



Addiction and Lifestyles in Contemporary Europe: Reframing Addictions Project (ALICE RAP)

Professional Images

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GLOSSARY WITH ABBREVIATIONS AND TERMS USED:

ED – Eating Disorders are illnesses defined by abnormal eating habits that may involve either insufficient or excessive food intake to the detriment of an individual's physical and mental health. Bulimia nervosa and anorexia nervosa are the most common specific forms of eating disorders. Other types of eating disorders include binge eating disorder and Other Specified Feeding and Eating Disorders (OSFED), where a person may present with many of the symptoms of other eating disorders, but will not meet the full criteria for diagnosis of these disorders.

Interactive constructs – The Canadian philosopher Ian Hacking (1999) distinguishes between two kinds of social constructions: indifferent and interactive. Indifferent constructions do not affect the objects of conceptualisation, while interactive constructions interact with peoples' conceptualisations. For example, excessive alcohol drinking becomes something different depending on perceptions of the drinker as a sinner, a criminal, or a sick person. In this case the perception is the interactive construction.

Macro-social factors/dimension – In the Polish analysis: reference to the explanations that are tied to the macro level of society (e.g. populations, public systems, policies that are connected to the problems).

Micro-social factors/dimension – In the Polish analysis: reference to the explanations tied to the micro-level of society (e.g. home, family, personal interaction etc.).

New Public Management (NPM) – A bundle of governance and management methods that have increasingly been introduced in the public sector in European welfare societies since the 1980s. NPM is a broad term for different governance and management ideas where many notions and philosophies are directly borrowed from the business world. The aim is often to make the public sector more efficient and more adapted to the market.

RAY – One of Finland's gambling monopolies. Raha-automaattiyhdistys (the society for slot machines)

Sobering station – service for severely intoxicated people, often taken from the streets by the police or municipal police (POL)

TCs – Therapeutic Communities (Italy) are participative, group-based approach to long-term mental illness, personality disorders and drug addiction. The approach was usually residential, with the clients and therapists living together, but increasingly residential units have been superseded by day units. It is based on milieu therapy principles, and includes group psychotherapy as well as practical activities.

Totolotek – name of a lottery game in Poland

VLT—Video Lottery Terminal



ABSTRACT

The objective of this study is to inquire the ways in which different European welfare states deal with alcoholism, compulsive gambling and eating disorders (ED). This is studied through the perceptions of these problems as expressed by two welfare professional groups, General Practitioners (GPs) and Social Workers (SWs), in three European countries: Finland, Italy and Poland. The tasks divisions and institutionalized ways of viewing the problems are assumed to be inscribed into the speech of the three professional groups in each country.

The study shows that **gambling problems are receiving increasing attention in all three countries, but that it is as a problem that is not yet fixed in its institutional place.** In all countries, the three problems were acknowledged to quite a large degree as relating to cognitive sciences. The cognitive sciences seem to have established themselves as authorities in all three problem areas. This was most visible for eating disorders and least visible for gambling.

In all countries we found that **there are a great deal of different social framings of reasons, consequences and ways of addressing the problems.** However, these were articulated in different ways in the different national contexts. In Italy, the family context was more pronounced than in Poland or Finland. In Poland and Finland, the macro level social framing was more common than in Italy among all groups interviewed. SWs tended to explain and view the three problems as complex environmental problems, and by doing so they reflected their professional scope and mandate. GPs paid much more attention to the more physical appearances of the people with the problems.

Neither one of the professional groups studied had had much contact with gambling problems or with ED. GPs in particular had rarely encountered gambling problems, while they saw a more natural scope in eating disorders (especially those that involved fluctuating body weight). In all professional groups the most familiar problem to encounter seemed to be alcoholism. Also, this was a problem area that both SWs and GPs had expertise in.

The study shows how **professional roles “shine through” interpretations of problematic situations of two professional groups, whose daily tasks involve solving problems in one way or another.** The professional roles hold similar traits to those dictated by the system of which they are part. Nevertheless, the professions – placed in certain disciplinary backgrounds, task formulations, and a specific praxis scope – show similarities across the three welfare state systems. This is valuable evidence of **how professions come to shape the agenda and the way problems are understood universally.**

However, to some degree, and in some questions, the national cultural context does indeed shine through in the professional’s discourse surrounding alcoholism, gambling problems and ED. Especially when it comes to deep-seated structures such as the role of the family and church, or the role that society has taken in the regulation of alcohol, for example.



1 BACKGROUND AND INTRODUCTION

Social scientists have expressed increasing concern over lack of methods for grasping new developments in contemporary welfare states. While welfare system and institutional theories offer advanced categorizations of regimes and deep structures, a rather large bulk of new analyses drawing on the New Public Management debate has identified threats to the welfare state's value-based constitution and mandate. A perspective that remains rather under-theorized is one that can be seated in between inquiries into structural system-analyses and ideological developments in viewing welfare state institutions as enterprises that gather, cultivate and generate specific repertoires of ideas that can be traced to their modus operandi and historical and geographical context. This grasp, which can be called a *macro-semiotic* perspective, aims at discerning the ways in which certain institutional and societal circumstances tie in with certain perceptions and understandings of the questions on the welfare state agendas.

In this study we are interested in institutional and professional trajectories. By that we mean that a problem will be dealt with in a certain way depending on the institutional setting that it is propelled into in any given society. For example, if a person suffers from alcoholism he will be grouped and treated in one way in the USA and in another way in Finland (see e.g. Hellman & Room 2014). Every system and culture comes together with a bundle of ideas and categories – general and typical understandings – of what the world looks like, what problems are all about and how they should be dealt with. The object of study in this report is the perceptions of addictive behaviours that are tied to, channelled through, and reproduced in two professional groups' discursive work. We studied how General Practitioners (GPs) and Social Workers (SWs) view alcoholism, gambling problems and eating disorders (over/compulsive/ binge eating) in three national welfare cultural contexts: Finland, Italy and Poland.

Comparative research designs are rarely able to embed a relation between culture and institutions. Often, comparative qualitative designs lean on descriptive national reports (e.g., Gómez & Kuronen, 2011; Wrede et al., 2006); and are concerned with configurations in particular systems (political, administrative, economic, legal etc., see Hantrais, 1999, p.101). While previous comparative designs typically describe national contexts and then make comparisons between descriptions (e.g. Hellman et al., 2012), our strategy in this study has been to study the views that the systems produce through the discursive work and the positions that the professional groups take in relation to problems of alcoholism, gambling problems and eating disorders (EDs).

Notions of communication about and societal reactions to behaviours reflect a idea world repertoire that is underpin and permeate society (Leuwen, 2005). Societies and countries are by no means closed idea world repertoires in today's world. However: they have shown to involve conceptual repertoires that are identifiable and traceable to their historical, cultural and geographical circumstances. Research has shown that the comparison of these conceptual repertoires is a productive strategy for identifying and explaining cross country variations in dealing with key questions: Ideas and concepts surrounding addiction problems in lay people, welfare professionals, and the mass media



have shown to correlate with basic repertoires in institutional settings (e.g. Egerer, 2014; Hirschovits-Gerz, 2014; Hellman et al., 2014)

Our technique of tying together conceptual dimensions (the conceptualisations expressed by the professional groups) and institutional arrangements (seeing the professional groups as representing systems that deal with the question under study), and comparing both levels between and within countries, constitutes a new research methodological contribution, especially as we have chosen to use film clips as stimulus texts in the focus group discussions. The strategy takes advantage of the fact that societies (including the professional groups assigned responsibilities in them) will inevitably articulate and act upon interactive constructs tied to the problems on their agenda (Hacking, 1999) and that they do so according to certain perceptible and comparable patterns. We asked the group of professionals under study (General Practitioners GPs and Social Workers SWs) to freely discuss short film clips concerning the problems that we wanted their spontaneous discursive framing of. This technique is called the Reception Analytical Group Interview (RAGI) method. As the researcher involvement is minimal, the method allows for qualitative research to produce comparable data sets from different countries.

We have mapped the overall trends found in our material. This report begins with background descriptions of the institutional and professional contexts and rationales in Social Workers' (SWs) and General Practitioners' (GPs) dealings with alcoholism, problematic gambling and eating disorders (EDs) in the different countries. This serves as a backdrop for the institutional setting in which we find the views presented by the professional groups. After that, we account for the empirical analyses (i.e. what they actually say and think). Finally, we draw conclusions from our inquiries regarding how institutional and national settings in different European countries underpin the ways in which addiction related problems are viewed and handled.

2. INSTITUTIONAL AND PROFESSIONAL CONTEXTS

FINLAND

GPs and SWs alike are in Finland mainly employed by the municipalities, which provide the overall national public health and social care services. There is a growing number of private health care providers (offering occupational health care), which, however, are organised similarly to health centres, with a rather large number of employed physicians and high turnover of employees. Given the way that primary health care is organised, GPs can seldom establish long-term relations with their patients and see them only as individual medical cases (in comparison to e.g. French or Danish family physicians, who have continuous contact over time and often also have contact with other family members). GPs do not receive any special education in addiction, but are obliged to attend continuous education (where addiction can be a topic). Similarly, the ordinary social workers (welfare workers) do not have specialised knowledge on addiction. Instead, social case workers are active in the 'A-Clinics'. A-Clinics are outpatient treatment centres specialised in addiction problems, and led by specialised social workers. The involvement of physicians in these centres is rather limited (Ahonen, 2007).



The overall objective of the work in the social field of the public sector, in accordance with the constitution, is to guarantee *all citizens* the right to services that ensure a dignified human life. It is important to emphasize that “all citizens” as the universal base of the Finnish welfare system is typical in Nordic countries. The tasks of the social sector are to steer, advise, support, nurture, care and educate (Public employment and business services, job descriptions, <http://www.ammattinetti.fi/ammattialat>.) The field of social work comprises helping people who live in the most difficult circumstances and to help prevent and alleviate suffering on the individual, community and societal levels. (Horsma & Jauhiainen, 2004).

Kallinen-Kräkin (2001) has described the aim of social work as that of acknowledging the client as a human entity in interaction with a context, with different roles and life environments. On the level of the social worker and client relationship, the main task consists of a professional, interactive, process aimed at problem-solving, and which should take as its departure point the identification, definition and evaluation of problems concerning the individual, family, and social contexts. The client is to be seen as a psychological, physical and social entity in his/her living environment. The viewpoint of social work is the human in his/her environment and the target of the social work is the relationship between the human and his/her environment. (Kallinen-Kräkin, 2001)

Regarding the education of medical doctors, lifestyle-questions of alcohol and food are integrated in the study curriculum at university, and there are also separate courses available in alcohol medicine specifically. An example of information integrated in the general curricula is that courses on cancer include both alcohol-, tobacco- and food – related behaviour and physical harm. In order to complete the medical doctor’s final exam (1st degree before the specialization), there are several compulsory courses in which students learn to identify the most basic psychiatric dysfunctions and learn the most basic treatment principles as alongside learning about the regular functions of the mind and the main psychological and biological processes. In the advanced studies the student can choose to study addiction medicine, in which emphasis is put on alcohol, legal and illegal substances, nicotine, identifying risk, complications due to problematic excessive use and different types of treatment. (University of Tampere, School of Medicine, Curricula Guides 2013-2014).

Being a dry drinking culture (meaning a tendency for drinking to intoxication) with high alcohol consumption people in Finland generally consider **alcohol problems** to represent one of the main threats to society (Hirschovits-Gerz & Koski-Jännes, 2010). The social aspects of these problems have traditionally been viewed as an important part of the alcohol question and have lain at the heart of the country’s alcohol policy (Bruun, 1971). The Finnish alcohol treatment system has typically relied heavily on the non-medical approach and has partly rejected the disease model (Takala & Lehto, 1992). In the non-medical approach, alcohol problems are considered part of the broader society. The problems are handled by nurses and social workers; medical doctors only care for the physical consequences of heavy drinking. Recent research (Pennonen & Koski-Jännes, 2010; Koski-Jännes et al., 2012) into how alcoholism is viewed by Finnish addiction treatment professionals has shown that social workers in the field of addiction treatment



(whom we refer to here as ‘social caseworkers’; see Satka, 1995) largely follow a moral and enlightenment model of helping and coping (see Brickman et al., 1982). They understand substance dependence mainly as a learned means of coping, a dysfunction of emotional life and, to some extent, as a socially conditioned lifestyle (Pennonen & Koski-Jännes, 2010). There is, however, only limited knowledge about how alcohol problems are conceptualized by social workers who work in a practice setting that is not focused on addiction problems (Bliss & Pecukonis, 2009), here referred to as ‘welfare workers’ (following Satka, 1995). Finnish welfare workers have to deal with problems caused by drinking on a daily basis. Working closely with schools, the police and other authorities, their assignments include following up on the state of the problems, assessing the need for support in families of alcoholics and any need to take children into custody, and organizing and executing the required measures (Gaslander & Östergren, 1982; Hall et al., 2000; Kallinen-Kräkin, 2001).

SUMMARY: alcohol in the Finnish system

- * GPs rarely have long continuous relationships with their clients and their families (in comparison with e.g. French and Danish GPs)
- * GPs are rarely specialized in addiction problems
- * GPs take a comprehensive ecological view on their clients’ health, and are trained to be sensitive to environmental circumstances and life situations of the client.
- * Alcohol in Finland is generally viewed as part of a broader problem tied to a Northern drinking culture and pattern.

As GPs are specialised “health workers”, One could expect that **problem gambling** (without any physical manifestation of symptoms) would be a very remote issue for their everyday praxis. SWs, on their part, are directly concerned, and assume a responsibility to clear out their clients’ financial situation. This, one would assume, make them naturally aware of problems tied to problem gambling. As in the cases of protecting children of problem drinkers, gamblers and eaters, SWs also have a remit to intervene in problem gamblers’ financial autonomy if the behaviour start to interfere with the clients’ and the client’s family’s welfare and health (Egerer et al., 2012; Egerer, 2013).

Gambling is a common thing to do in Finland and it is possible to play on slot machines and buy lottery tickets virtually at every corner; ca. two billion Euros are spent yearly on gambling by the Finnish population (Nikkinen, 2014). Finland has the biggest per capita expenses for gambling in the EU and about ¾ of the whole population indicated having gambled at least once during the last year (Valkama, 2006). In particular, slot machines are widely available, for example, in supermarkets and gas-stations (Jävinen-Tassopoulos, 2012). These non-casino slot machines are, together with lotteries, the most popular forms of gambling (Turja et al., 2012). There are three gambling monopolies in Finland: RAY for slot machines and casino(s)¹, Veikkaus for lottery and sports betting, and FinToto for horse race betting. Gambling profits have to be used for charitable causes, for national

¹ Currently the casino in Helsinki is the only one in the whole of Finland (mainland). There are plans to open a second casino in south-east Finland, close to the Russian border and targeted at Russian tourists. The autonomous Åland Islands have their own gambling monopoly (PAF) with one casino in Mariahamn, though the majority of PAF’s gambling activity happens in the Internet or on the Ferries between Finland and Sweden, and Sweden and Estonia.



defence, and on reducing gambling problems (i.e. treatment, research, prevention) (Nikkinen, 2014). The success of promoting the charitable work of the gambling monopolies can also be seen in recreational gamblers' positive attitudes towards the Finnish monopoly system (Pöysti, accepted).

An estimated 5.5 % of Finns over 15 experience gambling related problems at least sometimes (SOGS 3-5) (Jaakkola, 2009). These problems have a negative impact on nearly one fifth of the Finnish population (Salonen et al., 2014).

There is no specialised treatment system for gambling problems in Finland. Problem gamblers receive support and care through social and public health services, and in specialised services targeted at problem gamblers. The latter types of services are mostly produced by the third sector, separately or in cooperation with the municipalities. In particular, municipalities' basic services – in which both non-specialised social workers and general practitioners are included – play a growing role in identifying and bringing to light gambling problems (National Institute for Health and Welfare, online <http://www.thl.fi>).

The municipality has the overall responsibility for the treatment of gambling problems. According to the treatment services report from 2011 by THL (National Institute for Health and Welfare), gamblers are likely to be helped by or come in contact with the following professionals through the municipalities' services: the on-duty employee; the social therapist; the substance abuse worker; the GPs or other medical doctors; the on-duty nurse; substitute social worker (filling in for a permanent position); the district social worker; the practice of the social worker specialized in substance use; nurse; psychologist; on duty employees; on-duty social therapist (National Institute for Health and Welfare, <http://www.thl.fi>).

There is a gambling helpline (Peluuri) and one outpatient treatment programme specifically for problem gamblers (Peliklinikka) in the centre of Helsinki. However, the organisation of help for problem gamblers treatment is mainly provided by the (substance) addiction treatment system in Finland. However, financial limitations and the prioritisation of substance-using clients have tended to limit the places offered to problem gamblers (Sosiaali- ja Terveysministeriö, 2007; Jaakkola, 2009). Municipalities provide in- and outpatient treatment centres. The outpatient treatment service (A-Clinic) has adopted a medical vocabulary (clinic, treatment, therapists), but remains focused on social case work: a doctor is only involved part-time in the clinics, nurses handle treatment focused on withdrawal, but do not stay on night shifts and social workers take the key positions in an A-clinic (Takala & Lehto, 1992; Ahonen, 2007). Inside the A-clinics, the social casework is separated from legal and financial issues and problems (Toikko, 2005). Social workers outside the A-clinics, the welfare workers, in comparison are not included in therapy work, but handle the social problems related to alcoholism (Satka, 1995; Kallinen-Kräkin, 2001). They have to support the alcoholic's family, grant social benefits and if necessary take the children into custody. The division of labour between social caseworkers and welfare workers was more than simply a functional differentiation, but also a matter of social workers' identity, where welfare workers did not accept social



caseworkers as being the same profession, and vice versa (Satka, 1995). Other possible providers of problem gambling treatment are psychiatric clinics, self-help groups and congregations of the Finnish Lutheran Church (Jaakkola, 2009).

In Finland, the non-medical model (Bruun, 1971) seems to be the overall guiding principle, i.e. the social root, harm and treatment of gambling are perceived as important. However, the promotion of the gambling monopoly as charitable probably hinders discussion on a more restrictive, though more protective, gambling legislation in comparison to for example the alcohol question. On the other hand, typically Finnish values such as individualism (Hirschovits-Gerz, et al. 2011). are also visible in perceptions of gambling, as the problem gambler is held responsible for his/her problem and individual skills and competitiveness are important factors tied to gambling competence (Majamäki & Pöysti, 2012; Pöysti & Majamäki, 2013).

SUMMARY: gambling in the Finnish system

- * High accessibility of gambling opportunities
- * Three national monopolies, of which the profit must go to certain charity and charitable areas
- * Specialized treatment arranged by third sector in cooperation with municipality.
- * GPs may be working at treatment facilities (A-Clinics), but the professionals most likely to come in contact with gambling problems are Social Workers.
- * Regarding professional groups who address problem gambling, the social case workers, besides treatment, may also be concerned with dealing with the financial matters, whereas the specialized SWs in treatment will focus more on the scope of the treatment facility (= the addiction problem in itself)

Viewed as an injured relationship between the Cartesian entities of body and mind, **eating disorders** are most usually linked to mental illness, and therefore most of the work to develop treatments and care has been done in the mental health sector (among others: American Psychiatric Association, 2013; Klump et al., 2009)

According to the various action programmes set up to ensure guidelines for the health of Finnish citizens, the responsibility for managing with food intake and eating behaviour rests with a broad range of actors in the Finnish society: both the home, schools, grassroots associations and research institutes as well as agriculture, the media and food safety authorities are charged with promoting healthy food and eating habits (National Nutrition Council, 2003). The Finnish Medical Society Duodecim's guidelines for care of eating disorders recommend multi-professional cooperation from the earliest stages of diagnosis through to the end of treatment (Finnish Medical Society Duodecim, 2009). Both health care and social services contain objectives to obtain diverse multi-professional and multi-disciplinary in-depth knowledge about the client's/ patients' situation (Isoherranen et al., 2008). It has generally been claimed that multi-professionalism yields important added value by opening up different perspectives on the situation in hand (Karila & Nummenmaa, 2001; Payne, 2000; Carrier & Kendall, 1995; Metteri, 1996).



