

# **Building Knowledge of Stigma Related to Gambling and Gambling Harms in Great Britain**

**A scoping review of the literature**

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# Glossary

**DSM:** *The Diagnostic and Statistical Manual of Mental Disorders* is a publication by the American Psychiatric Association for the classification of mental disorders using a common language and standard criteria (American Psychiatric Association, 2013).

**GPI:** *The Gambling Problem Index* was developed in Canada and is a 31-item measure used for screening purposes to determine whether a person in the general population may have a gambling problem (McCready and Adlaf, 2006).

**GQPN:** *The Gambling Quantity and Perceived Norms* is a questionnaire used to assess the frequency of gambling, money spent (lost) and won due to gambling, perceptions of other's frequency of gambling, and perceptions of other's losses and wins due to gambling (Neighbors et al., 2002).

**GRTC:** *The Gambling Readiness to Change* questionnaire is designed to identify how someone feels about their gambling right now (Neighbors et al., 2002).

**PCC:** *The Population, Concept, Context* is a framework recommended by the Joanna Briggs Institute to identify the main concepts in primary review questions (Peters et al., 2020).

**PGSI:** *The Problem Gambling Severity Index* is a nine-item standardised measure for measuring the severity of gambling problems in the general population. It is a tool based on research on the common signs and consequences of problems related to gambling (Currie et al., 2013b, Ferris and Wynne, 2001).

**PRISMA-ScR:** *The Preferred Reporting Items for Systematic Reviews and Meta-Analyses Extension for Scoping Reviews* is a checklist that contains 20 essential reporting items and two optional items to include when completing a scoping review. Scoping reviews serve to synthesise evidence and assess the scope of literature on a topic (Tricco et al., 2018).

**HSDF:** *The Health Stigma and Discrimination Framework* is a global, crosscutting framework based on theory, research, and practice to conceptualise and respond to health-related stigmas (Stangl et al., 2019).

# Executive summary

Stigmatisation has been described as a negative consequence of gambling and gambling harms. While stigma related to health conditions (e.g. HIV, cancer, and obesity), identities (e.g. gender, sexuality, race, etc.), behaviours (e.g. sexual practice, drug use) and occupations (e.g. sex work) has been well-studied over the last few decades, stigma related to gambling and gambling harms is a nascent area of research.

To fill this gap, we carried out a scoping review of the literature to: (1) provide a critical analysis of current research and understandings, establishing how existing understandings of gambling and gambling harm reproduce stigma, (2) describe the nature of stigma related to gambling and gambling harms, how it comes about and how it compares to other forms of stigma, (3) examine stigma as a barrier to accessing support, service and healthcare provision, and support in the community and from peers, and (4) provide a set of recommendations for future research, service provision and policy for reducing stigma related to gambling and gambling harms.

In order to address these a priori aims of the scoping review, we used two different approaches: (A) we reviewed and synthesised the findings and insights from research into gambling stigma (i.e. scoping review), and (B) treated the gambling literature we identified as data which we analysed to measure presence of stigmatising content therein (i.e. textual analysis).

## Key findings from the review:

- Our textual analysis identified a significant amount of published research on gambling and gambling harms that used stigmatising language and portrayals to describe people who struggle with gambling and experience gambling harms. Labelling and stereotyping were common among the studies reviewed, linking gambling with other negative stereotypes and stigmatised conditions and behaviours, particularly around drug use, alcohol use and mental health.
- We found extensive use of stigmatising terms like 'problem gambler' and 'gambling addict' which can reflect/feed into narratives that construct people who experience gambling harms as being a 'problem', rather than 'having' a problem/illness. The use of such terms or narratives in research, public health campaigns, and on the websites of non-governmental organisations (NGOs) that provide services to mitigate gambling harms, unwittingly places blame directly on the individual who gambles.

- Importantly, our scoping review and textual analysis suggests that the stigmatisation process in people who struggle with gambling is very similar – and similarly detrimental (e.g. people experiencing stigma and discrimination are less likely to access support and treatment) – to the stigmatisation that unfolds in the context of health behaviours and conditions, such as mental health, substance and alcohol use, cancer, obesity and HIV.
- A few studies we reviewed examined stigma as a barrier to help-seeking among people who struggle with gambling (to mitigate gambling harms or limit/stop gambling) and offered insights for future programming. From the service and healthcare provider perspective, evidence-based models of delivery that involve collaboration and expertise from across sectors – notably including communities of people with lived experience of gambling harm and of stigmatisation, with services centrally located – can increase service uptake and may discourage feelings of stigma and shame.

## Key recommendations for research, service provision and policy:

### Best practice

- Establish how people who experience gambling harms are stigmatised in society and what their experience is of stigmatisation. For GambleAware, the remit of this would be in Great Britain. Particularly, research should identify how people who gamble and experience gambling harms are:
  - stigmatised and discriminated against by service and healthcare providers
  - stigmatised in civil society, and in the third sector
  - stigmatised and discriminated against in the community and by families
  - stigmatised in political and policy discourse.
- Conduct research on how gambling-related stigma affects multiply marginalised populations who struggle with gambling in addition to other challenges (e.g. drug use, anxiety and depression, minority status, homelessness, etc.) to inform policy and intervention development.

- Ensure that interventions, programmes and campaigns are evidence-based and informed by relevant stigma and discrimination frameworks, such as the Health Stigma and Discrimination Framework.
- Researchers and programmers should use person-first language in their studies and programmes to show that gambling disorder is a mental disorder, not an identity.
  - For example, use 'person with a gambling disorder' or 'person who struggles with gambling' instead of 'addict' or 'problem gambler'.
  - Using person-first language also shows that a person with gambling disorder 'has' a problem, rather than 'is' the problem.
  - Lastly, person-first language avoids eliciting negative associations, punitive attitudes, and individual blame.
  - Stigmatising terms should not be used about people who experience gambling harms. For example, the term 'addict' reduces someone to their disorder.

### Derived from our scoping review and textual analysis

- Ensure that people who struggle with gambling and those with lived experience of gambling harms are actively engaged in all research, programme, and policy development efforts. This may require supporting community members in the form of training and/or counselling to overcome internalised stigma, or the belief that negative stereotypes about people who struggle with gambling are true and apply to themselves.
- Raise awareness among the public, healthcare providers, the third sector, policy makers and the gambling industry of what gambling stigma is and how it is harmful to people who struggle with gambling, as well as their families (i.e. preventing them from accessing services to mitigate gambling harms). Campaigns should also note the intersectional nature of gambling stigma, which often co-occurs with stigmas related to identity (e.g. age, gender, race, socioeconomic status), other existing health conditions (e.g. mental health challenges, chronic illnesses) and behaviours (e.g. drug and alcohol use).
- Train healthcare providers on gambling stigma (including how it interferes with care and treatment), and on strategies they can use for helping their clients cope with gambling-related stigma, as well as gambling harms. For example, delivering integrated services in a one-stop-shop, co-located with other health services in a central location.

- Provide support services for people who struggle with gambling. These should be empowering; support autonomy, empathy, compassion and sincerity; and promote respectful communication, as well as tailored and holistic life planning.

### **Key recommendations for media campaigns and messaging (best practice / informed by the scoping review and textual analysis):**

To avoid stigmatizing the people you are trying to help when designing a campaign, **do not:**

- link gambling with other stigmatised conditions or behaviours
- try to instil fear with the images selected
- shame and blame people who gamble.

To facilitate behaviour change in a non-stigmatizing way when designing a campaign, **do:**

- use images that empower and motivate people to change their behaviour
- utilise opinion leaders (e.g. individuals who exert a significant amount of influence within their network and who can affect the opinions of connected individuals) to deliver messages
- actively engage the community of people who struggle with gambling throughout the campaign development process
- name stigma and describe its harmful consequences
- use person-first language.

# Introduction: from vice to normalisation

Gambling has been with us for centuries and has typically been viewed as sin or vice (Derevensky and Griffiths, 2019). Beginning in the 1990s with the establishment of the American Gaming Association in the United States, though, gambling was re-envisioned and normalised as acceptable entertainment (Derevensky and Griffiths, 2019) and is now increasingly constructed and perceived as leisure activity in most Western societies (Brown and Russell, 2020).

However, unlike most other leisure activities, gambling has been associated with adverse impacts on the health and wellbeing of individuals, their immediate family and social environment, and the wider community (Brown and Russell, 2020, Wöhr and Wuketich, 2021, Dinos et al., 2020). 'Gambling harms' reflect a wide range of negative consequences that include financial problems; disruption of work, health, emotional and psychological distress; relationship breakdown; and criminal activities (Hing et al., 2014, Wöhr and Wuketich, 2021).

## Box 1. Key psychological definitions related to gambling harm

*"Problem gambling – or gambling addiction – includes all gambling behaviour patterns that compromise, disrupt or damage personal, family or vocational pursuits. The symptoms include increasing preoccupation with gambling, a need to bet more money more frequently, restlessness or irritability when attempting to stop, 'chasing' losses, and loss of control manifested by continuation of the gambling behaviour despite mounting, serious, negative consequences. In extreme cases, problem gambling can result in financial ruin, legal problems, loss of career and family, or even suicide." (National Council on Problem Gambling, 2014, Royal College of Psychiatrists, 2021a)*

*Gambling disorder* (DSM-V), which replaced the DSM-IV diagnosis of *Pathological Gambling* (Rennert et al., 2014), is defined as: "a repeated pattern of gambling behaviour where someone:

- feels they have lost control
- continues to gamble despite negative consequences and
- sees gambling as more important to them than any other interest or activity.

Gambling disorder is also sometimes called *compulsive gambling, problem gambling or gambling addiction*. Gambling disorder can have a big impact on your personal and family life, your work and education, and the things you enjoy." (Royal College of Psychiatrists, 2021b)

In Great Britain, gambling is relatively common among the general population, including amongst children and young people: a research study by the Gambling Commission in 2018 found that about 39% of adolescents aged 11-16 years reported having gambled in the past 12 months, even though commercial gambling is only legal for those over 18 years of age (Gambling Commission, 2018).

In 2021, Public Health England (PHE) published a review into gambling-related harms, including an analysis on the prevalence of gambling and gambling-related harm in England using data from the Health Survey for England (HSE). PHE estimated that 54% of the adult population (or 40% if National Lottery is excluded) gambled, 0.5% of the adult population have a problem with gambling, 3.8% are gambling at at-risk levels (and approximately 4% when combining surveys for England, Scotland and Wales), and 7% are affected negatively by an others people's gambling (Public Health England, 2021).

A YouGov population survey (a nationally representative online survey of 12,161 participants carried out in 2019), estimated that three-fifths (61%) of adults in Britain have participated in any type of gambling activity in the last 12 months. One in nine adults (13%) scored one or higher on the Problem Gambling Severity Index (PGSI) scale. Also, 7% were classified as a low risk gambler (a score of 1-2)

and 3% as a moderate risk gambler (a score of 3–7), while 3% of adults had a score of 8 or higher, a score indicating someone who experiences problems with gambling (Dinos et al., 2020).

Data on adults from 2021 suggest that overall participation in any gambling activity (in the last four weeks) is around 42%. Approximately 0.4% of all adults experience problems with gambling (Gambling commission, 2021b). It is important to note that the true estimate of prevalence for those experiencing some level of gambling harm is more likely to be closer to the estimated prevalence from the HSE rather than the YouGov survey (Dinos et al., 2020, Public Health England, 2021).

