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Tarred with the same brush: An initial Inquiry into Courtesy Stigma and Problem Gambling

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Abstract

Introduction: This study explores the relative intensity of courtesy stigma around problem gambling to other stigmatized conditions, and the ways in which courtesy stigma (or fear thereof) impacts problem gambling.

Method: We draw on data from a government-commissioned national survey in a southern Caribbean country (*n* = 1,008). Comparative t-tests and multiple regression (ordinary least squares) were used to identify relative intensity and what impacts courtesy stigma of problem gambling, respectively. Statistical significance was set up at *P* < 0.05.

Results: Problem gambling by a family member elicits more shame/embarrassment (M = 1.75) than using a wheelchair (M = 1.15) and having a mental illness (M = 1.22), but less shame than having a drug problem (M = 2.12) and on par with having an alcohol problem (M = 1.79, ns). With respect to courtesy stigma around problem gambling, the extents to which one considers various activities 'gambling' (b = -0.031, B = -0.068), one gambles him or herself (b = -0.015, B = -0.127), and the quality of experience with gambling (i.e. positive/negative; b = -0.038 B = -0.095) impacts potential embarrassment of a family member with a gambling problem. Catholics (b = 0.357, B = 0.355) and Hindus (b = 0.378, B = 0.376) were more likely to be embarrassed or ashamed than Anglicans, Muslims, Protestants, and other religions. Additionally, the unemployed (b = 0.282, B = 0.150) and the self-employed (b = 0.292, B = 0.290) were more likely to be embarrassed of a family member with a gambling problem.

Discussion and conclusions: Normalization of gambling in the family impacts how much shame or embarrassment one feels about their problem-gambling family member. Moreover, some religions (Catholic and Hindu) and economic positioning (unemployed and self-employed) may affect embarrassment or shame of problem gambling family members.

KEY WORDS: courtesy stigma; problem gambling; shame; stigmatization.

Riassunto

Introduzione: Questo studio esplora la relativa intensità dello stigma di cortesia intorno al gioco d'azzardo rispetto ad altre condizioni stigmatizzate ed i modi in cui lo stigma di cortesia (o la paura dello stesso) impattano il gioco d'azzardo.

Metodi: Abbiamo ottenuto i dati da uno studio nazionale commissionato dal governo in uno stato meridionale dei Caraibi (n = 1,008). I T-tests comparativi e la regressione multipla (regressione lineare semplice) sono stati rispettivamente usati per identificare la relativa intensità e valutare cosa influenza lo stigma di cortesia relativamente al gioco d'azzardo. La significatività statistica è stata posta a $P < 0.05$.

Risultati: Il gioco d'azzardo di un membro della famiglia sollecita più vergogna ed imbarazzo (M = 1.75) che essere sulla carrozzella (M =1.15) ed essere affetti da una malattia mentale (M = 1.22), ma meno vergogna che avere un problema di tossicodipendenza (M = 2.12) ed alla pari con l'avere un problema di alcol (M = 1.79, ns). Rispetto allo stigma di cortesia sul gioco d'azzardo, il limite con cui uno considera le varie attività come "gioco d'azzardo" (b = -0.031, B = -0.068), con cui uno gioca d'azzardo (b = -0.015, B = -0.127), e la qualità dell'esperienza con il gioco d'azzardo (ovvero positiva/negativa; b = -0.038 B = -0.095) determinano un potenziale imbarazzo rispetto ad un membro della famiglia che gioca d'azzardo. I cattolici (b = 0.357, B = 0.355) e gli induisti (b = 0.378, B = 0.376) avevano più probabilità di essere imbarazzati o di provare vergogna degli anglicani, mussulmani, protestanti e di appartenenti ad alter religioni. In aggiunta, le persone disoccupate (b = 0.282, B = 0.150) ed i lavoratori impiegati in proprio (b =

0.292, B = 0.290) avevano più probabilità di essere imbarazzati per un membro della famiglia con un problema di gioco d'azzardo.

Discussione e Conclusioni: La normalizzazione del gioco d'azzardo nella famiglia determina quanta vergogna o imbarazzo una persona prova sui problemi relative al gioco d'azzardo di un membro della propria famiglia. Inoltre, alcune religioni (Cattolica ed Indù) e posizioni economiche (disoccupati e lavoratori in proprio) possono esercitare un influenza sull'imbarazzo o la vergogna dei membri di familiari con problemi di gioco d'azzardo.

TAKE-HOME MESSAGE: Courtesy stigma towards problem gambling family members varies by what one considers 'gambling', gambling participation, experiences with gambling, employment status, and religion. Moderate courtesy stigma is a protective factor against normalization of problematic gambling among family members.

