Int J Ment Health Addiction (2007) 5:292–306
DOI 10.1007/s11469-007-9063-y

# An Overview of Help Seeking by Problem Gamblers and their Families Including Barriers to and Relevance of Services

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Received: 3 January 2007 / Accepted: 15 March 2007 /
Published online: 11 May 2007


**Abstract** Research demonstrates that gambling support services often do not meet the needs of people seeking help for their gambling problems. In particular, the needs of cultural groups, and gender-specific needs of men and women are neglected. Understanding differences in help seeking behaviour can assist in developing early interventions to address gambling related problems and in developing effective strategies. This paper reviews the literature on help seeking by problem gamblers and their families, including barriers to and relevance of services through a gender and cultural lens. Research findings from international and New Zealand studies are examined, highlighting ways in which gender and culturally appropriate strategies can be implemented. Ways of changing barriers and social policies are proposed which may improve the responsiveness of services. Ultimately it may encourage health care access and utilisation for people and their families seeking help for problem gambling.

**Keywords** Gambling problems · Families · New Zealand

## Introduction

Understanding barriers to help-seeking behaviour for problem gamblers and their families is an essential step towards ensuring that services are accessible, appropriate and improve the mental health of the community. Many people who experience problems with gambling do not seek help (Duong-Ohtsuka and Ohtsuka 2001). The Australian Productivity Commission found that only about one tenth of people who experience problem gambling actually seek help for their problems (Productivity Commission 1999). Between five to ten people, usually family

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members and significant others are affected by the problem gambler (Productivity Commission 1999). Rankine and Haigh (2003) consider this estimate to be low.

In New Zealand, the Ministry of Health estimates that approximately 10% of problem gamblers seek formal help for their gambling problems (Ministry of Health 2005a). A study by Abbott et al. 1999a found that over one in four adults knew someone among their family or friends who they thought had a gambling problem. Recognising the need for help with gambling problems and making the decision to seek treatment are influenced by demographic factors such as age, gender, ethnicity, and level of education; and attitudinal factors such as perception of the helpfulness of services, perceived stigma, shame and health literacy.

This review highlights gender, social and cultural issues derived from New Zealand and international literature on barriers to help-seeking behaviour for problem gamblers and their families. It complements another paper (Clarke 2006) on intrinsic and extrinsic barriers to health care access and utilisation of formal and informal health care services for alcohol, substance abuse and mental health problems. It covers major literature databases such as PsychINFO and MEDLINE, web-based searches to identify unpublished research, and contacts with gambling research centres.

From our reviews of the literature and professional networks, apart from New Zealand studies and reviews (Abbott 2001b; Abbott et al. 2004; Abbott and Volberg 1992, 1996), we are aware of only four problem gambling studies that have direct relevance to the present investigation (Productivity Commission 1999; Evans and Delfabbro 2005; Hodgins and El-Guebaly 2000; Rockloff and Schofield 2004). Recent reviews (Abbott et al. 2004; Delfabbro and LeCouteur 2003) indicate that there is a paucity of research on barriers to treatment for problem gambling. These reviews did not locate any published studies focusing specifically on family members of problem gamblers, yet families are thought to be significant pathways to help-seeking (Rothi and Leavey 2006).

## Population Surveys

### New Zealand

Some aspects of help seeking were examined in detail in the second phases of both the 1991 (Abbott and Volberg 1992, 1996) and 1999 (Abbott 2001b) New Zealand national surveys of gambling prevalence and behaviour. In both 1991 and 1999, approximately half of the people identified as problem gamblers did not, themselves, believe that they had ever had a problem with gambling. This suggests that there had been no significant change over time with respect to self-recognition or awareness of problem gambling among people who have problems. In both surveys, people with more severe problems were much more likely than those with less serious problems to personally acknowledge having had problems currently or in the past. While there was no change in the proportion of self-assessed problem gamblers from 1991 to 1999, there was a very substantial increase in reported help seeking in this group (Abbott et al. 2004).

