International Journal of
*Environmental Research and Public Health*

MDPI

*Review*

# Shame, Stigma and Indebtedness in Gambling-Related Harm: A Rapid Review of Help-Seeking and Suicidality

**Sharon Mallon [1,*], Jessica Runacres [2], Fiona McCormack [3], Victoria Riley [3] and Emily Motta-Yanac [3]**

1 School of Social Work, University of Staffordshire, Stoke-on-Trent ST4 2DF, UK
2 School of Health, Science, and Wellbeing, University of Staffordshire, Stoke-on-Trent ST4 2DF, UK; jessica.runacres@staffs.ac.uk
3 Centre for Health and Development (CHAD), University of Staffordshire, Stoke-on-Trent ST4 2DF, UK; fiona.mccormack@staffs.ac.uk (F.M.); victoria.riley@staffs.ac.uk (V.R.); emily.mottayanac@research.staffs.ac.uk (E.M.-Y.)
* Correspondence: sharon.mallon@staffs.ac.uk

## Highlights

**Public health relevance—How does this work relate to a public health issue?**

- Gambling-related harm is shaped by wider social, cultural and service contexts, including the normalisation of gambling, stigma, shame and limited recognition of emerging problems.
- Help-seeking was often delayed until harms had escalated, indicating a need for earlier recognition and intervention across public health and associated services rather than relying solely on individuals to identify and manage harm themselves.

**Public health significance—Why is this work of significance to public health?**

- The review identifies a recurring pattern in which anticipated judgement, shame, concealment and attempts at private self-management may contribute to delayed disclosure.
- It highlights important gaps in the evidence, including limited research on suicidality, culturally and gender-informed understandings of harm, support for affected others, and the effectiveness of self-directed or early-intervention approaches.

**Public health implications—What are the key implications or messages for practitioners, policy makers and/or researchers in public health?**

- Public health responses should improve recognition of gambling-related harm without reinforcing blame, and provide confidential, non-judgemental, accessible and culturally appropriate routes into support, with stronger links between gambling services, debt advice, mental health provision and suicide-prevention services.
- Policy and research should address the wider social and commercial conditions in which gambling is normalised, recognise affected others as people experiencing harm in their own right, and prioritise research on shame, stigma, suicidality and delayed help-seeking.

Check for updates

Academic Editor: Paul R. Ward

Received: 23 July 2026
Revised: 21 August 2026
Accepted: 26 August 2026
Published: 2 September 2026

**Copyright:** © 2026 by the authors. Licensee MDPI, Basel, Switzerland. This article is an open access article distributed under the terms and conditions of the Creative Commons Attribution (CC BY) license.

## Abstract

**Background:** Gambling-related harm is recognised as a public health concern, yet limited synthesis has examined how shame, stigma and indebtedness shape help-seeking and suicidality across gendered and cultural contexts. This review addressed the following question: among individuals experiencing gambling-related harms, how do cultural and gender-based understandings of shame and indebtedness influence suicidality and help-seeking across diverse settings? **Methods:** This rapid review searched MEDLINE, PsycINFO and CINAHL, alongside grey-literature and reference-list searches, for studies

since 2000. Included studies were appraised (CASP, MMAT, or MQC-SP) and synthesised narratively. **Results:** Twenty-six qualitative, quantitative and mixed-methods studies were included. Gambling was portrayed as socially embedded and normalised, while gambling-related harm remained associated with judgement. Shame was linked to concealment, self-management and delayed disclosure. Indebtedness was associated with concealment, relationship strain, and sometimes made previously hidden gambling-related harm visible; however, the evidence did not allow firm conclusions about its relationship with crisis or suicidality. Help-seeking commonly occurred after harms had escalated and was facilitated by confidential, non-judgemental and culturally appropriate support. Gender and culture shaped meanings of responsibility, control, family reputation and disclosure, but were rarely examined analytically. **Conclusions:** Public health responses should improve early recognition of gambling-related harm through clear, non-judgemental messaging and stronger links between support services. Further research should clarify how shame, stigma and indebtedness relate to disclosure and suicidal distress, and should evaluate public health messaging, early-support routes, self-directed interventions and support for affected others.

**Keywords:** gambling-related harm; suicidality; shame; stigma; indebtedness; help-seeking; gender; culture

## 1. Introduction

### *1.1. Gambling-Related Harm as a Public Health Issue*

Gambling has become increasingly normalised as a mainstream leisure activity embedded within everyday social and cultural life. The expansion of gambling has been driven by the commercial development of products designed for mass consumption and efforts by industry to normalise gambling as a mainstream leisure activity [1]. Great Britain provides an illustrative example of the scale and increasing normalisation of gambling. The Gambling Survey for Great Britain reported that 48% of adults had gambled in the previous four weeks [2]. Although often framed as a male-dominated pursuit, women's engagement continues to rise, particularly in the context of online and mobile gambling [2–5]. Alongside this expansion, gambling-related harms have become increasingly recognised as a public health concern because their effects extend beyond individual gambling behaviour to include financial loss, emotional distress, relationship disruption and wider social consequences [6]. Gambling-related harms occur across diverse national and cultural settings, within which understandings of gambling, debt, shame and help-seeking may vary.

The distribution and experience of these harms are not uniform [7]. Gender-related differences have been identified in gambling behaviour, patterns of participation and how harm develops and is recognised [7]. A qualitative study with young men found that sports betting was understood as a gendered and normalised part of social life [8]. McCarthy et al.'s review [5] therefore called for gender-sensitive approaches to gambling research, policy and harm prevention.

Gambling-related behaviours are also shaped by ethnicity and culture [9]. Evidence suggests that some minoritised communities report lower gambling participation but higher levels of gambling-related harm, with stigma, discrimination, income inequality and barriers to support shaping these experiences [9]. Among minority ethnic and migrant communities, the experience and recognition of gambling-related harm may also be influenced by racism, language barriers, access to culturally responsive services, cultural and religious expectations, stigma, and concerns about family reputation [9–12].

Gambling-related harm should therefore be understood not simply as the consequence of individual choices, but as a public health issue shaped by the availability and promotion of gambling, its place within everyday life, and barriers to recognition of harm and support. A public health approach requires attention to who is exposed to gambling-related harm, how that harm and associated support needs are understood within different communities, and whether appropriate support is accessible before difficulties escalate to crisis [6]. This paper intends to contribute to public health approaches by drawing upon international evidence to examine how these experiences are shaped by gender and culture and how they relate to suicidality and help-seeking.

### 1.2. Review Question and Key Concepts

The rapid review addressed the following question:

Among individuals experiencing gambling-related harms, how do cultural and gender-based understandings of shame and indebtedness influence suicidality and help-seeking across diverse settings?

The review examined how shame, stigma and indebtedness were described in the literature; how they may influence concealment, disclosure, suicidal distress and help-seeking behaviour; and how gendered expectations and cultural norms shaped these experiences. It also considered the implications for public health responses to gambling-related harm and suicidality. This question brings together several related but distinct concepts, each of which we will expand upon before exploring how the evidence base led us to identify this as a gap in our current understanding.

Shame is understood as both an emotional and social experience that may shape distress, selfhood, identity and belonging [13]. In the context of gambling-related harm, shame may arise from concerns about personal failure, financial difficulties and the anticipated judgement of others. This may contribute to concealment and reluctance to seek help [14]. The Samaritans [15] demonstrated how shame can function as a silencing mechanism, discouraging disclosure and help-seeking where suicide, mental illness or addiction are stigmatised. Within the literature, shame is positioned as both an emotional and social experience that may shape distress, selfhood, identity and belonging, while also acting as a barrier to prevention and intervention [13].

Indebtedness is used here to encompass gambling-related debt and the financial obligations, relational and social meanings attached to it [16]. Debt can damage trust, strain relationships and create a perceived failure to meet responsibilities to others [14]. It may also contribute to relationship breakdown and employment loss, further weakening social support networks important to wellbeing [14]. Shame associated with indebtedness has been linked to depression, anxiety and suicidal thoughts [17]. Indebtedness and shame have been identified as potential processes connecting gambling-related harm and suicidal behaviour [18]. Shame, stigma and indebtedness may therefore contribute to a pattern in which gambling-related harm is privately managed or concealed until its financial, relational or psychological consequences become increasingly difficult to contain [14,16,17].

Suicidality refers to suicidal ideation and suicidal behaviour [15]. Help-seeking encompasses formal and informal attempts to access support for gambling-related financial, relational or psychological harms. Gender and culture are considered as social contexts that may shape expectations, meanings and responses to harm, rather than solely as demographic characteristics [5,9–12].

### 1.3. Previous Review Evidence Relevant to the Review Question

Studies provide evidence of the importance of examining these concepts together. Previous reviews have examined components of the research question but have approached

the concepts separately. For example, Marionneau and Nikkinen's [18] systematic review examined qualitative evidence on gambling-related suicide, suicidality and/or self-harm. However, the authors reported that gender differences and sociocultural contexts could not be systematically analysed because of limitations in the available evidence.

Bijker et al.'s [19] systematic review and meta-analysis examined the prevalence of help-seeking for gambling problems, concluding that 1 in 25 moderate-risk gamblers and 1 in 5 people with problem gambling have sought help for problems related to their gambling. While Aonso-Diego et al.'s [20] systematic review examined stigma, shame or guilt, gender differences and treatment-seeking in relation to gambling, it was limited to quantitative studies. Additionally, neither of these studies explored how shame, indebtedness, gender or culture shaped help-seeking or its relationship with suicidality.

McCarthy et al.'s [5] narrative review focused on women's gambling behaviours and experiences of harm and established the need for more gender-sensitive research, but did not bring these issues together with indebtedness, culture, suicidality and help-seeking.

Taken together, these reviews suggest that shame and indebtedness are important within gambling-related suicidality, that stigma can impede treatment-seeking and that experiences of gambling-related harm may be gendered. However, none brought together evidence examining how gendered and culturally informed understandings of both shame and indebtedness may shape suicidality and help-seeking across diverse settings. This is important because understanding these relationships may help explain disclosure, help-seeking and gambling-related suicidal distress.