INTRODUCTION

The relationship between public stigma and problem gambling is an emerging topic of interest, especially how stigma can act as a barrier to treatment for gambling addiction [1]. Fear of being shamed by others and self-stigmatization are some of the most researched barriers to treatment, and the negative affective and social impacts of this stigma are well-documented in the literature including social isolation, family problems, and financial hardship, among others [2–5]. Indeed, shame—either self-shaming or being shamed by others—is one of the most pertinent barriers to recovery for problem gamblers.

A symbolic interactionist, Erving Goffman had much to say about shame and stigma, and his work has been applied elsewhere to problem gambling [6]. In this study we concern ourselves specifically with Goffman's notion of *courtesy* stigma. In addition to his writings on public or general stigma, Goffman used the term "courtesy stigma" to describe a once-removed stigma; that is, the stigmatization of those associated with the stigmatized (in this study, problem gamblers) [7]. This association can be through family or marital ties, or voluntary connections, such as friendship. Courtesy stigma is especially difficult to endure, since an individual has reason to be rejected by both 'normal' and stigmatized groups. For this reason, courtesy-stigmatized relations tend to be terminated or avoided [7]. This point has been re-asserted in contemporary literature drawing on Goffman's concept, highlighting strain between caregivers and disabled children/patients [8–17]. Until now, these (typically qualitative) studies usually draw on smaller, purposive samples of family members or caregivers. However, researchers have

been recently applying the concept to shed light on other marginalized roles and relationships, including sex workers [12] and parents of mass murderers [18].

We wish to continue extending the idea of courtesy stigma, applying it to problem gambling. There are no published studies, theoretical or otherwise, that explicitly link courtesy stigma and its potential isolating effects to problem gamblers. As mentioned in the introduction, some studies hint at the detrimental effects of close friends and family members being embarrassed or ashamed of someone with a gambling addiction. Evans and Delfabbro found that having friends, family, and co-workers who know about one's gambling addiction were one of the biggest obstacles to seeking treatment [19]. This can lead problem gamblers to delay initiating the help-seeking process until they reach desperation, at which point social isolation (motivated by shame and secrecy) complicates recovery. As a result, fear of embarrassing one's primary and secondary social groups is a primary barrier to asking for help [1–3, 5, 20–22]. This is especially problematic, since according to one Canadian study, friends and family are the first step to recovery in nearly half of problem gambling cases [23]. These smaller-scale studies illustrate how courtesy stigma is relevant to understanding problem gambling and how to treat it, but only implicitly. Therefore, this study aimed to finally explicate the relationship between courtesy stigma and problem gambling, drawing on a large-scale survey.

The current study

Because this study was exploratory, we refrained from making hypotheses about relationships between specific variables. Nonetheless, it is worth noting that some theories about public stigma may be applicable to courtesy stigma. Social psychologists linking public stigma to problem gambling have highlighted the relevance of three factors: perception of control (i.e., whether the

stigmatized condition is caused by the person's voluntary behaviour), the perception of danger caused by the condition, and the level of contact the observer has with the condition in question [1, 24–26]. With respect to courtesy stigma, it might then be the case that individuals who blame family members for problem gambling, who see them as dangerous (physically, financially, or otherwise), and who have less experience with problem gamblers may be more apprehensive of courtesy stigma and more likely to avoid or terminate relationships with those family members.

The study objectives

This study was interested in exploring (a) the relative intensity of courtesy stigma associated with problem gambling, and (b) different factors that might underlie familial apprehension of courtesy stigma. As we explain in the methods section, we operationalize 'courtesy stigma' as the extent to which individuals would feel shame or embarrassment about being related to a problem gambler, due, in part, to fear of being stigmatized by association. Hence, we are examining individuals' attitudes toward hypothetical problem gambling family members, or their levels of *anticipatory* courtesy stigma. To do this, we drew on a survey commissioned by a Caribbean country to understand various issues associated with gambling.

