on those used in previous research (Horch & Hodgins, 2008; Link et al., 1999) but improved by (a) standardising the time frames of the vignettes (i.e., over the last year), (b) reducing cues that other people have already made value judgments of the protagonists, (c) keeping ethnicity and education level constant by having the first line simply read 'X is a man who lives in your community' and (d) being more inclusive of DSM-V criteria for each condition. Further, validity was checked through the use of 13 questions that provided a more direct measure of each of the constructs that were measured in the vignettes section.

All vignettes in the Victorian Adult Survey included only a male protagonist; therefore the results for public stigma may not generalise to women with the five conditions/behaviours depicted in the vignettes, including problem gambling. Like Horch and Hodgins (2008), this decision was made reluctantly, but was necessary to limit the number of vignettes and associated questions in order to contain the survey length and to control for unnecessary variance between vignettes. The decision to have a male rather than female protagonist was based on the higher prevalence of problem gambling amongst males in the Victorian population (Hing, Russell, Tolchard, & Nower, 2015).

The Survey of People with Gambling Problems recruited only respondents who had acknowledged a gambling problem. As explained in Chapter Three, it became evident when designing the survey that meaningful questions and responses could only be gained from respondents who had self-acknowledged a gambling problem. Thus, the results may not generalise to people who are in denial about having a gambling problem and whose perceived and self-stigma may therefore differ from those who have acknowledged their problem at least to themselves.

The sample for the Survey of People with Gambling Problems was also not representative of the broader population of people with gambling problems. Given the low prevalence of problem gambling in the population, gaining a representative sample was not considered feasible within time and budgetary constraints. Further, the response rate from those invited through the CGER database was 32.6%, while the completion rate for the survey was 57.8% overall (of those who commenced the

survey). It is not known how non-respondents and those who commenced but did not complete the survey may have differed from those who did.

Similarly, the interview sample of gamblers was not intended to be representative of the population of people with gambling problems, and was also recruited on a convenience basis. However, in-depth qualitative research aims to provide detailed insights and capture the range of experiences, rather than provide representative data. This was also the case for the sample of gambling counsellors who were interviewed. Interestingly, we had more difficulty recruiting gambling counsellors from mainstream population services than from multi-cultural and culturally-specific services, with the latter thus being overrepresented in the interview sample. While the resultant sample allowed insights to be gained into some cultural aspects of stigma, the various ethnic groups represented were too diverse to be able to draw firm conclusions about any one cultural group. Results from the counsellor interviews were used mostly to help triangulate the data from the other project stages, and to gain insights into how stigma is incorporated into treatment.

Any research into stigma may be subject to social desirability bias. To minimise this potential, we used measures that have been previously used in stigma research wherever possible, including those that ask respondents what 'most people' think, tacitly giving them permission to express highly stigmatising attitudes (Link & Cullen, 1983). Given that the survey results showed high levels of public stigma, perceived stigma and self-stigma associated with problem gambling, any social desirability bias appears low and probably errs on the side of underestimating, rather than overestimating, these types of stigma. Further, public stigma was measured in a comparative sense, relative to other vignette conditions; thus, any social desirability bias may be expected to be consistently applied to all the conditions included.

8.10 Conclusion

This study represents the first comprehensive examination of the stigma associated with problem gambling. It is the first research to examine public stigma using a general population sample, revealing how the public perceives the dimensions of problem gambling and stigmatises the condition through a process of labelling, stereotyping, separating, emotional reactions, and status loss and discrimination. Results indicate that problem gambling is considered by the public to be an addiction and largely due to reactions to stressful life circumstances. The stereotypes attached to 'problem gamblers' by respondents to the Victorian Adult Survey (that the person in the problem gambling vignette tended to be impulsive, irresponsible, greedy, irrational, anti-social, untrustworthy, unproductive, and foolish) highlight that the public generally assigns blame for the problem to the individuals affected. The public also generally desires some social distance from people with gambling problems, feels pity but also anger and apprehension towards them, and recognises that they are demeaned and discriminated against in numerous ways. This study also assessed the relative public stigma of problem gambling amongst the general population, compared to a range of other conditions and behaviours. Problem gambling was found to be more stigmatised than sub-clinical worries and than recreational gambling, but marginally less stigmatised than alcohol use disorder and schizophrenia.

This study also included a detailed examination of perceived and self-stigma amongst people with gambling problems. Findings revealed high levels of perceived stigma, with participants believing that the public attaches a range of negative stereotypes, negative emotional responses, demeaning attitudes, and discriminatory behaviours to people with gambling problems. Strong self-stigmatising beliefs were widespread amongst research participants, and accompanied by reduced self-esteem and self-efficacy. Secrecy was the main coping mechanism used to deal with the deep fears

associated with problem exposure. This secrecy delayed and hindered help-seeking from a range of sources, with respondents most commonly relying on self-help. Self-stigma was higher amongst those seeking help, and counsellors reported that reducing self-stigma is an important component of therapy. Relapse worsens self-stigma and can deter treatment adherence. Thus, counsellors noted how discussions with clients about the possibility of relapse and that it does not signal long-term recovery failure are vital to normalise relapse, reduce the associated self-stigma, and encourage treatment completion.

Schomerus et al. (2011) note that a precondition for effective stigma-reduction interventions is to arrive at a valid model for the stigma of the condition being examined. Because this study represents the first comprehensive examination of the stigma associated with problem gambling, it cannot claim to have developed a definitive model of problem gambling stigma. Additionally, stigma reduction interventions were not a specific focus of this study.¹⁴ Nevertheless, the findings of this study can inform stigma-reduction efforts in relation to problem gambling, such as public education campaigns, increasing community contact with people with gambling problems, challenging labelling and negative stereotypes by conveying more positive images of people with gambling problems, reducing professional stigma, and increasing options for anonymous forms of help and for early intervention. In addition, this study has identified numerous avenues for further research to better understand the causes, characteristics and consequences of problem gambling stigma, and how it can be reduced.

¹⁴ Our original grant application included an examination of stigma-reduction strategies for problem gambling. However, this stage was not funded.

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Appendices

Appendix A: Victorian Adult Survey questionnaire

Appendix B: Survey of People with Gambling Problems questionnaire

Appendix C: Interview schedule for gamblers

Appendix D: Interview schedule for counsellors

Appendix E: Detailed statistical tables for Chapter Four

Appendix F: Detailed statistical tables for Chapter Five

Appendix A: Victorian Adult Survey questionnaire

Please note that the names of each vignette condition (problem gambling, alcoholism, schizophrenia, sub-clinical control, sub-clinical gambling) were not visible to survey respondents in the online survey.



Preamble

ATTITUDES TOWARDS DIFFERENT HEALTH CONDITIONS

You are invited to participate in a study about attitudes towards several different health conditions. The study is being conducted by Southern Cross University.

Participation involves completing this online survey concerning demographic variables and reading a short description of persons with particular health conditions. You will be asked to answer questions in response to these descriptions. Completing the survey should take you 20-30 minutes.

Please be assured that your participation in the survey will be anonymous and confidential. The survey does not ask for your name or any other identifying details. Your information will be integrated with that from other survey respondents. Only the researchers will handle the information collected from the survey for analysis and report preparation. All research material is stored securely at Southern Cross University for five years in password protected computer files and in locked cabinets.

If you agree to participate, we ask that you be as honest as possible when answering the survey. Please know that you are under no pressure to divulge any information you may feel uncomfortable sharing. Please also note that your participation in the survey is entirely voluntary and you may

withdraw your participation at any time during the survey.

The research results will be written up as a research report for the funding body which will be available on their website at a later date. With their permission, the results may also be presented at conferences or via journal articles. You can also contact us and request a copy of any publications.

Thank you for considering participating in this important study which will provide very valuable input into government policy.

If you have additional questions please feel free to contact the Principal

Researcher:

Professor Nerilee Hing

Southern Cross University

PO Box 157, Lismore, N.S.W. 2480 Australia

Email: nerilee.hing@scu.edu.au, ph: 0428 115 291

The ethical aspects of this study have been approved by the Southern Cross University Human Research Ethics Committee (HREC). The Approval Number is ECN-13-148

If you have any complaints about the ethical conduct of this research, then contact the following:

Ethics Complaints Officer

Division of Research

Southern Cross University

PO Box 157 Lismore NSW 2480

Email ethics.lismore@scu.edu.au

Any complaint you make will be treated in confidence and investigated, and you will be informed of the outcome.

If you consent to participate in this study, please select the button below and click the "Next" button on the right of the page.

☐ I consent to participate in this study.

Demographics

First, we would like to ask some demographic questions to help us categorise responses.

What is your gender?

- ☐ Male
- ☐ Female

What is your postcode?

What year were you born?

How many years have you lived in Australia? If you have lived in Australia your whole life, put down your age.

What is the primary language you speak at home?

What is your highest level of education?

What political party do you mostly align yourself with?

- ☐ Liberal/National Party
- ☐ Labor Party
- ☐ The Greens
- ☐ Other
- ☐ Prefer not to answer

Where would you place your views or attitudes on a scale of political orientation from progressive (left-wing) to conservative (right-wing)? This might not necessarily reflect who you voted for in the last election.

- | | | | | | |
|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|------------------------|
| Extremely Progressive | Progressive | Slightly Progressive | Neutral | Slightly Conservative | Extremely Conservative |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Browser Meta Info

This question will not be displayed to the recipient.

Browser:
Version:
Operating System:
Screen Resolution:
Flash Version:
Java Support:
User Agent:

What is your religion?

How important would you say religion/spirituality is in your life?

Not at all important. | ☐ ☐ ☐ ☐ ☐ ☐ | Extremely important.

What do you estimate your total household income before taxes was last year?

Instructions

In the following section, we will ask you to carefully read three stories. You will then be asked to answer a series of questions about the main character in the story you have just read. Although you will not know every detail about the main character in each of the stories, we will ask you to respond to a series of statements based on the information that we have presented to you. We ask that you answer the questions based solely on the information that is presented to you and to the best of your ability.

After you have finished answering the questions about the stories, you will only have to answer a few more questions before you are finished.

Remember that your answers are completely confidential. Please note that you cannot use the back button during the survey because it's important you answer the questions in the order presented.

First Vignette

You're now starting the first of three stories. Each story includes seven pages of questions. After you have completed the questions from the first story, you will answer questions from two more stories.

ProblemGambling

Page 1 of 7 for Dan

In this section you will read a story, and answer questions, about a man named Dan.

Dan is a man who lives in your community. During the last twelve months, he has started to gamble more than his usual amount of money. He has even noticed that he needs to gamble much more than he used to in order to get the same feeling of excitement. Several times, he has tried to cut down, or stop gambling, but he can't. Each time he has tried to cut down, he became agitated and couldn't sleep, so he gambled again. He is often preoccupied by thoughts of gambling and gambles more to try to recover his losses. Dan has also lied to his family and friends about the extent of his gambling.

How noticeable would Dan's situation be to his family and friends if he hadn't told them about it?

Not at all noticeable ☐ Somewhat noticeable ☐ Moderately noticeable ☐ Very noticeable ☐ Extremely noticeable ☐

How strongly do you agree or disagree that people can recover from Dan's situation?

Strongly Disagree ☐ Disagree ☐ Neither agree nor disagree ☐ Agree ☐ Strongly Agree ☐

How much do you think Dan's situation will affect his ability to work or study?

Not at all ☐ A small amount ☐ A moderate amount ☐ A large amount ☐ An extreme amount ☐

How much do you think Dan's situation will affect his ability to live independently?

Not at all ☐ A small amount ☐ A moderate amount ☐ A large amount ☐ An extreme amount ☐

How much do you think Dan's situation will affect his ability to be in a serious relationship?

Not at all ☐ A small amount ☐ A moderate amount ☐ A large amount ☐ An extreme amount ☐

Page 2 of 7 for Dan

Refresh your memory about Dan:

Dan is a man who lives in your community. During the last twelve months, he has started to gamble more than his usual amount of money. He has even noticed that he needs to gamble much more than he used to in order to get the same feeling of excitement. Several times, he has tried to cut down, or stop gambling, but he can't. Each time he has tried to cut down, he became agitated and couldn't sleep, so he gambled again. He is often preoccupied by thoughts of gambling and gambles more to try to recover his losses. Dan has also lied to his family and friends about the extent of his gambling.

How likely do you think it is that Dan's situation is caused by:

His bad character ☐ Very Unlikely ☐ Unlikely ☐ Neither likely nor unlikely ☐ Likely ☐ Very Likely ☐

God's will ☐

A chemical imbalance in his brain ☐

A genetic or inherited problem ☐

The way he was raised ☐

Stressful circumstances in his life ☐

Page 3 of 7 for Dan

Refresh your memory about Dan:

Dan is a man who lives in your community. During the last twelve months, he has started to gamble more than his usual amount of money. He has even noticed that he needs to gamble much more than he used to in order to get the same feeling of excitement. Several times, he has tried to cut down, or stop gambling, but he can't. Each time he has tried to cut down, he became agitated and couldn't sleep, so he gambled again. He is often preoccupied by thoughts of gambling and gambles more to try to recover his losses. Dan has also lied to his family and friends about the extent of his gambling.

If you were aware of Dan's situation, to what extent do you think you would feel each of the following emotions towards him?

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
He would make me angry	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
He would make me feel uncomfortable	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would feel annoyed by him	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

He would make me feel apprehensive	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
He would scare me	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
He would disgust me	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would feel the need to help him	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would feel sorry for him	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would feel sympathy for him	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

How likely is it that Dan would do something violent to other people?

Very Unlikely	Unlikely	Neither likely nor unlikely	Likely	Very Likely
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

How likely is it that Dan would do something violent to himself?

Very Unlikely	Unlikely	Neither likely nor unlikely	Likely	Very Likely
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Page 4 of 7 for Dan

Refresh your memory about Dan:

Dan is a man who lives in your community. During the last twelve months, he has started to gamble more than his usual amount of money. He has even noticed that he needs to gamble much more than he used to in order to get the same feeling of excitement. Several times, he has tried to cut down, or stop gambling, but he can't. Each time he has tried to cut down, he became agitated and couldn't sleep, so he gambled again. He is often preoccupied by thoughts of gambling and gambles more to try to recover

his losses. Dan has also lied to his family and friends about the extent of his gambling.

Please rate the extent to which you believe each attribute applies to Dan.

Normal	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Deviant
Generous	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Greedy
Moral	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Immoral
Social	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Anti-Social
Trustworthy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Untrustworthy
Sensible	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Foolish
Rational	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Irrational
Productive	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Unproductive
Responsible	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Irresponsible
Cautious	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Impulsive

Page 5 of 7 for Dan

Refresh your memory about Dan:

Dan is a man who lives in your community. During the last twelve months, he has started to gamble more than his usual amount of money. He has even noticed that he needs to gamble much more than he used to in order to get the same feeling of excitement. Several times, he has tried to cut down, or stop gambling, but he can't. Each time he has tried to cut down, he became agitated and couldn't sleep, so he gambled again. He is often preoccupied by thoughts of gambling and gambles more to try to recover his losses. Dan has also lied to his family and friends about the extent of his gambling.

If you were aware of Dan's situation, how willing would you be to:

Definitely Unwilling	Probably Unwilling	Neither willing nor unwilling	Probably Willing	Definitely Willing
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Have a group household in your neighbourhood for people in Dan's situation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Start working closely with Dan on a project	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Spend an evening socialising with Dan	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Make friends with Dan	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Move next door to Dan	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have Dan marry into your family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Page 6 of 7 for Dan

Refresh your memory about Dan:

Dan is a man who lives in your community. During the last twelve months, he has started to gamble more than his usual amount of money. He has even noticed that he needs to gamble much more than he used to in order to get the same feeling of excitement. Several times, he has tried to cut down, or stop gambling, but he can't. Each time he has tried to cut down, he became agitated and couldn't sleep, so he gambled again. He is often preoccupied by thoughts of gambling and gambles more to try to recover his losses. Dan has also lied to his family and friends about the extent of his gambling.

To what extent do you agree to the following statements:

If they were aware of Dan's situation, most people would...

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
Think less of Dan if he	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

needed professional help.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Believe that Dan is just as intelligent as the average person.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Believe that Dan is just as trustworthy as the average citizen.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Most women would be reluctant to date Dan.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Accept Dan as a teacher of young children in a public school.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Think less of people in Dan's situation.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Take Dan's opinions less seriously.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pass over Dan in favour of another applicant.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hire Dan if he was qualified for the job.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hire Dan to take care of their children.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Treat Dan just as they would treat anyone.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Willingly accept Dan as a close friend.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Strongly Disagree Disagree Neither Agree nor Disagree Agree Strongly Agree

Page 7 of 7 for Dan

Refresh your memory about Dan:

Dan is a man who lives in your community. During the last twelve months,

he has started to gamble more than his usual amount of money. He has even noticed that he needs to gamble much more than he used to in order to get the same feeling of excitement. Several times, he has tried to cut down, or stop gambling, but he can't. Each time he has tried to cut down, he became agitated and couldn't sleep, so he gambled again. He is often preoccupied by thoughts of gambling and gambles more to try to recover his losses. Dan has also lied to his family and friends about the extent of his gambling.

Based on his situation as described, do you think Dan has:

	No	Unsure	Yes
A mental health disorder?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
A physical health disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
An addiction?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
A disease or illness?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
A diagnosable condition? (Note: This is your opinion regardless of whether you have clinical training)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

What condition do you think Dan has?

Second Vignette

You're now starting the second of three stories.

SubClinical Control 2

Page 1 of 7 for John

In this section you will read a story, and answer questions, about a man named John.

John is a man who lives in your community. During the last year, life has been pretty okay for John. Most of the time he is pretty content, although he sometimes feels worried, a little sad, or has trouble sleeping at night. When things go wrong, he can usually handle the situation pretty well, although sometimes things bother him more than they should and he gets a bit down or annoyed. Nevertheless, most of the time he manages to keep his emotions under control and he is getting along pretty well.

How noticeable would John's situation be to his family and friends if he hadn't told them about it?

Not at all noticeable	Somewhat noticeable	Moderately noticeable	Very noticeable	Extremely noticeable
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

How strongly do you agree or disagree that people can recover from John's situation?

Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

How much do you think John's situation will affect his ability to work or study?

Not at all	A small amount	A moderate amount	A large amount	An extreme amount
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

How much do you think John's situation will affect his ability to live independently?

Not at all ☐ A small amount ☐ A moderate amount ☐ A large amount ☐ An extreme amount ☐

How much do you think John's situation will affect his ability to be in a serious relationship?

Not at all	<input type="radio"/>	A small amount	<input type="radio"/>	A moderate amount	<input type="radio"/>	A large amount	<input type="radio"/>	An extreme amount	<input type="radio"/>
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Page 2 of 7 for John

Refresh your memory about John:

John is a man who lives in your community. During the last year, life has been pretty okay for John. Most of the time he is pretty content, although he sometimes feels worried, a little sad, or has trouble sleeping at night. When things go wrong, he can usually handle the situation pretty well, although sometimes things bother him more than they should and he gets a bit down or annoyed. Nevertheless, most of the time he manages to keep his emotions under control and he is getting along pretty well.

How likely do you think it is that John's situation is caused by:

	Very Unlikely	Unlikely	Neither likely nor unlikely	Likely	Very Likely
A genetic or inherited problem	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
God's will	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
His bad character	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Stressful circumstances in	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Page 3 of 7 for John

Refresh your memory about John:

John is a man who lives in your community. During the last year, life has been pretty okay for John. Most of the time he is pretty content, although he sometimes feels worried, a little sad, or has trouble sleeping at night. When things go wrong, he can usually handle the situation pretty well, although sometimes things bother him more than they should and he gets a bit down or annoyed. Nevertheless, most of the time he manages to keep his emotions under control and he is getting along pretty well.

How would you feel each of the following emotions towards him?

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
I would feel the need to help him	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
He would make me feel uncomfortable	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
He would disgust me	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
He would scare me	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would feel sorry for him	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would feel sympathy for him	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
He would make me angry	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

He would make me feel apprehensive

☐

I would feel annoyed by him

☐

How likely is it that John would do something violent to other people?

Very Unlikely

☐

Unlikely

☐

Neither likely nor unlikely

☐

Likely

☐

Very Likely

☐

How likely is it that John would do something violent to himself?