When it comes to the specialised care of EDs, the Finnish system is relatively fragmented. There are three specialised private clinics that provide both outpatient care and more intensive care through day units and 24h units. In addition, there are a few smaller private units that provide outpatient care and that have therapists who work in different parts of the country with individuals who have EDs (Syömishäiriöliitto-Syli, 2014).

In the public sector, patients with eating disorders can be treated on psychiatric wards, somatic wards, paediatric wards, mixed wards and at specialised eating disorder clinics. Three cities (Helsinki, Pietarsaari and Seinäjoki) have public eating disorders clinics with multi-professional staff who provide both outpatient care and more intensive treatment (Syömishäiriöliitto-Syli, 2014). Bigger hospitals with no specialised unit often have an eating disorders team that is convened when necessary, but the care chains and the care itself often vary (Syömishäiriöliitto-Syli, 2014).

When it comes to the professionals' conceptual frameworks, some determining and fixing underpinnings are inherent in the disciplinary backgrounds and the ontologically and epistemologically based roles and tasks; Professional and institutional mandates and accountability are articulated in knowledge and value work embedded in the professionals' operational configurations (see Evetts, 2003).

Social services are charged with providing the necessary advice, support, care and education to ensure all citizens have access to the subsistence and care that is necessary for a life of dignity (Ammattinetti, 2014). The "critical project that is intrinsic to social work" (Gray and Webb, 2009: 111) involves accepting and acknowledging clients as human entities who have different roles and who interact with different contexts and living environments (Kallinen-Kräkin, 2001). Clients should be seen as psychological, physical and social entities in their living environments (Kallinen-Kräkin, 2001). In social welfare legislation, social work is defined as "guidance, counselling and investigation of social problems by professional social welfare staff and other support measures intended to maintain and promote the security of individuals and families, their ability to cope and the functionality of communities." (Social Welfare Act 710/1982, section 18). The point of departure of social work can be defined as understanding the client's current social and cultural situation as well as their life changes, coping in everyday life and human interaction (Metteri, 1996). Interventions shall not only maintain the social security of individuals and families, but also strengthen their capacities to cope independently in society (Raunio, 2000).

When it comes to the role of GPs, many public health programmes emphasize the responsibility of GPs at general health centres and school and student health services in detecting eating disorders and in referring patients to appropriate care (see e.g. National Nutrition Council, 2003; National Institute for Health and Welfare, 2013). GPs indeed play a key role in identifying EDs as well as in supporting patients and persuading them that they need care. GPs will also decide whether patients are admitted for further treatment. For these reasons it has been stressed that GPs must have a sound basic knowledge that will allow them to assess their patients' nutritional status (National Nutrition Council, 2003). This separate mention of the nutritional status is an interesting circumstance since



most EDs do not involve any particularly visible fluctuations in the physical shape of the body (Lähteenmäki et al., 2014). Food intake, eating behaviour and other lifestyle issues are integrated in the medical curriculum at Finnish universities. Courses on cancer care, for instance, include alcohol, tobacco and food-related behaviour and bodily harm. Mental health issues and basic psychiatry are taught in the obligatory curriculum; the licentiate of medicine degree requires some compulsory courses in which students learn to identify the most basic psychiatric dysfunctions, including eating disorders.

Most GPs and social workers in Finland are employed by local authorities, which are responsible for the provision of public health and social services. Health centres – both private and municipal – have high staff turnover rates. It is therefore only rarely that GPs are able to establish long-term relationships with their patients. Instead they see them mostly as individual medical cases, making detection of eating disorders difficult.

SUMMARY: ED in the Finnish system

- * Fragmented treatment and care system.
- * Eating disorders typically categorized under mental health problems.
- * Multi-professionalism is an articulated goal, but GPs are especially mentioned as having the role of detecting such problems. In this, the patients nutritional status is emphasized as an important indicator of problem.

ITALY

SWs and GPs work in separate systems in Italy. Some considerations related to alcoholism are useful to understand the general GPs' views on addiction. GPs have been identified as a weak link in the Italian alcohol prevention and treatment process because of not adopting brief interventions nor, often, motivating patients to turn to specialist facilities (Beccaria & Rolando, 2010). GPs themselves cite several reasons to justify their lack of role: the patients' denial of the problem, the lack of specific training on addiction problems or appropriate knowledge to deal with them and lack of time. Furthermore, it has been noticed that the GP-client relationship is mostly structured "on-demand" rather than "on-initiative"; that is, the doctor has no interest or desire to deal with topics that could bother clients. Lastly, many GPs consider the Local Addiction Services not adequate to treat alcoholics, due to the fact that they were created to treat heroin addicts (although over the years the local services have changed greatly) (ibid.). It has to be considered that although GPs have usually no specific training on addiction problems, many of them have been sensitized to these problems by local associations (mostly Clubs of Alcoholics in Treatment - CATs). Moreover, elderly and catholic GPs in particular have been conditioned by the Church's position on addiction, which was especially influential during the Nineties, when a lot of therapeutic communities were run by religious leaders who were against the medicalization of the problem (that is pharmaceutical treatment) and strenuously promoted the social rehabilitation and re-education as the only solution (Beccaria & Rolando, 2013).

SWs mainly work in social services run by municipalities, other public institutions and social cooperatives. The Framework Law (n. 328/2000) has renewed the system toward a



concept of universality, which takes into account the needs of everybody, not only of ones who have problems with their work situation (as was the case in the past). The legislative competence is at the regional level while the administration is the responsibility of the municipalities (internal or externalised services). SWs do not receive any specific training on addictions, except those working in Local Addiction Services (but they are a minority). In Social Services there are not even specific units for this type of problems, which is then occasionally met in conjunction with other problems (social, economic, etc.) but not considered a matter for the social worker.

Alcoholism is primarily treated in Italy by the public Addiction Services placed at local level. Addiction services are organised in local units - either as autonomous department or part of the Mental Health Departments, depending on the Regional government - where a multidisciplinary team composed of psychiatrists, psychologists, nurses, educators and social workers works. Addiction services have begun to deal with gambling/eating disorders only in recent years, being primarily addressed to traditional substance addictions. Local addiction services were created mainly to address the heroin problem, but when the number of drug users decreased, they started to deal with alcoholics too. In recent years, due to the increased visibility of other addictions - and while the number of alcoholics is decreasing simultaneously - services are also open to “new” problems, such as EDs, gambling, etc. However, clients with these problems are few and not all service units provide this kind of treatments.

As regard to alcoholism, besides public services, Clubs of Alcoholics in Treatment (CATs) are the most widespread self-help groups in Italy. CATs played a very big role in “building a public arena” around alcohol in Italy. “The founder of the CAT movement, the Croatian professor Hudolin, came to Italy during the 1980s, after the 1978 psychiatric reform, when the problem was felt mostly at the community level because no one knew how to treat alcoholics who had previously been detained in psychiatric facilities. As “alcoholology was unknown” in health services, CATs “not only proposed new methods of intervention, but also a new definition of the problem” (Beccaria and Rolando, submitted). In Hudolin’s view there is no a quantity of alcohol that can be considered safe, and the definition of ‘responsible drinking’ is not accepted as the aim of the treatment is the abstinence. In contrast to AA – which is also spread around the country - CATs do not recognise alcoholism as a disease, but define it a lifestyle. Furthermore, they state that this is not an individual problem but a social problem and primarily a problem of a whole family. For this reason, persons in clubs are not only alcoholics but also their relatives.

During the Nineties CATs played the biggest role in “building of a public arena around alcohol” (ibid), raising awareness of the problem with the public and politicians. “By personally contacting health service managers and local administrators, CATs managed to organize awareness-training courses involving alcoholics and their relatives, health-services operators and local administrators” (ibid.). This process led to the approval of the first Italian Framework Law on alcohol (Law 125/01). The result of the alliance between CATs and alcohol units operating in Addiction public services can be considerable (ibid.). The Law formally recognised CATs and stated that public services should operate in



combination with self-help groups; which is what currently happens, according to different working models.

SUMMARY: alcoholism in the Italian system

- * GPs have been described as the weak link in alcohol addiction prevention
- * Alcohol treatment services were originally organized for heroin users
- * A history of church-related Therapeutic Communities
- * Tending towards a more universalistic system
- * Alcoholism treated under the mental health department.
- * Self-help groups are rather widespread

When it comes to **gambling** policy in Italy, a licence-based system has been settled that allows the sale of licenses to foreign operators against a payment of profits to the Italian State (Nikkinen, 2013). Gambling is regulated by the Agency of Customs and Monopolies, and therefore since 2002 by the AAMS (Independent Administration of States Monopolies). The process of legalisation began in 2006² with the Decree-Law 223 (converted into Law no. 248/2006) which has introduced the concept of a “game of skill” and deferred more detailed regulation to the AAMS. Subsequently, there have been numerous regulatory interventions: the Decree of the Minister of Economics (17 September 2007); the Law no.88/2009 which allowed new concessions for public games; the Decree-Law 39/2009, which assigned the gambling proceeds to support quake-hit areas; the Law 220/2010, which aimed to counteract illegal games by strengthening the role of AAMS; the AAMS Decree on 10 January 2011, which regulates (and distinguishes) games of skill and luck; the Law-Decree no. 98/2011, aimed at protecting minors; lastly, and particularly important, the Law-Decree no. 158/2012, which introduces essential assistance levels (LEA) for gamblers, regulates advertisements, and forbids devices for internet gambling in public premises. The Decree also prescribes risk labels and informative materials prepared by health institutions in gambling venues, and states that these venues must be far from schools, hospitals, and churches, and forbidden to minors. Gamblers and traders operating outside of the legal requirements can be punished with imprisonment and fines (Molinari & Chiellini, 2013).

The liberalisation has resulted in a considerable growth in the amounts gambled: 17.32 billion euros in 2002, 61 billion in 2010 and almost 80 billion in 2012 (AAMS, 2012). Compared to 2004, the total income from gambling has increased by 251%, while in the same period the Government revenues have increased only by 11%. The most widespread games are slot-machines, video-lotteries, poker and online casinos, lotteries and particularly instant lotteries (Report to the Parliament, 2013). According to Eurispes (2011) the gambling market reached 79.9 billion euro in 2011, compared to 47.5 billion in 2007 and 15.5 billion in 2003, in spite of consumption and savings of Italian families being reduced in the same period (ISTAT, 2012).

² According to other sources (Croce et al. 2009 as quoted by Nikkinen, 2013) 1992 represents a turning point towards gambling liberalisation and also corresponds to financial crisis due to the public debt



In 2013 the Department of Anti-Drugs Policies³ (DPA) published and circulated a manual on problematic and pathologic gambling, the first national document of this kind. The DPA is part of the Presidency of the Council of Ministers, and represents a reference point for the Ministries (Minister of Labour and Social Policies, Minister of Health, Minister of Justice) and other government departments, as it is responsible for the coordination of actions against the spread of addictions and for the monitoring of the phenomenon (see also Beccaria & Rolando, 2013). The manual is primarily addressed to the Local Addiction Services⁴, which are clearly indicated as the services primarily responsible for gamblers' treatment (although GPs are also cited as potential early-detectors of the problem). Addiction services are organised in local units - either as an autonomous department or part of the Mental Health Departments, depending on the Region - where a multidisciplinary team works composed of psychiatrists, psychologists, nurses, educators and social workers. Addiction services have begun to deal with the gamblers only in recent years, being primarily addressed to traditional addictions (drugs and alcohol).

In the Manual, as well as in the annual Report on addiction to the Parliament (DPA, 2013), it is stated that reliable and longitudinal data on gamblers in Italy are not available, however estimated problematic gamblers represent 1.3% to 3.8% of the general population, while the pathologic gamblers represent 0.5% to 2.2% (Ministry of Health, 2012)⁵. According to IPSAD, based on the Canadian Problem Gambling Index, low-risk gamblers are 11% of total gamblers, that is 2 million people, those at moderate risk represent 4,3% and are around 800,000 people, while problematic gamblers are 1,3% of total gamblers (Molinaro & Chiellini, 2013).

A national monitoring system (Osservatorio) has recently been established by Law 158/2012 (Balduzzi Decree), located within the Agenzia delle Dogane e dei Monopoli (Customers and Monopolies Office) under the technical and scientific coordination of DPA and with the support of an Advisory Committee constituted by dealers' associations, national representatives of the most relevant consumers associations, as well as representatives of Regions. According to the first available data, 5,138 subjects were in treatment for pathological gambling in 2011, of which 82% are males (but several Regions are not yet included in the data set). The main part of treatment takes place in Local Addictions Services and consists of counselling, examinations and psychotherapy (Report to the Parliament, 2013). The Manual for Addiction Departments establishes the essential levels of assistance and suggests multimodal and individualised treatment.

³ "part of the Presidency of the Council of Ministers, constitutes a reference point for the Ministries and other government departments with responsibility for drugs (Minister of Labour and Social Policies, Minister of Health, Minister of Justice), and it is responsible for the coordination of actions against the spread of drug consumption and for the monitoring of the phenomenon" (Beccaria & Rolando, 2013)

⁴ In Italy specific addiction treatment services became executive from 1980 with a great variation through the country (EMCDDA, 2000). "Nowadays, the national system is organised through 1,630 structures, among them 563 are "Servizi per le dipendenze" or SerD, local drug user services operating on outpatient basis, while the other 1,067 structures include mainly private residential services (comprising therapeutic communities - TCs) (Dipartimento delle Politiche Antidroga, 2012) and a minor number of private organizations, mainly of religious inspiration, which run private TCs independently from the public health system (Coletti & Grosso, 2011)" (Beccaria & Rolando, 2013).

⁵ Definition of problematic/pathological gambler is not clearly stated. Rates come from local researches conducted with different methods and measures.



In the DPA Manual the author (leader of DPA) complains about the lack of a scientific approach to the problem, noting that gambling “is a disease with a genetic basis, neurobiological and, consequently, behavioural” (p. 6). In general, gambling has only recently been formulated in terms of addiction by not only the media (Beccaria et al. 2014) and lay people, but also among professionals, as is demonstrated by the fact that a national monitoring system and general guidelines have just been issued. In addition, local services are still facing the problem in an experimental way (Ministero della Salute, 2012).

A first National Plan on pathological gambling 2013-2015 has been just released by the DPA, which represents a national strategy to approach the problem. This can be summarised as: listening centres, diffusion of information and prevention materials targeting the general population, TV and radio campaigns. Lastly, research is also promoted, particularly aimed at testing software able to identify problematic users while they are gambling and the creation of a mobile laboratory for in vivo behavioural research on slot machines and VLT systems.

SUMMARY: gambling in the Italian system

- * Licence system
- * Regulation of advertising and protection of youth, but some liberalisation of public games in the 2000s
- * First national document on problem gambling in 2013
- * Local addiction services are given the main responsibility for treatment.

Eating disorders (ED): Obesity is recognised as a primary cause of chronic disease, so prevention of obesity is among the priorities of the National Prevention Plan, which indicates an integrated approach to the problem (school and community-based programmes which promote healthy eating styles and physical activity). In Italy, there is no uniform system for addressing EDs. As a basic service, there are dedicated professional teams in some public Local Addiction Services; otherwise there are specialised centres in some hospitals, private nursing homes and associations (NGOs).

POLAND

Alcohol: For most of the last century, Poland had an alcohol monopoly with the primary aim of securing the economic interests of the state. Nevertheless, health and moral considerations were also present in consecutive laws. The most restrictive of these was the Law on upbringing in sobriety and counteracting alcoholism introduced in 1982. Since the beginning of economic and political transformations in 1989, this law has been amended more than 20 times. Alcohol distribution, including imports, were quickly privatised. As a result, alcohol availability increased both in terms of economic affordability and physical availability. Alcohol advertising is permitted for beer only and may be broadcast on television from 8 p.m. to 6 a.m. and presented in outdoor marketing only when accompanied by health warning information. In 1992 the local councils were empowered to license retail alcohol outlets and to collect relevant licensing fees. To generate funds for prevention and treatment at the community level, local councils were



very keen to offer licenses. In effect, the number of alcohol outlets in Poland increased threefold in the course of few years (Moskalewicz & Wieczorek, 2009).

In 2012, recorded alcohol consumption in Poland reached the level of 9.16 litres of pure alcohol per capita (parpa.pl). Recent years witnessed the highest volume of recorded alcohol consumption in last 150 years; since 2007 consumption per capita has never dropped under 9 litres. An average Pole consumes 95 litres of beer (Ibid.) which makes it the most popular drink of choice. Beer constitutes almost 60% of alcohol consumption while spirits comprise nearly 33%. According to recent study (Moskalewicz et al., 2012), lifetime DSM IV diagnoses of alcohol abuse could be given to about 3 million Polish citizens, which corresponds to 12% of the adult population. It is estimated that 616,000 Poles are addicted to alcohol (Świątkiewicz, 2012, p. 255). Alcohol is largely a masculine problem: one in five males drink harmfully and 4.4% can be considered as dependent drinkers.

In recent decades Poland has witnessed a rapid growth in the number of people treated for addiction-related problems. The number of clients admitted with alcohol disorders in out-patient clinics has doubled since the early 90s. In 2009 there were 185 thousand clients in out-patient treatment and 77 thousand patients in residential treatment.

SUMMARY: alcohol in the Polish system

- * Alcohol sales privatised after the 1989 liberalisation
- * High alcohol consumption levels, high level of alcohol-related harms
- * Both out-patience and in-patient treatment programmes are running at capacity

Gambling addiction is a quite recently acknowledged phenomenon in Poland. The introduction of the free market economy in 1989 brought an outbreak of gambling enterprises. Previously to that, gambling opportunities had been limited to lotto, lotteries and sports betting, including football and horse racing – all being under strict state control. Since the political transition, new forms of gambling have appeared. Casinos, slot machine gaming and betting saloons offer a wide range of gambling activities for individuals representing different social positions (Badora et al., 2013 p.37). Within years, the popularity of online gaming, SMS games and internet lotteries has increased. According to a recent study, about 25% of Polish adult population reported gambling activities in the last year (Badora et al., 2012, p.200). The most popular forms of gambling are numerical games (lotto), scratchcards, lotteries and quizzes. Slot machine gaming, betting and casino games are far less popular, ranging from 0.4% to 1% of the population. The prevalence of gambling addiction is rather low, but has been rising along with the number of players. Among all gamblers, 1% is at high risk and 4% at moderate risk of addiction. Translating these percentages into the numbers shows that about 75,000 Poles experience severe consequences of gambling addiction whereas 300,000 are exposed to risky gambling (ibid.).