METHODS

Study population and statistical analysis

This survey, administered to a sample of adults in a southern Caribbean country ($n = 1,008$), asked a variety of questions related to gambling behaviours. The sample consisted of 554 men (55%) and 454 women (45%), with a mean age of 43.22 ($SD = 16.54$). To ensure representativeness, a proportionate stratified random sample was drawn on at the national level

using the cluster method. Trained interviewers travelled to selected houses to complete face-to-face interviews, which were then recorded. Respondents answered 99 questions about the participation of respondents and their social networks in gambling activities, the socio-economic impact of pathological and compulsive gambling, and attitude towards gambling as a recreational activity more generally. At the time the study was carried out, the country and institution had no appropriate Institutional Review Board (IRB) from which to receive approval. However, researchers followed APA Ethical Guidelines, and informed consent was received from respondents before the interview was carried out. Comparative one-sample t-tests were used to assess courtesy stigma scales of gambling problems to other stigmatized conditions including using a wheelchair, mental illness, having an alcohol problem, and having a drug problem. To deal with missing data, multiple imputation was used and final bivariate and multivariate (OLS) estimates were averaged across 20 data sets. Table 1 shows a breakdown of discrete and continuous variables. Statistical significance was set up at $P < 0.05$. Both bivariate analyses as well as OLS regression modeling with attitudinal, experiential, and socio-demographic independent variables were conducted to test hypotheses relating these variables to courtesy stigma.

Study variables and instruments

The survey provided a unique opportunity to explore explanatory factors associated with courtesy stigma. The dependent variable in the study is illustrated in Table 1. It asked how ashamed respondents would be of a hypothetical family member who had a gambling problem; responses ranged from 'not embarrassed at all' (1) to 'very embarrassed' (4). We realized this was an indirect measure of courtesy stigma, insofar as it uses levels of shame to infer *fear* of

courtesy stigma. However, this was still a useful indicator, insofar as shame and embarrassment can tell us something about potential strain in relationships brought on by family members' problem gambling [2–3]. Others have also used similar measures when studying courtesy stigma [27]. In sum, we have measured a fear of courtesy stigma (i.e., fear of public stigma 'contaminating' family members) through levels of shame and embarrassment.

Although the dependent variable had only four categories, given that it was approximately normally distributed ($s = .997$; $k = .-377$), we chose to treat it as a continuous variable for the purposes of these analyses [28]. Last, because this is the first study of its kind, it is important to keep in mind the analyses generated here are largely exploratory.

For organizational purposes, independent variables in the model were categorized as attitudinal, experiential, and socio-demographic. The first category asked about beliefs and dispositions toward gambling more generally. These included Likert scale questions asking respondents whether they thought gambling was immoral, whether government should regulate it, or if controlling one's own gambling habits is a matter of willpower. This last variable is especially important as it concerns the characterization of problem gambling by respondents. For all these variables, a higher value indicated negative attitudes about gambling (gambling is immoral, government should regulate gambling) or gamblers (gambling problems reflect a lack of willpower). Further, two indexes were constructed for inclusion in this section. The first measured to what extent respondents hold a 'contemporary' or liberal view of gambling ($a = .674$, $r = .509$), constructed from two Likert scale items asking respondents whether 'most people can make a good living by gambling' and if 'gambling is a safe, enjoyable activity'. A higher score indicates stronger belief in both.

The second was constructed from twenty-one items and measured what we call 'gambling salience', or how broad respondents' conceptualization of gambling activity was as indicated by what activities they perceived as 'gambling' ($a = .930$). The higher a respondent's score on this index, the wider the range of gaming activities they considered to be gambling. For example, the index asked respondents if they considered casual betting on pool, sports games, or horse/dog racing as gambling. The index also asked respondents if they considered activities gambling when they are free of cost, such as internet gaming or 'text-to-win sweepstakes'. If one considers free activities gambling, then the act of gambling can become much more salient in that individual's life than someone who only considers costly activities gambling.

Experiential variables were concerned with the experiences respondents and their families have had around gambling. Several indices were constructed from relevant items in the dataset. With two exceptions addressed below, all indices were additive, with higher scores indicating more of the construct in question. For self-participation, a 21-item index was constructed ($a = .877$) asking how frequently the respondent participated in a series of different types of gambling activity. Family participation was measured by a single question asking respondents how many members of their immediate family participated in those same activities. A related question asked 'how much money respondents spent on gambling' (which can vary independently from how frequently they gamble). Other indices were included under this category, including the Problem Gambling Severity Index (PGSI) ($a = .877$); a 'negative experiences' index that measured how gambling negatively impacted the respondents' own lives—for example, whether gambling had ever led to the loss of a job, violent situations, or homelessness for themselves or members of their family ($a = .960$); and lastly, the extent to which gambling had impacted the professional

lives of the respondents (a = .791) or their families (a = .816). The latter two indices asked

respondents, for example, if gambling had ever made them or a family member late for school or

work or led to neglect of work or school-related duties.