Among the different forms of gambling, online gambling has seen the largest increase in Great Britain over the past 10 years and in 2019 accounted for more than one third of the total gambling market (Gambling Commission, 2021a).

Recent research on gambling among adolescents and young adults suggests that these age groups may be particularly vulnerable to emotional stress, suicidality and gambling harms due to the widespread opportunity to gamble, including at both physical, 'land based' (i.e. betting shops) and online spaces. They may also experience a lack of education which could otherwise raise awareness of the harms that are associated with problem gambling (Melendez-Torres et al., 2020, Wardle and McManus, 2021).

Evidence also suggests that gambling advertising has either a direct impact on immediate behaviour or indirect impact on emotional responses which can help shape attitudes to, and associations with, current and future involvement in gambling among children, young people, and vulnerable adults (Ipsos MORI, 2020). In addition, family and friends play a role in introducing people to gambling, often at a young age, and in informal settings (Ipsos MORI, 2020).

Adults from minority ethnic communities are more likely than white British people to be classified as experiencing some level of harm associated with gambling (Dinos et al., 2020). These population groups bear disproportionate burdens of harms associated with gambling driven by experiences of racism, discrimination, and trauma, as well as cultural and linguistic barriers (Levy et al., 2020). For these reasons, gambling is increasingly considered an important public health issue in Great Britain (Gambling Commission, 2022, Melendez-Torres et al., 2020, Wardle and McManus, 2021, Woodall and Freeman, 2021) with the provision of gambling treatment services playing a crucial role in forming a coherent public health response (Woodall and Freeman, 2021).

Stigmatisation has also been described as an important and attendant negative consequence in people who struggle with gambling (Hing et al., 2014, Hing et al., 2015b). People who struggle with gambling may internalise stigma, known as self-stigma, coming to believe that negative and stigmatising assumptions

about them and their communities are true, which impacts self-worth, wellbeing, and can delay their efforts to request and access healthcare services (Brown and Russell, 2020, Hing et al., 2014).

While stigma related to health conditions (e.g. HIV, cancer, and obesity), identities (e.g. gender, sexuality, race, etc.), behaviours (e.g. sexual practice, drug use) and occupations (e.g. sex work) has been well-studied over the last few decades (Chambers et al., 2015, Dijkstra et al., 2017, Fox et al., 2018, Longdon and Read, 2017, Schomerus et al., 2012, Sikorski et al., 2015, Stangl et al., 2013), stigma related to gambling and gambling harms is a nascent, but clearly important, area of research (Brown and Russell, 2020).

To address this gap, we conducted a scoping review of the literature to establish:

1. A critical analysis of current research and understandings, establishing how existing understandings of gambling and gambling harm reproduce stigma.
2. The nature of stigma of gambling and gambling harm: how it comes about and how it compares to other forms of stigma.
3. How stigma serves as a barrier to accessing support, service and healthcare provision, and support in the community and from peers.

In order to address these a priori aims of the scoping review, we use two different approaches: (a) we reviewed and synthesised the findings and insights from research into gambling stigma (i.e. scoping review), and (b) treated the gambling literature we identified as data which we analysed to measure presence of stigmatising content therein (i.e. textual analysis).

## What is stigma?

Before examining how stigma is associated with gambling and gambling harms, it is important to begin at the beginning: what is stigma? Sociologist Erving Goffman first identified stigma as “an attribute that is deeply discrediting [and that reduces the bearer] ...from a whole and usual person to a tainted, discounted one”.

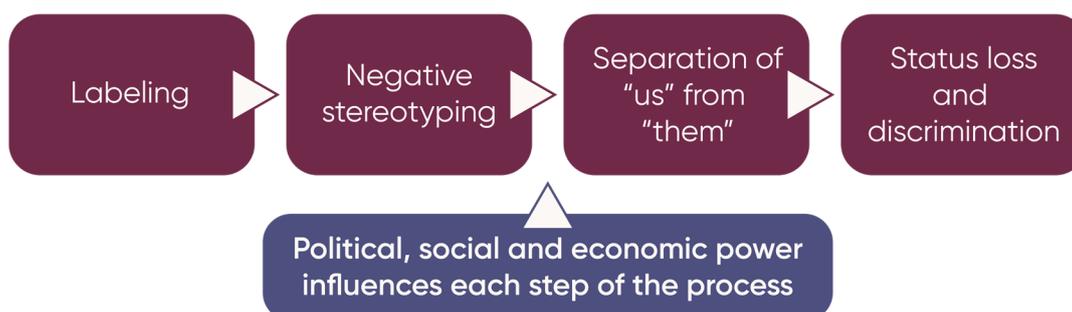
He went on to note that the attribute leads to “disqualification from full social acceptance...by definition, of course, we believe the person with a stigma is not quite human. On this assumption, we exercise varieties of discrimination, through which we effectively, if often unthinkingly, reduce his life chances” (Goffman, 1963).

Goffman’s definition holds true to this day, remaining an important sociological principle. However, it focuses on the *individual* experiencing stigma and does not describe how the stigmatisation process unfolds, nor the *underlying forces* which fuel that process.

More recently, Link and Phelan described how stigma emerges through a dynamic social process beginning when a difference is labelled, followed by negative stereotyping because of that difference. This leads to a separation of ‘us’ from ‘them’, followed by status loss and discrimination (Figure 1) (Link and Phelan, 2001).

The stigmatisation process is enabled by underlying social, political and economic powers that seek to devalue some groups to create superiority in others. By turning constructed ‘difference’ into *inequity* based on gender, age, sexual orientation, class, and so on, it leads to discrimination and social exclusion of individuals and groups (Parker and Aggleton, 2003).

Figure 1. The stigmatisation process as described by Link and Phelan (2001)





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# How does the stigmatisation process work in the context of health?

Now we shall apply these concepts in the context of health. The Health Stigma and Discrimination Framework (HSDF) describes the stigmatisation process as it unfolds across the socio-ecological spectrum in a health context (Figure 2) (Stangl et al., 2019). The process can be broken down into a series of domains that include drivers and facilitators, stigma 'marking', and stigma manifestations that influence a range of outcomes. While the framework was initially applied to health conditions, it also applies to other stigmatised conditions and behaviours, including gambling.

Drivers of stigma are inherently negative (e.g., social judgement and blame related to gambling, in this case) whereas facilitators of stigma may have positive or negative influence (e.g., laws that require warnings prior to online gaming; laws that protect against discrimination). The drivers and facilitators influence whether and to what extent stigma 'marking' occurs, where a stigma is applied to individuals or groups (e.g., people who gamble and/or experience gambling harms).

Once applied, stigma manifests in a range of stigma experiences (i.e. lived realities) and practices (i.e. beliefs, attitudes, and actions). Stigma experiences may include experienced discrimination, experienced stigma, and/or internalised, perceived, anticipated and secondary stigma. Each of these terms is discussed in detail below.

## Discrimination and experienced stigma

People often conflate the terms stigmatisation and discrimination, but the terms represent distinct concepts that require different responses to address them. The key difference revolves around legality. To help clarify this distinction, the Health Stigma and Discrimination Framework introduced the terms 'experienced discrimination' and 'experienced stigma'.

Informed by this, we use the term 'experienced discrimination' to refer to acts that are illegal (*"stigmatising behaviours that fall within the purview of international human rights law"*) or, in the UK, against anti-discrimination law e.g. expelling students from school or evicting people from their homes who are living with a

stigmatised health condition). We use the term 'experienced stigma' to refer to acts that are not illegal ("*stigmatising behaviours that fall outside the purview of international human rights law*" e.g. social exclusion, verbal abuse or gossip).

Experienced stigma and discrimination can both result in violence, structural violence, social exclusion, refusal to provide service and healthcare provision, and in some instances mob justice and killing (including, in some contexts, extrajudicial killing and execution). However, they can also lead to resilience among stigmatised communities, leading to the formation of networks of stigmatised groups and advocacy to ensure the rights of stigmatised communities.

Important examples of such resilience include: (a) the Treatment Action Campaign (TAC) in South Africa which successfully advocated to ensure free and easy access to antiretroviral therapy for all people living with HIV; (b) the Gay Men's Health Crisis and ACT UP advocated for the rights of people living with HIV and (c) the International Network of People who Use Drugs (INPUD) and the Global Network of Sex Work Projects advocated at United Nations and World Health Organization (WHO) levels on behalf of heavily stigmatised and criminalised communities.

Responses to address experienced discrimination include legal remedies, such as mediation or lawsuits; advocacy with law makers to de-criminalise behaviours or occupations and ensure legal protections for marginalised populations; and training for judges and law enforcement. On the other hand, addressing experienced stigma requires different responses.

These include population-based communication campaigns to increase awareness of stigma and its harmful effects, such as the ones undertaken on addressing stigma and mental health in England (Evans-Lacko et al., 2013), Scotland (SAMH, 2022) and elsewhere (Thornicroft et al., 2014, Collins et al., 2015) or HIV stigma (Boulay et al., 2008, Fakolade et al., 2010), and training for healthcare providers (Guilcher et al., 2016, Rao et al., 2019, van Brakel et al., 2019).

## **Internalised, perceived, anticipated stigma**

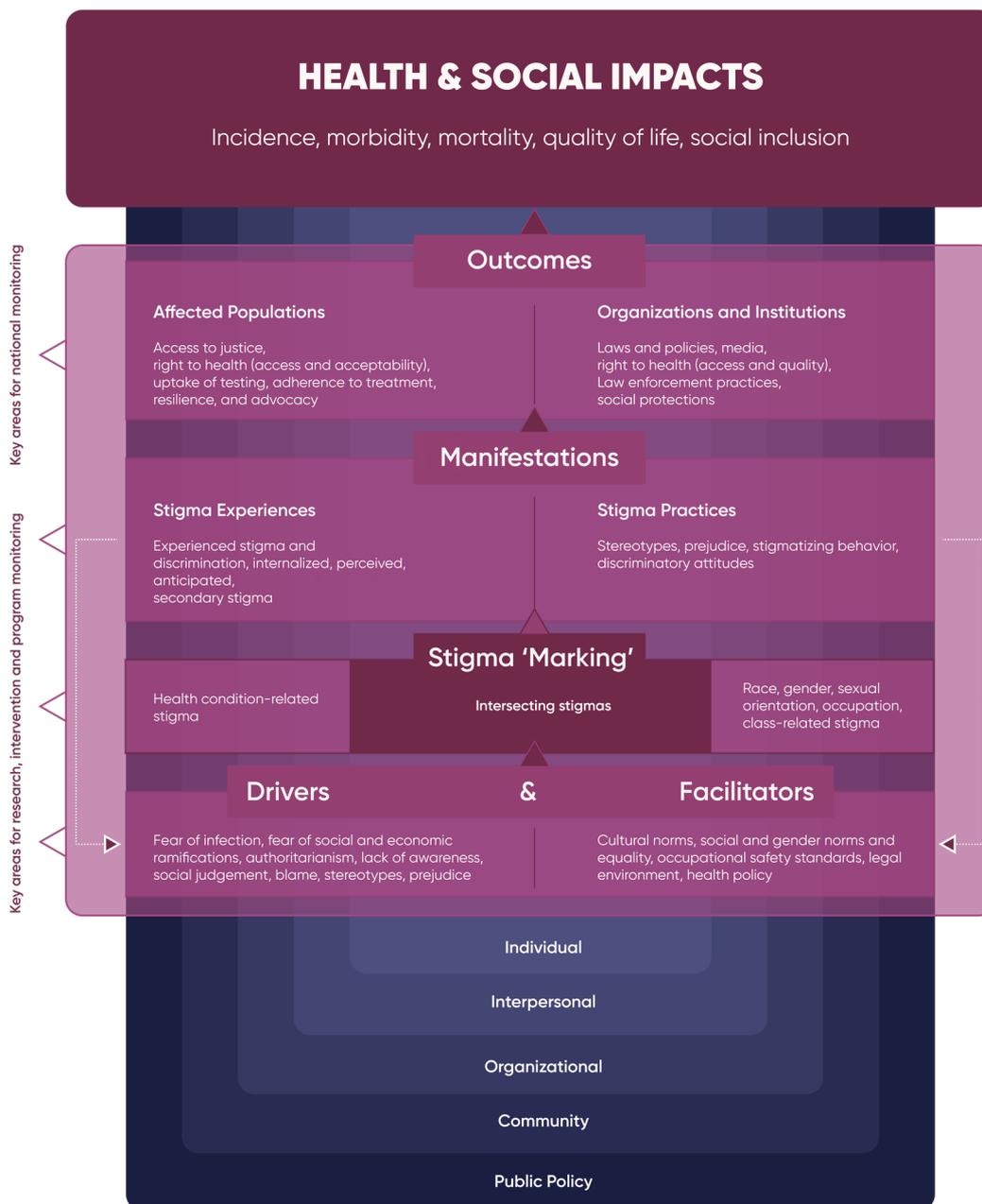
Internalised or 'self-stigma' is defined as "a stigmatised group member's own adoption of negative societal beliefs and feelings, as well as the social devaluation associated with their stigmatised status". Internalised stigma results in people coming to believe that negative and stigmatising assumptions about them and their communities are indeed true, which impacts wellbeing, and can serve as a barrier in requesting, as well as accessing healthcare and service provision.