Very Unlikely

☐

Unlikely

☐

Neither likely nor unlikely

☐

Likely

☐

Very Likely

☐

Page 4 of 7 for John

Refresh your memory about John:

John is a man who lives in your community. During the last year, life has been pretty okay for John. Most of the time he is pretty content, although he sometimes feels worried, a little sad, or has trouble sleeping at night. When things go wrong, he can usually handle the situation pretty well, although sometimes things bother him more than they should and he gets a bit down or annoyed. Nevertheless, most of the time he manages to keep his emotions under control and he is getting along pretty well.

Please rate the extent to which you believe each attribute applies to John.

Responsible	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Irresponsible
Sensible	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Foolish
Rational	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Irrational

Trustworthy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Untrustworthy
Normal	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Deviant
Moral	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Immoral
Cautious	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Impulsive
Generous	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Greedy
Social	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Anti-Social
Productive	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Unproductive

Page 5 of 7 for John

Refresh your memory about John:

John is a man who lives in your community. During the last year, life has been pretty okay for John. Most of the time he is pretty content, although he sometimes feels worried, a little sad, or has trouble sleeping at night. When things go wrong, he can usually handle the situation pretty well, although sometimes things bother him more than they should and he gets a bit down or annoyed. Nevertheless, most of the time he manages to keep his emotions under control and he is getting along pretty well.

If you were aware of John's situation, how willing would you be to:

	Definitely Unwilling	Probably Unwilling	Neither willing nor unwilling	Probably Willing	Definitely Willing
Start working closely with John on a project	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Make friends with John	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have a group household in your neighbourhood for people in John's situation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have John marry into your family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Spend an evening	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

socialising with John

Move next door to John

☐

☐

☐

☐

☐

Page 6 of 7 for John

Refresh your memory about John:

John is a man who lives in your community. During the last year, life has been pretty okay for John. Most of the time he is pretty content, although he sometimes feels worried, a little sad, or has trouble sleeping at night. When things go wrong, he can usually handle the situation pretty well, although sometimes things bother him more than they should and he gets a bit down or annoyed. Nevertheless, most of the time he manages to keep his emotions under control and he is getting along pretty well.

To what extent do you agree to the following statements:

If they were aware of John's situation, most people would...

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
Take John's opinions less seriously.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Believe that John is just as intelligent as the average person.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Please select "Disagree" in order to continue.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Think less of people in John's situation.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Willingly accept John as a close friend.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Accept John as a teacher of young children in a public school.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Treat John just as they would treat anyone.

Hire John if he was qualified for the job.

Think less of John if he needed professional help.

Most women would be reluctant to date John.

Pass over John in favour of another applicant.

Hire John to take care of their children.

Believe that John is just as trustworthy as the average citizen.

☐

☐

☐

☐

☐

☐

☐

☐

☐

☐

☐

☐

☐

☐

Strongly Disagree

Disagree

Neither Agree nor Disagree

Agree

Strongly Agree

Page 7 of 7 for John

Refresh your memory about John:

John is a man who lives in your community. During the last year, life has been pretty okay for John. Most of the time he is pretty content, although he sometimes feels worried, a little sad, or has trouble sleeping at night. When things go wrong, he can usually handle the situation pretty well, although sometimes things bother him more than they should and he gets a bit down or annoyed. Nevertheless, most of the time he manages to keep his emotions under control and he is getting along pretty well.

Based on his situation as described, do you think John has:

A mental health

No

Unsure

Yes

☐

disorder?

☐

A physical health disorder

☐

An addiction?

☐

A disease or illness?

☐

A diagnosable condition? (Note: This is your opinion regardless of whether you have clinical training)

☐

What condition do you think John has?

Third Vignette

You're now starting the final story.

Alcoholism 2

Page 1 of 7 for Peter

In this section you will read a story, and answer questions, about a man named Peter.

Peter is a man who lives in your community. During the last year Peter has started to drink more than his usual amount of alcohol. In fact, he has noticed that he needs to drink twice as much as he used to in order to get the same effect. Several times, he has tried to cut down, or stop drinking, but he can't. Each time he has tried to cut down, he became very agitated,

sweaty and he couldn't sleep, so he took another drink.

How noticeable would Peter's situation be to his family and friends if he hadn't told them about it?

Not at all noticeable

☐

Somewhat noticeable

☐

Moderately noticeable

☐

Very noticeable

☐

Extremely noticeable

☐

How strongly do you agree or disagree that people can recover from Peter's situation?

Strongly Disagree

☐

Disagree

☐

Neither agree nor disagree

☐

Agree

☐

Strongly Agree

☐

How much do you think Peter's situation will affect his ability to work or study?

Not at all

☐

A small amount

☐

A moderate amount

☐

A large amount

☐

An extreme amount

☐

How much do you think Peter's situation will affect his ability to live independently?

Not at all

☐

A small amount

☐

A moderate amount

☐

A large amount

☐

An extreme amount

☐

How much do you think Peter's situation will affect his ability to be in a serious relationship?

Not at all

☐

A small amount

☐

A moderate amount

☐

A large amount

☐

An extreme amount

☐

Page 2 of 7 for Peter

Refresh your memory about Peter:

Peter is a man who lives in your community. During the last year Peter has started to drink more than his usual amount of alcohol. In fact, he has noticed that he needs to drink twice as much as he used to in order to get the same effect. Several times, he has tried to cut down, or stop drinking, but he can't. Each time he has tried to cut down, he became very agitated, sweaty and he couldn't sleep, so he took another drink.

How likely do you think it is that Peter's situation is caused by:

	Very Unlikely	Unlikely	Neither likely nor unlikely	Likely	Very Likely
His bad character	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
A chemical imbalance in his brain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Stressful circumstances in his life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The way he was raised	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
God's will	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
A genetic or inherited problem	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Page 3 of 7 for Peter

Refresh your memory about Peter:

Peter is a man who lives in your community. During the last year Peter has started to drink more than his usual amount of alcohol. In fact, he has noticed that he needs to drink twice as much as he used to in order to get the same effect. Several times, he has tried to cut down, or stop drinking,

but he can't. Each time he has tried to cut down, he became very agitated, sweaty and he couldn't sleep, so he took another drink.

If you were aware of Peter's situation, to what extent do you think you would feel each of the following emotions towards him?

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
I would feel the need to help him	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
He would make me angry	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
He would disgust me	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would feel annoyed by him	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would feel sympathy for him	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
He would make me feel apprehensive	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
He would scare me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would feel sorry for him	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
He would make me feel uncomfortable	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

How likely is it that Peter would do something violent to other people?

Very Unlikely	Unlikely	Neither likely nor unlikely	Likely	Very Likely
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

How likely is it that Peter would do something violent to himself?

Neither likely nor

Very Unlikely

Unlikely

unlikely

Likely

Very Likely

☐

☐

☐

☐

☐

Page 4 of 7 for Peter

Refresh your memory about Peter:

Peter is a man who lives in your community. During the last year Peter has started to drink more than his usual amount of alcohol. In fact, he has noticed that he needs to drink twice as much as he used to in order to get the same effect. Several times, he has tried to cut down, or stop drinking, but he can't. Each time he has tried to cut down, he became very agitated, sweaty and he couldn't sleep, so he took another drink.

Please rate the extent to which you believe each attribute applies to Peter.

Responsible	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Irresponsible
Generous	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Greedy
Productive	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Unproductive
Trustworthy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Untrustworthy
Sensible	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Foolish
Social	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Anti-Social
Cautious	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Impulsive
Rational	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Irrational
Normal	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Deviant
Moral	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Immoral

Page 5 of 7 for Peter

Refresh your memory about Peter:

Peter is a man who lives in your community. During the last year Peter has started to drink more than his usual amount of alcohol. In fact, he has noticed that he needs to drink twice as much as he used to in order to get

the same effect. Several times, he has tried to cut down, or stop drinking, but he can't. Each time he has tried to cut down, he became very agitated, sweaty and he couldn't sleep, so he took another drink.

If you were aware of Peter's situation, how willing would you be to:

	Definitely Unwilling	Probably Unwilling	Neither willing nor unwilling	Probably Willing	Definitely Willing
Move next door to Peter	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have a group household in your neighbourhood for people in Peter's situation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Make friends with Peter	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Spend an evening socialising with Peter	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have Peter marry into your family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Start working closely with Peter on a project	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Page 6 of 7 for Peter

Refresh your memory about Peter:

Peter is a man who lives in your community. During the last year Peter has started to drink more than his usual amount of alcohol. In fact, he has noticed that he needs to drink twice as much as he used to in order to get the same effect. Several times, he has tried to cut down, or stop drinking, but he can't. Each time he has tried to cut down, he became very agitated, sweaty and he couldn't sleep, so he took another drink.

To what extent do you agree to the following statements:

If they were aware of Peter's situation, most people would...

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
Hire Peter if he was qualified for the job.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pass over Peter in favour of another applicant.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Take Peter's opinions less seriously.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Think less of Peter if he needed professional help.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Most women would be reluctant to date Peter.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hire Peter to take care of their children.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Accept Peter as a teacher of young children in a public school.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Believe that Peter is just as trustworthy as the average citizen.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Think less of people in Peter's situation.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Believe that Peter is just as intelligent as the average person.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Willingly accept Peter as a close friend.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Treat Peter just as they would treat anyone.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree

Page 7 of 7 for Peter

Refresh your memory about Peter:

Peter is a man who lives in your community. During the last year Peter has started to drink more than his usual amount of alcohol. In fact, he has noticed that he needs to drink twice as much as he used to in order to get the same effect. Several times, he has tried to cut down, or stop drinking, but he can't. Each time he has tried to cut down, he became very agitated, sweaty and he couldn't sleep, so he took another drink.

Based on his situation as described, do you think Peter has:

	No	Unsure	Yes
A mental health disorder?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
A physical health disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
An addiction?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
A disease or illness?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
A diagnosable condition? (Note: This is your opinion regardless of whether you have clinical training)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

What condition do you think Peter has?

Schizophrenia 2

Page 1 of 7 for Peter

In this section you will read a story, and answer questions, about a man named Peter.

Peter is a man who lives in your community. Up until a year ago, life was pretty okay for Peter. But then, things started to change. He thought that people around him were making disapproving comments and talking behind his back. Peter was convinced that people were spying on him and that they could hear what he was thinking. Peter lost his drive to participate in his usual work and family activities and retreated to his home, eventually spending most of his day in his room. Peter was hearing voices even though no one else was around. These voices told him what to do and what to think. He has been living this way for six months.

How noticeable would Peter's situation be to his family and friends if he hadn't told them about it?

Not at all noticeable	Somewhat noticeable	Moderately noticeable	Very noticeable	Extremely noticeable
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

How strongly do you agree or disagree that people can recover from Peter's situation?

Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

How much do you think Peter's situation will affect his ability to work or study?

Not at all	A small amount	A moderate amount	A large amount	An extreme amount
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

How much do you think Peter's situation will affect his ability to live independently?

Not at all	A small amount	A moderate amount	A large amount	An extreme amount
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

How much do you think Peter's situation will affect his ability to be in a serious relationship?

Not at all	A small amount	A moderate amount	A large amount	An extreme amount
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Page 2 of 7 for Peter

Refresh your memory about Peter:

Peter is a man who lives in your community. Up until a year ago, life was pretty okay for Peter. But then, things started to change. He thought that people around him were making disapproving comments and talking behind his back. Peter was convinced that people were spying on him and that they could hear what he was thinking. Peter lost his drive to participate in his usual work and family activities and retreated to his home, eventually spending most of his day in his room. Peter was hearing voices even though no one else was around. These voices told him what to do and what to think. He has been living this way for six months.

How likely do you think it is that Peter's situation is caused by:

	Very Unlikely	Unlikely	Neither likely nor unlikely	Likely	Very Likely
The way he was raised	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
God's will	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
A genetic or inherited problem	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

A chemical imbalance in his brain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
His bad character	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Stressful circumstances in his life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Page 3 of 7 for Peter

Refresh your memory about Peter:

Peter is a man who lives in your community. Up until a year ago, life was pretty okay for Peter. But then, things started to change. He thought that people around him were making disapproving comments and talking behind his back. Peter was convinced that people were spying on him and that they could hear what he was thinking. Peter lost his drive to participate in his usual work and family activities and retreated to his home, eventually spending most of his day in his room. Peter was hearing voices even though no one else was around. These voices told him what to do and what to think. He has been living this way for six months.

If you were aware of Peter's situation, to what extent do you think you would feel each of the following emotions towards him?

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
I would feel annoyed by him	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would feel sorry for him	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would feel sympathy for him	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would feel the need to help him	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
He would scare me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

He would make me feel apprehensive	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
He would disgust me	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
He would make me angry.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
He would make me feel uncomfortable	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

How likely is it that Peter would do something violent to other people?

Very Unlikely	Unlikely	Neither likely nor unlikely	Likely	Very Likely
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

How likely is it that Peter would do something violent to himself?

Very Unlikely	Unlikely	Neither likely nor unlikely	Likely	Very Likely
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Page 4 of 7 for Peter

Refresh your memory about Peter:

Peter is a man who lives in your community. Up until a year ago, life was pretty okay for Peter. But then, things started to change. He thought that people around him were making disapproving comments and talking behind his back. Peter was convinced that people were spying on him and that they could hear what he was thinking. Peter lost his drive to participate in his usual work and family activities and retreated to his home, eventually spending most of his day in his room. Peter was hearing voices even though no one else was around. These voices told him what to do and what to think. He has been living this way for six months.

Please rate the extent to which you believe each attribute applies to Peter.

Responsible	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Irresponsible
Social	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Anti-Social
Trustworthy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Untrustworthy
Generous	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Greedy
Moral	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Immoral
Productive	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Unproductive
Cautious	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Impulsive
Normal	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Deviant
Rational	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Irrational
Sensible	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Foolish

Page 5 of 7 for Peter

Refresh your memory about Peter:

Peter is a man who lives in your community. Up until a year ago, life was pretty okay for Peter. But then, things started to change. He thought that people around him were making disapproving comments and talking behind his back. Peter was convinced that people were spying on him and that they could hear what he was thinking. Peter lost his drive to participate in his usual work and family activities and retreated to his home, eventually spending most of his day in his room. Peter was hearing voices even though no one else was around. These voices told him what to do and what to think. He has been living this way for six months.

If you were aware of Peter's situation, how willing would you be to:

	Definitely Unwilling	Probably Unwilling	Neither willing nor unwilling	Probably Willing	Definitely Willing
Move next door to Peter	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Start working closely with Peter on a project	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Have a group household in your neighbourhood for people in Peter's situation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Make friends with Peter	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Spend an evening socialising with Peter	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have Peter marry into your family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Page 6 of 7 for Peter

Refresh your memory about Peter:

Peter is a man who lives in your community. Up until a year ago, life was pretty okay for Peter. But then, things started to change. He thought that people around him were making disapproving comments and talking behind his back. Peter was convinced that people were spying on him and that they could hear what he was thinking. Peter lost his drive to participate in his usual work and family activities and retreated to his home, eventually spending most of his day in his room. Peter was hearing voices even though no one else was around. These voices told him what to do and what to think. He has been living this way for six months.

To what extent do you agree to the following statements:

If they were aware of Peter's situation, most people would...

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
Think less of people in Peter's situation.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Believe that Peter is just as intelligent as the	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

average person.

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
Pass over Peter in favour of another applicant.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Think less of Peter if he needed professional help.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hire Peter to take care of their children.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Willingly accept Peter as a close friend.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hire Peter if he was qualified for the job.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Most women would be reluctant to date Peter.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Believe that Peter is just as trustworthy as the average citizen.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Treat Peter just as they would treat anyone.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Take Peter's opinions less seriously.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Accept Peter as a teacher of young children in a public school.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Page 7 of 7 for Peter

Refresh your memory about Peter:

Peter is a man who lives in your community. Up until a year ago, life was pretty okay for Peter. But then, things started to change. He thought that people around him were making disapproving comments and talking behind his back. Peter was convinced that people were spying on him and that they could hear what he was thinking. Peter lost his drive to

participate in his usual work and family activities and retreated to his home, eventually spending most of his day in his room. Peter was hearing voices even though no one else was around. These voices told him what to do and what to think. He has been living this way for six months.

Based on his situation as described, do you think Peter has:

	No	Unsure	Yes
A mental health disorder?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
A physical health disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
An addiction?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
A disease or illness?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
A diagnosable condition? (Note: This is your opinion regardless of whether you have clinical training)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

What condition do you think Peter has?

Sub-Clinical Gambler 2

Page 1 of 7 for Peter

In this section you will read a story, and answer questions, about a man named Peter.

Peter is a man who lives in your community. During the last year, Peter

has started to gamble occasionally. He usually bets the same amount of money and never bets more than he intends. He stops gambling when he is losing and doesn't lose very much money. He often goes long periods without gambling and does other leisure activities instead. He doesn't find he misses gambling and he doesn't think about gambling while he is away from it. Peter's family and friends know that he sometimes gambles.

How noticeable would Peter's situation be to his family and friends if he hadn't told them about it?

Not at all noticeable ☐ Somewhat noticeable ☐ Moderately noticeable ☐ Very noticeable ☐ Extremely noticeable ☐

How strongly do you agree or disagree that people can recover from Peter's situation?

Strongly Disagree ☐ Disagree ☐ Neither agree nor disagree ☐ Agree ☐ Strongly Agree ☐

How much do you think Peter's situation will affect his ability to work or study?

Not at all ☐ A small amount ☐ A moderate amount ☐ A large amount ☐ An extreme amount ☐

How much do you think Peter's situation will affect his ability to live independently?

Not at all ☐ A small amount ☐ A moderate amount ☐ A large amount ☐ An extreme amount ☐

How much do you think Peter's situation will affect his ability to be in a serious relationship?

Not at all ☐ A small amount ☐ A moderate amount ☐ A large amount ☐ An extreme amount ☐

Page 2 of 7 for Peter

Refresh your memory about Peter:

Peter is a man who lives in your community. During the last year, Peter has started to gamble occasionally. He usually bets the same amount of money and never bets more than he intends. He stops gambling when he is losing and doesn't lose very much money. He often goes long periods without gambling and does other leisure activities instead. He doesn't find he misses gambling and he doesn't think about gambling while he is away from it. Peter's family and friends know that he sometimes gambles.

How likely do you think it is that Peter's situation is caused by:

	Very Unlikely	Unlikely	Neither likely nor unlikely	Likely	Very Likely
God's will	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Stressful circumstances in his life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The way he was raised	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
A chemical imbalance in his brain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
His bad character	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
A genetic or inherited problem	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Page 3 of 7 for Peter

Refresh your memory about Peter:

Peter is a man who lives in your community. During the last year, Peter has started to gamble occasionally. He usually bets the same amount of money and never bets more than he intends. He stops gambling when he is losing and doesn't lose very much money. He often goes long periods without gambling and does other leisure activities instead. He doesn't find he misses gambling and he doesn't think about gambling while he is away from it. Peter's family and friends know that he sometimes gambles.

If you were aware of Peter's situation, to what extent do you think you would feel each of the following emotions towards him?

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
I would feel the need to help him	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
He would make me feel uncomfortable	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
He would make me angry	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would feel sympathy for him	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
He would disgust me	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would feel annoyed by him	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
He would make me feel apprehensive	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
He would scare me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would feel sorry for him	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

How likely is it that Peter would do something violent to other people?

Refresh your memory about Peter:

How likely is it that Peter would do something violent to himself?

Very Unlikely	Unlikely	Neutral	Likely	Very Likely
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Page 4 of 7 for Peter

Refresh your memory about Peter:

Peter is a man who lives in your community. During the last year, Peter has started to gamble occasionally. He usually bets the same amount of money and never bets more than he intends. He stops gambling when he is losing and doesn't lose very much money. He often goes long periods without gambling and does other leisure activities instead. He doesn't find he misses gambling and he doesn't think about gambling while he is away from it. Peter's family and friends know that he sometimes gambles.

Please rate the extent to which you believe each attribute applies to Peter.

