Professional Help-Seeking Attitudes and Behaviors among Ethnic Minorities Affected by Gambling and Substance Use Disorders

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Abstract

Background: Numerous international studies have suggested an overrepresentation of ethnic minorities among individuals with gambling problems and substance addiction. However, research also suggests that ethnic minorities are underrepresented in professional help-seeking for addiction, indicating a substantial treatment gap between need and utilization. These patterns have also been suggested in Danish studies, although research on the topic is limited. The disproportionate utilization of professional help sources points to an area that requires further exploration. Knowledge about help-seeking experiences, as well as attitudes and behaviors among ethnic minorities, may be beneficial in order to inform more appropriate support and address addiction within this group. **Aim:** This thesis investigates factors influencing professional help-seeking attitudes and behaviors among ethnic minorities in Denmark with substance use and gambling problems. It also examines the roles of self-stigma, perceived discrimination, and other barriers to professional help-seeking. A literature review was conducted to provide an overview of previous research. This indicated international findings of disproportionate utilization of mental health services, as well as consistent treatment-seeking barriers and attitudes across studies. However, significant research gaps were identified within Danish research, particularly regarding gambling addiction and help-seeking among ethnic minorities. **Method:** The thesis employed an anonymous survey design, chosen due to the sensitivity of the topic and the risk of non-disclosure. The survey aimed to produce qualitative material by including open-ended questions. Additionally, it included scales measuring self-stigma and subjective discrimination experience. A thematic analysis was conducted, generating themes related to recurring attitudes, barriers, and experiences. Results were organized into three themes titled: The Roles of Stigma, Shame and Honor, Mistrust of Professionals: The turn to Family, and Preference for Self-Sufficiency. The findings were interpreted using theoretical frameworks regarding stigma, self-stigma, cultural determinants of help-seeking and self-governance. **Results:** The thematic analysis identified shame, stigma, mistrust of professionals and treatment to be significant treatment-seeking barriers. The most prevalent barrier to professional help-seeking was mistrust in the effectiveness of professional treatment. Participants reported moderate to high levels of life impact of the addiction, alongside moderate levels of self-stigma and perceived discrimination. **Conclusion:** The survey provided results

that were similar to previous research. Overall, the findings suggest a substantial gap between addiction prevalence and professional help-seeking among ethnic minorities in Denmark. They also indicate that barriers such as stigma, mistrust, and different cultural understandings of addiction play a central role in shaping help-seeking behavior, alongside a tendency toward alternative help or self-sufficiency. The thesis contributes to the limited Danish research in this field by providing exploratory insights into both gambling and substance-related addiction among ethnic minorities.

Contents

1. Introduction

Several studies indicate that there exists an overrepresentation of ethnic minorities among individuals with gambling problems (Aarestad et al., 2023; Calado & Griffiths, 2016; Caler et al., 2017; Grant & Chamberlain, 2023) and substance abuse or addiction (Benjaminsen & Enemark, 2024; Elkassen & Csiernik, 2020; Masson et al., 2012; Nabben, Weijs & Van Amsterdam, 2021; Reid et al., 2016) in Europe and North America. However, ethnic minorities are underrepresented when it comes to treatment-seeking for these conditions (Benjaminsen & Enemark, 2024; Elkassen & Csiernik, 2020; Gunstone & Gosschalk, 2020; Masson et al., 2012; Nabben, Weijs & Van Amsterdam, 2021; Okuda et al., 2016; Reid et al., 2016; Ronzitti et al., 2016). Research on the topic in a Danish context is limited. Nevertheless, the few existing studies similarly suggest an overrepresentation of ethnic minorities with gambling problems (Håkansson et al., 2019) and, to some extent, drug abuse (Benjaminsen & Enemark, 2024). However, no studies have been identified that examine whether ethnic minorities in Denmark seek help for gambling problems or substance abuse or addiction in Denmark, revealing a significant research gap in a Danish context. This thesis therefore aims to explore treatment-seeking attitudes, experiences and behavior among ethnic minorities who experience gambling problems or substance abuse or addiction. It will also examine reasoning underlying decisions to seek or avoid treatment and explore the relation between the decision and the subjective experience of discrimination as well as self-stigma. This leads to the research question:

Which factors influence professional help-seeking attitudes and behaviors among ethnic minorities in Denmark with substance use disorders and gambling problems?

The thesis aims to answer the following sub-questions:

- *How does perceived discrimination influence treatment-seeking?*
- *What role does self-stigma play in treatment avoidance?*
- *Which influence does perceived life impact of addiction have on treatment-seeking?*

1.1 Conceptual Clarification and Delimitation

This section aims to clarify the focus of the thesis and the key concepts used in both the research question as well as the remainder of the thesis. It will provide a conceptual clarification of the terms "addiction" and "abuse" in relation to gambling and substances, define the target group "ethnic minorities", outline what constitutes professional treatment, and finally conceptualize discrimination and self-stigma.

Within substance use disorders, the International Classification of Diseases-10 (ICD-10) has provided clear definition and distinction of the concepts 'substance abuse' versus 'substance addiction'. According to the ICD-10, substance abuse is defined as "*A pattern of psychoactive substance use that is causing damage to health. The damage may be physical … or mental…*" (World Health Organization, 2016). Substance addiction is however defined as "*A cluster of behavioural, cognitive, and physiological phenomena that develop after repeated substance use and that typically include a strong desire to take the drug, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to drug use than to other activities and obligations, increased tolerance, and sometimes a physical withdrawal state*." (World Health Organization, 2016). Thus, according to the ICD-10, substance abuse and addiction are two distinct conditions, with drug addiction encompassing the harmful use described in abuse, while additionally including symptoms such as increased tolerance, physical withdrawal and loss of control. A similarly clear distinction is not present for pathological gambling, which is defined as "*The disorder consists of frequent, repeated episodes of gambling that dominate the patient's life to the detriment of social, occupational, material, and family values and commitments.*" (World Health Organization, 2016). As this thesis relies upon individual subjective interpretations of the respondents gambling or substance use problems, it will not be possible to determine whether their experiences meet the diagnostic criteria outlined in the ICD-10 or which specific criteria apply. However, this thesis is focused on treatment-seeking behavior for those experiencing problems with gambling or substances, rather than on diagnostic classification, making subjective interpretations particularly relevant.

The respondents included in this examination report a subjective experience of being addicted to either substances or gambling. Substances here include alcohol, medicine and illicit drugs. Gambling can involve various forms of activities such as

casino games, betting and lottery amongst other things. However, this thesis relies upon the respondents' subjective interpretation of experiencing addiction related to gambling activities and therefore does not differentiate between different gambling activities. Similarly, the study targets ethnic minorities in Denmark and includes all respondents identifying with a non-Danish ethnicity, therefore not making a distinction between being born in Denmark, adopted or having immigrated.

Regarding treatment seeking behavior, this is understood as any voluntary action involving contacting and seeking help from doctors, treatment centers, psychologists, or other relevant professionals. This treatment-seeking behavior is sought to be examined in relation to subjective experience of discrimination and self-stigma. Discrimination is conceptualized by Bruce Link and Jo Phelan as actions that start with labeling, stereotyping or status loss for a stigmatized group, and result in obstacles or limitations in the participation in societal institutions or activities for the stigmatized individual (Link & Phelan, 2001). Self-stigma is internalized from public stigma according to Patrick Corrigan and colleagues and is defined as "*the reduction in a person's self-esteem or sense of self-worth due to the perception that he or she is socially unacceptable*" (Corrigan 2014 as cited in Tucker et al., 2013). Both discrimination and self-stigma will be further elaborated in the theory section.

2. Literature Review

The literature review was conducted using multiple strategies to identify relevant studies. Much of the literature included in this thesis was identified during my 9th semester project, which was a systematic review on shame and treatment-seeking barriers among ethnic and religious minorities with drug addiction (Chaaban, 2025). The systematic review involved searches in the databases PsycNET, PubMed, and Scopus using the search terms shame, embarrass*, guilt*, "moral emotion*", "moral feeling*", "drug addict*", "drug dependen*", and "drug abuse*". While some studies met the inclusion criteria set for the systematic review, others were considered relevant for further exploration of the topic and were therefore included in the present thesis. Additional studies were identified through backward citation searches in recent relevant publications and through searches conducted in Google Scholar. The literature review begins with studies addressing help-seeking for mental illness more broadly before narrowing its focus to help-seeking for addiction among ethnic minorities in Denmark.

2.1 Help-Seeking for Mental Illness

Several studies have sought to understand why some individuals pursue professional treatment while others avoid it. Stigma has consistently been identified as a key barrier to treatment-seeking among individuals with mental illness, as demonstrated in systematic reviews by Clement et al. (2015) and Antonia Aguirre Velasco et al. (2025). One systematic review highlighted dissonance between the individuals preferred social identity and common stereotypes about mental illness as a central theme in the relationship between stigma and help-seeking. Additionally, anticipation of negative consequences and need for non-disclosure were found to play a role in this relationship (Clement et al., 2015). Stigma was the primary obstacle in help seeking for mental illness in 25 studies, with participants mentioning "community stigma", "self-stigma", and other related feelings such as shame, fear and embarrassment (Aguirre Velasco et al., 2025). Participants additionally reported confidentiality concerns regarding the fear of confidentiality breaches and their mental illness or help-seeking being disclosed (Clement et al., 2015; Aguirre Velasco et al., 2025).

Another barrier that was reported in several studies was low mental health literacy. This refers to the "*ability to use mental health information to recognise, manage and prevent mental health disorders and make informed decisions about help-seeking and professional support*" (Aguirre Velasco et al., 2025). Participants reported lack of knowledge and ability to recognize symptoms of mental illness as well as available sources of help (Gulliver et al., 2010; Aguirre Velasco et al., 2025). Participants also showed negative attitudes towards mental health professionals and services, believing that the treatment would not be helpful. This was an attitude that could also be detected in family members (Clement et al., 2015; Aguirre Velasco et al., 2025). Finally, a prevalent barrier was discovered to be self-reliance. This was a preference found in several studies, and one that was especially prevalent among adolescents (Clement et al., 2015; Gulliver et al., 2010; Aguirre Velasco et al., 2025). Adolescents demonstrated a wish to handle their problems on their own, and a need for autonomy, which was identified to be an important barrier (Clement et al., 2015; Aguirre Velasco et al., 2025).

Although numerous barriers to treatment-seeking were identified in relation to mental illness, some studies also found facilitators. They found evidence that positive past experiences with treatment and help seeking as well as social support and encouragement were factors that facilitated help-seeking. Furthermore, trusting and committed relationships with parents, teachers or counselors were also identified as facilitators for adolescents (Gulliver et al., 2010; Aguirre Velasco et al., 2025).

2.2 Help-Seeking for Mental Illness among Ethnic Minorities

In a Norwegian review it was identified that immigrant populations had a higher degree of mental health problems compared to the general population. However, their use of mental healthcare was revealed to be significantly lower compared to Norwegians, suggesting an underutilization of mental healthcare (Abebe et al. 2017). This pattern has been identified in several other countries and led to several studies exploring the treatment seeking barriers that immigrants and minority ethnic individuals experience in relation to mental illness (Bansal et al., 2022; Hassan et al., 2025; Nwokoroku et al., 2022; Prajapati & Liebling, 2022). Barriers identified for ethnic minorities proved to be very similar to ones experienced by the general population, although ethnic minorities experienced additional barriers relevant to being an ethnic

minority. Similarly to treatment barriers found in the general population, stigma about mental illness and help-seeking was identified as a barrier in relation to ethnic minorities (Nwokoroku et al., 2022; Prajapati & Liebling, 2022). Participants reported fearing labels caused by "*stigma attached to being a bit crazy or depressed*" or "*the impression of people who go to counselling*" (Prajapati & Liebling, 2022). Although stigma as a treatment barrier was similar to stigma perceived by the general population, ethnic minorities were disproportionately deterred by stigma, perhaps caused by the double stigma that they experience (Clement et al., 2015).

Some participants in the studies reported avoiding mental health care in order to avoid discrimination, labeling or misjudgment based on their ethnic background (Nwokoroku et al., 2022; Prajapati & Liebling, 2022). Other participants avoided treatment-seeking due to past negative experiences related to racism (Nwokoroku et al., 2022). Apart from the experience of direct racism and discriminatory behavior, studies identified practices and features in mental healthcare that deterred ethnic minorities from seeking it. These practices had to do with monocultural frameworks of treatment and general cultural insensitivity. Participants perceived differences in fundamental beliefs leading to patients feeling misunderstood and receiving advice that was contrary to their values and world views (Bansal et al, 2022; Hassan et al., 2025; Nwokoroku et al., 2022; Prajapati & Liebling, 2022). Additionally, participants experienced a lack of training in professionals regarding topics such as migration, systematic racism and complex trauma, which was difficult for participants who attributed their problems to these experiences (Bansal et al, 2022).

Another treatment-seeking barrier experienced by minority ethnic people with mental illness was the wish to maintain a good family reputation. The participants wanted to avoid community gossip regarding their mental health problems and help-seeking, thereby avoiding help-seeking due to fear of confidentiality breach (Nwokoroku et al., 2022; Prajapati & Liebling, 2022). The fear of an impaired family reputation was caused by both stigma and cultural norms discouraging help-seeking from professionals. This refers to norms discouraging help-seeking outside the family and community, with an addition of mistrust of mental health diagnosis and practitioners (Prajapati & Liebling, 2022; Aguirre Velasco et al., 2025). Certain cultural expectations were also identified in Asian communities, where speaking publicly about feelings was frowned upon for women, while men were expected to conform to traditional masculinity constructs (Prajapati & Liebling, 2022).

2.3 Help-Seeking for Addiction among Ethnic Minorities

A few studies have examined gambling addiction in relation to ethnic minorities. One study found a higher prevalence of both participation and gambling problems among Asian, black and Hispanic communities in New Jersey (Caler et al., 2017), while one systematic review found higher rates of problem gambling among ethnic minorities in European countries (Calado & Griffiths, 2016). Aarestad and colleagues (2023) linked the overrepresentation of ethnic minorities within gambling addiction to their lover socioeconomic status, which has proved to be associated with gambling problems. Ethnic minorities were also experiencing more severe symptoms and psychosocial impairment in relation to gambling, while also having their gambling debut at a significantly earlier age (Grant & Chamberlain, 2023). Nevertheless, ethnic minorities showed a lower rate of treatment seeking compared to the ethnic majority, although there was a demand for treatment (Braun et al., 2014; Gunstone & Gosschalk, 2020; Okuda et al., 2016; Ronzitti et al., 2016). According to Braun and colleagues (2014), the individuals that sought treatment were more likely to have done so in a situation of crisis.