Perceived stigma refers to perceptions about how stigmatised groups are treated in a given context. Anticipated stigma refers to the expectations of bias being

How does the stigmatisation process work in the context of health?

perpetrated by others if their stigmatised behaviour (e.g. gambling) becomes known. Finally, secondary or 'associative' stigma, refers to the experience of stigma by family or friends of members of stigmatised groups (e.g. people who gamble) (Stangl et al., 2019).

**Figure 2. The Health Stigma and Discrimination Framework\***  
(Stangl et al., 2019)



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## Intersectional stigma

Related to these underlying processes is intersectional stigma. This is a new term and also an emerging area of public health research (Turan et al., 2019). Intersectional stigma occurs at the juncture, or *intersection*, of multiple stigmatising forces that fall within or across several categories: (1) health-related stigma that affects one or more co-existing health conditions such as HIV, mental illness or substance use disorder; (2) stigma based on sociodemographic characteristics such as racial, ethnic, gender, sexual orientation and immigration status; and (3) stigma related to behaviours or experiences such as gambling, drug use and sex work (NIH, 2020).

In the context of gambling harms, people who struggle with gambling may be more likely to belong to historically marginalised groups in Great Britain, such as migrants, people of colour, or people of lower socioeconomic status. The Health Stigma and Discrimination Framework (and an understanding of intersectional stigmatisation) is therefore a helpful tool for researchers, programme implementers and policy makers to understand how the stigmatisation process unfolds in societies. It can also help them identify opportunities where intervention can disrupt the process and/or mitigate the negative consequences of stigma and discrimination.



# Methodology

## Sources for review

In order to provide a critical analysis of current research and understandings, describe the nature of stigma related to gambling and gambling harms, examine stigma as a barrier to accessing support, and provide a set of recommendations for future research, we looked at studies published in peer reviewed journals and grey literature. We searched the following academic databases to identify relevant peer reviewed literature:

- PubMed
- Scopus
- PsycINFO
- Web of Science.

GambleAware commissions services for people who experience gambling harms in Great Britain. We searched the websites of the following organisations that are at least in part funded by GambleAware to illustratively identify relevant non-peer reviewed literature, such as reports or briefing documents:

- GamCare: <https://www.gamcare.org.uk/>
- Gordon Moody: <https://gordonmoody.org.uk/>
- BeGambleAware: <https://www.begambleaware.org/ngts>

## Search methodology

We followed the Population, Concept, Context framework to develop the search strategy. We followed the PRISMA-ScR reporting guidelines (Tricco et al., 2018) and followed the methodological stages developed by Arksey and O'Malley (Arksey and O'Malley, 2005). The search strategy was guided conceptually by the Health Stigma and Discrimination Framework, in terms of selecting search terms related to stigma drivers, facilitators and manifestations (Stangl et al., 2019) (Figure 3). We used two blocks of keywords to capture studies related to gambling and stigma. We used a third block to capture studies that might discuss stigma of gambling and gambling harm, as well as how it compares to other forms of stigma (i.e. intersection of multiple stigmatising forces).

One reviewer (MS) conducted the abstract screening, full-text screening, and data extraction using EndNote. A randomly selected 5-10% of studies were screened at both title/abstract and full-text stages by a second reviewer (TP) in order to ensure that studies which satisfy the inclusion and exclusion criteria were selected.

We extracted information from articles related to:

- the study author
- year of publication
- country
- study design
- study population and sample
- intervention duration and details (where applicable)
- stigma measures used (if any)
- socio-ecological level<sup>1</sup> of the study or intervention (where applicable)
- concepts related to gambling and gambling harms
- gambling outcomes
- impact estimates of the intervention (where applicable) on gambling outcomes.

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1 The socio-ecological model considers the complex interplay between individual, relationship, community, and societal factors

Box 2. Search terms used in four databases (Search strings are provided in Appendix S1).

Gambling OR Gambling disorder OR Perception of gamblers OR Problem gambler OR Problem gambling OR Gambling problems OR Gambling harm OR Gambling expenditures OR Readiness to change OR Help seeking OR Mental health OR Social distance OR Treatment-seeking OR Norms OR Severity

AND

Social stigma OR Public stigma OR Societal stigma OR Social discrimination OR Prejudice OR Stereotyping OR Stigma OR Discrimination OR Equalit\* OR Inequalit\* OR Equit\* OR Inequit\* OR Oppress\* OR Racis\* OR Marginaliz\* OR Coping OR Stereotypes OR Devaluat\*

AND

Intersect\* OR Multipl\* OR Interlock\* OR Overlap\* OR Layer\* OR Nexus

### Inclusion and exclusion criteria

Only studies published in English were included. We did not apply any time restriction to our searches. Our search covered all peer-reviewed papers published up until the search date of 5 October 2021. We included observational research and intervention studies, where applicable, reporting on the concepts, potentially stigmatising terms, and/or language described below. Studies included observational studies (cohort, case-control, cross sectional/post only assessments), qualitative studies, intervention studies (quasi experimental and experimental) and systematic and scoping reviews. We excluded commentaries or letters, opinion pieces and conference abstracts.

Since stigmatising processes occur internationally in establishing dominant discourse (politically and in the academic/research spheres), the scoping review was global. We did not apply restrictions on the geographic region or country income level. We only included studies to population groups that covered people who gamble, people with gambling disorder, people with gambling problems, people experiencing gambling harms/problems and those harmed by gambling. We excluded studies that did not include terms related to gambling and/or

stigma during title screening. We excluded studies that did not include terms related to gambling during abstract screening. We decided not to exclude studies if stigma terms were not included at this stage as we wanted to examine the extent to which stigmatising language is used in gambling research.

### Concepts and outcomes

For the purposes of this report, we considered manifestations (e.g. experienced, perceived or anticipated stigma) and drivers (e.g. cultural norms) of stigma, informed by the Health Stigma and Discrimination Framework (Stangl et al., 2019). We also considered gambling outcomes that are associated with health and social consequences including suicide, work and educational disruption, criminal arrest, financial difficulties, and familial disruption. Our literature search, including selecting search terms and screening the title/abstract and full-text, was partly informed by the following established gambling outcome measures:

- Gambling Quantity and Perceived Norms (GQPN)
- Gambling Problem Index (GPI)
- Gambling Readiness to Change Questionnaire (GRTC)
- Problem Gambling Severity Index (PGSI).

### Evidence synthesis

We took a narrative approach to evidence synthesis, and we did not register a protocol for this review. In order to address the a priori aims of the scoping review, we use two different approaches: (a) we reviewed and synthesised the findings and insights from research into gambling stigma (i.e. scoping review), and (b) undertook textual analysis to identify language used that could potentially be stigmatising and feed/reproduce negative stereotypes (i.e. textual analysis).

Using current knowledge on health-related stigmas (Budenz, 2018, Craig and Richeson, 2016, Hatzenbuehler and Link, 2014, Rao et al., 2019, Turan et al., 2019, Tyler and Slater, 2018), gambling and stigma (Brown and Russell, 2020, Hing et al., 2014, Hing et al., 2016a, Hing et al., 2015b, Hing et al., 2016b, Hing et al., 2016c, Livingstone and Rintoul, 2021, Sweet and Levy, 2020) and informed by the Health Stigma and Discrimination Framework (Stangl et al., 2019), we first examined how papers conceptualised stigma of gambling and gambling harms (i.e. scoping review of the literature).

We then focused on discussion points (i.e. textual analysis) where stigma was described as a barrier for people who gamble, or people who experience gambling harms, to access services, help and treatment. In addition, we reviewed

discussion points where stigma around gambling was discussed and where gambling was discussed in relation to other health-related behaviours, outcomes or stigmas.

Furthermore, we examined the extent to which papers could be potentially stigmatising. We combined the findings of the scoping review with the textual analysis to discuss (i) stigma drivers: labelling, blaming and stereotyping, (ii) stigma manifestations and coping mechanisms and (iii) stigma practices: service delivery and campaign messages that reinforce stigma.

In the textual analysis, we focused on the following terms, phrases and narratives:

**Terms** (which reductively define people as a behaviour instead of as an individual):

*Problem gambler, pathological gambler, addict/gambling addict.*

**Phrases** (which define behaviours in terms of 'good' or 'bad', 'right' or 'wrong', 'problematic' or 'responsible'):

*Problematic gambling.*

**Narratives** (which link people who gamble directly with other stigmatised groups or behaviours, shame and blame specific groups for their behaviour, and/or seek to create fear in order to lessen gambling or gambling harms):

*Shame and blame people who gamble (Sweet and Levy, 2020), use shocking images to stop people from engaging in 'risky' behaviours by instilling fear, use stereotypical narratives to link gambling with other stigmatising conditions or behaviours (e.g. smoking, alcohol, mental health problems or neurodevelopment disorders, such as attention deficit hyperactivity disorder), identify key population groups, such as men who have sex with men, as more likely to engage in 'risky' behaviours, or link gambling with drug use and drug dependence. All of these may heighten negative stereotypes, assumptions, and generalisations about the 'type' of people who gamble (and who use drugs).*

Finally, we put together a set of recommendations for future research, service provision and policy for reducing stigma related to gambling and gambling harms. These were based on best practice from stigma research in other areas such as HIV and mental health, as well as the scoping review and textual analysis of the studies we identified.

## Limitations of this review

A few limitations should be noted. This report was not meant to capture all the published literature on stigma and gambling or gambling harms. It is possible that our search strategy may have missed publications on gambling and stigma, particularly related to intersectional stigma. For example, we did not identify any studies on gambling and stigma among ethnic minority groups and found only two studies looking at people with multiple marginalised statuses in addition to struggling with gambling (Guilcher et al., 2016, Bush et al., 2021).