In addition to these measures, two more indices were constructed. The first was an additive,

bidirectional 'Family Impact' index constructed from five items asking respondents how

gambling activities impacted their families on different dimensions. This included finances,

communication, trust, planning for the future, and family obligations (a = .900). The

bidirectionality of this index tapped into an important nuance that has yet to be addressed in the

literature: the possibility of gambling being perceived as having positive impacts on the family. A

greater positive score indicated that the respondent reported a perceived positive impact, where a

greater negative score indicated a negative impact.

The other index was an 'intensity of harm' scale that measured how gambling impacted

respondents' acquaintances, friends, and family (a = .884). This index was weighted and

consisted of three categories of contacts: those close to the respondent (e.g., spouse), those less

close (e.g., neighbour) and those in between (e.g., a friend). Each category was weighted in

proportion to their closeness to the contact, and subsequently added to create an index that

captures the intensity of harm done to a respondent's social network. To introduce appropriate

controls and further explore associations with courtesy stigma, we included all available

sociodemographic variables from the survey: income, education, age, religion, ethnicity, sex, and

marital status. Income was measured on a 12-point scale (1 = no income; 12 ≥ $50,000) while

education was measured on an 8-point scale (1 = no education; 8 = university-educated). Due to

multicollinearity (VIF > 10) between the Urban-Rural indicator and Indian ethnicity, we opted to exclude the former variable as it had less impact in the model than the latter.

RESULTS

Descriptive analysis

Univariate descriptive statistics are reported in Table 1. Table 2 shows the intensity of respondents' anticipatory courtesy stigma toward family members with gambling problems compared to other conditions. Embarrassment or shame of family members having a gambling problem ($M = 1.75$) was significantly greater than that associated with using a wheelchair ($M = 1.15$, $P < .05$) or having a mental illness ($M = 1.22$, $P < .05$), nearly identical to that associated with an alcohol problem ($M = 1.79$, ns), and significantly less than that associated with a drug problem ($M = 2.12$, $P < .05$).

Table 1. Summary of discrete and continuous variables.

	Mean	Standard deviation	Min	Max
Attitudinal				
Immorality	2.97	1.42	1	5
Willpower	2.37	1.26	1	5
Benefits economy	2.58	1.09	1	5
Should be regulated	2.36	0.981	1	5
Contemporary worldview	3.75	2.25	2	10
Gambling salience index	21.6	2.174	21	42
Experiential				
Self-participation	25.5	8.38	21	82
Family participation	1	1.56	0	10
Spending on gambling	2.5	3.35	0	16
PGSI	0.952	2.46	0	24
Family Impact Index	-0.96	2.56	-10	10
Intensity of Harm	27.07	20.36	0	56

Negative Experiences	0.792	1.86	0	9
Professional life (self)	0.328	1.92	0	15
Professional life (family)	0.736	2.48	0	18
Socio-demographics				
Income	3.22	1.19	1	12
Age	43.22	16.54	18	99
Education	4.11	1.1	1	8

With respect to gambling among the respondents themselves, 51% (n = 514) reported gambling

at least once a month. In the entire sample, 75.5% scored 0 on the PGSI, indicating no risk for

problem gambling; 16.2% were at low risk for problem gambling (1-4), 4.5% were of medium

risk (5-7), and 3.8% were high risk (8+). With respect to loved ones and family members, 46.4%

reported that at least one family member gambles regularly.

Bivariate analysis

The correlation matrix (Table 3) reveals a pattern of weak correlations that suggest there is

limited applicability of concepts from research on public stigma and problem gambling.

Attitudinally, these included negligible associations with whether respondents believed gambling

benefits the economy (r = -.067, P =.033) and the contemporary worldview index (r = -.097, P =.

002). Importantly, the variable that aligns most closely to attribution theory—whether controlling

gambling habits is a matter of willpower—was neither impactful nor significant (r = -.009, P =.

569). This was also the case for experiential variables.

Table 2. Relative intensity of courtesy stigma of problem gambling.

Notes: Distribution of responses to the question "Would you feel ashamed of a family member who…"

* Indicates significant difference t from gambling problem (P < .001)

Condition	Not at all embarrassed	A little embarrassed	Embarrassed	Very embarrassed	Mean (SD)

Has to use a wheelchair	91.3	4.7	2.1	2	1.15 * (.536)
Is mentally ill	86.6	7.5	3.5	2.4	1.22* (.618)
Has a gambling problem	57.9	17.1	16.7	8.2	1.75 (1.008)
Has an alcohol problem	55.6	19.2	16.2	9	1.79 (1.017)
Has a drug problem	46.1	14.1	21.7	18.1	2.12* (1.178)