Productive	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Unproductive
Responsible	<input type="radio"/> <td><input type="radio"/><td><input type="radio"/><td><input type="radio"/><td>Irresponsible</td></td></td></td>	<input type="radio"/> <td><input type="radio"/><td><input type="radio"/><td>Irresponsible</td></td></td>	<input type="radio"/> <td><input type="radio"/><td>Irresponsible</td></td>	<input type="radio"/> <td>Irresponsible</td>	Irresponsible
Generous	<input type="radio"/> <td><input type="radio"/><td><input type="radio"/><td><input type="radio"/><td>Greedy</td></td></td></td>	<input type="radio"/> <td><input type="radio"/><td><input type="radio"/><td>Greedy</td></td></td>	<input type="radio"/> <td><input type="radio"/><td>Greedy</td></td>	<input type="radio"/> <td>Greedy</td>	Greedy
Cautious	<input type="radio"/> <td><input type="radio"/><td><input type="radio"/><td><input type="radio"/><td>Impulsive</td></td></td></td>	<input type="radio"/> <td><input type="radio"/><td><input type="radio"/><td>Impulsive</td></td></td>	<input type="radio"/> <td><input type="radio"/><td>Impulsive</td></td>	<input type="radio"/> <td>Impulsive</td>	Impulsive
Rational	<input type="radio"/> <td><input type="radio"/><td><input type="radio"/><td><input type="radio"/><td>Irrational</td></td></td></td>	<input type="radio"/> <td><input type="radio"/><td><input type="radio"/><td>Irrational</td></td></td>	<input type="radio"/> <td><input type="radio"/><td>Irrational</td></td>	<input type="radio"/> <td>Irrational</td>	Irrational
Normal	<input type="radio"/> <td><input type="radio"/><td><input type="radio"/><td><input type="radio"/><td>Deviant</td></td></td></td>	<input type="radio"/> <td><input type="radio"/><td><input type="radio"/><td>Deviant</td></td></td>	<input type="radio"/> <td><input type="radio"/><td>Deviant</td></td>	<input type="radio"/> <td>Deviant</td>	Deviant
Moral	<input type="radio"/> <td><input type="radio"/><td><input type="radio"/><td><input type="radio"/><td>Immoral</td></td></td></td>	<input type="radio"/> <td><input type="radio"/><td><input type="radio"/><td>Immoral</td></td></td>	<input type="radio"/> <td><input type="radio"/><td>Immoral</td></td>	<input type="radio"/> <td>Immoral</td>	Immoral
Trustworthy	<input type="radio"/> <td><input type="radio"/><td><input type="radio"/><td><input type="radio"/><td>Untrustworthy</td></td></td></td>	<input type="radio"/> <td><input type="radio"/><td><input type="radio"/><td>Untrustworthy</td></td></td>	<input type="radio"/> <td><input type="radio"/><td>Untrustworthy</td></td>	<input type="radio"/> <td>Untrustworthy</td>	Untrustworthy
Social	<input type="radio"/> <td><input type="radio"/><td><input type="radio"/><td><input type="radio"/><td>Anti-Social</td></td></td></td>	<input type="radio"/> <td><input type="radio"/><td><input type="radio"/><td>Anti-Social</td></td></td>	<input type="radio"/> <td><input type="radio"/><td>Anti-Social</td></td>	<input type="radio"/> <td>Anti-Social</td>	Anti-Social
Sensible	<input type="radio"/> <td><input type="radio"/><td><input type="radio"/><td><input type="radio"/><td>Foolish</td></td></td></td>	<input type="radio"/> <td><input type="radio"/><td><input type="radio"/><td>Foolish</td></td></td>	<input type="radio"/> <td><input type="radio"/><td>Foolish</td></td>	<input type="radio"/> <td>Foolish</td>	Foolish

Page 5 of 7 for Peter

Refresh your memory about Peter:

Peter is a man who lives in your community. During the last year, Peter has started to gamble occasionally. He usually bets the same amount of money and never bets more than he intends. He stops gambling when he is losing and doesn't lose very much money. He often goes long periods without gambling and does other leisure activities instead. He doesn't find he misses gambling and he doesn't think about gambling while he is away from it. Peter's family and friends know that he sometimes gambles.

If you were aware of Peter's situation, how willing would you be to:

	Definitely Unwilling	Probably Unwilling	Neither willing nor unwilling	Probably Willing	Definitely Willing
Make friends with Peter	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have Peter marry into your family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Move next door to Peter	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have a group household in your neighbourhood for people in Peter's situation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Start working closely with Peter on a project	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Spend an evening socialising with Peter	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Page 6 of 7 for Peter

Refresh your memory about Peter:

Peter is a man who lives in your community. During the last year, Peter has started to gamble occasionally. He usually bets the same amount of money and never bets more than he intends. He stops gambling when he is losing and doesn't lose very much money. He often goes long periods without gambling and does other leisure activities instead. He doesn't find he misses gambling and he doesn't think about gambling while he is away from it. Peter's family and friends know that he sometimes gambles.

To what extent do you agree to the following statements:

If they were aware of Peter's situation, most people would...

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
Hire Peter if he was qualified for the job.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Take Peter's opinions less seriously.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Think less of people in Peter's situation.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Most women would be reluctant to date Peter.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Accept Peter as a teacher of young children in a public school.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Treat Peter just as they would treat anyone.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Believe that Peter is just as intelligent as the average person.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Believe that Peter is just as trustworthy as the average citizen.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pass over Peter in favour of another applicant.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Willingly accept Peter as a close friend.

☐

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Think less of Peter if he needed professional help.

☐

☐

☐

☐

☐

Hire Peter to take care of their children.

☐

☐

☐

☐

☐

Strongly Disagree

Disagree

Neither Agree nor Disagree

Agree

Strongly Agree

Global Stigma- Alcohol- Order1

Page 7 of 7 for Peter

Refresh your memory about Peter:

Peter is a man who lives in your community. During the last year, Peter has started to gamble occasionally. He usually bets the same amount of money and never bets more than he intends. He stops gambling when he is losing and doesn't lose very much money. He often goes long periods without gambling and does other leisure activities instead. He doesn't find he misses gambling and he doesn't think about gambling while he is away from it. Peter's family and friends know that he sometimes gambles.

Based on his situation as described, do you think Peter has:

	No	Unsure	Yes
A mental health disorder?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
A physical health disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
An addiction?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
A disease or illness?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
A diagnosable condition? (Note: This is your opinion regardless of whether	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

John is a man who lives in your community. During the last year, life has been pretty okay for John. Most of the time he is pretty content, although he sometimes feels worried, a little sad, or has trouble sleeping at night. When things go wrong, he can usually handle the situation pretty well, although sometimes things bother him more than they should and he gets a bit down or annoyed. Nevertheless, most of the time he manages to keep his emotions under control and he is getting along pretty well.

Peter is a man who lives in your community. During the last year Peter has started to drink more than his usual amount of alcohol. In fact, he has noticed that he needs to drink twice as much as he used to in order to get the same effect. Several times, he has tried to cut down, or stop drinking, but he can't. Each time he has tried to cut down, he became very agitated,

sweaty and he couldn't sleep, so he took another drink.

Thinking back to the three stories you have read, please rank the three people described in the stories in terms of who you think has most value to society with "1" indicating the most value and "3" indicating the least value.

	1	2	3
Dan	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
John	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Peter	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Page 27 of 32

Global Stigma - Schizophrenia- Order1

Please refresh your memory about the three people whose stories you have read:

Dan is a man who lives in your community. During the last twelve months, he has started to gamble more than his usual amount of money. He has even noticed that he needs to gamble much more than he used to in order to get the same feeling of excitement. Several times, he has tried to cut down, or stop gambling, but he can't. Each time he has tried to cut down, he became agitated and couldn't sleep, so he gambled again. He is often preoccupied by thoughts of gambling and gambles more to try to recover his losses. Dan has also lied to his family and friends about the extent of his gambling.

John is a man who lives in your community. During the last year, life has been pretty okay for John. Most of the time he is pretty content, although he sometimes feels worried, a little sad, or has trouble sleeping at night. When things go wrong, he can usually handle the situation pretty well, although sometimes things bother him more than they should and he gets

a bit down or annoyed. Nevertheless, most of the time he manages to keep his emotions under control and he is getting along pretty well.

Peter is a man who lives in your community. Up until a year ago, life was pretty okay for Peter. But then, things started to change. He thought that people around him were making disapproving comments and talking behind his back. Peter was convinced that people were spying on him and that they could hear what he was thinking. Peter lost his drive to participate in his usual work and family activities and retreated to his home, eventually spending most of his day in his room. Peter was hearing voices even though no one else was around. These voices told him what to do and what to think. He has been living this way for six months.

Thinking back to the three stories you have read, please rank the three people described in the stories in terms of who you think has most value to society with "1" indicating the most value and "3" indicating the least value.

	1	2	3
Dan	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
John	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Peter	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Page 27 of 32

Global Stigma - Gambling - Order 1

Please refresh your memory about the three people whose stories you have read:

Dan is a man who lives in your community. During the last twelve months, he has started to gamble more than his usual amount of money. He has even noticed that he needs to gamble much more than he used to in order to get the same feeling of excitement. Several times, he has tried to cut

down, or stop gambling, but he can't. Each time he has tried to cut down, he became agitated and couldn't sleep, so he gambled again. He is often preoccupied by thoughts of gambling and gambles more to try to recover his losses. Dan has also lied to his family and friends about the extent of his gambling.

John is a man who lives in your community. During the last year, life has been pretty okay for John. Most of the time he is pretty content, although he sometimes feels worried, a little sad, or has trouble sleeping at night. When things go wrong, he can usually handle the situation pretty well, although sometimes things bother him more than they should and he gets a bit down or annoyed. Nevertheless, most of the time he manages to keep his emotions under control and he is getting along pretty well.

Peter is a man who lives in your community. During the last year, Peter has started to gamble occasionally. He usually bets the same amount of money and never bets more than he intends. He stops gambling when he is losing and doesn't lose very much money. He often goes long periods without gambling and does other leisure activities instead. He doesn't find he misses gambling and he doesn't think about gambling while he is away from it. Peter's family and friends know that he sometimes gambles.

Thinking back to the three stories you have read, please rank the three people described in the stories in terms of who you think has most value to society with "1" indicating the most value and "3" indicating the least value.

	1	2	3
Dan	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
John	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Peter	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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Global Stigma - Alcohol-Order2

Please refresh your memory about the three people whose stories you have read:

Peter is a man who lives in your community. During the last year Peter has started to drink more than his usual amount of alcohol. In fact, he has noticed that he needs to drink twice as much as he used to in order to get the same effect. Several times, he has tried to cut down, or stop drinking, but he can't. Each time he has tried to cut down, he became very agitated, sweaty and he couldn't sleep, so he took another drink.

Dan is a man who lives in your community. During the last twelve months, he has started to gamble more than his usual amount of money. He has even noticed that he needs to gamble much more than he used to in order to get the same feeling of excitement. Several times, he has tried to cut down, or stop gambling, but he can't. Each time he has tried to cut down, he became agitated and couldn't sleep, so he gambled again. He is often preoccupied by thoughts of gambling and gambles more to try to recover his losses. Dan has also lied to his family and friends about the extent of his gambling.

John is a man who lives in your community. During the last year, life has been pretty okay for John. Most of the time he is pretty content, although he sometimes feels worried, a little sad, or has trouble sleeping at night. When things go wrong, he can usually handle the situation pretty well, although sometimes things bother him more than they should and he gets a bit down or annoyed. Nevertheless, most of the time he manages to keep his emotions under control and he is getting along pretty well.

Thinking back to the three stories you have read, please rank the three people described in the stories in terms of who you think has most value to society with "1" indicating the most value and "3" indicating the least value.

	1	2	3
Peter	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dan	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

John

☐

☐

☐

Page 27 of 32

Global Stigma - Schizophrenia-Order2

Please refresh your memory about the three people whose stories you have read:

Peter is a man who lives in your community. Up until a year ago, life was pretty okay for Peter. But then, things started to change. He thought that people around him were making disapproving comments and talking behind his back. Peter was convinced that people were spying on him and that they could hear what he was thinking. Peter lost his drive to participate in his usual work and family activities and retreated to his home, eventually spending most of his day in his room. Peter was hearing voices even though no one else was around. These voices told him what to do and what to think. He has been living this way for six months

Dan is a man who lives in your community. During the last twelve months, he has started to gamble more than his usual amount of money. He has even noticed that he needs to gamble much more than he used to in order to get the same feeling of excitement. Several times, he has tried to cut down, or stop gambling, but he can't. Each time he has tried to cut down, he became agitated and couldn't sleep, so he gambled again. He is often preoccupied by thoughts of gambling and gambles more to try to recover his losses. Dan has also lied to his family and friends about the extent of his gambling.

John is a man who lives in your community. During the last year, life has been pretty okay for John. Most of the time he is pretty content, although he sometimes feels worried, a little sad, or has trouble sleeping at night. When things go wrong, he can usually handle the situation pretty well, although sometimes things bother him more than they should and he gets a bit down or annoyed. Nevertheless, most of the time he manages to

keep his emotions under control and he is getting along pretty well.

Thinking back to the three stories you have read, please rank the three people described in the stories in terms of who you think has most value to society with "1" indicating the most value and "3" indicating the least value.

	1	2	3
Peter	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dan	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
John	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Page 27 of 32

Global Stigma - Gambling - Order2

Please refresh your memory about the three people whose stories you have read:

Peter is a man who lives in your community. During the last year, Peter has started to gamble occasionally. He usually bets the same amount of money and never bets more than he intends. He stops gambling when he is losing and doesn't lose very much money. He often goes long periods without gambling and does other leisure activities instead. He doesn't find he misses gambling and he doesn't think about gambling while he is away from it. Peter's family and friends know that he sometimes gambles.

Dan is a man who lives in your community. During the last twelve months, he has started to gamble more than his usual amount of money. He has even noticed that he needs to gamble much more than he used to in order to get the same feeling of excitement. Several times, he has tried to cut down, or stop gambling, but he can't. Each time he has tried to cut down, he became agitated and couldn't sleep, so he gambled again. He is often preoccupied by thoughts of gambling and gambles more to try to recover

his losses. Dan has also lied to his family and friends about the extent of his gambling.

John is a man who lives in your community. During the last year, life has been pretty okay for John. Most of the time he is pretty content, although he sometimes feels worried, a little sad, or has trouble sleeping at night. When things go wrong, he can usually handle the situation pretty well, although sometimes things bother him more than they should and he gets a bit down or annoyed. Nevertheless, most of the time he manages to keep his emotions under control and he is getting along pretty well.

Thinking back to the three stories you have read, please rank the three people described in the stories in terms of who you think has most value to society with "1" indicating the most value and "3" indicating the least value.

	1	2	3
Peter	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dan	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
John	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Page 27 of 32

Global Stigma - Alcohol- Order3

Please refresh your memory about the three people whose stories you have read:

John is a man who lives in your community. During the last year, life has been pretty okay for John. Most of the time he is pretty content, although he sometimes feels worried, a little sad, or has trouble sleeping at night. When things go wrong, he can usually handle the situation pretty well, although sometimes things bother him more than they should and he gets a bit down or annoyed. Nevertheless, most of the time he manages to

keep his emotions under control and he is getting along pretty well.

Peter is a man who lives in your community. During the last year Peter has started to drink more than his usual amount of alcohol. In fact, he has noticed that he needs to drink twice as much as he used to in order to get the same effect. Several times, he has tried to cut down, or stop drinking, but he can't. Each time he has tried to cut down, he became very agitated, sweaty and he couldn't sleep, so he took another drink.

Dan is a man who lives in your community. During the last twelve months, he has started to gamble more than his usual amount of money. He has even noticed that he needs to gamble much more than he used to in order to get the same feeling of excitement. Several times, he has tried to cut down, or stop gambling, but he can't. Each time he has tried to cut down, he became agitated and couldn't sleep, so he gambled again. He is often preoccupied by thoughts of gambling and gambles more to try to recover his losses. Dan has also lied to his family and friends about the extent of his gambling.

Thinking back to the three stories you have read, please rank the three people described in the stories in terms of who you think has most value to society with "1" indicating the most value and "3" indicating the least value.

	1	2	3
John	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Peter	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dan	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Page 27 of 32

Global Stigma - Schizophrenia - Order3

Please refresh your memory about the three people whose stories you have read:

John is a man who lives in your community. During the last year, life has been pretty okay for John. Most of the time he is pretty content, although he sometimes feels worried, a little sad, or has trouble sleeping at night. When things go wrong, he can usually handle the situation pretty well, although sometimes things bother him more than they should and he gets a bit down or annoyed. Nevertheless, most of the time he manages to keep his emotions under control and he is getting along pretty well.

Peter is a man who lives in your community. Up until a year ago, life was pretty okay for Peter. But then, things started to change. He thought that people around him were making disapproving comments and talking behind his back. Peter was convinced that people were spying on him and that they could hear what he was thinking. Peter lost his drive to participate in his usual work and family activities and retreated to his home, eventually spending most of his day in his room. Peter was hearing voices even though no one else was around. These voices told him what to do and what to think. He has been living this way for six months.

Dan is a man who lives in your community. During the last twelve months, he has started to gamble more than his usual amount of money. He has even noticed that he needs to gamble much more than he used to in order to get the same feeling of excitement. Several times, he has tried to cut down, or stop gambling, but he can't. Each time he has tried to cut down, he became agitated and couldn't sleep, so he gambled again. He is often preoccupied by thoughts of gambling and gambles more to try to recover his losses. Dan has also lied to his family and friends about the extent of his gambling.

Thinking back to the three stories you have read, please rank the three people described in the stories in terms of who you think has most value to society with "1" indicating the most value and "3" indicating the least value.

John
Peter
Dan

1	2	3
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Page 27 of 32

Global Stigma - Gambling - Order3

Please refresh your memory about the three people whose stories you have read:

John is a man who lives in your community. During the last year, life has been pretty okay for John. Most of the time he is pretty content, although he sometimes feels worried, a little sad, or has trouble sleeping at night. When things go wrong, he can usually handle the situation pretty well, although sometimes things bother him more than they should and he gets a bit down or annoyed. Nevertheless, most of the time he manages to keep his emotions under control and he is getting along pretty well.

Peter is a man who lives in your community. During the last year, Peter has started to gamble occasionally. He usually bets the same amount of money and never bets more than he intends. He stops gambling when he is losing and doesn't lose very much money. He often goes long periods without gambling and does other leisure activities instead. He doesn't find he misses gambling and he doesn't think about gambling while he is away from it. Peter's family and friends know that he sometimes gambles.

Dan is a man who lives in your community. During the last twelve months, he has started to gamble more than his usual amount of money. He has even noticed that he needs to gamble much more than he used to in order to get the same feeling of excitement. Several times, he has tried to cut down, or stop gambling, but he can't. Each time he has tried to cut down, he became agitated and couldn't sleep, so he gambled again. He is often preoccupied by thoughts of gambling and gambles more to try to recover

Thinking back to the three stories you have read, please rank the three people described in the stories in terms of who you think has most value to society with "1" indicating the most value and "3" indicating the least value.

Page 27 of 32

You are almost finished. Finally, we would like to ask you some questions about gambling.

Extra Questions

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
I would be afraid of a problem gambler.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would look down upon problem	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Exposure to Stigmatised Condition

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
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Please select all of the options that apply to you.

	False	True
I have watched a movie or TV show where a person with a gambling problem was depicted.	<input type="radio"/>	<input type="radio"/>
I have had or do currently have a gambling problem.	<input type="radio"/>	<input type="radio"/>
I have never observed a person that I was aware had a gambling problem	<input type="radio"/>	<input type="radio"/>
I have worked with a person who had a gambling problem.	<input type="radio"/>	<input type="radio"/>
I have observed, in passing, a person I believe may have had a gambling problem	<input type="radio"/>	<input type="radio"/>
I have had a job that involves providing treatment for people with a gambling problem.	<input type="radio"/>	<input type="radio"/>
I have observed people with a gambling problem on a frequent basis.	<input type="radio"/>	<input type="radio"/>
I have watched a documentary on television about gambling problems.	<input type="radio"/>	<input type="radio"/>
A friend of the family has had a gambling problem.	<input type="radio"/>	<input type="radio"/>
I have had a job that includes interacting with people with a gambling problem.	<input type="radio"/>	<input type="radio"/>
I have lived with a person who has had a gambling problem.	<input type="radio"/>	<input type="radio"/>
I have a relative who has had a gambling problem.	<input type="radio"/>	<input type="radio"/>

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Gambling Involvement

In the last 12 months, how often have you gambled on:

	Never	Monthly or less	2-4 times a month	2-4 times a week	5 or more times a week
Casino table games	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Electronic gaming machines (pokies)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Private games with friends for money (e.g. Cards, dice games, mahjong)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sporting events	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Horse races	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bingo	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Keno	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lottery, lotto, pools or instant scratch tickets	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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PGSI

In the last 12 months, how often:

	Never	Sometimes	Most of the time	Almost Always
Have you bet more than you could really afford to lose?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have people criticized your betting or told you that you had a gambling problem, regardless of whether or not you thought it was true?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

When you gambled, did you go back another day to try to win back the money you lost?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have you felt that you might have a problem with gambling?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have you needed to gamble with larger amounts of money to get the same feeling of excitement?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have you felt guilty about the way you gamble or what happens when you gamble?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Has your gambling caused any financial problems for you or your household?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have you borrowed money or sold anything to get money to gamble?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Has gambling caused you any health problems, including stress or anxiety?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Never	Sometimes	Most of the time	Almost Always

Appendix B: Survey of People with Gambling Problems questionnaire

Consent

A SURVEY ABOUT STIGMA ASSOCIATED WITH PROBLEM GAMBLING

You are invited to participate in a study about the stigma attached to problem gambling. Stigma occurs when an individual is shamed by society because of a characteristic they have that is regarded as socially unacceptable. People experiencing gambling problems can be judged negatively by others and discriminated against. This can make them feel ashamed and avoid seeking help for their gambling.