In contrast to the 1991 study, its 1999 counterpart found that a third of "self recognition" problem gamblers reported seeking help for themselves—a large increase since 1991 (8%). Approximately half of reported help seeking instances involved family members, mutual help groups and other informal sources of assistance. Further, in marked contrast to 1991, a half involved specialist services and health professionals. Of the services, mental health professionals were most often mentioned, followed by the gambling helpline, alcohol and drug treatment centres and general medical practitioners. With respect to seeking help for

other people, there was also an increase in the use of gambling helpline and mental health professionals. However, family, friends and mutual help groups continued to be mentioned most often.

The 1999 study also examined satisfaction with help sought. Problem gamblers regarded most sources as very helpful or helpful. Only mental health professionals and general practitioners were considered to be unhelpful. People seeking help for others also generally reported that sources were helpful, especially in the case of informal sources including family and friends.

Problem gamblers in 1999 who acknowledged having problems were also asked if they had experienced periods of 6 months or more when they were free or mostly free of gambling problems (Abbott et al. 2004). Nearly two-thirds reported one or more instances of this type. These people were asked what methods they had used to overcome their problems on these occasions. They could mention more than one method. While over half indicated using one or more types of informal or formal help, the great majority referred to doing it on their own. Three-quarters reported that their "own efforts" was the most effective method to overcome gambling problems. The only other "most effective" methods mentioned (by 10% of respondents) were alcohol or drug treatment centres.

### Australia

The Australian Government Productivity Commission (Productivity Commission 1999) surveyed the national prevalence of problem gambling and consulted widely with service providers. Various factors that influenced help seeking and service use were considered, including ethnic differences. As in the New Zealand national surveys, a substantial number of people identified as having gambling problems did not, themselves, consider that they had a problem, or that their problems were not considered serious enough. Similarly, problem gamblers most often first turned to spouses, families and friends for help, followed by other people outside their immediate personal network such as general practitioners, social workers or clergy. Those who subsequently received counselling or support mentioned a wide variety of services including Gamblers Anonymous.

Rockloff and Schofield (2004) developed and administered a questionnaire concerning barriers to treatment for problem gambling to 1,203 Central Queensland adults chosen by random digit dialling of households. Factor analysis of the questionnaire responses identified five potential barriers to treatment, namely availability, stigma, cost, uncertainty and avoidance. Relative to people with few gambling problems, those with numerous problems more often reported treatment costs, availability and effectiveness of treatment. Respondents with more formal education had more positive attitudes to problem gamblers and treatment seeking than those with less formal education. The study's authors indicated that further research is required to determine whether these factors do, in fact, influence treatment seeking behaviour including "readiness to change" (Prochaska et al. 1992). They also suggested cognitive distortions that are common among problem gamblers, such as superstitions, denial of odds of winning and feelings of omnipotence, may correlate with these factors in a common syndrome of resistance to change.

## Gender and Ethnicity

A criticism of evidence from studies of problem gambling is the focus on male pathological gamblers while women have been overlooked (Mark and Lesieur 1992; Volberg 2003).

Assumptions have been made that what is true for men will also be applicable to women and culturally diverse groups. There is growing evidence that there are gender differences for gambling health-related behaviours, such as treatment utilisation, substance use, psychiatric symptoms and diagnoses (Westphal and Johnson 2003).

For example, a review of the research literature (Crisp et al. 2000) showed that women make up the majority of service users at most health services. They are more than twice as likely as males to seek help from a counsellor at some point in their life. This difference is not necessarily an indication that women have a greater need for such services but is more likely to reflect gender differences in help-seeking behaviours. However, when it comes to problem gambling, samples of problem gamblers in treatment are predominantly men in the United States and Australia, despite evidence that suggests men and women are equally likely to gamble. This under-representation of women could arise from male problem gamblers being more likely to be in male oriented treatment programmes than female problem gamblers, or from women being less likely to be routinely assessed for gambling problems.

