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Gender differences in felt stigma and barriers to help-seeking for problem gambling

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ABSTRACT

Background: Men and women differ in their patterns of help-seeking for health and social problems. For people experiencing problem gambling, feelings of stigma may affect if and when they reach out for help. In this study we examine men's and women's perceptions of felt stigma in relation to help-seeking for problematic gambling.
Methods: Using concept mapping, we engaged ten men and eighteen women in group activities. We asked men and women about their perceptions of the pleasurable aspects and negative consequences of gambling; they generated a list of four hundred and sixteen statements. These statements were parsed for duplication and for relevance to the study focal question and reduced to seventy-three statements by the research team. We then asked participants to rate their perceptions of how much felt stigma (negative impact on one's own or family's reputation) interfered with help-seeking for gambling. We analyzed the data using a gender lens.
Findings: Men and women felt that shame associated with gambling-related financial difficulties was detrimental to help-seeking. For men, the addictive qualities of and emotional responses to gambling were perceived as stigma-related barriers to help-seeking. For women, being seduced by the 'bells and whistles' of the gambling venue, their denial of their addiction, their belief in luck and that the casino can be beat, and the shame of being dishonest were perceived as barriers to help-seeking.
Conclusions: Efforts to engage people who face gambling problems need to consider gendered perceptions of what is viewed as stigmatizing.

1. Background

1.1. Gambling, stigma, and help-seeking

Like mental illness and substance use, help-seeking for problem gambling can be impeded by public stigma and discrimination (Hing, Holdsworth, Tiyce, & Breen, 2013; Hing & Nuske, 2011; Horch, 2011; Horch & Hodgins, 2008; Pulford et al., 2009; Suurvali, Cordingley, Hodgins, & Cunningham, 2009). People with gambling disorders may fail to seek treatment because of felt stigma. For example, only 25% of people experiencing a gambling problem seek help (Suurvali, Hodgins, Toneatto, & Cunningham, 2008). The reasons that people fail to seek help are related to their sense of self and reputation. In their review, Suurvali et al. (2009) found that people want to avoid embarrassment, shame and stigma and in so doing do not reach out for help. This fear of stigma is a predictor of delayed treatment-seeking (Tavares et al., 2003). Hing and Nuske (2011), for example, discovered that patrons of gambling venues were reticent to seek help because of feelings of shame.

Stigmatization by professionals working with clients diagnosed as pathological gamblers is reinforced by the language of the medical community and the media (Grunfeld, Zangeneh, & Grunfeld, 2004; Rockloff & Schofield, 2004). Many providers endorse popular stereotypes of pathological gambling that create a picture of the 'gambler' as unable to control him/herself, irresponsible, and as liars and criminals (Grunfeld et al., 2004; Rockloff & Schofield, 2004). Such labeling breeds stigma and can stand in the way of a person seeking help especially if problem gambling is viewed as socially unacceptable and an activity shrouded in secrecy and shame. This is compounded by the fact that people who engage in problem gambling are often perceived as weak willed and irresponsible by work colleagues and family (Rosecrance, 1985).

Public stigma, when internalized by people experiencing gambling problems, is then experienced as felt stigma; the experiences of shame and embarrassment felt by an individual who holds a particular attribute or engages in a particular behavior that is deemed socially or morally unacceptable by the 'majority' of society (Goffman, 1959; Hing et al., 2013). Hing et al. (2013) argue that there has been little

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research on how felt stigma may impact help seeking behaviours, especially in relation to problem gambling.

1.2. Gender and help-seeking

Women are more likely to seek help for problem gambling. An Australian study found that 32% of women versus 13% of men sought treatment for gambling problems (Slutske, Blaszczynski, & Martin, 2009). Rockloff and Schofield (2004) identified several gender-based differences in willingness to seek help for problem gambling. Men are less likely to seek help because of perceived shame, embarrassment and associated stigma. Women often delay seeking help because they deny that they have a problem; they can be reticent to stop gambling because they will lose an important social network. What is missing from the literature are those forces or factors that generate feelings of shame and how these may differ by gender. For example are men more likely to feel shame or perceive that financial difficulties are shameful and delay seeking help?

Findings from qualitative studies of problem gambling suggest that stigma plays a key role in the public's perception of gamblers and that women with gambling problems are perceived more negatively than men (Grunfeld et al., 2004; Panel, 2003). This may explain why women who are pathological gamblers are less likely to seek or enter treatment for gambling-related problems, a situation analogous to treatment of women with alcohol problems. In the past, the stigma of being an alcoholic was sufficiently excessive that women were reluctant to seek treatment. Furthermore, when women did reach out for help they were often misdiagnosed (Sandmaier, 1980; Volberg, 1994). Studies suggest that those who seek help have a greater variety and intensity of psychological problems than those who do not seek help (Shaffer & Korn, 2002).