The study aims to assess the nature of stigma and its impacts on problem gambling. The study is particularly interested in how stigma reduces treatment-seeking and how it influences recovery from problem gambling. The study is funded by the Victorian Responsible Gambling Foundation. The research is being conducted by the Centre for Gambling Education and Research at Southern Cross University.

We will give you a \$20 shopping voucher for taking the time to complete this survey. At the end of the survey, we ask you to email us your contact details so we can send you this voucher. Your contact details will only be used to send you this voucher and will not be passed on to anyone else.

If you agree, your involvement will include completing this online survey. It should take you about 20 minutes. The questions ask about your attitudes and behaviours regarding stigma associated with problem gambling. Some of the questions are challenging and confronting, but please know that your participation will greatly assist the Victorian Responsible Gambling Foundation and other organisations in their efforts to reduce the stigma attached to problem gambling.

Please be assured that your participation in the survey will be anonymous, private and confidential. The survey does not ask for your name or any other identifying details. Your information will be combined with that from other survey respondents. Only the researchers will handle the information collected for analysis and report preparation. All research material is stored securely at Southern Cross University for five years in password protected computer files and in locked cabinets.

We ask that you be as honest as possible when answering the survey. You are under no pressure to share any information you may feel uncomfortable about. Please note that your participation is entirely voluntary and you may withdraw your participation at any time during the survey. You can also partly complete the survey, have a break, and come back to it as long as you do this within one week of when you start. You can also request that we remove your partial or completed survey response from the data, if you change your mind about participating.

The research results will be written up as a research report for the Victorian Responsible Gambling Foundation which will be available on their website at a later date. With their permission, the results may also be presented at conferences or in journal articles. You can also contact us and request a copy of any publications.

Thank you for considering participating in this important study which will provide very valuable input into public health policies.

If you have additional questions please feel free to contact the Principal Researcher:

Professor Nerilee Hing
Director, Centre for Gambling Education and Research
Southern Cross University
PO Box 157, Lismore, NSW 2480 Australia
Email: nerilee.hing@scu.edu.au
Ph: 02 6620 3928 or 0428 115 291

The ethical aspects of this study have been approved by the Southern Cross University Human Research Ethics Committee (HREC). The Approval Number is ECN-13-148. If you have any complaints about the ethical conduct of this research, then contact the following:

Ethics Complaints Officer
Division of Research
Southern Cross University
PO Box 157 Lismore NSW 2480
Email ethics.lismore@scu.edu.au

Any complaint you make will be treated in confidence and investigated, and you will be informed of the outcome.

Please select the button below to indicate your consent to participate in this study.



I consent to participate in this study

1. Comparison with other Conditions

Let's start with your views on how much stigma the general public attaches to various conditions and behaviours. Stigma means that people are judged negatively by society because of a characteristic or condition that they have.

How much stigma do you think **most people** attach to each of the following conditions and behaviours? Note that this question refers to your perception of other people's views, not your own views.

	None	A small amount	A moderate amount	A large amount	An extreme amount
Recreational gambling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Schizophrenia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Alcoholism	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Depression	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Drug addiction	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bankruptcy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Problem gambling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Obesity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

2.1.1 Global Questions

Our next few questions ask for your views on how problem gamblers are typically perceived by the general public.

How strongly do you agree or disagree that **most people** would do the following? Note that this question refers to your perception of other people's views, not your own views. (Please click one response on each line)

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
Would feel sorry for a problem gambler	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Would look down upon problem gamblers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Would not want to interact with a problem gambler	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feel that problem gamblers make them angry	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Think that problem gamblers are likely to do something violent to other people	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Think that being a problem gambler disrupts the person's life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Think that becoming a problem gambler is the person's own fault	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Would notice if a close friend was a problem gambler	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Think problem gamblers are mentally ill	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Think that problem gamblers are addicts	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Think that problem gamblers are irresponsible	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Would be afraid of a problem gambler	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Think that people can recover from being a problem gambler	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

2.1.2 Stereotyping

Please indicate how much you think that **most people** believe that each characteristic below applies to problem gamblers. Again, note that this question refers to your perception of other people's views, not your own views. (Please click one response on each line)

Social	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Anti-Social
Trustworthy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Untrustworthy
Intelligent	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Stupid
Sensible	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Foolish
Risk-seeking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Risk-averse
Selfish	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Unselfish
Cautious	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Impulsive
Rational	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Irrational
Moral	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Immoral
Generous	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Greedy
Responsible	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Irresponsible
Normal	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Deviant
Pitiful	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Admirable
Open	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Secretive
Have weak self-control	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Have strong self-control
Productive	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Unproductive

2.1.3 Expressions of Public Stigma

The next question also refers to your perception of other people's views, not your own views.

How strongly do you agree or disagree that **most people** think problem gamblers ...

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
Are in denial about having a gambling problem	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feel no guilt about how much they lose at gambling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Are likely to be of low socio-economic status	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Are always in debt	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Have an addictive personality	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have no concern for their families	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Spend all their free time gambling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have no concern for themselves	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Are irresponsible with money	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Would have another addiction problem if they didn't have a gambling problem	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have unrealistic beliefs about winning at gambling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Are bored and lonely people	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Neglect their other responsibilities such as work or family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

2.2 Experienced Stigma

Instructions: Our next few questions are about any discrimination you have experienced in relation to your own gambling.

First, we would like to know whether the following people are aware of how much you have gambled. **Please select not applicable if you do not have, or interact with, the group in question.** (Please click one response on each line)

	They don't know I gamble	They think I gamble less than I actually do	They know I gamble as much as I actually do	They think I gamble more than I actually do	Not applicable
Partner/spouse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Children	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Parents	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other family members	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Friends you gamble with	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Friends you don't gamble with	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Your employer(s)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Your other work colleagues	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Gaming venue managers or staff where you gamble	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Your doctor/other health professionals you are in contact with	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Welfare or other service providers you are in contact with.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other organisations you are in contact with, such as banks, housing providers, insurance companies, police, legal professionals, correctional officers, education and training providers, etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

2.2.1 Day to Day Discrimination

How often have you **experienced** each of the following because someone **thought** you had a gambling problem? (Please click one response on each line)

	Never	Rarely	Sometimes	Often
Been treated less politely	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Been treated as if you are not smart	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Been treated as if others are afraid of you	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Been threatened or harassed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Been treated with less respect	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Been insulted or called names	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Been treated as if you are inferior	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Been treated as if you are dishonest	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Been provided with worse service	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

2.2.2 Major lifetime discrimination

Have you ever been **discriminated** against in the following ways because people thought you had a gambling problem? (Please click one response on each line)

	Yes	No
Denied, or received second-rate, education or training	<input type="radio"/>	<input type="radio"/>
Denied, or received second-rate, financial advice	<input type="radio"/>	<input type="radio"/>
Not hired for a job	<input type="radio"/>	<input type="radio"/>
Denied insurance cover	<input type="radio"/>	<input type="radio"/>
Not given a promotion	<input type="radio"/>	<input type="radio"/>
Hassled by legal or correctional officers	<input type="radio"/>	<input type="radio"/>
Denied, or received second-rate, medical or health care	<input type="radio"/>	<input type="radio"/>
Fired from a job	<input type="radio"/>	<input type="radio"/>
Hassled by police	<input type="radio"/>	<input type="radio"/>
Denied a bank loan	<input type="radio"/>	<input type="radio"/>
Denied, or received second-rate, help from welfare providers	<input type="radio"/>	<input type="radio"/>
Prevented from renting somewhere to live	<input type="radio"/>	<input type="radio"/>
Denied, or received second-rate, legal help	<input type="radio"/>	<input type="radio"/>
Forced to leave the neighbourhood	<input type="radio"/>	<input type="radio"/>

If you clicked on "Yes" for any of the above items, did the person explicitly state that their actions or decision was due to your gambling?

☐ Yes, in all cases

- ☐ Yes, in some cases
- ☐ No, not in any cases

2.3 Self-Stigma

Some people have said their gambling makes them feel bad about themselves. We'd like to know if these feelings are shared by others who gamble regularly. Many terms are confronting, but please try to be as honest as possible in your responses.

How strongly do you agree or disagree that your gambling has made **you** feel ...

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
That you are entirely to blame for having the problem	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
That you should be punished for your gambling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Embarrassed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Inadequate	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Shocked at yourself	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Guilty	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Disappointed in yourself	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Weak	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Undeserving of good things	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
That you should be able to fix the problem on your own	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
That there is something wrong with you	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
That you have a problem that nobody else has	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
That you lack willpower/self-control	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Socially unacceptable/ an outcast	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
That you are worse than people who can control their gambling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
A failure or a loser	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ashamed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Stupid	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
That you have lost your identity or feel like a different person	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

If you thought that you had a gambling problem, how afraid would **you** be of the following:

	Not at all afraid	A little bit afraid	Somewhat afraid	Very Afraid	Extremely afraid
Admitting to yourself that you had a gambling problem	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Being exposed as a person with a gambling problem	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Being labeled a problem gambler	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Your partner/spouse finding out	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other family members finding out	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Your friends finding out	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Gaming venue staff finding out	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other patrons in the gaming venue finding out	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Gambling counsellors finding out	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other health professionals finding out (e.g. doctor, psychologist, nurse)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Welfare providers finding out	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Embarrassing your family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Damage to your social standing or respect in the community	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Damage to your employment or career	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Police finding out	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Legal or correctional officers finding out	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

3. Coping Strategies

How strongly do you agree or disagree with each of the following statements?

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
You have lied to others about the extent of your gambling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Smoking cigarettes helps you cope with feeling embarrassed about your gambling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Drinking alcohol helps you cope with feeling embarrassed about your gambling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Taking illicit drugs helps you cope with feeling embarrassed about your gambling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
You avoid people who have negative opinions about problem gamblers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
You find it easier to be friendly with people who have had gambling problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It is important to point out stigmatising behavior or discrimination when it occurs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
You have hidden evidence of your gambling from others	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
You have explained to others what it means to have a gambling problem	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
You have participated in organised efforts to teach the public more about problem gambling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
You are very different from most people who have gambling problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Most problem gamblers have very different problems than you have	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
When someone stigmatises or discriminates against problem gamblers you let them know you disagree with them	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

4. Impacts of Stigma on Help Seeking

Going to a therapist for psychological help with a gambling problem would make **you** feel...

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
Stupid	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Inadequate	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
More self-confident	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
More empowered	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Self-excluding from a gambling venue for a gambling problem would make **you** feel...

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
Stupid	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Inadequate	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
More self-confident	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
More empowered	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Seeking help from family or friends for a gambling problem would make **you** feel...

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
Stupid	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Inadequate	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
More self-confident	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
More empowered	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Thinking about your gambling **over your lifetime**, how would you rate your gambling?

- ☐ I have never had a gambling problem
- ☐ I have had a slight gambling problem at some point in my life
- ☐ I have had a moderate gambling problem at some point in my life
- ☐ I have had a severe gambling problem at some point in my life

What type of gambling has caused you the **most** problems? (Please click only one response)

- ☐ Lottery, lotto, pools or instant scratch tickets
- ☐ Electronic gaming machines (pokies)
- ☐ Betting on horse or dog races
- ☐ Betting on sports

- ☐ Poker at a casino, hotel, club or online
- ☐ Other casino table games (not including poker)
- ☐ Keno
- ☐ Bingo
- ☐ Private games with friends for money (e.g. Cards, dice games, mahjong)
- ☐ Other (Please specify)

Have you ever felt you had successfully **overcome** a gambling problem or regained control over your gambling?

Yes

☐

No

☐

Have you ever **relapsed** back into having a gambling problem? Relapse means that your gambling got worse again after a period of improvement

Yes

☐

No

☐

Did you **seek help** from any of the following before and/or after you relapsed back into having a gambling problem? (Please click on all responses that apply)

	Never	Before relapsing	After relapsing
Face-to-face from a specialist gambling counsellor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Face-to-face from a non-gambling specialist professional, including doctor, psychologist/psychiatrist, financial, legal or other advisor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
From a gambling telephone helpline	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
From online or email gambling counselling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
From a residential treatment program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
From a face-to-face support group, such as Gamblers Anonymous or Pokies Anonymous	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
From an online support group or discussion board, such as an Internet forum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
From family or friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
By excluding yourself from a land-based gambling venue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
By excluding yourself from a gambling website or online gambling operator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Through self-help strategies, such as by limiting access to money for gambling, avoiding gaming venues, taking up other activities, learning more about problem gambling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Did you find it more or less embarrassing to seek this help after relapsing, compared to before relapsing?

- ☐ It was much more embarrassing seeking help after a relapse than before
- ☐ It was somewhat more embarrassing seeking help after a relapse than before
- ☐ It was equally embarrassing seeking help after a relapse than before
- ☐ It was somewhat less embarrassing seeking help after a relapse than before
- ☐ It was much less embarrassing seeking help after a relapse than before

Have you ever sought help or support for your gambling from any of the following

	Yes	No
From a residential treatment program	<input type="radio"/>	<input type="radio"/>
By excluding yourself from a land-based gambling venue	<input type="radio"/>	<input type="radio"/>
Face-to-face from a non-gambling specialist professional, including doctor, psychologist/psychiatrist, financial, legal or other advisor	<input type="radio"/>	<input type="radio"/>
Through self-help strategies, such as by limiting access to money for gambling, avoiding gaming venues, taking up other activities, learning more about problem gambling	<input type="radio"/>	<input type="radio"/>
From an online support group or discussion board, such as an Internet forum	<input type="radio"/>	<input type="radio"/>
By excluding yourself from a gambling website or online gambling operator	<input type="radio"/>	<input type="radio"/>
From online or email gambling counselling	<input type="radio"/>	<input type="radio"/>
From family or friends	<input type="radio"/>	<input type="radio"/>
From a face-to-face support group, such as Gamblers Anonymous or Pokies Anonymous	<input type="radio"/>	<input type="radio"/>
From a gambling telephone helpline	<input type="radio"/>	<input type="radio"/>
Face-to-face from a specialist gambling counsellor	<input type="radio"/>	<input type="radio"/>

5. Personal Confidence and Hope

Have **other people's views** about problem gambling increased or decreased your willingness to...

	Decreased	Neither increased nor decreased	Increased
Ask family and friends for help with your gambling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Participate in online support groups to help with your gambling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Seek professional help to help with your gambling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Learn more about problem gambling and responsible gambling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Socialise with people outside your family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Meet your responsibilities (e.g., work, study, parenting, main role)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Participate in face-to-face support groups to help with your gambling (e.g., Gamblers Anonymous, Pokies Anonymous)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Self-exclude to help with your gambling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Have **other people's views** about problem gambling increased or decreased your ability to...

	Decreased	Neither increased nor decreased	Increased
Cope with needing to control your gambling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have confidence and hope that you can control your gambling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Do the things that you would like to	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Develop a plan to resist gambling urges	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cope with having a gambling problem	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Benefit from any help you have received for your gambling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Self-Esteem

How strongly do you agree or disagree with the following statements? (Please click one response on each line)

	Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree
I wish I could have more respect for myself	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
At times I think I am no good at all	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel that I am a failure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel that I have a number of good qualities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel I do not have much to be proud of	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I take a positive attitude toward myself	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
On the whole, I am satisfied with myself	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am able to do things as well as most other people	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel that I am a person of worth, at least equal with others	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel useless at times.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Kessler-6

During the **past 4 weeks (28 days)**, how often did you feel:

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
Nervous	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Worthless	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
So sad that nothing could cheer you up	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Hopeless	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
That everything was an effort	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Restless or fidgety	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

PGSI

In the **last 12 months**, how often:

	Never	Sometimes	Most of the time	Almost Always
Have you felt guilty about the way you gamble or what happens when you gamble?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
When you gambled, did you go back another day to try to win back the money you lost?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have you needed to gamble with larger amounts of money to get the same feeling of excitement?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have you bet more than you could really afford to lose?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Has gambling caused you any health problems, including stress or anxiety?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have people criticized your betting or told you that you had a gambling problem, regardless of whether or not you thought it was true?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Has your gambling caused any financial problems for you or your household?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have you borrowed money or sold anything to get money to gamble?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have you felt that you might have a problem with gambling?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Never	Sometimes	Most of the time	Almost Always

Self-Consciousness

Please indicate how much each of the following statements is like you.

	Not like me at all	A little like me	Somewhat like me	A lot like me
I'm concerned about what other people think of me	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Large groups make me nervous	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It takes me time to get over my shyness in new situations	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel nervous when I speak in front of a group	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I'm always trying to figure myself out	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I usually worry about making a good impression	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It's hard for me to work when someone is watching me	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I'm usually aware of my appearance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I'm self-conscious about the way I look	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I care a lot about how I present	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

myself to others	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I get embarrassed very easily	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It's easy for me to talk to strangers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Before I leave my house, I check how I look	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Demographics

Lastly, we would like to ask some demographic questions to help us categorise responses.

What is your gender?

- ☐ Male
- ☐ Female

What is your postcode?

What year were you born?

How many years have you lived in Australia? If you have lived in Australia your whole life, put down your age.

What is the primary language you speak at home?

What is your highest level of education?

Browser Meta Info

This question will not be displayed to the recipient.

Browser: **Safari**

Version: **5.1.9**

Operating System: **Macintosh**

Screen Resolution: **1280x800**

Flash Version: **13.0.0**

Java Support: **1**

User Agent: **Mozilla/5.0 (Macintosh; Intel Mac OS X 10_6_8) AppleWebKit/534.59.10 (KHTML, like Gecko) Version/5.1.9**

Safari/534.59.10

What is your religion?

How important would you say religion/spirituality is in your life?

Not at all important.

☐☐☐☐☐☐☐

Extremely important.

What do you estimate your total household income before taxes was last year?

Closing

Would you like to receive a \$20 shopping voucher for completing this survey?

No

☐

Yes - please provide your contact details using the email link below and we will send you a \$20 Starcash Voucher which can be used to purchase petrol or any other goods sold at any Caltex service station Australia-wide.

☐

Would you like to be invited to participate in future research studies, both paid and unpaid?

No

☐

Yes - please provide your contact details using the email link below

☐

Would you like to participate in a telephone interview about stigma associated with gambling problems? If so, we will contact you within the next month to arrange this. We will reimburse you with a \$50 shopping voucher for participating in a telephone interview.

No

☐

Yes - please provide your contact details using the email link below

☐

Thank you for completing the survey.

To receive your \$20 Caltex voucher, register to participate in future surveys and/or participate in a telephone interview about stigma and gambling problems, please email your name, address and telephone number to cgerstigma@gmail.com

If clicking on the above email address fails to launch an email for you, simply cut and paste the email address into a blank email, include your name, address and telephone number, and send.

Your contact details will not be used for any purpose other than to send you your

shopping voucher and for recruitment for an interview and future research studies if you agreed to this. Your details will not be shared with any 3rd parties for any purpose.

Please click on ">>" at the bottom of this page to submit your responses.

Remember, you may stop your participation at any time during the survey if you find it too uncomfortable or distressing. If you need crisis support, call Lifeline now on 13 11 14. If gambling is a problem for you, you can contact the Gambling Helpline: 1800 858 858 or the Gambling Help Online: <http://www.gamblinghelponline.org.au/>

Appendix C: Interview schedule for gamblers

STIGMA AND PROBLEM GAMBLING: GAMBLER INTERVIEWS

Relevant Research Objectives

- Determine how stigma associated with problem gambling is perceived and experienced by different groups in Victoria.
- Determine how significant stigma is as an impediment to treatment or interventions for problem gambling and how recovery from problem gambling is impacted by stigma.
- Analyse how stigma impacts people with gambling problems seeking treatment for the first time, and those seeking treatment after a relapse.