In New Zealand, the number of women participating in gambling activities and seeking help for gambling-related problems is increasing, especially amongst Pacific women (Davis and Avery 2004; Delfabbro 1998; Ministry of Health 2005b; Ministry of Health and Ministry of Pacific Island Affairs 2004; Potenza et al. 2001). An Australian study by McMillen et al. (2004) found that there were differences in help seeking behaviour between men and women which are crucial factors in early interventions to address gambling related problems and developing effective strategies. Men of different ages, ethnicities and social backgrounds are, on average, less likely than women to seek professional help for gambling problems. Men appear to prefer group support to mainstream counselling services, while women gamblers and family members express a preference for alternative forms of help to counselling. For example, in 2002/2003 approximately 20% of New Zealand women used telephone help-lines in the previous 12 months relative to approximately 10% of men (Ministry of Health 2005a). Compared to New Zealand Europeans and Maori, Pacifica and Asian people generally are low users of telephone and other services, but their usage is increasing proportionately to their populations (Bellringer et al. 2006). In 2004 over 62% of the Pacific peoples ($N$=173) that accessed the Pacific specific gambling telephone helpline were female (Gambling Helpline New Zealand, 2005, personal communication).

From problem gambling prevalence surveys in New Zealand, Maori have high rates of problem gambling. Maori used to under-use gambling treatment services in relation to need (Abbott 2001b; Paton-Simpson and Gruys 2002, 2003) but recent statistics indicate that the percentage of Maori clients accessing face-to-face counselling services is consistent with the established prevalence of problem gambling amongst Maori in New Zealand (Ministry of Health 2006). Approximately one third of people accessing gambling treatment or helpline services are Maori, of which most are women (Ministry of Health 2006). For Maori men and women presenting for help, gambling machines are the primary form of gambling.

In general, the main reasons for not seeking treatment include the desire to handle the problem without help, the negative attitudes related to stigmatisation of addiction problems, embarrassment and pride (Goodyear-Smith et al. 2006; Hodgins and El-Guebaly 2000). Females in New Zealand are more likely than males to seek help for someone else's gambling, especially for new Maori and Pacific clients (Abbott 2001a; Ministry of Health 2006).

Help seeking was also considered in the New Zealand surveys of recently sentenced male and female prisoners (Abbott and McKenna 2000; Abbott et al. 2000). Findings were

similar to those reported for the general adult population. Twenty-two percent of men and 15% of women problem gamblers who considered that they had a problem reported having received help for gambling problems in the past, mainly from mutual help groups, family and friends, but also from professional and specialist services to a somewhat lesser extent. A significant minority wanted and sought help for gambling while they were in prison but very few said they obtained it.

A review by Australia's Productivity Commission (Productivity Commission 1999) identified the "feminization" of problem gambling, defined as the notion that more women are gambling, developing gambling problems and seeking help for such problems than in the past. Growing numbers of women are seeking help for gambling problems which appear to be related to the increased availability of gaming machines which are their preferred mode of gambling (Volberg 2003). Men are primarily engaged in "strategic," skill-based and competitive forms of gambling while women remain predominantly engaged in "non-strategic," luck-based forms of gambling. For example, younger males are more likely than women to gamble on racing activities, casino games, card games, and sports, while women are more likely to gamble on bingo (Delfabbro and LeCouteur 2003).

Opportunities for women to participate in gambling in venues outside the home such as restaurants, hotels and bars that are considered safe has increased (Bunkle 2003; Volberg 2003). These facilities are especially conducive for women from ethnic communities and indigenous groups (Dyall 2003; Morrison 2003). Women seeking treatment for problem gambling differ significantly from men. They are more likely to report childhood abuse, previous suicide attempts, and having a mother who is a compulsive gambler. They are also less likely to have been arrested.

## Socio-cultural Barriers

Reasons why people from ethnic communities do not seek help include limited knowledge of available services, lack of awareness regarding the severity of problems, cultural and/or gender factors and the stigma associated with problem gambling (Duong-Ohtsuka and Ohtsuka 2001). This lack of knowledge of services is also compounded by the lack of availability of helpers from a similar cultural, ethnic and linguistic background.