Briefly turning our attention to the rest of the bivariate correlations (Table 3), some of the more notable variables include contemporary worldview and the PGSI. Notably, a liberal attitude toward gambling—thinking that it is a safe activity and a legitimate way to make money—is positively correlated with self-participation (r = .373, P <.0001), spending money on gambling (r = .358, P <.0001) and problem gambling (r = .255, P <.0001). As expected, problem gambling interferes with the professional lives of both gamblers themselves (r = .537, P <.0001) and to a lesser extent, their families (r = .119, P <.001). Additionally, those scoring higher on the PGSI reported more gambling-related harms to their social networks in the intensity of harm index (r = .148, P = .042), indicating either a social component to the behaviour itself, or problem gamblers perceive themselves to be causing harm to their loved ones. Considering the positive correlations between viewing gambling as immoral and participation-related variables, it is likely that participant shame about the latter is feeding the former [2, 3, 29].

Multivariate analysis

As shown in Table 4, OLS Regression analysis indicates some shifts from the bivariate analyses. A goodness of fit test indicated that the model was of good fit to the data (X^2 = 73.7, P < .001). Notably, all attitudinal variables became non-significant while the gambling salience index (B =

-0.068, $P < .05$) became significant with a weak impact on anticipatory courtesy stigma. This suggests that the extent to which the other attitudinal variables impact anticipatory courtesy stigma depends on how many activities qualify as 'gambling' to a respondent. Significant experiential variables retained from the bivariate analyses included self-participation ($B = -0.127$, $P < .05$) as well as the family impact index ($B = -0.095$, $P < .05$) with the former having a stronger influence.

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
1	-														
2	.120**	-													
3	-0.063*	.062*	-												
4	0.011	.076*	.310***	-											
5	-0.066*	.175***	.248***	.145***	-										
6	0.052	-0.034	-0.048	0.00	-.111**	-									
7	.101**	-.095**	-.135**	-.102**	.373***	-.121**	-								
8	.120**	-0.064*	.164***	.128***	.358***	.133***	.747**	-							
9	0.077*	-0.076*	.085**	-0.064*	.255***	0.041	.579**	.514**	-						
10	-0.027	0.06	-0.061	-0.013	0.028	-0.081*	0.00	0.037	-0.004	-					
11	0.071	-0.066	-0.047	.192**	0.028	-0.001	.253***	.192**	.148*	0.001	-				

	1	2	3	4	5	6	7	8	9	10	11	12	13	14
12	-0.036	-0.061	-0.057	-0.023	0.019	-0.073	0.171**	.107*	.277*	-.220*	0.067	-		
13	0.023	0.015	.124**	-0.05	.152**	-0.003	.423***	.320***	.537***	-0.034	0.003	.366**	-	
14	-0.018	-0.034	0.000	-0.024	0.007	-0.021	.097*	0.057	.119***	.269***	-0.121	.518**	.254**	-
15	0.018	0.009	-.067*	-0.002	-.097*	-0.058	-.067*	-.065*	0.008	-.086*	0.068	.104**	0.011	0.056

Notes: 1 Immorality; 2 Willpower; 3 Benefits economy; 4 Should be regulated; 5 Contemporary worldview; 6 Gambling salience index; 7 Self-participation; 8 Amount spent on gambling; 9 PGSI; 10 Family impact index; 11 Intensity of harm index; 12 Negative experience index; 13 Affects own work life; 14 Affects family work life; 15 Courtesy stigma index

* P <.05; ** P <.01; *** P <.001

Table 3. Bivariate correlations of all variables.

There are also socio-demographic differences apparent in the shift from bivariate to multivariate analysis. Neither having African ancestry, nor being male affected anticipatory courtesy stigma in the regression model. Religion and economic positioning were positively associated with anticipatory courtesy stigma, more strongly than either the attitudinal or experiential variables. Identifying as either Catholic ($B = 0.355$, $P < .05$) or Hindu ($B = 0.376$, $P < .05$) was associated with greater likelihood of reporting higher shame of problem gambling family members than those identifying with no religion. With respect to economic positioning, the unemployed ($B = 0.282$, $P <. 05$) and the self-employed ($B = 0.292$, $P < .05$) were also more likely to report more shame of problem gambling family members than the regularly employed. Looking at the standardized beta weights of all variables, it is apparent that *who* respondents are matters more than *what* they believe or *how* they experience gambling.

Table 4. Results of OLS regression.