Gambling has become a lucrative market in Poland and the source of significant profits for gambling industry as well as of public controversies. In 2009, during the work on the amendment to the Act on Gambling, the media revealed controversial political lobbying



aiming at the exclusion of low-stakes slot machine gaming from surcharges. This so called “gambling scandal” overshadowed other gambling-related issues. However, the new regulations on gambling were laid down in the Act of 19 November 2009 on Gambling. The Act sets out the conditions of the organisation and conduct of business rules in the field of games of chance, betting and slot machine gaming. Providing participation in Internet gambling is limited to licensed games (betting only). Gambling is regulated by the Ministry of Finance. The national monopoly, set up in 2010, controls most gambling activities (Nikkinen 2014) According to the Ministry, by the end of 2012 there were 1,705 betting venues, 5,540 slot machine sites⁶, 233 gaming saloons and 45 casinos across the country (Ministry of Finance 2013: 14). The number of registered slot machines decreased from 14,157 in 2011 to 10,973 a year later. The total revenue of gambling operators in 2012 was 14.3 billion PLN (nearly 3.4 billion EUR) with 37% coming from slot machines (Ibid. p. 16), while the gambling tax amounted to 1.4 billion PLN (Ibid. p.17)⁷.

According to the Act on Gambling, games within the national monopoly (lotto, lotteries and tele-bingo) pay a surcharge⁸ to cover the Fund for Development of Physical Culture (77%), the Fund for Promotion of Culture (20%) and the Gambling Problem Solving Fund (3%). The latter is administered by the National Bureau for Drug Prevention, offering grants for gambling prevention, treatment and research. The total sum of these surcharges amounted to 794 million PLN in 2012. Private stakeholders operating in the gambling sector are members of trade associations. The first gambling industry organisations in Poland were set up in late 90s – the Chamber of Commerce for Manufacturers and Operators of Entertainment Devices (est. 1998) and Association of Gambling and Betting Employers (est. 1999). The other organisations were founded a decade later, when new regulations on gambling were introduced – the Polish Association for Promotion of Responsible Gaming (est., 2008) and Polish Union of Employers of Entertainment Industry (est., 2010).

Compared to alcohol or illicit drugs, in the last twenty years gambling-related issues have rarely been the subject of scientific inquiry. The situation changed after 2009 when the National Bureau for Drug Prevention began to promote and fund research projects on gambling. Most articles on gambling are published in non-peer-reviewed or professional journals focusing on prevention and therapy.

SUMMARY: gambling in the Polish system

* Gambling problems only recently acknowledged

* The national monopoly controls most gambling activities and licence for online gambling since July 2011.

*An increasing amount of research is produced about gambling and gambling problems

Eating disorders in Poland are a relatively new topic in public debate. The question of bulimia, anorexia and compulsive eating mostly is presented in media as affecting young

⁶ With the number of slot machines in each site ranging from one to dozens

⁷ By comparison, in 2012 alcohol and tobacco tax amounted to almost 29.2 billion PLN. Of this sum, 10.6 billion PLN derived from alcohol (Polish Ministry of Finance).

⁸ The sum of surcharge amounts to 25% of stakes or a ticket in the case of numerical games and 10% in the case of lotto games and tele-bingo (Art 80. of the Act on Gambling).



women and teenagers. The discussion is framed in medical terms, but EDs are not considered as a public health issue.

The case of obesity is different. Among EU countries, Poland has one of the highest percentages of obese and overweight males aged 15 and over (GUS 2012, Eurostat). Obesity can be considered a growing risk to public health. In 1996, 10% of males and 12% of females were obese while in 2009 these percentages had increased to 17% and 15% respectively. In about the same period excessive body weight rose from 19% to 45% among males and from 14% to 30% among females (GUS 1996, 2011). The problem also affects young people – data from the HSBC 2010 study shows that every fifth Polish teenager is overweight (IMD 2011).

3. Methods and Material

We performed 39 focus group interviews with General Practitioners (GP) and Social Workers (SW). The total amount of participants was 230. In Finland we collected material through 7 focus groups with GPs and 8 groups with SWs (total N=66). In Italy we had 6 group interviews with GPs and 6 with SWs (total N=79). In Poland we had 6 focus groups with GPs and 6 with SWs (total N=85). The group interviews, which concerned alcoholism, problematic gambling and eating disorders, were conducted in 2009 in Finland, and in 2013-2014 in Italy and Poland. Each group discussed a standardized set of brief scenes from 9 movies, concerning issues of alcohol, gambling and compulsive eating. In table 1 we have shortly described the overall theme that was to stimulate to discussions in the focus group interview settings.

The Reception Analytical Group Interview (RAGI) method (Sulkunen & Egerer, 2009) consists of focus group interviews in which short film clips are used as stimulus texts (Table 1.). The participants are explicitly told that the film clips are shown for the purpose of stimulating discussion, but they need not be the topic of discussion. This procedure enables minimal researcher interference.

Table 1. Overall thematic topics on alcohol gambling and eating problems showed in the stimulus clips

	Alcohol	Gambling	Eating
Loss of control	The Happy Alcoholic (UK: 1984): Alun wakes up with a hangover. He goes down to the yard to get his hidden bottle. He drinks, although he is coughing and choking.	Owning Mahowny (CAN: 2003): Dan Mahowny “busts” the table. Later he continues and loses everything. Spectators around him turn away.	Pullahiiri (FIN: 1989): During the night Taina eats a whole cake in her bed. Later she makes herself vomit in the bathroom.
Neglect of duty	Once Were Warriors (NZE: 1994): Jack gets drunk in a bar, while his family waits in the car.	Bord de mer (F: 2002): Rose promises to quit gambling, when she wins the jackpot. However, she later loses her house and her son’s inheritance.	What’s Eating Gilbert Grape (USA: 1993): Gilbert’s mother is morbidly obese. She tells Gilbert to get his younger brother off the tree, instead of doing it herself.
Cue-dependency/Relapse	16 Years of Alcohol (UK: 2003): When his girlfriend leaves Frankie, he starts to drink again.	Going for Broke (USA: 2003): While shopping, the fruits in the supermarket remind	I Want Someone to Eat Cheese with (USA: 2006): When his girlfriend leaves James, because of his



		<p>Laura of slot-machines. Afterwards she gambles at the machine in the shop. She has no money left to buy her groceries.</p>	<p>obesity, he buys sweets and eats them alone.</p>
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The clips were shown according to themes (loss of control, neglect of duty, cue-dependency) in the cases of alcohol and gambling together (three sets of film clips with three different discussions). After that all three clips on eating disorders were shown in sequence after which there was a fourth discussion. We decided to stick to this order since previous materials from Germany and France also had been collected showing the clips in this order.

Clip 1: Happy Alcoholic; Clip 2: Owing Mahown / Discussion 1/
 Clip 3: Once We Were Warriors; Clip 4: Bord de Mer /Discussion 2/
 Clip5: 16 Years of Alcohol; Clip 6: Going for Broke /Discussion 3/
 Clip7: Pullahiiri; Clip 8 What’s Eating Gilbert Grape; Clip 9: I Want Someone to Eat Cheese With. /Discussion 4/

The material was analysed with NVIVO7 qualitative text grouping software in Poland. In Finland and in Italy with the help of Atlas.ti. The material was coded in accordance to a coding scheme employed by country partners, comprising three coding families: (i) consequences of problems, (ii) reasons that the problems occur and (iii) ways of dealing with and treating the problems (a code that we referred to as “therapy”). In Appendix 1 we have listed the codes.

In each coding family we included three groups of categories: biological, psychological and social. The synchronised coding was important for similar categorising and for the first joint cross-country comparisons of materials between countries. Although the amount of codes found in different code categories may imply some emphasis on that question, the focus is on the qualitative aspects in our materials: In what manner do the professional groups perceive the problems and their solution? In what manner can their professional frames of reference be tied to these conceptions?

4. COUNTRY REPORTS FROM ANALYSES

FINLAND

How Finnish social workers view alcoholism has been laid out in an earlier report by Egerer, Hellman, and Sulkunen (2012) who analysed the focus group discussions by the help of narrative modality theory.

The Finnish welfare workers interviewed in this study articulate alcohol misuse within two paradigms of understanding: First, there is repetitive heavy drinking, a coping strategy described as a wrong but nevertheless understandable way of balancing earlier family dysfunctions and of being oneself in contemporary society. Second, there is alcoholism, excessive drinking, which cannot be explained by itself, but mainly by the articulation of the harms caused to the alcoholic’s family and other people around. These two



perspectives on alcohol problems are applied in the stories of welfare workers' own role in handling the problems. In the first of these stories the welfare worker is the facilitator, helping the heavy drinker discover a proper way of being oneself and meet his/her inner needs. The subject in the story is the heavy drinker him/herself, who has to beat his/her habit, i.e. find a new and accepted way of coping. In the explanatory background we do not find oppressive family structures (Rice, 1996), but rather the free modern society, which demands too much responsibility from the 'dislocated' individual (Alexander, 2000).

SW1: *We all have some weak spot so that it's easier for us to cope with some things and harder with others. That was clear from what he said before, that in everyone's life there may be situations where you cannot perform. It's something very human.*

In the second story the welfare worker takes up the position of the subject. Aided by the state monopoly and the police, the welfare worker's role is to save the family members (or other persons harmed by the alcoholic) from the deprivation of their basic needs and the pressures of modern life, and so prevent addiction (or other problems) in the next generation. Here we can identify the opponent in the harm inflicted by the alcoholic upon people close to them.

SW1: *Well, all I have to say is that this family portrayal is a clear case for the child protection service – a family that is a typical client of the child protection service and in this case its private integrity will be broken, and [that will be done] exactly in the name of child protection. And in this case it is not a matter of asking the mother whether she wants to stay with her husband or not. Instead, she would be asked whether she wants to choose her husband or her kids. She'd be asked that question because these children are at constant risk in a home where people are drinking and being beaten up, both the children and the wife. In these kinds of cases, when kids are involved, then in Finland at least the integrity of privacy rights will be taken away.*

SW2: *But that's also a good thing.*

SW1: *It is, and it's in the child's interests. But there are different ways of doing that.*

SW3: *But even in those cases it's good to reach an agreement. It's impossible to achieve results if the welfare worker has to.... (unclear)*

SW2: *Yes. But did you get the impression that this man, when he's sober he's cooperative and so on. But in a way this cooperation is aimed at creating a dialogue and at figuring out the child's interests, where it would be safe for the child to live.*

SW1: *But at some point you just have to put an end to it and say that this just has to end now.*

The conclusion emerging from the two stories is that welfare workers seem to have a compensatory model of helping and coping (Brickman et al., 1982). They take the view that the heavy drinker and alcoholic are not responsible for their problems, but *are* responsible for the solution. In this they differ from social caseworkers, who have a moral and to some degree enlightenment model of helping and coping and consequently do not consider the wrong way of coping as excusable by the circumstances (Pennonen & Koski-Jännes, 2010; Koski-Jännes et al., 2012). This implies that the context, which matters in conceptualizing alcoholism, is not limited to alcohol culture and policies. Furthermore, factors that at first sight seems to have no connection to the alcohol field, such as the organization of primary health care, can nevertheless impact the understanding of alcoholism (Egerer, 2011). Such a non-alcoholism-related institutional context, that could be seen as a factor influencing the understanding of alcoholism, can be identified in the history of professional social work in Finland. Satka (1995) and Toikko (2005) draw



attention to the depth of the split between social caseworkers and welfare workers. This split in the profession of social work not only reinforced the functional differentiation of responsibilities in addiction treatment, but also the identity of the two groups of social workers. Welfare workers have originally received their training in administration and law, and they work in welfare institutions. They seem to view guidance and control as a way of preventing alcohol problems and dependence. Welfare workers do not consider the source of the problem to lie in the drinker but in society, and thus primarily apply a 'social view' to the problems (Palm, 2004).

Finally, Finnish welfare workers make a distinction between heavy drinkers and alcoholics. Such a categorization of already marginalized population groups is similar to that made by other welfare providers in Finland and elsewhere. One widely recognized negative trend is that the most excluded population group – i.e. the people most in need of help – become even more excluded, even though the support services provided might have been especially designed for them (e.g. Hänninen et al., 2007; Vomastkova, 2011). However, in the context of the functional differentiation of social work in Finland, where the welfare worker's role is outside the treatment of addiction, it is crucial to ask whether this exclusion jeopardizes the position of those who are most in need of help – the alcoholics.

When it comes to views on **gambling problems**, Finnish GPs, to some degree, and SWs, to a great degree, focus on social harm, especially to those other than the gambler. GPs emphasize the early involvement and identification of the problem by close relatives. (but remember: the social problems are the signs of the gambling problem, so this is a "natural" explanation model, a component of the prototype of the problem gambler). Problem gambling is not a medical issue according to GPs and SWs (except when psychiatrists are named an expert group).

In the Finnish data the social workers seem more engaged in the question and speak more about it. GPs question their own role in treating problem gambling, GPs do not medicalize the problem, they say that it is not in their remit; they do not see patients with this problem. GPs do not see that this is a problem that they are able to handle, and they say that this problem is not part of their everyday professional practice – they question their abilities and resources to do so. GPs occasionally refer to group therapy, but more often mention the role played by family members and people close to the gambler in the recovery process. In the end, a psychological intervention "therapy" is seen as the only measure to solve the problem.

H: And, I have never seen that we would have the resources for something like that. Well, perhaps one gets RAY (Finland's Slot Machine Association) money for that, but at least never from the city budget.

Instead they demand the will and wish of the problem gambler to start the recovery process. The gambler themselves decides to give away credit cards or ask for a ban from gambling places. [Note: This is different to French GPs, who discuss the same measures, but are prepared do this also against the will/wish of the gambler, see Egerer 2014] :



- GP4: *It is not directly [but secondarily] dangerous for the health, is the money for food goes to playing.*
- GP3: *Well, then the danger is dying due to starvation, if you do not get some social help from the social bureau.*
/--/
- GP4: *I have had some experience from the occupational health care— but the patients were in such an early stage [of the gambling addiction process] that I sent them directly to a psychiatry, one of those who is specialized in this...*
/--/
- GP5: *I have not at all [come in contact with this problem]. I have had two persons during my 18 year career who have talked about this problem. It is such a great shame to speak about it...*
/--/
/--/
- GP1: *This is like straight from a psychology book, but it feels that an addicted person can do anything just to avoid the feeling of distress. I feel that the core of the question lies in such a relief from or overcoming [“winning over”] the distress. But how a medical doctor is supposed to help people’s distress is another question..*
- GP5: *It feels like the whole matter of gambling is a foreign domain for medical doctors, We lack tools, how can we interfere, how can we meet the patient and give advice? .. /--/ it has not yet become internalized in the help for ordinary people such as the use of alcohol and drugs.*
/--/
- GP2: *-- at least for me it is a totally strange world, the gambling. I have heard stories, but I don’t know of any patient who would have had such problems.*
/--/
- GP1: *In the practice it is hard to say, because the signs might not come up other than when the patient is to pay the fee (s)he might say that “oh no, I do not have the money to pay” or something alike. There are no other signs. And it has not really crossed my mind to ask that how much do you use money on gaming.*

The Finnish GPs focus on cognitive and emotional framings and explanations (the significant features of the problems attached to these). GPs give the following reasons for problem gambling: Compulsion, repeat good feeling. They “psychologize” the problem: the problems are defined, understood and treated as a problem relating to cognitive and emotive experiences.

- GP3: */.../ one has the urge to repeat the experience.*
/--/
- GP2: *Yes, it is the notion of the coins starting to pour into the lap, and you want to hear it once more.*
- GP1: *I came to think about human psychology, and one of the characters was so obsessed and depressed. This one feels more that she is a house wife who has lived a boring and depressing life and now dreams of anything that can make her life better.*
- GP2: *Change.*
/--/
- GP1: *Gambling can be a nice thing for anybody, but in this case it is just something about the experience of proportions*
/../
- GP3: *Here, the sense of proportions is dislocated.*

Finnish GPs note that easy availability can lead to problem gambling behaviour. Finnish GPs see the social problems and the harm to others as one outcome of problematic gambling. The family’s food, or rent money seems a common topic here.



GP3: *Yes, but she, she did not get any food for the family, as she gambled her purse empty.*

On the other hand, when talking about the gambler's personal social costs, Finns particularly point out the problem of a pension gambled away. [Note: this is not a topic at all for their French colleagues, although the French clip is about a pensioner]. It seems that in a culture of everyday gambling (Matilainen, 2006; Valkama, 2006) an especially vulnerable group (here: older people) has to be constructed to point out one's own competence of gambling reasonably.

Finnish SWs see the role of social work as helping others than the gambler, harmed by this behaviour and restricting finances of the problem gamer:

- SW5: *What will happen directly after this? The man [husband] will say that it is enough, if she has a husband, and the children will be taken care of by the child protection. They won't get any food, and after that they will receive some help..*
- SW1: *To a group [help group]. If houses are being gambled then [the gambler] will be ascribed a supervisor.*
- SW3: *Yes. For these sorts of people bankruptcy can be prevented by allowing weekly budgets for food. There are no other ways of disciplining it.*
- SW6: *If houses have been gambled away then a social office's transmission account can be used, money on the account once a week.*

Finnish SWs often focus on social problems and harms to others:

- SW5: *Well, hunger there will be. There are kids who are left hungry when their mothers game away all money. [Comment: Familiarity with problem – this language is not heard at all among Finnish GPs]*
- SW3: */.../ I am thinking about the situation when [the woman] is going home, will she be able to pay for the groceries or does she have to leave them there. What does it mean when she is feeding herself with the gaming and the kids are left without.. [Comment: priorities in view of responsibility for others, this is more common among SWs than GPs]*

According to the Finnish SWs addictive behaviours are socially rooted problems:

- SW5: *I am really convinced that these addictions have social roots (or anchorage), their roots in society, yes it is true, the gambling starts or the alcoholism starts cause..it is a sort of persons..*
- SW3: *Exactly, the ones that goes for the same kind. There doesn't need to be anything. Well, of course we can always speculate, that that the person has some problem and that is why she/he do this. But it does not need to be like that.*
- SW5: *Yes or there are not any alternatives as in the Finnish culture when there is a possibility to take part and be [part of]. Many people suffer from loneliness due to being in a couple's relationship.*
- SW4: */--/there's an awful lot of lonely people. You can't really do anything, although you see that they are destroying themselves. But you can't do anything because this right of autonomy has gone a bit too far. People don't dare to interfere with it that way no more. In the old times all the family was there to support..."*

According to the Finnish GPs, the expert on gambling problems is a psychiatrist:

- GP1: *This was probably quite a rare case, there should be a psychiatrist here.*



Then we could find out how it really is in real life.

Finnish GPs emphasize that family members and those close to the gambler must interfere at a very early stage in order to properly deal with the problems:

- GP4: *././ the family could have interfered in an earlier stage and more forcefully prevent it...*
GP6: *The son and the daughter in law, yes..*
GP5: *Could they have really, if the mother is stubborn?*
GP3: *Well, they could have tried. But such a jackpot gambling person you just can't confront.*

Eating disorders: All Finnish focus groups expressed the notion that background factors to EDs are of a diverse nature, but all expressed the view that the disorders might be triggered by one specific factor such as an illness or divorce in the family, by study-related stress or by someone making an inappropriate comment or an insult.

In general the Finnish SWs make frequent reference to family circumstances and everyday life situations which are considered to lie behind the development and persistence of eating disorders. They consider the case of an overweight woman appearing in one of the film clips and who hasn't been out of the house for seven years: "The whole environment is geared to bringing food to the table" and "The family's role is twisted". The key thing, according to the SWs, is that the family recognizes the extent of the problem and starts to take action, to provide support and to talk with one another.

The SWs discussion extends to some of the human factors that have driven the protagonist in the film clip to excessive eating: that her difficulties stem from having a mentally handicapped child and the fear of having the child taken away from her into care. SWs often discussed the great self-contempt felt by sufferers over the fact that one cannot resist eating or thinking of eating. The behaviour can also become a protest against external demands. According to SWs, it is important to identify this circumstance and realize how behaviour models and routines can be changed, as well as relations between people.