This is a key gap in the literature, as multiply marginalised populations may be more vulnerable to gambling harms (Hing et al., 2016a, Woodall and Freeman, 2021) and may experience intersectional stigma (Turan et al., 2019), as is the case with other marginalised and socially excluded communities (Bowleg, 2021, Sievwright et al., 2022). Nevertheless, we undertook an extensive search of the literature looking at over 22,000 records to identify research that addressed the main objectives of this work.

Additionally, to assess the level of stigmatising language utilised in existing research on gambling stigma, we relied on terms and statements that would be considered stigmatising based on broadly applicable understandings of stigma and health research (Brown and Russell, 2020, Hing et al., 2014, Hing et al., 2016b, Hing et al., 2016c, Livingstone and Rintoul, 2021). It is possible that some of the studies we classified as using stigmatising language only used such language to point out how people who gamble have been described by others or, especially in the case of review papers, may have cited terms or statements that come from another source.

Moreover, the focus of this study was to examine the latent and patent meaning of the reviewed literature, rather than examining the quality of the included studies. Yet, it should be stressed that we used established methodological approaches to develop the search strategy and report the findings of this scoping review.

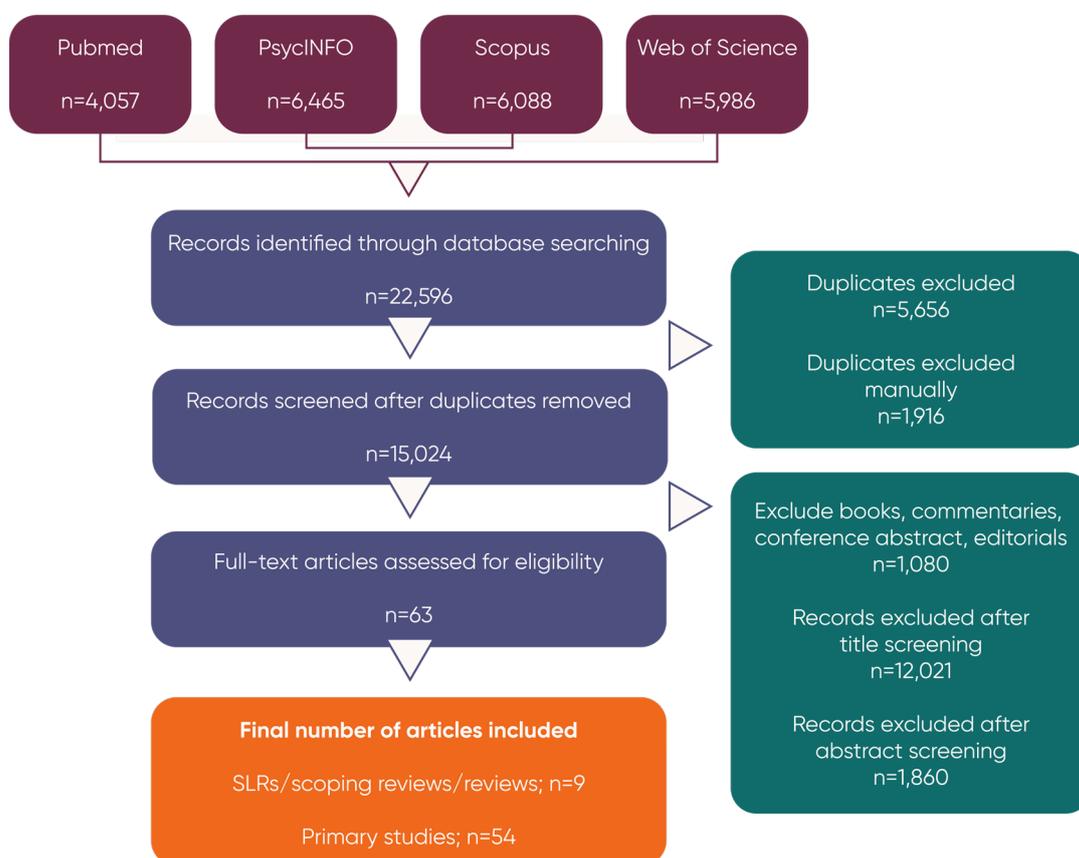
Lastly, GambleAware is a commissioner of services for people who experience gambling harms in Great Britain. However, we only identified a few studies conducted in Great Britain. Furthermore, stigmatisation and the processes that drive stigma, exist in an increasingly globalised and interconnected context, where discourse and social construction do not respect or mirror international (or, indeed, linguistic) separation. An understanding of stigma in the context of gambling and gambling harm must, therefore, be driven by a report on global evidence around stigma and gambling and gambling harms, with the cautious caveat that context can be an important feature to consider when examining studies on stigma (Gavriel-Fried et al., 2015).

# Results

## Overview of published papers

Below, we provide evidence on stigma and gambling, as well as gambling harms, from a total of 63 studies. Nine of those studies were scoping or systematic reviews (Figure 3, Table 1).

Figure 3. PRISMA flowchart



SLRs: Systematic literature reviews

Most studies (n=54) were published since 2015 and were from Canada (n=16) and Australia (n=8). We identified three studies published in Great Britain (Melendez-Torres et al., 2020, Wardle and McManus, 2021, Woodall and Freeman, 2021). The included studies represented a variety of population groups, including the general population (n=13), people who gamble (n=7), people experiencing gambling harms (n=8) and people who struggle with gambling (n=23).

In the textual analysis, we found eight of the review papers included language which could reinforce stigma through labelling, negative stereotyping and separating 'us' from 'them'. Strikingly, 45 of the 55 primary studies used language which could reinforce stigma through labelling, negative stereotyping and separating of 'us' from 'them'. About half of the primary studies (n=27) compared gambling to other health-related behaviours and outcomes that have been framed using stigmatising language (e.g. alcohol and drug use) serving to reinforce or compound stigmatisation.

In the scoping review, we found six studies which discussed the stigmatisation process, coping mechanisms for people who gamble or people who struggle with gambling (Cousins and Witcher, 2007, Gavriel-Fried et al., 2015, Guilcher et al., 2016, Hing et al., 2016a, Lamont and Hing, 2019, Yi and Kanetkar, 2011). Stigma was discussed as a barrier to disclosure and accessing help, care and treatment to mitigate gambling harms in six studies (Guilcher et al., 2016, Hing et al., 2016a, Magnusson et al., 2019, Marinaci et al., 2020, Pickering et al., 2018, Woodall and Freeman, 2021).

One study from England examined the approaches needed to improve services for people who struggle with gambling from a health provider perspective. Findings suggested that working in partnership with communities and the voluntary sector to bring expertise from across sectors, adopting an evidence-based approach, and having services within a busy local government facility in a central geographical location were critical for engaging and providing services to people who struggle with gambling and reducing the stigma experienced (Woodall and Freeman, 2021).



Table 1. Description of studies included in the scoping review

First author (year)	Country	Sample and population characteristics	Study design	Statements/terms using stigmatising language (i.e. textual analysis)	Study remarks on: - Stigma as a barrier to seek support and treatment - Stigma related to gambling and/or comparison of gambling to other health-related behaviours, outcomes or stigmas (i.e. textual analysis and scoping review)
<b>SYSTEMATIC/SCOPING REVIEWS</b>					
Christensen and Patsdaughter (2004)	Multiple	Gambling studies with participants aged 50 years and older and included any form of gambling such as casino games, bingo, lotteries, betting on sports, or in mahjong houses.	Systematic review	<i>Labelling and negative stereotypes</i> Problematic, gambling addiction, gambling behaviour, disordered gambling, resulting in impairments in the areas of work, studies, and social and family relationships, problem gambler.	<i>Negative stereotypes</i> Stigma is not reported but reference is made in relation to mental health problems and seeking treatment.
Luo and Ferguson (2017)	Multiple	18 articles with a total sample of 11,296 non-Caucasian older gamblers.	Systematic review	<i>Labelling</i> Problem gamblers.	<i>Negative stereotypes</i> Stigma is not reported but reference is made in relation to mental health problems and seeking treatment.
McMahon et al. (2019)	Multiple	Ten systematic reviews reporting 55 unique, relevant primary studies to examine the effects of prevention and harm reduction interventions on gambling behaviours, and gambling-related harm.	Systematic review	<i>Labelling</i> Problem gamblers.	<i>Negative stereotypes</i> Stigma is not reported but reference is made in relation to mental health problems and seeking treatment, as well as substance use problems.
Saxton et al. (2021)	Multiple	Online poker players and university students using Personalized Normative Feedback to address addictive disorders.  34 studies looking at (k = 28 alcohol, k = 3 gambling, k = 3 cannabis, k = 0 tobacco).	Systematic review	<i>Labelling and negative stereotypes</i> Problem gambling, disordered gambling, and pathological gambling, diverse backgrounds, lack stability in obtaining finances as a result of their environment.	<i>Negative stereotypes</i> Substance use disorder (relating gambling to substance use).

First author (year)	Country	Sample and population characteristics	Study design	Statements/terms using stigmatising language (i.e. textual analysis)	Study remarks on: – Stigma as a barrier to seek support and treatment – Stigma related to gambling and/or comparison of gambling to other health-related behaviours, outcomes or stigmas (i.e. textual analysis and scoping review)
Tabri et al. (2021)	Multiple	Student, community and clinical samples of people who gamble.	Systematic review	No.	No.
Figuee et al. (2016)	Multiple	Unclear	Scoping review	Labelling Pathological gambling, pathological gambler.	Negative stereotypes Stigma is not reported but relates problem gambling to obsessive-compulsive disorder.
Henkel and Zemlin (2016)	Germany	Adolescents (11–17 years) and young adults (18–25 years) with addictive behaviours (smoking, binge and hazardous drinking, consumption of cannabis and other illegal drugs, the non-medical use of prescription drugs and problematic gambling).	Scoping review	Labelling, negative stereotypes, separation of 'us' from 'them' The authors identify specific sociodemographic characteristics linked to a significantly increased risk of problematic gambling habits: "being male, of low educational attainment, unemployed, receiving social welfare, and having a migration background".	Negative stereotypes Stigma is not reported but reference is made in relation to mental health problems and seeking treatment.
Hilbrecht et al. (2020)	Multiple	<i>The Conceptual Framework of Harmful Gambling.</i>  Literature review and expert input.	Scoping review	No.	Negative stereotypes Compares gambling with schizophrenia and alcohol use disorder.
Richard et al. (2017)	Multiple	Studies looking at problem gambling by race and ethnicity (Latino/Hispanic, Asian, American Indian/Aboriginal, Black).	Scoping review	Labelling Problematic gambling.	Negative stereotypes Reference to the use of cognitive behavioral therapy to treat people with gambling problems and the stigma or fear around the seeking of this kind of mental health treatment.  Describe how individuals of Asian background might find it more difficult to seek help and treatment because of the shame they bring to the family.