While barriers to help-seeking can vary in relation to cultural background, the most common factors identified from research include: language difficulties and few interpreters at helping agencies; cultural patterns of help-seeking; suspicion of mainstream services; concerns about trust and confidentiality; lack of cultural sensitivity by service providers; financial barriers; lack of service availability; inappropriate treatments including lack of family involvement; a lack of information or misinformation; and a greater degree of stigma and shame associated with mental illnesses and related problems than among Western peoples (Brown 2002; McMillen et al. 2004; Raylu and Oei 2004). If services are not culturally appropriate then the research focus on rates of utilisation may actually underestimate the barriers in access to service; that is, services are used but are not appropriate to the culture of a group and therefore equivalent benefits might not be derived (Thomas 2006).

The first step in the pathway to seeking help is the recognition of symptoms of distress in oneself or in another. This is mediated by the culture and context in which it is experienced, so that what is recognised as a problem in some contexts may not be so in others. Studying the help-seeking pathways that people use is critical to understanding the link between the onset of symptoms of mental health distress and the use of mental health

services (Fuller et al. 2000). Before seeking professional help, gamblers and family members utilise creative ways to help and support themselves, often with some success (McMillen et al. 2004). People primarily turn to families and friends, to group support or to other generic community agencies for help.

For example, Chinese gamblers in Australia will only seek help if there is no other way to solve the problem (McMillen et al. 2004). They tend to rely on a trusted family member, then friends or employer. Raylu and Oei (2004) found that different cultural groups in Australia assume that help for problem gamblers should come from different sources. Government or gambling help service providers were the choice of Arabic, Greek, Italian, Korean, Macedonian, Spanish, and Vietnamese individuals and families, while Chinese and Croatians nominated themselves, their family or community as being responsible for managing gambling problems.

Across many ethno-cultural communities, people can be unaware that specialist services are available to help problem gamblers and their families. Language and familiarity with health services play an important part in accessing information. If information is only available in English, this could make it difficult for those who do not read English to learn more about problem gambling and available support services, thereby exacerbating gambling problems (Niagara Multilingual Problem Gambling Program undated; Scull and Woolcock 2005). A perception that there might be poor levels of cultural understanding in a gambling help service can also prevent access (Scull and Woolcock 2005).

## Cultural Beliefs, Values, Shame and Stigma

Culture-specific beliefs and values can reinforce the importance of gambling in people's lives, such as perceptions of luck, the desire to fit culturally into a gambling society, and the incorporation of gambling into cultural festivities such as the Chinese New Year celebrations (McMillen et al. 2004). For some Pacifica groups, community based gambling such as card games and bingo are promoted to strengthen social ties and to redistribute money within the community (McMillen et al. 2004; Perese and Faleafa 2000). Beliefs and values can also be contradictory and ambivalent. For example, Chinese in Canberra were found to have ambivalent attitudes to gambling (McMillen et al. 2004). On the one hand it is accepted as part of Chinese culture and most people see the positive side and keep it under control. On the other hand, problem gambling is highly stigmatised, especially if it impacts on achievements in business or study, or on family stability.

Cultural beliefs and values affect not only individuals' gambling behaviours but also help-seeking attitudes and utilisation of treatment and other health care services (McMillen et al. 2004; Raylu and Oei 2004). Duong-Ohtsuka and Ohtsuka (2001) suggest that help seeking behaviour is unique to specific cultural groups. In their research of differences in attitudes towards psychological help seeking between Vietnamese- and Australian-born respondents, they found that recognition of need for help, stigma tolerance, confidence in helpers and knowledge about services distinguished the two groups. Although Vietnamese expressed significantly higher confidence in helpers, they were less certain about where to get help as expected. Australian-born respondents showed both higher stigma tolerance and greater knowledge about what services were available.

Social stigma attached to gambling among ethno-cultural populations within their own communities may prevent problem gamblers from seeking professional help. It is assumed that family members will deal with the problem and provide the necessary health, financial and legal care (Niagara Multilingual Problem Gambling Program undated). Problem

gambling is hidden due to shame, pride and loss of face, not only for the gambler but also for the whole family. Hence, most problem gamblers try to resolve the problem themselves or within the family rather than seeking professional help (McMillen et al. 2004). In some communities, there may also be a reluctance to talk about problem gambling for fear the whole community may become stigmatised.