### *1.4. The Scale and Complexity of Gambling-Related Harm, Crisis and Suicidality*

The broader evidence also highlights why these relationships warrant closer examination, showing both the scale of gambling-related suicidality and the social complexity surrounding it. The 2007 English Adult Psychiatric Morbidity Survey reported that 19.2% of people experiencing problem gambling had thought about suicide and 4.7% had attempted suicide in the previous year. These figures were substantially higher than those reported among people with no indicators of problem gambling (4.1% and 0.6%, respectively) [11]. More recent evidence found that 22% of people reporting high levels of gambling problems had attempted suicide during their lifetime, with 66% of this group linking their most recent attempt to gambling [21].

Wardle et al. [22] found that regular bettors who engaged in multiple forms of online and in-person gambling, particularly electronic gambling machines, had significantly higher odds of subsequent suicidal ideation than other gambling groups. A recorded gambling diagnosis was also a significant predictor of death by suicide in a population-based study in Wales, with those who died having higher levels of contact with mental health services, particularly inpatient services, before death [23].

These studies highlight the importance of research into gambling-related suicidality. However, much of the evidence identifies associations and risk factors rather than explaining the social and relational circumstances through which gambling-related harms may develop into suicidal distress or crisis [24,25]. Suicide research has often prioritised individual and clinical explanations, giving less attention to the wider social circumstances in which suicidal distress develops [24–26].

A broader contextual approach has been used to examine how distress develops, how it is shaped by gender and culture, and how it may progress towards crisis [27]. In the case of gambling-related harms there remains a need to examine the social and relational processes that may shape the development, recognition and disclosure of gambling-related distress, including that which is linked with suicidal ideation and action [21]. One example, David et al. [21], found that, among participants whose most recent suicide attempt was

linked to gambling, 76% reported that other people's judgement of their gambling had been important, while 79% identified gambling-related shame or guilt as important. Qualitative findings from the same study suggested that gambling stigma and self-stigma could lead people to hide their gambling, increasing isolation and potentially worsening suicidal distress. Some participants perceived gambling-related stigma as more damaging than suicide-related stigma because depression or suicidality were considered more understandable than gambling harm. This indicates that the shame attached to gambling may have distinctive features and may intersect with, but not be reducible to, wider mental-health stigma [20]. This study provides an example of how shame and stigma may intersect with suicidality, but does not establish that the same relationships operate consistently across genders and cultural settings.

These processes may also be connected to how responsibility for gambling harm is understood. The responsible gambling discourse has been critiqued for framing harm primarily as a matter of individual responsibility, while giving less attention to factors such as product design, availability and regulation [28]. Where difficulties are understood as evidence of personal irresponsibility or failure, shame may be intensified and disclosure further delayed [29].

### *1.5. Gender, Culture and Help-Seeking*

Gender-related differences have been reported in studies showing that gendered expectations concerning self-reliance, control and social responsibility may influence gambling behaviour and willingness to seek support [5]. Gambling-related behaviours are also shaped by ethnicity and culture [12]. Cultural and religious norms may influence how gambling is understood, concerns about family reputation and the forms of help considered acceptable [10,11,21]. Minority ethnic and migrant communities may also face racism, language barriers and limited access to culturally responsive services, alongside stigma within families and communities [10].

People experiencing gambling-related harms may have complex and overlapping support needs [30]. Studies show that a relatively small proportion of those who experience gambling-related harms seek professional help, with stigma often cited as a barrier to accessing support [31]. A recent National Centre for Social Research report found that support was often accessed at crisis points, including significant financial harm, debt and contact with debt collectors [12]. Help may therefore be sought only when financial, relational or psychological harms have become severe.

The existing primary evidence therefore points towards potential relationships between shame, indebtedness, gender, culture, suicidality and help-seeking, but does not itself provide an integrated synthesis of how these concepts interact.

### *1.6. Review Aim*

This rapid review was undertaken to address this gap by synthesising qualitative, quantitative and mixed evidence from a range of national and cultural settings. Although gambling-related harms are increasingly recognised as a public health concern there remains limited understanding of how cultural and gender-based meanings of shame and indebtedness influence suicidality and help-seeking among people experiencing these harms. Existing research has considered gambling-related harm, suicidality, shame, indebtedness and help-seeking, but there has been limited synthesis of how these factors are connected. In particular, further understanding is needed of how shame, stigma and indebtedness may shape concealment, delayed disclosure and crisis-driven help-seeking, and how these processes are influenced by gender and culture. Addressing this gap is im-

portant for informing earlier recognition of gambling-related distress, access to appropriate support and public health approaches to suicide prevention.

In contrast to previous reviews that examined individual components of the topic, the present review considered shame, stigma and indebtedness alongside gender and culture in relation to both suicidality and help-seeking.

## 2. Materials and Methods

### 2.1. Review Design

In accordance with guidance from Haby et al. [32], this rapid evidence review followed systematic review principles while applying proportionate approaches to selected stages of the review process to enable a timely synthesis of a broad and heterogeneous evidence base.

The review protocol was developed following an initial scoping exercise and consultation with the project advisory group, and was preregistered on the Open Science Framework (OSF; registration ID: 8npkv) before the commencement of the review. No amendments have been made since registration. The review followed a structured six-stage process comprising protocol development, literature searching, study selection, data extraction, methodological quality appraisal, and narrative synthesis. Reporting follows the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) 2020 Statement and a PRISMA 2020 checklist is included in Table S4 [33].

### 2.2. Search Strategy

A systematic search strategy was developed to identify empirical evidence examining the relationship between gambling-related harms, shame, indebtedness, culture, gender, help-seeking, and suicidality. The search strategy combined four broad concepts: (1) gambling and gambling-related harms; (2) culture and gender; (3) shame, stigma, and indebtedness; and (4) suicidality and help-seeking. Search terms were developed iteratively through preliminary scoping searches using keywords and Boolean operators. Benchmark studies identified during the scoping phase were used to validate the search strategy, with search terms refined where necessary to ensure retrieval of key publications.

Systematic searches were conducted in MEDLINE, PsycINFO, and CINAHL via the EBSCOhost platform during January and February 2026. Searches were limited to studies published from 2000 onwards in the English language. No restrictions were placed on geographical location or study design.

Targeted searches of official reports or publications from the following institutions were also undertaken: GambleAware, Public Health England, the Gambling Commission, the Howard League for Penal Reform, Samaritans, the World Health Organization (WHO), the Organisation for Economic Co-operation and Development (OECD), and the Bristol Gambling Research Hub. Reference lists of all included studies were hand-searched to identify additional eligible publications. Consistent with rapid review methodology, the search was conducted once and was not rerun before completion of the review. Full search strategies for each database are provided in Supplementary Table S1.

### 2.3. Eligibility Criteria

Eligibility criteria were established during protocol development and applied consistently throughout title and abstract screening and full-text screening. The review included empirical qualitative, quantitative, and mixed-methods studies examining how cultural and gender-based understandings of shame and indebtedness influence suicidality and help-seeking among adults ($\geq$18 years) experiencing gambling-related harms. Studies that reported shame, debt/financial difficulties, gender, or cultural characteristics solely as demographic variables, correlates, prevalence estimates, or risk factors, without examining

their meanings or experiences in relation to suicidality or help-seeking, were outside the scope of the review. Given the inconsistent use of sex and gender terminology across studies, evidence relating to either was eligible, with study-specific terminology retained when reporting findings. 'Gender' and 'gendered' are used in the synthesis when referring to socially constructed roles, expectations and identities.

Studies published before 2000 were excluded to reflect the expansion of online gambling and contemporary developments in gambling-related harm and suicidology. Additional exclusion criteria included studies that did not report empirical research, studies focusing exclusively on non-adult populations where adult findings could not be disaggregated, literature reviews, and purely theoretical or conceptual papers that did not meaningfully inform the empirical evidence base.

### 2.4. Screening

All records identified through database and grey literature searches were imported into Rayyan® (version 1.7.2), where duplicate records were identified using the platform's automated deduplication function and verified through manual checking. Rayyan's AI-assisted functions were used solely to prioritise potentially relevant records and identify possible duplicate records. All screening decisions were made independently by the research team using the predefined eligibility criteria.

Screening was undertaken in two stages. Titles and abstracts were screened by one reviewer, with a second reviewer independently screening a random 10% sample as a verification measure. Potentially eligible studies then underwent full-text screening, with one reviewer assessing all full-text articles and a second reviewer independently screening a random 10% sample. Disagreements were resolved through discussion and consensus, with a third reviewer consulted where necessary. This approach represents pragmatic methodological streamlining in keeping with the rapid review design and associated time and resource constraints. Reasons for exclusion at the full-text stage were recorded to maintain a transparent audit trail. Blinding of bibliographic information was not undertaken, consistent with the proportionate approach adopted for this rapid evidence review. The study selection process is presented in a PRISMA 2020 [33] flow diagram in Figure 1.

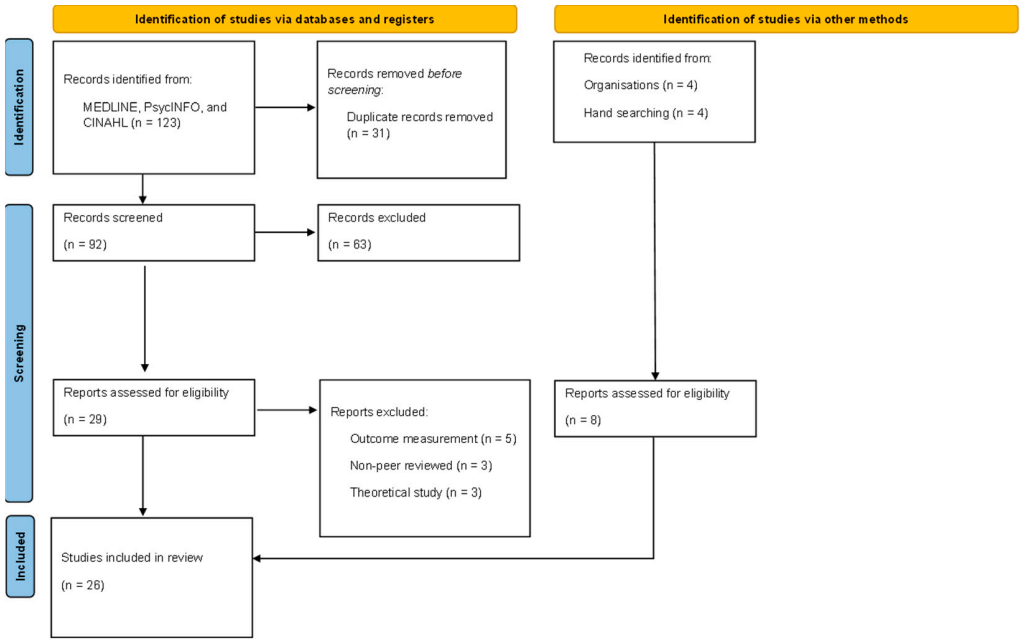



**Figure 1.** The 2020 PRISMA flow diagram of the study identification and selection process.

### 2.5. Data Extraction

Data were extracted using a structured extraction template developed specifically for this review and piloted on a sample of included studies before full data extraction commenced. The data extraction template captured study characteristics, including author, year of publication, geographical region, study aims, funding or conflicts of interest, cultural context, sample size and gender composition, age, study setting, socioeconomic and relationship status, gambling types, terminology used to describe gambling, and study quality or limitations reported by the authors (Supplementary Table S2). Participant characteristics included cultural context, sample size, age, gender, study setting, socioeconomic characteristics, relationship status, and reported comorbidities. Methodological information included study design, data source, analytical approach, interventions (where applicable), and methodological limitations identified by the study authors.