First author (year)	Country	Sample and population characteristics	Study design	Statements/terms using stigmatising language (i.e. textual analysis)	Study remarks on: – Stigma as a barrier to seek support and treatment – Stigma related to gambling and/or comparison of gambling to other health-related behaviours, outcomes or stigmas (i.e. textual analysis and scoping review)
<b>PRIMARY STUDIES</b>					
<b>Describing how stigma comes about</b>					
Cousins and Witcher (2007)	Canada	People who gamble. 400 Albertans aged 65+. A sub-sample of 44 bingo players was added to the population sample.	Cross sectional survey – quantitative	No.  <i>Describes how stigma comes about in older gamblers who play bingo.</i>	The authors discuss stereotypes, e.g. how bingo is still an older women's game.
Gavriel-Fried et al. (2015)	Israel	17 women diagnosed with a gambling disorder.	Cross sectional survey – qualitative	<i>Labelling, negative stereotypes</i> Pathological gambling, compulsivity in substance-use disorders.  <i>Describes how stigma comes about in women with gambling problems.</i>	The study looked at how women with a gambling problem construct their social identity and the stigma attached to having gambling problems.
Guilcher et al. (2016)	Canada	People with gambling disorder or gambling problems.  30 men aged 26 to 77 years.	Cross sectional survey – qualitative	<i>Labelling, negative stereotypes</i> Gambling addiction, problem gambler.  <i>Describes how stigma comes about in men with gambling problems.</i>	The study described how men who gamble experienced stigma from service providers and how this can be improved by training them.  Stigma is described as a barrier to access services.
Hing et al. (2016a)	Australia	People with gambling disorder or gambling problems.  44 interviewees, 28 males, with about two-fifths of participants aged under 35 years.	Cross sectional survey – qualitative	<i>Describes how stigma comes about in men with gambling problems.</i>	This study explored perceived and self-stigma to examine stigmatising beliefs held, how they may be internalised, coping mechanisms, and effects on help-seeking.  Perceived and self-stigma found to act as major barriers to disclosure and help-seeking.
Lamont and Hing (2019)	Australia	People who gamble.  35 participants.	Cross sectional survey – qualitative	<i>Labelling</i> Problem gambler.	This study explored masculinity and sport betting in relation to gambling and the impact on personal relationships.  Anticipated and perceived stigma in relation to gambling is discussed.

First author (year)	Country	Sample and population characteristics	Study design	Statements/terms using stigmatising language (i.e. textual analysis)	Study remarks on: – Stigma as a barrier to seek support and treatment – Stigma related to gambling and/or comparison of gambling to other health-related behaviours, outcomes or stigmas (i.e. textual analysis and scoping review)
Yi and Kanetkar (2011)	Canada	General population.  284 participants.	Cross sectional survey – quantitative	<i>Labelling</i> Pathological gambler	Stigma is not reported but coping strategies in response to shame following gambling losses are discussed.
<b>Other studies</b>					
Abouzari et al. (2015)	Canada	People with gambling disorder or gambling problems.	Cross sectional survey – quantitative	<i>Labelling</i> Problem gambler.	Negative stereotypes Stigma is not reported but the authors state the possible comorbidity between 'problem gambling' and ADHD.
Baggio et al. (2017)	France	Random representative sample of the general population aged 18–64 (n = 12,852).	Cross sectional survey – quantitative	No.	No.
Burton et al. (2015)	United States	People experiencing gambling harms/problems and those harmed by gambling (i.e. family members).	Cross sectional survey – quantitative	No.	No.
Bush et al. (2021)	Australia	People with gambling disorder or gambling problems.  101 sexual minority men and 207 heterosexual men.	Cross sectional survey – qualitative	<i>Labelling</i> Problematic gambling.	No.
Canale et al. (2017)	Italy	People experiencing gambling harms/problems and those harmed by gambling (i.e. family members).  The sample comprised of 20,791 students (male, 50.3%) nested within 1,050 schools and 21 Italian regions/cities.	Cross sectional survey – quantitative	<i>Labelling</i> Problem gambling, at risk and problem gamblers.	Negative stereotypes Gambling disorder described as a recognised mental health condition.

First author (year)	Country	Sample and population characteristics	Study design	Statements/terms using stigmatising language (i.e. textual analysis)	Study remarks on: – Stigma as a barrier to seek support and treatment – Stigma related to gambling and/or comparison of gambling to other health-related behaviours, outcomes or stigmas (i.e. textual analysis and scoping review)
Chan et al. (2018)	Hong Kong SAR, China	People who gamble.  44 participants.	Quantitative pre/post test with control group	No.	<i>Negative stereotypes, separation of 'us' from 'them'</i> The authors describe the recruitment of people in the programme "with various expressions of addiction including gambling disorder, sex addiction, compulsive buying, compulsive stealing, internet gaming disorder, alcohol, and cigarette addiction".
Currie et al. (2013)	Canada	People with gambling disorder or gambling problems.  Community-based sample of Aboriginal adults living in a mid-sized city in Western Canada (n = 381).	Cross sectional survey – quantitative	<i>Labelling</i> Problem gambler.	<i>Negative stereotypes</i> Stigma is not reported but reference is made in relation to mental health problems (PTSD symptoms).
Dowling et al. (2021)	Australia	People with gambling disorder or gambling problems.  141 new voluntary clients (100 male, 39 female, two unspecified gender) to a specialist problem gambling service.	Cross sectional survey – quantitative	<i>Labelling</i> Problem gambler.	<i>Negative stereotypes</i> Stigma is not reported but reference is made in relation to psychological distress, symptoms of PTSD.
Edgerton et al. (2018)	Canada	People with gambling disorder or gambling problems.  517 Manitobans aged 18–20.	Cross sectional survey – quantitative	<i>Labelling</i> Problem gambler, pathological gambler.	<i>Negative stereotypes</i> Stigma is not reported but reference is made in relation to mental health problems and seeking treatment.
Edgerton et al. (2015)	Canada	People with gambling disorder or gambling problems.  517 Manitobans aged 18–20.	Cross sectional survey – quantitative	<i>Labelling</i> Problem gambler, pathological gambler.	<i>Negative stereotypes</i> Stigma is not reported but reference is made in relation to mental health problems and seeking treatment.

First author (year)	Country	Sample and population characteristics	Study design	Statements/terms using stigmatising language (i.e. textual analysis)	Study remarks on: – Stigma as a barrier to seek support and treatment – Stigma related to gambling and/or comparison of gambling to other health-related behaviours, outcomes or stigmas (i.e. textual analysis and scoping review)
Ellis et al. (2018)	United States	275 subjects across various categories of anxiety disorders.	Cross sectional survey – quantitative	<i>Labelling</i> Problem gambling, problem gambler.	No.
Glowacki et al. (2021)	Multiple	General population. 3,301 tweets captured between 31 January and 23 April, 2020.	Cross sectional survey – quantitative	<i>Labelling, negative stereotypes</i> Gambling addiction.	The authors discuss addiction in general.
Hänninen and Koski-Jännes (1999)	Finland	51 (22 men and 29 women) autobiographical stories of people who had been able to quit their addiction to alcohol, multiple drugs, binge eating, smoking, sex and gambling.	Cross sectional survey – qualitative	No.	No.
Heiskanen and Matilainen (2020)	Finland	People with gambling disorder or gambling problems.  25 people were interviewed in six focus groups.	Cross sectional survey – qualitative	<i>Labelling</i> Problematic gambling, problem gamblers.	<i>Separation of 'us' from 'them'</i> Stigma is not reported but the authors frame the discussion in part as the separation of 'us' from 'them'.
Hing et al. (2015a)	Australia	People with gambling disorder or gambling problems.  Online survey of 4,594 Australian gamblers.	Cross sectional survey – quantitative	<i>Labelling</i> Problem gambler, pathological gambler.	<i>Negative stereotypes, separation of 'us' from 'them'</i> Stigma is not reported but groups with specific sociodemographic characteristics (“young, single male, with limited education and ethnic minority status”) to implement intervention aiming “at de-stigmatising problem gambling and de-glamorising professional gambling” in order to encourage individuals with gambling problem to seek help and treatment.

First author (year)	Country	Sample and population characteristics	Study design	Statements/terms using stigmatising language (i.e. textual analysis)	Study remarks on: – Stigma as a barrier to seek support and treatment – Stigma related to gambling and/or comparison of gambling to other health-related behaviours, outcomes or stigmas (i.e. textual analysis and scoping review)
Konkoly Thege et al. (2015)	Canada	People with gambling disorder or gambling problems.  4,000 adults recruited from an online research panel.	Cross sectional survey – quantitative	<i>Labelling</i> Problematic gambling, pathological gambling.	<i>Negative stereotypes</i> , The authors underline the distinction between substance-related and behavioral addictions and describe how “people believed to manifest behavioral addictions feel stigmatised, seek treatment, or initiate behavior changes on their own”.  Relate gambling versus problematic sexual behaviour.
Koski-Jannes and Turner (1999)	Canada	76 participants (n = 38 women) solicited mainly by newspaper ads.	Cross sectional survey – quantitative	<i>Labelling</i> Problematic gambling, problem gamblers, pathological gambling.	<i>Negative stereotypes</i> Stigma is not reported but there are comparisons between gambling, substance use, and drinking alcohol.
Kruger et al. (2020)	United States	People with gambling disorder or gambling problems.  111 slot machine gamblers.	Cross sectional survey – quantitative	<i>Labelling</i> Problem gambler.	<i>Negative stereotypes</i> Stigma is not reported but there are comparisons between gambling and depression symptoms.
Kwan et al. (2020)	Hong Kong SAR, China	People experiencing gambling harms/problems and those harmed by gambling (i.e. family members).  23 participants, Chinese women aged between 31 and 70 years.	Cross sectional survey – qualitative	<i>Labelling</i> Problematic gambling, pathological gamblers.	<i>Negative stereotypes</i> Stigma is not reported but impacts on family/personal relationships are discussed, which may be associated with associative or secondary stigma.
Ladouceur et al. (1994)	Canada	People with gambling disorder or gambling problems.  Four adults.	Cross sectional survey – qualitative	<i>Labelling</i> Pathological gambler.	No.
LaPlante et al. (2006)	United States	People with gambling disorder or gambling problems.  2,356 identified gamblers. 1,367 are men and 989 are women.	Cross sectional survey – quantitative	<i>Labelling</i> Pathological gambler/gambling, problem gambler.	No.

First author (year)	Country	Sample and population characteristics	Study design	Statements/terms using stigmatising language (i.e. textual analysis)	Study remarks on: – Stigma as a barrier to seek support and treatment – Stigma related to gambling and/or comparison of gambling to other health-related behaviours, outcomes or stigmas (i.e. textual analysis and scoping review)
Luquiens et al. (2018)	France	People who gamble.  1,996 participants.	Cross sectional survey – qualitative	<i>Labelling</i> Problem gambler, pathological gambler.	No.
Magnusson et al. (2019)	Denmark	People experiencing gambling harms/problems and those harmed by gambling (i.e. family members).  100 concerned significant others of problem gamblers.	Quantitative pre/post test with control group	<i>Labelling</i> Problem gambler.	Only state stigma as a barrier to seek help and treatment without elaborating further.
Marinaci et al. (2020)	Italy	People who gamble.  67 participants.	Cross sectional survey – quantitative	<i>Labelling</i> Problem gamblers, pathological gamblers.	Only state stigma as a barrier to seek help and treatment without elaborating further.
Marinaci et al. (2020)	Malta	People who gamble.  67 participants.	Cross sectional survey – quantitative	<i>Labelling</i> Problem gamblers, pathological gamblers.	Only state stigma as a barrier to seek help and treatment without elaborating further.
Maroney et al. (2019)	Australia	People with gambling disorder or gambling problems.  Video game players (n = 2,261).	Cross sectional survey – quantitative	<i>Negative stereotypes</i> Gambling addiction	<i>Negative stereotypes</i> Stigma is not reported but there are comparisons between gambling and addictions.
Melendez-Torres et al. (2020)	United Kingdom, Wales	People experiencing gambling harms/problems and those harmed by gambling (i.e. family members).  Data was drawn from a subsample of students (n = 37,363) who completed gambling questions.	Cross sectional survey – quantitative	<i>Labelling</i> Problem gambler.	No.
Morvannou et al. (2017)	Canada	People with gambling disorder or gambling problems.  A sample of 159 poker players.	Cross sectional survey – quantitative	<i>Labelling</i> Problem gambler.	No.