Research by Scull and Woolcock (2005) into problem gambling among non-English speaking background communities in Queensland, Australia found that there was a pervasive sense of denial associated with problem gambling in the Chinese, Greek and Vietnamese communities. In addition, they found that due to shame and stigma, lack of recognition of a gambling problem was one of the most widely reported and significant barriers to seeking help, particularly within the Chinese and Vietnamese communities. The extended family is the traditional source of support, and to seek help outside this is perceived as an admission of family failure. It is unlikely that gamblers with non-English speaking backgrounds will seek help from gambling help services. Even if help is sought outside the family, it is more likely to be from church members or community leaders, rather than mainstream government services. The shameful nature of gambling often makes problem gamblers reluctant to use even these informal channels of help which can be compounded if members of a community are small, making people even more reluctant to admit to a gambling problem or to seek help.

Raylu and Oei (2004) suggest that shame can be interpreted in varying ways in different ethnic communities, and is influenced by religious and cultural beliefs. They note shame in Arab and Turkish individuals as being religious based as gambling is prohibited in Islam, while shame in Chinese communities relates more to the loss of face and respect. Restraint is valued as a means of maintaining harmony, placing the needs of the collective above those of the individual. Citing Cheung (1993) they suggest that the head of the family would be the key to accessing appropriate help. Assistance would initially include traditional remedies such as herbal medicines, before turning to other more mainstream forms of help if the traditional forms were not successful.

Tse et al. (2003) also suggest that shame is a critical factor preventing Asians in New Zealand from accessing help. Help seeking from professionals becomes a last resort strategy as the primary aim is to avert humiliating the family by keeping problems a secret, which in turn limits self-disclosure. Groups who are particularly at risk include people working in the food industry, tourist operators, international Asian students, South East Asian refugees, and members of "astronaut" families, whereby mothers stay behind in a foreign country to look after their children while husbands return to their home countries to work.

## Migrants and Acculturation

Migration is a major life transition and the extra stress of settlement on newcomers and refugees can increase their vulnerability, leading to gambling as an escape to release feelings of loneliness and homesickness. For people who are adjusting to living in a new country, gambling can be an attempt to regain the status they might have lost (Niagara Multilingual Problem Gambling Program undated). In New Zealand, for example, migrants are twice as likely to be unemployed than the local population despite being twice as likely to be tertiary qualified (Abbott et al. 1999a, b; Scragg and Maitra 2005). Gambling can also assist people to feel as if they belong as part of the new community.

Settlement difficulties associated with adjusting to living in a new country have been identified as major factors in the development of gambling problems (Raylu and Oei 2004).

Several factors are frequently identified as triggering gambling related problems in migrant and refugee groups, especially for women. They include social isolation, disconnectedness, boredom, socio-cultural ambivalence, financial hardship, under-employment and the need to participate in acceptable recreational activities (DeSouza 2006; McMillen et al. 2004; Niagara Multilingual Problem Gambling Program undated; Tse et al. 2003).

The impact of migration can last for significant periods of time. Scull and Woolcock (2005) found that the problem gamblers interviewed in their study had lived in Australia between 10 and 23 years, suggesting that settlement issues can continue for a number of years. Gambling was used as a coping mechanism for managing problems, unhappiness, boredom and isolation. The authors suggest that many popular social activities in Australia may not be enjoyed to the same extent by individuals from other cultural backgrounds. Lack of English language skills might also prevent participation in other mainstream entertainment activities.

## Life Events and Problem Severity

Service providers participating in the Australian Government Productivity Commission's survey (Productivity Commission 1999) commented that problem gamblers rarely sought their help until a crisis point was reached when they experienced major financial problems, family breakdown, job loss or criminal charges. Typically other sources of support such as family and friends were depleted, and there was a high level of psychological distress, desperation and panic. Problem gamblers themselves usually recognise the seriousness of their gambling problem when these factors become salient (Duong-Ohtsuka and Ohtsuka 2001; McMillen et al. 2004). In addition, there are immediate effects on interpersonal relationships, self-esteem, self-worth, their own standards of behaviour and long-term impacts on their future (McMillen et al. 2004).