When it comes to the GPs interviewed for this study there is considerable uncertainty and discrepancy over the question of how and where to draw the line between healthy and unhealthy eating behaviour. Within the professional group, GPs had very different assessments of the health of the individuals featured in the film clips, and there seemed to be no consensus about what constitutes an eating disorder. The only situation on which all the GPs shared the same assessment was that described in the second film clip, which portrays a severely obese mother. They all agreed that her situation is serious and that her prospects of regaining health are poor. Nevertheless, her behaviour was not described in terms of an eating disorder. Rather the main concern and focus was on the physiological consequences of her obesity. In their assessments of the underlying reasons of EDs, GPs tend to lean quite heavily on biological explanations:

- GP3: *././ Yes, in these cases I would expect to find a problem with some neurotransmitter or a chromosome or gene ...*
GP1: *A virus infection*
GP5: *Well some causative agent.*



The SWs discussed their role in society and their own professional views on clients and society. It seems they do not have a lot of experience of direct contact with clients with EDs. In their own role SWs feel they have no option but to show respect and acceptance:

SW3: *But in all social work, in all kinds of helping work, at least I feel the individual is accepted. I know this is a cliché but there's centuries of wisdom in the notion that even when the act is reprehensible, you have to accept the individual. I often think that if clients behave violently or do stupid things, I've said we still must show respect. I'm sorry, this happened again, but you can change your actions and do something else. So treating people with respect means empowering them, giving them responsibility for their own actions. So even in the case of addictions you can lecture them about drinking or whatever, but it won't make all that much difference, you have to strike an alliance with the individual and work together against the problem. We all do these things in our own ways. This individual will feel they're valuable and important and that they're showing unwanted behaviour and I mean generally people will agree, that it's unwanted. There are not many people who say I really want to do this; beat the wife or drink myself to death or that there's no food for the kids, they're beyond treatment.*

The GPs see their role as the one of judging individual's outer appearance and wellbeing when they make their assessments of the patients' condition. Very little speculation is given to the inner motives that drive the characters' behaviours. In their daily job, GPs often have to make their judgements within very limited time constraints, so this reliance on what they can see on the outside is probably in large part a function of their professional role. When the characters appearing in the film clips are not clearly overweight, the GPs tend to assume that the situation is not particularly serious:

GP3: *././ he seemed to have quite a fair bit of it, and he was eating it there in public on the car deck. And for me it looked like comfort eating, rather than... This was still within normal limits.*

GP1: *././ Of course there's a bit of overweight and other issues, but it wasn't all fat, there was quite a lot of muscle too.*

GP5: *"Right, he wasn't pathologically fat, he was just fat ...*

The GPs in this excerpt are not considering the inner struggles and urges of the protagonist but draw a line between what they consider pathologically fat and "just fat". This distinction is based on bodily appearances as well as on when, how and what the individual concerned is eating. In their discussions the SWs also touch upon the beauty ideals and strict norms of appearance and dress within the global media society. In addition, they address more general philosophical questions that problematize normative positions and actions: Can anyone ever be genuinely free? Who decides on demarcation of illness? GPs base their judgement of who is healthy and who is not only on what is immediately observable, such as eating behaviour and outer appearance. The GPs that we interviewed tended to focus mainly on how, what, when and how much people eat, whereas specialised staff additionally emphasized the individual's psychological condition. SWs gave much thought to the emergence and logic of EDs. They referred more often than the other professionals to contextual circumstances and to the changes that must happen in the clients everyday life situations.

ITALY

Among some of the focus groups with GPs there was a debate about the origins of **alcoholism** , and two positions emerged. Some claimed that the addict is 'pathologic'



even *before* practising the compulsive behaviour, suffering previously from psychiatric problems/depression, while others stated that these kinds of problems can happen to anyone as a consequence of a trauma.

Both among GPs and SWs there are several references to the addict's weakness, his fragility and inability to face the difficulties of the life. The idea is that this 'psychic fragility', or the presence of emptiness, can be brought out by the addictive behaviour or by a trauma, after which a person self-medicates - using alcohol as a psychotropic drug. (The ** marker signifies that citations are taken from different focus groups discussions)

SW6: *Maybe this also kind of a reaction to life. It is indeed the search for an addiction, for something – substance or behaviour – to fill the emptiness.*
**

GP6: *but because there is a fragility at the base*

GP5: *there is also a lot of depression, isn't there? The depressive syndrome. And many people deal with depression in this way, with a substance that acts like a medicine*

**

GP5: *It is also a psychiatric pathology, an alteration, because more than this...*

GP7: *it is a depression, all these [characters] are depressed, because at the end the depressive trait is there anyway.*

Among GPs, causes related to the psychological character (24) and referring to compulsion (33) are the most prevalent within data. Among SWs, reasons related to the family (26) and loneliness (21) prevail. However, considering all data together, the most discussed and agreed reasons behind alcohol addictions, are those related to the social context, and particularly the family (on the other hand, loneliness is understood mainly as a lack of family). According to many interviewees, the most frequent reasons for becoming an alcoholic are problems at home: a divorce, a bereavement. The addict is seen as someone incapable of facing the difficulties of life.

GP1: *There are frustrations, or traumas, that unload there [on addictions], so it is difficult...I have a couple of clients where there was a trauma in the beginning, the lost of the father or the husband or wife leaving. Causes are always those. As he said, the sense of inadequacy, feeling not able to keep up with things, so you run away..*

But, they also recognise that also the opposite is true. Some people lose their family because of alcohol.

GP7: *Both alcoholism and gambling are like a cat chasing its tail. That is a vicious circle, I mean, some fall into these addictions because maybe something is missing within his family, because he/she lacks something, because he/she doesn't feel fulfilled, because he/she does not have children and jumps on these things, but sometimes it is just the opposite.*

It is worth noting that this view is common also among GPs who did not have a substantially diverse view of main causes, compared to SWs. When they talk about repetitive cases of alcoholism within the same family, they do not talk about genes (only a few references have been retrieved in the data), but about modelling.

GP5: *There is always the environment, there is always the cultural and environmental values that interfere...*



(...)

- GP5: *Or if you are born into a family - it seems to me that this guy was the case – where the whole family is already made of alcoholics*
- GP3: *Sure, then he is more likely*
- GP5: *If you are already born within such a family, then that is the example that you got when you were a baby.*
**
- SW3: *When you are born and grow up in a family where, as a reaction to certain circumstances, some behavioural patterns such as drinking are used – looking for a solution in alcohol – it is then really hard when you are grown up to find other instruments which you have not received. So this becomes the most normal thing, even if, inside you, you know that maybe this is not the right choice, however you react in the same way you have been taught and you have seen.*

Along with this view about reasons, the most quoted and discussed consequences of alcoholism also related to the family, in both professional groups. Several times interviewees dwell on the damage that the alcoholic does to his family, and sometimes, linked to this aspect, a moral judgement leaked out. Avoiding family responsibilities seemed to be the most difficult aspect to understand (and justify) among participants. Some, especially among the GPs, in reference to the clips 3-4 (Neglect of duty), considered it an inability also linked to the culture of origin (FG1, FG5, FG7).

- SW5: *So how do you explain the addicts ... drug addicts or alcoholics that ravage the family, destroy it, who might have the love of relatives ... so if you are interested in what others think, you stop, because –*
- SW6: *You end up losing family-*
- SW5: *At some point, you don't care anymore*
- SW6: *You are not capable, it's not that you do not care. You do care, you know that you're hurting deeply and continue to hurt yourself. Maybe there's even at a certain point, not only the self-harm, but self-punishment, deep, unconscious. I cannot tell you, but there are excesses that make you think that it's no longer just a fun, like getting a little drunk, forgetting the family.*
- SW5: *Yes, but when you're at that stage there, you are no longer interested in what your wife, your husband, your son or your mother think. Do not care anymore...*
- SW6: *I don't know. In my opinion, you're still interested, and say, "Look, I'm not really capable of. Look what an asshole I am!" and I drink because of this. I feel that it is just raging with themselves, instead*
- SW4: *Yes, a self-*
- SW6: *Yes, I do not know how consciously*
(SWs)
**
- GP4: *What strikes me is the feelings shut down, the aridity. I mean, not being conscious of being part of a family, but being so detached from the familiar context by this mania.*
- GP5: *I think the big problem of alcoholism, gambling, addictions, is not universal, and it emerges here. In the first case [clips 1-2: Loss of control] the characters were alone, had no context, here [clips 3-4: Neglect of duty] the context here is there, there is family, there are feelings, there is everything, but there is an inability of management the addiction, and this is also very cultural /? / very cultural not valuing the family and children in comparison to peers, friends, fun.*



Alcoholism itself is considered a sign of lack of responsibility towards family, which is seen either at the beginning or as a consequence of addiction for the following GP:

GP5: *Yes, there is a lack of responsibility. Either there was already before, or it is following on [from the addiction]*

If the alcoholic's shortcomings towards his/her family are discussed great deal, the addict's relatives are also easily criticized because of the collusive relationship they have with the alcoholic. In the view of participants, especially SWs, the family can play a role in shaping the addiction, and especially in covering up and going along with it. Thus, a woman who continues to stay with an alcoholic husband is blamed because it is perceived that in doing so she does not take proper care of her children.

SW5: *In this case [clips 3-4: Neglect of duty], I'm sure that is a pathology of the [whole] family, as there is not a perpetrator if there's not a victim.*

SW3: *This is to say, maybe, that alcoholism involves the family, which is conditioned by the single subject's behaviour, who is accepted despite having problems, because the family around that person has created a dependency, which can also be an emotional dependence, or economic because maybe he's the only person how somehow keeps the family. And this is the cause that often determines the people to deal with what is really the problem, the behaviour, which is generally tolerated by the family, because they cannot see alternatives or possibilities to escape the situation.*

SW1: *I have to say that this man makes me angry because of his family involvement (...) where there is this woman who stays there, even though he drinks and beats her. Thus, he really bothers me, and a bit also this woman. I have imagined the woman who will never leave him, so... in a while social services will take the children away, because the two of them are the typical couple who never will split, and she will choose him rather than children. This is my professional interpretation.*

The prevailing view of the causes, mainly located in the social context, and particularly within the family, means that there is a widespread perception of powerlessness by Social Workers about the possibility of helping the alcoholic.

SW2: *Facing this kind of situation, often you feel powerless. Because at the end it is the individual who decides, who has to find the motivation. Knowing that this thing is so strong that is really really hard to do it yourself.*

SW1: *Sometimes you work with these children, these kids, and you say, maybe a little resignedly, "however the context they come from is that one, in quotes, genetically". I mean, there are families who carry on over generations... in these situations, though, you do what you want, but you are also a little disillusioned about the future, you don't see many chances.*

For these reasons the handling of the problem is discussed mostly in relation to the social environment. Coherently with the view of the problem, and the CAT (Club for Alcoholics in Treatment) approach, many interviewees, and in particular SWs, think that the addict's whole family should receive treatment.

SW5: *It is true that these circuits are created at the family level, with the other [addict] pressing, then maybe you do not realise how to lose than to win ... because there is an addiction, and then, as I am convinced indeed - and with this I go back to what someone should do - what is certain is that you should take charge of the whole family.*



GPs also discussed environmental treatment much more than medical treatments. They also seem to rely on Therapeutic Communities, as, in their opinion, rehabilitation requires a change of context and life - a period when the alcoholic is separated from his/her family.

GP4: *Then, how to do it [treatment]? Through a complete change of life, because maybe things go better when people manage to go in a [Therapeutic] Community and there they found a context where they can share their problem. And they find also a denial of the opportunity to reiterate their attitude. You can't get out [from addiction] if you stay in the same condition, or if you go to the psychologist. I think just that the alcoholic in a family continues to be an alcoholic.*

If SWs feel a little powerless and pessimistic about the possibility of help alcoholic, GPs seem to not even feel responsible for their treatment, because they place it outside of their own competencies. When they talk about possible help they mention social services, therapeutic communities, self-help-group (only a few references are made about addiction local services). They also question their role, because lifestyles are the issue (people are free to live as they wish) and often the patient's is not willing to seek help, which is essential.

Discussing self-help groups, they think they are a good option as the alcoholic can see how other people managed the problem. When talking about who should encourage the addict to join the groups, they joke about whether this should be the GP or the priest:

GP2: *who should intervene?*

GP3: *I don't know... the doctor or the priest*

GP1: *whatever significant figure...*

GP3: *but how to raise awareness... the move from addiction to the will of recovery, this is what I miss, and I don't know how [laughing]*

Laws, and particularly restrictive measures, are not claimed with respect to alcohol (differently from gambling), except in reference to young people.

Compared to GPs, SWs seem to be more reflexive and aware about their own attitude towards the problem. They are conscious of not considering alcoholism as a disease, also they are aware of sometimes indulging in moral judgments.

SW5: *we should not judge, but it happens and it comes also from moral things... "this person had [a lot of things], had health, why..?!". And we don't see it as a disease.*

In the Italian data, both GPs and SWs generally discussed handling **gambling problems** mainly from a social perspective and particularly focusing on the role of family and friends (39 GPs quotes; 28 SWs quotes). Only GPs gave some importance to biological therapy (22 quotes), that is medicalization, while both categories talked equally about the need for willpower on the addict's part in order to quit (21 quotes in both groups). Other ways of handling the problem received a little attention. Both categories, but especially SWs, highlighted the need for more regulation and criticized the State harshly. GPs are quite sceptical about the Local Addiction Services' capacity to 'hook up' clients, while they seem to have more confidence in the efficacy of self-help groups or TCs.

References to their own role in facing the gambling problem are scarce in both of the two professional categories, maybe because neither are sure if this should be their task. GPs opinions about their own role in the gambling problem (or, more generally, addiction)



treatment, are primarily the following. Identifying the symptoms of gambling is really difficult, as there are not physical signs that the doctor can see and gamblers do not ask for help.

- GP5: *we see these things quite often in this area, it's not rare...*
GP3: *yes, that kind of persons, especially the first (alcoholic vs gambler) is somehow common*
GP7: *yes, but it's not that they come to us. We see them by chance but they don't...*
GP1: *indeed they never see them [in the health centre]*
GP3: *yes, it is easier to notice these situations as neighbours rather than as doctors.*
GP5: *yes, yes. As friend, relative or neighbour.*

They cannot do much for gamblers as they have not proper instruments:

- GP2: *(...) when someone [gambler] arrives and asks you for an help, actually, you, I mean, us... maybe if we had some support, a group... otherwise what can you do? You can do nothing! /--/*
GP5: *Maybe [for] the real addictions – cocaine, heroin,... - local services, the doctor, they can do a lot. Instead, for alcoholism and gambling less is done. Maybe because we do not have instruments and ways to help these people.*

They cannot inquire/give suggestions about clients' behaviours. Curiously, this is viewed by somebody as a priest's role. Also, this is considered an interference in a family matter:

- GP3: *(...) as a medical practitioner, I answer to the client's needs when the patient asks me, because I'm not a priest. I cannot tell him "Come on, don't do these things!" I mean, he would tell me to go to hell, and he would ask "who asked your opinion?" So I limit myself, if the patient ask me for help, then I intervene as a medical doctor, purely in the field of health. Especially since it is very difficult, or at least it seems to me, to intervene at family level, when you do not have all the members' consent. So it is not that you can act as the Great Sage of the situation, teaching lessons about life! (GP)*
GP1: *Maybe the relatives send you there, and you try to say something to him and [the addict]: "I do not look at what you smoke or drink!" Those are unpleasant clients, but maybe more in need than others who come in your medical office.*

Gambling is not the responsibility of the GP:

- GP1: *Gamblers for instance, none of them will come to ask your help (...)*
GP3: *What is the problem? We do not have to solve the problem!*
GP7: *We begin to recognize the problem, to help him, and this is (already) a lot!*

Even among medical doctors, the concept of pathological gambling as a disease is anything but fully established. In addition, a non-judgmental attitude is considered by some as peculiar. Maybe also for this reason GPs seem to not consider gambling as coming under their competence.

- GP3: *Sometimes I have a doubt about facing these problems negatively - I mean, "aren't you able to quit gambling?" – or as a pathology. In this sense, I don't know how to face the thing, I mean, if saying "Come on!"... It's like in the case of mental illness, or depression. The common opinion is [to say to the addict]: "these are all lies, come on!". But I sometimes try to address them a bit like a stomach ache: a stomach ache is not wanted, it came and we treat it. Depression or dependence maybe are not voluntary. I don't know how to approach... (clip 3-4)*



SWs' opinions about their own role in facing the gambling problem (or more generally addiction) were rather pessimistic, as are those of doctors. However, this topic was not discussed much, perhaps because solving the problem is not seen by SWs as their task, even less than among GPs. The role of the SWs is somehow reduced by the fact that gambling problem does not emerge easily and is rarely reported to the services, also because there is not a network among operators (thus, as a consequence, SWs have less experiences of gambling compared to traditional addictions):

SW1: *(...) the first person [alcoholic] arrives more [than the gambler], as the same person [the gambler] has more difficult in recognizing - it is hard to recognize both the dependencies, however, the addiction of the first scene [alcoholism] arrives to us more easily through some way... And then in some situations it is easier - easy is not the right word, but anyway – it is easier to act on these situations, it is not easy, but it is easier to know about these situations than about the latter [gambling problems], because in the first case we have some links, such as the doctor, or other operators, while in the second case is more difficult.*

SWs say that the addict's will to recover is the necessary condition in order to success:

SW1: *(...) so if the person at a certain point decides to get help, then you can plan programme, but we know that this kind of people [addicts] have a will... a will that changes very much, so if there isn't someone who support you [the addict], who spurs you on and so on, many times willpower is not enough, so, as social workers, as social services, we have some instruments... poor instruments, I mean, they are based mostly on your willingness, so interrupting problematic circuits that are generational is not easy...*

SWs also highlight that the addict's family (setting a bad example) has much more influence than services' efforts:

SW3: *And that's what always that upsets me a little as an operator, so I always say that I'm not able to work with minors because the biggest difficulty is, say, "What can you do for this minor, who lives 24 hours with a family that lives in a certain way?"*

SWs also think that the police are more effective than services, which currently do not have resources.

The role of family, which was the most cited, was also debated at length. On one hand, the relatives are seen as crucial to the ability to overcome the problem; accordingly, the lack of family somehow contributes to a prediction of failure. This image was frequent both among the GPs and the SWs, with a particular emphasis among the first group.

GP2: *(...) maybe the first help is to be by the family*
GP5: *Yes, when there is a family*
GP2: *Indeed the housewife has done everything...*
GP3: *And surely people who are close to him*
GP2: *Without family, alone, he can't do it*

**

GP1: *In my opinion the woman would manage [the problem] because she has a family*



- GP5: *But she could still recover, the elderly woman who gambles. It could also Happen that you recover, if the family-*
- GP6: *If the son does not get tired [of helping her]*
- GP7: *Look, she must remain without a Euro, because if she has a Euro in her hand she gambles*
- GP5: *Indeed, this above all, if the family controls her and leaves her without money... in my opinion, it depends on what the family can do for her...
(...)*
- GP5: *She could also recover. [But] if she is left alone, she'll become a bum, definitely.*

On the other hand, the family's capacity to actually help the gambler is often questioned especially by SWs. The whole family is considered ill (with a collusive role) and in need of help, as well as in the view of CATs (clubs for alcoholics in treatment) which are the most widespread association for alcoholic treatment in Italy. This is particularly clear in the mind of SWs:

- SW3: *Even if a person has maybe some problems, nevertheless it is accepted by the family, because the family around that person has also created the addiction (...). Also in this case (clip 4: Bord de Mer) the son tends to help the mother. (...) I mean, in both clips [3-4: Neglect of duty] relatives follow the dependent person, perhaps because there is a dependency in the rest of the people around the addict.*

Relatives are quite often criticized because in the interviewees' view they are not strict enough with the addict:

- SW3: *(...) the scene that mostly annoyed me is the moment in which she [the gambler] collects coins and the other two collect coins with her, because if on the one hand, as you said, a son loses everything due to his mother's fault... but either you stay away completely from that stuff, and then you do not share what your mother does at that moment, otherwise it's not that in the moment of victory you collect [the coins] with her...

