Problem Gambling and the Non-Medical Addiction Model

Finnish General Practitioners' and Social Workers' Perceptions

Michael Egerer & Anna Alanko

VERTAISARVIOITU
KOLLEGIALT GRANSKAD
PEER-REVIEWED
www.tsv.fi/tunnus

Abstract

Excessive gambling is increasingly understood in medical terms. Instead of criticizing this process as "medicalization" and an enlargement of the medical profession's area of influence, we question this understanding from the context of the Finnish non-medical model of addiction. Group interviews with seven groups of general practitioners (GPs) and eight groups of social workers in Finland (altogether 66 participants) were conducted. Film clips portraying gambling problems served as a discussion stimulus. Neither of the professional groups medicalized the issue, but both interpreted it as a social problem. However, participants still held individual gamblers responsible for overcoming the problem. GPs contest their responsibility to treat problem gambling, whereas social workers claim a position of caring for those harmed by the person's problem gambling, rather than for the gambler him-/herself. We argue that a medical framing of excessive gambling would risk limiting social workers' efforts even further. In the context of the Finnish non-medical model of addiction, this would coincide with a medical profession unwilling to fill the gap, leaving problem gambling unattended by both professions. Finally, we question the frequently made equation between medicalization and individualization.

KEYWORDS: Finland, general practitioners, medicalization, problem gambling, social workers.

Introduction

Professions are often accused of attempting to enlarge their turf (e.g. Abbott 1988). The widening of the medical profession's realm of influence has been referred to as "medicalization" and has been the subject of severe criticism: the widening of the medical sphere of control has been perceived as unjustified, driven by the interests of the medical industry, individualizing the blame for problems, and targeting women and men differently (e.g. Conrad & Schneider 1992; Davis 2009; Fingarette 1988; Illich [1976] 1995; Peele 1989; Riska 2003; Zola

1972). The medicalization thesis, however, has also been subjected to criticism and reframing. It has been called "a cliché of critical social analysis" and argued to falsely assume a single agenda for medicine (Rose 2007a, 700). Advances in medicine bear promises and modify our conceptions of life, and medical expertise is indeed desired rather than forced upon us (Helén 2002). Even the same authors who earlier wrote about expertise-led medicalization have pointed out that lately consumers themselves have also become "engines" of medicalization (Conrad 2005). The uniformity of the interests and understandings of medicine has been questioned in empirical studies, such as the study by Kari Tikkinen and colleagues (2012) which showed that Finnish doctors disagree on what states of being can be defined as diseases.

In this study, we focus on problem gambling. Most of its symptoms are of a social nature, and hence it cannot be integrated into the medical field as easily as a physical problem, such as a broken arm. This places problem gambling at the intersection of two professions: general practitioners (GPs) and social workers. Elsewhere, Michael Egerer (2014) has identified GPs and social workers as "gate keepers". These professionals are often the first officials to come into contact with addictions and addiction-like behaviours, and have the responsibility to decide on further measures. In Finland, the gate-keeping position is particularly pronounced, as general practitioners in primary healthcare centres, and social workers in municipal social offices, provide basic health and social services and refer clients to the appropriate specialists. The specialists in Finnish addiction treatment, in turn, are mainly social caseworkers (e.g. Ahonen 2007; Satka 1995). This particular division of labour in addiction treatment in Finland, together with the social framing of addiction, has been identified as the "Finnish non-medical model of addiction" (Bruun 1971; Stenius 2007; Takala & Lehto 1992). This approach still serves Finnish medical, social and treatment personnel as a framework for making sense of alcohol problems (Egerer 2012; Egerer et al. 2012; Pennonen & Koski-Jännes 2010), yet, the question of which profession is responsible for dealing with problem gambling is still somewhat open. Responsibilities are distributed on the basis of local circumstances rather than a planned programme. The list provided to those who need help for a gambling problem includes a great variety of providers and professions: health centres, social offices, Gamblers Anonymous groups, psychologists, nurses and social workers (THL 2011). This makes the positioning of GPs and social workers in relation to problem gambling an intriguing issue.