To address the review objectives, additional data were extracted on the presence, measurement and type of shame constructs, the cultural and gendered framing of shame, the suicidality outcome type, and forms of help-seeking (Supplementary Table S3). Information relating to the core review concepts was also extracted, including conceptualisations of shame, gendered framing of shame, the presence and type of indebtedness, the moral meanings attributed to debt, and the visibility or concealment of debt. Outcomes relating to help-seeking and suicidality were extracted, including suicidality outcomes, help-seeking behaviours, and reported barriers and facilitators to seeking support. Any additional information considered relevant to the review question was also recorded.

One reviewer undertook data extraction, and this was checked for completeness and accuracy by two additional members of the research team. Any discrepancies, omissions, or uncertainties were resolved through discussion and reference to the original publication.

### 2.6. Quality Appraisal

Methodological quality was assessed using appraisal tools appropriate to each study design. Qualitative and quantitative studies were appraised using the relevant Critical Appraisal Skills Programme (CASP) checklist, mixed-methods studies were assessed using the Mixed Methods Appraisal Tool (MMAT), and grey literature was appraised using the Methodological Quality Checklist for Stakeholder Documents and Position Papers (MQC-SP). Each study was independently appraised by two reviewers, with disagreements resolved through discussion and consensus. Quality appraisal findings were not used to exclude studies but were considered during the narrative synthesis to contextualise the methodological strengths and limitations of the available evidence. A summary of the appraisal findings is provided in Appendix A.

### 2.7. Data Synthesis

Given the methodological heterogeneity of the included studies, statistical meta-analysis was not appropriate [32]. Findings were therefore synthesised using a narrative synthesis approach informed by the guidance of Popay et al. [34].

The synthesis was undertaken in three stages. First, descriptive characteristics of the included studies were summarised to provide an overview of the evidence base. Second, relationships within and between studies were explored to examine how shame, indebtedness, gender, culture, help-seeking, and suicidality were conceptualised across different populations and contexts. Finally, findings were synthesised narratively to identify patterns, relationships, inconsistencies, and explanatory mechanisms across the evidence base. Data contributing to the synthesis were drawn from empirical findings reported. Introductory and discussion material was used for contextual understanding but was not treated as empirical evidence or used independently to generate themes.

### 2.8. Lived Experience and Stakeholder Involvement

Lived experience and stakeholder involvement formed an integral component of the review. An advisory group comprising researchers with expertise in gambling-related harms and individuals with lived experience contributed to refining the review focus, interpreting emerging findings, and informing dissemination activities. Feedback was obtained through both group and individual meetings throughout the review.

### 2.9. Ethical Considerations

An ethics waiver for the review was obtained from the University of Staffordshire ethics board. As this was desk-based secondary research and did not involve empirical data collection, the ethical review process was proportionate to the nature of the project.

## 3. Results

### 3.1. Study Characteristics

The 26 included studies were published between 2001 and 2026, with 15 published from 2021 onwards. The largest proportion of studies was conducted in the United Kingdom ($n$ = 8), followed by Australia ($n$ = 7) and Canada ($n$ = 2). One study was conducted in each of Brazil, Finland, Germany, Hong Kong, Italy, New Zealand, Singapore, Sweden and the United States.

The studies employed a range of designs. These included qualitative interview studies ($n$ = 7), mixed-methods studies combining survey data with follow-up interviews or open-ended responses ($n$ = 6), and cross-sectional surveys of clinical, helpline or general-population samples ($n$ = 7). Four studies used content analysis or secondary analysis, including analyses of social media comments and online forums, an annual treatment survey, and a national report on young people. The evidence base also included one longitudinal study and one case–control study examining population-level suicide risk.

Sample sizes varied considerably, ranging from qualitative and clinical studies with fewer than ten participants to national surveys involving approximately 17,000–19,000 participants. Community and clinical studies with samples of approximately 100–1200 participants were also common and, in some cases, enabled comparisons by gender or gambling severity. While most studies recruited people who gambled, some included affected others or family members, and one recruited gambling counsellors as key informants [35,36]. Two studies used large national datasets, including linked routine health records, providing population-level evidence that was not available from the smaller interview and clinical studies [2,23].

Most studies included both men and women, although the gender composition of samples varied considerably. Several clinical studies were predominantly male, including studies conducted in Singapore, where 98% of participants were men [37], and Hong Kong, where 88% were men [38]. In contrast, some community surveys reported more balanced samples, including 46.7% women in an Ontario study [39] and 51.8% women in a UK study [36]. A smaller group of studies focused specifically on women or affected others [31,40,41], while one qualitative study focused exclusively on young men's perspectives on preventing sports-betting harms [8]. Overall, the evidence base remained weighted towards male participants, particularly within clinical samples.

Ethnicity was less consistently examined or reported. Two UK reports identified elevated experiences of gambling-related harm, stigma or discrimination among some minority ethnic groups, including Black British young adults. However, ethnicity was not reported in 11 of the included studies, and minority ethnic populations were otherwise poorly represented. Two studies explicitly examined Aboriginal experiences [40,42], while three included predominantly Chinese samples: 100% in Hong Kong, 91% in Singapore

and 32% in a Canadian mixed-methods study [37,38,43]. This limited and inconsistent reporting constrained comparisons across ethnic and cultural groups.

### 3.2. Gambling as Socially Embedded and Normalised Leisure

Across the included studies, gambling was portrayed as a culturally embedded and socially acceptable activity, integrated into everyday life through sport, family practices, peer relationships, military culture, digital technologies and broader leisure environments [35,44]. Rather than being understood solely as a risky or harmful behaviour, gambling was often described as a routine feature of contemporary social life, a casual social activity and a means of bonding with others [44].

Examples included young people being first introduced to gambling through everyday social and family activities, including receiving lottery tickets, observing family members place sports bets, or participating in games such as bingo with relatives [45].

The expansion of online and mobile gambling extended access to gambling within everyday settings. Participants in Zhang et al.'s [37] study identified convenience and accessibility as key reasons for gambling online. Digital environments also contributed to blurred boundaries between gambling and other leisure activities, particularly gaming. Gosschalk et al. [45] highlighted exposure to loot boxes, skins betting, esports betting and other gambling-like mechanics embedded within video games. These activities introduced gambling-like features including uncertain outcomes, intermittent rewards and near-miss experiences into entertainment settings that young people might not otherwise recognise as gambling [44].

Together, these findings indicated that gambling was embedded across mainstream social, family and digital leisure settings rather than being confined to traditional gambling environments [37].

This finding connects to our review question because participants reported that, as participation could be experienced as ordinary, gambling-related harm was associated with concerns about judgement, responsibility and the social consequences of disclosure. This distinction between the normalisation of gambling participation and the stigmatisation of gambling-related harm provides the context for the findings on shame and stigma presented below.

### 3.3. Socially Produced Shame, Stigma and Anticipated Judgement

When gambling behaviour crossed the boundaries of 'social activity' to a source of harm, shame was frequently reported. Across the included studies, it was described as both an internal or individual emotional response and relationally through fears of actual or anticipated judgement from families, peers, services and wider communities. Studies frequently discussed shame and stigma together and did not always distinguish clearly between them. However, the findings indicated an interaction between fears of external judgement and participants' feelings of embarrassment, blame and rejection [8,35,46].

Fear of social judgement was a recurring feature of gambling-related shame. Participants described worries about how others might interpret their gambling behaviour and its consequences [39,40,43,46]. Shame was particularly evident where participants anticipated being viewed as irresponsible, lacking control or having failed family members and others close to them [40]. Embarrassment, pride and reluctance for others to become aware of the gambling problem also made disclosure and help-seeking more difficult [47].

Anticipated judgement also influenced preferences for anonymity. Some participants were reluctant to discuss gambling-related difficulties openly and preferred forms of support that reduced the possibility of being identified or judged [40,45]. Evidence of wider public stigma was also identified. In a German analysis of YouTube comments, people

experiencing gambling disorder were blamed for their difficulties and characterised as irresponsible or morally deficient [48]. These findings help to explain why disclosure may feel risky, and why some people may conceal gambling-related harms until help-seeking is delayed or occurs at a point of crisis.

Shame was also relational, arising from the actual or anticipated effects of gambling-related harm on close relationships. Participants described fears of being excluded, loss of belonging or disappointing relatives [49]. Shame therefore related not only to gambling behaviour itself, but also to its perceived consequences for family responsibilities, relationships and social identity. In a study of partners, participants reported attempts to keep gambling-related difficulties hidden from friends, parents and in-laws [41]. Shame was heightened when partners discovered depleted bank accounts, debt or other hidden financial problems. Affected family members in a UK veteran study similarly described the damage caused by secrecy and deception associated with gambling [35]. Across these studies, disclosure involved revealing not only the gambling itself, but also its financial and relational consequences, including dishonesty towards family members and employers [43].

The findings therefore suggested that gambling-related shame was socially and relationally produced. Actual or anticipated stigma shaped how individuals understood themselves, while the possibility of exposing debt, deception and harm to close relationships increased the perceived risks of disclosure. The meanings attached to judgement, responsibility and disclosure were also shaped by gendered and cultural contexts, and these are considered in the following sections.

### *3.4. Gendered Dimensions of Gambling-Related Shame and Help-Seeking*

The included studies identified both similarities and differences in gambling-related shame among women and men [43,46]. Baxter et al. [43] found that both women and men viewed financial shame as a major barrier to seeking help for gambling-related harm. Across the evidence, shame was particularly evident where gambling-related harms were perceived as failures to meet expectations concerning family roles and responsibility [46].