The aim of this paper is to better understand experiences of felt stigma as a barrier to help-seeking for men and women experiencing problem gambling. Understanding the factors that inhibit people from getting the help they need for problem gambling can be beneficial in our design of gender-based interventions that facilitate behavior change. We also recognize that there is a paucity of studies that explore problem gambling, help-seeking and stigma from a gendered lens (Hing et al., 2013). This paper explores the idea that felt stigma may be connected to the decisions of men and women to seek help for gambling problems. We did this by asking people – those engaged in gambling behavior, family of people engaged in such behavior and health service providers – about their perceptions of the impact of felt stigma on help-seeking for gambling problems.

2. Methods

2.1. Research design

We used Concept Mapping,[1] a mixed methods approach, to engage with a sample of twenty-eight individuals who were identified as appropriate candidates for the research study (Kane & Trochim, 2007; Trochim, 1989). Concept Mapping is a unique approach to collecting data, as not only do research participants come together as a group to respond to research questions, but they also have the opportunity during the Concept Mapping process to contribute to the analysis and interpretation of the data (O'Campo, Burke, Peak, Mcdonnell, & Gielen, 2005). Used commonly in program evaluation and public health and most recently in studies of mental health and violence (Burke, O'Campo, & Peak, 2006; Johnsen, Biegel, & Shafran, 2000; O'Campo, Salmon, & Burke, 2009; O'Campo et al., 2005), Concept Mapping is also considered to be in keeping with feminist approaches to social research as the perspectives of the participants take precedence over the interpretations of the researcher (Campbell & Salem, 1999).

Concept mapping is a participatory research method that was developed by social scientist William Trochim and has been frequently used in evaluation, education and organizational planning. According to Trochim (2006): "Concept mapping is a structured process, focused on a topic or construct of interest, involving input from one or more participants, that produces an interpretable, pictorial view (concept map) of their ideas and concepts and how they are interrelated." In essence it is a method that encompasses integrated Knowledge Translation practices (CIHR, 2012), such that participants and researchers work together to create, analyse and interpret knowledge. Concept Mapping uses a staged approach to collect and collate data. In our case, participants came together as a group to brainstorm answers to a focal question, participants and researchers reviewed the final list of items (parsed for duplicates by the research team), participants sorted the items into piles of similar items and provided names for each group of items. These data were input into the software to facilitate the co-development of concept maps. Finally, participants rated each item according to rating questions specific to help-seeking in the context of stigma. The Concept Mapping software allows researchers to input data on site with participants to enable co-interpretation of the data (e.g., co-creation of the concept maps). The study team was particularly intent on obtaining an in-depth understanding of the research participants' negative and positive perceptions of gambling and how felt stigma might impact their willingness to seek help for gambling problems. The study was approved by the Research Ethics Board of St. Michael's Hospital and all participants gave written and informed consent.

2.2. Participants

Purposive sampling was used to recruit participants who reflected: people who engaged in gambling as a leisure activity and those for whom gambling was problematic, family members of people experiencing gambling problems, and health care providers who deliver gambling treatment. Purposive sampling is the "deliberate choice of an informant based on the qualities the informant possesses" (Tongco, 2007). Purposive sampling allows the researcher to select key informants who are particularly knowledgeable in the area that is the subject of the research and are very willing to share their knowledge (Tongco, 2007). In order to more fully understand problem gambling, it is not only important to understand the views of people experiencing gambling problems, but also the perspectives of other people whose lives are affected by someone who has a gambling problem. Consequently, it was decided that family members of people with gambling problems and health care providers would also be recruited to participate in the study. The majority of research participants were recruited by placing flyers at a gambling facility in Toronto, Ontario operated by the Ontario Lottery and Gaming Corporation. Interested participants called the study personnel and were screened for the following criteria: over the age of eighteen, had themselves gambled or had a family member who gambled within the last twelve months, had good oral and written English language skills and were able to attend two group activities held on different dates. Health care professionals were recruited for the study through research staff members who had worked with those individuals in the past.

2.3. Materials

During the screening process, individuals (other than health care providers) were screened for problems using the South Oaks Gambling Screen Short Form (SOGS-SF) (Strong, Breen, Lesieur, & Lejuez, 2003). The SOGS-SF is a reliable and valid instrument that can quickly determine if an individual is experiencing pathological gambling (Lesieur & Blume, 1987; Strong et al., 2003).

[1] Concept Systems. The Concept System. Ithaca, NY: Concept Systems Inc.; 2004. http://www.conceptsystems.com.http://www.conceptsystems.com.