Gambling is a very popular pastime in Finland, and the country has one of the highest household expenditures for gambling in Europe (Besson 2005). In 2011, gambling expenses added up to 1.7 billion euros, which means that each Finn (15–74 years) spent on average 2.2 % of their monthly net income on gambling (Turja et al. 2012). Three state monopolies control gambling: one for slot machines and casino games (Slot Machine Association, RAY), one for lotteries *(Veikkaus)* and one for tote betting *(FinToto)*.

The prevalence rate of problem gambling in Finland is 2.7 % (3+ SOGS points), one of the highest in Europe (Turja et al. 2012; Williams et al. 2012).[1] Furthermore, problem gamblers seem to "contaminate" their wider social network; in a cross-sectional population study in Finland, Anne H. Salonen and colleagues (2014) identified nearly every fifth respondent as concerned about the problem gambling of a significant other.

In the context of growing awareness of gambling problems in Finland, the two groups of clinical

1 See, however, Monika Sassen and colleagues (2011) concerning the limited comparability of pathological gambling prevalence rates.

professionals, GPs and social workers (Scott 2008), need to make sense of and react to their clients' gambling problems without "textbook knowledge" readily available to guide their decisions. To compensate for the lack of official guidelines, they refer to the already available "scripts" of their profession, to standard practices when available, and to common sense on gambling issues. In order to simulate encounters with clients' problem gambling, focus group interviews with Finnish GPs and social workers were conducted, using short film vignettes to present instances of gambling problems as discussion stimuli (Sulkunen & Egerer 2009).

If the standard medicalization thesis held, GPs would refer to their medical expert knowledge and engage in enlarging their profession's realm of influence. Social workers, on the other hand, would have a hard time supporting their profession's claim of a "social" definition of problem gambling. However, if the Finnish non-medical model had a stronger impact, a social framework would be prominent also in the GPs' comments.

In our analysis of the group discussion, we demonstrate the weaknesses of the standard medicalization thesis in professionals' understandings of gambling. We suggest that the focus on power and the interests of the medical professions should be abandoned as the supposed engines of medicalization. Instead, we propose that the given institutionalized setting and the division of labour of welfare professions is an important factor involved in the process of medicalization.

Medicalization and the Conceptualization of Problem Gambling

Peter Conrad and Joseph W. Schneider (1980) describe the process of medicalization as a progress from establishing a medical terminology for a problem, to achieving the leading positions in institutions, and to working towards integrating the problem into everyday medical practice. Medicalization can be simply described as the process of understanding a former moral and social problem as one that demands medical attention (Conrad & Schneider 1992). "Medicalized" problems are also situated within individuals (bodies) rather than in society (Nye 2003). This change in conceptualization is accompanied by a change in the agents involved in handling the issue: from priests or the police towards the medical profession.

The critique of medicalization can be categorized into several variants. The first critiques addressed the shift in the agents of social control. Before medicalization, priests or the police were often the experts that judged and controlled many deviant behaviours; via medicalization the doctor has become the main agent of social control (e.g. Zola 1972). The second main critique of medicalization can be traced back to Ivan Illich's book *Medical Nemesis* from 1976 (Illich [1976] 1995), where he claimed that what is disguised as medical altruism is in fact the economic interest of the medical industry or the medical profession. Nikolas Rose (2007b) follows a similar stream by critically discussing the rise of the bio-technology industry. Alan Petersen and Deborah Lupton (1996), on the other hand, abandoned the concept of medicalization but concentrated their critique on the diffusion of questions of health into all areas of life. A feminist variant of the discussion has pointed out that issues related to sex and/or gender and reproduction have also become objects of medicalization (for example, Kohler Riessman 2003).

Until fairly recently, processes of medicalization have been discussed mainly as interest-driven and as a matter of power (e.g. Bernhard 2007). For example, the discussion on the de-medicalization of homosexuality illustrates power struggles in the success story of lobbying, together with changing coalitions and the empowerment of civil rights

groups (e.g. Conrad & Schneider 1992). The influence of scripts, habits, taken-for-granted practices and institutional dispositions of acting (e.g. Gronow 2011) have, however, seldom been in focus. Although a part of the critique of medicalization originates from the critique of mental asylums as total institutions (Goffman 1961; Szasz 1961), the role of institutionalized practices in the process of (de-)medicalization itself has remained neglected.