Several studies suggested that these expectations were gendered [8,31,36,43,46]. For women, shame was often framed in relation to gendered expectations about appropriate behaviour, respectability and caregiving [31]. Women's accounts also included shame associated with entering gambling environments, denying the extent of gambling-related difficulties, beliefs about luck and dishonesty towards others [44]. Women described gambling as a predominantly "male" activity, which contributed to feelings of abnormality, embarrassment and social isolation. This was exacerbated when accessing male-dominated gambling or recovery spaces, such as bookmakers or Gamblers Anonymous [38]. Some women also experienced barriers linked to caring responsibilities, childcare and concerns about leaving children to attend treatment. Fear of judgement and reluctance to disclose gambling-related difficulties to family members, professionals or peers further constrained help-seeking among women in these studies [43].

For men, shame was associated with perceived weakness, failure and loss of control [44,46], as well as addiction and emotional vulnerability [44]. For example, men's accounts included gambling taking over their lives, an inability to stop, using gambling to cope, loss of self-respect, anxiety, relationship conflict, family anger and dishonesty [43]. Within these accounts, shame was linked to perceived failures of control, responsibility and masculine self-image.

Hing et al. [36] identified a group of help-seekers, the majority of whom were men, who tended to seek anonymous, rapid and confidential support for immediate problems, often financial, while being less open to exploring the underlying causes of gambling. This preference was associated with concerns about publicity and the management of

stigma [30]. Similarly, the normalisation of sports betting and the difficulty of being the person who spoke openly about harm were identified within male peer cultures [8].

Overall, the evidence suggested that gendered expectations shaped the meanings attached to financial loss, responsibility, control and disclosure. However, these patterns were drawn from a small and uneven evidence base, including several predominantly male samples, and should not be interpreted as fixed or universal differences between women and men. Few studies explicitly distinguished sex from gender or used gender as an analytical framework, and there was limited consideration of gender identities beyond women and men or of how gender intersected with indebtedness, culture and suicidality.

### 3.5. Culture, Community and Moral Framings of Shame

Across several studies, gambling-related shame was shaped by the social, moral, religious, familial and community meanings attached to gambling-related harm, rather than being described solely as an individual emotional response [3,40,43,44,50,51]. For example, Gupta et al. [40] found that, among Aboriginal communities in Australia, participants were concerned both about experiencing gambling-related difficulties and about potential judgement from services or the wider community.

Cultural expectations also shaped shame in other settings. In a UK veteran study, military identity and culture delayed help-seeking, in part because norms discouraging vulnerability may have intensified shame [35]. However, the sample was strongly gendered: all participating veterans were men, while all participating family members were women. This indicated a possible overlap between military culture and gendered expectations, although the sample did not allow these influences to be examined separately [35]. Similar dynamics were evident in Rolando et al.'s [51] study in Piedmont, Italy, where gambling-related harm was framed as a weakness of character, a moral failing or "just a vice", rather than an illness. Shame could therefore threaten both personal and family identity, particularly in communities where family reputation and social standing were highly valued [51].

Shame associated with gambling-related harm was also shaped by religious and moral condemnation, concerns about family and community reputation, fear of public exposure and "loss of face", particularly within some minority ethnic and religious contexts [46].

Collectively, these studies indicated that cultural framings influenced how gambling-related harm was understood and whether disclosure was experienced as possible, risky or unacceptable. However, the findings arose from diverse settings and populations and should not be interpreted as applying uniformly across cultural or ethnic groups.

In other studies, shame and stigma were discussed at a descriptive level, without deeper conceptualisation. One recent study used the Gambling Internalised Stigma Scale [46], while others discussed the concepts through qualitative accounts or coded self-report data [36,39,47]. These differences limited comparison across studies, although a recurring pattern was that shame was socially and culturally shaped rather than solely experienced at an individual level.

Few studies explicitly examined how cultural norms interacted with shame, stigma, indebtedness and help-seeking. Culture was more commonly treated as contextual background, including through descriptions of family expectations, religion and community values, than used as an analytical framework for understanding how gambling-related harms were disclosed or responded to. Several accounts also linked shame to financial loss, family responsibility and the possibility of exposing gambling-related harm to others; the role of indebtedness and relational exposure is considered next.

### 3.6. Indebtedness, Concealment, Self-Management and Delayed Disclosure

Indebtedness was a prominent consequence of gambling-related harm and was closely connected to concealment, shame and delayed exposure. Participants described attempts to hide financial losses, depleted bank accounts and accumulating debt from partners, relatives and others close to them [41].

Indebtedness formed part of this wider escalation of harm. The evidence presented in the preceding sections showed that financial losses and debts were often concealed while individuals attempted to recover losses or manage the consequences privately. However, relatively few studies directly examined whether indebtedness itself precipitated disclosure, engagement with support or the onset of crisis.

Across the included studies, shame was closely associated with concealment and delayed access to support [31,40,50,52,53]. Participants frequently believed that gambling-related difficulties could be managed privately or brought under control without formal support [42,47,49,50,52]. Some continued gambling in the belief that losses could be recovered and thus remain concealed before the extent of the harm became known [52]. Further gambling was also described as an attempted means of resolving financial difficulties [47], or a way to hide financial shame [43]. These attempts to manage gambling-related harm were shaped by embarrassment, humiliation and concerns about how others might respond if the gambling and its consequences were disclosed [50]. Participants often did not want others to know about their gambling behaviour [35,36,47,51,52].

Self-management and private coping were closely connected to secrecy, embarrassment and a desire to retain control over who knew about the gambling-related harm. Although self-management was preferred by some participants [52], there was limited evidence about whether these strategies were effective in reducing harm [47,50].

Disclosure was also delayed when gambling-related harm was minimised or not recognised as being serious enough to require support [31,35–37,39,42,44,47,50,52,53]. Resistance to withdrawing from gambling activities [39,47] and active treatment avoidance were also reported [36]. Private attempts to control gambling sometimes occurred alongside informal support from friends or family members [8,35,40,42,51].

Collectively, the studies' findings suggested that disclosure was often postponed while individuals attempted to manage gambling and its consequences privately. Shame, fear of judgement, limited recognition of harm and the wish to avoid exposing gambling-related difficulties to others all contributed to this pattern of delayed disclosure.

These findings concern whether gambling-related harm was revealed to others; the following section considers the related but distinct question of whether and how support was accessed.

### 3.7. Barriers and Facilitators to Help-Seeking

Help-seeking was related to disclosure, but involved a distinct set of service-level, structural and relational factors shaping whether and how support was accessed. A range of service-level, structural and relational barriers to help-seeking were identified across the included studies. Practical barriers included cost [50,54], distance, waiting times and service inflexibility [8,31,40,45,53]. Limited availability of appropriate support and a lack of awareness of existing services were also commonly reported [31,35,41,42,44,49,53,54]. The duration of gambling-related difficulties and the time spent gambling also appeared to influence when support was sought [50,52].

Limited awareness of where to seek help and uncertainty about the support being offered were additional barriers [45]. Privacy concerns [36,42,44,49], negative views of services [36,37,39,42,45,51], and limited confidence in treatment effectiveness [47] were also reported.

Mainstream services were not always experienced as accessible or appropriate for minority ethnic communities, particularly in relation to outreach, language and cultural fit [7]. Studies also identified gaps in culturally safe support and services for minority ethnic communities [7,40,50], a lack of veteran-tailored provision [35], limited support for affected others [41], and services for children and young people [44].

Barriers to help-seeking were not solely practical. Trust, privacy and the anticipated consequences of disclosure also influenced willingness to engage with services. Some participants feared that seeking help would reveal their gambling-related difficulties to family members, employers or wider communities, with possible consequences for relationships, reputation and social standing [43,49]. Seeking help could therefore feel risky, particularly where gambling-related harm was associated with shame, irresponsibility or personal failure. Where support was considered, anonymous and confidential forms were often preferred because they reduced the perceived risk of exposure [42,53].

Help-seeking often began with recognising that gambling-related difficulties could no longer be managed without support [35,40,41,50–52]. In some cases, gambling was framed as a vice rather than an illness [51], while limited awareness that gambling disorder could be understood as a diagnosable condition shaped recognition of the potential need for support [49]. Family members, peers and affected others also played an important role in encouraging engagement with treatment [8,35,41]. They recognised escalating harm or prompted engagement with formal support, sometimes in combination with an associated crisis [8,35,40,42,51]. In some studies, counselling [40] was perceived as easier to approach than GP-led intervention [8]. More formal treatment was generally considered later, with some evidence of preferences for psychiatry and regional addiction clinics [49], although evidence about preferences for particular services was limited.

Practical facilitators to help-seeking included access to anonymous or confidential support [36,42,44–46], provision located within or close to local communities [40], and services that were easy to access [8,51,52]. Online and telephone support also offered flexible routes into services [31,44], particularly for young people [44]. Greater awareness of where and how to obtain support was also identified as important [31,44,45].

Feeling safe when accessing support [42] and having a positive view of the intervention being offered [42,49] were also recognised as facilitators. Across the included studies, helpful interventions were described as person-centred [31], non-judgemental and relatable [36,44–46], and relevant and understandable to those using them [35].

Informal support could make help-seeking feel less exposing, while encouragement or pressure from family and friends sometimes prompted engagement with formal services, particularly when gambling-related harms had escalated [8,35,40,42,51]. Informal support, peer-based discussion, reduced stigma and shame, open conversations, youth-friendly support structures, and the co-creation of support strategies were also identified as potentially helpful [8,36,46]. Other helpful features included discussions that normalised relapse [36], reframed gambling as a health issue rather than a moral failing [46,51], and supported a strong therapeutic relationship [31,36]. Culturally appropriate conversations about gambling-related harm were also identified as important [40].

Studies focusing on specific populations suggested that confidential, relatable and digital routes into support may be particularly helpful for young men [44], while women may benefit from approaches that address shame and stigma directly [31]. Among veterans, encouragement from family and friends, informal support and the escalation of gambling-related harms were identified as important prompts for help-seeking [35].