- GP3: *I think that it is easier for a stranger than for a relative to help a patient of this type.*
- GP2: *But I don't say help him. I say convince him to get help.*

The concept of "reaching bottom rock" is also recurrent, especially among SWs. This corresponds to the typical recommendation given by Therapeutic Communities' workers to addicts' relatives at the time of the heroin wave, to leave the addict alone, without help and money, in order to push him to enter in a therapeutic community (Coletti & Grosso, 2011). This view survives in both categories, even though the Therapeutic Communities themselves have now recognized that it was not a successful approach in several cases (ivi). It relates to the Church's moral view of the addiction, which accuses the addict primarily of not carrying out his responsibilities towards the family, and sees the possibility of redemption in the punishment of isolation.

- SW5: *I think that surely someone can get out [of the problem], [but] what we see is a great difficulty. As my colleagues said, maybe because there are not such effective instruments and maybe also because if you don't reach the bottom, you can't do it.*
- SW6: *They need to touch the absolute bottom of the abyss in order to start to go up.*

The discourses on eating disorders in the Italian materials are quite fragmented and not discussed as much as the other problems. Regarding causes of EDs, GPs talk about problems with the family (mainly with parents, and, specifically, mothers) but also think



that there is a sort of psychological predisposition that makes them fragile in facing life/relational difficulties. This is what EDs have in common with other addictions, in their view:

- GP5: *All these people have a mental disposition, though. They are ill. In their lives they create some situations that take these aspects on an extreme level, whereby they become alcoholics, bulimics or anorexics (...). When problems come, such as the loss of a son, or someone left you, or...*
- GP6: *Also the opposite is true. There are also those who.. – in my opinion they are people who don't have many difficulties, because if they had, they would not think about gambling, drinking...*
- GP5: *But a normal person. A person who is not normal has another attitude. The first maybe says: my girl left me, I'll find another one. Instead this one ends up there [in the addiction].*

An internal personal fragility is the most frequently quoted reason, together with the family. However, when talking about fragility, GPs refer usually to a sort of predisposition, while SWs seem more to think that fragility is inherent to human beings, in that everybody can develop these kind of problems:

- SW2: *It makes me reflect a lot how certain fragilities...isn't it?... that everyone has inside, can be emphasised by something that happens to you, I mean, therefore none of us is safe from these kind of reactions, above all boys and girls. All this scares me.*
- **
- GP2: *...the layabout or the worker, what's the difference? It counts for nothing. Maybe there are 5 brothers, and in one of them it happens, but because... I don't know why. Because it is pathological! This is a pathology, it's like when somebody has a cancer and someone else has not.*

GPs are the only ones who talk about psychiatric illness (sometimes this concept seems to overlaps with depression or with 'obsessive compulsive disorder') to refer to people with EDs, while SWs talk instead about psychological problems. A recurring discourse is about emptiness: the person with eating problems, tries to fill his/her emptiness with food. Another recurring concept is that of "vent": the addict gives vent to his/her problems by eating.

- GP7: *Bulimia. A woman who I weighed, weighing one hundred and one pounds, not so high (...) and she said: "Yes, I was so hungry, I went ..." she bought eight ounces of "tiramisu" and ate it in half a minute. Here the disease is psychiatry. And anorexia nervosa is a very serious psychiatric illness, very serious, very serious and much.*
- GP5: *That is just a reversal of a brain mechanism and you see yourself different from how you are really. I mean, you misrepresent the reality*
- GP2: *Because you're a skeleton and you see as fat. And there, there ...*
- **
- SW3: *It's just a more internal pain, psychological, for which you somehow fill voids eating.*

Despite these differences, also GPs recognise that EDs can originate through culture, though this is a view more widespread among SWs. The idea is that the society is changing for the worse, and that there is a growing competition that also involves



children and young people, creating suffering and distress. References to culture also include the fashion world and its unhealthy models.

GP6: *15-16 year-olds who live in this society can be psychologically very strong but... All the school competitions and they must be the first, because otherwise their parents... fuck! Is it possible that a 5 years old child has spastic colitis?! Or that at the age of 15 someone comes and ask you some pills for sleeping because otherwise they can't sleep?! These are societal symptoms... it's not good.*

However, interviewees make a distinction between obesity and EDs. The woman in the second clip (the obese mother - What's Eating Gilbert Grape) is seen as being happier than the other characters shown; she is not isolated and seems to be satisfied. So in this case a hormonal disorder was also posited as a reason for her weight.

Another recurring feature is that the talks easily shift from bulimia/obesity (problems shown in the clips) to anorexia, which seems to be perceived as graver problem. This could be related to the fact that when EDs became known to the general public during the Nineties, mass media focused on anorexia stories (Beccaria et al., accepted). In contrast, obesity seems to be not perceived as a problem. A GP says:

GP7: *In my view the problem of obesity, as well as of alcoholism, is not perceived enough. It is not perceived enough except than by us, medical doctors, because we do prevention and treat obese persons. But what do the others do? Nothing. They do nothing. Within families very often food is seen as... "come on, eat! Eat! Come on!" I mean, it is seen as a haven, isn't it? Among my clients I have a lot of obese people (...) and none of them has never asked me "Doctor, what can I do for my obese daughter?". Most children are obese. (...) And mothers and relatives, the community, the school, they don't realise this, they don't because they do not see it as a problem.*

With respect to handling EDs, most of the quotes refer to the importance of the family, as in the other cases. The addict's family is seen as necessary to overcome the problem, but not sufficient without the self-motivation, which is also another key topic. The role of the family is again seen as ambiguous, so that, in the view of participants, sometimes what is needed to help the addict is for them to be abandoned by their relatives. On the other hand, new emotional ties and relationships could assist the recovery process.

SW6: *If someone can do something for the obese woman [Clip 8: What's Eating Gilbert Grape], in my opinion it is her family. I mean they must not be available to do things for her, thus it comes the moment when conflicts are necessary to make the addict react. Sometimes, being a little harsh can be useful to make the other [addict] move.*

**

GP2: *Maybe she will find a romantic satisfying relationship and so she will quit eating.*

A certain disillusionment about the prospects of recovery is also widespread. Among both the professional groups the same discourse occurs, as already seen with regard to other addictions: the idea that the person with ED will always have and will always be at risk.

GP7: *I have had some cases of anorexia and I had several girls and in general ... – moreover some of them made a special experience, because they got married, have a son - but I must say that basically they have not got rid of their anorexia. They bring it with them. So anorexia has, according to me, definitely a rather unfortunate prognosis.*



GP6: *In any case, even if you escape [from the problem] you have to be alert for life, because all your life you are at risk. Even if you do not drink anymore, even if you do not play anymore, even if you're not anorexic, you're not bulimic - but you know that anything, a new critical period, a moment, can make you fall into addiction again. I think this is the big difference between "normal" fragilities or general depressions that everybody is used to having in his life, and the disease.*

This sense of powerlessness is subjected to reflection by SWs, who see this aspect as reflecting the general distrust of services that characterizes this moment (SW6).

Consequences of ED are not discussed much and are perceived as more individual than in the case of other addictive behaviour. In any case, there is a recurrent distinction between the predictions made for the three characters. The case of the obese woman is seen as hopeless because of her physical conditions that, in the view of participants, will quickly lead to her death. On the contrary, the last character, the man left by the young woman, is seen as able to overcome the critical moment.

Consistent with the GPs' hypotheses, a common feature among SWs is that EDs are different from the other problems shown. In all 6 groups this discourse comes out. Participants reflected on the fact that it is difficult to think about food as a drug, since it is ordinary and essential to life (FG2). Within two focus groups (FG9, FG5), EDs are classified as a 'real disease' unlike other addictions (which have more moral connotations)

In the view of some of the SWs ED are more tolerated (FG12) and less stigmatised (FG6) compared to the other problems, also because they are more understandable and seem to be more self-harming than doing harms to others (FG8). Seeking comfort in food is a common experience among the participants too, so the EDs and obesity are not perceived as so distant as 'real' addictions.

Especially the character of the last scene (from the movie "I want someone to eat the cheese with") is considered by most of interviewees – also among GPs – to not have any particular "real" problem.

SW3: *Instead, the last [clip] also I do find it hard to ... [see a problem]. I do not, maybe because I also take it out with food [laughs], with the cheese in his case, in my case it is a bowl of ice cream, and then the next day, [life] starts again.*

POLAND

In the Polish material, the social framings were the most common among the explanations, reasons and treatments for the three problems. Among the reasons of alcohol addiction, social macro categories were most often referred to by social workers in terms of societal institutions and systems for dealing with the problems, while GPs were more likely to point to both macro and micro social categories and psychological features of the drinker's character; biological circumstances were referred to, mainly by GPs, in the discussions of both consequences and also dealing with the problems. The most common kinds of consequences referred to by both professional groups were those affecting the social environment, while biological and psychological consequences were conceptualized as more closely tied to the individual drinker's personal life quality and



whereabouts. The social environment was the most referred to area of addressing alcohol problems. Nevertheless, psychological personal characteristics relevant to dealing with the problems were felt to play a vital role, even more important than specialized therapy with a psychologist.

When it comes to the reasons for **alcohol problems** among the Polish professionals, biological reasons for alcohol abuse and addiction were scarce and were found mostly among GPs, who mentioned the genetic background of alcoholism:

GP7: *Because of genetics, there are individuals who get into addiction quicker.*

Genetics was seen as corresponding to inclinations and predispositions for alcohol misuse in an individual:

GP3: *He is prepared from childhood*

GP4: *Yes, definitely he has "baggage"*

GP1: *There are inclinations, predispositions. Supposedly, there is a gene of addiction*

Psychological determinants of alcoholism were more commonly raised than biological ones. Among them, emotional reasons were believed to be important among the Polish GPs, who were more likely to attribute positive, even ludic, characteristics of alcohol drinking than SWs, highlighting its social dimension:

GP5: *In alcoholism there is a layer of good fun, colleagues, some adrenaline, just as it was presented in this video*

GP3: *Beer drinking gives a some kind of pleasure that cannot be obtained in any other way.*

Alcohol abuse might be a response to harmful or depressing events in the life of an ordinary individual. It can help people unwind, being a specific "reward", says the following GP:

GP2: *... he rewards the leaving of his girlfriend with alcohol.*

Drinking to reduce the pressure or tensions of everyday life was also found in focus discussions with social workers:

SW4: *Failures, tensions, stress, getting alcohol*

SW3: *Many people start to drink because they have lost a job*

SW1: *It is a way to diffuse stress, to forget, to reduce the pressure.*

People fall prey to addictions as drugs or alcohol because of inability to cope with tensions, which is also noticeable in young people:

SW3: *Many young people who start their mature life don't have knowledge of how to relieve tension and they become so called 'weekend alcoholics' from big international corporations.*

The motives of compulsion, *why* people suffer from the problems, appear more often among social workers than GPs in the Polish material, sometimes described as *a psychological dependence with a physical dependence*. Coercion is a specific trait of this behaviour:

SW3: *This is coercion of a certain activity. You don't want it, but you must do this so you can*



operate comfortably, despite harming yourself (SW)

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SW3: *They knew that they do not benefit but they repeat these activities they learned.*

Harmful drinking is continued with no regard for its destructive impact. Moreover, an addict cannot make himself aware and find a way out:

SW3: *This is an addiction mechanism. You crawl this way ignoring the losses. An alcoholic feels ugly but he still drinks.*

The most common category of psychological reasons for alcohol addiction in both reviewed groups was specific character traits. For GPs, the question of addiction lies deep in the individual psyche: *“This is a psyche thing and one has an addiction or not. It will go off in gambling, eating or alcoholism.”*(GP1)

It also can be described as a distinguishing feature of a character or personality. Addicts reveal specific traits of character that drive their behaviour. As a result addicts were described by GPs as: *psychically immature person* (GP3) or, in contrast, as *a macho type*. Another common motive was a weakness of the character that can lead to addiction as an individual cannot oppose or resist the will to drink.

“Weak character” was also found to be a reason for alcohol addiction according to social workers. An alcoholic could be an *emotionally disturbed person* (SW). Moreover, he is powerless and unable to cope with problems of everyday life:

SW2: *Inability to cope with the problem. Killing the problem with most effective measure (alcohol).*

A “strong character” can protect individual from addiction as well as prevent relapse:

SW4: *It seems to me that someone who has a strong psyche, a decent basis in the family, will not get himself into such situation. They just cannot handle life.*

GPs often raised the issue of social consent on alcohol abuse, which may lead to addiction. Social consent also refers to young people drinking. Drinking in a family takes place on occasions such as family reunions, celebrations. Moreover they expressed that it is relatively easy for young people to buy alcoholic beverages in shops. In the opinions of GPs, a serious contribution to alcohol misuse is the prevalent masculine culture:

GP1: *He wants to yell that everyone say: “get a grip, bro”, “be strong, be a man, don’t drink”. It is all bullshit (...). It solves nothing. Quite the contrary: I am the man, I will drink*

GP5: *All men drink.*

Among the social-macro reasons, GPs also found the issue of alcohol availability and economic interests of the state. The increasing number of alcohol outlets is believed to play a crucial role in ratios of alcohol-related problems. The question of increasing physical availability of alcohol, however, raised doubts about opportunities for its reduction:

GP1: *This is a case for local communities and the law in general. Where alcohol outlets should be situated, how far from schools or public institutions, how many 24-hours stores in particular community. But you cannot ban alcohol, each of us has contact with alcohol..*



Moreover, GPs raised the question of conflicting interests on policy level, viewing the fact that the state earns money on alcohol, this a conflicting interest (to restrict alcohol sales).

Reasons pertaining to a social macro level were most commonly referred to by social workers who referred to such circumstances even more frequently than GPs. One of these circumstances raised was the cultural determinants of alcohol drinking. According to SWs, in Poland there is a *cultural acceptance for drinking* (SW5); *“We are a tolerant society [when it comes to alcohol] (K3SW3)*. Social workers also emphasized the fact that a cultural acceptance for drinking includes the help and care of intoxicated or addicted individuals. The issue of alcohol availability was often referred to by social workers: *“One goes to the store and sees alcohol, you’re exposed to alcohol in almost every store”* says one SW.

Alcohol producers respond to the demand for alcohol with customization of the offer. Children are also targeted with specially designed non-alcoholic products which make them more prone to learn alcohol-drinking behaviours:

SW4: *This is education of society from the beginning. Kids are raised in the cult of drinking. There is a special champagne for children - Piccolo. Parents buy it, kids grow with it – name day, birthday parties means alcohol.*

The question of alcohol controls was set in the context of regulation of alcohol policy in Nordic countries. However, the Nordic restrictions on physical and economical availability of alcohol were believed to be somehow ineffective:

SW1: *This is a different alcohol availability model. In Sweden or Norway there are about 200 stores selling alcohol whilst in the city of Bydgoszcz alone there are 220. (...) Young people preload alcohol before parties and then buy a bottle of beer in the bar. Alcohol is expensive, so they get it another way.*

Social workers also put emphasis on the fact that alcohol consumption is boosted by marketing and advertising which delivers the pattern of lifestyle. The question of alcohol commercials targeting young people was also raised. SWs also noticed the role of media in setting the patterns of drinking and its promotion. Social reasons on the micro level (family, home, near living environment) were the most common among GPs and generally concerned the family. Besides the problems occurring between spouses or partners, especially resulting in the divorce, GPs pointed to the personal addiction-related “baggage” experienced in addicts’ family of origin:

GP1: *A classic. A person with troubles in a childhood, in family where addicts lived. It is easy for him to get in addiction; after all, he experienced it in childhood.*

GP3: *This affects cognitive and behavioural aspects of alcohol behaviours: Escape to alcohol is the only way he saw. He made this a defensive mechanism. He could not solve problems in another way because of being raised in such an environment.*

According to social workers, several addictive behaviours can be attributed to the family, mainly to the family of origin. Families actively participate in the process of learning addictive behaviours, buying children non-alcohol drinks such as non-alcohol champagnes *“which is a symbol of alcohol”* or offering them a head on the beer. The social workers’ professional experience included cases of inheritance of addiction in families: *“I have families in which if parents were alcoholics then their children also have alcohol problem”* (SW). Another micro social reason referred to by SWs were the mutual relationships in



family resulting in co-dependence of both parents and children, which has to be stopped:

SW2: *Alcoholics have the consent of their families to drink. I have a client whose mother drinks. And she buys her beer, because after all she is her mother. She also wants to pay her debts. It is a great consent on drinking.*

The social micro level also comprises friends or a peer group that make up the closest environment. Families are not alone in setting the conditions for drinking, but also peers and the drinkers' environment in general. The binding norms of drinking in the addicts' environment are so pervasive, that they increase chances of relapse.

Regarding views on the consequences of alcohol problems, GPs raised several health issues related to alcohol consumption. According to them, alcohol leads to physical destruction and other tragic results, such as loss of health or life, drinking to death, liver cirrhosis. Moreover, alcoholics suffer from serious health damages as brain swelling or damaging the cerebral cortex.

Social workers also remarked on the negative biological consequences of long-term consumption of alcohol:

SW1: *They stop drinking and they die;*

SW4: *Individuals who drink vast amount of alcohol in their lifetime have damaged central nervous system.*

According to the SWs, alcohol elicits physical addiction (contrary to psychological addiction in gambling), leading to overdoses or withdrawal symptoms. Among other biological consequences were the so-called 'vedge' (drinking to wipe out the painful consequences of alcohol intoxication or withdrawal) and a bad mood.

GPs stressed the fact that alcohol leads to both mental and physical destruction. *Hitting the skids means no perspective but alcohol* (GP) as there is no escape without a help from others. In addition, staying sober was seen as a question of strong character. Some GPs argued that alcohol can serve also as a remedy to problems as may be a better help than anything else (around). Social workers rarely raised the personal consequences of alcohol addiction. If so, they pointed to psychiatric treatment-related issues. For GPs, social personal consequences of alcohol problems were loneliness and alienation: *there was no one to give them a hand, to explain*, as well as social marginalization after several years of drinking. An addict may end up in a residential home or even in jail after trouble resulting from alcohol. Consequences may also affect the private sphere, as in a case of the loss of a life-partner - but it can be also a *trigger to start a change as well* (GP).

Social workers also argued that alcoholism is the kind of addiction that *degrades the individual in social context*. As one may lose one's family, job, become a homeless person, be imprisoned or put in corrections facilities. The social marginalization degrades the individual and affects motivation. Consequences to the social environment of the addict were the most frequently referenced category of consequences in both professional groups, who raised the issues of violence, victimization and co-dependence of family members.