Gambling has a long history of being considered a moral issue that causes social problems (e.g. Bernhard 2007; Rosecrane 1985). Gerda Reith (2006b) describes the conceptualization of problem gambling as a prime example of medicalization, progressing from a sin through conceptions of irrationality and criminality, to a pathology. Peter Ferentzy and Nigel Turner (2013) point out the power of metaphors when describing problem gambling in medical terms. At the latest with the integration of pathological gambling into the DSM-III *(Diagnostic and Statistical Manual of Mental Disorders)* of the American Psychiatric Association in 1980, a medical vocabulary to describe the problem was manifested. By analysing a successful "insanity plea" (on the grounds of pathological gambling) in a US court case, Brian Castellani (2000) demonstrates that this shift of the boundaries of the medical profession's area into the legal profession's turf had real consequences. In the recent DSM-V[2], gambling disorder is included in addictive disorders. In line with other addictions, GPs' offices are named as suitable places for the early identification of and intervention to problem gambling (Miller 1996; Pasternak & Fleming 1999; Sullivan et al. 1998). This would make problem gambling a part of everyday medical practice. Despite these medicalization tendencies, social workers are also considered actors in dealing with problem gambling (e.g. Griffiths 2013; Gross 2004; Momper 2010; Murto 2010; Rogers 2013a; 2013b). Gambling problems often relate to monetary problems, and treating problem gambling needs then to also address problem gamblers' finances, which is an established field of social work (Mesch 2011; Murto 2010; Rogers 2013b). In comparison to many other countries, specialized social workers are the leading profession in the Finnish non-medical approach towards addictions, and are involved in everyday treatment practice (Ahonen 2007). This makes the Finnish case an interesting one to follow.

The Finnish Case of the Division of Welfare Professions

Social work as a profession is younger than the medical profession. It has never managed to achieve a similar position, and its status as a profession has been a matter of debate since the early 20th century (Flexner 2001). Social work has always been a "female" profession, and Pamela Abbott and Claire Wallace (1990; see also Davies 1996) identified the gender aspect as one reason for social work's weak position as a (caring) profession.

The history of social work demonstrates how this profession has not reached equality with the medical profession. In Finland, manifold origins of social work have been identified and include, among others, early charity institutions of the church, poor relief and orphanages (e.g. Jaakkola et al. 1994). The Welfare Acts *(Huoltolait)* of 1936 established paid professionals in poor relief, and these acts can be interpreted as the beginning of professional social work in Finland (Toikko 2005). Earlier, poor relief had been run by voluntary laymen, who exercised patriarchal power over the

2 Although the DSM is important in scientific research, it is not used by Finnish practitioners. Instead, the ICD-10 *(International Statistical Classification of Diseases and Related Health Problems)* of the World Health Organization is consulted by medical practitioners (Castrén et al. 2014).

needy, and women were encouraged to participate in the practical work of these boards due to their "caring nature" (Satka 1994; 1995). With the rise of the welfare state after the Second World War, the professionalization of social work was given a boost. However, this was more due to the institutionalization of the welfare worker as an agent of the state, and should not be directly interpreted as an expression of professional power. Welfare workers were educated in administration and law and showed loyalty towards the state (Satka 1995). In comparison with physicians, several paths lead to becoming a social worker in Finland, and even a career change into a social office from another educational background is possible (e.g. Murto 2005).

The medical profession, in comparison, is well established. It has been the most efficient profession in securing a monopolized position within the division of labour concerning the enhancement of citizen's wellbeing (e.g. Abbott 1988; Freidson 1970; Gallagher & Searle 1989). Its expert professional knowledge, as well as the history of medical success in treating illnesses in the last two centuries, serve as the main justifications for its authority (e.g. Freidson 1970). In Finland, medical doctors and medical knowledge have had a remarkable role in nation-building and public administration, which may also have reinforced their status (Helén & Jauho 2003). Medicalization critiques (e.g. Conrad & Schneider 1992; Illich [1976] 1995) describe, however, the success story as less a matter of medical interventions, and more of improvements in food security and sanitation. Furthermore, Eliot Freidson (1970) has questioned whether the medical turf could be secured by exclusive *medical* specialist knowledge. Instead, he suggests that undisputed medical authority lies more in its deeply institutionalized position of power within the system of the bureaucratic nation-state and its welfare system.