Note to interviewers

The interview schedule is a guide and we would like all areas covered please. However, there is no need to ask particular questions if participants' answers to earlier questions have covered the relevant information. Please use your best judgment here and when you need to probe for more details.

Please also be mindful that the interviewees are problem gamblers and may need to be directed to appropriate support services. If they disclose anything that makes you concerned about their immediate safety, or the safety of those around them, please follow the protocols that you would use with clients in these instances.

INTERVIEW SCHEDULE FOR TELEPHONE INTERVIEWS

Introduction

- Hello, my name is _____ and I'm calling to conduct the telephone interview with you about gambling and stigma. Before I go any further I would like to inform you that this call will be recorded for research purposes. Only your first name will be used during the call to ensure anonymity and the recording will not be included in any research report, but will be compiled with other interviews that will all be reported together. Do I have your permission to continue?
- (If signed Informed Consent Form has been received ...) We previously sent you the Participant Information Sheet and have now received your signed Informed Consent Form – thank you.
- (If signed Informed Consent Form has not been received, ask...) Having read the Informed Consent Form, are you willing to give your verbal informed consent to participate in this research?
- In this interview, we will be talking mostly about any stigma attached to problem gambling.
- Part of the inclusion criteria for this interview is that you have experienced a gambling problem, so I hope we can talk reasonably openly about that, although there is no need to tell me anything you feel too uncomfortable about disclosing.
- Do you have any questions before we start?

Background

Our first few questions are about you and your problems with gambling.

1. Just as background, can you please tell me your age, gender, and what ethnicity you most identify with.
2. Can you please tell me about how long your gambling has been problematic, and what type(s) of gambling have caused you most problems?
3. Do you mostly do that (those) type(s) of gambling in land-based venues or online?

Stigma

1. Can you please describe what you think stigma is? There are no right or wrong answers here. We'd just like to hear what stigma means to you.

Internalised stigma

I now have some questions about your own feelings about having a gambling problem.

2. Can you please tell me how it makes you feel to have a gambling problem? (probe for details, e.g. has it affected your self-esteem? Your view of yourself? Your mental and physical health? Your confidence you can resolve your gambling problem?)
3. Can you please tell me why you feel like this? Is it because you are thinking about yourself, or more because you are thinking about how others perceive you? (prompt if necessary: Is it because of feelings you have about yourself that come from within, or is it more because of what other people have said or done?)

Perceived stigma

Let's now focus on how problem gamblers are viewed by others.

4. First of all, can you please tell me what feelings you have when you look at problem gamblers?
5. How do you think other people who don't have a gambling problem view problem gamblers? (probe for details, e.g., do they stereotype problem gamblers in certain ways? Do they associate certain characteristics with problem gamblers? Who or what do others think causes problem gambling?)
6. Do you think people view problem gamblers differently than they view non-problem gamblers (i.e. others who gamble but who don't have problems with it)? How? Why?
7. Who do you think stigmatises problem gamblers? Is it gamblers and staff in the venue, the general community, friends and family, the media, certain types of people? (prompt for each)
8. Have you ever felt that you were being judged because you had a gambling problem? Please tell me about these experiences.
9. Have you ever thought someone would react in a certain way, but they turned out to react differently than you thought they would? If so, please tell me about this.
10. Have you ever been actively discriminated against, criticised or avoided because you had a gambling problem? Please tell me about these experiences.

11. Do you think that some problem gamblers are more stigmatised than others? (prompt for: characteristics such as age, gender, cultural group (If of non-Australian ethnicity, probe for any specific cultural attitudes to problem gambling).
12. Do you think the views of others about problem gamblers are fair/unfair or accurate/inaccurate? That is, when people have criticised you or other problem gamblers, have you agreed or disagreed with some of their points? Which ones?

Your reactions to perceived stigma

Let's now focus on your own actual experiences of how the stigmatizing attitudes and behaviours of others make you feel.

13. If you feel others judge you, how does this make you feel? (probe for details, e.g. has it affected your self-esteem? Your view of yourself? Your mental and physical health? Your confidence that you can resolve your gambling problem?)
14. If you feel others judge you, how has this affected your willingness to admit to yourself that you have a problem with gambling? How? Why?
15. What would you say are the main ways that you have reacted to the stigmatizing attitudes and behaviours of others? (prompt: e.g., has it affected what you talk about with others, how open you are with others about your gambling experiences, whether or not you interact with others?)

Help-seeking

Let's now focus on how stigma may have affected your efforts to seek support and help for your gambling.

Note: Some of these questions may have already been answered, or may be covered within the questions, but it is important that we gather at least some information about the impact of stigma on each of the categories of help-seeking

16. Have feelings of shame or stigma affected how willing you have been to tell family and friends about your gambling problem? (probe e.g., Why or why not? How did or do you expect that they would react? How did or would it make you feel to tell them?)
17. Have feelings of shame or stigma affected how willing you have been to self-exclude from gaming venues or websites? (probe e.g., Why or why not? How did or do you expect that venues, staff and patrons would react? How did or would it make you feel to ask to self-exclude?)
18. Have feelings of shame or stigma affected how willing you have been to join peer support groups like Gamblers Anonymous? (probe e.g., Why or why not? How did or do you expect that these groups would react? How did or would it make you feel to join a peer support group?)
19. Have feelings of shame or stigma affected how willing you have been to seek professional help, such as from a gambling counsellor? (probe e.g., Why or why not willing? How did or do you expect that a counsellor would react? How did or would it make you feel to seek counselling?)
20. Are there any (other) types of help or support you may have sought? E.g., telephone, online, email support or help? Why did you choose this type of help?
21. Do you think public health messages about problem gambling, such as television ads, billboards, online materials, raise or lower the associated stigma? How? Why?
22. What do you think about the 'gamble responsibly' messages that are commonly displayed?

Relapse and recovery

I now have a couple of questions on stigma in relation to relapse and recovery.

23. Overall, do you think that the stigma associated with problem gambling has affected your ability to address and recover from your gambling problem? How? Why?
24. If you have ever tried to quit gambling but then relapsed into gambling again, was any stigma you felt different after relapsing? And did this impact on your willingness to seek help and support? Please tell me about this.

Stigma reduction

Finally ...

25. Do you think that the stigma associated with problem gambling can possibly have any beneficial effects or do you think it's harmful?
26. If you think it's harmful, how do you think it should be reduced?

Any other comments

27. That's the end of the interview questions. Are there any other things you would like to add to tell us about your experiences with stigma and gambling?

Gambling Help Services

28. Would you like any details of help services, including telephone and online help for gambling?

If yes, provide:

Gambling Helpline: 1800 858 858

Gambling Help Online: <http://www.gamblinghelponline.org.au>

Lifeline: 13 11 14 for immediate crisis

Thank you. We'll send a \$50 Starcash voucher to you. Is your address the same as you gave to Margaret Louise, who was the lady who scheduled your telephone interview? (If not, pls write below and insert correct address on dropbox file).

Name: _____

Postal address: _____

Appendix D: Interview schedule for counsellors

INTERVIEW QUESTIONS FOR GAMBLING COUNSELLORS

The first few questions relate to what you think stigma is and what you can tell me about how your clients have experienced stigma in relation to their problem gambling. This is followed by a few questions about your own views as a professional counsellor.

A. What you think stigma is.

1. Firstly, are you please able to describe what you think stigma is.

B. The perceptions and experiences of your clients: *Prompt – ask for concrete examples throughout*

1. How do your clients feel they are viewed by others because of their gambling? *Prompt – do they feel labeled or stereotyped or frowned upon?*
2. Have clients talked about feeling stigmatised or ashamed because of their gambling? *Prompt – past and present experiences.*
3. How have client experiences of any stigma or shame affected their acknowledgement of having a gambling problem?
4. How have client experiences of any stigma or shame affected their decision to seek treatment? *Prompt – in what ways, e.g., delayed, a barrier? Do they feel shame or stigma in seeking treatment?*
5. How have client experiences of any stigma or shame affected their decision (or not) to self-exclude *Prompt – in what way has it affected this decision?*
6. How have client experiences of any stigma or shame affected their decision (or not) to engage with peer support groups, such as GA? *Prompt –How? Why?*
7. Do clients report feeling stigmatised by family and friends? How does this affect whether they reach out for or get offered support from family and friends? And do family and friends themselves feel stigma or shame because of their loved one's gambling?
8. How have client experiences of any stigma or shame affected their recovery overall? Can you provide some examples?
9. How have client experiences of any stigma or shame affected relapse? And how has this affected their help-seeking after a relapse?
10. Have clients talked about experiencing any direct discrimination because of a gambling problem?
11. Anything we have missed about what your clients have said to you about shame/stigma?

C. Your own professional views:

1. How do you view the nature and intensity of stigma felt toward problem gamblers? *Prompt – why do you think they are stigmatised by society in this way?*
2. How are client feelings of stigma, shame or low self-esteem incorporated into your approach to treatment?
3. Do you think that stigma affects treatment and recovery for problem gamblers? How? Why? *(May have already covered this in previous client questions)*
4. Is the impact of stigma/shame on treatment different for first time and relapsed problem gamblers who are seeking help? How? Why? *(May have already covered this in previous client questions)*

5. Do you consider that there are some groups of gamblers that are more stigmatised/shamed/ashamed than others? *Prompt for demographics, CALD clients or those with comorbidities*
6. Any thoughts on stigma-reducing strategies? *Prompt – for those specific groups mentioned above. And how can seeking help be destigmatised?*
7. Do you think public health messages about problem gambling, such as gamble responsibly, affect its stigmatisation? How? Why?
8. Anything else you would like to say about stigma in your professional view?

Appendix E: Detailed statistical tables for Chapter Four

Table E1 – Scores on individual items that were combined into scales (problem gambling vignette only)

Scale	Item	Mean	SD
Disruptiveness	How much do you think Dan's situation will affect his ability to work or study?	2.91	0.79
Disruptiveness	How much do you think Dan's situation will affect his ability to live independently?	2.61	1.04
Disruptiveness	How much do you think Dan's situation will affect his ability to be in a serious relationship?	3.03	0.81
Pity	I would feel sorry for him	2.50	0.96
Pity	I would feel sympathy for him	2.47	0.94
Pity	I would feel the need to help him	2.47	0.89
Anger	I would feel annoyed by him	2.04	1.07
Anger	He would make me angry	1.81	1.06
Anger	He would disgust me	1.30	0.98
Fear	He would scare me	1.33	0.97
Fear	He would make me feel uncomfortable	1.78	1.03
Fear	He would make me feel apprehensive	1.88	0.99
Stereotyping	Cautious to Impulsive	4.98	1.06
Stereotyping	Responsible to Irresponsible	4.80	1.10
Stereotyping	Sensible to Foolish	4.64	1.16
Stereotyping	Rational to Irrational	4.59	1.13
Stereotyping	Trustworthy to Untrustworthy	4.51	1.18
Stereotyping	Productive to Unproductive	4.31	1.19
Stereotyping	Generous to Greedy	4.06	1.25
Stereotyping	Social to Anti-Social	3.87	1.29
Stereotyping	Normal to Deviant	3.54	1.22
Stereotyping	Moral to Immoral	3.46	1.12
Separating	Make friends with Dan	2.07	0.97
Separating	Spend an evening socialising with X	2.19	1.00
Separating	Start working closely with X on a project	1.80	1.00
Separating	Have a group household in your neighbourhood for people in Dan's situation	2.05	1.05
Separating	Have Dan marry into your family	0.99	0.87
Separating	Move next door to Dan	1.94	1.02
Status loss & discrimination	Willingly accept Dan as a close friend.*	2.20	0.87
Status loss & discrimination	Think less of people in Dan's situation.	2.08	0.99
Status loss & discrimination	Take Dan's opinions less seriously.	2.08	0.92
Status loss & discrimination	Accept Dan as a teacher of young children in a public school.*	2.62	1.00
Status loss & discrimination	Think less of Dan if he needed professional help.	1.43	1.07
Status loss & discrimination	Hire Dan to take care of their children.*	2.78	0.94
Status loss & discrimination	Hire Dan if he was qualified for the job.*	2.21	0.97
Status loss & discrimination	Pass over Dan in favour of another applicant.	2.54	0.94
Status loss & discrimination	Treat Dan just as they would treat anyone.*	2.06	0.94
Status loss & discrimination	Most women would be reluctant to date Dan.	2.65	0.95
Status loss & discrimination	Believe that Dan is just as intelligent as the average person.*	1.79	0.92
Status loss & discrimination	Believe that Dan is just as trustworthy as the average citizen.*	2.65	0.89

Note: All scales are scored from 0-4, except for the stereotyping scales, which are scored from 0-6. Higher scores indicate stronger agreement with the items, except for items marked with *, which were reverse scored. Disruptiveness scales are scored from 0 = "Not at all" to 4 = "An extreme amount", emotion and status loss and discrimination scales from 0 = "Strongly disagree" to 4 = "Strongly agree", separating scales from 0 = "Definitely unwilling" to 4 = "Definitely willing", and stereotyping scales did not have anchors. Higher scores on the stereotyping scales refer to closer agreement with the second adjective.

Table E2 – Summary of means (and SDs) for each scale for each vignette

	Problem Gambling	Sub-clinical Distress	Alcohol use disorder	Schizophrenia	Sub-clinical Gambling
Concealability	2.18 (1.04)	0.93 (0.93)	2.62 (0.95)	2.97 (1.01)	0.89 (0.99)
Course	0.97 (0.80)	1.11 (0.75)	1.05 (0.72)	0.62 (0.83)	1.13 (0.82)
Disruptiveness	2.85 (0.73)	1.31 (0.85)	2.67 (0.75)	3.21 (0.70)	0.53 (0.82)
Peril to others	1.72 (0.97)	1.05 (0.93)	2.48 (0.82)	2.43 (0.89)	0.53 (0.79)
Peril to self	2.20 (0.94)	1.55 (1.03)	2.41 (0.83)	2.81 (0.76)	0.59 (0.84)
Pity	2.48 (0.76)	2.42 (0.82)	2.44 (0.72)	2.85 (3.00)	1.06 (0.92)
Anger	1.72 (0.87)	0.72 (0.70)	1.74 (0.86)	1.05 (0.78)	0.66 (0.79)
Fear	1.66 (0.84)	0.95 (0.79)	2.07 (0.88)	2.25 (0.89)	0.67 (0.79)
Stereotyping	4.28 (0.81)	2.15 (0.94)	3.80 (0.81)	3.78 (0.83)	1.95 (1.19)
Separating	1.84 (0.74)	2.64 (0.70)	1.66 (0.76)	1.78 (0.85)	2.74 (0.80)
Status loss & discrimination	2.26 (0.57)	1.39 (0.62)	2.35 (0.53)	2.46 (0.63)	1.14 (0.64)
Origin - His bad character	1.45 (1.06)	0.78 (0.91)	1.42 (1.08)	0.81 (0.90)	0.71 (0.92)
Origin - A chemical imbalance in the brain	1.87 (1.08)	2.10 (1.14)	2.22 (1.02)	3.24 (0.86)	0.84 (0.98)
Origin - Stressful circumstances in his life	2.74 (0.89)	3.07 (0.76)	2.99 (0.74)	2.78 (0.92)	1.54 (1.21)
Origin - A genetic or inherited problem	1.62 (1.10)	1.85 (1.10)	2.07 (1.05)	2.56 (0.98)	0.87 (1.01)
Origin - God's will	0.45 (0.83)	0.54 (0.90)	0.46 (0.81)	0.49 (0.90)	0.45 (0.86)
Origin - The way he was raised	1.91 (1.05)	1.81 (1.09)	2.23 (0.97)	1.34 (1.09)	1.60 (1.24)

Table E3 – Statistical comparisons for each vignette compared to the problem gambling vignette for each scale

Scale	Sub-clinical distress	Alcohol use disorder	Schizophrenia	Sub-clinical gambling
Concealability	$t(1999) = 46.38, p < 0.001, d = 2.08$	$t(679) = 10.99, p < 0.001, d = 0.84$	$t(629) = 16.47, p < 0.001, d = 1.31$	$t(689) = 29.10, p < 0.001, d = 2.32$
Course	$t(1999) = 6.41, p < 0.001, d = 0.29$	n.s.	$t(629) = 13.16, p < 0.001, d = 1.05$	$t(689) = 8.42, p < 0.001, d = 0.67$
Disruptiveness	$t(1999) = 71.66, p < 0.001, d = 3.21$	$t(679) = 6.93, p < 0.001, d = 0.53$	$t(629) = 13.75, p < 0.001, d = 1.10$	$t(689) = 64.81, p < 0.001, d = 5.17$
Peril to others	$t(1999) = 27.90, p < 0.001, d = 1.25$	$t(679) = 20.40, p < 0.001, d = 1.57$	$t(629) = 18.58, p < 0.001, d = 1.48$	$t(689) = 35.02, p < 0.001, d = 2.79$
Peril to self	$t(1999) = 24.39, p < 0.001, d = 1.09$	$t(679) = 6.61, p < 0.001, d = 0.51$	$t(629) = 15.88, p < 0.001, d = 1.27$	$t(689) = 42.58, p < 0.001, d = 3.40$
Pity	$t(1999) = 3.11, p = 0.002, d = 0.14$	n.s.	$t(629) = 12.81, p < 0.001, d = 1.02$	$t(689) = 36.71, p < 0.001, d = 2.93$
Anger	$t(1999) = 48.73, p < 0.001, d = 2.18$	n.s.	$t(629) = 18.13, p < 0.001, d = 1.45$	$t(689) = 29.75, p < 0.001, d = 2.37$
Fear	$t(1999) = 35.02, p < 0.001, d = 1.57$	$t(679) = 11.73, p < 0.001, d = 0.90$	$t(629) = 17.30, p < 0.001, d = 1.38$	$t(689) = 32.61, p < 0.001, d = 2.60$
Stereotyping	$t(1999) = 76.99, p < 0.001, d = 3.44$	$t(679) = 18.43, p < 0.001, d = 1.42$	$t(629) = 15.15, p < 0.001, d = 1.21$	$t(689) = 43.81, p < 0.001, d = 3.49$
Separating	$t(1999) = 45.62, p < 0.001, d = 2.04$	$t(679) = 4.93, p < 0.001, d = 0.38$	$t(629) = 5.44, p < 0.001, d = 0.43$	$t(689) = 28.25, p < 0.001, d = 2.25$
Status loss & discrimination	$t(1999) = 54.34, p < 0.001, d = 2.43$	$t(679) = 4.15, p < 0.001, d = 0.32$	$t(629) = 10.21, p < 0.001, d = 0.81$	$t(689) = 39.42, p < 0.001, d = 3.14$

Table E4 – Statistical comparisons for each vignette compared to the problem gambling vignette for each origin question

Scale	Sub-clinical distress	Alcohol use disorder	Schizophrenia	Sub-clinical gambling
Origin - His bad character	$t(1999) = 27.15, p < 0.001, d = 1.21$	n.s.	$t(629) = 13.49, p < 0.001, d = 1.08$	$t(689) = 19.11, p < 0.001, d = 1.52$
Origin - A chemical imbalance in the brain	$t(1999) = 7.64, p < 0.001, d = 0.34$	$t(679) = 8.33, p < 0.001, d = 0.64$	$t(629) = 29.93, p < 0.001, d = 2.39$	$t(689) = 24.24, p < 0.001, d = 1.93$
Origin - Stressful circumstances in his life	$t(1999) = 14.07, p < 0.001, d = 0.63$	$t(679) = 8.92, p < 0.001, d = 0.69$	n.s.	$t(689) = 25.87, p < 0.001, d = 2.06$
Origin - A genetic or inherited problem	$t(1999) = 7.81, p < 0.001, d = 0.35$	$t(679) = 10.20, p < 0.001, d = 0.78$	$t(629) = 20.30, p < 0.001, d = 1.62$	$t(689) = 17.56, p < 0.001, d = 1.40$
Origin - God's will	$t(1999) = 5.24, p < 0.001, d = 0.23$	n.s.	$t(629) = 3.89, p < 0.001, d = 0.31$	n.s.
Origin - The way he was raised	$t(1999) = 3.78, p < 0.001, d = 0.17$	$t(679) = 6.27, p < 0.001, d = 0.48$	$t(629) = 8.38, p < 0.001, d = 0.67$	$t(689) = 8.54, p < 0.001, d = 0.68$

Note: n.s. = a difference that was not statistically significant.