Variables	b (se)	B
Intercept	0.495 (0.526)	
Attitudes and Worldview		
Gambling is an immoral act	0.024 (0.028)	-0.034
Gambling is a matter of willpower	-0.017 (0.029)	-0.022
Gambling benefits the economy	-0.035 (0.032)	-0.038
Gambling should be regulated	-0.010 (0.045)	-0.010
Contemporary Worldview	-0.015 (0.020)	-0.034
Gambling Salience Index	-0.031 (0.017)*	-0.068
Experience with Gambling		
Self Participation	-0.015 (0.009)*	-0.127
Family Participation	0.032 (0.033)	0.050
Amount Spent on Gambling	-0.008 (0.016)	-0.025
PGSI	0.023 (0.020)	0.056

Family Impact Index	-0.038 (0.020)*	-0.095
Intensity of Harm Index	0.007 (0.007)	0.160
Negative Experiences Index	0.058 (0.037)	0.109
Affects Own Professional Life	-0.011 (0.029)	-0.021
Affects Family's Professional Life	0.021 (0.039)	0.050
Socio-demographic Variables		
Sex – Male	-0.077 (0.075)	-0.077
Marital Status - Married	0.039 (0.078)	0.039
Income	0.045 (0.035)	0.053
Education	0.069 (0.034)	0.075
Age	-0.001 (0.003)	-0.018
Ethnicity		
African	-0.137 (0.109)	-0.136
White	0.122 (0.293)	0.121
Mixed	-0.172 (0.112)	-0.171
Religion		
Catholic	0.357 (0.187)*	0.355
Hindu	0.378 (0.189)*	0.376
Anglican	0.171 (0.199)	0.170
Muslim	0.268 (0.217)	0.266
Protestant	0.132 (0.168)	0.131
Other Religions	0.253 (0.256)	0.251
Occupational Status		
Retired	0.105 (0.105)	0.104
Unemployed	0.282 (0.150)*	0.280
Wife/Homemaker	0.048 (0.143)	0.048
Self-Employed	0.292 (0.167)*	0.290

Notes: * P < .05; robust standard errors in parentheses; R^2 = .106

DISCUSSION

First, it should be noted that our finding about the comparative courtesy stigmatization contrasts with other studies, where mental illness and drinking problems were more dangerous than problem gamblers [25]. However, from an attribution perspective, this finding does align with

conclusions by Hing and colleagues, who argued mental illness is typically seen as beyond the control of the stigmatized person in question [4]. One limitation of the available evidence is that 'mental illness' encompasses a wide range of issues. Feldman and Crandall for example found participants wanted more social distance from those with antisocial personality disorder, but less distance from those with depression [24]. As such, we make this comparison with care.

Second, bivariate analyses suggest most concepts from the literature on public stigma and problem gambling—specifically the danger posed by the individual with the condition, and the level of contact with the condition more broadly—have, at best, a very weak impact on courtesy stigma. When controls are introduced at the multivariate level, it appears that one's experience with gambling is more strongly supported in terms of explaining courtesy stigma as we measure it here.

We suggest this finding is germane to the study of courtesy stigma itself. As all problem gambling research so far is about *public* or *self-stigma*, and asks participants about strangers or themselves, our dependent variable asks about individuals related to respondents, or the 'wise' others of (hypothetical) problem gamblers. By 'wise', Goffman meant greater intimacy and familiarity with the stigmatized individual, allowing a wise person to see 'past the condition' and assess the individual more holistically. This 'wisdom' hence acts as protectant against potentially blaming the individual for their condition and seeing them as a dangerous person. What remains interesting, and constitutes the major findings of this study, is the contact, and the *quality* of contact, respondents have with gambling as a practice. We suggest, as others have, that the quality of contact with gambling (i.e., positive or negative experiences) has critical effects on relationships within the family [30].

Most importantly, our results carve a path forward for further research linking courtesy stigma to problem gambling. This path has to do with the quality of one's contact and experience with gambling as a recreational activity. Two new findings from this study contribute to understanding this relationship: (a) the importance of the extent to which gambling is normalized within the family, and (b) the influence of religion and economic positioning on embarrassment or shame of problem gambling family members.

Both bivariate correlations (Table 3) and multivariate analyses (Table 4) suggest that the normalization of gambling in the family impacts how much shame or embarrassment one feels about their problem-gambling family member. This normalization is dually constituted by both an attitudinal and experiential dimension. Attitudinally, what counts as 'gambling' behaviour will influence how a spouse, child, or other family member will feel about their problem-gambling relative. The negative correlation of the gambling salience index indicates that anticipatory courtesy stigma decreases as the range of activities considered gambling increases.