In Finland, primary healthcare is organized and secured by the municipalities. Doctors' training follows a clear career path; they have always been servants of the state. As civil servants, their responsibility covers the society as a whole. Following the Public Health Act of 1972, the Finnish welfare state established health centres employing general practitioners. The Public Health Act had important consequences for professionals' autonomy and the doctor–patient relationship. The new institutional setting caused a high turnover of doctors and limited the duration of the doctor–patient relationship (Hakosalo 2010; c.f. Helén & Jauho 2003). This kind of medical setting, also called "clinic organization" (Freidson 1970), is known to hinder continuity in medical care and in the personal relationship between doctors and their patients (e.g. Baker 1997; Hakosalo 2010; Hjortdahl 1992; Kearley et al. 2001; Mayntz 1970). These structural characteristics remain part of the Finnish healthcare system, although attempts have been made to institutionalize more continuity in doctor–patient contacts (e.g. assigning personal nurses and GPs to clients). Nowadays, most GPs work in municipal or occupational/private health centres, where the emphasis is on pharmacological treatment of somatic and bodily conditions. In sum, GPs, on the one hand, are responsible for the welfare of society as a whole, and their medical practice, on the other hand, is strongly centred on their patients' somatic concerns.

To conclude, the case of these two professions in Finland closely resembles analyses from many other countries, where medical doctors have also been more successful in securing their turf and in enlarging their professional boundaries (e.g. Abbott 1988; Freidson 1970). Nevertheless, we expect that the division of labour in the Finnish welfare state and especially in addiction treatment will leave its marks on the approach the professions take in relation to problem gambling.

Method and Data

In the group interviews, where we applied the Reception Analytical Group Interview (RAGI) method, participants were asked to interpret and discuss three[3] film clips showing gambling problems (Sulkunen & Egerer 2009). Based on reception studies, we consider that the meaning of the presented film clips is not fixed, but instead forms in the audience's interpretation (Barthes 1977; Fish 1980). Although not fixed in meaning, the stimulus clips are not "blank slates" either, into which anything could be read (e.g. Sulkunen 2007; Törrönen 2002). Instead, new experiences – such as viewing the clips we presented in the interview situation or having a client with gambling problems – are interpreted based on previous knowledge (e.g. Boulding 1956). From this perspective, the interviewees' reactions are not a report on the clips, but an interpretation triggered by the proto-narrative offered in the vignettes. This is similar to directly asking interviewees about how they understand problem gambling or who should be responsible for dealing with it, as interviewees also have to decode and interpret the questions from a survey or interviewer. However, the film clips as an audio-visual stimulus are more powerful in triggering respondents' reflections than written questions. They represent a more natural trigger for openly discussing one's opinions with colleagues. Opinions and meanings are not readily waiting in respondents' minds to be asked for; research enquiries themselves are part of a continuous meaning-making and re-interpretation process (Sulkunen & Egerer 2009). During a group interview situation, participants are encouraged to interactively create meaning and to become aware of their implicit perspectives (Morgan 1988). In the case that the medicalization theory is valid, we would expect that the general practitioners use the group discussion to construct their medical view as the correct understanding of the shown gambling problems, in order to justify their authority over the problem. Social workers, in contrast, might promote their hold over the problem by establishing an image of being the protector of citizens' social welfare. However, professional expert knowledge is not the only source for making sense of the world, as one's own lay experiences also help to form an interpretation of the problems shown in the film clips (Egerer 2014, Livingston 2014). In fact, expert knowledge itself is also not only the result of education, but knowledge interpreted by what the professionals know and experience in their "lay" lives (Livingston 2014).

The three clips were chosen after a long and thorough process involving trial interviews with students (see Egerer 2010; 2014 for details). They follow the themes of loss of control, neglect of duty and cue dependency,[4] all characteristics strongly associated with addiction (Egerer 2010). In clip one, the protagonist Dan Mahowny continues to gamble until he loses everything, in spite of having just beaten the casino at a table of baccarat (from the film *Owning Mahowny,* directed by Richard Kwietniowski, 2003). Clip two discusses the neglect of family duty and shows Rose, an older woman, gambling away her house and her son's inheritance, even though she had promised to quit gambling (from the film *Bord de mer,* directed by Julie Lopes-Curval, 2002). Clip three tells the story of Laura, a successful businesswoman and loving mother, who cannot pass the fruit section in a supermarket without being reminded of slot machines; she then gambles at the shop's slot machine, forgetting her groceries (from the film *Going for Broke,* directed by Graeme Campbell, 2003).