Raylu and Oei (2004) found that Arabic, Chinese, Korean and Vietnamese in Australia were less likely to seek professional help than other cultural groups despite having higher amounts of unpaid debts, having problems clearing their gambling debts, spending more money than they could afford, or thinking their gambling was a problem. Reasons for not seeking help included language problems, a limited knowledge of the availability of services, and insufficient social and financial resources to support treatment entry and behaviour change, all of which can often be related to settlement difficulties.

Hodgins and El-Guebaly (2000) in Calgary, Canada, undertook a study to increase understanding of recovery from problem gambling. It involved 106 adults predominantly recruited from the general population by media advertisements and announcements. Participants included problem gamblers whose problems were resolved as well as those who continued to experience problems. Most mentioned that their goal to stop or control their gambling was a conscious decision. Reasons most often given for seeking to resolve gambling problems were negative emotions, financial concerns and seeing their gambling as something incompatible with their self image or goals. Particular life events, per se, did not appear to trigger change.

The majority of 'resolved' and 'active' problem gamblers reported that they had never sought treatment for gambling problems. People with more serious gambling problems were more likely to have entered formal treatment programmes. While there is a strong relationship between current alcohol dependence and current pathological gambling (Welte et al. 2001), comorbid alcohol or other drug problems did not, however, appear to increase help seeking in the Canadian sample. Examination of recovery processes included assessing

barriers to treatment. Just over four out of five problem gamblers said they did not seek treatment because they wanted to handle the problem on their own. This was the most frequently mentioned reason for not seeking treatment by resolved and active problem gamblers. Approximately a half of respondents also mentioned one or more of embarrassment/pride, no problem/help needed, ignorance of treatment or availability, inability to share problems and stigma. Relatively few people mentioned negative attitudes towards treatment or cost as a reason for not seeking treatment.

In Adelaide, South Australia, telephone interviews with 77 problem gamblers recruited through the mass media and from treatment agencies found that most had received professional help (Evans and Delfabbro 2005). A minority had used self-help strategies solely or predominantly. Treatment and self-help groups most often sought help as a consequence of deteriorating psychological and physical health and/or serious financial hardship. Relationship problems, legal issues, employment and housing problems also played a role but were rated as being less important. Over half of the problem gamblers sought help for multiple reasons.

In both the 1991 and 1999 New Zealand national surveys, problem and non-problem gamblers were asked about factors that led to past increases and decreases in gambling involvement (Abbott 2001b; Abbott et al. 2004; Abbott and Volberg 1992, 1996). In 1991, problem gamblers reported that the arrival of children and leaving paid employment were life transitions that had the most impact in terms of gambling reduction. Reasons given for reduced gambling, in both 1991 and 1999, included less money available, loss of interest in gambling, not winning, other life priorities and changed circumstances.

Of particular relevance in the present context is the 1998 re-assessment of 1991 phase two respondents (Abbott et al. 2004; Abbott et al. 1999a). Of those with serious gambling problems in 1991, approximately a quarter had problems of this severity seven years later. However, about a third still experienced problems of less severity and just under half were problem-free. Of those with less serious problems in 1991, only 10% remained in this category in 1998. A slightly larger percentage developed more serious problems and over three-quarters were non-problematic.

When various factors, measured in 1991, that predicted future problem gambling status in 1998 were considered together in multivariate analyses, it was found that initial problem gambling severity, comorbid hazardous or problematic alcohol use, and a preference for track betting were the strongest individual predictors of continued gambling problems. In one analysis there were indications that non-European ethnicity and male gender were additional risk factors for problem chronicity. The great majority of problem gamblers who preferred electronic gaming machines, as well as those who did not use alcohol excessively, were free of problems 7 years later. None of the participants in this study reported ever having received professional or specialist help for their own gambling problems, although some had sought such help for other people.