First author (year)	Country	Sample and population characteristics	Study design	Statements/terms using stigmatising language (i.e. textual analysis)	Study remarks on: – Stigma as a barrier to seek support and treatment – Stigma related to gambling and/or comparison of gambling to other health-related behaviours, outcomes or stigmas (i.e. textual analysis and scoping review)
Paleologou et al. (2021)	Greece	People with gambling disorder or gambling problems.  A total of 339 students.	Cross sectional survey – quantitative	<i>Labelling</i> Problem gambler, pathological gambler.	<i>Negative stereotypes</i> Stigma is not reported but groups with specific sociodemographic characteristics are identified (i.e. adolescent immigrants).
Papineau et al. (2020)	Canada	Characterisation of gambling environments using geographical information systems and secondary data sources.	Cross sectional survey – quantitative	<i>Labelling</i> Problem gambler, pathological gambler.	No.
Pchajek et al. (2020)	Canada	People who gamble.  Adult gambler sample (n = 391).	Cross sectional survey – quantitative	<i>Labelling</i> Problem gamblers, pathological gambling.	No.
Pearce et al. (2008)	New Zealand	People experiencing gambling harms/problems and those harmed by gambling (i.e. family members).  12,529 respondents.	Cross sectional survey – quantitative	<i>Labelling</i> Problem gamblers.	No.
Pickering et al. (2018)	Australia	People with gambling disorder or gambling problems.  44 participants.	Cross sectional survey – quantitative	<i>Labelling</i> Problem gamblers.	Only state stigma as a barrier without elaborating further.
Pilatti and Tuzinkievich (2015)	Argentina	People with gambling disorder or gambling problems.  355 participants.	Cross sectional survey – quantitative	<i>Labelling</i> Problem gamblers.	No.
Purcell et al. (2020)	Australia	General population.  1,566 athletes.	Cross sectional survey – quantitative	<i>Labelling</i> Problematic gambling.	<i>Negative stereotypes</i> Stigma not reported but link discussed between problematic alcohol consumption and gambling.

First author (year)	Country	Sample and population characteristics	Study design	Statements/terms using stigmatising language (i.e. textual analysis)	Study remarks on: – Stigma as a barrier to seek support and treatment – Stigma related to gambling and/or comparison of gambling to other health-related behaviours, outcomes or stigmas (i.e. textual analysis and scoping review)
Rahman et al. (2014)	United States	People experiencing gambling harms/problems and those harmed by gambling (i.e. family members).  4,523 participants.	Cross sectional survey – quantitative	<i>Labelling</i> At-risk problematic gamblers.	<i>Negative stereotypes</i> Stigma not reported but link discussed between problematic alcohol consumption and gambling.
Rossen et al. (2016)	New Zealand	8,500 secondary school students.	Cross sectional survey – quantitative	No.	No.
Syvertsen et al. (2021)	Norway	General population.  5,830 participants.	Cross sectional survey – quantitative	No.	No.
Takamatsu et al. (2016)	United States	General population.  333 participants.	Cross sectional survey – quantitative	<i>Labelling</i> Problem gambling, pathological gambling.	<i>Negative stereotypes</i> Stigma is not reported but reference is made in relation to mental health problems and seeking treatment.
Tang et al. (2019)	United States	General population.  1,233 participants	Cross sectional survey – quantitative	<i>Labelling</i> Problematic gambling.	No.
Thomas et al. (2020)	Canada	General population.  1200 participants.	Cross sectional survey – quantitative	<i>Labelling</i> Problem gambler.	<i>Negative stereotypes</i> Stigma not reported but link discussed between problematic alcohol consumption and gambling.
Torrado et al. (2020)	Portugal	People with gambling disorder or gambling problems.  Pilot study with 117 Portuguese-speaking young adults from a public university.	Cross sectional survey – quantitative	<i>Labelling</i> Problematic gambling.	No.
van der Tempel et al. (2020)	Canada	People with gambling disorder or gambling problems.  Nine women.	Quantitative pre/post test with control group	<i>Labelling</i> Problem gambler.	No.

First author (year)	Country	Sample and population characteristics	Study design	Statements/terms using stigmatising language (i.e. textual analysis)	Study remarks on: – Stigma as a barrier to seek support and treatment – Stigma related to gambling and/or comparison of gambling to other health-related behaviours, outcomes or stigmas (i.e. textual analysis and scoping review)
Volberg et al. (2001)	Sweden	General population. 9917 individuals.	Cross sectional survey – quantitative	<i>Labelling</i> Problem gambler, pathological gambling.	No.
Wardle and McManus (2021)	United Kingdom, Great Britain	General population. 3,549 participants.	Cross sectional survey – quantitative	<i>Labelling</i> Problem gambler, pathological gambling.	<i>Negative stereotypes</i> Stigma not reported but problem gambling described as a substantial risk factor for suicide attempts among both young men and young women.
Weidberg et al. (2007)	Canada	2,750 male and 2,563 female adolescents.	Cross sectional survey – quantitative	<i>Labelling</i> Problem gambler, pathological gambling.	<i>Negative stereotypes</i> Stigma is not reported but reference is made in relation to mental health problems and seeking treatment, as well as ADHD.
Wiehler et al. (2015)	Germany	General population. 20 participants fulfilling the DSM-5 criteria and 20 healthy control participants.	Cross sectional survey – quantitative	<i>Labelling</i> Pathological gambling/gambler.	<i>Negative stereotypes</i> Stigma is not reported but there are comparisons between gambling and addictions.
Wong et al. (2019)	China	General population. 530 participants.	Cross sectional survey – quantitative	<i>Labelling</i> Pathological gambling/gambler.	No.
Woodall and Freeman (2021)	United Kingdom, England	Expert opinion (n=11).	Cross sectional survey – qualitative	<i>Labelling</i> Problem gamblers.	Discuss how the (central) location of services where people with gambling problems can seek help and treatment is important.  Service design (co-location with other generic services) may hamper attempts to visit services and seek help and treatment.

ADHD: Attention Deficit Hyperactivity Disorder; DSM: Diagnostic and Statistical Manual of Mental Disorders; PTSD: Post-Traumatic Stress Disorder.



## Grey literature

We reviewed the websites of three organisations based in Great Britain, including GamCare, Gordon Moody and GambleAware.

On the GamCare website, we reviewed a list of annual and published reports. In our textual analysis, we did not find any evidence of stigmatising language used. In our scoping review, we found that GamCare has developed programmes including outreach and networking to engage professionals and accredited training for professionals to increase awareness about and reduce the risks of gambling harms. Stigma, particularly shame and fear, is a key component of GamCare's Women and Gambling Programme (GamCare, 2020).

We did not find reports or documents which we could download when we reviewed Gordon Moody's website in order to undertake a textual analysis. However, we found news items describing a gambling residential programme, commissioned by GambleAware. This depicts gambling as an addiction and frames gambling addiction in relation to other forms of addiction, including substance misuse, eating disorder, alcohol abuse and mental health (Gordon Moody, 2022a).

On the website, it is noted that a comprehensive clinical assessment is used, whereby clients apply for treatment with the residential programme. It is highlighted that gamblers are often complex cases, requiring integrated care and that Gordon Moody's process tries to engage hard-to-reach groups and under-represented populations, including ethnic minorities, women and young people (Gordon Moody, 2022b). We did not find any text on the website that discussed stigma, or fear and shame in relation to gambling and gambling harms, or discussed stigma as a barrier to seeking help and treatment among people who struggle with gambling.

In our scoping review, stigma, shame and fear experienced by people who gamble is discussed as a key barrier to accessing services in a number of key GambleAware-commissioned reports and programmes, especially among women (Collard et al., 2022, Dinos et al., 2020, Gunstone and Gosschalk, 2019, University of Bristol et al., 2021). This includes a programme led by GamCare called the Women and Gambling Programme (GamCare, 2020).

## Stigmatising language and characterisations

### Stigma drivers: Labelling, blaming and stereotyping

In our textual analysis, we observed that it was common to use terminology such as 'problem gamblers' or 'gambling addicts', which places blame on the

individual, as being a 'problem' and solely responsible for their behaviour. It distinguishes them as different from others who 'have control over their gambling behaviour'.

People who experience gambling harms were characterised in publications conversely as lacking control, as being pathological and as unable to fully exercise agency and self-determination. Similarly, these communities and their activities are moralised and subject to unempirical value judgements in some of the literature reviewed.

The distinction we observe in the scoping review between those who are non-pathological and responsible, and those who are pathological and irresponsible leads to a separation of 'us' from 'them', which allows people to treat them differently based on this distinction (e.g. by separating themselves from or socially excluding the 'problem gambler'). This problematisation of people who experience gambling harms also informs discriminatory generalisations and stereotypes that classify individuals as compulsive, impulsive, and lacking self-control (Hing et al., 2016a).

Other stereotypes also emerged in the scoping review that relate to specific groups, such as older women who gamble. One study describes a 'little old lady' stereotype, which it identifies as relating to older women with more health problems, who rent and receive state income supplements that they spend specifically on gambling in the form of bingo. The authors highlight that this 'little old lady' stereotype appears to be driven by the fact that bingo, among other types of gambling, is more accessible and culturally acceptable for women, particularly older women who may be widowed and seeking some social interaction and inclusion (Cousins and Witcher, 2007).

This construction was found, however, to be stigmatising in its being linked to other negative stereotypes and, in turn, may amplify intersectional stigma. Though these associations and assumptions were not found to have evidentiary support, and the researchers found that the gambling habits of older women were not related to unhealthy lifestyles, negative stereotypes and associations about older women remain common, including smoking, drinking alcohol, or having a poor diet.

Another study examines the construction of social identities of women diagnosed with a gambling disorder. The analysis highlighted how women who gamble can "*construct their identities to fit normative patterns of behaviour*". Specifically, respondents felt they had to establish their identities as normal or 'normative' in order to distance themselves from the stigmatisation associated with gambling.

To do this, the women did not consider themselves to be gamblers, and instead described themselves as multi-dimensional (e.g. working mother, Israeli, wife, etc.), excluding their identity as a 'gambler'. Women would describe themselves as a

working wife and mother and sometimes as a victim of difficult circumstances. Most women would minimise or keep a distance from their gambling identity by emphasising that either they did not know what they were getting into, or that 'this is not them' (Gavriel-Fried et al., 2015).

Second, women justified their gambling as normative by describing their gambling as "*responsible and appropriate when compared to other gamblers*" or by "*normalising the gambling scene*". Third, women who had previously gambled considered themselves as having changed for the better by linking their identity as a gambler to past difficult experiences and hardships (Gavriel-Fried et al., 2015).

The researchers noted the importance of raising awareness among women who gamble about the double stigma they bear as both (1) gamblers and (2) women, as well as the complex processes that underlie the construction of identity and how this might impact the construction of their own identities within societies (Gavriel-Fried et al., 2015, Hing et al., 2016a). Raising awareness of the double stigma will help women better understand the harms associated with gambling (Gavriel-Fried et al., 2015).

Similar to these gendered stigmatisations of gambling and gambling harm, among men – especially young men – sports gambling was found to play a role in the formative construction of their masculine identity. Sports betting success was seen as a means of acquiring cultural capital and better social status among male peers or older males. However, sports betting was perceived by women as 'stigmatising leisure activity' that was capable of prejudicing the young men's prospective or existing intimate relationship with women (Lamont and Hing, 2019).