3 The original study also contained six other clips about alcohol problems and eating disorders (see Egerer 2010).

4 A situation where a problem gambler reacts to a stimulus (i.e. cue) instantaneously like a reflex (e.g. Elster 1999).

The RAGI follows a protocol that lists the order of the clips and the time remaining for discussion. The interviewees receive a set of orienting questions intended to facilitate discussion. These questions are: a) What happens in the scene, and who are the persons in the film? b) What happened before this event? c) What happens immediately after it? d) How will the same person appear ten years later? e) Can something like this happen in real life? f) Should someone do something about the problem shown? The interview moderator, however, instructs that these questions need not be explicitly answered – they are, again, meant to facilitate discussion. Besides running the clips, the moderator is not involved in the discussions. To introduce the interview setting and explain the expected character of the discussion, we often used the metaphor of a coffee lounge talk between colleagues. Even if interviews are always somewhat artificial, the interaction that occurs can be considered natural (Demant 2012). The interviews lasted ca. 90–120 minutes. We video-recorded the ensuing discussions and transcribed them verbatim.

A total of 15 group interviews with GPs (7 groups; 35 participants) and social workers (from now on referred to as SWs) (8 groups; 31 participants) were conducted in major Finnish cities between May 2008 and February 2011. The exclusion of professionals from rural areas from our dataset is a limitation that should be taken into account when reading the results and interpreting our conclusions. The participants were recruited by contacting the heads of municipal social and health centres, as well as by posting advertisements in major professional journals. This recruitment strategy resulted in both "natural" groups and groups who met for the first time at the interview. The recruitment took place in the context of the *Images of Addiction* research project, in which other teams focused on the lay population or treatment specialists (e.g. Hirschovits-Gerz et al. 2011; Pennonen & Koski-Jännes 2010). The present study took GPs and SWs as subjects of its enquiry. These professionals have the first contact with addiction problems but do not have specialized training on the matter. The study focused on how these professionals in the Finnish welfare system, with its specific division of "welfare labour", viewed addictions, and we therefore attempted to recruit homogenous groups of professions. Most of the participating SWs (27/31), as well as the GPs (23/35), were women. The GPs and SWs differed only slightly in age, with the social workers being younger (median: 50 years [GPs] and 46 years [SWs]). The SWs were not specialized in addiction treatment, but were recruited from general social offices of the municipality, mostly from adult social work and family services.[5] This was to ensure their position as gate-keepers of addiction (Egerer 2014).

Like in previous studies on similar data (e.g. Egerer 2014; Pöysti & Majamäki 2013), the interview transcripts were analysed in three steps: first, we followed predefined categories as sociologically constructed codes (Strauss 1987) in order to organize the interview data. These categories are *reasons*, *consequences* and *therapies*,[6] and they are further separated into biological, psychological and social discourse frames. In the second step, a numerical overview was established in the tradition of quasi-statistics in order to organize our data before the qualitative and thematic analysis (Becker 1970; Silverman 2001).

Results

Perceived Reasons for Problem Gambling

The SWs took their daily work experiences as a starting point to explain the existence of problem

5 One social worker working in addiction treatment participated in focus group no. 4.

6 We included in the category of therapies all the functions that interviewees deemed necessary in the recovery from problem gambling.

gambling. They employed a social framework and referred to the downsides of modern society.

> I4: I guess this kind of detachment, which in a way [results from] people leaving their roots and are kind of ... there are an awful lot of lonely people here. You can't really do anything, although you see that the person is destroying him-/herself. But you can't do anything because this right to autonomy has gone a bit too far. People don't dare to interfere anymore. In the past the whole family was there to support...
> (SW group 5)

This perspective quite closely resembles the writings of Alain Ehrenberg (2004) and Bruce K. Alexander (2000) in that they describe addiction as an ontological phenomenon of post-modernity and capitalism. Due to the stress of life in the current anonymous society, some people suffer from addictions as a kind of inappropriate means of coping. Ehrenberg (2004) considers addiction as the alternative to depression; Alexander (2000) goes into detail about how the free market economy is the underlying cause of addiction.