Similarly, studies suggest that ethnic minorities underutilize services in relation to substance addiction, despite a higher rate of substance addiction within the group (Benjaminsen & Enemark, 2024; Elkassen & Csiernik, 2020; Masson et al., 2012; Nabben, Weijs & Van Amsterdam, 2021; Reid et al., 2016). Research also suggests that there is a tendency among ethnic minorities to postpone professional help-seeking for addition until the problem is severe (Kwok, 2000; Lidster & Cannon, 2013; Masson et al., 2012). Treatment seeking barriers experienced in relation to gambling and substance addiction among ethnic minorities were similar to ones they experienced in relation to mental illness-treatment in general. They reported mistrust in mental health professionals due to cultural differences and not recognizing the help as appropriate or relevant (Gainsbury et al., 2013; Gunstone & Gosschalk, 2020; Nabben, Weijs & Van Amsterdam, 2021; Reid, Crofts & Beyer, 2001). Furthermore, lack of knowledge on treatment options were reported as well as concerns about confidentiality breach with the worry of negative consequences such as labeling and an impaired reputation within the community. Uniquely, substance abuse and addiction lead to a different set of barriers, related to lacking knowledge

about substances, fearing being registered in the system as substance addicts and experiencing an alternative form of treatment. This alternative treatment could entail being locked inside the home in order to avoid access to substances (Kwok, 2000; Mantovani & Evans, 2018; Nabben, Weijs & Van Amsterdam, 2021; Reid, Crofts & Beyer, 2001).

Stigma was also identified as a treatment-seeking barrier for minority ethnic individuals with substance or gambling addictions. However, the contents and degree of stigma differed compared to stigma about mental illness in general. In relation to substance abuse, minority ethnic individuals reported avoiding treatment based on the pressure to positively represent their already stigmatized community and avoid contributing to further negative stereotyping of ethnic minorities (Douglass et al., 2023). In relation to gambling addiction, one study examined the desired social distance that participants expressed toward individuals with gambling problems. East Asian Canadian participants reported a greater desire for social distance from individuals with their own ethnic background who had gambling problems than they did to Caucasian individuals with the same problems (Dhillon et al., 2011).

2.4 Help-Seeking for Addiction among Ethnic Minorities in Denmark

Research is limited when it comes to gambling or substance addiction and help seeking behavior among ethnic minorities in Denmark. Available data suggest that mental health outcomes are significantly worse among ethnic minorities in Denmark compared to the ethnic majority, with one study reporting rates of mental illness that are two to four times higher (Singhammer et al., 2008). More recent numbers also suggest that individuals with a Middle Eastern or North African background score lower on mental well-being and higher on depression and sleep problems (Sundhedsstyrelsen, 2023). Håkansson and colleagues examined gambling problems in Denmark and found a higher prevalence of problem gambling among first- and second-generation immigrants, suggesting that ethnic minority groups have a higher prevalence of gambling addiction compared to the ethnic majority (Aarestad et al., 2023; Håkansson et al., 2019). Although there are no comparative studies directly examining the prevalence of substance addiction for ethnic minorities in Denmark, one study comes close. In 2024, Lars Benjaminsen and Morten Holm Enemark conducted a registry-based study with Vive (Det Nationale Forsknings- og Analysecenter for

Velfærd), which compared social vulnerability between ethnic Danish and men from MENAPT (Middle East, North Africa, Pakistan, and Turkey) countries (Benjaminsen & Enemark, 2024). It found that male refugees and male descendants of refugees from MENAPT countries have almost doubled chances of experiencing a combination of mental illness and drug abuse in addition to experiencing homelessness, unconditional prison sentence or substance abuse-related chronic physical illness compared to ethnically Danish males. For the descendants of ethnic minorities from countries apart from MENAPT, there was also an overrepresentation, albeit a smaller one (Benjaminsen & Enemark, 2024).

One older study from 2005 studied drug abuse among ethnic minorities. It examined causes and circumstances surrounding the abuse and delved into treatment-seeking barriers and experiences with treatment (Hvenegård et al., 2005). The study found that many causes and circumstances surrounding the drug abuse were similar to ones found in the ethnic majority. However, the ethnic minorities experienced them to a more severe degree and differed from the ethnic majority in three different ways. The ethnic minority could often have a migration history, escape war themselves or have parents that had escaped from war, which led to an upbringing with trauma or traumatized parents. This could result in self-medication (Hvenegård et al., 2005). The ethnic minority furthermore experienced otherness in the Danish society, caused by experiences of discrimination or negative discourse about ethnic minorities in the media or politics. Finally, they differed from the ethnic majority in relation to condemnation from their community. Although drug abuse is a taboo and a cause for stigmatization in general society, this seemed to be worse for those with an ethnic minority background. Their families were more worried about gossip in the community, experienced higher levels of shame and this affected how the families would handle the drug abuse (Hvenegård et al., 2005).

No studies were found that delved into treatment seeking-behavior for ethnic minorities experiencing substance or gambling problems in a Danish context. One study found that treatment-seeking was significantly lower for immigrants and descendants when it came to mental illness in general. For this group, the numbers were higher when it came to compulsory hospitalization compared to the ethnic majority (Baez et al., 2007). Although Hvenegård and colleagues (2005) did not inspect numbers for treatment seeking for ethnic minorities, they did look into barriers that could be relevant when it came to treatment-seeking for drug abuse. Their findings

were similar to ones found in international studies, suggesting that ethnic minorities in Denmark also experienced lack of knowledge regarding treatment options, fear of gossip and labeling, mistrust in public authorities and a preference for alternative treatment. For these individuals, family had a bigger significance and responsibility in helping, which sometimes led to alternative treatment including marriage, religion, being locked inside a room or other forms of detoxification (Hvenegård et al., 2005).

2.5 Summary

Internationally, research has suggested that stigma plays a role in help-seeking behavior in relation to mental illness (Clement et al., 2015; Aguirre Velasco et al., 2025). Other treatment seeking barriers mentioned were lack of knowledge about both mental illness and treatment options, negative attitudes towards professionals and treatment (Clement et al., 2015; Aguirre Velasco et al., 2025), and a preference for self-reliance, which was especially found in adolescents (Clement et al., 2015; Gulliver et al., 2010; Aguirre Velasco et al., 2025). These treatment-barriers were also found among ethnic minorities, who appear to experience higher degrees of mental health problems in general (Abebe et al. 2017), and are overrepresented in both gambling addiction and substance addiction (Bansal et al., 2022; Calado & Griffiths, 2016; Caler et al., 2017; Hassan et al., 2025; Nwokoroku et al., 2022; Prajapati & Liebling, 2022). Despite being overrepresented in mental health problems and addiction of substances and gambling, studies suggested that minority ethnic individuals avoided treatment-seeking more than the ethnic majority (Benjaminsen & Enemark, 2024; Braun et al., 2014; Elkassen & Csiernik, 2020; Gunstone & Gosschalk, 2020; Masson et al., 2012; Nabben, Weijs & Van Amsterdam, 2021; Okuda et al., 2016; Reid et al., 2016; Ronzitti et al., 2016). Apart from experiencing the treatment barriers found in the general population, ethnic minorities experienced additional ones such as: fear of discrimination, labeling or misjudgment based on their ethnic background (Nwokoroku et al., 2022; Prajapati & Liebling, 2022), perceived differences in values and world views compared to the professionals (Bansal et al, 2022; Hassan et al., 2025; Nwokoroku et al., 2022; Prajapati & Liebling, 2022), concerns about community gossip and confidentiality breach (Nwokoroku et al., 2022; Prajapati & Liebling, 2022), discouragement from community or family caused by cultural differences or mistrust of professionals (Prajapati & Liebling, 2022; Aguirre

Velasco et al., 2025) and a stronger degree of stigma (Dhillon et al., 2011; Douglass et al., 2023).

In a Danish context, the literature review found the research on the topic to be limited and older when it came to gambling or substance addiction and help seeking behavior among ethnic minorities in Denmark. Danish studies suggest that ethnic minorities experience worse mental health than the general population (Singhammer et al., 2008; Sundhedsstyrelsen, 2023). One study found a higher prevalence of gambling problems among ethnic minorities (Håkansson et al., 2019), while another study found doubled chances of experiencing a combination of mental illness and drug abuse in addition to homelessness, unconditional prison sentence or substance abuse-related chronic physical illness (Benjaminsen & Enemark, 2024). Only one study was found that delved into treatment barriers in relation to drug abuse for ethnic minorities, and it found similar barriers as ones found in international studies. In addition, it found ethnic minorities to experience them in a worse degree compared to the ethnic majority, and to differ from the majority by experiencing refugee history, otherness and stronger concerns about gossip (Hvenegård et al., 2005).

2.6 Research Gaps

Since Danish research on the topic is limited, there are several research gaps to be found. No studies were found that delved into treatment seeking-behavior for ethnic minorities experiencing substance or gambling problems in a Danish context. Although one study found an overrepresentation of gambling problems and another indicated a partial overrepresentation in drug abuse, no evidence was identified regarding whether these individuals sought help or avoided treatment. Additionally, no studies were found that explored the prevalence of substance abuse or addiction among ethnic minorities in Denmark, although international research suggests high numbers. No Danish studies were identified that examine treatment barriers among ethnic minorities with gambling problems. While one study addressed barriers related to drug treatment, it is over two decades old, highlighting the need for more recent research on barriers to substance use treatment.

This thesis aims to address some of these research gaps by examining whether individuals from ethnic minority backgrounds in Denmark seek help for

gambling or substance addiction or avoid it. It further explores the factors influencing decisions to seek or avoid treatment, as well as how treatment is experienced. Given that several studies identify discrimination and stigma as barriers to treatment, the thesis also investigates how help-seeking decisions are associated with perceived discrimination and self-stigma. It will attempt to address this by including conceptualization by Bruce Link and Jo Phelan about stigma and discrimination as well as theory about self-stigma and the internalization process by Patrick Corrigan and colleagues. Furthermore, it will be aided by theory about help-seeking behavior by Nathaniel Wade and colleagues, Author Kleinman and Denise Saint Arnhault as well as theory related to self-reliance, which was also mentioned as a barrier in international research.

3. Theory

To understand the factors influencing professional help-seeking attitudes and behaviors among ethnic minorities with addiction, and in light of the findings presented in the literature review, several theoretical concepts are relevant. Stigma has been identified in multiple studies as a barrier to seeking treatment, and the conceptualization of stigma developed by Bruce Link and Jo Phelan is therefore included. This leads to the concept of self-stigma, understood as the internalization of stigmatizing beliefs, as described by Patrick Corrigan and colleagues. The relationship between self-stigma and help-seeking behavior is further explored through the theoretical framework developed by Wade, Vogel, and colleagues, which explains how self-stigma may influence help-seeking attitudes and behaviors. These processes are understood as being situated within broader cultural and structural systems. Arthur Kleinman and Denise Saint Arnault contribute perspectives on help-seeking within cultural systems, while Nikolas Rose's theory of self-governance helps contextualize help-seeking within broader structural patterns.

3.1 Stigma and Discrimination

Bruce Link and Jo Phelan (2001) conceptualize the term 'stigma' through the co-existence of four interrelated components. The first component has to do with distinguishing and labelling human differences. They suggest that our understanding of human differences is based on a social selection of differences that matter socially. Although many differences exist between human beings, some are ignored while others are identified as differences that matter. This distinguishment is made possible through an oversimplification of the differences between humans, in order to create groups. An example of this is the distinction between 'black' and 'white' people, who are grouped into different simplified categories, although many differences exist within the groups. This social selection of human differences changes through time and space (Link & Phelan, 2001). In the next component an association of negative attributes with human differences takes place. This refers to the process of stereotyping, where a linking of undesirable characteristics to a group that is labeled as different occurs. The third component is a feature of stigma that takes place in the separa-

tion of different groups through “us” versus “them”. Here, the stereotyping of specific groups becomes the rationale for the belief about one’s own group being different and sometimes superior to another group. It becomes possible to attach negative attributes to the other group, which in extreme cases leads to dehumanization. One way this is achieved is through labeling an individual as an “addict” rather than an individual who has an addiction, creating a group of people labeled as “addicts” who are different (Link & Phelan, 2001). The fourth and last component is the part of the stigma process where the stigmatized group experiences status loss and discrimination. The stigmatized group is devalued, rejected and excluded, which affects its chances of achieving good income, careers, housing and more. It experiences a status loss caused by the attached negative attributes and is placed lower in a status hierarchy (Link & Phelan, 2001). Furthermore, the group experiences different forms of discrimination, which will be elaborated in the next paragraph. Link and Phelan thus define stigma to exist when “*elements of labeling, stereotyping, separation, status loss and discrimination occur together in a power situation that allows them*” (Link & Phelan, 2001).

3.1.1 Discrimination

Link and Phelan differentiate individual discrimination from structural discrimination. Discrimination starts with labeling, stereotyping or status loss for the stigmatized group. Individual discrimination occurs when an individual participates in discriminatory behavior such as rejecting job applications or refusing a tenant based on the group that they belong to. On the other hand, structural discrimination limits a group's participation in society through excluding practices. One example of this can be limited accessibility to the job market when job candidates are picked through personal recommendation of people from the same group. Another example is non-accessible environments where people with disabilities are limited in their ability to participate (Link & Phelan, 2001). Discrimination thus creates obstacles and limits the stigmatized group's ability to participate in different societal institutions and activities.

3.1.2 Stigma and Power

According to Link and Phelan's (2001) definition of stigma, power is a factor that needs to be identified in the process, for stigma to occur. The cognitive components

of stigma can occur within groups that hold little to no power in a society. These can be groups such as patients with mental illnesses or people in homelessness. Within these groups, labels and stereotypes can be created about powerful groups, and the powerful groups can become subject to avoidance or derogatory terms. Yet these groups do not have the power to ensure that their labeling and stereotypes reach a larger part of society. Nor do they have the power to control access to important life domains such as employment, housing or health care. This means that they lack the ability to cause serious discriminatory consequences for the recipient of their labeling and stereotypes. Stigma is therefore dependent on social, economic and political power, which is essential to the social production of stigma (Link & Phelan, 2001).