Overall, help-seeking depended not only on recognising that support was needed, but also on whether services were accessible, acceptable and felt safe. Shame, anticipated judgement and concerns about exposing financial or relational harm were recurring barriers,

while confidential, non-judgemental, culturally appropriate and person-centred provision were identified as facilitators. The findings therefore show important links between delayed disclosure and help-seeking, but do not establish a single progression from concealment to crisis. Evidence concerning suicidality is considered in the following section.

### 3.8. Suicidality and Evidence Limits

Direct evidence concerning suicidality was comparatively limited. Wardle et al. [22] reported an association between engagement across multiple gambling formats and an increased risk of subsequent suicidal ideation. Evans and Delfabbro [47] identified suicide attempts among the harms associated with crisis-driven help-seeking, while Baxter et al. [43] reported suicidal thoughts among the difficulties described by men experiencing gambling-related harm. However, few studies directly examined how shame, stigma, concealment or indebtedness contributed to the development of suicidal distress over time.

Overall, the findings indicated that help-seeking frequently occurred after gambling-related harms had escalated. Nevertheless, the evidence was insufficient to establish a consistent or causal pathway from indebtedness through crisis to suicidal thoughts or behaviour.

## 4. Discussion

This review suggests that shame, stigma and indebtedness are best understood not as isolated barriers to help-seeking, but as interconnected social processes that shape disclosure and help-seeking, while evidence regarding their progression towards crisis was more limited. By synthesising qualitative, quantitative, and mixed-methods evidence, the review indicates that these processes operate within a wider social context in which gambling has become increasingly normalised, yet gambling-related harm remains stigmatised. This tension appears to be associated with concealment and delayed help-seeking, with financial harms and indebtedness sometimes making previously hidden gambling problems more visible to others. In doing so, the review extends previous research identifying shame and stigma as barriers to help-seeking [31,40,50,52,53] by suggesting how these experiences interact with financial harms and broader social expectations to shape patterns of concealment and delayed help-seeking. Taken together, the findings suggest how shame, stigma, concealment and delayed help-seeking may become interconnected as gambling-related harms escalate, although the evidence does not establish a consistent progression between these processes.

A key finding from the review is the apparent paradox created by the contemporary gambling environment. This finding is consistent with previous research describing broader commercial and social processes that have normalised gambling participation across sport, online environments, gaming and other leisure activities [1,29]. This wider social acceptance was reflected across several of the included studies, where gambling was described as a normal part of family life, peer relationships, and social participation. However, this apparent contrast was evident in studies in which participants described fears of judgement, blame, damaged reputation, and disappointing others once gambling resulted in visible harm [31,36,46,53]. These findings suggest that while gambling participation has become increasingly normalised, gambling-related harm remains stigmatised.

These findings may be interpreted alongside critiques of responsible gambling approaches in which responsibility is positioned primarily with the individual gambler rather than with increasingly accessible gambling products and environments [1,29]. Consequently, when gambling-related harms develop, they may be interpreted as evidence of personal failure rather than being understood in relation to highly commercialised and socially embedded gambling environments. Rather than reducing stigma, the normalisation

of gambling may therefore reinforce expectations that people should be able to gamble responsibly, intensifying shame and self-blame when these expectations cannot be met. This broader social context provides an important backdrop against which concealment and reluctance to seek support can be understood.

However, recognising the structural conditions that shape gambling-related harm does not remove individual agency. Research on gambling recovery has highlighted the role of personal agency, self-determination and self-regulation in recovery processes [30]. At the same time, responsibility should not be located wholly with the individual, as the capacity to exercise choice may be shaped by product design, accessibility and wider commercial and social environments [29]. Reducing individual blame therefore need not mean positioning people experiencing gambling-related harm as passive in relation to change.

Delayed help-seeking was also shaped by limited recognition and minimisation of gambling-related harm. Where difficulties were regarded as controllable without support, or gambling was framed as a vice rather than a health concern, opportunities for earlier recognition and intervention could be reduced. This highlights the importance of public health messaging that increases awareness of gambling-related harm without reinforcing individual blame.

The review also suggests that indebtedness represents considerably more than a financial consequence of gambling. This extends evidence identifying gambling-related debt as one of the most significant harms associated with gambling [55]; it is consistently associated with increased psychological distress and suicidality [18]. However, the present synthesis suggests that indebtedness also carries an important social meaning that has received comparatively less attention within the existing literature. Across the included studies, financial losses and debt sometimes became visible when partners or family members discovered previously concealed gambling-related harm. While gambling itself could often remain hidden, its financial consequences could become increasingly difficult to conceal. The findings suggest that indebtedness therefore could contribute to the transition from private harm to social exposure. The discovery of debt could intensify shame by threatening personal identity, trust and close relationships. Rather than functioning solely as an economic consequence of gambling, indebtedness may therefore be one process through which concealed gambling harm becomes socially visible.

This interpretation provides a broader understanding of delayed help-seeking than viewing barriers and facilitators in isolation. Across several studies, participants attempted to manage gambling-related harms privately before seeking formal support, including attempts to control their gambling, recover losses or manage financial consequences independently [47,50,52]. These efforts appeared to reflect attempts not only to address the practical consequences of gambling but also to avoid the anticipated shame and stigma associated with disclosure. In some studies, financial and relational harms had escalated by the time concealment became more difficult to sustain or support was accessed, sometimes following intervention by others.

The synthesis therefore suggests a possible interpretive pattern in which anticipated stigma and shame were associated with concealment and private self-management, disclosure was delayed, while financial or relational harms could make continued concealment more difficult. Help-seeking frequently occurred only after harms had escalated, although the evidence was not sufficient to determine whether these experiences formed a consistent sequence. This was reflected in other findings that engagement with support was commonly prompted by family members or significant others, while interventions perceived as non-judgemental and person-centred appeared to facilitate engagement [31,36,46]. Affected others occupied an important but under-examined position within this process. Partners and family members were often involved in discovering concealed financial harm and

prompting help-seeking, while also experiencing damaged trust, financial consequences and relationship disruption. Public health responses should therefore recognise affected others both as people experiencing harm and as potential sources of early recognition and support.

Practical barriers relating to service accessibility identified in this review have also been reported previously [7,31,40,50,53,54]. However, the present synthesis suggests that delayed help-seeking is better understood as a socially embedded process shaped by interactions between structural barriers, trust, privacy, stigma, shame, indebtedness, and the wider social meanings attached to gambling-related harm. These wider social meanings did not emerge uniformly across the included studies. Rather, the review suggests that cultural and gendered expectations appeared to influence how gambling-related harms were experienced and disclosed. Although the evidence relating to gender and culture was less developed than that concerning shame, stigma and help-seeking, the available studies suggested that these factors shaped the social meanings attached to gambling-related harm.

This also helps to explain why anonymous, confidential and accessible support was valued across the included studies. This was reflected in evidence that support perceived as non-judgemental, person-centred and culturally appropriate could make disclosure feel less risky, while family members, peers and affected others often played an important role in recognising escalating harm and encouraging engagement with formal support [35,36,40–42,45]. These findings may support a layered public health response. Population-level messaging should improve recognition of gambling-related harm without reinforcing narratives of individual failure, while confidential, non-judgemental and culturally appropriate routes into support may reduce the perceived risks of disclosure. Closer links between gambling support, debt advice, mental health services and suicide-prevention provision may also help identify escalating harm earlier. Affected others should be recognised both as people experiencing harm in their own right and as potential partners in early intervention.

Across several studies, gambling-related shame appeared closely connected to gendered expectations surrounding financial responsibility, self-reliance, control, respectability and caregiving. Women's accounts highlighted caring responsibilities and discomfort within male-dominated gambling and recovery spaces, while men's accounts linked shame to weakness, loss of control and masculine self-image [8,31,43,46]. These findings are consistent with the broader literature suggesting that dominant masculine norms may discourage emotional disclosure and professional help-seeking, encouraging individuals instead to manage difficulties privately until they become overwhelming [5]. Within this review, however, relatively few studies moved beyond describing these gendered expectations to examine how they actively shaped concealment, delayed help-seeking, and suicidal distress. Gender was often reported as a demographic characteristic rather than used as an analytical lens through which gambling-related harms were interpreted.

A similar pattern was evident in relation to culture. Studies highlighted the importance of family reputation, community expectations, religious beliefs, and concerns about shame or loss of face, suggesting that gambling-related harms were often experienced within wider relational and cultural contexts rather than solely as individual problems [35,40,50]. These findings align with previous work demonstrating that gambling harms within some minority ethnic communities may be compounded by experiences of stigma, discrimination, racism, language barriers, and limited access to culturally appropriate support [9,12]. Across the studies included in this review, concerns about bringing shame upon the family, damaging community standing or violating cultural and religious expectations could increase reluctance to disclose gambling-related harm. However, culture was generally treated as contextual background rather than examined analytically. Conse-

quently, while the review suggests that cultural expectations shape how gambling-related harms are experienced and responded to, there remains limited understanding of the complex ways in which cultural norms interact with shame, indebtedness and help-seeking across different communities.

Gender and culture should not be understood as separate influences on gambling-related harm, but as factors that shape the broader social processes identified within this review. Patterns of shame, concealment, financial harm and delayed help-seeking recurred across the evidence, while the meanings attached to financial loss, disclosure, and help-seeking differed according to the social, cultural and gendered expectations within which gambling-related harms occurred. Future research would therefore benefit from moving beyond descriptive comparisons between demographic groups towards a more theoretically informed understanding of how these intersecting social processes influence experiences of gambling-related harm.

Alongside the findings of the review, an important conceptual observation was the inconsistent use of shame and stigma across the included studies. Although these concepts are widely recognised as distinct but overlapping, many of the included studies used them interchangeably or did not clearly define how they were related. In this discussion, stigma is conceptualised as the social process through which gambling-related harm is associated with negative stereotypes, judgement and discrimination, whereas shame refers to the internal emotional experience of feeling exposed, defective or a failure following actual or anticipated social judgement. While these processes are closely connected, greater conceptual distinction is important because they represent different, albeit interacting, mechanisms through which gambling-related harms may influence disclosure and help-seeking.

The review findings were in keeping with previous evidence implicitly linking actual or anticipated stigma with feelings of shame, concealment, self-management and delayed help-seeking [31,46,53,56]. However, relatively few studies explicitly examined these relationships or considered how experiences of public stigma may become internalised as self-stigma. Instead, shame, stigma, embarrassment, and self-blame were frequently reported together as barriers to disclosure and treatment engagement without distinguishing their respective contributions to these processes [8,36,51]. This lack of conceptual clarity makes it difficult to identify the mechanisms through which gambling-related harms become concealed and, consequently, where interventions may be most effective.