GPs stressed the problem of violence against family members and their co-dependence on the first place:

GP5: *Violent behaviour and destruction (...) Alcoholism is often combined with violence in a family;*

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GP5: *Violence breeds violence, this women may psychically destroy everyone around.*

As a result, violence, terror, the helplessness of the victims, and the subordination of family members may breed co-dependence. In general, the issue of co-dependence was often raised as a serious problem for addicts' environment. GPs also asserted that the dominance of male abusers and social consent given on oppressive behaviours become the norm:

GP4: *This is a social consensus here, one can have a fun while others are out of range. This is the norm: this man may drink, his wife and children have to wait.*

Similarly to GPs, social workers also largely covered the issue of violence as main consequence in the social environment. Violence also becomes a major problem they face in their professional experience:

SW1: *I have realized that in last year's people access of social assistance changed. The boundary has been altered. It used to be persons who lost jobs or the main reason was poverty. Now the range of problems is wider. (...) These people do not apply for financial support. They come for counselling and support of that kind.*

SW2: *Because of alcohol and violence.*

SW1: *Yes, mainly because of that.*

Alcoholics are believed to blame their partners for their own mistakes and failures, and this can bring about a co-dependence:

SW2: *He will blame her. Make her feeling guilty. The psychological violence will escalate. This is a typical violent behaviour. According to my experience, 80% of alcohol cases are also cases of psychological violence.*

Violence is usually reported by third parties: mothers, spouses of the addict – and the scale of a problem is high: *80% of violence is alcohol-related* (SW). These are hard cases in social workers' duties because the mechanism of co-dependence has broad implications:

SW3: *I have a lot of such clients: addicted or violent. These are hard relationships: mother-child, a very different relation than husband-wife. There are a lot of cases of 70-year old mother and 40-year old drinking son. She sees a little boy in him that needs a care from her.*

Therefore, social workers highlighted the need of co-dependence treatment:

SW5: *If we consider alcoholism as a disease, then we should consider co-dependence as a disease too and treat it. (...) If he dies, then also children will be affected. This is not his personal disease only.*

Among other social problems, social workers mentioned emotional problems of children, economic deprivation of families who become poor, indebted and evicted (SW). SWs also pointed out the process by which drinking consequences turn into to drinking reasons.

Regarding how to deal with alcohol problems, some biological environment interventions were raised in discussions, particularly by Polish GPs, in the form of the problem of more integrated treatment and the lack of knowledge among medical personnel:



GP1: *This is a problem of ignorance of medical milieu. I have been a family doctor for 14 years and don't know where the nearest therapy centre is. This is hardly organized. It's embarrassing but patients know more than me. (...) They come for a week-long sick-leave because they want to go into treatment.*

Another GP acknowledged the medical ignorance of addiction-related issues and said that that patients, rather than a doctor, have to take care of their own treatment and find a proper service. Nevertheless, some GPs claimed that individuals with alcohol related problems visit a physician only to get a sick leave, not to be treated. On the contrary, some social workers raised critical objections to the biological determinants of addiction and its medical treatment.

One common opinion among GPs was that the addict will not realize that he is in trouble unless he hits rock bottom: *They have to feel, they are pitting the bottom, that something bothers them, that they want to get away from this. According to GPs Nothing can be done by force.* (GPs.) The addict has to show readiness to try, being properly motivated to start treatment. Nevertheless, GPs argued that chances for successful recovery are small, even if a patient is properly motivated. The question of the effectiveness of addiction therapy spread to cover the issue of compulsory treatment, which also raised doubts among participants. Similarly to GPs, social workers also stressed the role of motivation in addiction therapy. According to the social workers, one of their tasks is enhancing the motivation of clients to visit an addiction treatment specialist, as well as to help in the identification of the problem:

SW5: *Each therapy must be based on voluntary participation or we implement pharmacotherapy that might help somehow. There are options but this is work, work, work and encouraging motivation.*

The effort is crucial as a person must understand his or her own situation. Moreover, there is a need to raise the individual awareness and responsibility of the addict. In addition to therapy, some SWs proposed the life skills learning:

SW1: *He must learn how to solve problems in everyday life, otherwise he will become an alcoholic.*

Some social workers argued that the effective way of dealing with an addict is to make him scared of the consequences:

SW3: *According to my experience, alcoholics have to be scared of consequences – they obtain a court order (...) or they almost die but somehow come out intact and start a new life.*

These consequences often include formal measures set up by a court decisions. However, they often fail to be enforced.

Considering any obligatory measures in a wider perspective, compulsory treatment was also believed to be ineffective:

SW4: *The individual has a right to choose whether he wants the treatment or not. It is very rare that a person that was forced to treatment will recover.*

GPs recommended contact with psychologists. However, they find it difficult in their professional practice as they claim there is an insufficient number of psychotherapists and the psychotherapy is expensive. GPs refer both patients and their families to therapists as they claim that addiction is not in their range of expertise:



GP7: *Psychotherapist should be employed in each out-patient clinic. There are many problems which patients address to the doctor when they should meet a psychologist. As a result, a doctor wastes his time, it is psychologist who should solve his problems.*

Social workers also refer addicts to treatment specialists:

SW4: *The first thing that an individual receives from me is the information about his problem and getting sent to a specialist in addiction treatment. As a social worker, I don't have the time or ability; I'm not a doctor to treat them.*

According to SWs, the treatment provision is inadequate in relation to the actual demand, especially for long-term alcoholics who have experienced several therapies and for residents of small cities (SW6). Moreover, some argued that treatment obligation should be reconsidered (SW3) and treatment services should also cover family members. Among the barriers to treatment, the requirement that the client must be sober at the moment of admission to treatment was mentioned.

Personal social aspects of alcohol therapy came up only occasionally in the material. They comprised sports or physical activity: *Some travelling, sports, so he would more active outdoor, outside the home* (GP7). The role of religious motivation was also stressed. Nevertheless, the issue of the AA movement or 12 steps therapy were mentioned only twice in the material, one time in each group.

The last way of dealing with a problem (in the coding system) – social environment – was the most frequently discussed of all categories in both professional groups. The collected material is vast and can be divided into four subcategories: alcohol policy, prevention and communication, treatment and social assistance and family. Each of these categories is presented below for both GPs and social workers.

Some interesting views on alcohol policy were expressed by the Polish professionals. As GPs found that an economic model of consumption leads to widespread alcohol retail chain (GP5), they pointed to physical restrictions on alcohol sales at the level of Gmina (Polish equivalent of community or municipality) in setting limits on the distance of outlets from schools or, in some cases, also on the number of alcohol retail outlets in a certain community (GP1). They also stressed the need for integrated policy: *comprising different mechanisms: enhancing individual motivation, family support, state policy instruments, AA. All of these should interact* (GP7) as they recognized the absence of coordination of actions taken by the police or social assistance (GP6).

Social workers raised the question of alcohol policy more often than GPs, stressing the need to limit alcohol availability and also its affordability. They argued that relatively low prices of beer and strong alcohol offered in small packaging facilitates the consumption and changes the pattern of drinking among women and the middle class (SW1). Restrictions on alcohol retail sales are believed to play an important role in increasing the alcohol-related harm.

The restrictions on physical and economic availability of alcohol should be a part of comprehensive state policy towards alcohol, said the SWs. Nevertheless, some social workers called into question the alcohol control policy:

SW4: *Excuse me, but why does the rest of society have to suffer the effects of restrictions on alcohol availability because of some alcoholics out there?*



The notion of strict policy measures also raised doubts of its potential consequences:

- SW2: *They should introduce prohibition in Poland but I do not believe in such miracles*
SW5: *But society needs alcohol*
SW4: *Some of them will be blind because of drinking methyl*
SW1: *Even worse consequences.*

Moreover, employing strict measures in alcohol policy is believed to be impossible as the state *does not have an interest in reducing alcohol consumption as it has benefits from alcohols sales* (SW5).

Regarding prevention and communication, the GPs expressed the view that professional information must reach all social groups introducing the notion of the addiction as a disease. However, some specific professional groups should be equipped with detailed knowledge on addiction, such as school teachers and physicians, so they could refer an individual to further specialized treatment. A third kind of information aimed at parents should be available in schools, clinics and hospitals. It has to be comprehensive and intelligible; e.g. bullet point leaflets about the rules of behaviour in addiction problems (GP). Another specific group mentioned by GPS were individuals suffering from co-dependence:

- GP1: *In general, information should reach co-dependent individuals in the first place, so they could learn how to behave in certain situations.*

GPs also stressed the need for social campaigns targeting minors. In general, knowledge about addiction may also serve to help addicts realize they are already addicted.

Social workers also identified the need for raising public awareness. Prevention is believed to play an important role in reducing the risk of alcohol-related problems. The influence of stereotypes, cultural norms and the effects of stigmatization were mentioned. Social workers also mentioned the impact of anti-addiction messages in the media: e.g. a celebrity speaking out on her alcohol addiction: *this may help overcome the shame which impedes the decision to start treatment* (SW1). They argued that presenting ex-addicts speaking on their problems in the media may discourage youth from alcohol or drug use. According to social workers, social campaigns in the media, should convey messages about alcohol addiction, risky drinking, co-dependence but also finding professional help. They also identified the need to spread information on addiction problems among professional groups:

- SW2: *We should build awareness and teach all professional groups who meet this problem about addiction. Social workers, medical services, teachers, so they would know what addiction is about.*

The prevention of alcohol problems among young people was of specific importance. Social workers stressed the crucial role of school. Schools could also organize trainings of resilience to avoid alcohol-related problem behaviours. This is important as the young people are exposed to fancy alcohol marketing. Moreover, young people should be protected against alcohol advertising.

When it comes to issues of treatment and social assistance the Polish GPs expressed the view that compulsory treatment would be the appropriate instrument to reduce alcohol-



related harm. However, it was also claimed to be ineffective. GPs complained about the lack of information on addiction treatment options which was considered a serious barrier to treatment. Polish GPs also stressed that young people avoid contact with physicians and are prone to look for help on the internet as it offers anonymity and serves as a source of information on free of charge treatment options.

According to the Polish social workers of the study, addiction treatment should respond to changes in the profiles of drinkers, as the number of high-risk drinkers increases among women. Social support services should cooperate or employ an addiction therapist in social bureaus to contact, motivate and refer addicts to specialized treatment (SW). Social workers also stressed the fact that GPs do not refer patients with alcohol problems to social assistance centres (SW). They also found difficulties in cooperation with emergency help services. Social workers also meet with criticism as people wag the moral finger at them because they are believed to *focus too much on alcoholism*, and alcoholism is claimed to be *an illness created by psychologists and social workers* (SW4). According to some SWs, addiction treatment is generally ineffective, there is scarce treatment offer in small cities or in rural areas (SW1) and months-long waiting lists for addiction therapy (SW5).

Social workers highlighted the need to include co-dependent members of the family, not only the drinker, in treatment procedure. They also criticized the institution of obligatory treatment, which is claimed to be ineffective as clients don't have a proper motivation to change and agree to it only to get the court out of the way. Social workers also criticized the current law: *the law on prevention of alcoholism is leaky, it does not work* (SW6). According to the opinions of some SWs, existing social policy toward alcohol addicts is unjust and, in fact, perpetuates alcohol addiction. Most of the criticism came from SWs with professional experience in the field of alcohol addiction. They stressed the fact that addiction obligatory treatment by court order can be terminated on the patient's demand (SW4) or through intentional violation of the rules of treatment (SW6). They also highlighted the lack of an instrument of direct control.

Both GPs and SWs stressed the role of family in the process of addiction recovery:. According to GPs, social policy should support women and children living in families with their alcohol drinking husbands:

GP1: *As we have seen in the videos, the addicts were the dominant ones. Physical advantage of husband over the wife and kids. It is very important that families should be supported. A wife who is a victim of violence will not have the strength to fight her husband's addiction.*

There is also a need for specific services for women who decide to leave drinking husbands. GPs also identified the need for help for victims of psychical violence:

Social workers also point out that the family helps in taking decision on entering treatment, support and protect the addict. However at the same time they stressed that the family must be properly protected. SWs noticed that for some addicts, the motivation for treatment or sobriety can be reinforced when the children are taken from parents by a court decision. Moreover, when an addiction problem concerns children, other members of the family are more eager to look for help. Social workers often referred to the procedure of so-called 'Blue card' introduced by the Law on domestic violence (the



procedure protecting members of family against domestic violence) which gives them instruments to control the situation in families suffering the alcohol-related problems such as violence and oppression: *Domestic violence is democratic and affects also better-off families* (SW2). However, SWs claim that while it helps victims, it has no further implications for the addicts who cause the alcohol-related violence.

The General Practitioners (GPs) interviewed in Poland expressed opinions that **gambling** is a type of addiction often described as a specific opposition to alcohol. Nevertheless, whereas alcoholism is considered a valid social problem, gambling is not: *This is a margin-- a small percentage of our population*⁹, says one of the GPs. In general, their perception of gambling is limited due to lack of experience and knowledge; its image is rather vague with exception of slot machine gaming. This particular form of gambling engages young people and individuals with lower social status. The following GPs reason around the socioeconomic status slot gamers:

GP6: *Those who play slot machines are not better-off people, they spend their last money on it;*
GP3: *Poor people do not go to casinos.*

Slot machines offer gambling for all as it is relatively cheap to play and their high density facilitates the access. Gambling is considered a “hidden” addiction. Its invisibility is a serious barrier to treatment services. This problem with the identification of gambling addiction appeared in all focus groups. Gambling is much harder to recognise than alcohol addiction.

Alcohol addiction is a familiar problem as GPs often have a contact with such patients but at the same time they admit: *we don't recognize the fact that people may have that (gambling) problem* (GP8). Physicians claimed that they see and can sense those who abuse alcohol as the drug affects the body which makes the addiction noticeable. As one GP put it: *you see the destruction* (GP7). The alcoholic hits the skids and visits a doctor with somatic health problems. Gambling is a *more psychological problem. It does not affect somatic health* (GP6). However, to some extent a physiological mechanism is also acknowledged to be “*certainly the same*” but “*so far less well-known*” (GP). The lack of knowledge on gambling issues creates a gap that must be filled with patients’ initiative and motivation for treatment – they have to declare the fact of their addiction by themselves. As GP4 admitted: *we don't have the knowledge because these are people who do not confess to be gamblers*. This can be a “great surprise” when revealed by a long-time patients, especially females.

Compared with other addictions, gambling was seen as more difficult to recover from. Addicts of substances sooner or later find the turning point that stimulates them to make a change – drinkers can change their lives since they hit the bottom but there is a doubt if gamblers can: *they lose money, home and family, yet they still play* (GP2).

Similarly to the GPs’ experiences, gambling rarely appears as the problem for social workers. Most of their professional experiences entail alcohol-related issues. The most



common opinion was that gambling is an exceptional problem affecting very few people and produces less harm than alcohol: *“These are rare cases, some individual cases happen. [Contrary to alcohol, gambling is a] twilight zone; gambling is well hidden while alcohol is much more visible; statistically concerning lesser group of people. (SWs)*

Social workers report that clients do not present with this problem: *This takes place but we do not face it, you are able to recognize typical alcoholics but you cannot recognize a gambler in any case, because they do not stand out as our alcoholics do.*

Some social workers claim: *This is not a problem for us. This is not a problem to us, professionally.*

Social workers say they do not have sufficient knowledge to deal with gambling-related problems: *We cannot recognize these people. Frankly, I did not have any training on gambling issues for many years (SW4).*

Their knowledge on gambling comes from their private experiences or from the media and popular culture. Among the reasons for the absence of gambling-related problems in the social workers’ professional experience were economic issues. Some social workers share the common belief that gambling is a choice of better-off people. Nevertheless, the SWs make a distinction between “small” and “big” forms of gambling. Small gambling includes slot machine gaming, betting and lotto, “big” gambling includes casino games:

For some clients of social welfare, playing lotto, slot machines, betting and scratchcards became an important part of life:

SW5: *Totalotek, scratchcards for one Zloty or two, on which they spend the majority of their incomes*

SW2: *Our clients play sometimes, they lose pennies but still play (...) on slot machines, horse racings, betting. Of course they do not admit it.*

In some cases - during interviews with clients - gambling comes up together with alcohol misuse and psychological problems such as depression. Alcohol reduces the pressure associated with gambling. Nevertheless, gambling leads to depression, debts, and introductions into the criminal underworld, endangering family. Gamblers lose all money, their families are disrupted:

SW5: *They fall into the spiral of debt, as one debt pays another, debt collectors take most of their income.*

Consequences of gambling are severe: gambling *wreaks havoc*, while those affected by gambling *lose faster and more* (SW3) and, unlike alcohol addiction, gambling-related harm comes some time later and has high costs: *“Contrary to appearances you can also lose a lot of money on these slot machines. Even a few hundred Zlotys a day” (SW). A common opinion is that gamblers decide to undertake the treatment only when they lost everything.*

When it comes to the reasons expressed for gambling by the professional groups in Poland, only GPs perceived gambling to be a physiological mechanism that may affect biological functions of the body, similarly to alcohol:



GP1: *She sees that machine and she leaves all behind... It is just like drinking the first bottle.*

GP7: *Gambling is a physiological mechanism, maybe not well-known so far. These are similar addictions (gambling and alcoholism – MB), they affect the health and the body (...) the mechanism is definitely the same.*

GPs also raised topic of the role of individual predisposition to gambling and specific mental or personality disorders that can contribute to addictive behaviours in general:

GP3: *They (addicts) were normal people who, as we all are, were not evil. They had to have some predispositions...*

Emotions were the most common reason for gambling according to GPs. The moment when the money comes out of a slot machine or the dice hit the table is a great experience for all players. But fun, thrill, as well as gaining the attention of people around, may hide the progress of addiction behaviour. Aroused emotions distort rational thinking:

GP1: *This was the story of free falling into addiction. He sees that he drowns in, he likes it and so it goes. He probably even wins some millions.*

Gambling is also the way to cope with the boredom and to spice up everyday life:

GP2: *Maybe she has gone through weariness, boredom and a well-rounded life before. She was a good mother, a good employee having high salaries, and then such an impulse as she wanted to feel the excitement, to try something. else.*

Social workers see gambling as a way to cope with stress: *she calmed down and relaxed when she started playing (SW)*. Like GPs, they guess that gambling may help to overcome boredom: *killing time makes people doing all sort of things, finding a pleasure in it, repeat it continuously (SW4)*.

Compulsion plays an essential role in gambling. GPs believed that gamblers are not able to control their instincts (GP1). Gambling is *automatic, they do it again and again, without repentance (GP2)*, it stimulates the gambler while the prize to win recedes into the background:

Compulsion was the major reason of gambling according to SWs too. Compulsion means *self-winding mechanism (SW5)*, being out of control, unable to take rational action, thinking about playing only: *All connotes the game (SW1)*. The control of behaviour is vital: *It is sad to see that a man cannot control himself, cannot stop, don't have a free will (SW3)*. Gamblers cannot stop until the money is gone. The need to play is immense: *It gets deep in your blood (SW4)*. Strong addiction makes a strong need to play and reliefs the craving. Common events were also relapse and loss of control even after several years of gambling abstinence:

SW5: *I had a client who had been a gambler for 5 years, went through therapy. High social status, private treatment and when he thought that he was strong enough, succeeded for 15 years, he went to the casino. He went because he wanted to show everyone that strength. And everything went back to the start: apartment, a car, everything was gone.*

Individual character features were not presented by SWs as reasons for gambling addiction. However, according to GPs, having a “weak character” as well as some specific character traits facilitate gambling addiction. According to GPs a “strong character” is a protective factor in gambling addiction:



- GP4: *They are predisposed to become addicted. Some personality traits that predispose to addiction*
GP1: *Exactly. I just think they are weak. I had a neighbour who was addicted, his wife was mentally stronger.*

Gambling affordability is one of the major issues among the reasons of gambling or not gambling for GPs. In general, they claim that gambling is available for people having sufficient financial resources to afford it. However, lotto and scratchcards are forms of gambling designed to the wider public:

- GP6: *People with no money would not get into gambling*
GP7: *This goes a little bit into the other direction. Perhaps the issue of gambling is less visible to the public, while the alcoholism is somehow more current*
GP1: *Gambling is more expensive after all...*
GP7: *We're a poor society*
GP6: *Not everyone may afford it*
GP4: *But "Lotto" lottery is some form of gambling as well and a lot of people playing it. ...There are scratchcards*
GP1: *There is also gambling in the internet after all.*

The high density of sites offering easy accessible forms of gambling as slot machines was recognized to be a purposeful action geared solely towards profit of the operators. Easy access to different forms of gambling may increase the risk of gambling addiction, however this threat is overshadowed by the lack of knowledge on its destructive effects:

- GP6: *There is no social consciousness that gambling is also a form of addiction, that it needs some kind treatment.*

The issue of gambling availability and vested interests of gambling operators were also raised by social workers: *there is too easy access to slot machines. It offers great profits. These slot machines are placed everywhere, they should be placed only in casinos (SW).* The decision to start gaming might be facilitated by the placement of slot machines and gambling sites: *The placement of slot machine may encourage the individual to play (SW).* The SWs addressed also the question of affordability of slot machine gaming or betting. In the social workers' opinion, governmental interventions are not likely to improve situation. Conflicting legal regulations are used by gambling operators to evade the law:

- SW1: *In Poland we have the ban on gambling out of casinos, ban on advertisement, but for example in sport there are betting companies that evade it..*

The problem of "small" gambling, especially slot machine gambling seemed to be unsolved:

**

- SW1: *We are helpless, how we are supposed to fight this? No one controls the age, no one controls the situation...*

Among the social reasons for gambling on the micro level, GPs raised the problems occurring in the life course of the individual, such as a loss of work, loss of family or a partner and suffering from loneliness and alienation. These events can be both reasons and consequences of a gambling addiction. The role of the family is ambiguous – it may provide a support for a gambler who gets into trouble, however may also accept the fact of gambling addiction if a gambler wins.