The findings referred to above, from the world's first prospective general population study of problem and non-problem gamblers, suggest that many, probably most, problem gamblers overcome their problems without professional or specialist assistance. While some of these people abstain from gambling, most continue to gamble without significant problems. The findings also indicate that some people have more persistent or relapsing problems and the study identifies some characteristics that differentiate these two groups. This and other New Zealand studies found that most people attribute problem gambling cessation to their own efforts and many also indicate that family members, friends and mutual help organisations assist. Some major life events such as the arrival of children, maturation, adverse experiences associated with excessive gambling and financial hardship

are among the factors that appear to play a part in what has been referred to as self recovery or spontaneous remission.

## Changing Barriers to Health Care Access and Utilisation

From the above review and from literature on barriers to health care access and utilisation for alcohol, substance abuse and mental health problems (Clarke 2006), some suggestions can be made for altering barriers to help seeking for problem gamblers and their families.

### Social Networks

Across all ethnic groups, problem gamblers could be guided into treatment by informing their social networks in ways of encouraging help seeking behaviour (Booth et al. 2000; Grant 1997; Pescosolido et al. 1998; Wagner et al. 2006; Zhu et al. 2006). These ways include provision of information such as identification of symptoms and referral sources, and reducing stress in the problem gambler. Individual problem gamblers and their families can be empowered by recognising symptoms, by writing questions and concerns in advance of formal assessment, by asking for clarification and by voicing doubts about the suitability or feasibility of recommendations (de Bonnaire et al. 2000; DeSouza and Garrett 2005; Kwok 2000). Large social networks, closely tied communities and employee assistance programmes can be conducive for getting problem gamblers into treatment (Booth et al. 2000). Women whose male partners are problem gamblers could be especially targeted (Zhu et al. 2006). Female problem gamblers may be more likely than males to respond to encouragement from family, friends and advertisements (Booth et al. 2000).

### Social Tolerance

The stigma of mental health disorders in Western societies seems to be diminishing, encouraging more young people to seek help (Kessler et al. 1998). It is possible that by changing social attitudes, the shame and fears of problem gamblers might be diminished (Cunningham et al. 1993; de Bonnaire et al. 2000; De Zwart et al. 2002; Goldberg 1995; Kessler et al. 1998; Wu and Ringwalt 2004). Attitudes may change due to increased public awareness of the symptoms of problem gambling, availability of services and their effectiveness, and information about care-giving skills for relapse prevention (Abbott 2007; Cowan et al. 2003; Cunningham et al. 1993; DeSouza and Garrett 2005; Grant 1997). If social attitudes change, then the barrier for problem gamblers of expectations of adverse reactions from society, friends, family and social networks could be lowered (Barney et al. 2006; Dixon et al. 1995).

New Zealand research, using nationally representative samples, has documented increased public awareness of, and concern about, problem gambling, including growing support for the need for services to help people overcome gambling problems (Abbott 2001b; Abbott and Volberg 1992, 1996). It has also indicated significant change in the prevalence of problem gambling including marked variation in the population sectors most at risk. Comparison of these findings with national gambling helpline and counselling service data has enabled the identification of groups that appear to be under accessing services such as Pacific peoples.

## Helping Agencies

Evans and Delfabbro (2005) concluded that gambling treatment services were not regarded as "points of intervention, but merely last resorts when all other possibilities had been exhausted" (p. 205). Rather than a lack of knowledge of services or dissatisfaction with them, they considered the main barriers to be psychological—denial, embarrassment and shame. They considered it likely that many current problem gamblers remain trapped at the pre-contemplation phase (Prochaska et al. 1992), not acknowledging problems which are largely hidden from people around them. For this reason they urged treatment services to be proactive and argued that more emphasis needs to be given to community education to counter stigma and assist family members to recognise warning signs and give support and advice. They also pointed to successful efforts to promote screening and self-identification in primary health care settings (Sullivan et al. 2000).