Studies relating to suicidality were limited. Wardle et al. [22] reported an association between engagement across multiple gambling formats and subsequent suicidal ideation, while Evans and Delfabbro [47] identified suicide attempts among the harms associated with crisis-driven help-seeking. However, the included studies did not directly establish how shame, stigma, concealment or indebtedness contributed to suicidal distress over time. This leaves an important gap in understanding how these factors may interact in the development of suicidal distress.

This review brings together evidence concerning the intersections between shame, stigma, indebtedness, gender, culture, help-seeking and suicidality in relation to gambling-related harms. In relation to the review objectives, the synthesis identified clear links between shame, stigma, indebtedness, concealment and delayed help-seeking. However, the evidence was less developed in relation to gender and culture, and particularly limited in explaining how these factors were associated with crisis and suicidality. By integrating qualitative, quantitative and mixed-methods evidence from several international settings, and presenting an accompanying evidence gap map, the review provides a broader conceptual understanding of how these factors may interact. The findings should be interpreted in light of several limitations. As a rapid review, only English-language studies were included, and the heterogeneity of the evidence precluded quantitative synthesis. The

evidence was concentrated in high-income, predominantly English-speaking countries; ethnicity was frequently unreported; and several clinical samples were heavily weighted towards men. Gender and culture were often reported descriptively rather than examined analytically. Interpretation of the findings relating to suicidality is also complicated by co-occurring mental health difficulties, which make it difficult to isolate the contribution of gambling-related harms, shame or indebtedness to suicidal distress. In addition, much of the available evidence was not designed to establish how these relationships developed over time or to support causal conclusions. Consequently, the review identifies potential pathways linking shame, stigma, indebtedness and help-seeking, but cannot establish a consistent pathway or causal relationships.

## 5. Conclusions

Overall, this review suggests that shame, stigma and indebtedness appear to operate as interconnected social processes associated with concealment and delayed help-seeking among people experiencing gambling-related harms. Gambling was embedded within everyday life through sport, family practices, peer relationships and digital leisure environments, while gambling-related harm was associated with blame, judgement and assumptions of personal failure. Financial harms and indebtedness sometimes made previously concealed gambling problems more visible to others, although the evidence did not establish a consistent progression from these processes to crisis or suicidality.

This tension may help explain why emerging harms may remain concealed and why disclosure and help-seeking are often delayed. Understanding these interactions may help shift research, policy and practice away from viewing delayed help-seeking as an individual failure and towards recognising the wider social conditions that shape concealment, disclosure and escalation towards crisis.

In relation to the review question, the evidence was strongest in showing how shame, stigma and indebtedness were associated with concealment and delayed disclosure and help-seeking. Evidence concerning how these relationships varied by gender and culture was less developed, and evidence linking them to progression towards crisis and suicidality was limited. The review therefore provides a clearer account of the help-seeking dimensions of the question than of the pathways to suicidal distress.

The findings support public health communication that improves awareness of gambling-related harm without reproducing moralising or stigmatising messages. Campaigns should help individuals and families recognise early indicators of harm, including increasing secrecy, attempts to recover losses, changes in financial behaviour and relationship disruption. Such messaging should make clear that gambling-related harm can arise within widely available and socially accepted gambling environments.

The review also highlighted the role of affected others. Partners, relatives and friends may discover concealed financial harm, encourage engagement with services and experience substantial financial and relational consequences themselves. They should therefore be understood both as people experiencing harm in their own right and as potential partners in recognition and early intervention.

Future research should move beyond identifying shame as a barrier to help-seeking and examine how shame, stigma and indebtedness interact over time in relation to concealment, disclosure, treatment engagement and suicidal distress. Greater conceptual clarity is required to distinguish shame, public stigma, anticipated stigma and internalised stigma, and to identify their different implications for intervention. Direct evidence concerning suicidality in this context remains particularly limited, and further research should investigate how gambling-related debt, shame, social exposure and barriers to support may be related to suicidal thoughts and behaviour. Evaluations of public health messaging, confidential

early-support routes, self-directed interventions and support for affected others are also required to establish what promotes earlier and safer engagement.

Reducing gambling-related harm therefore requires more than encouraging individuals to seek help. This review supports calls for a coordinated public health approach that challenges stigma, improves recognition, addresses financial and relational harms, supports affected others and responds to the wider environments in which gambling-related crises and suicidality develop.

**Supplementary Materials:** The following supporting information can be downloaded at https://www.mdpi.com/article/10.3390/ijerph23091141/s1, Table S1: Search Strings; Table S2: Characteristics of included studies [2,7,8,22,23,31,35–54]; Table S3: Gambling-related variables, shame, indebtedness, help-seeking and suicidality outcomes [2,7,8,22,23,31,35–54]; Table S4: PRISMA 2020 checklist [33].

**Author Contributions:** Conceptualisation, S.M. and J.R.; methodology, J.R.; formal analysis, S.M., F.M., V.R. and E.M.-Y.; writing—original draft preparation, S.M., J.R., F.M. and V.R.; writing—review and editing, S.M., J.R., F.M., V.R. and E.M.-Y.; supervision, S.M. and J.R.; project administration, S.M.; funding acquisition, S.M. and J.R.; S.M. led the review and preparation of the manuscript; J.R. drafted the Discussion; E.M.-Y. conducted the literature searches and critical appraisal; and F.M. and V.R. prepared the initial draft of the Results. All authors have read and agreed to the published version of the manuscript.

**Funding:** This research project APP98657 was funded by UKRI (UKRI3806) as part of the Research Programme on Gambling, which is funded by the UK Government's gambling levy.

**Institutional Review Board Statement:** Ethical review was not required for this desk-based evidence review. Confirmation of this was obtained from the University of Staffordshire ethics board (Ref: DEF-SM91-001).

**Informed Consent Statement:** Not applicable.

**Data Availability Statement:** No new data were created or analysed in this study. Data sharing is not applicable to this article.

**Acknowledgments:** The authors gratefully acknowledge the members of the lived experience advisory group for their valuable contributions to refining the review focus, interpreting the findings and informing dissemination. We also thank Sarah Page for her expert oversight, guidance and supervision throughout the project. During the preparation of this manuscript, the authors used ChatGPT (OpenAI, GPT-5.6 Sol.) to support language editing and refinement of author-generated text. The tool was not used to conduct literature searches, determine study eligibility, extract data, undertake critical appraisal or generate the primary analysis. The authors reviewed and edited suggested changes and take full responsibility for the content of this publication.

**Conflicts of Interest:** The authors declare no personal conflicts of interest. The university for which they work has an institutional relationship with the Peter Coates Foundation, which funds postgraduate bursaries. The Foundation is associated with an individual who has links to the gambling industry. However, the university has no direct relationship with any gambling operators, and neither the research team nor the conduct or outcomes of the research are influenced by this institutional relationship. The research team has no personal or financial involvement with the Foundation or any gambling-related entity. The funders had no role in the design of the study; in the collection, analyses, or interpretation of data; in the writing of the manuscript; or in the decision to publish the results.

# Appendix A

**Table A1.** Summary of appraisal findings for included studies.

| Study | Design | Appraisal Tool | Summary of Appraisal Findings |
| --- | --- | --- | --- |
| Tavares et al. [52] | Qualitative | CASP | Generally good quality. The study addressed a focused issue, used an appropriate method, recruited acceptably, and had sufficient participants, rigorous analysis, clear findings and applicability. Measurement bias was unclear because a key delay-to-treatment measure appeared to have been developed for the study with limited evidence of prior validation. |
| Singer [48] | Qualitative | CASP | Good quality with some uncertainty. Aims, methodology, design, recruitment, data collection, analysis and findings were appraised positively. Researcher reflexivity and ethical reporting were judged to be unclear. |
| Gupta et al. [40] | Qualitative | CASP | Strong overall quality. Most domains were rated positively, including aims, design, recruitment, data collection, ethics, analysis and findings. The study described careful interpretation and collaborative coding, but explicit reflexivity was limited. |
| Dighton et al. [35] | Qualitative | CASP | Generally good quality. The study had clear aims, appropriate methodology and design, relevant recruitment/data collection, rigorous analysis and clear findings. Limitations were incomplete reporting of researcher reflexivity and ethical procedures, both judged as unclear. |
| Schettini [49] | Mixed-methods approach | MMAT | Good-quality mixed-methods study. Screening questions and qualitative criteria were met, and integration of qualitative and quantitative components was strong. Quantitative descriptive component was adequate, but sample representativeness and nonresponse bias were unclear. |
| Suurvali et al. [39] | Cross-sectional survey | CASP | Good overall quality. The study addressed a focused issue, used an appropriate method, recruited acceptably, used relevant measures, collected appropriate data, conducted rigorous analysis, reported clear findings and was considered applicable. The only main uncertainty was the sample-size justification. |
| Evans and Delfabbro [47] | Cross-sectional survey | CASP | Generally good quality with measurement and sampling caveats. The study had a focused issue, suitable method, acceptable recruitment, relevant data collection, rigorous analysis, clear findings and applicability. Limitations were reliance on self-report measures and unclear sample-size/power justification. |