Issues related to family were also pointed to by the social workers, who were eager to look for tragic events in gamblers biographies that may have pushed them into gambling. Unlike the GPs, the social workers evaluated measures undertaken to prevent gambling critically for failing to recognize the role of family:

When it comes to the consequences expressed by the Polish professionals, biological consequences came up in the material only once. According to GPs, psychological consequences are severe, including depression, and may lead to social and economic marginalization, as well as death. Salvation for a gambler is through therapy or significant others - family and friends: *“ I would predict suicide, because he is already against the wall, unless he has someone who keeps him alive, so he would be able to break out of this”*, says GP6.

In general, doctors claim that individuals who try to overcome gambling problems alone, without help from other people or institutions, are destined to fail. Social workers' opinions were similarly pessimistic. Gamblers lose control over their actions and are expected to feel moral guilt and remorse. Individual problems as well as problems in the workplace and professional life may push them to depression and even suicide. They end up in rehab or in a psychiatric hospital. Gamblers face addiction problem early because of *enormous tension (...) an additional factor, not a stressor, but causing the mental degradation, typically psychological* (SW2).

GPs highlighted social consequences of gambling, such as marginalization, alienation and loneliness. As gamblers lose money, they risk homelessness, being cleaned out or even being detained. Losing property is perceived as a harm to the gambler rather than to his family.

Loneliness and isolation were highlighted by social workers. However, their professional experiences also show that some of their clients indeed suffer homelessness, and have family and legal problem problems due to different kinds of gambling: lotto, scratch-cards and slot machine games. Gambling was also by SWs pointed out as occurring together with alcohol abuse: *“Some of those who are homeless, end up like that because of gambling, alcohol and gambling, alcohol first. These are two main reasons. Prisons, family problems, but you begin to uncover their stories, some of these elements are coming out”* (SW1).

The gambling addiction encloses a gambler in a loop – each lost game fuels the next try. In this way, gambling consequences are, in fact, reasons to start another game. According to GPs, in comparison to alcohol, gambling entails less violence and anger in family relationships (GP1). However, consequences of gamblers' destructive behaviour affect their families. Even if a family overcomes the problem, it may still suffer from the financial consequences for a long period of time (GP2). Social workers pointed out the problem of co-dependence and the responsibility taken on by children on behalf of their parents who are gamblers (SW4).



When it comes to views on how to solve gambling problems, biological aspects of therapy for gambling were almost entirely absent in both professional groups, whilst psychological questions of therapy were often raised, particularly among the GPs.

The subject's willingness to quit was often linked with motivation due to "*hitting the bottom*". GPs claimed that an addict or a person who gambles or abuses psychoactive substances has to realise that there is nothing left; to have found himself at the lowest point of life. In this particular moment, a gambler or any other addict begins to be aware of the problem. This is when a decision about entering treatment can be made. Individual motivation is crucial, otherwise any kind of therapy will be futile: GPs argue that very often people keep the problem inside the home; they are afraid of letting it out. Moreover, gambling is thought of as a special case in addiction and seems difficult to deal with through therapy.

GP2: *This is a kind of pleasure for them – if you take it away, then the rehab won't give anything. He must take the decision by himself. A gambler is a hard case because you have to offer some substitute for gambling.*

In social workers' conversations, individual motivation was also found in a question of using treatment services. Entering the treatment or therapy programme was perceived as the result of an individual's decision, not an external pressure. Support from those closest in the environment may facilitate change as the individual is often powerless in his or her addiction:

Information and knowledge about where to seek professional help must reach gamblers before they lose everything. Gamblers may not see the solution on their own, and therefore need to have access to key information about health and treatment options. In their professional practice, GPs propose and refer gamblers to psychologist therapy programmes, although not everyone can afford them. Visiting a psychiatrist, on the other hand, is free of charge, but gamblers are often not eager to go to psychiatrists, especially if there is a "*2-months long waiting list*" (GP8). Moreover, the client entering therapy must be properly motivated.

For social workers, individuals should avoid gambling sites and slot machines in general, which obviously would prevent them from gambling. Psychotherapy may help to stop the "*gambling loop*" (SW), but it was perceived as a complementary measure to practical adjustments. Hobbies, integration into a new lifestyle or the need to create intellectual and emotional resources that can be used by an individual to overcome the potential problems were mentioned: "*The people who make sense of their lives rarely fall into addictions. Those which have a purpose in life, motivation, religious or any other, enjoy what have, they can appreciate this, they can overcome all difficulties* (GP7)."

Environment-based measures and macro categories in ways of dealing with gambling were the most frequently coded in the Polish material. In both groups the issues of restrictions on gambling availability, the role of the family, information and providing treatment services were identified.



The question of availability was often raised and concerned slot machine gambling in the first place. The limitation of availability of slot machines was believed to be a key issue in solving the problem, and therefore the restrictions on gambling must include restrictions on its physical availability, e.g. placing them only in particular designated areas: *It should not be present in places that we pass by going, because the temptation is greater* (GP6).

Effective measures in gambling policy should be supported by adequate health communication, emphasized the Polish GPs. The role of information in gambling therapy was claimed to be vital for both gamblers and those affected by co-dependency. Another trait among the environmental categories of ways of dealing with gambling was the role of the family. The family was claimed to be the main source of motivation and support for a gambler, and key in facilitating the process of recovery from gambling addiction:

GP7: *The family, who see this, have the most to say. Someone from the outside may not know about the problem;*

GP4: *There must be a support from the family, because if there is no support and no agreement from a patient – there is nothing we can do.*

The family is the first and most important witness of the problem; other people can be tricked or simply unaware of the problem. Nevertheless, support from others close to the addict – friends or partners – may also play a vital role, since they help the sufferer to overcome the worst enemy addiction –loneliness:

GP4: *Support from the family, closest friends is important. Alcoholism, gambling or compulsive eating – a man will not help himself, he needs a support from the group of closest persons, someone who gives a hand, not hit more.*

The structure of environmental aspects of ways of dealing with gambling was the same in the groups of social workers as with GPs. The availability of gambling seems to play a crucial role in the expansion of the problem. Similarly to GPs' opinions, the low threshold for accessibility concerned slot machine gambling. According to social workers, the gambling question can be solved by employing measures of social policy corresponding to restrictions on availability and promotion of alcohol:

SW1: *I think that the government policy should be quite the opposite to promoting drinking or gambling – it should restrict (number of) outlets or gambling sites operating for 24-hours.*

According to the social workers, gamblers face obstacles in accessing treatment services as public addiction services focus on alcohol and drug addiction. Therefore, gamblers often look for alcohol therapy, given that they have to pay for specialized gambling therapy in private clinics. As a result, mixed therapy groups are formed, comprising more gamblers than alcohol addicts. Moreover, the number of female patients is increasing (SW). There is little or no information on treatments available:

SW4: *There is a lack of information, or even no information and places for people addicted to other things. This is a real tragedy in case of gambling or sex addiction. (...) There is only a private treatment on offer in Warsaw (...) a lot of talking about alcoholism, drug addiction, eating disorders but other addictions are completely ignored while there are a lot of them.*

Social workers highlighted the problem of incompetence among several professional groups in dealing with gambling-related issues and the need to disseminate information and knowledge:



SW5: *First of all, the social awareness and learning about the addiction has to be developed in all professional groups who are in contact with the problem: from social workers, through medical services and schooling. I do not mean the level of expertise of therapists, but they should know about the gambling mechanisms and should try to systemically include the family. Yet, we do not consider the family systemically. We help addicts but do not help co-dependent wife and children.*

Members of family witness gambling, alcoholism and other addictions. At the same time, as the negative effects of gambling, such as social and economic decline, occur, it is the family who suffer the most:

SW4: *There is always a problem where there is a family around, minors, those dependent from a person who has a [gambling –MB] problem. And then there is a real problem when you come back home and you feel the eyes of your children and you know they are hungry.*

In the collected material, social and psychological categories dominate among the reasons and ways of dealing with **eating disorders (ED)** – psychological emotions and social macro as well as micro categories were most often referred to by both GPs and social workers. The GPs were also more likely to point out psychological features of the individual. The most common types of consequences cited were those of biological nature affecting the individual, while social consequences covered the issue of co-dependency. Psychological consequences were not raised. Social environment codes were dominant in talking about ways of dealing with eating disorders. Nevertheless, biological environment features, comprising several instances of medical intervention, were found by GPs to play an essential role, even more important than specialised psychologist treatment.

The question of EDs among Polish professionals is of a different kind than alcohol or gambling addiction. There are no major differences between GPs' and social workers' perceptions of the problem. Both groups made a clear distinction between diseases as anorexia or bulimia and obesity. The material illustrates the potential for framing eating-related problems in the context of addiction behaviour. GPs were more eager to stress the problem of eating disorders than social workers in all analytic categories. The largest differences were found in discussions around the therapy-related issues, particularly in considering biological and social environment perspectives. GPs were also more likely to point to the role of individual character traits as reasons for EDs.

In discussing reasons, GPs claimed that eating can be a form of consolation as it improves mood and relieves prevailing tensions and stress. SWs also stressed the fact that food provides a pleasure and can be considered a reward. Both professional groups pointed to sorrow and frustration in daily life as the motive of "overeating". Some SWs articulated the idea of eating in the context of emotion management. Both GPs and SWs claimed that Individuals suffering from eating disorders are of a specific psychological construction characterized by low level of self-esteem and high sensitivity.

In both groups, eating disorders are believed to be strongly influenced by the diffusion of a specifically western-style culture in the globalized world. Another thing mentioned is the transmission of patterns of behaviour which take place in the family, creating a predisposition to excessive eating in children. The essential role of the family in the



creation of unhealthy eating habits was often present in discussions among social workers. The influence of the peer group was also mentioned. Moreover, SWs stressed the idea that that food plays a role in enhancing social relations and integration.

Consequences of eating-related problems mentioned in the focus group discussions include death and several health disorders, such as diabetes, metabolic disorders, hypertension, hormonal disturbances, osteoporosis, cardiac arrest, stroke, atherosclerosis, problems with circulatory system, joints and liver. Psychological consequences were not present in the material. Relating to social consequences, both professional groups pointed to the problem of social rejection and exclusion. Negative consequences to those in the same environment were often mentioned as eating disorders were posited as strongly affecting the family, particularly in terms of co-dependence. GPs proposed several medical interventions by nutritionists, physicians and surgeons, including gastric by-pass surgery and stomach stapling, as adequate measures to tackle eating-related problems.

Both groups stressed the role of motivation and self-determination as well as need to use specialized treatment services. However, GPs pointed out the problem of limited access to specialized treatment. Both GPs and SWs had a high opinion of the effectiveness of social campaigns and school prevention programmes in tackling EDs. The role of friends and family was also mentioned. Unlike their views on alcohol and gambling addiction, GPs were more eager to recommend the adoption of new, healthy lifestyles, as a way of tackling EDs, as well as changes in the government policy such as banning the sales of unhealthy food in schools.

5. DISCUSSION AND CONCLUSIONS

In the Appendix we have integrated interpretations of how the two professions in the different countries view and deal with the problems under study (see Appendix 2). Following the vertical columns in Appendix 2, one can tie together the background and scope of the professions as logical underpinnings of the action repertoires of the two professional groups.

Although the main circumstances such as educational background are the same, our comparisons show some country-specific differences. Not only are these differences interesting when it comes to how these European countries deal with addiction related problems, but they are also interesting for general comparisons of the different welfare state arrangements.

Alcoholism is seen by both social workers and general practitioners from **FINLAND** as a socially anchored problem. The traditional Finnish non-medical (i.e. social) approach towards alcohol problems (Bruun, 1971) seems to be the most important factor in forming addiction images. However, it is not the only disposition for interpretation triggered by the stimulus clips. The organisation of primary health care in Finland might also play a part in forming images of problem drinking. Finnish GPs' medical practice within the context of the welfare state reacts to drinking problems by following a social framework. Also, the perceptions of problem drinking by Finnish social workers reflect



both the Finnish approach towards addiction and their profession's historical position as welfare agents in the welfare state, as compared to therapists giving treatment. Such a resemblance of professional practices with addiction images was earlier identified by Pennonen and Koski-Jännes (2010), who showed that different professions, even though all involved in treatment, express a different ascription of responsibility of addicts for their problem and recovery. This study confirms Davies' (1997) claim that the kind of attribution (here: external or internal) is influenced by "major structural components" and is influenced by the dispositions given by institutions. These dispositions include the (medical and social work) profession's history, the organisation of primary health care, and the approach towards addiction manifested in the task division between professions concerning citizens' welfare.

Egerer (2013) has shown that the institutional context involves not only the country-specific approach towards addiction, the organisation of primary health care and a profession's history, but also gambling legislation. Like Pöysti (forthcoming), he could also identify in interview material that, in the context of the relatively restrictive French gambling legislation, French informants "use" this setting for understanding the rather new phenomenon of problem gambling. They do, however, nevertheless focus on the suffering individual gambler in a similar way to that in which they focus on the drinker. However, in Finland the focus remains, on the drinker's, gambler's, or eater's family for all problems. This pattern of focalisation might hint to another, deeper, level of culture, such as the degree of individualism as an underlying value (Hirschovits-Gerz et al. 2011, Sulkunen 2013).

These results illustrate how the focus-group participants used their existing perceptions to interpret the film clips and the problems involved. It shows how institutions' dispositions are especially potent in structuring participants' perceptions of the world. Institutions are what Berger and Luckmann (1967) call reified structures: the inhabitants of the life world experience these structures as an unalterable part of social reality. This study hopes that unveiling these mechanisms in the case of addiction offers a possibility for reflection and an opportunity to question the inalterability of institutional dispositions, presenting them as interactive in Hacking's (1999) sense of the term. The possibility for such a reflection seems to us especially important for the persons concerned –problem drinkers, gamblers and problem eaters. Neither the Finnish nor the French framing of the three problems should be regarded as better. Instead they entail certain advantages as well as risks: In Finland the social framework might be advantageous in enabling the drinker's family to get help more easily. On the other hand, in this context, the problem drinker (gambler, or eater) might be more easily led to neutralise his/her wrongdoings by blaming his/her condition on unfortunate societal circumstances.

Furthermore, the study hints towards which images play a bigger role and for which problem behaviour. The question is now why in the Finnish context the traditional approach towards addiction plays such a large part in conceptualising the three problems. It seems that the Finnish social framing also fits well in understanding behavioural addictions like problem gambling, whereas in countries, where a medical model is strong, replicating the image of addiction would become rather difficult.



When it comes to the Finnish GPs interpretations and perceptions of gambling problems, they also employ a social frame:

GP3: *I would say that /../ there is no chemical process happening, this is a clean case of senses and thought. Of course, it destroys, but it destroys peoples' own composition. Nothing strange that will [come into the body] and change its activity.*

Finnish SWs discuss the involvement of their profession in helping others harmed by the problem gambler, or in limiting gambler's financial liberties; they also employ a social frame.

A medical framing of problem gambling seems to exist only on the conceptual level of speech; for example, in copying addiction policy and treatment from other types of problems. General practitioners widely discussed social problems linked to gambling, and questioned their abilities and responsibility to act on problem gambling. Social workers also employed a social frame and were critical about their role in treating their clients' problem gambling. However, they claimed a key position in acting on the social harm caused by the gambler to others.

When it comes to eating disorders, both SWs and GPs seem to rarely come into contact with these problems in Finland. Social workers paid more attention than the GPs to the complicated social and cultural background of these problems. The GPs evaluated the characters in the film clips as patients that they were to diagnose from their outer appearance. The division between views on different problems between social work and general practitioners in Finland is especially interesting to discuss given that the country is about to embark upon a complete overhaul of its health care and social services sectors. The declared objectives of this 'SOTE-reform' are the close integration of the social and health service sectors; to fully integrate care and treatment chains whenever possible in order to achieve better outcomes; and to achieve significant financial benefits through economies of scale (Ministry of social affairs and health, 2014). On the basis of the professional and institutional roles in handling addiction problems, we might be able to predict some possible and likely consequences of the SOTE-reform's complete rearrangement and integration of the public sectors' institutions for future prevention and care.

When it comes to **ITALY**, the way in which the selected clips were shown seem often to stimulate the interviewees to compare gambling to alcoholism. These spontaneous comparisons offer an interesting perspective, enabling us to better understand how gambling – a “new” addiction – is conceptualised compared to a traditional addiction.

One Italian GP voiced the opinion that gambling is more easily treatable because it does not involve physical dependence. SWs' opinions are more reflexive and complex. They point out that this kind of distinction is more imaginary than objective. They also seem aware of holding more judgemental attitudes towards gamblers than alcoholics and to apply a moral vision to gambling, as they have difficulties in conceiving it a disease. This is not a novelty in Italian research on addictions, as the medical view has been always



criticized both by Church and also by those who support harm reduction approaches (see Beccaria & Rolando, 2013). Often the operators' anger towards the gamblers is particularly directed at their neglect of responsibilities to their family.

Both professional categories in Italy emphasise the social context as the main cause of addictions (mostly family shortcomings). In parallel, they both discussed a great deal about consequences for the addict's family, and both thought that rehab should involve the whole life context and solutions should be found at the social level. The State is severely criticised for gambling policies, while not for the other problems.

Because of the view that there are a wide range of causes, both categories are pessimistic about the possibility of dealing with the three problems effectively. However, neither felt that this is part of their role as a professional; they also felt that they do not have the resources to do it.

Addiction is not fully perceived as a disease, often there are moral judgements about addictive behaviours. SWs seem to be more conscious and reflexive about this.

Addictions without substances are more difficult to understand (e.g., gambling vs. alcoholism). Conversely, to vent by eating is a more common experience, also among interviewees, but, on the other hand, there was a difficulty in viewing it as a serious problem (except in the case of anorexia).