This is linked, in turn, to the perception of how common or deviant gambling activities are. The more activities one considers 'gambling', the more 'gamblers' one will witness in one's life and the more tolerant one is of, or habituated to, gambling activity—hence, if one perceives gambling and gamblers as prevalent and normal, a problem gambler's behaviour will seem relatively unremarkable or unproblematic. The shifts in significance from bivariate to multivariate analyses further suggest that this variable could be an important moderator between variables (i.e., how 'normal' gambling seems to a family member impacts how much loss/ negativity they will tolerate from gambling behavior).

Experientially, there are two variables of interest evident in the regression analysis. These are the self-participation and the family impact index. First, it seems intuitive that those who gamble themselves will consider problem gambling less embarrassing or shameful. This suggests that familiarity with the activity of gambling (and not simply familiarity or contact with problem gamblers themselves) will dampen potential embarrassment or shame toward family member's problem gambling. The second variable of interest is the 'family impact' index. This finding is interesting because of the index's bidirectionality, meaning that it measured not only experience with gambling in the family, but the *quality* of that experience. Participants had the opportunity of reporting positive experiences they have had through or because of gambling, such as the perception of 'winning big'. Like the other experiential variable, this relationship is also intuitive; reporting a negative impact on the family implies more embarrassment or shame regarding a family member who problem gambles. Conversely, reporting a positive impact implies *less* embarrassment or shame. In other words, the more negative the family impact, the greater the embarrassment or shame, the more positive the family impact the lesser the embarrassment or shame.

These insights are particularly important for existing research on 'concerned significant others' (CSOs) and their role in recovery from problem gambling. For example, Svensson and colleagues (2013) found that CSOs—particularly male CSOs—are also likely to be engaged in problem gambling alongside their partners. A growing body of literature has taken up the task of studying CSOs as well as other family members, and the detrimental health effects of financial and emotional strain within families caused by problem gambling [30–35]. The fear of courtesy stigma plays a clear role in families where gambling has been perceived to have a negative

impact, and this may interfere with family-centric dynamics designed to help with addiction. This is especially true in the case of problem gamblers' spouses, where it is the latter who primarily initiate treatment [36–38]. Importantly, it may interfere differently depending on the quality of experience with gambling within the family. If the experience has been primarily seen as negative, a fear of courtesy stigma can interfere with recovery by putting strain on relationships, with shame feeding denial and withdrawal by the at-risk gambler. If the experience has been primarily seen as *positive*, however, a different type of interference may occur insofar as clinically problematic gambling is not seen as problematic. This contrasts with the unanimity of previous studies, which take as their starting point that family members are unambiguous in their view of gambling as a negative habit. What previous studies miss is that gambling, as an inherently social activity, can be collectively constructed by spouses and partners as a *positive* activity, thereby rendering it subjectively non-problematic (though it may be objectively problematic from a well-being or financial standpoint).

Of course, much of what this finding suggests hinges on what constitutes a 'positive' experience from gambling. Parke, Griffiths and Parke itemize a variety of positive thinking strategies used by problem gamblers to manage negative affect [39]. The list includes thinking that gambling has potential return on investment, winning happens more than losing, or a delusion of skill (thinking they are one of few that can 'beat the odds'). Breaking our Family Impact index down, courtesy stigma has a strong negative correlation with impact on family finances. This would suggest that thinking of money spent on gambling as having a 'return on investment' occurs in our sample and is a reason why gambling would be defined as having positive qualities (rather than, e.g., collective triumph over addiction).

In sum, our findings, in relation to this literature, suggest that the normalization of problematic gambling behaviour (i.e., a lack of shame or embarrassment of a problem-gambling family member, and hence unafraid of courtesy stigma) may undermine gamblers' perceptions of gambling risks and harms, thereby increasing vulnerability for problematic gambling by inhibiting responsible gambling and help-seeking behaviour. Recall from Table 3 that holding a 'contemporary' worldview of gambling—that it is a safe recreational activity and a legitimate way to earn income—is significantly associated with problem gambling and gambling-related spending among respondents in our sample. If this view goes unchallenged by relatives and partners who share the perception of gambling as a harmless or even beneficial, activity, the problematic behaviour may be perpetuated. Contrasted with this, some level of anticipatory courtesy stigma may not be an unequivocally bad thing; in fact, it may act as a *protective* factor against normalizing potentially problematic gambling behaviour.

This finding invites further research exploring under what conditions gambling leads to positive experiences, and how such experiences might interfere with the concern of significant others and other family members. Moving the literature in this direction can help generate new strategies to mitigate problem gambling risk, by drawing attention to normalization of potentially problematic gambling-related behaviour as a barrier to responsible gambling and/or help-seeking.