3.2 Self-Stigma: Internalization of Public Stigma

3.2.1 Modified Labeling Theory

The modified labeling theory serves as a background for the theory on self-stigma by Patrick Corrigan and colleagues, which will be presented in the next paragraph. According to the modified labeling theory by Link, people develop a conception about certain groups from childhood through the process of socialization. The individual gets an idea about how people within their group view other groups, and whether a group member would be rejected or devalued. If the individual finds themselves to become a part of the stigmatized group, for instance by developing an addiction or mental illness, the individual now must worry about rejection from their own group (Corrigan & Rao, et al., 2012; Link & Phelan, 2001). This social rejection that stems from stigmatization can contribute to low self-esteem for the stigmatized, which leads to withdrawal and avoidance of situations or places where devaluation or disrespect is anticipated. The avoidance and withdrawal results in difficulty achieving better health if the stigmatized person is ill and ultimately poorer life quality. Although there are no obvious forms of discrimination, the consequences can be severe (Corrigan et al., 2009; Corrigan & Rao, et al., 2012; Link et al., 1989; Link & Phelan, 2001).

3.2.2 Self-Stigma

Patrick Corrigan and Amy Watson differentiate between public- and self-stigma. According to Corrigan and Watson (2002), public stigma can be conceptualized as the

general population's reaction to the stigmatized group. It contains three components, which are stereotypes, prejudice and discrimination. Stereotypes can be viewed as social knowledge structures that represent notions of a group of people that are agreed upon. They create impressions and expectations about individuals that belong to a certain group. Stereotypes can exist for an individual although the individual does not agree with them. This occurs when the individual is aware of certain stereotypes but disagrees in their validity (Corrigan & Rao, et al., 2012: Corrigan & Watson, 2002). When an individual agrees with and endorses the stereotypes, then it turns into prejudice, which is accompanied by negative emotional reactions such as fear. Discrimination, which is the behavioral reaction, stems from prejudice. It takes form in loss of opportunities, coercion and segregation (Corrigan et al., 2009). An individual from the general public can discriminate against an individual from a stigmatized group because of their prejudice and stereotypes (Corrigan & Rao, et al., 2012).

Public stigma can lead to self-stigma, which is defined by Corrigan as "*the reduction in a person's self-esteem or sense of self-worth due to the perception that he or she is socially unacceptable*" (Corrigan 2014 as cited in Tucker et al., 2013). This occurs when the individual internalizes negative public stigma. Corrigan's studies suggest that this internalization process happens when individuals from a stigmatized group experience the three aforementioned components in relation to themselves. The three components of self-stigma can be translated from public stigma as the "three A's", with awareness stemming from stereotypes, agreement from prejudice and application from discrimination (Corrigan et.al, 2009). The experience of self-stigma requires an awareness of stereotypes regarding the stigmatized group that they are a part of. Furthermore, it requires the individual to agree with the stereotypes about their own group. Finally, the individual must apply the stereotypes to themselves, agreeing that because they are a part of a certain group, they fit into the stereotypes attached to the group (Corrigan et.al, 2009).

3.3 Attitudes and Help-Seeking Behavior

Vogel, Wade and colleagues (2013) make a conceptual distinction between self-stigma related to mental illness and self-stigma related to professional help-seeking. Their study found that both types of self-stigmas predicted shame. However, they

were different with regards to self-blame and social inadequacy. Self-blame was found in relation to self-stigma of seeking help, which is explained by the perceived controllability of treatment-seeking compared to having a mental illness. This may be different with regards to substance abuse or addiction in general, which have a higher perceived controllability and are more stigmatizing than mental illness in general (Vogel & Wade, 2009: Vogel et al., 2013). In correspondence with research showing that self-stigma of mental illness is related to feeling less valuable, Vogel and colleagues found social inadequacy in relation to self-stigma of mental illness. Their findings suggest that the two self-stigmas are associated with their corresponding public stigmas, and that self-stigma of help-seeking may be more relevant than self-stigma of mental illness in the decision of treatment-seeking (Vogel et al., 2013).

Vogel, Wade and Hackler (2007) built a model explaining the roles of perceived public stigma, self-stigma and attitudes in seeking professional help. Their model builds upon Corrigan's conceptualization of public and self-stigma and the modified labeling theory by Phelan and Link, which are previously explained. It additionally builds upon the theory of reasoned action by Ajzen and Fishbein. According to this theory, the willingness to commit a certain action is determined by the individual's attitude, which is based on the individual's expectations about the consequence of that action. In this context, the decision to seek professional help is primarily determined by the individual's attitude toward professional help, which is determined by their expectations about seeking help (Vogel & Wester, 2003). Vogel and Wade introduce public stigma and self-stigma to this equation and argue that the individual's attitude and expectation about seeking help is associated with the degree of public- and self-stigma they experience (Hackler et al., 2007).

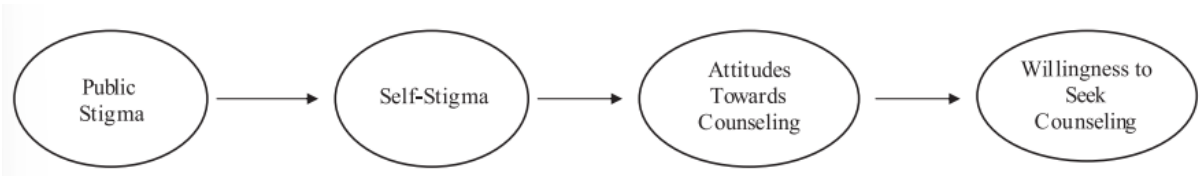


Figure 1. Hypothesized mediated model.

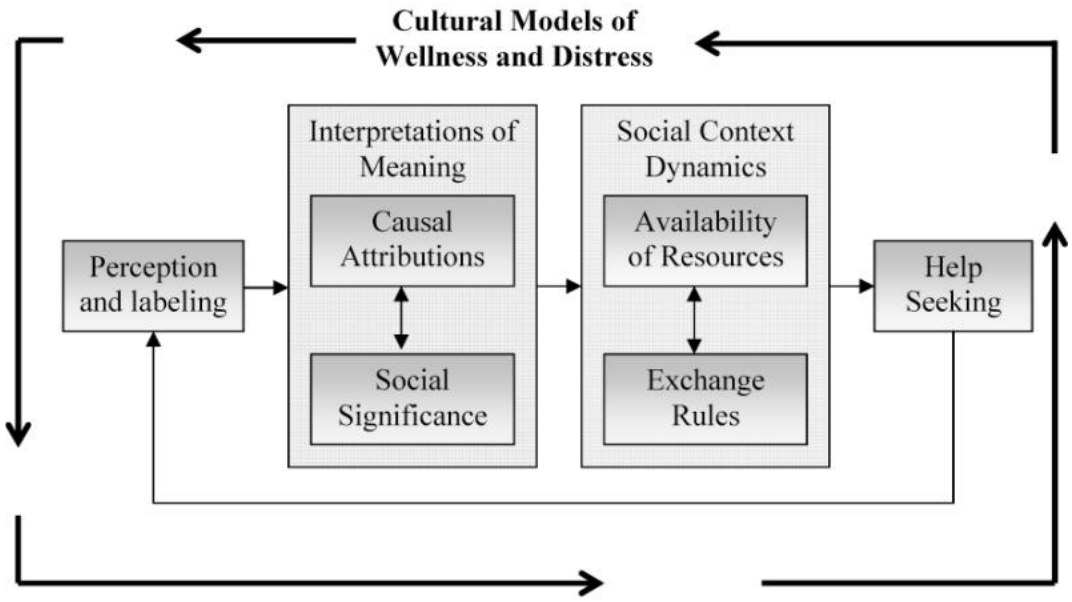
There is public stigma surrounding mental illness and treatment seeking, which have proven to be clear. For example, individuals that have sought professional help are more likely to be rated as emotionally unstable and less confident (Ben-Porath, 2002 as cited in Hackler et al., 2007). The perception of this public stigma can be internalized through the process explained in Corrigan's theory about internalization of stigma. This is where self-stigma comes in, which in this context is internalized negative perceptions that an individual can have of themselves, if they decide to seek help. The self-stigma associated with seeking professional help was found to predict attitudes toward professional help-seeking, thereby playing a role in the formation of attitudes. Here, attitudes are meant as positive or negative perceptions of professional help in general, and lead to the individual deciding to seek professional help or avoid it. Thus, this model suggests that self-stigma of help-seeking mediates the relationship between perceived public stigma and attitudes toward professional help-seeking behavior (Hackler et al., 2007). The model then shows that public stigma is internalized and turned into self-stigma, which in turn forms attitudes about a certain behavior and finally predicts the actions of the stigmatized individual. This additionally fits with Link and Phelan's modified labeling theory, which suggests that the stigmatized individual withdraws or avoids certain situations where devaluation is anticipated (Hackler et al., 2007; Link et al., 1989; Link & Phelan, 2001).

Furthermore, Wade, Vogel and colleagues (2007) studied the influence of social networks on seeking help from mental health professionals. They found that 92-95% of those who had sought professional help knew someone else who had sought professional help, while 74-78% of them were prompted to seek help. Their results point to people's social networks influencing the decision to seek professional treatment. Furthermore, their study showed that those who were prompted to seek help had more positive expectations about both therapy and what their social network would think of their decision to seek therapy. They also showed more positive attitudes towards seeking therapy, suggesting that a person's attitude regarding treatment-seeking was partially affected by their social network (Vogel et al., 2007).

3.4 Cultural Determinants of Help Seeking

Arthur Kleinman and colleagues have studied the importance of culture in the experience of having from a disease. They distinguish the term "disease" from “illness”. Whereas disease is conceptualized as abnormalities or malfunctioning in biologic and psychophysiologic processes, illness is understood as the human experience of sickness (Kleinman et al., 2006). They argue that illness is strongly influenced by culture, representing personal, interpersonal and cultural reactions to disease. The system of meaning that one employs is argued to shape the perception, experience and response to the disease, affecting the way health problems are communicated and coped with. Kleinman uses the concept of “Explanatory models” to present how culturally specific explanations of illness and health are achieved (Kleinman, 1988, 1995 in Arnault, 2009). Explanatory models result in predictable shared and meaningful patterns of explanations about health and the causes of illness within a group, and may differ across ethnic groups, families and more (Kleinman et al., 2006). Denise Saint Arnault builds upon the ideas of Kleinman in order to explain the cultural determinants of help seeking (Arnault, 2009).

Arnault synthesizes different disciplines such as social psychology and medical and psychological anthropology in order to propose a theoretical model to explore cultural determinants of help seeking (Arnault, 2009). In the article, culture is understood to be a “*system-level, multidimensional construct that describes the social processes of beliefs and values, rules about social behavior, and social practice*.”. Through the Cultural Determinants of Help Seeking (CDHS) theoretical model, Arnault attempts to explain help seeking, which she defines as “attempts to maximize wellness or to ameliorate, mitigate, or eliminate distress.” (Arnault, 2009). The model contains several factors that affect and are affected by each other.



When an individual experiences physical or emotional sensations, Arnault argues that these sensations are labelled based on how they are interpreted. When interpreted as desired or optimal states, they are labeled as signs of wellness, whereas sensations interpreted as disturbances or pathology are labeled as symptoms. This leads to the interpretations of meaning, where the individual considers the meanings of the labelled sensations, based on the explanation provided by their cultural model. This is where Kleinman's Explanatory Models are presented, with cultural models providing explanations about the causal attributions of wellness or distress (Arnault, 2009). Here, the causes of wellness or distress can have different types of interpretations. During the interpretation of the meaning of the sensation, the individual will also make estimations about the social significance of their wellness or distress. The individual can risk experiencing negative evaluations in forms of interpretations indicating signs of moral weakness or failure when experiencing distress or illness, which can lead to shame or fear. Within a group-oriented system, these negative evaluations can be extended to the group which the individual belongs to, such as the family. Ultimately the individual may avoid disclosing their illness based on the estimated negative social significance (Arnault, 2009).

Other factors that can influence help seeking have to do with the social context dynamics. Help seeking oftentimes involves disclosing the illness to one's social network. Across these networks, cultural models differ in their emphasis on the indi-

vidual or the group, and the individual must navigate the social rules that are enforced within their group (Arnault, 2009). Whereas the responsibility of health falls on the individual in individually oriented cultural models, this responsibility can be shared by the family and sometimes the community in group-oriented cultural models. This may lead to expectations from the group to only use resources of help within the known in-group (Arnault, 2009).

The CDHS theoretical model thus incorporates cultural models into the process of help seeking. This process is argued to begin with the perception of physical or emotional sensations. After labelling the symptoms or illness as significant, the individual may determine the causal attribution. Sometimes, the individual will attribute their illness to their own perceived failures. If this is estimated to have a negative social significance, the individual may decide that it is safest to hide the illness, in order to avoid negative social consequences. This results in the individual attempting to eliminate certain behaviors and deal with the illness by themselves. Alternatively, the individual may decide to disclose it and must navigate the social rules within their group. Within group-oriented cultural models, social rules may lead the individual to only disclose the illness to people they have a reciprocal helping relationship with, such as the family (Arnault, 2009).

3.5 The Enterprising Self

In relation to help-seeking behavior among individuals with gambling and substance addiction, Nikolas Rose's theory of self-governance is relevant for understanding how broader societal expectations of personal responsibility may influence whether individuals seek help or attempt to manage addiction-related problems on their own. Rose develops the concept of self-governance through inspiration from Michel Foucault's work on power and governmentality. Rose argues that governance in liberal-democratic societies increasingly operates through individuals' self-regulation rather than direct external control (Rose, 1998). Modern democracy is argued to be dependent upon a certain type of subjects, who are able to govern themselves without external policing. This is achieved through the internalization of norms and expectations, where external forms of control are translated into self-monitoring and self-discipline (Rose, 1999). From a Foucauldian perspective, power does not simply suppress subjectivity but operates through it. Building on this, Rose argues that contemporary

forms of governing work through the freedom and aspirations of individuals rather than against them. Subjectivity becomes an essential object, target and resource for strategies of regulation (Rose, 1998). Within this framework, Rose describes the emergence of the "enterprising self", in which individuals are expected to act as entrepreneurs of their own lives. According to Rose, this is achieved through a form of false freedom, where subjects are made to believe that their choices are based on personal desires. However, subjects choose between a repertoire of options that are shaped by advertising and promotion through media such as television, magazines and shop windows (Rose, 1998; 1999). In this sense, Rose also points to how institutions such as schools, families and media contribute to shaping individuals' capacities for self-regulation, moral responsibility and self-evaluation. Individuals are therefore encouraged to govern themselves through ongoing self-inspection and self-assessment in accordance with socially valued norms of autonomy and responsibility. Individuals are thus encouraged to interpret life challenges as matters of personal responsibility and self-management (Rose, 1998; 1999). In relation to addiction and help-seeking, Rose's theory can therefore contribute to understanding how the internalization of norms surrounding responsibility and self-management may contribute to reluctance toward seeking help for gambling and substance addiction.