Table E5 – Statistical comparisons for each vignette compared to the problem gambling vignette for each of the labels

Scale	Sub-clinical distress	Alcohol use disorder	Schizophrenia	Sub-clinical gambling
A mental health disorder	$\chi^2(3, N = 2,000) = 32.52, p < 0.001, \phi_c = 0.07$	$\chi^2(3, N = 679) = 12.90, p < 0.001, \phi_c = 0.08$	$\chi^2(3, N = 631) = 361.48, p < 0.001, \phi_c = 0.44$	$\chi^2(3, N = 691) = 441.33, p < 0.001, \phi_c = 0.46$
A physical health disorder	$\chi^2(3, N = 2,000) = 12.41, p = 0.006, \phi_c = 0.05$	$\chi^2(3, N = 679) = 224.52, p < 0.001, \phi_c = 0.33$	$\chi^2(3, N = 631) = 95.24, p < 0.001, \phi_c = 0.22$	$\chi^2(3, N = 691) = 150.48, p < 0.001, \phi_c = 0.27$
An addiction	$\chi^2(3, N = 2,000) = 1846.16, p < 0.001, \phi_c = 0.55$	$\chi^2(3, N = 679) = 17.52, p < 0.001, \phi_c = 0.09$	$\chi^2(3, N = 631) = 565.53, p < 0.001, \phi_c = 0.55$	$\chi^2(3, N = 691) = 570.27, p < 0.001, \phi_c = 0.52$
A disease or illness	$\chi^2(3, N = 2,000) = 69.67, p < 0.001, \phi_c = 0.11$	$\chi^2(3, N = 679) = 56.41, p < 0.001, \phi_c = 0.17$	$\chi^2(3, N = 631) = 241.89, p < 0.001, \phi_c = 0.36$	$\chi^2(3, N = 691) = 338.32, p < 0.001, \phi_c = 0.40$
A diagnosable condition	$\chi^2(3, N = 2,000) = 86.19, p < 0.001, \phi_c = 0.12$	$\chi^2(3, N = 679) = 51.58, p < 0.001, \phi_c = 0.16$	$\chi^2(3, N = 631) = 167.84, p < 0.001, \phi_c = 0.30$	$\chi^2(3, N = 691) = 451.66, p < 0.001, \phi_c = 0.47$

Note: n.s. = a difference that was not statistically significant. The statistical values reported are chi-square values, tested using the McNemar-Bowker Test.

Table E6 - N and % of respondents for ratings of each of the 13 direct questions on their views of problem gamblers

	Strongly disagree		Disagree		Neither agree nor disagree		Agree		Strongly agree		Scale Score	
	N	%	N	%	N	%	N	%	N	%	Mean	SD
I would notice if a close friend was a problem gambler	39	1.9	279	14.0	591	29.6	927	46.4	163	8.2	2.46	0.89
People can recover from being a problem gambler	8	0.4	56	2.8	186	9.3	1,166	58.3	583	29.2	3.13	0.73
Being a problem gambler disrupts the person's life	21	1.1	17	0.9	72	3.6	898	44.9	991	49.6	3.41	0.70
Becoming a problem gambler is the person's own fault	114	5.7	453	22.7	681	34.0	616	30.8	136	6.8	2.10	1.01
Problem gamblers are likely to do something violent to other people	227	11.3	709	35.5	725	36.2	293	14.6	46	2.3	1.62	0.95
I would be afraid of a problem gambler	288	14.4	828	41.4	552	27.6	268	13.4	63	3.2	1.50	1.00
Problem gamblers make me angry	205	10.3	601	30.1	713	35.7	389	19.4	92	4.6	1.78	1.02
I would feel sorry for a problem gambler	67	3.3	224	11.2	443	22.1	1,063	53.2	203	10.1	2.56	0.93
Problem gamblers are addicts	15	0.7	29	1.4	110	5.5	1,101	55.0	746	37.3	3.26	0.70
Problem gamblers are mentally ill	116	5.8	397	19.9	712	35.6	668	33.4	106	5.3	2.13	0.99
Problem gamblers are irresponsible	39	1.9	203	10.1	505	25.3	999	49.9	255	12.8	2.62	0.90
I would not want to interact with a problem gambler	159	8.0	608	30.4	673	33.6	479	23.9	81	4.1	1.86	1.00
I would look down upon problem gamblers	243	12.1	745	37.2	609	30.5	353	17.7	49	2.5	1.62	1.00

Note: Each scale was scored from 0 = "Strongly disagree" to 4 = "Strongly agree". The reported means and SDs are based on these scores.

Table E7 – Correlations between Direct Questions about dimensions of stigma and process of stigma creation and corresponding scale (Stage 2)

Scale	Single item	Correlation (Spearman's rho)
Concealability	I would notice if a close friend was a problem gambler	.28
Course	People can recover from being a problem gambler	.56
Disrupt	Being a problem gambler disrupts the person's life	.22
Peril to others	Problem gamblers are likely to do something violent to other people	.58
Emotions – pity	I would feel sorry for a problem gambler	.56
Emotions - anger	Problem gamblers make me angry	.60
Emotions – fear	I would be afraid of a problem gambler	.51
Separating	I would not want to interact with a problem gambler	-.53
Status loss & discrimination	I would look down upon problem gamblers	.28

Note: All correlations were statistically significant, $p < 0.001$

Open-ended responses on labelling

The following tables relate to Section 4.7.1. Respondents were asked what condition they thought the person in each vignette had. The questions were open-ended and the responses were categorised, with results presented in Tables E8 to E12.

Table E8 - Open-ended responses for what condition the respondents believed was present in the problem gambling vignette

Response	N	%	Valid %
Gambling (addiction)	665	33.3	73.6
Unspecified addiction or addictive disorder/personality	93	4.7	10.3
Compulsive/impulse control disorder	65	3.3	7.2
Distress, anxiety and/or stress	57	2.9	6.3
Other (e.g., social problems, boredom, lack of self esteem)	13	0.7	1.4
Mental illness	10	0.5	1.1
<i>No answer given</i>	1059	53.0	
<i>Unsure/don't know</i>	38	1.9	
Total	2000	100.0	100.0

Note: Valid % is based on those who gave a firm response and does not take into account the 'unsure/don't know' responses or those who did not give a response.

Table E9 – Open-ended responses for what condition the respondents believed was present in the sub-clinical distress vignette

Response	N	%	Valid %
Distress (115 said mild or slight distress, 94 also said anxiety with distress)	612	30.6	71.2
Anxiety, stress, worry and/or nervousness (but not distress)	152	7.6	17.7
Mental disorder	35	1.8	4.1
Normal life	23	1.2	2.7
Insomnia and/or sleep apnea	15	0.8	1.7
Lonely/lack of self esteem/confidence	11	0.6	1.3
Impulse control/compulsive disorder	9	0.5	1.1
Other	3	0.2	0.4
<i>No answer</i>	1110	55.5	
<i>Unsure/don't know</i>	30	1.5	
Total	2000	100.0	100.0

Note: Valid % is based on those who gave a firm response and does not take into account the 'unsure/don't know' responses or those who did not give a response.

Table E10 – Open-ended responses for what condition the respondents believed was present in the alcohol disorder vignette

Response	N	%	Valid %
Alcohol (addiction)	371	55.2	92.1
Unspecified addiction/dependency	17	2.5	4.2
Other diagnoses (e.g., distress, stress, unspecified mental disorder)	15	2.2	3.7
<i>No answer given</i>	257	38.2	
<i>Unsure/don't know</i>	12	1.8	
Total	672	100.0	100.0

Note: Valid % is based on those who gave a firm response and does not take into account the 'unsure/don't know' responses or those who did not give a response.

Table E11 – Open-ended responses for what condition the respondents believed was present in the schizophrenia vignette

Response	N	%	Valid %
Schizophrenia (13 also mentioned distress, 22 also mentioned bipolar, 37 also mentioned paranoia, 6 also mentioned psychosis)	312	49.3	62.4
Distress, bipolar, paranoia and/or psychosis without schizophrenia	100	15.8	20.0
Unspecified mental disorder (2 said brain injury/tumour)	52	8.2	10.4
Other specified conditions (e.g., drug addiction, agoraphobia, insomnia, PTSD)	19	3.0	3.8
Anxiety (with or without distress)	14	2.2	2.8
Dementia	3	0.5	0.6
<i>No answer given</i>	<i>100</i>	<i>15.8</i>	
<i>Unsure/don't know</i>	<i>33</i>	<i>5.2</i>	
Total	633	100.0	100.0

Note: Valid % is based on those who gave a firm response and does not take into account the 'unsure/don't know' responses or those who did not give a response.

Table E12 – Open-ended responses for what condition the respondents believed was present in the sub-clinical gambling vignette

Response	N	%	Valid %
Gambling addiction (4 stated 'minor')	20	2.9	51.3
Unspecified addiction	7	1.0	18.0
Compulsive/impulse control disorder/OCD	4	0.6	10.3
Boredom/loneliness	3	0.4	7.7
He is normal	3	0.4	7.7
Other (e.g., low self esteem, unspecified mental illness)	2	0.3	5.1
No answer given	651	93.7	
Unsure/don't know	5	0.7	
Total	695	100.0	100.0

Note: Valid % is based on those who gave a firm response and does not take into account the 'unsure/don't know' responses or those who did not give a response.

Who stigmatises people with gambling problems? Differences between groups

This section of Appendix E relates to Section 4.8 in the main report. It compares the responses between various groups in terms of the perceived nature of problem gambling and the process of stigma creation, as presented in the vignette. For this section, all scales were tested, but we have opted to report the results for the separating and status loss and discrimination scales in the text. Where two groups are compared, * indicates a statistically significantly higher mean or proportion in a row. Where more than two groups are compared (e.g., education), subscripts are used to denote significant differences, with notes underneath the table explaining how to interpret the results. Where no results are reported for some demographic variables (e.g., age), this indicates that no significant relationships were found with the separating and status loss and discrimination scales.

Gender

Males were significantly more likely than females to rate the condition in the problem gambling vignette as one that results in status loss and discrimination. No significant difference between genders was found for their mean score on the separating scale.

Table E13 – Mean and SD on the status loss and discrimination scale for the problem gambling vignette by gender

Scale	Statistic	Male	Female
Status loss & discrimination	Mean	2.28*	2.24
	SD	0.57	0.57
$F(1, 2065) = 3.87, p = 0.049, \eta^2 = 0.002$			

Note: Statistics for non-significant comparisons are not reported. * indicates the significantly higher mean.

Years in Australia.

Respondents who have lived in Australia for longer were significantly more likely to be willing to socialise with the person in the problem gambling vignette and were significantly less likely to believe that the condition in the problem gambling vignette leads to status loss and discrimination.

Table E14 – Relationship between number of years lived in Australia and the separating and status loss and discrimination scales for the problem gambling vignette

Scale	Correlation Statistic
Separating	$r = 0.07, p = 0.003$
Status loss & discrimination	$r = -0.06, p = 0.008$

Main language spoken at home

Respondents who did not speak mainly English at home felt significantly less willing to socialise with the person in the problem gambling vignette and were more likely to believe that the condition in the problem gambling vignette leads to status loss and discrimination.

Table E15 – Mean and SD on the separating and status loss and discrimination scales for the problem gambling vignette by main language spoken at home

Scale	Statistic	English	Not English
Separating	Mean	1.87*	1.54
	SD	0.74	0.73
$F(1, 2065) = 32.46, p < 0.001, \eta^2 = 0.015$			
Status loss & discrimination	Mean	2.25	2.34*
	SD	0.48	0.49
$F(1, 2065) = 4.77, p = 0.029, \eta^2 = 0.002$			

* indicates the significantly higher mean.

Education

Respondents with higher levels of education were significantly more likely to believe that the condition in the problem gambling vignette leads to status loss and discrimination. No significant differences were found on the separating scale based on respondents' highest educational level.

Table E16 – Mean and SD on the status loss and discrimination for the problem gambling vignette by highest level of education

Scale	Statistic	Year 10 or below	Year 12 or equivalent	Trade or tech cert diploma	Uni or college degree	Postgrad qual
Status loss & discrimination	Mean	2.12a	2.22ab	2.30b	2.27b	2.28b
	SD	0.58	0.57	0.58	0.56	0.55
$F(4,2062) = 4.05, p = 0.003, \eta^2 = 0.008$						

Note: Means in the same row with different subscripts are significant different from each other.

Political affiliation

The means and percentages for responses for The Greens and Other were not significantly different in any of the scales, so these groups were combined. Those who preferred not to answer this question were removed from the analysis. Thus, political party analyses compare those aligned with the Liberal/National Party, the Labor Party and other parties.

Respondents aligned with the major parties were significantly less likely to be willing to socialise with the person in the problem gambling vignette. Those aligned with Labor were significantly less likely to believe that the problem gambling condition as presented in the vignette leads to status loss compared to those aligned with the other parties.

Table E17 – Mean and SD on the separating and status loss and discrimination scales for the problem gambling vignette by political affiliation

Scale	Statistic	Liberal/National	Labor	Other
Separating	Mean	1.82a	1.85a	1.96b
	SD	0.75	0.74	0.77
$F(2,1663) = 5.34, p = 0.005, \eta^2 = 0.006$				
Status loss and discrimination	Mean	2.25ab	2.23a	2.33b
	SD	0.56	0.59	0.57
$F(2,1663) = 3.39, p = 0.034, \eta^2 = 0.004$				

Note: Means in the same row with different subscripts are significant different from each other.

Progressive/conservative

People who reported they were more conservative were less willing to socialise with the person in the problem gambling vignette, but were less likely to believe that the problem gambling condition in the vignette leads to a reduction in social status.

Table E18 – Relationship between progressive/conservative scale and the separating and status loss and discrimination scales for the problem gambling vignette

Scale	Correlation Statistic
Separating	$r = -0.07, p = 0.003$
Status loss and discrimination	$r = -0.06, p = 0.009$

Religion

The religion variable was recoded into 'Christian', 'Other religion' and 'No religion'. The 69 respondents who said 'Prefer not to say' were excluded from this analysis. Non-Christian religious people were significantly less willing to socialise with the person in the problem gambling vignette (compared to all others). No significant differences were found amongst these religious grouping on the status loss and discrimination scale.

Table E19 – Mean and SD on the separating scale for the problem gambling vignette by religion

Scale	Statistic	Christian	Other religion	No religion
Separating	Mean	1.87a	1.64b	1.88a
	SD	0.71	0.79	0.76
$F(2,1994) = 9.92, p < 0.001, \eta^2 = 0.010$				

Note: Means in the same row with different subscripts are significant different from each other.

Problem gambling status (PGSI)

Mean scores on the two scales were compared between PGSI groups. In general, significant differences in means for both scales were due to non-problem gamblers or problem gamblers, with low-risk and moderate-risk gamblers generally not differing significantly from one of these groups. Problem gamblers were more willing to socialise with the person in the problem gambling vignette and believed that the problem gambling condition as presented in the vignette was less likely to result in status loss and discrimination.

Table E20 – Mean and SD on the separating and status loss and discrimination scales for the problem gambling vignette by PGSI group

Scale	Statistic	Non-problem gambler	Low risk gambler	Moderate risk gambler	Problem gambler
Separating	Mean	1.81a	1.86a	1.91ab	2.19b
	SD	0.74	0.74	0.74	0.75
$F(3,2063) = 8.69, p < 0.001, \eta^2 = 0.012$					
Status loss and discrimination	Mean	2.29a	2.19ab	2.10b	2.04b
	SD	0.56	0.59	0.57	0.62
$F(3,2063) = 11.20, p < 0.001, \eta^2 = 0.016$					

Note: Means in the same row with different subscripts are significant different from each other.

Exposure to problem gambling

Respondents with higher levels of exposure to problem gambling (measured through a modified version of the *Level of Contact Report*; Holmes et al., 1999) were more willing to socialise with the person in the problem gambling vignette than were those with lower levels of this exposure. No significant differences were found for mean scores on the status loss and discrimination scale based on level of exposure to problem gambling.

Table E21 – Relationship between exposure to problem gambling and the separating scale for the problem gambling vignette

Scale	Correlation Statistic
Separating	$r = 0.11, p < 0.001$

Gambling involvement

Gambling involvement was related to both the separating and status loss and discrimination scales. Respondents with higher gambling involvement were more willing to socialise with the person in the problem gambling vignette and rated the person as less likely to lose status due to their condition compared to those with lower levels of gambling involvement.

Table E22 – Relationship between gambling involvement and the separating and status loss and discrimination scales for the problem gambling vignette

Scale	Correlation Statistic
Separating	$r = 0.13, p < 0.001$
Status loss and discrimination	$r = -0.15, p < 0.001$

Appendix F: Detailed statistical tables for Chapter Five

Table F1 – Statistical results for the relationship between coping strategies and stigma – those who had not relapsed

Coping strategy (DV)	Independent variable	Linear term					Quadratic term				
		<i>b</i>	SE <i>b</i>	β	<i>t</i>	<i>p</i>	<i>b</i>	SE <i>b</i>	β	<i>t</i>	<i>p</i>
Secrecy	Perceived Stereotyping	0.293	0.108	0.284	2.71	0.008	0.051	0.064	0.083	0.80	0.427
	Devaluation	0.163	0.118	0.138	1.38	0.172	-0.357	0.121	-0.296	-2.94	0.004
	Discrimination	3.457	1.325	0.441	2.61	0.010	-10.845	3.301	-0.555	-3.29	0.001
	Self-Stigma	0.642	0.134	0.484	4.80	<0.001	-0.017	0.093	-0.018	-0.18	0.857
Withdrawal	Perceived Stereotyping	0.103	0.133	0.083	0.77	0.443	0.011	0.079	0.015	0.14	0.887
	Devaluation	0.134	0.146	0.095	0.91	0.362	0.031	0.150	0.021	0.21	0.838
	Discrimination	2.188	1.648	0.233	1.33	0.187	-5.215	4.108	-0.223	-1.27	0.207
	Self-Stigma	0.317	0.181	0.200	1.75	0.083	0.066	0.126	0.060	0.53	0.600
Educating	Perceived Stereotyping	0.065	0.122	0.058	0.54	0.593	0.060	0.072	0.089	0.82	0.412
	Devaluation	0.485	0.122	0.377	3.96	<0.001	0.091	0.125	0.069	0.73	0.469
	Discrimination	-0.642	1.499	-0.075	-0.43	0.669	4.462	3.736	0.209	1.19	0.235
	Self-Stigma	0.033	0.167	0.023	0.20	0.842	0.092	0.117	0.091	0.79	0.432
Challenging	Perceived Stereotyping	-0.145	0.123	-0.127	-1.18	0.240	0.026	0.073	0.039	0.36	0.719
	Devaluation	0.204	0.135	0.156	1.51	0.134	-0.083	0.138	-0.062	-0.60	0.547
	Discrimination	1.376	1.533	0.158	0.90	0.371	-1.802	3.820	-0.083	-0.47	0.638
	Self-Stigma	-0.027	0.170	-0.018	-0.16	0.876	0.000	0.119	0.000	0.00	0.997
Distancing	Perceived Stereotyping	-0.172	0.104	-0.178	-1.66	0.100	-0.052	0.062	-0.090	-0.84	0.403
	Devaluation	0.255	0.110	0.231	2.32	0.022	0.141	0.113	0.124	1.25	0.214
	Discrimination	1.410	1.294	0.191	1.09	0.278	-1.787	3.226	-0.097	-0.55	0.581
	Self-Stigma	-0.122	0.144	-0.098	-0.85	0.398	-0.028	0.100	-0.032	-0.28	0.780
Alcohol use	Perceived Stereotyping	-0.077	0.158	-0.052	-0.49	0.629	-0.030	0.094	-0.035	-0.32	0.750
	Devaluation	0.295	0.171	0.177	1.72	0.088	-0.134	0.176	-0.079	-0.76	0.447
	Discrimination	-0.410	1.939	-0.037	-0.21	0.833	5.089	4.833	0.184	1.05	0.295
	Self-Stigma	-0.203	0.216	-0.108	-0.94	0.349	-0.137	0.151	-0.105	-0.91	0.365
Drug use	Perceived Stereotyping	-0.244	0.132	-0.198	-1.86	0.066	-0.053	0.078	-0.072	-0.67	0.502
	Devaluation	0.344	0.142	0.244	2.42	0.017	0.047	0.145	0.033	0.33	0.745
	Discrimination	-0.120	1.613	-0.013	-0.08	0.941	5.773	4.021	0.247	1.44	0.154
	Self-Stigma	-0.124	0.183	-0.078	-0.68	0.498	0.003	0.128	0.002	0.02	0.983
Cigarette use	Perceived Stereotyping	0.015	0.164	0.010	0.09	0.929	0.026	0.098	0.029	0.27	0.791
	Devaluation	0.501	0.174	0.290	2.88	0.005	-0.142	0.178	-0.080	-0.80	0.428
	Discrimination	1.843	1.998	0.160	0.92	0.358	1.337	4.979	0.047	0.27	0.789
	Self-Stigma	0.414	0.222	0.213	1.86	0.065	0.182	0.155	0.134	1.18	0.242

Note: Each analysis was run as a hierarchical linear regression, first testing the (mean-centred) linear term of the independent variable, then adding the quadratic term to the model. The results presented are from the second model. *b* refers to the unstandardized coefficient and β refers to the standardised coefficient.