Second, two socio-demographic dimensions—religion and employment status—had significant influences on anticipatory courtesy stigma. The fact that religion—specifically identifying as Catholic or Hindu—has significant impact contrasts with studies that measure social distance [1, 25–26]. This is most likely because the personal implications of a family member's gambling addiction are different than that of a relative stranger. In our sample, Catholics and Hindus were

far more ashamed of problem gambling family members than those reporting no religion. These findings therefore suggest that Catholic and Hindu beliefs systems render problem gambling particularly shameful in contrast with their Anglican, Muslim or Protestant counterparts. This is significant, considering the growing literature on problem gambling's impact on the family, and associated barriers to treatment, has yet to seriously engage the topic of religion or religiosity.

Employment status was a close second to religion in terms of impact. Both the unemployed and self-employed were more likely to report embarrassment/shame of problem gambling than those with regular employment. We know of no study to date that has observed the effects of employment status on feelings towards problem gamblers. Because the unemployed and the self-employed are economically vulnerable, it makes sense that this lens of vulnerability would spawn more shame or embarrassment of problem gambling family members. Interestingly, while self-identifying homemakers/wives were more likely to be embarrassed or ashamed in bivariate analysis, this correlation disappeared in OLS regression. While this would initially appear promising given spouses' central role in starting treatment, the control variables once again suggest this spuriousness is related to the level of normalization of gambling in the household, or the extent to which positive perceptions of gambling are evident.

Strengths and limitations of the study

This study has some limitations. First, using secondary data did not allow us to examine specific familial relationships, such as parent-child or between siblings. This differentiation is important because literature examining courtesy stigma elsewhere agrees that its form and intensity will vary depending on the specific type of relationship. There is little reason to think problem gambling would be any different. Second, our data consists of persons from a single Caribbean

country, which may provide a specific cultural context in which stigma operates. As such, generalizing to other cultural contexts, especially with respect to socio-demographic characteristics like religion, should be done with care. Despite these limitations, this study does begin to provide an understanding of how courtesy stigma, first theorized by Goffman, is related to problem gambling in a modern context. Two novel findings from this study contribute to understanding this relationship: normalization of gambling within the family may reduce apprehension of courtesy stigma, and there is some socio-demographic variation—specifically in terms of religion and employment status—in proneness to embarrassment and shame regarding problem gambling family members. This is the first study that attempts to assess the influence of courtesy stigma rather than public stigma, and the findings have potential implications for promoting responsible gambling behaviour, and help-seeking and treatment for problem gambling. Anticipatory courtesy stigma may work in concert with public stigma as a barrier to treatment. This finding is particularly important considering less than 10% of problem gamblers ever seek treatment [40–43].

Because these data addressed family members, and not problem gamblers themselves, we can only speculate about the effects of anticipatory courtesy stigma as a barrier to problem gamblers seeking help. Future work in this area should thus assess the effect of shame/embarrassment due to a fear of courtesy stigma (fear of stigma by association) from the perspective of problem gamblers themselves. The nuance we contribute is that, unlike other forms of stigma, too *little* apprehension of courtesy stigma may in fact be a risk factor alongside too *much* courtesy stigma, since problem gambling may be normalized within the home. This nuance is important to take into consideration when studying problem gamblers, or in practice, helping those who may not

consider themselves in need of help. As such, the study provides a basis for further exploration in this area, which may lend important insights as research, policy and practice aimed at preventing and treating disordered gambling continues to evolve.

CONCLUSION

In conclusion, we have introduced the concept of 'courtesy stigma', first theorized by Erving Goffman, to the literature on problem gambling. Courtesy stigma is stigmatization by association with a stigmatized person. While problem gambling literature addresses public stigma and self-stigma, courtesy stigma is all but ignored in problem gambling literature. This is problematic, given that shaming friends and family is a primary barrier to recovery. This study may contribute to understanding the importance of the extent to which gambling is normalized within the family, because normalization of gambling in the family impacts how much shame or embarrassment one feels about their problem-gambling family member, and the more influence of some religions (Catholic and Hindu) and economic positioning (unemployed and self-employed) on embarrassment or shame of problem gambling family members. Contrary to common ideas around stigma more broadly, moderate anticipatory stigma may be a protective factor against familial attitudes that normalize problem gambling. Too much or too little courtesy stigma thus may inhibit help-seeking behaviors due to shame and normalization, respectively. Further research should examine how/why gambling comes to be constructed as 'positive' for some problem gamblers and their families. This may have important implications for support and treatment.

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