4. Method

To examine help-seeking attitudes and behaviors among ethnic minorities with addiction, a mixed-methods research design was applied. This method-section begins by presenting the scientific theory underlying the methodological decisions. Here, the ontology of critical realism is applied to the research topic, while a pragmatic epistemology is used to explain the use of a mixed-methods approach. The proposed hypotheses are then presented and situated within the studies and theories on which they are based. This is followed by a description of the study design, in which both the qualitative and quantitative components are outlined. Subsequently, the data collection process and ethical considerations are presented, before thematic analysis as an analytical approach is introduced.

4.1 Scientific Theory

This project is inspired by a critical theoretical perspective in the investigation of help-seeking behavior among ethnic minorities with addiction. Experiences of ethnic minorities and people with addiction are interpreted in the social context in which they exist. Many studies suggest that socioeconomic status and ethnicity are associated with gambling-related harm (Aarestad et al., 2023; Calado & Griffiths, 2016; Caler et al., 2017; Grant & Chamberlain, 2023) and substance addiction (Benjaminsen & Enemark, 2024; Elkassen & Csiernik, 2020; Masson et al., 2012; Nabben, Weijs & Van Amsterdam, 2021; Reid et al., 2016). Similar patterns have also been identified in Denmark. Gro Askgaard and colleagues found that among 17,473 patients with an alcohol-related disease in Denmark, 86% had a low or medium-low level of education (Askgaard et al., 2021). Similarly, Stephanie Vincent Lyk-Jensen found that at-risk gambling was more prevalent for immigrants, as well as people with low education and low income in Denmark (Lyk-Jensen, 2010). Spillemyndigheden (2021) found similar results, indicating an association between low income and gambling problems. These studies suggest that in order to interpret help-seeking behavior for ethnic minorities with addiction, their socioeconomic status and the social context should be taken into consideration. The project assumes power relations between the participants and the broader society to be a relevant factor, for example in the case of self-stigma. According to Link & Phelan, stigma cannot exist without

power imbalance, and this suggests that self-stigma may be understood as the internalization of stigmatizing attitudes reproduced through unequal social power relations. To further frame how these findings are interpreted and how knowledge about them is understood, the following section introduces the ontological assumptions of critical realism.

4.1.1 Ontology

Critical realism as a social science originated in a series of books by Roy Bhaskar. The ontology of critical realism assumes the existence of an objective world which can be investigated scientifically, yet views knowledge as a subjective and changing social construction (Vincent & O'Mahoney, 2017). According to critical realism, the objective world is filled with entities, which are described as material or immaterial things that exist and have their own properties. These can be things such as plants, human beings or social structures. All entities have causal powers, which is their ability to affect another entity. These powers should be understood in the relation of entities as parts of a greater whole (Vincent & O'Mahoney, 2017). Critical realism assumes reality to be multiply determined, suggesting that there are several causes to an event and therefore deeper levels to discover, yet also that some mechanisms will remain invisible to the researcher (Bhaskar, 1975 in Vincent & O'Mahoney, 2017). It assumes that reality is multi-layered and distinguished between the real, the actual and the empirical (Lawani, 2020; Vincent & O'Mahoney, 2017). The real covers entities and powers that exist whether we observe them or not. The entities or structures of the real generate and explain events, which happen in the domain of the actual. These events take place as a result of entities and powers in the real domain and may be different to how we perceive them and sometimes not observable. The empirical covers the events that we experience, perceive and observe, and therefore covers what we are able to report on (Lawani, 2020; Vincent & O'Mahoney, 2017).

This project has a critical realist ontology. It conceptualizes addiction as a real phenomenon that exists independently of observation and has the power to cause observable behavioral and psychological effects for the individual who experiences it. At the same time, the experience and interpretation of the addiction is viewed as socially and culturally constructed and understood through culturally specific explanatory models presented by Kleinman (1988, 1995 in Arnault, 2009). The individual is also an entity which is viewed as containing the power to affect the addiction through

certain behaviors such as help-seeking. While the addiction exists as an entity in the real domain and can cause events through its power in the actual domain, this project only has access to the empirical domain through the experiences shared by participants. Furthermore, the concept of ethnic minorities is understood as a socially constructed categorization that nevertheless has real social consequences. The consequences of this categorization, including discrimination and stigma, are understood as events generated by underlying social mechanisms operating within the real domain. The experiences of these events become accessible through the empirical domain. Individuals may therefore share different perceptions and experiences in the empirical domain, even when referring to similar events in the actual domain.

4.1.2 Epistemology

Critical realism has been associated with pragmatism due to their shared belief that an external reality exists and motivation to use a mixed-methods approach to research it (Lawani, 2020). In pragmatism, knowledge is evaluated in relation to its practical usefulness for understanding and addressing problems, and the researcher should be flexible in their choice of methods and knowledge in order to understand a phenomenon (Florczak, 2014; Howe, 1988 in Lawani, 2020). Thus, pragmatism prioritizes answering the research question and having the research question guide the choice of suitable methods. Pragmatism therefore supports the use of multiple methods to achieve a broader understanding of a certain problem. In the use of mixed methods, both qualitative and quantitative data is collected, and interpretations are based on the strengths of both components in order to achieve a better understanding of the problem (Creswell, 2015 in Florczak 2014). This project used mixed-methods in the search for an understanding of help-seeking behavior among ethnic minorities with addiction. While the quantitative method was used in order to identify patterns in professional help-seeking behavior, the qualitative method provided a deeper insight into the experiences of the participants. The qualitative component was given interpretive priority due to the study's emphasis on participants' experiences and attitudes and their influence on help-seeking behavior.

4.2 Hypotheses

Four hypotheses have been formulated based on the research question and sub-questions presented in the introduction. The thesis includes different hypotheses regarding the relationship between four variables. These four variables were professional help-seeking, impact of the addiction on life aspects, self-stigma and subjective experience of discrimination. Furthermore, it includes a hypothesis that predicts an answer to the research question and includes data predicted from qualitative responses. The hypotheses were created based on relevant theory and studies presented in the literature review.

The studies reviewed in the literature review pointed to several factors that influenced professional help-seeking behaviors and attitudes for ethnic minorities with addiction. Studies indicated that treatment seeking behavior was altered by perceived differences in world views between patient and professional (Bansal et al, 2022; Hassan et al., 2025; Nwokoroku et al., 2022; Prajapati & Liebling, 2022). Furthermore, they suggested that concerns about community gossip and confidentiality breach played a role (Nwokoroku et al., 2022; Prajapati & Liebling, 2022), as well as family or community discouragement caused by cultural differences or mistrust of professionals (Prajapati & Liebling, 2022; Velasco et al., 2025). These findings relate to Kleinman's culturally specific explanatory models (Kleinman 1988, 1995 in Arnault, 2009), and Arnault's Cultural Determinants of Help Seeking (CDHS) theoretical model (Arnault, 2009). These theories suggest that help-seeking is influenced by cultural models of wellness and distress, as well as social significance of help-seeking and the social dynamics context. Together with findings from the review, these lead to the first hypothesis (H1) which proposes that mistrust of professional treatment and culturally different understandings of illness and health are negatively associated with professional help-seeking attitudes and behaviors.

Several studies have found indications of a tendency to postpone professional treatment among ethnic minorities. For some ethnic minorities, professional treatment is sought when the addiction has become unmanageable individually or within the family context (Kwok, 2000; Lidster & Cannon, 2013; Masson et al., 2012). Although immigrants and descendants are underrepresented in professional help-seeking for mental illness in general, they are overrepresented in compulsory hospitalizations

in Denmark (Baez et al., 2007). These findings suggest that some ethnic minority individuals may seek professional help only when addiction or mental illness has reached a greater level of severity. This leads to the second hypothesis (H2), which proposes that higher perceived life impact of addiction is associated with a higher likelihood of professional help-seeking.

The postponement or complete avoidance of professional help-seeking among ethnic minorities with addictions may partly be explained by the stigma they experience due to the addiction. A review of 25 studies identified stigma as the primary barrier to seeking help for mental illness in general (Aguirre Velasco et al., 2025). Stigma was also encountered in studies investigating help-seeking among ethnic minorities with addiction (Nwokoroku et al., 2022; Prajapati & Liebling, 2022), while other studies also discovered this stigma to be stronger among ethnic minorities (Dhillon et al., 2011; Douglass et al., 2023). The internalized form of stigma, self-stigma, was identified in a few studies investigating help-seeking for mental illness (Aguirre Velasco et al., 2025). A combination of theory presented by Corrigan and colleagues (Corrigan et al., 2009) and Wade, Vogel and colleagues (Hackler et al., 2007) leads to the indication that self-stigma may influence help-seeking behavior. These theories and studies thus point to self-stigma being a possible barrier for professional help-seeking, and lead to the hypothesis (H3) that higher levels of self-stigma are associated with lower likelihood of professional help-seeking.

Finally, the fourth hypothesis (H4) proposes that higher levels of subjective experiences of discrimination are associated with lower likelihood of professional help-seeking. This expectation is based on studies on professional help-seeking for ethnic minorities with mental illness. These studies have indicated that avoidance of mental health care may be caused by expectations of discrimination and cultural misunderstandings in mental health care among ethnic minorities (Hassan et al., 2025; Nwokoroku et al., 2022; Prajapati & Liebling, 2022). Furthermore, the modified labeling theory by Link and Phelan (2001) proposes that as a result of stigmatization and the connected discrimination, the individual will avoid places or situations where devaluation is anticipated. Together, these studies and theory suggest that the participants may avoid professional help based on an anticipation of experiencing discrimination or being misunderstood because of their ethnicity. Accordingly, H4 proposes that subjective experience of discrimination is negatively associated with professional help-seeking among ethnic minorities with addiction.

4.3 Study design

The study was conducted using a survey. The survey was chosen as a form of data collection based on literature which identified individual shame as a prevalent barrier for help-seeking among ethnic minorities with addiction (Allen, 1995; Kwok, 2000; Lidster & Cannon, 2013; McCann et al., 2017; Nabben, Weijs & Van Amsterdam, 2021). Shame has frequently been associated with withdrawal and concealment of the source of shame (Tangney et al., 1996). This may make it difficult to reach individuals who are experiencing shame in situations where they are expected to disclose their source of shame. Based on the behavioral manifestations of shame, it may be expected that many individuals dealing with addiction and shame may be underrepresented in interview-based studies involving direct interpersonal disclosure. In order to ensure opportunity for participation for ethnic minorities who are experiencing shame in relation to their addiction, the anonymous survey was chosen as a method of data collection. Several studies additionally found that some ethnic minorities experienced a mistrust of mental health professionals (Gainsbury et al., 2013; Gunstone & Gosschalk, 2020; Nabben, Weijs & Van Amsterdam, 2021; Reid, Crofts & Beyer, 2001). The mistrust of majority ethnic mental health professionals was based on anticipation of discrimination and cultural misunderstandings. However, respondents also experienced mistrust of mental health professionals with a similar ethnic background to themselves, caused by concerns of confidentiality breach and gossip in the minority ethnic community. An anonymous survey was therefore assessed to be a safer option than interviews. This assessment was due to my own ethnic minority background which could create a concern about confidentiality breach or gossip for the participant involved.

The survey was created and distributed using the platform SurveyXact. The survey included both a quantitative and qualitative component. The questions included in the survey were formulated based on included theory and literature review. The survey additionally included a few questions which were open-ended such as "How was your experience with professional treatment?", which gave the participants the opportunity to provide answers which were not based on included theory or reviews. It began with questions about age, gender, ethnicity and whether they had an addiction and which type. This was followed by a question regarding the impact

of the addiction on their life, and whether or not they had sought professional treatment. The participants were then asked treatment-related questions if they had sought treatment, and avoidance-related questions if they had not. Multiple choice questions were asked regarding where the participants sought help, and what caused them to avoid it, if they did not. Barriers included in the multiple-choice questions were taken from my 9th semester systematic review (Chaaban, 2025), which investigated treatment seeking barriers for ethnic minorities with substance addiction. The survey was tested on five people with different educational backgrounds who provided feedback and recorded the time it took them to answer the survey. Feedback was used in order to ensure the questions in the survey were comprehensible and understood in the way they were intended. In order to encourage longer answers to the qualitative questions, these were placed at the start of the survey, while the quantitative questions were placed in the second part. The full survey is provided in appendix 1.

4.3.1 The Quantitative Component

The quantitative component of the survey included two different scales. The first scale measured self-stigma (Cronbach's alpha=.812) and consisted of 12 items divided into three parts. The questions were operationalized based on the theoretical framework proposed by Corrigan and colleagues (2009) and a systematic review by Douglass and colleagues (2025). Corrigan and colleagues proposed that public stigma is internalized through three stages: awareness of public stigma, agreement with public stigma and application of public stigma to oneself. In order to measure self-stigma, these three stages were included in the survey as three separate parts, where participants were asked to rate their agreement with four statements on a 5-point Likert scale. Items measuring awareness of stigma were formulated “Most people think that…”, while items measuring agreement were formulated “I think that…” and items measuring application were formulated “Because I have an addiction, I think that I….”. The contents of stigma-related statements included were taken from the systematic review conducted by Douglass and colleagues (2025). The review found that both ethnic minorities and the ethnic majority shared similar stigmatizing perceptions of individuals with addiction. The most prevalent labels found were included in the survey items measuring self-stigma. Participants reported their awareness of, agreement with and application of statements about these labels related to individuals with addictions.

The Everyday Discrimination Scale (Cronbach's alpha=.891) (Williams et al.,1997) was included in the survey in order to measure the participants' subjective experience of discrimination. The validated scale consisted of nine items which measured the subjective experience of everyday encounters with discrimination. These questions had to do with how often they experienced discriminatory actions such as poorer service, being followed in stores or negative stereotypes. The participants rated how often they experience a certain type of everyday discrimination on a 6-point Likert scale ranging from “Never” to “Almost every day”. All nine items were translated from English to Danish and backtranslated to ensure linguistic equivalence.