Similarly to alcohol problems (Egerer et al. 2012), the SWS regretted the fading of the traditional "Gemeinschaft" and the traditional welfare state. The social workers frequently discussed psychological mechanisms as a source of problem gambling, but still inflated their profession's importance by deploying a social interpretation of the problem. This led to rather contradictory statements combining different explanations, such as the following.

> I5: I am really convinced that these addictions have social roots, their roots are in society, yes it is true, the gambling starts or the alcoholism starts because...they are a certain kind of people.
> (SW group 6)

Although only "certain kind of people" in the same environment become problem gamblers, interviewee 5 was nevertheless convinced that addictions have social roots. The observation that only a minority of people in similar conditions become addicted, whereas the majority do not, led also Alexander (2000) to distinguish between the *severely dislocated* and the *dislocated* in order to retain a contextual explanation of addictions. The SWS' reasoning may also be an expression of the growing internalization of addictive problems and the rise of a therapeutic authority (Hellman 2010; Miller & Rose 2008), and an attempt to struggle with this challenge to the SWS' expertise.

GPS claimed that the reason for problem gambling lies in emotional and cognitive shortcomings. In comparison to the SWS, the GPS, however, explained these shortcomings less by wider societal circumstances. Their reasons for the appearance of problem gambling related more to the person and to the game's characteristics, as well as to the immediate surroundings of the gambling activity (such as a cheering audience).

> I1: Well, I suppose the feeling of winning brought pleasure and that is one thing one is addicted to, the feelings in the situation. The same occurred when the surrounding world and people were shut out quite totally, that he focused so strongly on that thing. "Go away, this is my thing."

> I3: But simultaneously I was thinking about, there was the audience, what is the significance of the audience in this. In a way the whole community accepts this way of being. A part of it is that everyone is like [interviewee lifts thumb], let's sacrifice one person so that everyone gets excited. Like in the old days and wherever similar things have existed. In a way the gang encourages you. Maybe one thing is how to stay in the gang?

> [...]

I8: The touch with the machine, she nearly hugged it.

I2: To let off steam for a while.

I3: Yeah, it can be something like that.
(GP group 5)

The structural characteristics of the game, such as the lighting and the noise of the coins when winning, have been identified as contributors to the addiction risks related to slot machines (Parke & Griffiths 2007). However, besides these structural characteristics, the GPs also discussed the situational characteristics, such as the cheering crowd around Dan Mahowny in the clip from *Owning Mahowny*. The discourse on the reasons for problem gambling seems to be partly individualizing, but not medicalizing. Whereas GPs embrace a cognitive psychological framework as obviously being closer to their *métier,* SWs struggle with such an internalization of addiction and addictive behaviours in contemporary Finnish society (Hellman 2010).

The Consequences of Problem Gambling

The interviewees from the two professional groups expressed similar views concerning the consequences of problem gambling. They discussed most of all the negative social outcome of problem gambling for the gambler and his/her close relationships. Taking the stimulus subtext as given, the clip from *Going for Broke* especially resulted in quite similar reactions from GPs and SWs.

I2: Yes, but she, she did not get any food for the family, as she had gambled away all her money.
(GP group 3)

I5: Well, you do get hungry. There are children who stay hungry, when the mother gambles away all the money.
(SW group 3)

In comparison to perceptions of alcohol problems in a previous study (see Egerer 2012, Egerer et al. 2012), which focused heavily on the family and close relationships, the social harm of problem gambling was discussed by both groups – GPs and SWs – by also taking into account the misery of the problem gamblers themselves. Problem gamblers are lonely figures who lose their money and property and end up in debt. Money, perhaps unsurprisingly, has been identified as an important factor in gambling: as a medium for participation in the game and an indicator of gambling skills (see e.g. Oldman 1974, Reith 2006a). Its importance in distinguishing social gambling from problem gambling became obvious in the following statement from a GP focus group, a reaction to the clip from *Bord de mer* (see also Egerer & Marionneau 2015 on details concerning this topic).