**Table A1.** *Cont.*

| Study | Design | Appraisal Tool | Summary of Appraisal Findings |
| --- | --- | --- | --- |
| Tang et al. [38] | Cross-sectional survey | CASP | Moderately good quality. The study had a focused issue, an appropriate method, acceptable recruitment, relevant measurement and clear findings. Limitations were uncertainty around sample size adequacy and limited transferability to local populations because the study was culturally and clinically specific. |
| Nyemcsok et al. [8] | Qualitative | CASP | Strong overall quality. Aims, qualitative methodology, design, recruitment, data collection, ethics, analysis and findings were appraised positively. Limitations related mainly to convenience-style recruitment and limited reporting of interviewer/reflexive positioning. |
| Rolando et al. [51] | Qualitative | CASP | Strong overall quality. The appraisal found clear aims, appropriate qualitative design, suitable recruitment, appropriate data collection, ethical consideration, rigorous analysis and clear findings. The main limitation was the limited explicit discussion of researcher reflexivity. |
| Järvinen-Tassopoulos [41] | Qualitative | CASP | Strong overall quality. The study met most CASP criteria, including clear aims, appropriate methodology/design, suitable recruitment and data collection, ethical consideration, rigorous analysis and clear findings. The main limitation was limited visible discussion of researcher reflexivity. |
| Gupta et al. [42] | Qualitative | CASP | Strong overall appraisal. The study met most CASP criteria, including clear aims, appropriate qualitative methodology/design, relevant recruitment and data collection, ethical reporting, rigorous analysis and clear findings. Reflexivity was the main area with insufficient detail. |
| Zhang et al. [37] | Cross-sectional survey | CASP | Mixed appraisal. The study had a focused issue, an appropriate method, acceptable recruitment, relevant data collection, rigorous analysis and clear findings. Important limitations were reliance on self-report measures, unclear sample-size adequacy, and uncertain applicability to the local population. |
| Gainsbury et al. [50] | Cross-sectional survey | CASP | Good overall appraisal. The study had a focused issue, appropriate method, acceptable recruitment, appropriate data collection, enough participants, rigorous analysis, clear findings and local applicability. Measurement bias could not be ruled out. |
| Rockloff and Schofield [54] | Cross-sectional survey | CASP | Mostly positive appraisal. The study addressed a focused issue, used an appropriate method, recruited acceptably, measured relevant variables, collected appropriate data, and reported clear findings. The main uncertainty was whether the sample size was sufficient to minimise chance, as a formal sample-size justification was not clear. |

**Table A1.** *Cont.*

| Study | Design | Appraisal Tool | Summary of Appraisal Findings |
| --- | --- | --- | --- |
| Potenza et al. [7] | Cross-sectional survey | CASP | Generally good quality. The study addressed a focused issue, used an appropriate method, recruited acceptably, had adequate participant numbers, rigorous analysis, clear findings and apparent applicability. Measurement bias remained unclear due to reliance on self-reported data and limited discussion of recall bias. |
| Pulford et al. [53] | Cross-sectional survey | CASP | Generally good quality, but with notable uncertainty. The study had a focused issue, an appropriate method, acceptable recruitment, relevant data collection, rigorous analysis, clear findings and applicability. Limitations were the unclear use of validated measures and no clear sample-size justification. |
| Kaufman et al. [31] | Qualitative | CASP | Strong overall quality. The study had clear aims, an appropriate qualitative design, suitable recruitment, relevant data collection, ethical consideration, rigorous analysis and clear findings. The main limitation was limited explicit reflexivity around the researcher–participant relationship. |
| Wardle et al. [22] | Longitudinal observational | CASP | The study's large longitudinal sample allowed gambling profiles to be linked with later suicidal ideation. However, reliance on a non-probability online panel and self-report limits generalisability, and the suicide-attempt analyses were underpowered. |
| Jones et al. [23] | Observational | CASP | Strong overall quality. The study had clear aims, an appropriate qualitative design, suitable recruitment, relevant data collection, ethical consideration, rigorous analysis and clear findings. |
| Baxter et al. [43] | Mixed-methods approach | CASP | The mixed-methods study used a strong participatory approach and multiple perspectives. However, purposive sampling, unclear sample adequacy and an older participant group limited generalisability. |
| Hing et al. [36] | Qualitative | CASP | The phenomenological design and transparent analysis were appropriate for this sensitive, under-researched topic. However, the small convenience sample from one Australian state limited transferability. |
| Gosschalk et al. [45] | Mixed-methods approach | MQC-SP | The GambleAware report demonstrates high transparency regarding its methodological changes. Validity is supported by benchmarking against external Gambling Commission data, and the study maintains consistent use of validated, standardised measurement tools. |
| Lloyd et al. [46] | Mixed-methods approach | MQC-SP | The report is presented as a foundational synthesis that successfully integrates diverse data sources to provide a nuanced understanding of stigma in gambling harms. The authors express high confidence in the findings, which are supported by multiple, convergent lines of evidence. |

**Table A1.** *Cont.*

| Study | Design | Appraisal Tool | Summary of Appraisal Findings |
| --- | --- | --- | --- |
| Hunter et al. [44] | Evidence mapping and thematic synthesis | MQC-SP | The report is presented as a reliable synthesis of GambleAware-funded research, with the authors concluding that the evidence clearly demonstrates an urgent need for "coordinated action" across all stakeholders. |
| Gambling Commission [2] | Cross-sectional survey | MQC-SP | The community-based study is well presented with a large sample size. However, only small amounts of data were analysed and reported. |

## References


1. Lopez-Gonzalez, H.; Guerrero-Solé, F.; Griffiths, M.D. A content analysis of how "normal" sports betting behaviour is represented in gambling advertising. *Addict. Res. Theory* **2018**, *26*, 238–247. [CrossRef]
2. Gambling Commission. Gambling Survey for Great Britain (Annual Report 2024): Official Statistics. Available online: https://www.gamblingcommission.gov.uk/statistics-and-research/publication/statistics-on-gambling-participation-annual-report-year-2-2024-official (accessed on 20 August 2026).
3. Riley, L. *Treatment and Support Services for Women Experiencing Gambling Harms: What Women Get and What Women Want*; Betknowmore: London, UK, 2021. Available online: https://assets.website-files.com/6083d49a695f4ad43b5148c9/61e691bec135a273411b61d9_BKM_Women_%26_Gambling_2021_Part%202_v04.pdf (accessed on 20 August 2026).
4. Gambling Commission. *Gambling Behaviour in 2021: Findings from the Quarterly Telephone Survey*; Official Statistics: Birmingham, UK, 2022. Available online: https://www.gamblingcommission.gov.uk/statistics-and-research/publication/gambling-behaviour-in-2021-findings-from-the-quarterly-telephone-survey (accessed on 20 August 2026).
5. McCarthy, S.; Thomas, S.L.; Bellringer, M.E.; Cassidy, R. Women and gambling-related harm: A narrative literature review and implications for research, policy and practice. *Harm Reduct. J.* **2019**, *16*, 18. [CrossRef] [PubMed]
6. Price, A.; Hilbrecht, M.; Billi, R. Charting a path towards a public health approach for gambling harm prevention. *J. Public Health* **2021**, *29*, 37–53. [CrossRef] [PubMed]
7. Potenza, M.N.; Steinberg, M.A.; McLaughlin, S.D.; Wu, R.; Rounsaville, B.J.; O'Malley, S.S. Gender-related differences in the characteristics of problem gamblers using a gambling helpline. *Am. J. Psychiatry* **2001**, *158*, 1500–1505. [CrossRef] [PubMed]
8. Nyemcsok, C.; Pitt, H.; Kremer, P.; Thomas, S.L. "Drugs and alcohol get talked about, why not betting?" Young men's qualitative insights about strategies to prevent gambling harm. *Health Promot. J. Austr.* **2023**, *34*, 276–283. [CrossRef] [PubMed]
9. Moss, N.; Wheeler, J.; Sarkany, A. *Minority Communities and Gambling Harms: Quantitative Report: Lived Experience, Racism, Discrimination and Stigma*; Ipsos UK/GambleAware: London, UK, 2023. Available online: https://www.gambleaware.org/media/ykghinzd/minority-communities-final-report_0.pdf (accessed on 19 June 2026).
10. Raylu, N.; Oei, T.P. The Gambling Related Cognitions Scale (GRCS): Development, confirmatory factor validation and psychometric properties. *Addiction* **2004**, *99*, 757–769. [CrossRef] [PubMed]
11. Wardle, H.; Dymond, S.; John, A.; McManus, S. Problem Gambling and Suicidal Thoughts, Suicide Attempts and Non-Suicidal Self-Harm in England: Evidence from the Adult Psychiatric Morbidity Survey 2007. Available online: https://www.gambleaware.org/our-research/publication-library/articles/problem-gambling-and-suicidal-thoughts-suicide-attempts-and-non-suicidal-self-harm-in-england-evidence-from-the-adult-psychiatric-morbidity-survey-2007/ (accessed on 22 July 2026).
12. Levy, J.; O'Driscoll, C.; Sweet, A. *Disproportionate Burdens of Gambling Harms Among Minority Communities: A Review of the Literature*; GambleAware: London, UK, 2020. Available online: https://www.gambleaware.org/our-research/publication-library/articles/disproportionate-burdens-of-gambling-harms-among-minority-communities-a-review-of-the-literature/ (accessed on 5 July 2026).
13. Sheehy, K.; Noureen, A.; Khaliq, A.; Dhingra, K.; Husain, N.; Pontin, E.E.; Cawley, R.; Taylor, P.J. An examination of the relationship between shame, guilt and self-harm: A systematic review and meta-analysis. *Clin. Psychol. Rev.* **2019**, *73*, 101779. [CrossRef] [PubMed]
14. Brown, G.; Trebilcock, J.; Harding, N. *Lived Experiences of Gambling, Gambling-Related Harms, and Crime Within Ethnic Minority Communities*; Howard League for Penal Reform: London, UK, 2023.
15. Samaritans. Men, Suicide and Society: Why Disadvantaged Men in Mid-Life Die by Suicide. Available online: https://media.samaritans.org/documents/Samaritans_MenSuicideSociety_ResearchReport2012.pdf (accessed on 20 August 2026).