4.3.2 The Qualitative Component

All multiple-choice questions included in the survey provided the participants with the ability to choose several answers. They also included the ability to choose “other” and give an alternative answer. The survey additionally included questions which the participants could answer by writing their answer with no word limit. Participants who did seek professional help were asked how their experience with the treatment was, if anything made it difficult to complete the treatment and what they thought would make professional treatment-seeking easier for ethnic minorities with addiction. Participants who did not seek treatment were asked similar questions. First, they were asked how they experienced not receiving professional help or receiving alternative help. Then they were asked what would make it easier for them to seek professional help. The purpose of these questions was to be exploratory, in order to identify barriers and experiences not found by predefined response categories or existing literature.

4.4 Data Collection

Participants were found through several recruitment strategies. Posters were designed with a QR-code linking directly to the survey. These posters were hung at two different educational institutions, four treatment centers and one youth club for youth in the ages 18-25. The physical posters generated only a limited number of responses. The survey was also posted on two different social media platforms: Facebook and

Instagram. On Facebook, the post was shared over 50 times, reached a larger audience and brought more respondents. Additionally, the survey was shared by an Instagram account (FolketiDK) targeted at ethnic minorities in Denmark with over 57 thousand followers. This also proved to be successful and generated approximately 100 clicks and 17 full responses. Finally, the most successful method of data collection was through the snowball effect, where participants received the survey as a direct message from a friend or family member.

4.5 Ethical Considerations

Considering the shame, taboo and stigma associated with substance and gambling addiction found in the literature, several ethical considerations were necessary during the selection of research methods, creation of the survey and the data collection. Due to shame being a prevalent treatment-seeking barrier in the reviewed literature, the anonymous survey was selected to reduce potential experiences of shame that participants could endure in face-to-face situations. The survey needed to be anonymous, in order to comply with GDPR requirements, as well as making the respondents feel safe enough to answer the survey. The questionnaire asked the respondents for their age, gender and ethnicity, but not any other information that could be used to identify them, in order to ensure their anonymity. Respondents were informed that their participation was voluntary, and that they could end their participation whenever they wished. Furthermore, an email was provided if they wished to ask questions and they were informed about their right to make a complaint if they did not perceive the survey to live up to GDPR standards. Anonymity was also a consideration in relation to the placement of the physical posters. Posters were therefore primarily placed in private locations, such as bathroom stalls and study areas, to reduce the visibility of participation.

4.6 Analytical Method

Through thematic analysis, patterns found in the data were turned into themes that captured something relevant within the data in relation to professional treatment-seeking attitudes, experiences and behavior. The themes also sought to represent a pattern in the responses provided by the participants (Braun & Clarke, 2008). The analysis was conducted on an explicit level, where the themes were identified

through the explicit contents of the data. The summarization patterns found in the data were followed by an interpretation where the data was related to theory and previous research (Braun & Clarke, 2008).

The aim of the analysis was to identify and interpret barriers, attitudes and experiences embedded within the participants' responses. The qualitative data were treated with an inductive approach, where the data shaped the themes, rather than being fit into preexisting frames, in order to make way for unexpected responses (Braun & Clarke, 2008). This approach involved the coding of the qualitative responses and the search for themes within the data. The coding was systemized in order to achieve consistency. After a familiarization with the data, each qualitative response was examined for references of barriers, attitudes or evaluations regarding professional help seeking and help seeking in general. These were coded and organized into a table documenting their occurrence across responses. The most prevalent attitudes, barriers or evaluations were then searched for themes together with results from the quantitative analyses.

The quantitative component in the survey was designed and analyzed with a deductive approach. While The Everyday Discrimination Scale was included as a validated scale, the self-stigma scale was based on Corrigan and colleagues (2009) theoretical contribution as well as Douglass and colleagues (2025) findings about stigma. The data resulting from the quantitative component were therefore interpreted through preexisting theory. Two types of statistical analyses were conducted to test the hypotheses. The first analysis examined differences between the group of participants who did seek professional help and the group that did not. The sample size in the group of participants that did seek professional help (N=5) was very small, and the groups were therefore unequal in size. The data thus failed to meet the parametric assumptions that are required for the selection of an independent t-test, thereby resulting in an analysis conducted using a non-parametric test (Field, 2018; Kim, 2019). The Mann-Whitney U-test was selected to evaluate the significance of differences between the two groups by using the sum of ranks rather than the mean difference. It was selected based on the two samples being independent and the participant scores on the scales being used as continuous observations. In the analysis using the Mann-Whitney U-test, statistically significant observed rank differences are determined by a p-value at $p<.05$ (Chicco et al., 2025).

While the Mann-Whitney U-test examined the differences between participants, the aim of the second analysis was to investigate the relationships between the variables. One of the variables used in the survey was a yes-or-no question of whether the participants had sought professional help and was therefore dichotomous. The remaining variables were measured using Likert scales. This made Point-Biserial Correlations an appropriate choice to measure correlations, because it is a Pearson's method which allows the assessment of correlations between dichotomous and continuous variables. The Point-Biserial Correlation coefficient was used instead of the Biserial Correlation, based on one of the variables being naturally occurring or discrete (Field, 2018). Both the Mann-Whitney U-test and the Point-Biserial Correlations were conducted using the IBM SPSS Statistics software.

5. Results

The dataset consists of three different categories of material. First, it includes qualitative responses to open-ended survey questions, where the participants provided responses with no word-limit. This section includes participant responses to multiple-choice questions, due to the order and thematic connectivity between the questions and the qualitative responses. These responses consisted of attitudes shared by the participants regarding help-seeking. They also included the participants' experiences with both professional and alternative help, and the participants' thoughts about their help-seeking decisions. This was followed by descriptive statistics, where data was explored and mean scores as well as standard deviations were found for the three scales: Impact of addiction, Self-stigma and Subjective Experience of Discrimination. Finally, these three scales were subjected to two statistical analyses: A Point Biserial Correlational analysis and the Mann-Whitney U-test. Results from the statistical tests are shared in the last section (5.4), while all results are documented in appendix 1.

5.1 Participants

After exclusion of participants who reported only nicotine addiction and responses from participants with a Danish ethnic background, the survey was left with 80 participants. Among the 80 participants that met the inclusion criteria, 43 completed the survey, while 37 provided partial responses.

Table 1: Ethnicity

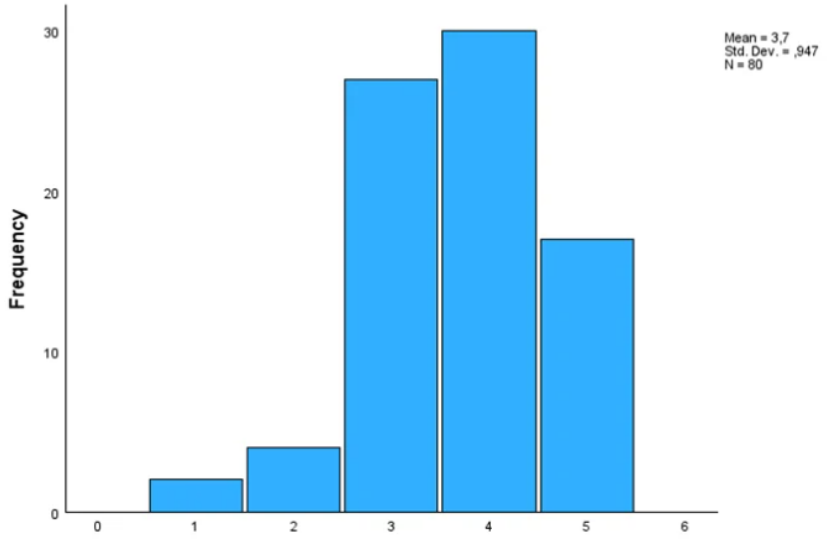
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Anden etnisk	2	2,5	2,5	2,5
	Balkanhalvøen	5	6,3	6,3	8,8
	Mellemøsten	47	58,8	58,8	67,5
	Nordafrika	2	2,5	2,5	70,0
	Sydasien	8	10,0	10,0	80,0
	Vesteuropa	3	3,8	3,8	83,8
	Østafrika	8	10,0	10,0	93,8
	Østeuropa	5	6,3	6,3	100,0
	Total	80	100,0	100,0	

Most of the participants shared a Middle Eastern background (N=47), while the rest varied across South Asia (N=8), East Africa (N=8), East Europe (N=5), The Balkans (N=5), with the few remaining participants responding Western Europe, North Africa

or unknown other ethnicity (table 1). The participants consist of 45 men and 35 women, with ages spanning from 18 to 56 (M=24.5). The overrepresentation of Middle Eastern and 18–24-year-old (N=40) participants could be explained by the snowball effect and the sharing of the survey on social media platforms with a majority of Muslim followers.

The participants reported experiencing either alcohol, drug, medicine or gambling addiction. 21 participants had co-occurrent addictions, reporting experience of addiction to two or more of the mentioned substance or behavioral addictions. 55% reported addiction of drugs, 33% a gambling addiction, 27% experienced alcohol addiction, while 25% had an addiction to medicine. When asked to rate the severity of the impact of their addiction (figure 1) on various aspects of their lives (e.g., school, work, family, friends, finances, and health) on a Likert scale from 1 to 5, the mean score was above the midpoint (M = 3.7).

Figure 1: Life impact of addiciton



Although the participants generally scored high on severity of impact on life, merely 13 out of 80 participants sought professional treatment for their addiction. This meant that 16,25% of the participants who experienced a substance or behavioral addiction sought professional treatment.

5.2 Multiple-Choice and Qualitative Responses

5.2.1 Participants who Sought Professional Treatment

Out of the 13 participants that sought professional treatment, six sought treatment in public treatment centers, three from a psychologist or therapist, one from their doctor, and one in prison while the last participant was forced into treatment. One participant did not provide an answer, while seven others ended their participation in the survey during the qualitative questions that followed. The six remaining participants reported different experiences of their treatment. While three participants completed their treatment, the remaining three quit treatment before completion. Four participants expressed good experiences with treatment, sharing feelings of growth, self-insight and plans for times of crisis. The negative experiences shared were partly related to concerns about confidentiality breach, which caused one participant to quit the treatment. Another participant shared that "*What made it difficult in the beginning were the thoughts in the back of my mind that saw it as being a junkie if you needed help from a psychologist etc. but when you have been there a couple of times you realize that it's the opposite*". This participant experienced difficulties at first, which were then changed the further they got in the treatment.

5.2.2 Participants who Avoided Professional Treatment

The 67 participants who avoided treatment chose one or several reasons for avoiding professional treatment (table 2). The most prevalent cause for avoiding professional treatment was mistrust of the effectiveness of the treatment. This was followed by feelings of shame, the fear of other people finding out about the addiction, and concerns about it damaging their family's honor. The concern about family honor outweighed the concern for their own honor for some participants, although 19.6% were concerned about their own honor. Some were concerned about other people finding out about their treatment-seeking, some did not know where to seek help, while 19.6% did not believe that the professional would understand their culture.

Table 2: Causes for avoidence

Causes for avoidance of professional help-seeking		
Causes	**N**	**Percent of cases**
I was ashamed	17	33,3%
I did not trust that it would help me	20	39,2%
I was afraid others would find out about my addiction	16	31,4%
I was afraid others would find out about my treatment	9	17,6%
I was afraid it would damage my honor	10	19,6%
I was afraid it would damage my family's honor	15	29,4%
I did not know where to seek help	9	17,6%
I did not believe that the professional would understand my culture	10	19,6%
I need treatment in my own language	2	3,9%
Long waiting times	2	3,9%
Other	10	19,6%
Total	120	235,3%

Ten participants experienced treatment-seeking barriers that were not listed and provided their own answers. Some of these participants reported that they were not ready to admit it was a problem (N=4), while others believed that they were able to handle the addiction by themselves (N=2). One of the participants expressed worries that it would negatively affect his wife and kids, another believed it was taboo to seek help, while the final participant did not believe her addiction warranted treatment and instead used ChatGPT for help. Apart from ChatGPT, other forms of alternative help were sought by the participants (table 3).

Table 3: Alternative help

Alternative help		
Help	**N**	**Percent of cases**
Family	6	11,8%
Partner/Spouse	7	13,7%
Friends	14	27,5%
Religious community	9	17,6%
Online community	1	2%
No one	29	56,9%
Other	2	3,9%
Total	68	133,3%

Some participants sought help for their addiction through their friends, some from a religious community, and some from their partner or family. However, most of the participants (56.9%) did not seek help from anyone and instead dealt with their addiction on their own. Out of the six that sought help from family, four shared positive experiences based on receiving support and being met with understanding, while two shared being met with people they deemed "*unhelpful*". Participants reported similar mixed yet mostly positive experiences with seeking help from their friends or partners. Most participants reported positive experiences from seeking support through religion or religious communities. One participant shared that they "*cried day and night because I lost my salary already after 3 days and then I started praying and I felt that Allah helped me become stronger and delete it.*". Another shared that "*It has helped a lot to get into one's religion and realize that some things are not okay*". While most participants who sought help through religion experienced positive results, one shared that "*It is just hard when you don't have anyone to talk with*". This was a feeling shared by several of the participants, who did not seek help from anyone. One shared that they felt "*powerless and that I did not have life-meaning. An emptiness that only got bigger with time*", while others experienced hardship in the beginning but overcame their addiction. The participants showed mixed experiences with dealing with their addiction by themselves, and some believed that it was the only way, since "*taboo*" or "*culture*" got in the way of them disclosing their problem.

When asked what would make it easier to seek professional treatment, the participants expressed different ideas. Five participants answered that there was nothing that could make them seek professional help. Four participants shared that they would seek professional help if people did not shame them about their addiction, and three participants found taboo around addiction to be the problem. For some (N=6), a good professional who understands their culture would help, with some specifying a need for minority ethnic professionals. Mistrust was also a barrier to seeking treatment, with six participants mentioning concerns about confidentiality breach, or documentation being used against them in the future. One participant presented the idea of treatment remaining free, but with the added ability to remain anonymous or have the option of choosing the professional.