I1: Then she wins the whole jackpot and buys the whole retirement home [laughs].

I7: Hardly [laughs]. Somehow I understood it more clearly with this old lady. When she plays, she doesn't play to win, it is only the supposed reason. She plays to play. The playing has her on a leash.

I2: She seems really fragile and lonely.
(GP group 5)

Concentrating on the social side effects of excessive gambling did not, however, mean that the interviewees did not talk about consequences for health. These comments, nevertheless, not only remained low in quantity, but were also controversial.

I4: Yes, is this a medical problem? Do we let them handle it themselves?

I3: In my opinion this looks very little like a medical problem.

[…]

I6: It is not directly a health risk if all the money that is supposed to buy food goes. Though there is a risk of starving to death, if one does not get social assistance. You do not necessarily get help from the social office if they know that you have some income.
(GP group 1)

The GPs were sceptical about the medical status of problem gambling. Furthermore, as the quote above shows, although they discussed the health risk of starving to death, they did not use it to establish a medical ownership over problem gambling. They might have touched upon the conceptual level of medicalization (Conrad & Schneider 1980), but did not use it as a resource to claim it as their field of intervention. Instead, social offices were mentioned as a place where the problem could be handled. Even after mentioning social offices, they still limited the social worker's turf by remaining sceptical about the social office's capacity to deal with the issue.

The SWs, on the other hand, conceptualized even physical reactions as fundamentally related to morality and social harm, and in this way rather clearly claimed problem gambling as an issue for their profession.

I4: He physically reacts to the situation and that exactly [shows] how morally inappropriate it is that he endangers his whole job and career, it is exactly the issue in severe dependency that one does not think about the next moment at all.

I2: No, and he has a lot of compulsive movements.
(SW group 6)

The SWs' discussions, however, were not limited to the conceptual level, but addressed integrating the problem into social work. This also occurred in their discussions about their profession's role in handling problem gambling.

Actors in the Recovery of Problem Gambling

Especially when the stimulus clips concerned questions of monetary issues, the SWs' discussion included their own profession as possible actors and the social office as the right place to handle problem gambling.

I1: Should be placed in a support group. And if they lose their houses, they should be placed under custody.

I3: Yes. There are measures that could prevent her bankruptcy, a weekly allowance, which can be used for food. Most likely there is no other way to help.

I6: If houses are lost, yes, probably some social office can transfer money into her account weekly.
(SW group 7)

The excerpt above shows how social workers integrate dealing with problem gambling into their realm of everyday practice. Clients' financial problems indeed have an important negative influence on their social welfare, and consequently, social workers can more easily claim jurisdiction in this field. GPs, on the other hand, may often face clients with financial problems, but their everyday practice is not supposed to be concerned with this matter, nor would they have the means to help with financial issues.

I3: And, I have never seen that we would have the resources for something like that. Well, perhaps one gets Slot Machine Association's [RAY] money for that, but at least never from the municipality budget.

I6: Well, of course it is going to end up badly as he works in a bank and gambles with his customers' money.

I3: Yes, he will be released from prison in ten years. (GP group 1)

Interviewee 3 mentioned the lack of resources as a reason for not dealing with problem gambling in primary healthcare. As understandable as this explanation is, it was, however, not pursued in the following discussion in order to promote the medical profession. The lack of resources remains a fact that is not challenged by demanding additional financial support for municipal health centres. Instead, the same interviewee used one of the orienting questions ("How will the same person appear ten years later?") and returned to talking about the adverse social consequences of problem gambling (possible imprisonment) .

The SWs may be eager to integrate problem gambling into their realm of expertise when discussing their profession's involvement, but they also deemed the will of the problem gamblers themselves as paramount. They argued that without the gambler's participation, external interventions are in vain.

I6: Yeah. Should somebody do something about it? Well, there was already something done. I think the casino employee already tried there. But it is the person himself who makes the decision, and the decision was this.