Table F2 – Statistical results for the relationship between coping strategies and stigma – those who had relapsed

Coping strategy (DV)	Independent variable	Linear term					Quadratic term				
		<i>b</i>	<i>SEb</i>	β	<i>t</i>	<i>p</i>	<i>b</i>	<i>SEb</i>	β	<i>t</i>	<i>p</i>
Secrecy	Perceived Stereotyping	0.241	0.098	0.318	2.46	0.016	0.050	0.060	0.109	0.84	0.404
	Devaluation	0.023	0.127	0.021	0.18	0.856	-0.139	0.177	-0.090	-0.78	0.437
	Discrimination	0.085	1.293	0.014	0.07	0.948	-0.494	2.249	-0.046	-0.22	0.827
	Self-Stigma	0.311	0.136	0.244	2.29	0.025	0.002	0.163	0.001	0.01	0.990
Withdrawal	Perceived Stereotyping	0.322	0.167	0.252	1.93	0.057	0.207	0.101	0.267	2.05	0.044
	Devaluation	0.761	0.197	0.413	3.86	<0.001	-0.333	0.276	-0.129	-1.21	0.231
	Discrimination	4.339	2.121	0.419	2.05	0.044	-5.691	3.688	-0.316	-1.54	0.127
	Self-Stigma	0.217	0.235	0.101	0.93	0.357	-0.085	0.280	-0.033	-0.30	0.762
Educating	Perceived Stereotyping	0.312	0.139	0.292	2.24	0.028	0.146	0.084	0.226	1.73	0.087
	Devaluation	0.600	0.161	0.390	3.73	<0.001	0.229	0.225	0.106	1.01	0.313
	Discrimination	4.269	1.745	0.493	2.45	0.017	-4.479	3.034	-0.297	-1.48	0.144
	Self-Stigma	0.367	0.193	0.205	1.90	0.061	-0.049	0.231	-0.023	-0.21	0.833
Challenging	Perceived Stereotyping	-0.012	0.146	-0.011	-0.08	0.935	0.004	0.088	0.006	0.04	0.965
	Devaluation	0.376	0.174	0.240	2.16	0.033	0.245	0.243	0.112	1.01	0.317
	Discrimination	2.552	1.827	0.290	1.40	0.166	-2.771	3.177	-0.181	-0.87	0.385
	Self-Stigma	-0.094	0.200	-0.052	-0.47	0.640	-0.078	0.239	-0.036	-0.33	0.745
Distancing	Perceived Stereotyping	-0.170	0.126	-0.177	-1.35	0.181	-0.148	0.077	-0.254	-1.93	0.057
	Devaluation	0.035	0.157	0.025	0.22	0.827	0.392	0.220	0.202	1.78	0.079
	Discrimination	1.279	1.629	0.164	0.79	0.435	-1.185	2.833	-0.087	-0.42	0.677
	Self-Stigma	-0.062	0.177	-0.038	-0.35	0.729	0.025	0.212	0.013	0.12	0.908
Alcohol use	Perceived Stereotyping	0.172	0.185	0.124	0.93	0.355	-0.028	0.112	-0.033	-0.25	0.806
	Devaluation	-0.318	0.231	-0.159	-1.38	0.171	0.203	0.323	0.072	0.63	0.531
	Discrimination	0.837	2.360	0.074	0.36	0.724	0.596	4.105	0.030	0.15	0.885
	Self-Stigma	-0.048	0.257	-0.020	-0.19	0.853	-0.025	0.307	-0.009	-0.08	0.935
Drug use	Perceived Stereotyping	-0.064	0.171	-0.050	-0.38	0.709	-0.103	0.104	-0.133	-1.00	0.321
	Devaluation	0.362	0.211	0.196	1.72	0.090	-0.034	0.295	-0.013	-0.12	0.907
	Discrimination	-0.389	2.171	-0.037	-0.18	0.858	2.287	3.776	0.127	0.61	0.546
	Self-Stigma	-0.225	0.235	-0.105	-0.96	0.340	-0.212	0.280	-0.083	-0.76	0.451
Cigarette use	Perceived Stereotyping	0.120	0.180	0.089	0.67	0.507	-0.062	0.109	-0.075	-0.57	0.572
	Devaluation	0.452	0.220	0.232	2.05	0.043	0.055	0.308	0.020	0.18	0.858
	Discrimination	-1.601	2.276	-0.146	-0.70	0.484	4.979	3.958	0.261	1.26	0.212
	Self-Stigma	0.334	0.246	0.147	1.36	0.179	-0.181	0.294	-0.067	-0.62	0.540

Note: Each analysis was run as a hierarchical linear regression, first testing the (mean-centred) linear term of the independent variable, then adding the quadratic term to the model. The results presented are from the second model. *b* refers to the unstandardized coefficient and β refers to the standardised coefficient.

Table F3 – Scores on the perceived and experienced stigma scales by those who had relapsed or not and those who had and had not sought help from a face-to-face gambling counsellor

Relapse status	Non-relapsed				Relapsed				Interaction statistic
Sought this type of help	No help		Yes help		No help		Yes help		
	Mean	SD	Mean	SD	Mean	SD	Mean	SD	
Perceived Stereotyping	5.44	.981	5.59	.844	5.45	.930	5.42	1.154	$F(1,195) = 0.373, p = 0.542$
Devaluation	.88	.801	1.37	.800	.94	.708	1.24	.713	$F(1,195) = 0.751, p = 0.387$
Discrimination	.07	.139	.05	.072	.06	.118	.08	.139	$F(1,195) = 1.414, p = 0.236$
Self-Stigma	.92	.748	1.02	.702	1.09	.517	1.10	.716	$F(1,195) = 0.192, p = 0.662$

Table F4 – Scores on the perceived and experienced stigma scales by those who had relapsed or not and those who had and had not sought help from a face-to-face non-gambling counsellor

Relapse status	Non-relapsed				Relapsed				Interaction statistic
Sought this type of help	No help		Yes help		No help		Yes help		
	Mean	SD	Mean	SD	Mean	SD	Mean	SD	
Perceived Stereotyping	5.48	1.015	5.49	.771	5.35	.986	5.55	1.109	$F(1,195) = 0.422, p = 0.517$
Devaluation	.87	.773	1.35	.859	.84	.681	1.41	.650	$F(1,195) = 0.144, p = 0.705$
Discrimination	.07	.135	.06	.098	.05	.094	.10	.159	$F(1,195) = 2.947, p = 0.088$
Self-Stigma	.90	.750	1.05	.697	.98	.633	1.24	.574	$F(1,195) = 0.288, p = 0.592$

Table F5 – Scores on the perceived and experienced stigma scales by those who had relapsed or not and those who had and had not sought help from a telephone gambling helpline

Relapse status	Non-relapsed				Relapsed				Interaction statistic
Sought this type of help	No help		Yes help		No help		Yes help		
	Mean	SD	Mean	SD	Mean	SD	Mean	SD	
Perceived Stereotyping	5.36	.996	5.83	.659	5.28	1.143	5.65	.845	$F(1,195) = 0.098, p = 0.755$
Devaluation	.94	.795	1.28	.883	.96	.720	1.26	.694	$F(1,195) = 0.027, p = 0.869$
Discrimination	.07	.138	.05	.064	.04	.062	.11	.178	$F(1,195) = 5.015, p = 0.026$
Self-Stigma	.86	.741	1.22	.653	1.04	.637	1.17	.592	$F(1,195) = 1.197, p = 0.275$

Table F6 – Scores on the perceived and experienced stigma scales by those who had relapsed or not and those who had and had not sought help from online or email gambling counselling

Relapse status	Non-relapsed				Relapsed				Interaction statistic
Sought this type of help	No help		Yes help		No help		Yes help		
	Mean	SD	Mean	SD	Mean	SD	Mean	SD	
Perceived Stereotyping	5.44	1.010	5.62	.668	5.46	1.041	5.39	1.054	$F(1,195) = 0.607, p = 0.437$
Devaluation	.91	.796	1.38	.845	.94	.712	1.40	.648	$F(1,195) = 0.002, p = 0.963$
Discrimination	.06	.134	.06	.084	.06	.108	.09	.165	$F(1,195) = 0.446, p = 0.505$
Self-Stigma	.92	.758	1.05	.652	1.04	.639	1.22	.564	$F(1,195) = 0.046, p = 0.830$

Table F7 – Scores on the perceived and experienced stigma scales by those who had relapsed or not and those who had and had not sought help from a residential gambling treatment program

Relapse status	Non-relapsed				Relapsed				Interaction statistic
Sought this type of help	No help		Yes help		No help		Yes help		
	Mean	SD	Mean	SD	Mean	SD	Mean	SD	
Perceived Stereotyping	5.49	.961	5.31	.688	5.43	1.004	5.44	1.424	$F(1,195) = 0.125, p = 0.724$
Devaluation	.96	.806	1.85	.680	1.05	.724	1.42	.644	$F(1,195) = 1.735, p = 0.189$
Discrimination	.06	.126	.08	.104	.05	.080	.21	.325	$F(1,195) = 4.236, p = 0.041$
Self-Stigma	.95	.744	.95	.627	1.11	.623	.91	.577	$F(1,195) = 0.308, p = 0.580$

Table F8 – Scores on the perceived and experienced stigma scales by those who had relapsed or not and those who had and had not sought help from a face-to-face service like Gamblers Anonymous

Relapse status	Non-relapsed				Relapsed				Interaction statistic
Sought this type of help	No help		Yes help		No help		Yes help		
	Mean	SD	Mean	SD	Mean	SD	Mean	SD	
Perceived Stereotyping	5.42	.949	5.75	.889	5.44	.867	5.41	1.395	$F(1,195) = 1.142, p = 0.287$
Devaluation	.95	.834	1.35	.725	.90	.684	1.55	.600	$F(1,195) = 0.928, p = 0.336$
Discrimination	.06	.132	.06	.082	.04	.067	.13	.204	$F(1,195) = 4.692, p = 0.032$
Self-Stigma	.90	.755	1.18	.589	1.04	.613	1.22	.627	$F(1,195) = 0.208, p = 0.649$

Table F9 – Scores on the perceived and experienced stigma scales by those who had relapsed or not and those who had and had not sought help from a online support group or discussion forum

Relapse status	Non-relapsed				Relapsed				Interaction statistic
Sought this type of help	No help		Yes help		No help		Yes help		
	Mean	SD	Mean	SD	Mean	SD	Mean	SD	
Perceived Stereotyping	5.42	.973	5.67	.823	5.49	.962	5.21	1.320	$F(1,195) = 2.255, p = 0.135$
Devaluation	.92	.827	1.37	.740	1.02	.702	1.37	.751	$F(1,195) = 0.144, p = 0.705$
Discrimination	.06	.130	.06	.103	.05	.088	.14	.218	$F(1,195) = 4.661, p = 0.032$
Self-Stigma	.91	.758	1.05	.648	1.06	.610	1.23	.652	$F(1,195) = 0.015, p = 0.902$

Table F10 – Scores on the perceived and experienced stigma scales by those who had relapsed or not and those who had and had not sought help from family or friends

Relapse status	Non-relapsed				Relapsed				Interaction statistic
Sought this type of help	No help		Yes help		No help		Yes help		
	Mean	SD	Mean	SD	Mean	SD	Mean	SD	
Perceived Stereotyping	5.39	1.002	5.64	.810	5.42	.894	5.45	1.161	$F(1,195) = 0.605, p = 0.438$
Devaluation	.78	.749	1.46	.786	.88	.706	1.27	.691	$F(1,195) = 1.895, p = 0.170$
Discrimination	.07	.139	.06	.093	.05	.100	.08	.148	$F(1,195) = 1.115, p = 0.292$
Self-Stigma	.83	.760	1.15	.642	1.08	.627	1.10	.618	$F(1,195) = 2.317, p = 0.130$

Table F11 – Scores on the perceived and experienced stigma scales by those who had relapsed or not and those who had and had not sought help by self-exclusion from venue

Relapse status	Non-relapsed				Relapsed				Interaction statistic
Sought this type of help	No help		Yes help		No help		Yes help		
	Mean	SD	Mean	SD	Mean	SD	Mean	SD	
Perceived Stereotyping	5.40	.918	5.66	.986	5.47	.937	5.38	1.192	$F(1,195) = 1.423, p = 0.234$
Devaluation	.96	.792	1.16	.897	1.00	.695	1.23	.747	$F(1,195) = 0.016, p = 0.899$
Discrimination	.07	.133	.04	.101	.07	.113	.06	.150	$F(1,195) = 0.132, p = 0.717$
Self-Stigma	.93	.772	.98	.651	.99	.670	1.25	.501	$F(1,195) = 1.008, p = 0.317$

Table F12 – Scores on the perceived and experienced stigma scales by those who had relapsed or not and those who had and had not sought help by self-exclusion from website or operator

Relapse status	Non-relapsed				Relapsed				Interaction statistic
Sought this type of help	No help		Yes help		No help		Yes help		
	Mean	SD	Mean	SD	Mean	SD	Mean	SD	
Perceived Stereotyping	5.48	.974	5.48	.862	5.51	1.057	5.29	1.006	$F(1,195) = 0.478, p = 0.490$
Devaluation	.97	.814	1.16	.866	1.14	.707	.97	.747	$F(1,195) = 2.116, p = 0.147$
Discrimination	.07	.136	.05	.080	.07	.106	.07	.167	$F(1,195) = 0.252, p = 0.616$
Self-Stigma	.92	.796	1.03	.520	1.08	.634	1.13	.596	$F(1,195) = 0.062, p = 0.804$

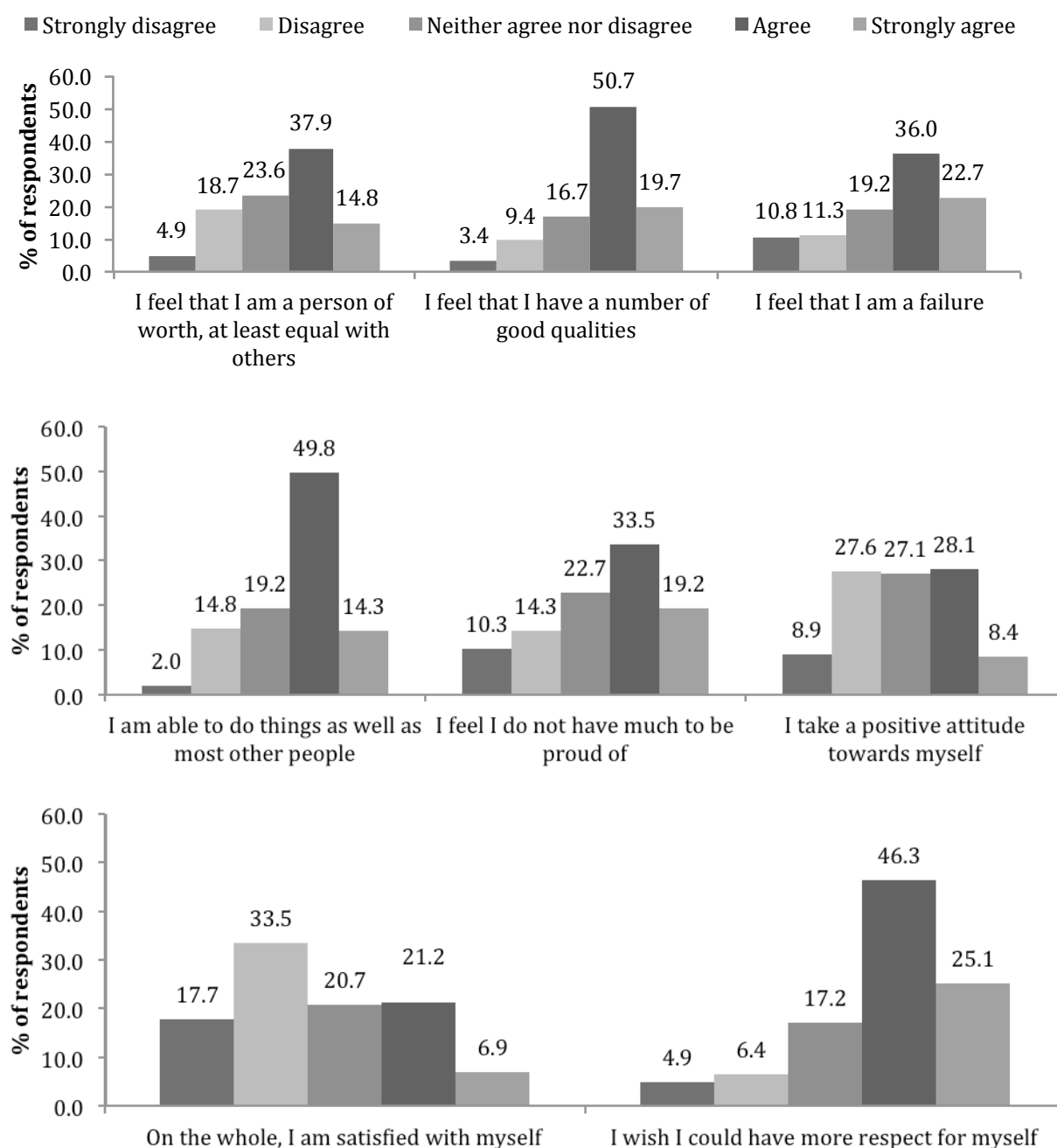
Table F13 – Scores on the perceived and experienced stigma scales by those who had relapsed or not and those who had and had not sought help from self-help strategies

Relapse status	Non-relapsed				Relapsed				Interaction statistic
Sought this type of help	No help		Yes help		No help		Yes help		
	Mean	SD	Mean	SD	Mean	SD	Mean	SD	
Perceived Stereotyping	5.21	.920	5.70	.908	5.08	.926	5.54	1.055	$F(1,195) = 0.014, p = 0.905$
Devaluation	.92	.838	1.10	.816	.88	.724	1.15	.714	$F(1,195) = 0.136, p = 0.713$
Discrimination	.07	.130	.03	.049	.06	.120	.08	.142	$F(1,195) = 1.917, p = 0.168$
Self-Stigma	.81	.799	1.05	.663	.93	.575	1.14	.627	$F(1,195) = 0.010, p = 0.922$

Psychological constructs

Self-esteem

In response to the self-esteem scale, most respondents reported being at least somewhat dissatisfied with themselves, feeling useless, wishing they could have more respect for themselves, that at times they think they are no good at all, that they are a failure and that they do not have much to be proud of. However, most respondents also reported feeling that they have a number of good qualities, that they are able to do things as well as most other people, and that they feel that they are of worth, at least equal with others (Figure F1).



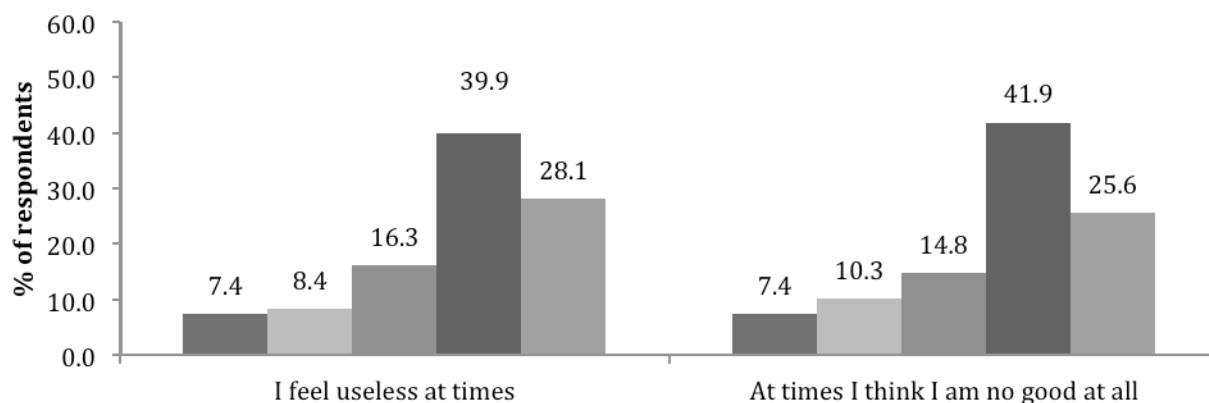


Figure F1 – Responses to items on the Self-Esteem Scale

Psychological distress

Responses for each item on the Kessler 6 scale indicate that these feelings of lack of self-worth illustrated in Figure F2 are present at least some of the time for the majority of respondents in the sample.