5.3 Descriptive Statistics

The survey contained three different scales: Impact of addiction, Self-stigma and Subjective Experience of Discrimination. Although the sample size started with 80 participants, several of these participants quit the survey before answering questions on the Self-stigma and Discrimination scales. Two groups were established: one consisting of participants who sought professional help, and another comprising participants who did not. As previously mentioned, 80 participants rated the impact severity of their addiction on various aspects of their lives on a 5-point Likert scale. Across both groups, the mean scores were above the midpoint of the scale, which indicates moderate to high severity of impact. However, the mean score was higher among participants who did seek professional help (N=13, M=4.31, SD=.75), compared to those who did not (N=67, M=3.58, SD=.94).

A total of 47 participants rated their agreement on twelve statements designed to measure self-stigma in relation to addiction, using a 5-point Likert scale. Overall, scores across both groups were around the midpoint of the scale, indicating a moderate level of self-stigma regarding addiction. The mean score was slightly higher among participants who did not seek professional help (N=41, M=2.74, SD=.72), compared to those who did (N=6, M=2.34, SD=.5). This indicates slightly higher ratings of self-stigma among participants who did not seek professional treatment, although comparisons should be interpreted with caution due to the small sample size of participants who did seek professional help. Additionally, 43 participants assessed

their subjective experience of discrimination on nine items using a 6-point Likert scale. This rating also resulted in a mean around the midpoint of the scale, suggesting moderate subjective experiences of discrimination. The participants who did seek professional help (N=5, M=3.75, SD=1.8) scored somewhat higher levels of perceived discrimination than those who did not (N=38, M=2.97, SD=1), although the difference was statistically insignificant. When asked about their assumption of what triggered the discrimination, 84% attributed it to their ethnic background, 65% to their religious background and 33% to their physical appearance.

5.4 Statistical Analysis

A Mann-Whitney U test was conducted in order to examine differences between participants who sought professional treatment and those who did not (table 4). The groups were compared in relation to the three scales: Impact of addiction, Subjective Discrimination Experience and Self-stigma. The test found a significant difference in impact of addiction between the groups (U =247.5, Z=-2.59, p=.01), where participants who did seek professional help scored higher on impact of addiction. This suggests that participants who sought professional treatment experienced a more severe impact of the addiction on various aspects of their lives. The Mann-Whitney U test found no significant differences between the groups when it came to self-stigma (U=79, Z=-1.41, p=.16), or subjective discrimination experience (U=65.5, Z=-1.12, p=.263). The sample size across the tests was uneven due to participants responding to only some parts of the survey. This means that the sample size for the Impact-scale was substantially higher (N=80) than the sample size of the Self-stigma scale (N=47) and the Subjectively Experienced Discrimination-scale (N=43). The smaller sample size led to a small number of participants who did seek professional help on the Self-stigma scale (N=6) and on the Subjectively Experienced Discrimination scale (N=5). Due to the small sample of participants who did seek professional help, the results of the Mann-Whitney U test of differences in self-stigma and subjective discrimination experience are unreliable.

Table 4: Mann-Whitney U test

	Life impact	Subjective discrimination experience	Self-stigma
Mann-Whitney U	247,500	65,500	79,000
Wilcoxon W	2525,500	806,500	100,000
Z	-2,586	-1,119	-1,405
Asymp. Sig. (2-tailed)	,010	,263	,160
Exact Sig. [2*(1-tailed Sig.)]		,273[b]	,170[b]

a. Grouping Variable: Nyhjælpsøgning

b. Not corrected for ties.

Apart from the Mann-Whitney U test, Pearson (Point-Biserial) correlations were conducted in order to examine the relationships between professional help-seeking, impact of the addiction, subjective discrimination experience and self-stigma (table 5). Professional help-seeking was coded as 1=No and 2=Yes, and correlations were tested across both help-seeking and scales. Point-Biserial Correlational analysis found a significant positive correlation between professional help-seeking and perceived life impact (r=.29, p=.011). This suggests that the higher the impact of addiction on their life, the more likely the participants were to seek professional help. However, no significant correlations were found between professional help-seeking and subjective discrimination experience (r=.21, p=.184) or self-stigma (r=-.19, p=.206), or between the continuous variables. Apart from the results regarding the correlation between professional help-seeking and life-impact, these results should again be treated with caution, based on the small sample size of participants who did seek professional help.

Table 5: Point-Biserial Correlation

		Help-seeking	Impact on life	Subjective discrimination experience	Selfstigma
Help-seeking	Pearson Correlation	1	,285*	,207	-,188
	Sig. (2-tailed)		,011	,184	,206
	N	80	80	43	47
Impact on life	Pearson Correlation	,285*	1	,280	,067
	Sig. (2-tailed)	,011		,069	,654
	N	80	80	43	47
Subjective discrimination experience	Pearson Correlation	,207	,280	1	,004
	Sig. (2-tailed)	,184	,069		,982
	N	43	43	43	43
Selfstigma	Pearson Correlation	-,188	,067	,004	1
	Sig. (2-tailed)	,206	,654	,982	
	N	47	47	43	47

*. Correlation is significant at the 0.05 level (2-tailed).

5.5 Hypotheses

The Mann-Whitney U test revealed a difference between participants who sought professional help and those who did not, when it came to the severity of the impact that the addiction had on their life. This fit with the Point Biserial Correlational analysis, which suggested a positive correlation between professional help-seeking and life-impact of addiction. Both tests did not result in significant results regarding the relationship between professional help-seeking and self-stigma or subjective experience of discrimination. Results based on tests including the scales for self-stigma and subjective discrimination experience can be assessed as unreliable, due to the low sample size of those who did seek professional help (N=5-6). Nevertheless, results from both tests support the hypothesis regarding professional help-seeking and severity of life-impact, while rejecting hypotheses regarding professional-help seeking and self-stigma, and professional help-seeking and subjective discrimination experience.

Table 6: Hypotheses

Hypothesis	Mann-Whitney U-test	Point-Biserial Correlation
H2: Higher perceived impact of addiction on life is associated with a higher likelihood of professional help-seeking.	Supported	Supported
H3: Higher levels of self-stigma is associated with lower likelihood of professional help-seeking.	Rejected	Rejected
H4: Higher levels of subjective discrimination experience is associated with lower likelihood of professional help-seeking.	Rejected	Rejected

Despite the data limitation in relation to the statistical tests of hypotheses H3 and H4, the data included rich qualitative material. In the qualitative material, participants shared and explained their attitudes and decisions regarding professional help-seeking in their own words. Additionally, they shared experiences with alternative help seeking and explained their decision and experience with non-disclosure and handling addiction alone. These findings were useful in the interpretation of the participants help-seeking attitudes and behavior. Qualitative results were therefore prioritized in the interpretation of the findings. This leads to the next section where a thematic analysis will be conducted. In the thematic analysis, themes related to stigma, shame, mistrust, alternative treatment, self-reliance and more will be explored.

6. Thematic Analysis

The results identified several barriers to seeking professional help for ethnic minorities with gambling or substance addiction. These barriers will be investigated further in the following analytical section through a thematic analysis. The theoretical frameworks, which both inspired the survey and were inspired by the survey's findings, will be integrated into the thematic analysis and aid in the interpretation of responses provided by the participants. Firstly, the analysis will delve into stigma, self-stigma, shame and honor, which are combined as a theme titled The Roles of Stigma, Shame and Honor. This is followed by barriers such as doubting the effect of treatment, concerns about confidentiality breach, cultural barriers and alternative help, which are grouped and titled Mistrust of Professionals: The turn to Family. The final theme is titled Preference for Self-sufficiency, and involves secrecy, self-sufficiency, religion and the decision to seek help when addiction becomes too severe to handle.

6.1 The Roles of Stigma, Shame and Honor

6.1.1 Stigma and Taboo

For several participants, concerns regarding how they would be perceived by other people limited their professional help-seeking behavior. Whereas 31% of the participants worried their addiction would be disclosed to other people, 18% worried others would find out that they had sought professional treatment. Several participants agreed that it was taboo to seek professional help, expressing that "*I received no help, and it was taboo to go to a psychologist or rehab* or "*It was taboo to seek help*". While others expressed that they would seek help "*If it wasn't such a big taboo.*" and thought it would help if "it *is a topic that is talked about. So you can seek help without feeling embarrassed*.". These participants thus agreed that the act of seeking professional help would be received negatively by other people. This can be linked to Arnault's social context dynamics (Arnault, 2009), where individuals have to navigate the social rules enforced in their group related to handling illness. The understanding that some participants share about professional help-seeking being taboo indicates professional help-seeking to be against social rules about treating illness in their group. This could explain some participants' choices to avoid professional help-seeking. Although some participants attributed their help-seeking behav-

ior to concerns about the treatment being taboo or getting disclosed, other participants emphasized concerns about their addiction being revealed. Arnault's concept of social significance (Arnault, 2009) could play a role here. Some participants appear to have negatively estimated the social significance of their addiction, thus attempting to avoid negative evaluations by keeping the addiction private. This could explain their decision to avoid professional help-seeking and thus limit the chances of their addiction being revealed.

Concerns about the disclosure of one's addiction or professional-help seeking could be rooted in the fear of being stereotyped as a result of belonging to a stigmatized group (Link & Phelan, 2001). One participant linked their decision not to seek help to their fear of being prejudiced, explaining "*I was afraid of prejudice, so I didn't seek help*". This behavior could be explained by Link and Phelan's modified labeling theory (Link & Phelan, 2001), where the individual who has become part of a stigmatized group tends to worry about rejection. This worry leads the individual to avoid certain situations or places where devaluation is expected and could explain why this participant avoided help-seeking and thereby also devaluation caused by prejudice they could risk experiencing.

6.1.2 Self-stigma, Shame and Honor

Public stigma, as conceptualized by Link and Phelan (2001) is something that one can risk internalizing in the sense that the individual develops self-stigma. This is achieved through the process of awareness, acceptance and application of different components of public stigma, such as negative attributions (Corrigan et al., 2009). One participant explains their thought process regarding professional help-seeking, where they share that "*What made it difficult in the beginning were the thoughts in the back of my mind that saw it as being a junkie if you needed help from a psychologist*". The participant explains how their perception of an individual seeking professional help from a psychologist would make them similar to a "*junkie*". This could indicate an internalization of labeling and stereotyping of individuals with addictions as having undesirable characteristics. The participant could have been attempting to avoid being associated with individuals needing treatment, and thus avoid experiencing status loss (Corrigan et al., 2009; Link & Phelan, 2001).

According to Vogel, Wade and colleagues (2013), self-stigma related to mental illness and self-stigma related to professional help-seeking both predict shame.

This accords with responses from the participants regarding their causes for avoiding treatment, where 33% of participants responded that they were ashamed. Shame was the second most frequently chosen barrier, indicating that shame plays a role in the help-seeking behavior. One participant further explained that they would seek help, if "*you don't get shamed for having committed a stupid deed*". This points to a wish to avoid negative evaluations from other people such as shaming, which can be related to Arnault's (2009) interpretations of meaning. The participant seems to have attributed their addiction to personal failure, labeling behavior caused by addiction as a "*stupid deed*". This in turn forms the estimated social significance to be negative, which could have led the participant to avoid help-seeking. Similarly, causal attributions and social significance could have played a role for other participants who experienced shame. The interpretation of the addiction as a sign of personal failure could lead to shame (Arnault, 2009), and finally avoidance of help-seeking.

For participants existing within a group-oriented system, the negative evaluations could be extended to their primary or extended family (Arnault, 2009). When asked about their causes for avoiding professional help, 20% responded that they were concerned about their honor. However, 29% of the participants were concerned about the honor of their family, indicating a greater concern regarding family honor rather than individual honor. The worry about the damage of one's family's honor based on the participants own addiction fits with Arnault's theory about the extension of negative evaluations. This suggests that extended negative evaluations or damage of family honor also play a role as a barrier to professional help-seeking.

6.2 Mistrust of Professionals: The Turn to Family

6.2.1 Mistrust and Help-Seeking

Previous studies have mentioned a preference of keeping struggles such as addiction within the family, in order to avoid gossip and damage of family honor (Chaaban, 2025). Although several participants expressed worries regarding confidentiality breach and damaging their family reputation, none of them explicitly shared that there was a connection between this worry and their decision to seek help within the family. However, 12% of participants sought help from their family, 14% from their partner and 28% from their friends, showing help-seeking which was alternative to

the professional treatment options. This could be explained by Arnault's social context dynamics (2009), where individuals navigate social rules regarding treatment of illness, and where cultural models that emphasize the group have a certain availability of resources. These participants could exist within a group-oriented cultural system, where the responsibility of health falls upon the group, and where there exist social rules favoring the use of the available resources within the group. This may have led them to use their available resources through their partner, family and friends, rather than seeking professional help. One participant describes this as "*Help from an acquaintance instead of a stranger*", emphasizing their preference to utilize resources within the group as opposed to receiving help from "*strangers*".

While some participants may have chosen alternative help based on the wish to use available resources within their group, others point out other reasons. The participants reported different sources of mistrust of mental health professionals. Several participants shared worries regarding confidentiality breach. One participant shared their belief that "*There is no real confidentiality, even if they say so.*", while others wished for "*Confidentiality! REAL confidentiality, no reason to keep a journal and save things for 100 years.*". This points to mistrust of the validity of the promised confidentiality that individuals would meet in professional treatment. One participant did seek professional treatment but quit before completion, sharing that they "*didn't dare to show up because I have another ethnic background, and there were others who worked there who I know love to talk about who they are working with*". This points to a widespread concern about confidentiality breach among the participants, who either have avoided or quit professional treatment based on their concern. This concern could be based on the fear of negative social evaluations and status loss, that the participants could experience in the disclosure of their addiction or treatment (Arnault, 2009: Link & Phelan, 2001). Others feared the consequences that the documentation could have on their lives in the future. One participant shared their belief that "*they write everything down and can use it against you one day*.", showing a belief that their professional help-seeking would have negative consequences for them in the future. Some participants ascribed their mistrust of professionals to their family, sharing that "*Because of my family etc. I haven't had trust to the professionals*" and "*Since I was young, I've been told that I shouldn't tell anyone anything. When I was beaten, I wasn't supposed to tell anyone because Danes would have me removed*

so this has followed.". These participants thus explain how their mistrust of professionals was inherited from their families, with one participant sharing that the mistrust was created during childhood, caused by a fear of their parents losing custody based on physical violence. This could also suggest social context dynamics (Arnault, 2009) with social rules of not seeking help from professionals who are deemed untrustworthy. It could also be explained by a lack of prompting to seek professional help by their social network. Several studies found this to be especially important in relation to the individual's attitude to help-seeking and expectation about the social significance of help-seeking within the individual's social network (Gulliver et al., 2010; Aguirre Velasco et al., 2025; Vogel et al., 2007).