In **POLAND** the neoliberal transition towards a market economy had a profound impact on alcohol economy, alcohol policy, consumption and the spread of alcohol-related problems. The century-long monopoly system was broken; the Polish alcohol market has become privatised; affordability as well as availability has increased, followed by a large wave of alcohol-related problems.

This was clearly reflected in focus group discussions carried out with GPs and SWs. Both professional groups attributed the high prevalence of alcohol addiction to the growing supply of alcohol, its unrestricted availability and low prices; in particular, inexpensive small containers which make vodka affordable to everybody, including the poor and the young. Despite economic determinants, there are specific, long-lasting features of Polish culture which encourage risky drinking, such as a tradition of heavy drinking and a general tolerance towards drunken behaviour. These macro-social factors were pointed to by both professions, but SWs seemed to pay more attention to them compared to GPs. Both groups seemed to be equally sensitive to micro-social dimensions indicating that alcohol addiction may be related to family problems, inter-generational transmission of heavy drinking pattern, peer pressure to drink – the *wet* social environment, generally speaking.

Psychological reasons followed social determinants but seemed to be of lesser importance. Both groups stressed the view that specific features of one's character increase the risk of alcohol addiction. Nevertheless, GPs were more sensitive to traits such as premature personality or macho behaviour patterns while SWs talked more about 'weak' character as a predisposing trait.



Regarding consequences, similarly to the views expressed on reasons, the *social* consequences of drinking problems prevailed in perceptions of both professions, with particular stress on consequences for the social environment. Family problems, primarily domestic violence, were seen as the most important consequences. Against this background, a question of the co-dependence of spouses was often raised. However, the social consequences suffered by an individual with alcohol problems, such as loneliness, alienation and social rejection, were also noted. GPs mostly claimed that addiction affects mental and physical health, leads to psychological impairment and the deterioration of somatic health, including brain damage. SWs paid more attention to the physical symptoms of dependence, including severe withdrawal symptoms.

Striking similarities emerged in perceptions on the management of alcohol addiction. Both groups were very critical regarding the existing system and stressed the importance of social environmental interventions, including alcohol policy, prevention and communication, treatment, and social assistance, as well as on families.

The majority of the participants from both groups called for access to alcohol to be reduced through economic and physical measures. In their opinion it was problematic that alcohol would be available round-the-clock and they saw a need for prices to be higher. Nevertheless, the perceived limitations of alcohol policy were also noted; restrictive alcohol policy contradicts economic interests and may be seen as unjust in that it affects everybody, those with addiction problem and “normal” drinkers alike.

Deficiencies of existing alcohol treatment were stressed by both groups. Some GPs demanded a return to compulsory treatment. Some SWs claimed that alcohol treatment is inflexible: not appropriate for different groups such as new patients such as women or young people.

The family was perceived as crucial in a process of recovery. At the same time, participants mentioned that the families of addicted people have to be protected and their safety should have priority over the interests of an addicted family member. Psychological therapy, for addicts but also for family members were more often referred to than biological treatment approaches. GPs referred more often to comprehensive treatment approaches while some SWs questioned biological nature of addiction. Both groups seemed to shift the responsibility for treatment onto the addicted person, with the view that the patient has to reach their lowest ebb to be motivated enough to undertake treatment.

For over four post-war decades, Polish gambling was under strict State control and was limited to the State lottery, lotto type games and sports betting, including horse races and football. Casinos and slot machines did not exist until the neo-liberal transitions towards market economy in the 1990s. Despite the visible expansion of different forms of gambling, problems related to addictive gambling have not been subject of systematic research in Poland until very recently. The present study could be considered a pioneering step in researching the perception of gambling by the primary professions



helping those with problems, namely general practitioners and social workers. It is clear from a number of focus group discussions that gambling is not recognised as a frequently appearing problem in the everyday work of these two professional groups, in particular against a background of wide-spread alcohol-related problems. They attribute their limited experience with gambling problems to a relatively low prevalence of “serious” gambling, an absence of immediate deteriorating impact of this problem on physical health, and, to some extent, to their limited competence in identifying and approaching those with gambling problems. Moreover, gamblers are not very likely to admit to their addiction problems or to seek help in health and social welfare sectors.

The gap in professionals’ knowledge about gambling addiction is compensated by comparing similarities and contrasts to better-recognised alcohol use disorders, which constitutes a useful model in describing and explaining more vague gambling issues.

Regarding the reasons for gambling, both groups highlighted psychological factors, including positive emotions that are satisfied by gambling on the one hand, and compulsive traits of gambling, which force individuals to gamble no matter what the consequences, on the other. It was argued by GPs that the loss of control over gambling lasts for years and, similarly to alcohol addiction, is likely to lead to relapse even after many years of abstaining. Biological reasons, however, were rarely mentioned and only by general practitioners. In contrast, social reasons constituted an important part of the discussions among GPs and social workers alike. Among the macro-level issues, questions of unrestricted access to gambling and dense networks of gambling opportunities were stressed, as well as its relative affordability, particularly as far as slot machines are concerned. Micro-level reasons given comprise sudden changes in the life course, such as loss of significant others through divorce or death and consequent loneliness.

According to our respondents, the consequences of problem gambling appear first of all in psycho-social spheres. Only suicide was considered a biological consequence of continuous stress related to gambling, cumulating debts and social alienation. Depression and chronic stress are seen as major psychological consequences. Social consequences, however, predominate: loss of work, loss of a partner, family violence, disintegration of the family, social marginalisation, all very much similar to well-known harms in substance-related addictions.

Neither group considered biological therapy for gambling problems. According to the professionals in this study, a gambler’s individual motivation is crucial; As in the AA model, hitting the bottom is often considered a turning point which may build the foundations of determination to recover and undertake treatment. Of course, support from significant others may reinforce individual motivation and bring about recovery. All participants were aware of a shortage of professional therapy for gamblers. The addiction therapy field is dominated by substance-related addictions and very few professionals are competent enough to offer effective treatment. Problem gamblers are forced to attend alcohol treatment centres or to pay for treatment in a few private establishments. Nevertheless, the primary solution suggested by both groups was to decrease availability



and affordability of gambling, reducing the number of slot machines and moving them to casinos where a higher level of control on their use can be exercised.

Surprisingly, there have been very few differences between GPs' and social workers' perceptions of gambling problems. Among the psychological reasons which dominated discussions in both groups, GPs stressed positive emotions while social workers highlighted psychological compulsion as major motives for gambling. In principle, perceptions of the consequences of gambling were similar. Regarding therapy, both groups thought environmental interventions, i.e. reducing access, the most appropriate approach to reduce gambling problems. In addition, GPs were more likely to prescribe individual psychological treatment, while social workers stressed a role of family support and saw treatment as a complementary measure, supplementing gambling control measures.

The question of eating disorders among Polish professionals is of a different kind than alcohol or gambling addiction. There are no major differences between GPs' and social workers' perceptions of the problem. The material illustrates the potential for framing eating-related problems in the context of addiction behaviour.

In discussing reasons, psychological ones were emphasized. GPs claimed that eating can be a form of consolation as it improves mood and relieves prevailing tensions and stress. *She didn't cope mentally and was overeating stress (GP5); eating is a medicine for everything bad (GP2), It is such a consolation. I think that this is the element of reward - every situation, every failure she simply overeats (GP4).* Social workers also stressed the fact that food provides a pleasure and can be considered a reward. *He takes the food reward after he failed. I think he did what he always does for a pleasure (SW1); Eating is a pleasure for them, they recompense bad things, they want to improve their mood, endorphins secrete (SW5).* Both professional groups pointed to sorrow and frustration in daily life as the motive of "overeating". Some SWs articulated the idea of eating in the context of emotion management. Both GPs and SWs claimed that individuals suffering from eating disorders are of a specific psychological construction characterized by low level of self-esteem and high level of sensitivity. *Her husband left her with children, she did not handle that and was overeating sadness (GP7); He was overeating sadness, this was his way to deal with emotions (GP8).*

In both groups, eating disorders are believed to be strongly influenced by the diffusion of a specifically western-style culture in the globalized world. GPs are aware of the process of diffusion of the cultural patterns in the globalized world: *In the US there are a lot of obese people, over 300 kilos. This is really a problem. McDonalds and other stuff. In Poland there's already discussion regarding the fact that children have type II diabetes (GP3); There is a social consent for it, soon we will have the same as in USA (GP7).* The transmission of eating patterns includes consumption of *fast food, instant food, semi-finished products, drinking carbonated excessively sweetened drinks – all in high volumes (GP1).*



To sum up the Polish part, psychological and social considerations of gambling were highlighted while the biological aspects in its development and therapy were almost completely absent. Perceptions of gambling are strongly characterised by a non-medical framing; it is seen as a psychological problem, rather than social, arising from specific traits of an individual, either his/her psychological characteristics or life events, which are reinforced by easy access to gambling temptations. Unlike alcohol problems which can be seen as a product of social (dis)organisation, the perception of gambling problems (except perhaps for slot machine gaming) lacks a general social structure perspective.



CONCLUSIONS:

- In all countries gambling problems are receiving increasing attention. Gambling as a problem seems to be still finding its institutional place (where it should be handled, institutional task divisions, understanding of the nature of the problem) in the countries studied.
- In all countries SWs tended to explain and view the three problems as complex situational-environmental problems, and by doing so they reflected their professional scope and mandate.
- In all countries, cognitive sciences were acknowledged to quite a large degree as the key discipline for understanding the three addictive problems. When pointing out that the problems were “not on their table”, the professional groups would especially refer to the psychological/psychiatric fields. The cognitive sciences seem to have established themselves as authorities in all three problem areas. This was most visible for eating disorders and least visible for gambling.
- In all countries we found a great deal of social framings regarding reasons, consequences and ways of addressing the problems. However, these were articulated in different ways in the different national contexts. In Italy the family context was more pronounced than in Poland and Finland. In Poland and Finland, the macro level social framing was more common than in Italy among all groups interviewed.
- GPs paid more attention to the more physical appearances of the people with the problems than the SWs. While this may be a natural result of their professional scope, it is still important to remember, especially when it comes to gambling and EDs as these problems may be “hidden” on the judgement of appearance. National programmes tend sometimes to emphasize the role of GPs in identifying the problems, but GPs as a profession do not always seem to have the full repertoire of instruments for how to go about in this task
- Neither of the professional groups studied had had much contact with gambling problems or ED. GPs in particular had not encountered gambling problems, while they saw a more natural role for themselves in handling eating disorders (especially those related to fluctuating body weight). In all professional groups in all three countries, the most familiar problem encountered seemed to be alcoholism. Also, this was a problem area that both SWs and GPs had expertise in.
- The study shows how professional roles “shine through” in the interpretations of problematic situations of two professional groups, both of whose daily tasks involve problem solving, in one way or another. The professional roles hold similar traits to those dictated by the system of which they are part.



Nevertheless, the professions – situated in certain disciplinary backgrounds, task formulations, and a specific praxis scope – show strong similarities across the three welfare state systems. This is valuable evidence of how professions come to shape the agenda and understandings of problems on an inter-national level.

- However, to some degree, and on some topics, the national cultural context does indeed shine through in the professional's discourse surrounding alcoholism, gambling problems and ED. This happens, in particular, when it comes to deep-seated structures such as the role of family and church, or the role that society has taken in regulation of alcohol, for example.



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APPENDIX 1. Coding scheme

Alcohol/Addiction¹⁰/Gambling/Eating: Finland/Italy/Poland, General Practitioners/Social workers:

Consequences of problems (“Code name “Consequences”):

Biological:

Individual¹¹: health problems like liver cirrhosis or death

Environment: public health problems and accidents

Psychological:

Individual: psychological problems like depression or suicide

Environment: public psychological health like suicide rates

Social:

Individual: social problems, like loss of status, prison and alienation

Environment: social problems of the people around the alcoholic, like violence and family/work problems

Reasons for problem (Code name “Reason”):

Biological:

Body: changes in brain and the body due to alcoholism

Genes: genetic predisposition to alcoholism

Psychological:

Emotion: fun, thrill

Compulsion: non-specific mention of compulsion or something they “have to do”

Character: psychological problems like depression, as well as character traits such as extroversion

Social:

Macro: merges together former four codes:

- + Culture: modernity and country specific cultures
- + Economy: economic interests
- + State: laws and availability
- + Media: images and stereotypes

Micro: replaces former code: Family: childhood, present family structure, but as well peers and poverty

Competence: of proper use of alcohol/gambling/eating, hubris of being smarter than others, which lead to problem

The way to address the problem (Code name “Therapy”):

Biological:

Individual: consume less

Environment: doctors, medication and health centres

Psychological:

Individual: own willingness of addict to quit

Environment: therapy with psychologists, treatment and psychoanalysis

Social:

Individual: integration into new “lifestyle” e.g. AA/GA; religion; hobbies like sports

Environment: social workers, prison, family/friends, employer, availability, advertisements, stigmatization

¹⁰ If addiction in general and/or not alcoholism, gambling, or eating

¹¹ The alcoholic/pathological gambler or eating disordered him-/herself



APPENDIX 2. Table with overview of how the problems are viewed and dealt with by the two professions in the three countries.

Actor	Non-specialised social workers (SWs) FINLAND	General Practitioners (GPs) FINLAND	Non-specialised social workers (SWs) ITALY	General Practitioners (GPs) ITALY	Non-specialised social workers (SWs) POLAND	General Practitioners (GPs) POLAND
Professional epistemological background	Social work	Medicine	Social work	Medicine	Social work	Medicine
Collective role of actor in addressing problem	Part of and affecting everyday social context of client(s), and family members.	Identification of problem, referral to further treatment and care.	Occasionally meet in conjunction with other problems (social, economic, ...) but not considered a matter for the social worker	They intervene "on-demand" by the client. If there is this condition they refer to other services. outside of their own competencies (except for obesity)	To help to manage addiction-related problems being an element of complex, problematic situation	Solving somatic problems and referral to specialist services, first of all psychologists
Phase of problem progression	Identification, solutions adapted to living conditions and context.	Identification, gatekeeper to specialized care	Identification, dealing with the outcomes of the problem (pessimistic about their possibility to do something about for solving the problem)	Identification (many difficulties are recognised that hinder it).	Identification, solutions adapted to living conditions and context	Identification, gatekeeper to specialized care
Ontological problem view (mostly based on code "REASON")	Contextual: alcoholism problematic gambling and eating disorders, gambling is treated in the context of prevailing in a social context. This context needs to be fixed	Physical appearance, health condition, possibilities to refer to other institutions which can deal with the problems on a more specialized level.	mainly located in the social context, and particularly within the family of origin	Not completely perceived as a medical/physical problem. Often seen as a psychological/psychiatric problem, outcome of a personal weakness and of a deficient social context. Some intend the personal weakness as a personality trait, a sort of predisposition for addiction.	Social reasons prevail such as availability and social policy as well as individual life events affecting emotions	Except for gambling, social reasons dominate. In alcohol and eating disorders, social perspective seems to be stronger than psychological one. Biological reasons are unexpectedly almost non-existent
Frequency of contact with problem	Very high in alcohol problems, Low in gambling problems, Low eating disorders.	Seems low in all problems, a bit higher in alcoholism, Low in gambling problems, Low eating disorders.	More used to alcoholism, while gambling is perceived as quite new. Not so clear for EDs	Not so high because people with this problems do not ask for help. Alcoholism simpler to be detected than gambling, so more visible. High contact with obesity, occasional cases of EATDs.	Very high in alcohol problems, Low in gambling problems, Low eating disorders	High/medium in alcohol problems, Low in gambling problems, Medium in eating disorders



Actor	Non-specialised social workers (SWs) FINLAND	General Practitioners (GPs) FINLAND	Non-specialised social workers (SWs) ITALY	General Practitioners (GPs) ITALY	Non-specialised social workers (SWs) POLAND	General Practitioners (GPs) POLAND
Actor identification: tasks and roles	Assistance is part of a comprehensive picture of life situation, prevention.	Evaluation of bodily and mental state, measurements.	widespread perception of powerlessness (emphasis on environmental treatment, family, policies)	widespread perception of powerlessness (emphasis on environmental treatment, family, policies)	Assistance as part of a comprehensive picture of life situation	Medical examination, referral to specialized treatment
Relation to problem and patient	Outsider eating disorder, insider when dealing with financial state in gambling, insider in helping families cope with alcoholism.	Outsider who treats patients who present their problems.	Outsider in solving the problem, insider in helping the families	Insider in treating the physical problems related to, outsider in addressing the "real" problems	Insider in helping individuals and families cope with alcoholism. Outsider in gambling and eating disorders	Outsider in all disorders - referring clients to specialized treatment
Overall operational paradigm	SOCIAL. Situational, solutions with far-reaching consequences, social framing.	BODY PHYSIOLOGY. A problem framed and addressed as a bodily defect	SOCIAL (emphasis on prevention, culture, policies, education)	Social/psychological (emphasis on family, self-help-groups/communities, psychological therapy)	Complex social/policy and social/family context	Psychological paradigm dominates
Axiology: the type of values and norms expressed in the speech surrounding the problems	Client's life situation	Patient's health status	Life situation. Presence of moral judgements, but high level of reflexivity.	Life situation and health status. Presence of moral judgements.	Client's life situation	Patient's physical health status



APPENDIX 3: RAGI Analysis overview: Table with amounts of textual units coded in the data sets

	Finland SW	Finland GP	Italy SW	Italy GP	Poland SW	Poland GP
Consequences Bio Personal	9 (5%)	8 (9%)	14 (20%)	10 (12%)	1 (3%)	2 (9%)
Consequences Psy Personal	33 (20%)	17 (18%)	11 (16%)	11 (14%)	11 (40%)	6 (27%)
Consequences Social Personal	81 (48%)	38 (42%)	13 (18%)	29 (36%)	15 (50%)	9 (41%)
Consequences Social Environment	45 (27%)	28 (31%)	33 (46%)	30 (38%)	3 (10%)	5 (23%)
Consequences Σ	168 (100%)	91 (100%)	71 (100%)	80 (100%)	30 (100%)	22 (100%)
Reasons						
Reasons Bio	9 (6%)	14 (12%)	3 (2%)	11 (8%)	0 (0%)	3 (9%)
Reasons Psy Character	42 (27%)	12 (10%)	20 (16%)	20 (15%)	1 (3%)	6 (17%)
Reasons Psy Compulsion	23 (15%)	26 (22%)	16 (13%)	25 (18%)	20 (51%)	4 (12%)
Reasons Psy Emotion	34 (22%)	28 (24%)	6 (5%)	8 (6%)	2 (5%)	11 (32%)
Reasons Social Micro	10 (7%)	10 (9%)	53 (42%)	35 (26%)	7 (18%)	5 (15%)
Reasons Social Macro	35 (23%)	27 (23%)	29 (23%)	37 (27%)	9 (23%)	5 (15%)
Reasons Σ	153 (100%)	117 (100%)	127 (100%)	136 (100%)	39 (100%)	34 (100%)
Therapy						
Therapy Bio Environment	3 (2%)	10 (17%)	3 (4%)	27 (30%)	0 (0%)	2 (5%)
Therapy Psy Environment	18 (14%)	7 (12%)	2 (2%)	3 (3%)	3 (16%)	5 (13%)
Therapy Psy Person	19 (15%)	12 (20%)	17 (21%)	17 (19%)	4 (21%)	11 (29%)
Therapy Social Environment	77 59%	24 (41%)	56 (69%)	37 (41%)	11 (58%)	19 (50%)
Therapy Social Person	14 (10%)	6 (10%)	3 (4%)	6 (7%)	1 (5%)	1 (3%)
Therapy Σ	131 (100%)	59 (100%)	81 (100%)	90 (100%)	19 (100%)	38 (100%)
Σ	452	267	279	306	88	94