Although the enabling factors of availability, accessibility, affordability and acceptability are not as important as individual factors, social attitudes, social consequences and severity of symptoms in access to treatment (Booth et al. 2000; Hajema et al. 1999), increasing the enabling factors for problem gambling may be more realistic to achieve in the short term than trying to change attitudes (Grant 1997). For example, Scull and Woolcock (2005) argue that practical assistance such as financial counselling may be more useful than talking about a gambling problem. Many people who need help might view their problem as being beyond help especially if they have financial problems. Similarly, because migrants with non-English speaking backgrounds tend to be particularly reluctant to seek assistance for gambling health-related problems from mainstream services, settlement services need to be an integral aspect of help that is available (Delfabbro and LeCouteur 2003).

Within the managed health care system, clinicians need to ensure that clients understand technical terms, what they need to do and match explanations with realistic outcomes (DiMatteo 1997; Dixon et al. 1995; Todd et al. 2002). Further, clinicians need to be aware of their professional attitudes and ways of changing them to provide appropriate services for different genders and ethnic groups (Marsh et al. 2000). These attitudes include judgements about impulse control disorders and the different needs of men and women. Although trust in treatment providers is important for people with mental health problems, individuals with impulse control disorders such as problem gambling may consider professional knowledge and training more salient (Lane and Addis 2005). Problem gamblers from minority groups should be able to choose group interventions that are suitable for their respective backgrounds, and with sufficient numbers of members that they do not feel alone (Kwok 2000).

For comorbid problem gambling and substance abuse, integration of treatment services and coordinated strategies could be improved. Case managers could be assigned to coordinate multi-disciplinary teams, clinicians could be trained in assessment, treatment planning and interventions for comorbid disorders, motivational interviewing and cognitive behavioural strategies could be applied for treatment and relapse prevention (Todd et al. 2002).

## New Technologies

There is some evidence that media usage can overcome some of the barriers associated with privacy (Hill et al. 2006; Marks 2005), and enable access for rural dwellers (Schopp et al. 2006). For example, from interviews and a focus group with lower socioeconomic status men, a television men's health documentary seemed useful in promoting awareness of physical health care and help-seeking (Hodgetts and Chamberlain 2002). Men may be

reluctant to seek help from their male friends for problems such as depression, substance abuse and pathological gambling, but anonymous Internet groups and cellphone text messaging seem to be more acceptable (Humphreys and Klaw 2001; Lane and Addis 2005). In addition to lowering the perceived stigma of having a problem and the privacy, they learn that other men can have similar problems and that mutual help is available. Formal and informal treatment programmes seem to be more suited to men (Goldberg 1995; Marsh et al. 2000; McMillen et al. 2004). However, women are more likely than men to visit Internet self-assessment and mutual help sites (Cunningham et al. 2000; Humphreys and Klaw 2001). With 24-hour access, women do not need to disclose personal thoughts and feelings in the presence of men.

## Conclusion

This review of literature has highlighted some social and cultural barriers to health care access and utilisation for problem gamblers and their families. Cultural factors influence problem gambling behaviour, perceptions of problems, help-seeking pathways and options. It is important to identify the pathways and trajectories of help seeking so that family, friends and communities can provide support and efforts at self-efficacy and self-recovery can be supported. The review demonstrates that wider community campaigns and enlisting social networks and community leaders can also help to reduce denial, stigma and shame. Suggestions are also made about making services more accessible and appropriate including providing indirect, practical help and financial counselling. Clearly the experiences of certain sub-groups need further exploration. Research and more effective ethnicity data collection are proposed to better understand the experience of men and women in different cultural groups to ensure that problem gambling interventions are both evidence based and culturally appropriate. By changing barriers, integrating health services, and promoting public and professional awareness of the barriers, social policies can be adopted to encourage the seeking and obtaining of help. New technologies offer the potential for dealing with some of these barriers, especially those associated with the intrinsic factors of shame and self-reliance.

**Acknowledgements** The research on which this paper is based was funded by a grant from the New Zealand Ministry of Health (MOH: 467589/303177/00).

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