### Stigma manifestations and coping mechanisms

In our scoping review, one study (Hing et al., 2016a) examined how stigma manifests and what coping mechanisms for stigma are used by people who struggle with gambling. They used in-depth qualitative interviews with 44 people who struggle with gambling and find that public stigma around 'problem gambling' is highly prevalent. Many people who struggle with gambling manifest stigma in the form of perceived and internalised stigma and shame.

The authors note that people who struggle with gambling would often describe themselves as "*being entirely to blame*" for the difficulties they come to experience. They use strong language which demonstrates personal failings that they attribute to their apparent blame-worthiness. These perceptions in turn have a negative impact on self-esteem and self-efficacy, resulting in self-stigma. This acts as a major barrier to disclosing their struggle with gambling and their experience of gambling harms to seek help.

Mental and physical health problems, reported by personal accounts during the qualitative interviews, were quite common among people experiencing stigma and discrimination because of their gambling. Secrecy was found to be the main coping mechanism. This coping strategy was linked to fewer people seeking help and treatment, to self-exclusion from gambling venues or to increased online gambling (Hing et al., 2016a).

Another study, based on recall of a recent gambling loss experience, similarly highlighted the fact that shame is strongly associated with the severity of problems related to gambling following gambling loss (Yi and Kanetkar, 2011).

### **Stigma practices: Service delivery and campaign messages that reinforce stigma**

In our scoping review, one study (Guilcher et al., 2016) explores how men with a history of gambling problems, drug use and housing instability experience health and social services in Canada. The authors report a disconnect between the key messages delivered through treatment programmes and the actual experiences of men who struggle with gambling and gambling harms. For example, participants in these programmes learn how important it is not to judge others, but at the same time, paradoxically report being judged by providers wherever they go.

The researchers found that the health and social needs of most men participating in the treatment programme were not met. Ongoing challenges with perceived stigma (by men) and judgment (by providers) highlighted important areas for improvement, not only with the types of services delivered, but also how these services should be delivered. For example, improving communication competency or increasing awareness of gambling-related harms through the provision of training to service providers, may help minimise stigma and judgement.

Researchers suggested that future interventions should use a 'person-centred' engagement framework to improve service delivery and treatment by service providers. They further suggested that such a framework should include the following key components: empowerment and autonomy; empathy, compassion, and sincerity; respectful communication; and tailored and holistic life plans (Guilcher et al., 2016).

Another study notes the challenges of current public health responses to people who struggle with gambling, stating that *"some campaigns about problem gambling may actually increase stigma, by increasing the separation between 'us' and 'them', such as by describing people with gambling problems as neglecting their families, unable to pay their bills, and irresponsible (Hing et al., 2016a)"*.

The authors therefore emphasise that information campaigns themselves can stigmatise people who experience gambling harms, driving social exclusion, and making damaging and pejorative generalisations about these communities. Ensuring that messages and campaigns do not stigmatise already marginalised populations is clearly both critical and challenging when considering how to create an appropriate message. Emphasis should be placed on getting families and people who struggle with gambling involved, from the inception stage in the development of awareness campaigns, programmes, services and policies, as well as educating health professionals about gambling-related stigma (Hing et al., 2016a).





## Discussion

Our scoping review has identified a significant amount of published research on gambling and gambling harms which uses stigmatising language and portrayals to describe people who struggle with gambling and experience gambling harms. Through highlighting this, we are endeavouring to provide a broader picture in the area of gambling research of the type/extent of (stigmatising) language that is used, and how stigma affects people who struggle with gambling.

We are not making the case that researchers should not report empirical findings on comorbid conditions/difficulties, but instead emphasise the importance of increasing awareness in the research community that stigma is important and that communication strategies, including published work, need to take into account how messages are reported and communicated.

Many of the studies we reviewed linked gambling with other negative stereotypes, and stigmatised conditions and behaviours – particularly around drug use, alcohol use and mental health – even though generalising one stigmatised status as being concomitant with another can exacerbate experienced stigma and discrimination. A few studies examined stigma as a barrier to help-seeking among people who struggle with gambling (to mitigate gambling harms or limit/stop gambling) and offered insights for future programming.

Importantly, our review suggests that the stigmatisation process in people who struggle with gambling is very similar to the stigmatisation that unfolds in the context of health behaviours and conditions, such as mental health, drug and alcohol use, cancer, obesity, and HIV. Specifically, people who experience gambling harms and who gamble come to be understood as being certain types of people with certain generalised attributes. This then drives understandings of these communities as being less worthy than other communities, which in turn drives discrimination and social exclusion.

Using Link and Phelan's model, therefore, we can now see how gambling stigma has emerged in society. In the context of public health, healthcare providers, researchers, and programme implementers typically distinguish between 'healthy' and 'unhealthy' conditions and behaviours. Through this process, we may see how people who struggle with gambling or experience gambling harms are stigmatised, as discussed in this paper, which can lead to discrimination and social exclusion:

- **Labelling.** People who gamble may be split into two groups by their families and communities: 'responsible' or 'irresponsible', based on the outcomes of their gambling behaviour (e.g. financial losses, etc.).

Likewise, researchers may label people who gamble as 'non-problem gamblers' or 'problem gamblers' based on how they score on metrics that assess gambling behaviour. Lastly, healthcare providers may provide a clinical diagnosis based on specific symptoms (e.g. the DSM-V), labelling someone as being a 'gambling addict' versus a 'non-addict'. These labels denote a difference between 'healthy' and 'unhealthy' behaviours.

- **Negative stereotypes.** Once a difference is labelled, it can then be linked to negative stereotypes and assumptions about people who struggle with gambling by family and community members, researchers, healthcare providers and policy makers. For example, individuals labelled as 'problem gamblers' or 'gambling addicts' may be associated with stereotypes about 'the type of people' who are addicts; for example they may be assumed to be selfish, worthless, impulsive, or irresponsible (Brown and Russell, 2020, Ahern et al., 2007, Keane, 2002, Levy, 2014)[2]. Importantly, labelling people who experience gambling harms as 'addicts' identifies them as people who are "pitied, and disempowered as being mentally and physically sick and unable to make decisions about their own lives." (Levy, 2014)
- **Separation of 'us' from 'them'.** Those sorted into distinct categories, such as 'problem gamblers' or 'gambling addicts', and stereotyped, are then considered to be a type of person, not just a person with certain characteristics. This process involves making labels part of a person's identity, part of who they are and part of how others understand them to be, which leads to a separation of 'us' (normatively acceptable) from 'them' (deviant).
- **Status loss and discrimination.** Once a person is separated from the norm (e.g. by being labelled a 'problem gambler', as 'them' as opposed to 'us'), they may experience stigma, including being ostracised by family and friends, and discrimination, such as loss of employment, which may reduce their life chances. Studies have shown that the stigma associated with gambling and gambling harms has been linked with poorer mental health outcomes and less access to and engagement in healthcare services (Hing et al., 2016b, Hing et al., 2016c).
- **Political, social, and economic power reinforces the stigmatisation process.** Public health campaigns that frame 'problem gambling' as the responsibility of individuals (the individuals experiencing gambling harms), relieve the gambling industry and the state of their responsibility in perpetuating a system that is designed to keep people gambling and may lead to poorer health and social outcomes for the most marginalised communities (e.g. minorities, people of a lower socioeconomic status financially, youth, etc.) (Johnstone and Regan, 2020).

As such, the nascent field of gambling-related stigma research would benefit considerably from using existing frameworks of understanding stigmatisation processes, notably the Health Stigma and Discrimination Framework (Stangl et al., 2019) which we have made use of above, and which are based on decades of research on stigma and health conditions. This would allow for these considerable understandings of processes of stigmatisation to inform future research on gambling and gambling harms, as well as intervention development and testing, to mitigate gambling harms.

Labelling and stereotyping were common among the studies reviewed, with people who struggle with gambling being described as compulsive, impulsive and lacking self-control. In addition, stigmatising terms like 'problem gambler' and 'gambling addict' were ubiquitous in research. Their use in research, public health campaigns, and on the websites of non-governmental organisations (NGOs) which provide services to mitigate gambling harms, unwittingly places blame directly on the individual who gambles.

They construct people who experience gambling harms as being a 'problem' and reduce their having a disorder to their entire personhood. As opposed to describing certain types of people (e.g. people who experience gambling harms), they are reduced to 'addicts' and 'problem gamblers'. This approach locates blame and stigma squarely with the individual suffering difficulty and harm, and distracts from addressing the elephants in the room, which are structural determinants that drive gambling harm. These determinants are well understood to be in areas of industry, legislation and policy, as well as sociocultural determinants, notably marginalisation and broader social vulnerabilities.

The use of stigmatising language is problematic, as it reinforces the second stage of Link and Phelan's stigma framework (Link and Phelan, 2001), thus allowing researchers to both view and describe people who struggle with gambling as 'different', as 'the problem'. This leads to a separation of 'us' from 'them'. The distinction negatively influences the type of programming and services provided to support people who struggle with gambling, with the understanding of people who experience gambling harms as being 'them' as opposed to 'us', driving discrimination by service and healthcare providers, denial of services, barriers to accessing services, and other forms of structural violence (Belenko et al., 2016, Camlin et al., 2020, Mbote et al., 2020, Stangl et al., 2019, Turan et al., 2019).

Moving forward, it will be critical for researchers who study gambling and gambling stigma, and programmers who develop support interventions and marketing campaigns, to instead use person-first language to show that gambling disorder is just that: a disorder, not an identity. As we have stressed, it is more appropriate to use, for example, 'person with a gambling disorder' or 'person who struggles with gambling' instead of 'addict' or 'problem gambler'. Using person-first language also shows that a person with gambling disorder

'has' a problem/illness, rather than 'is' the problem. Additionally, person-first language avoids eliciting negative associations, punitive attitudes, and individual blame.

Existing research suggests that people who struggle with gambling can construct their identities to fit normative patterns of behaviour, as a result of the stigma experienced, and use avoidance coping strategies to hide their gambling. These behaviours resemble those found in other population groups who experience health-related stigmas, such as people with mental health problems (Hilbrecht et al., 2020, Isaksson et al., 2018, van Brakel et al., 2019).

In addition, multiple marginalised identities within an individual may be linked to intersectional stigma (Turan et al., 2019), where experiences of stigma in relation to each identity, behaviour or sociodemographic characteristic have a synergistic impact on health and well-being. This is discussed in studies among men who have sex with men and women who have sex with women (Abubakari et al., 2021), cancer patients (Chambers et al., 2015), people with mental health problems (Isaksson et al., 2018) and sex workers (Nnko et al., 2019).

Indeed, gambling may itself be used as a coping mechanism to deal with stress due to other stigmatised conditions or identities (e.g. alcohol use, racism, abuse etc.) (Brown and Russell, 2020, Collard et al., 2022, Currie et al., 2013a, Dowling et al., 2021). This suggests that programmes to support people who struggle with gambling may need to include components addressing intersectional stigma and discrimination due to ethnicity, racism, socio-economic status, alcohol use and/or mental health. This would thus address the underlying issues linked with gambling behaviour.

Understandings of stigmatisation, experienced stigma and discrimination driven by it, as well as broader barriers in accessing services, are key to improve access to and quality of services. From this service and healthcare provider perspective, evidence-based models of delivery which involve collaboration and expertise from across sectors (with services centrally located) can increase service uptake and may discourage feelings of stigma and shame. Central location of services is noted to break down barriers to accessing services (Woodall and Freeman, 2021).