6.2.2 Effectiveness and Alternative Treatment

The reported mistrust of professionals extended further than the participants' mistrust in client confidentiality and concerns about their addiction being used against them in the future. 20% of the participants did not expect the professional to understand their culture and rated the cultural barrier as a reason they did not seek professional help. One thought that "*Danes do not understand immigrant problems and that's a fact!"* while other participants shared a preference for a professional with an ethnic minority background. One explained "*for an immigrant like me, I think there is a need for an immigrant who knows how it is to be an immigrant. I feel that there is a better understanding between each other*". This could suggest a difference in explanatory models (Kleinman et al., 2006) utilized by the participants and the ethnically Danish professionals. The participants could have differing culturally specific explanations of the addiction and how successful treatment should be achieved, creating a gap between the professional and the participant. This gap caused by different explanatory models based on cultural differences could be interpreted as playing a role in the decision to seek professional help for the participants.

Furthermore, results of the survey suggested that the participants did not trust in the effectiveness of the professional treatment. 39% of the participants did not believe that the treatment would help them, making mistrust in the effectiveness of professional treatment the most prevalent barrier. This mistrust in effectiveness of professional treatment, concerns about confidentiality breach and addiction being used against them, and finally cultural barriers could all aid in understanding the preference of seeking help within one's social network. The participants would not have to

worry about confidentiality breach and their addiction being the cause of damage to their family honor, if they keep their addiction within the family. Moreover, cultural barriers may not be as prevalent within their own family, as they expect them to be in professional settings, and they may view the explanatory models used by friends and family to be more fitting to them. Some participants reported good experiences with seeking help from family and friends, sharing stories like "*My family helped me a lot. Especially my mom made sure I got out of the vicious spiral."* and "*It was a supportive episode where you were pushed closer together because one lets out something that exists so deep within oneself*". This indicates that some participants benefitted from the available resources within their social network. However, not all participants had the same experience, and most participants decided to deal with their addiction on their own.

6.3 Preference for Self-Sufficiency

6.3.1 Barriers and Expectations

Although some participants may have reacted to mistrust of professionals and treatment, cultural barriers and fear of damaging their family honor by reaching out to family and friends, others dealt with their addiction on their own. Some participants avoided professional treatment as well as seeking help within their group, which they explained by "*Because of family or/and culture it has been really difficult to seek help from the family. I have felt that I have stood alone with it...*". This participant shared that their family and culture made it difficult to reach out to family. Another participant thought it would aid in their help-seeking to "*to know that I had a network. A mom and a dad that could look me in the eye - and who would not punish me for the way that I have punished myself*". Here, approval was needed from both parents and the social network in order for the participant to seek help. Although some participants were able to seek help from their social network, this points to others who did not have that opportunity due to difficulties disclosing the addiction and fear of disapproval. This difficulty in disclosing their addiction to their social network, as well as other mentioned barriers, could partly aid in understanding why most (57%) of the participants reported that they dealt with their addiction on their own.

Several participants described addiction as something that should be handled independently. Many expressed the belief that they could and should overcome addiction on their own, explaining that "*I don't feel that I need help, I can stop by myself.*" and "*I don't feel that professionals can help one with abuse at all. In my opinion it is a battle one has to go through alone.*". For these participants, addiction was understood as a personal struggle that should be managed privately rather than through professional treatment. For the last participant, treatment of addiction was a battle that one should fight alone. One participant shared a similar attitude and explained where this view was developed by answering "*Well where we come from, it is not something we talk about. It's something you deal with alone. If you're strong you get through it, or else you fall. Rather fall than show "weakness"*". According to this participant, the belief that one should deal with addiction alone originates from a wish to avoid showing weakness. These statements may be interpreted through Rose's theory of self-governance, where individuals are encouraged to understand personal difficulties as matters of individual responsibility and self-management (Rose, 1998; 1999). The participants' emphasis on handling addiction alone and avoiding displays of weakness reflects ideals of autonomy, self-control and self-regulation. Addiction is therefore understood as a personal struggle that should be managed privately. At the same time, the participant's statement that "*where we come from*" addiction is something dealt with alone suggests that these attitudes are also shaped by social and cultural norms within families or communities. The emphasis on concealment and the fear of appearing "*weak*" may therefore reflect concerns related to stigma, honor and social status. This may further be interpreted through Arnault's CDHS model (2009). After interpreting addiction as a sign of personal weakness and anticipating negative social consequences, the participant may not have perceived disclosure as a possibility. Since professional help-seeking requires disclosure of the addiction, navigating these social rules may have contributed to the preference for handling addiction alone.

6.3.2 Consequences and Spirituality

The decision to avoid disclosure of the addiction and deal with it alone had different consequences for the participants. For some participants, dealing with addiction alone caused a great amount of difficulty, loneliness and pain. One participant "*Felt I*

was powerless and that I did not have life-meaning. An emptiness that only got bigger with time.". Another thought it was " *hard when you don't have anyone to talk with*", and one found it to be one of the most challenging things in their life, sharing "*I never wanted to stop but needed to - to have to fight with that exact thought, and to stand on my own has been the most difficult thing in my life so far.*". This indicated that for some participants, having to keep their addiction to themselves and dealing with it on their own was difficult, lonely and for some made life feel meaningless. However, some participants did not share experiences that were as difficult and reported that they "*actually stopped completely but it required discipline*" and "*I handled it fine on my own*". This suggests that similar to participants who sought alternative help, participants had different experiences with dealing with addiction alone.

While most participants were alone with their addiction, some found ways to combat loss of meaning. Another source of help for the participants was revealed to be religion. While 18% of participants reported seeking help from religious communities, several participants shared how they used religion as a resource for help. For one participant, religion was something that gave them strength in a difficult time. They described a time where they "*I cried day and night because I lost my salary already after 3 days and then I started praying and I felt that Allah helped me become stronger and delete it*.". Here, God is perceived to be a source of support providing the participant with strength to treat the addiction. The participant explains how they felt God's support through prayer, and how that gave them strength to fight the addiction. Other participants shared that "*It has helped a lot to get into one's religion and realize that some things are not okay*" and "*…Allah is my guide*". For these participants, religion and God appear to provide them with behavior guidance to follow. The first participant explains how religion made them realize that their behavior related to addiction was not acceptable, while the other participant perceived God as their guide. Although all three participants used religion as a source of help in a difficult time, it appears that the way religion was utilized was different. The first participant appears to have relied on God as a source of support, while the other participants perceived religion to provide guidance for acceptable behavior.

6.3.3 Life-Impact of Addiction

While most participants kept the addiction to themselves, and some sought alternative help, a few participants did seek professional help. Six participants sought professional help through public treatment centers, three through a psychologist or therapist, while the remaining two sought help through their doctor and prison. The participants had different experiences in treatment ranging from good experiences including self-insight and plans for a crisis, while others quit their treatment early.

The ones that did seek professional treatment appeared to differ from participants in perceived severity of addiction. In the survey, the participants were asked to rate the severity of the impact of the addiction on different aspects of their lives such as education, finance, health, social relations and more. Both the Mann-Whitney U test and the Pearson correlation test resulted in significant results regarding professional help-seeking and severity of the impact that the addiction had on the participants' lives. The Mann-Whitney U test suggested a difference between participants that sought professional help and those who did not regarding the impact that the addiction had on their lives. The group that did seek professional help had rated the addiction to have a greater impact on their lives compared to the other group. Moreover, the Pearson correlation test indicated a positive correlation between impact of addiction and professional help seeking. This suggests that higher perceived impact of addiction was associated with a greater likelihood of seeking professional help. These results correspond with some of the responses provided by the participants, where one participant shared that they would only seek professional help if "*That I ended up in deep shit*". This suggests that the participant would seek help if the addiction became too difficult to handle. Furthermore, one participant, who did seek professional help shared that "*I was afraid of prejudice, so I didn't seek help, until I was trapped in it, then I sought help***".** Here, the participant shares that although they did not prefer to seek professional help based on their fear of prejudice, they eventually did when they felt "trapped" by their addiction. These statements in addition to the results of the statistical analyses point to the decision to seek professional help to be partly affected by the severity of the impact of addiction on various aspects of their lives.

7. Discussion

As previous European and North American studies (Aarestad et al., 2023; Benjaminsen & Enemark, 2024; Calado & Griffiths, 2016; Caler et al., 2017; Elkassen & Csiernik, 2020; Grant & Chamberlain, 2023; Masson et al., 2012; Nabben, Weijs & Van Amsterdam, 2021; Reid et al., 2016) have shown repeated and continuous indications of disproportionate utilization of treatment for addiction among ethnic minorities, this thesis aimed to explore the topic further. Due to limited research leading to substantial research gaps in a Danish context, this thesis explored which factors influenced professional help-seeking attitudes and behavior among ethnic minorities with substance- or gambling addictions in Denmark. Furthermore, it sought to explore the roles of subjective experiences of discrimination, self-stigma, life-impact and other factors related to avoiding professional help-seeking.

This discussion will begin by presenting results based on the hypotheses made earlier, which will be related to previous literature. Here, the discussion will investigate findings related to mistrust and cultural models, impact of addiction, self-stigma and perceived discrimination, and present additional findings. This will be followed by methodological limitations and reflections, where included scales, data collection method and recruitment will be discussed. The discussion will then consider practical implications of the findings, suggest further research and present the contribution of this thesis.

7.1 Hypotheses and Previous Research

Four hypotheses were proposed that aimed to answer the research question and sub-questions. These hypotheses were based on previous research and included theoretical frameworks. In this section, the thesis findings will be presented and related to previous research, and the findings will be considered in relation to the four hypotheses. Furthermore, additional findings, which were not related to the four hypotheses, will be presented.

7.1.1 Mistrust and Cultural Models

The first hypothesis (H1) proposed in the thesis predicted that mistrust of professional treatment and culturally different understandings of illness and health would be negatively associated with professional help-seeking attitudes and behaviors. This

hypothesis was based on previous research identifying mistrust and cultural differences as important barriers to treatment among ethnic minorities. Concerns regarding confidentiality breach and mistrust in professional services have been widely documented among ethnic minorities in previous research (Elkassem & Csiernik, 2020; Mantovani & Evans, 2018; Masson et al., 2012; Reid, Crofts & Beyer, 2001). Similar concerns emerged in the qualitative responses of the present study, where participants expressed doubts about whether professionals would maintain confidentiality regarding their addiction.

Previous studies have also identified skepticism towards the usefulness of treatment programs as a significant barrier to help-seeking (Gainsbury et al., 2013; Gunstone & Gosschalk, 2020; Nabben, Weijs & Van Amsterdam, 2021; Reid, Crofts & Beyer, 2001). This finding aligns with responses from the multiple-choice question in the survey asking about treatment barriers. Here, the lack of faith that professional treatment would be beneficial was the most frequently chosen barrier. Additionally, participants described perceived differences in values and worldviews between themselves and professionals, which has similarly been reported in previous literature (Bansal et al, 2022; Hassan et al., 2025; Nwokoroku et al., 2022; Prajapati & Liebling, 2022). Some participants also described discouragement from family members regarding professional treatment, reflecting findings from earlier studies suggesting that mistrust and cultural differences may influence help-seeking through social networks and community expectations (Prajapati & Liebling, 2022; Aguirre Velasco et al., 2025).

Another recurring finding concerned reliance on alternative sources of support. Earlier research has shown that ethnic minority individuals may seek help from family members, friends, religious leaders, or community networks instead of professional treatment services (Kwok, 2000; Mantovani & Evans, 2018; Nabben, Weijs & Van Amsterdam, 2021; Reid, Crofts & Beyer, 2001). Similarly, participants in this study reported reliance on alternative support networks, including family, friends, partners, and religious communities, rather than professional treatment services. This suggests that alternative support networks may play a central role in help-seeking strategies among ethnic minorities with addiction.

Overall, the survey findings broadly aligned with patterns identified in the reviewed literature. Through the theoretical perspectives of explanatory models and the CDHS model (Arnault, 2009; Kleinman, 1988, 1995), these findings may indicate

that participants avoided professional treatment due to culturally specific understandings of addiction, illness, and recovery. Importantly, mistrust extended beyond doubts about treatment effectiveness and also involved fears of disclosure and breaches of confidentiality. In the analysis, these concerns were closely connected to participants' experiences of shame and fears of damaging family honor. Drawing on Arnault (2009) and Link and Phelan's (2001) theory of stigma, this may reflect anticipated negative social consequences and attempts to avoid status loss within their social communities. Thus, the findings provide support for H1, suggesting that mistrust of professional treatment and differences in culturally specific understandings of addiction and recovery may act as barriers to professional help-seeking among ethnic minorities in Denmark.

7.1.2 Impact of Addiction

Previous research has indicated a tendency to postpone professional help-seeking among ethnic minorities until the addiction has become unmanageable. This is shared by participants in other studies (Kwok, 2000; Lidster & Cannon, 2013; Masson et al., 2012) and reflected in the overrepresentation of ethnic minorities in compulsory hospitalizations in Denmark (Baez et al., 2007). These findings led to the second hypothesis, which proposed that higher perceived life impact of addiction is associated with a higher likelihood of professional help-seeking. Participants in the survey reported experiencing moderate to high levels of impact of the addiction on various aspects of their lives. The Mann-Whitney U-test generated a significant result, suggesting that the group that had sought professional help experienced a greater addiction-related impact on daily life. Similarly, the Point-Biserial correlations test provided a significant positive correlation between impact of addiction and professional help-seeking. This finding corresponds with previous studies (Kwok, 2000; Lidster & Cannon, 2013; Masson et al., 2012. This suggests that professional help-seeking may be partly driven by the perceived severity and life impact of addiction, thereby supporting H2.

7.1.3 Self-Stigma and Perceived Discrimination

The literature review presented findings that indicated that self-stigma and perceived discrimination could play a role in the decision to seek professional help (Nwokoroku et al., 2022; Prajapati & Liebling, 2022; Aguirre Velasco et al., 2025).