16. Marko, S.; Thomas, S.L.; Pitt, H.; Daube, M. The lived experience of financial harm from gambling in Australia. *Health Promot. Int.* **2023**, *38*, daad062. [CrossRef] [PubMed]
17. Richardson, T.; Elliott, P.; Roberts, R. The relationship between personal unsecured debt and mental and physical health: A systematic review and meta-analysis. *Clin. Psychol. Rev.* **2013**, *33*, 1148–1162. [CrossRef] [PubMed]
18. Marionneau, V.; Nikkinen, J. Gambling-related suicides and suicidality: A systematic review of qualitative evidence. *Front. Psychiatry* **2022**, *13*, 980303. [CrossRef] [PubMed]
19. Bijker, R.; Booth, N.; Merkouris, S.S.; Dowling, N.A.; Rodda, S.N. Global prevalence of help-seeking for problem gambling: A systematic review and meta-analysis. *Addiction* **2022**, *117*, 2972–2985. [CrossRef] [PubMed]
20. Aonso-Diego, G.; Etxaburu, N.; Martínez-Cabrero, C.; Liendo, M.; Estévez, A. The role of stigma in gambling disorder: A systematic review. *Stigma Health* **2026**, *11*, 517–537. [CrossRef]
21. David, M.; Trégan, F.; Brearley-Bayliss, H.; Cohen, E.; Nashef, C.; Martin, I.; Stephens, A.; Dinos, S.; White, G. *Exploring the Relationship Between Gambling Behaviour, Suicidality, and Treatment and Support*; National Centre for Social Research/GambleAware: London, UK, 2025. Available online: https://www.gambleaware.org/media/tospdtqp/exploring-the-relationship-between-gambling-behaviour-suicidality-and-treatment-and-support-dec-2025.pdf (accessed on 22 July 2026).
22. Wardle, H.; Wetherall, K.; Wyllie, J.; Tipping, S.; Cleare, S.; Jones, M.; McManus, S.; O'Connor, R.C. Suicidal ideation among people with different gambling behaviour profiles: Analysis of a longitudinal survey of people who gamble regularly in the UK. *BJPsych Open* **2026**, *12*, e38. [CrossRef] [PubMed]
23. Jones, M.; Boering, P.; Patel, K.; Leightley, D.; Dymond, S. Gambling, suicide and mental health treatment utilisation in Wales: Case-control, whole-population-based study. *BJPsych Open* **2025**, *11*, e234. [CrossRef] [PubMed]
24. Marsh, I. *Suicide: Foucault, History and Truth*; Cambridge University Press: Cambridge, UK, 2010.
25. White, J.; Marsh, I.; Kral, M.; Morris, J. (Eds.) *Critical Suicidology: Transforming Suicide Research and Prevention for the 21st Century*; UBC Press: Vancouver, BC, Canada, 2016.
26. Chandler, A.; Cover, R.; Fitzpatrick, S.J. Critical suicide studies, between methodology and ethics: Introduction. *Health* **2022**, *26*, 3–9. [CrossRef] [PubMed]
27. Chandler, A.; Wright, S. Suicide as slow death: Towards a haunted sociology of suicide. *Sociol. Rev.* **2024**, *72*, 1038–1056. [CrossRef] [PubMed]
28. Trebilcock, J. *Holding It All Together and Picking Up the Pieces: Women's Experiences of Gambling and Crime*; Howard League for Penal Reform: London, UK, 2023; pp. 1–84.
29. Livingstone, C. The end of "responsible gambling": Reinvigorating gambling studies. *Crit. Gambl. Stud.* **2023**, *4*, 1–14. [CrossRef]
30. Vasiliadis, S.; Thomas, A. Recovery agency and informal recovery pathways from gambling problems. *Int. J. Ment. Health Addict.* **2018**, *16*, 874–887. [CrossRef] [PubMed]
31. Kaufman, A.; Jones Nielsen, J.D.; Bowden-Jones, H. Barriers to treatment for female problem gamblers: A UK perspective. *J. Gambl. Stud.* **2017**, *33*, 975–991. [CrossRef] [PubMed]
32. Haby, M.M.; Barreto, J.O.M.; Kim, J.Y.H.; Peiris, S.; Mansilla, C.; Torres, M.; Guerrero-Magaña, D.E.; Reveiz, L. What are the best methods for rapid reviews of the research evidence? A systematic review of reviews and primary studies. *Res. Synth. Methods* **2024**, *15*, 2–20. [CrossRef] [PubMed]
33. Page, M.J.; McKenzie, J.E.; Bossuyt, P.M.; Boutron, I.; Hoffmann, T.C.; Mulrow, C.D.; Shamseer, L.; Tetzlaff, J.M.; Akl, E.A.; Brennan, S.E.; et al. The PRISMA 2020 statement: An updated guideline for reporting systematic reviews. *BMJ* **2021**, *372*, n71. [CrossRef] [PubMed]
34. Popay, J.; Roberts, H.; Sowden, A.; Petticrew, M.; Arai, L.; Rodgers, M.; Britten, N.; Roen, K.; Duffy, S. *Guidance on the Conduct of Narrative Synthesis in Systematic Reviews: A Product from the ESRC Methods Programme*; Lancaster University: Lancaster, UK, 2006.
35. Dighton, G.; Treacy, S.; Hoon, A.; Dymond, S. Gambling-related harm as experienced by UK Armed Forces veterans and affected others: A thematic framework analysis. *BMJ Mil. Health* **2025**, *Epub ahead of printing*. [CrossRef] [PubMed]
36. Hing, N.; Nuske, E.; Gainsbury, S.M.; Russell, A.M.T.; Breen, H. How does the stigma of problem gambling influence help-seeking, treatment and recovery? A view from the counselling sector. *Int. Gambl. Stud.* **2016**, *16*, 263–280. [CrossRef]
37. Zhang, M.; Yang, Y.; Guo, S.; Cheok, C.; Wong, K.E.; Kandasami, G. Online gambling among treatment-seeking patients in Singapore: A cross-sectional study. *Int. J. Environ. Res. Public Health* **2018**, *15*, 832. [CrossRef] [PubMed]
38. Tang, C.S.; Wu, A.M.; Tang, J.Y. Gender differences in characteristics of Chinese treatment-seeking problem gamblers. *J. Gambl. Stud.* **2007**, *23*, 145–156. [CrossRef] [PubMed]
39. Suurvali, H.; Hodgins, D.C.; Toneatto, T.; Cunningham, J.A. Hesitation to seek gambling-related treatment among Ontario problem gamblers. *J. Addict. Med.* **2012**, *6*, 39–49. [CrossRef] [PubMed]
40. Gupta, H.; Tari-Keresztes, N.; Aanundsen, D.; Smith, J.A. "When people reach out that is when they're desperate": Understanding informal and formal help-seeking practices for gambling among Aboriginal peoples in the Northern Territory, Australia. *J. Gambl. Stud.* **2025**, *41*, 643–662. [CrossRef] [PubMed]

41. Järvinen-Tassopoulos, J. The impact of problem gambling: Are there enough services available for families with children? *Public Health* **2020**, *184*, 28–32. [CrossRef] [PubMed]
42. Gupta, H.; Stevens, M. "It started 30 years ago, and it still haunts me": An exploratory investigation of Territorians' gambling behaviours, harm, and help-seeking for gambling issues in an Australian jurisdiction. *BMC Public Health* **2021**, *21*, 96. [CrossRef] [PubMed]
43. Baxter, A.; Salmon, C.; Dufresne, K.; Carasco-Lee, A.; Matheson, F.I. Gender differences in felt stigma and barriers to help-seeking for problem gambling. *Addict. Behav. Rep.* **2016**, *3*, 1–8. [CrossRef] [PubMed]
44. Hunter, L.; O'Young Vlies, M.; Okonkwo, S. *Gambling Harms and Young People in Great Britain: A State of the Nation Report*; GambleAware: London, UK, 2025. Available online: https://www.gambleaware.org/our-research/publication-library/articles/gambling-harms-and-young-people-in-great-britain-a-state-of-the-nation-report/ (accessed on 5 July 2026).
45. Gosschalk, K.; Cotton, C.; Chamberlain, Z.; Harmer, L.; Bondareva, E.; Mackintosh, J. *Annual GB Treatment and Support Survey 2024*; YouGov/GambleAware: London, UK, 2025. Available online: https://www.gambleaware.org/our-research/publication-library/articles/annual-gb-treatment-and-support-survey-2024/ (accessed on 22 July 2026).
46. Lloyd, J.; Penfold, K.; Nicklin, L.L.; Martin, I.; Martin, A.; Dinos, S.; Chadwick, D. *Stigmatisation and Discrimination of People Who Experience Gambling Harms in Great Britain: Synthesis Report*; National Centre for Social Research: London, UK, 2025. Available online: https://natcen.ac.uk/publications/stigmatisation-and-discrimination-people-who-experience-gambling-harms (accessed on 22 July 2026).
47. Evans, L.; Delfabbro, P.H. Motivators for change and barriers to help-seeking in Australian problem gamblers. *J. Gambl. Stud.* **2005**, *21*, 133–155. [CrossRef] [PubMed]
48. Singer, J. Stigmatisation of gambling disorder in social media: A tailored deep learning approach for YouTube comments. *Harm Reduct. J.* **2025**, *22*, 56. [CrossRef] [PubMed]
49. Schettini, G.; Lindner, P.; Ekström, V.; Johansson, M. A mixed method study exploring similarities and differences in general and social services-specific barriers to treatment-seeking among individuals with a problematic use of alcohol, cannabis, or gambling. *BMC Health Serv. Res.* **2024**, *24*, 970. [CrossRef] [PubMed]
50. Gainsbury, S.; Hing, N.; Suhonen, N. Professional help-seeking for gambling problems: Awareness, barriers and motivators for treatment. *J. Gambl. Stud.* **2014**, *30*, 503–519. [CrossRef] [PubMed]
51. Rolando, S.; Ferrari, C.; Beccaria, F. "To me, it was just a vice": Stigma and other barriers to gambling treatment in Piedmont, Italy. *J. Gambl. Stud.* **2023**, *39*, 1909–1925. [CrossRef] [PubMed]
52. Tavares, H.; Martins, S.S.; Zilberman, M.L.; El-Guebaly, N. Gamblers seeking treatment: Why haven't they come earlier? *Addict. Disord. Their Treat.* **2002**, *1*, 65–69. [CrossRef]
53. Pulford, J.; Bellringer, M.; Abbott, M.; Clarke, D.; Hodgins, D.; Williams, J. Barriers to help-seeking for a gambling problem: The experiences of gamblers who have sought specialist assistance and the perceptions of those who have not. *J. Gambl. Stud.* **2009**, *25*, 33–48. [CrossRef] [PubMed]
54. Rockloff, M.J.; Schofield, G. Factor analysis of barriers to treatment for problem gambling. *J. Gambl. Stud.* **2004**, *20*, 121–126. [CrossRef] [PubMed]
55. Langham, E.; Thorne, H.; Browne, M.; Donaldson, P.; Rose, J.; Rockloff, M. Understanding gambling related harm: A proposed definition, conceptual framework, and taxonomy of harms. *BMC Public Health* **2016**, *16*, 80. [CrossRef] [PubMed]
56. Leslie, R.D.; McGrath, D.S. Stigma-related predictors of help-seeking for problem gambling. *Addict. Res. Theory* **2024**, *32*, 38–45. [CrossRef]


**Disclaimer/Publisher's Note:** The statements, opinions and data contained in all publications are solely those of the individual author(s) and contributor(s) and not of MDPI and/or the editor(s). MDPI and/or the editor(s) disclaim responsibility for any injury to people or property resulting from any ideas, methods, instructions or products referred to in the content.