The proximity of services to home is noted to break down barriers to accessing services, especially when treatment services are made more patient-centred and flexible, as seen in other areas of research (i.e. HIV). In addition, the ability to connect with other community members who face stigma and discrimination reduces social isolation, anticipated stigma and disclosure fears (Camlin et al., 2020), which may also have implications for people who struggle with gambling.

These facilitators of service uptake have also been observed with other stigmatised communities. For example, awareness of the availability of care and treatment services is an important facilitator in accessing HIV testing and

counselling services among sex workers (Nnko et al., 2019), young marginalised people (Geibel et al., 2017) and young men who have sex with men and transgender women (Logie et al., 2017). Thus, we may infer that ease of access and comfort with the location of service provision may be helpful for people who struggle with gambling as well, although further research is needed to explore these issues.

Previous research on reducing stigma in other fields, such as HIV, should be drawn upon to develop interventions to reduce gambling stigma and gambling harms (Stangl et al., 2013). For example, mass media campaigns that a) depict people living with HIV as healthy people who are successfully engaged in treatment, and b) encourage support for people living with HIV alongside HIV testing and treatment, coupled with anti-discriminatory laws, have been found to reduce experiences of discrimination and stereotyping reported by people living with HIV (Camlin et al., 2020).

Different approaches may need to be considered for campaigns related to gambling. Key to the success of many stigma-reduction interventions is the engagement of people from communities experiencing stigma and marginalisation. Such engagement ensures that interventions meet the needs of the community, while enhancing the ability of research findings to influence decision-making at service delivery and policy levels (van Brakel et al., 2019, Sievwright et al., 2022).

## Recommendations for research, service provision, and policy

Based on our review of the literature and our expertise on health-related stigma more broadly, we have put together the following recommendations for future research, service provision and policy for reducing stigma related to gambling and gambling harms:

### Best practice

- Establish how people who experience gambling harms are stigmatised in society, and what their experience is of stigmatisation. For GambleAware, the remit of this would be in Great Britain. Particularly, research should identify how people who gamble, and experience gambling harms are:
  - stigmatised and discriminated against by service and healthcare providers
  - stigmatised in civil society, and in the third sector

- stigmatised and discriminated against in the community and by families
- stigmatised in political and policy discourse.
- Conduct research on how gambling-related stigma affects multiply marginalised populations who struggle with gambling in addition to other challenges (e.g. drug use, anxiety and depression, minority status, homelessness, etc.) (Hing et al., 2016a) to inform policy and intervention development.
- Ensure that interventions, programmes and campaigns are evidence-based and informed by relevant stigma and discrimination frameworks, such as the Health Stigma and Discrimination Framework (Stangl et al., 2019)
- Researchers and programmers should use person-first language in their studies and programmes to show that gambling disorder is a mental disorder, not an identity.
  - For example, use 'person with a gambling disorder' or 'person who struggles with gambling' instead of 'addict' or 'problem gambler'.
  - Using person-first language also shows that a person with gambling disorder 'has' a problem, rather than 'is' the problem.
  - Lastly, person-first language avoids eliciting negative associations, punitive attitudes, and individual blame.
  - Stigmatising terms should not be used about people who experience gambling harms. For example, the term 'addict' reduces someone to their disorder.

#### Derived from our scoping review and textual analysis

- Ensure that people who struggle with gambling are actively engaged in all research, programme, and policy development efforts. This may require supporting community members in the form of training and/or counselling to overcome internalised stigma, or the belief that negative stereotypes about people who struggle with gambling are true and apply to themselves.
- Raise awareness among the public, healthcare providers, policy makers and the gambling industry of what gambling stigma is and how it is harmful to people who struggle with gambling and their families, preventing them from accessing services to mitigate gambling harms.

Campaigns should also note the intersectional nature of gambling stigma, which often co-occurs with stigmas related to identity (e.g. age, gender, race, socioeconomic status), other existing health conditions (e.g. mental health challenges, chronic illnesses) and behaviours (e.g. drug and alcohol use) (Hing et al., 2016a).

- Train healthcare providers on gambling stigma, including how it interferes with care and treatment, as well as on strategies they can use for helping their clients cope with gambling-related stigma and gambling harms (Hing et al., 2016a). For example, delivering integrated services in a one-stop-shop, co-located with other health services in a central location (Guilcher et al., 2016, Woodall and Freeman, 2021).
- Provide support services for people who struggle with gambling that are empowering, support autonomy, empathy, compassion and sincerity, and promote respectful communication, and tailored and holistic life planning (Dinos et al., 2020, Guilcher et al., 2016, Woodall and Freeman, 2021).

## Recommendations for media campaigns and messaging

To avoid stigmatising populations targeted when designing a campaign, **do not:**

- link gambling with other stigmatised conditions or behaviours
- try to instil fear with the images selected
- shame and blame people who gamble.

To facilitate behaviour change in a non-stigmatising way when designing a campaign, **do:**

- use images that empower and motivate people to change their behaviour
- utilise opinion leaders (e.g. individuals who exert a significant amount of influence within their network and who can affect the opinions of connected individuals) to deliver messages
- actively engage the community of people who struggle with gambling throughout the campaign development process
- name stigma and describe its harmful consequences
- use person-first language.



## Conclusion

In this paper, we synthesised evidence on stigma, discrimination and gambling from 54 individual studies and nine review papers across 19 countries. We used this to provide key recommendations for research, service provision, policy, and media campaigns which can strengthen the evidence-base and improve programmatic responses in order to reduce stigma and discrimination experienced by people who gamble moving forwards.

Given the high prevalence of gambling in Great Britain and the significant harms being reported among both adolescents and adults, it is critical that programmes and policies to prevent or mitigate such harms are prioritised. Stigma reduction interventions in order to reduce gambling-related harms would be beneficial.

These could include the training of healthcare providers on gambling stigma, along with raising awareness among the public, healthcare providers, policy makers and the gambling industry of the impact of gambling stigma on people who struggle with gambling. Such interventions should be evidence-based and guided by conceptual frameworks which incorporate gambling-related stigma and are informed by the breadth of research on reducing health-related stigma and discrimination.

In addition, more research is needed about stigma and gambling, and the factors associated with gambling harms in Great Britain, to inform programmes and policies. This is particularly true among multiply marginalised populations. People who struggle with gambling should be central to these efforts and actively engaged in the research, programme, and policy agenda. Only then will support, care and treatment services meet their needs.

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## Appendix S1. Search strings in four databases

### PubMed

((((((((((((((((((Gambling[MeSH Terms]) OR ("Gambling disorder"[Title/Abstract])) OR ("Perception of gamblers"[Title/Abstract])) OR ("Problem gambler"[Title/Abstract])) OR ("gambling problems"[Title/Abstract])) OR ("Help seeking"[Title/Abstract])) OR ("Gambling expenditures"[Title/Abstract])) OR ("Readiness to change"[Title/Abstract])) OR ("Problem gambling"[Title/Abstract])) OR ("Mental health"[Title/Abstract])) OR ("Gambling harm"[Title/Abstract])) OR ("Social distance"[Title/Abstract])) OR ("Treatment-seeking"[Title/Abstract])) OR (Norms)) OR (Severity))

AND

((((((((((((((((((("Social stigma") OR ("Public stigma")) OR ("Societal stigma")) OR ("Social Discrimination")) OR (Prejudice[MeSH Terms])) OR (stereotyping[MeSH Terms])) OR (stigma[MeSH Terms])) OR (discrimination[MeSH Terms])) OR (equalit\*[Title/Abstract])) OR (inequalit\*[Title/Abstract])) OR (equit\*[Title/Abstract])) OR (inequit\*[Title/Abstract])) OR (oppress\*[Title/Abstract])) OR (racis\*[Title/Abstract])) OR (marginaliz\*[Title/Abstract])) OR (coping[MeSH Terms])) OR (stereotypes[MeSH Terms])) OR (devaluat\*[Title/Abstract]))

AND

(((((intersect\*) OR (multipl\*)) OR (interlock\*)) OR (overlap\*)) OR (layer\*)) OR (nexus))

### Scopus

( ABS ( gambling OR "Gambling disorder" OR "Perception of gamblers" OR "Problem gambler" OR "gambling problems" OR "Help seeking" OR "Gambling expenditures" OR "Readiness to change" OR "Problem gambling" OR "Mental health" OR "Gambling harm" OR "Social distance" OR "Treatment-seeking" OR norms OR severity )

AND

ABS ( "Social stigma" OR "Public stigma" OR "Societal stigma" OR "Social Discrimination" OR prejudice OR stereotyping OR stigma OR discrimination OR equalit\* OR inequalit\* OR equit\* OR inequit\* OR oppress\* OR racis\* OR marginaliz\* OR coping OR stereotypes OR devaluat\* )

AND

ABS ( intersect\* OR multipl\* OR interlock\* OR overlap\* OR layer\* OR nexus ) )

**PsychINFO (Multi-field search, there is the option for MeSH, text word, title, abstract, all fields)**

("gambling"[MeSH Terms] OR "Gambling disorder"[Title/Abstract] OR "Perception of gamblers"[Title/Abstract] OR "Problem gambler"[Title/Abstract] OR "gambling problems"[Title/Abstract] OR "Help seeking"[Title/Abstract] OR "Gambling expenditures"[Title/Abstract] OR "Readiness to change"[Title/Abstract] OR "Problem gambling"[Title/Abstract] OR "Mental health"[Title/Abstract] OR "Gambling harm"[Title/Abstract] OR "Social distance"[Title/Abstract] OR "Treatment-seeking"[Title/Abstract] OR ("normative"[All Fields] OR "normatively"[All Fields] OR "normativeness"[All Fields] OR "normatives"[All Fields] OR "normativity"[All Fields] OR "normed"[All Fields] OR "norming"[All Fields] OR "norms"[All Fields]) OR ("sever"[All Fields] OR "severe"[All Fields] OR "severed"[All Fields] OR "severely"[All Fields] OR "severer"[All Fields] OR "severes"[All Fields] OR "severing"[All Fields] OR "severities"[All Fields] OR "severity"[All Fields] OR "severs"[All Fields]))

AND

("Social stigma"[All Fields] OR "Public stigma"[All Fields] OR "Societal stigma"[All Fields] OR "Social Discrimination"[All Fields] OR "prejudice"[MeSH Terms] OR "stereotyping"[MeSH Terms] OR "Social stigma"[MeSH Terms] OR "discrimination, psychological"[MeSH Terms] OR "equalit\*" [Title/Abstract] OR "inequalit\*" [Title/Abstract] OR "equit\*" [Title/Abstract] OR "inequit\*" [Title/Abstract] OR "oppress\*" [Title/Abstract] OR "racis\*" [Title/Abstract] OR "marginaliz\*" [Title/Abstract] OR "adaptation, psychological"[MeSH Terms] OR "stereotypic movement disorder"[MeSH Terms] OR "devaluat\*" [Title/Abstract])

AND

("intersect\*" [All Fields] OR "multipl\*" [All Fields] OR "interlock\*" [All Fields] OR "overlap\*" [All Fields] OR "layer\*" [All Fields] OR ("nexus"[Supplementary Concept] OR "nexus"[All Fields] OR "nexus"[All Fields] OR "gap junctions"[MeSH Terms] OR ("gap"[All Fields] AND "junctions"[All Fields]) OR "gap junctions"[All Fields]))

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