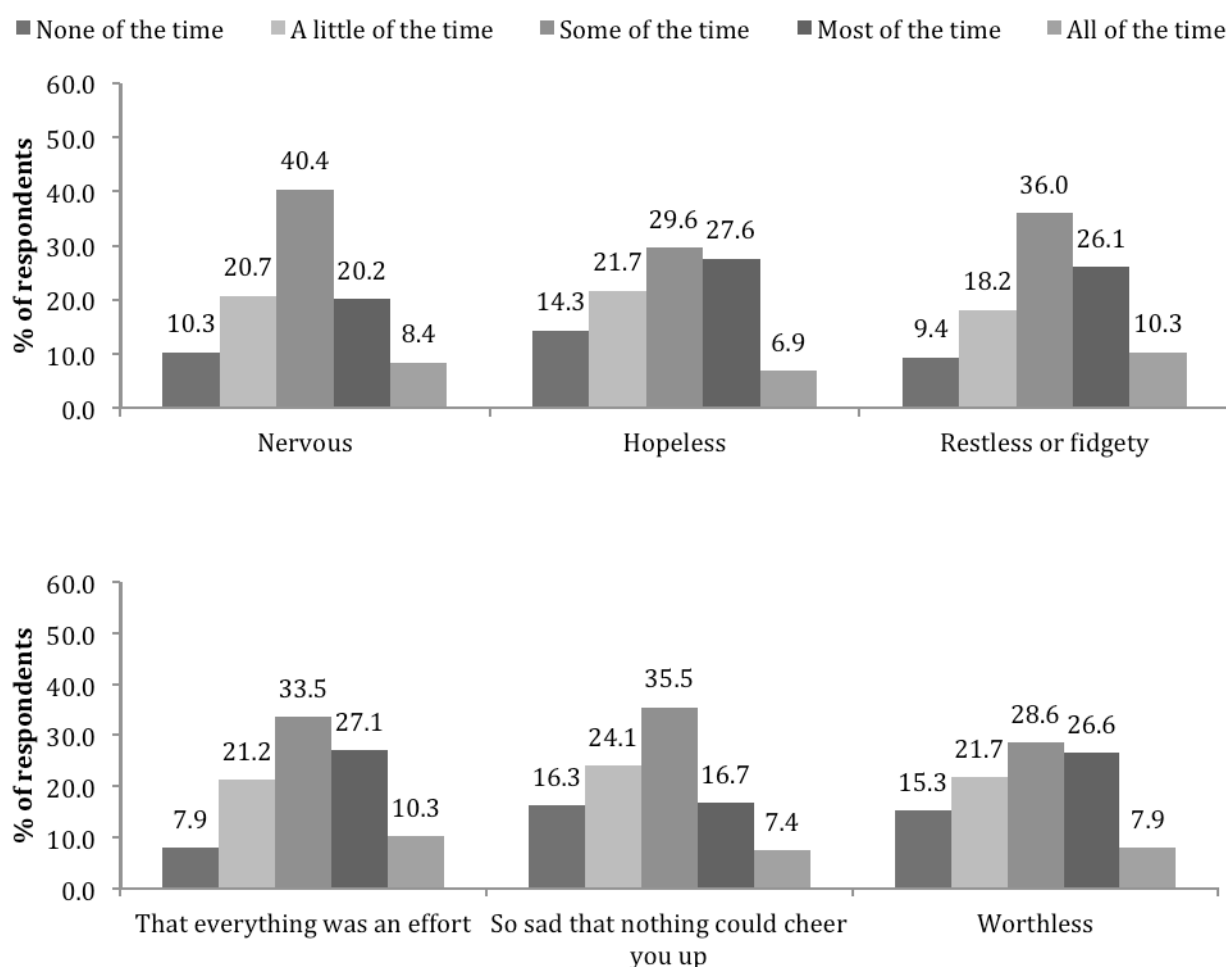


Figure F2 – Responses to items on the Kessler 6 Scale

Note: The question stem was “During the past 4 weeks (28 days), how often did you feel:”

Problem gambling

Responses to the PGSI indicate that more than two-thirds of respondents had experienced each of the PGSI items at least some of the time in the last 12 months, with more than half experiencing most items most of the time with the exception of: borrowing or selling anything to get money to gamble and being criticised by others about their gambling (Figure F3).

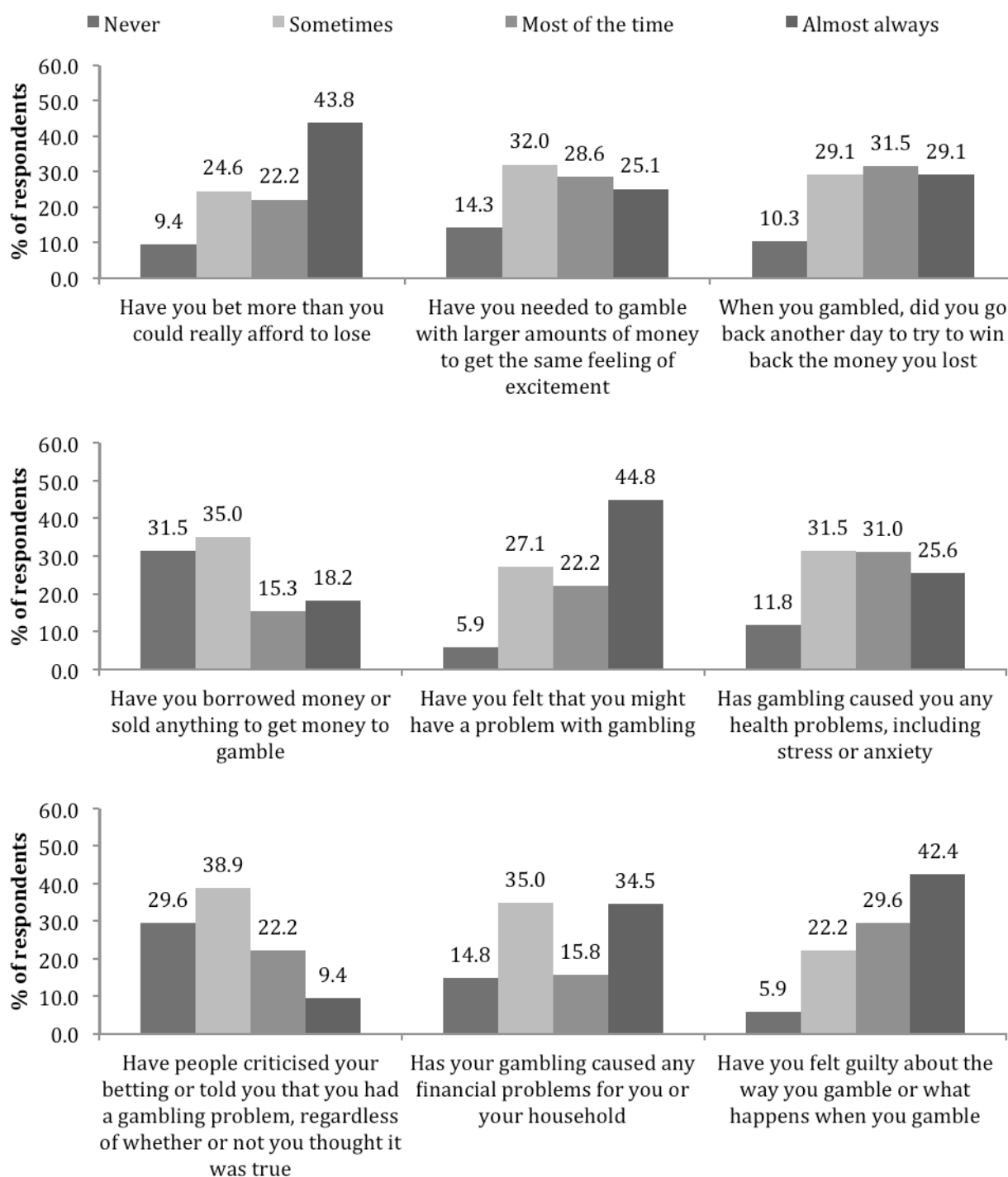


Figure F3 – Responses to items on the PGSI

Note: The question stem was “In the last 12 months, how often:”

Most problematic gambling form

More than half of the respondents reported that EGMs were the form of gambling that has caused them most problems, with horse or dog race betting and sports betting rated as the second and third most problematic forms (Figure F4).

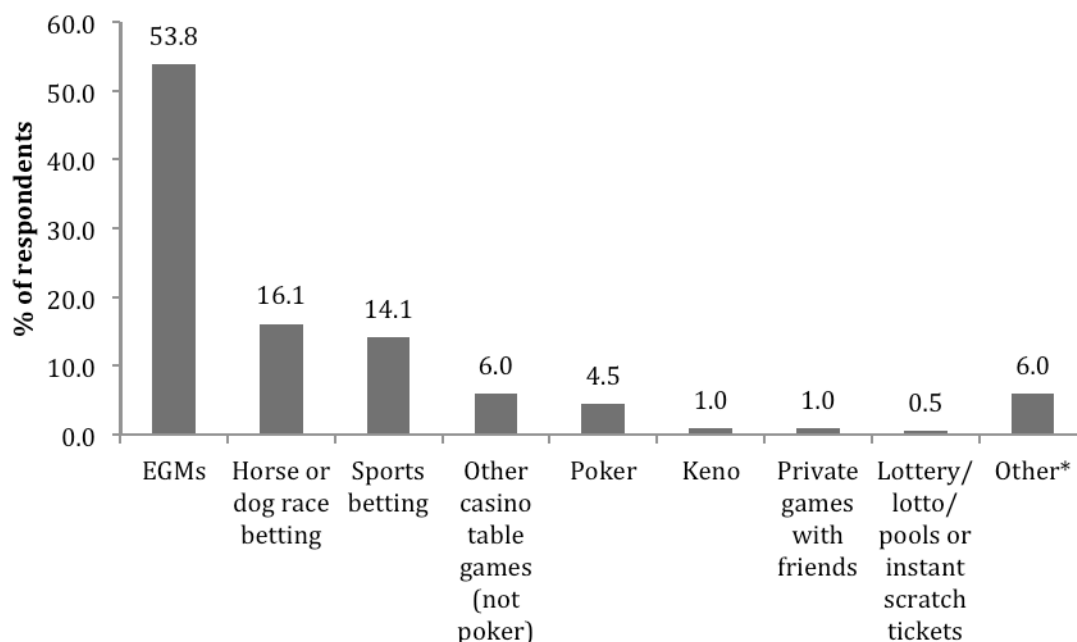


Figure F4 – Responses to question about most problematic type of gambling

Note: Of the seven “other” responses, three indicated a combination of EGMs and sports betting, two indicated EGMs online or as an app on their tablet, one indicated online gaming casinos and one indicated foreign currency.

Self-consciousness

Most respondents reported being conscious about how they look to others, both physically and in terms of making good impressions (Figure F5).

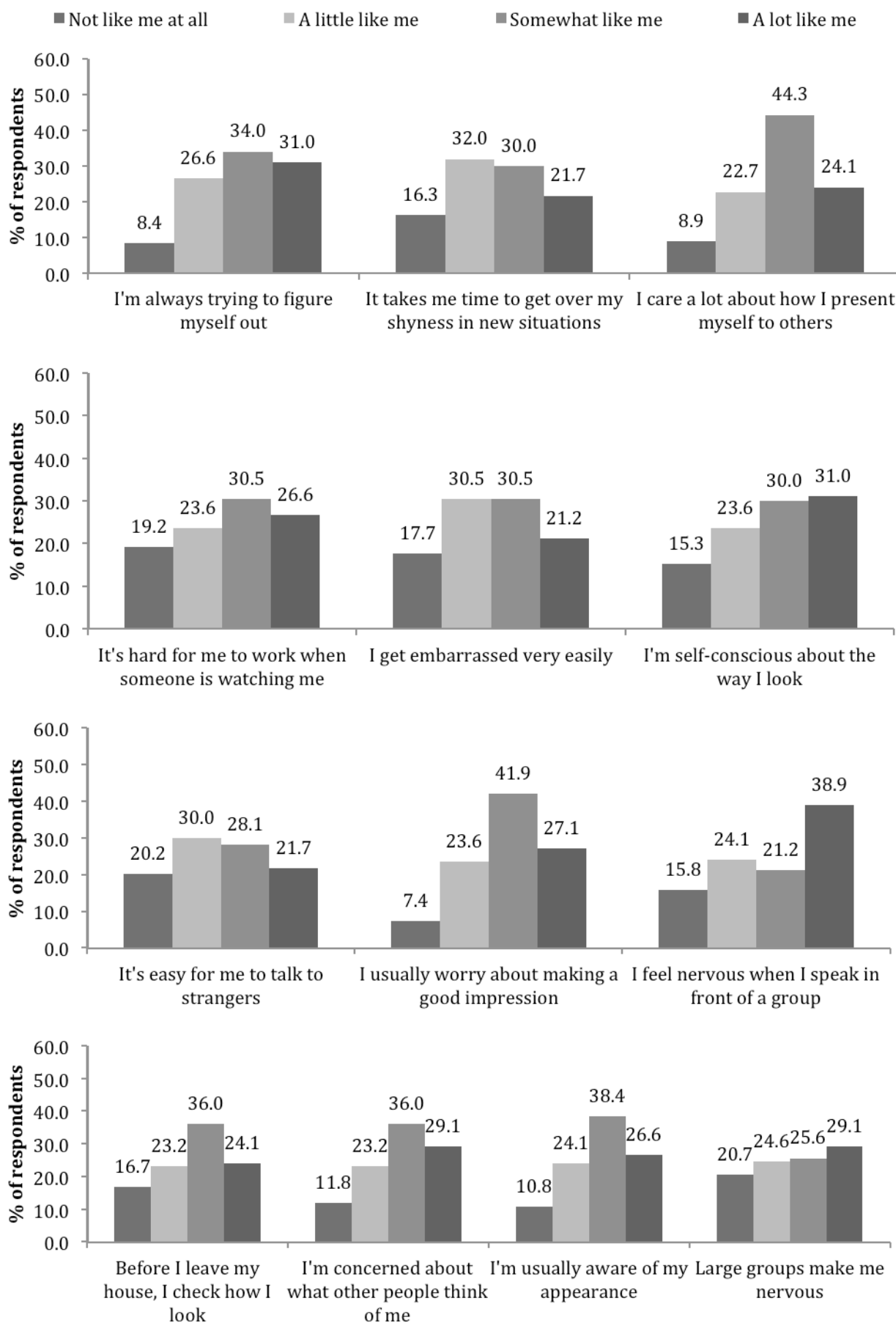


Figure F5 – Responses to items on the Self-Consciousness Scale

Comparisons of perceived and experienced stigma by demographic variables

The tables and text below relate to the bivariate analyses conducted for Section 5.9.1.

Gender

Females were significantly more likely to have higher scores on the Perceived Stereotyping Scale and the Self-Stigma Scale compared to males. No gender differences were observed for scores on the Devaluation Scale or Discrimination Scale.

Table F14 – Gender comparisons on perceived and experienced stigma scales

Scale	Male		Female		Statistic
	Mean	SD	Mean	SD	
Perceived Stereotyping	5.30	0.94	5.76*	1.00	$t(201) = 3.24, p = 0.001$
Devaluation	1.08	0.76	0.94	0.82	$t(201) = 1.25, p = 0.214$
Discrimination	0.07	0.13	0.06	0.11	$t(201) = 0.65, p = 0.517$
Self-Stigma	0.83	0.75	1.20*	0.77	$t(201) = 3.29, p = 0.001$

Note: * indicates the significantly higher mean.

Age

Relationships between age of the respondents and the four scales were analysed using linear regression. Linear terms were initially considered, as were curvilinear (such as quadratic) terms. No non-linear terms were significant, so linear terms are presented below.

Older respondents were significantly more likely to report lower levels of devaluation and lower levels of discrimination. No significant linear relationship was observed between age and perceived stereotyping or self-stigma.

Table F15 – Results from linear regressions predicting perceived and experienced stigma scales with age

Scale	Linear term				
	<i>b</i>	<i>SEb</i>	β	<i>t</i>	<i>p</i>
Perceived Stereotyping	0.002	0.005	0.031	0.44	0.658
Devaluation	-0.009	0.004	-0.164	2.36	0.019
Discrimination	-0.001	0.001	-0.159	2.28	0.024
Self-Stigma	0.007	0.004	0.128	1.82	0.070

State of residence

Respondents from different jurisdictions were compared on the four scales using a series of one-way ANOVAs followed by Tukey pairwise comparisons. None of the ANOVA omnibus tests or the pairwise comparisons were statistically significant, indicating no significant difference between residents of different states and territories in terms of perceived or experienced stigma.

Language spoken at home

No significant differences were observed in any of the four scales between those who speak English as their first language at home and those who do not.

Table F16 – Comparisons between those who speak English at home and those who do not on perceived and experienced stigma scales

Scale	English		Language other than English		Statistic
	Mean	SD	Mean	SD	
Perceived Stereotyping	5.42	0.99	5.79	0.82	$t(201) = 1.47, p = 0.144$
Devaluation	1.02	0.77	1.18	0.90	$t(201) = 0.82, p = 0.410$
Discrimination	0.06	0.13	0.05	0.07	$t(201) = 0.31, p = 0.755$
Self-Stigma	0.94	0.79	1.11	0.55	$t(201) = 0.82, p = 0.415$

Religion

Comparisons were made between those identifying with different religions in terms of the four scales used to measure perceived and experienced stigma. However, as some groups had only a small number of respondents (one respondent each for Islam and Judaism and three respondents each for Buddhism and Hinduism), these groups were combined into an 'other' religion category. No differences were observed between the Christian religions in terms of the scales and they were also combined below.

Those in the 'other' religious category reported significantly higher levels of perceived stereotyping compared to the Christian and No Religion groups. No significant differences were detected in terms of devaluation, discrimination or self-stigma.

Table F17 – Religion comparisons on perceived and experienced stigma scales

Scale	Christian		Other		No religion		Statistic
	Mean	SD	Mean	SD	Mean	SD	
Perceived Stereotyping	5.45 _a	1.01	6.25 _b	0.43	5.40 _a	0.92	$F(2,188) = 4.64, p = 0.011$
Devaluation	1.00	0.76	1.18	0.76	0.99	0.78	$F(2,188) = 0.36, p = 0.697$
Discrimination	0.05	0.08	0.05	0.07	0.08	0.15	$F(2,188) = 1.79, p = 0.169$
Self-Stigma	1.03	0.75	1.12	0.93	0.89	0.77	$F(2,188) = 1.06, p = 0.348$

Note: 'Christian' here refers to anyone identifying as Catholic, Protestant/Anglican or 'other Christian', while 'Other' refers to anyone identifying their religion as Buddhism, Hinduism, Islam, Judaism or 'other religion'. Subscripts (a,b) denote significant differences between the groups where they were detected. Groups with the same subscript do not differ significantly from each other.

Household income

Relationships between household income of respondents and the four scales were analysed using linear regression. Linear terms were initially considered, as were curvilinear (such as quadratic) terms. No non-linear terms were significant, so linear terms are presented below. Non-parametric (Spearman's) correlations were also considered and no significant results were found.

The results suggest no relationship between household income and perceived or experienced gambling-related stigma.

Table F18 – Results from linear regressions predicting perceived and experienced stigma scales with income

Scale	Linear term				
	<i>b</i>	<i>SEb</i>	β	<i>t</i>	<i>p</i>
Perceived Stereotyping	-0.012	0.014	-0.063	-0.82	0.411
Devaluation	0.001	0.010	0.004	0.05	0.959
Discrimination	-0.001	0.002	-0.043	0.55	0.581
Self-Stigma	-0.002	0.011	-0.011	0.14	0.889