Based on previous findings identifying self-stigma as a barrier to help-seeking, as well as theoretical perspectives proposed by Corrigan et al. (2009) and Wade, Vogel and colleagues (Hackler et al., 2007), the third hypothesis (H3) could be formulated. This hypothesis expected that higher levels of self-stigma would be associated with lower likelihood of professional help-seeking. Similarly, drawing on findings related to discrimination and Link and Phelan's (2001) theory of anticipated devaluation, H4 proposed that subjective experiences of discrimination would be negatively associated with professional help-seeking among ethnic minorities with addiction. Self-stigma and perceived discrimination were found at a moderate level among the participants, suggesting that participants did experience self-stigma and perceive discrimination. However, the sample size was insufficient to provide adequate statistical power to reliably test the relationship between the scales and professional help-seeking. Consequently, no significant statistical results were found regarding the relationship between professional help-seeking and self-stigma and perceived discrimination. Consequently, the findings did not provide support for H3 or H4.

7.1.4 Additional Relevant Findings

While the study supported H1 and H2 and did not support H3 and H4, several additional findings were important for understanding participants' help-seeking attitudes and behavior. The survey's findings showed that merely 16.25% of the participants who admitted to having a gambling or substance addiction sought professional help. While several studies suggested an underrepresentation of ethnic minorities in professional treatment (Benjaminsen & Enemark, 2024; Braun et al., 2014; Elkassen & Csiernik, 2020; Gunstone & Gosschalk, 2020; Masson et al., 2012; Nabben, Weijs & Van Amsterdam, 2021; Okuda et al., 2016; Reid et al., 2016; Ronzitti et al., 2016), this finding suggests that only a small proportion of participants reporting addiction had sought professional help. Together, these findings indicate a substantial treatment gap between need and service utilization. Participants frequently linked avoidance of professional help-seeking to feelings of shame, which was the second most frequently reported treatment barrier. Shame was similarly found to be a barrier for professional help seeking in the reviewed literature (Allen, 1995; Kwok, 2000; Lidster & Cannon, 2013; McCann et al., 2017; Nabben, Weijs & Van Amsterdam, 2021; Nwokoroku et al., 2022; Aguirre Velasco et al., 2025), suggesting that shame plays a significant role in avoidance of help-seeking. Among participants who had not

sought professional help, most also reported that they had not sought alternative forms of support. The large proportion of participants managing addiction alone was an unexpected finding that was not prominent in the reviewed literature. Participants explained this self-reliance through mistrust, fear of disclosure, and beliefs that addiction should be handled independently. This was partly interpreted through Arnault's (2009) concept of social context dynamics, in which social norms encourage concealment of addiction. Furthermore, drawing on Rose (1998; 1999), the finding may also reflect forms of self-governance in which addiction is understood primarily as an issue of personal responsibility.

7.2 Methodological Reflections and Limitations

Given the sensitivity of the research topic and the challenges associated with recruiting participants from the target population, several methodological considerations had to be taken into account in relation to data collection and recruitment strategies. Despite employing multiple recruitment approaches, the survey did not obtain a sufficient number of respondents to achieve adequate statistical power for all intended analyses. This section therefore reflects on the methodological decisions made throughout the project and considers how these may have influenced the findings. It will first discuss the scales utilized in the survey, followed by reflections on the use of surveys as a data collection method, before considering the recruitment strategies and how these may have influenced the composition of the participant group.

7.2.1 Scales

The survey included the Everyday Discrimination Scale (Williams et al.,1997), which is a validated and frequently used scale in measuring subjective experiences of discrimination. This was not the case for the scale measuring self-stigma. This scale was inspired by the theoretical framework proposed by Corrigan and colleagues (2009) and a systematic review by Douglass and colleagues (2025). The scale had a high internal consistency (Cronbach's alpha=.812), but was not a validated scale, which limits the interpretability and generalizability of the results.

Statistical tests measuring the relationship between professional help-seeking and self-stigma or perceived discrimination had to be conducted with unequal groups. In addition to the groups being unequal in size, one of the groups had a low sample size of five or six participants. The statistical analysis testing the relationship

between professional help-seeking and self-stigma as well as subjective experienced discrimination therefore had limited statistical power. Although no reliable statistical analyses could be conducted regarding self-stigma and subjective discrimination experience, descriptive statistics pointed to a moderate score on both scales. These moderate mean scores on both scales point to a presence of self-stigma and perceived discrimination, which could be useful in understanding the participants. Furthermore, the project placed interpretive priority on the qualitative material, which offered more useful data, due to limitations within the quantitative material. The qualitative data, as well as significant results from the quantitative data, were used to interpret attitudes, experiences and help-seeking behavior among the participants.

7.2.2 Data Collection Method

Data was collected using an anonymous survey, where participants responded to questions from both a qualitative and quantitative component. The anonymous survey as a data collection method creates several limitations. One limitation involves the inability to collect in-depth answers, which would have been more likely if an interview was conducted. With the use of a semi-structured interview, follow-up questions would have been possible, and it may have generated responses that could have been clarified further. Responses given in an anonymous survey may therefore have been misunderstood or taken out of a context which was not provided by the participant. The survey furthermore creates an inability to include observations of nonverbal information, which could have contributed information about signs of discomfort, or positive or negative feelings. However, the survey made it possible to measure the scores of the participants on the included scales. Additionally, anonymity may have led to an inclusion of individuals who would not have participated if the data collection method did not provide anonymity, increasing accessibility for stigmatized individuals.

By using an anonymous survey, participants are asked to self-report. This may also generate some limitations which could have been relevant in the interpretation of the answers. Self-reporting in a sensitive survey involving actions or attitudes that are illegal or perceived as shameful can result in a social-desirability bias (Krumpal, 2011). This is especially relevant for a survey involving addiction, which, as previously mentioned, is associated with shame and stigma. The survey thus may have generated inaccurate answers, caused by the participants' concerns about self-

presentation leading to underreporting of socially undesirable behaviors or attitudes. Carlo C. DiClemente and colleagues (2004) wrote a review investigating readiness and stages of change in addiction treatment. They found indications of a pattern of underestimation of the problem, overestimation of readiness to change and a tendency to tell the treatment provider what they believe is expected of them among individuals with addiction. This could be a relevant factor of the social-desirability bias, since participants might experience an outside expectation of behavior change regarding the addiction. They may therefore avoid disclosing their ambivalence about treating the addiction or continued engagement in gambling or substance use.

7.2.3 Recruitment and Participants

In the recruitment of participants for the survey, online and physical posters were designed. The posters included a question in the title asking: "*Do you have, or have you had, an addiction to substances or gambling?*". The formulation of this question might have had an impact on which participants decided to participate. In order to participate in the survey, the individual would have to agree that they have an addiction to substances or gambling. This excludes individuals that may experience problem-gambling or abuse substances, but do not perceive it to be severe enough to label it an addiction. This may suggest that the individuals who proceeded to participate in the survey were individuals who had reached an acknowledgment that they had an addiction. The survey may therefore have excluded participants who have not reached this acknowledgment. This may explain why denial was not a prominent treatment barrier in this survey, like it previously has been (Masson et al., 2012). Furthermore, the sample may not be representative of the population of minority ethnic individuals with gambling and substance addiction. Besides the possible exclusion of individuals who have not labeled their problem as an addiction, the survey may not include the individuals who are more severely affected by their addiction. These individuals may not have the energy or capacity to participate in a survey. The exclusion of these participants might have led to an overlooking of barriers, attitudes or experiences by individuals who are severely impacted by the addiction.

The recruitment strategies applied during the requirement phase mainly consisted of social media, the snowball effect and posters. These strategies may have influenced the sample. Firstly, recruitment through the social media platforms such as

Facebook and Instagram may have favored individuals who frequently use social media and are comfortable participating online. This could have excluded the older population, which may explain the mean age of 24.5 in the sample. Furthermore, it could also have resulted in the exclusion of immigrants and individuals who may not be comfortable responding in written Danish. Surveys posted on Facebook are also usually shared by friends and acquaintances and may therefore not reach a larger geographical area. This obstacle was attempted to be overcome through sharing the survey through an Instagram account with a large national following. Secondly, recruitment through the snowball effect also has its limitations. Individuals who are reached through the snowball effect may again be located in the same geographical area. They may also have similar attitudes and backgrounds, due to having a relationship with the individual who contacted them. Finally, posters hung in educational institutions and a youth club also favor young individuals. These recruitment strategies may partly explain the demographic composition of the sample, which consists mostly of young individuals. Moreover, most of the individuals who participated in the study shared a Middle Eastern background (58.8%), while the ethnic background of the remaining participants was relatively scattered. This may be explained by the snowball effect and the use of Facebook as recruitment strategies. All strategies of recruitment additionally could mean that highly isolated individuals are not represented in the sample. Participants willing to complete an anonymous survey may differ systematically from individuals experiencing more severe stigma or social isolation. The findings thus cannot be generalized to all ethnic minorities in Denmark due to the exploratory nature of the study, limited sample size, self-selection in recruitment and general recruitment strategies applied.

7.3 Practical Implications

The analysis found several cases of cultural misunderstanding being a barrier to seeking professional help. Some participants shared that they did not believe an ethnically Danish professional would be able to understand them, while others preferred a mental health professional with a minority ethnic background. This appeared to reflect expectations of cultural misunderstanding. Hvenegård and colleagues (2005) presented similar findings, where patients and treatment providers recommended more ethnically diverse addiction treatment providers. The cultural barrier might also

be reduced through training in culturally sensitive practice. This could include theoretical frameworks such as the one presented by Kleinman and colleagues (2006) about culturally specific explanations of illness and health. It could also include theoretical models such as The Cultural Determinants of Help Seeking model by Arnault (2009), in order to better understand the process of help seeking for ethnic minorities.

Several participants emphasized their wish to receive help from people they know, rather than receiving it from professionals who they perceived as strangers. These findings may suggest that, in some cases, involving family members in treatment could strengthen support. Family members could be provided with tools to help the patient. However, this would need to be balanced against concerns regarding confidentiality and stigma. Other participants also shared their wish to get acquainted with the treatment provider, suggesting that outreach initiatives could improve familiarity and trust. One participant argued that it would help them seek help if they could sense who the professionals were.

The qualitative component received several responses from participants who were worried about disclosure of their addiction and did not trust that confidentiality was upheld by professionals. This concern was also found in several other studies (Elkassem & Csiernik, 2020; Mantovani & Evans, 2018; Masson et al., 2012; Reid, Crofts & Beyer, 2001) and appears as a prevalent barrier to professional help-seeking. While some participants were worried that this would damage their family honor, other participants worried that it would be used against them in the future. Some also worried that it would affect their career. These concerns have also been identified in other studies and appear to be other prevalent treatment-seeking barriers (Mantovani & Evans, 2018; Masson et al., 2012; McCann et al., 2017; Nabben, Weijs & Van Amsterdam, 2021). This barrier might be addressed through greater access to confidential or partially anonymous treatment services. It might lead to more people seeking professional help without fearing that it would negatively affect their lives in the future. Due to mistrust of the professionals, one participant shared that it would help them if they got to choose their treatment provider. This might encourage some individuals to seek professional help due to the ability to choose the treatment provider they feel that they can trust.

7.4 Future Research

In the qualitative component of the survey, several participants provided responses which could be investigated further. As the method chosen for data collection was an anonymous survey, it was not possible to ask follow-up questions to the participants. In-depth answers were therefore not possible to obtain. Some participants briefly shared that they had a mistrust of professionals, which appeared to originate within family. This could be investigated further, in order to gain an understanding of the process in which the participant has developed a mistrust of professionals. Furthermore, an unexpected finding had to do with how many participants chose to deal with the addiction alone. Some participants shared attitudes stating that they believed addiction was a condition that needed to be solved alone. The analysis interpreted this as a possible example of self-governance inspired by a theoretical framework by Rose (1998; 1999). This could also be investigated further, to gain a better understanding of the origin of this attitude. This may be done through semi-structured interviews which leave space for follow-up questions. Furthermore, a narrative framework with a focus on self-reliance and mistrust of professionals could be beneficial to achieve a more holistic understanding.

Several participants reported using religion in order to achieve support or guidance. Some of them shared their belief that professional help would not be beneficial for them, viewing religion as sufficient support. The analysis interpreted experiences by the participants who sought help through religion differently. It suggested that while some perceived God to be a source of strength and support, others viewed religion as a guide to avoid immoral behavior. Experiences by religious people who also have addiction could be explored further. It could be beneficial to gain a better understanding of the experience of using religion as a source of help when dealing with addiction. Substance use and gambling are often regarded as sinful or morally problematic within many major religious traditions and it may be suitable to investigate if and how this relates to feelings of shame. Some studies have presented findings which indicated that Muslims could experience an added layer of stigma due to addiction being associated with a loss of the Muslim identity (Elkassem & Csiernik, 2020; Nabben, Weijs & Van Amsterdam, 2021). It could be possible that the turn to religion may also function as a strategy for avoiding status loss (Link & Phelan, 2001) and maintaining or reclaiming religious identity. This may be investigated

through a similar mixed methods approach to the one applied in this project. The experience of stigma as a religious individual with addiction could be explored through a scale inspired by Corrigan's theory on the process of self-stigma (Corrigan et al., 2009). This could be conducted similarly to how it was in this project, with the inclusion of Awareness, Agreement and Application. Additionally, semi-structured interviews could be conducted in order to achieve a greater understanding of their turn to religion and experience of self-stigma.

7.5 Contribution

Literature on addiction among ethnic minorities in Denmark was generally limited. The study found which was most similar to this project was the study by Hvenegård and colleagues (2005). This study found barriers to professional-help seeking among ethnic minorities with drug addiction that resembled findings from international research. However, the existing Danish literature leaves substantial gaps regarding gambling addiction among ethnic minorities, as well as professional help-seeking behavior related to addiction more broadly. By including both substance- and gambling addiction, this thesis contributes exploratory insights into an area that has received limited attention in Denmark. The findings suggest that only a small proportion of ethnic minorities reporting addiction had sought professional treatment, indicating a potential treatment gap between need and service utilization. Furthermore, the project contributes insight into the barriers that may influence professional help-seeking among ethnic minorities in Denmark. These included mistrust of professionals, culturally shaped understandings of addiction and recovery, stigma and reliance on alternative support systems. The findings additionally suggested that many participants dealt with addiction without seeking either professional or alternative support, which was a particularly notable finding that was not strongly reflected in the reviewed literature.

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