I3: It was probably indeed a good description of how an outsider's intervention might be for a substance and alcohol addict. You tell them to stop drinking and they take a bottle and continue drinking. Triumphant social workers' intervention.
(SW group 7)

The quote above seems to contradict the initial claim of responsibility by the SWs, as it remains rather pessimistic about the possibility for social work to successfully intervene. However, Anja Koski-Jännes et al. (2012) pointed out that it is necessary to look at the difference between assigning responsibility for recovery and the belief in the ability to successfully achieve this goal. It is rather common to hold addicts responsible for their recovery while questioning their capacity to succeed on their own (ibid.). The GPs also expressed the need for individual mental strength – a highly valued character trait in Finland (see also Hirschovits-Gerz et al. 2011) – to start the recovery process. However, they elaborated more on the possibilities of the social context for intervention. They discussed regulations and outside control (by the family or the shop clerks[7]) as measures in problem gambling prevention and recovery.

I1: There should be a limit, a maximum of five coins per customer. [laughs]

I8: I have seen a good one in a supermarket, there was a remote control. I saw the cashier turning off the machines when boys – they were minors – were about to gamble.

I5: That is a good system.

I8: Yeah.

I5: You could make a deal, if you had problems. On a good moment you could say that if you see me approaching that machine, please turn it off. [laughs]
(GP group 5)

7 In Finland shop personnel are responsible for controlling the slot machines placed in the shop's premises (Warpenius et al. 2012). The provider, the Slot Machine Association (RAY), is nevertheless the monopoly holder.

However, ending the statement with laughter implies scepticism towards whether the described measure is useful or realistic. This suspicion is well-founded, since the control of slot machines in shops and gas stations seems to be indeed insufficient (Warpenius et al. 2012). Yet this scepticism is not used to promote a medical intervention.

Although internal psychological mechanisms seem to have some importance in the GPs' and SWs' explanations of the existence of problem gambling, psychologists or psychiatrists as actors of the recovery phase were rather seldom explicitly mentioned. SWs, however, sometimes mentioned (unspecific) therapy/care when promoting their profession's realm in their statements about the Finnish municipal outpatient units for addiction treatment, called A-clinics, which are often led by social workers (Ahonen 2007).

Conclusion

In this study we have analysed general practitioners' and social workers' approaches to problem gambling. The GPs employed a withdrawal strategy by using socio-psychological terminology, and questioned whether they had the necessary knowledge and resources to help patients with their gambling problems. Accordingly, the GPs were very critical of the idea that they would have a role in the handling of problem gambling. The SWs, on the other hand, engaged in integrating problem gambling into their profession's realm by using social terminology to describe it. However, they only touched on the integration of problem gambling into the daily practice of social work, and were unsure about their own role in actually handling the matter. They acknowledged a role in helping and preventing social harm (e.g. to the family) caused by the problem gambler. Due to their lack of knowledge and experience with problem gambling, the social workers were unsure about their possibilities to help with the actual issue of problem gambling itself.

Ferentzy and Turner (2013) describe the contradictory situation of problem gambling: on the one hand, it is conceptualized via a medical model, whereas on the other hand, non-medical professionals define and treat the problem. The situation seems to be different in Finland. The framing of problem gambling follows the traditional Finnish non-medical model of addiction, where social problems are in focus and, consequently, social workers primarily handle the issue. This social frame, however, does not seem to contradict the individualizing perspective on problem gamblers' recovery. Tanja Hirschovits-Gerz and colleagues (2011) have identified the reliance on individual strength to overcome hardships as an important value in Finnish culture. Such a focus on the individual and the internal mind might be an explanation of the importance of cognitive psychological explanations for the cause of problem gambling for both professions. Further studies need to look into this issue, as well as revisit the frequent inclusion of psychiatry and psychology under the frame of medicalization.

Our findings show the need to distinguish three concepts that are often used interchangeably: medicalization, individualization and addiction. Ferentzy and Turner (2013) have reminded us that medical terminology is not only part of the individualized disease model, but also enables a public health perspective. The medicalization critique has often criticized the individualization of problems, for example, liberating alcohol or game providers from their due responsibility in causing problem drinking or gambling. This study has shown that the individualization of a problem does not necessarily involve the use of medical terminology. Finally, conceptualizing something as an addiction has often been equated as medicalization of the

problem. In the context of the Finnish non-medical model of addiction and the findings in this study, such an equation becomes questionable. This is illustrated in the translation of the DSM-5 criteria of Gambling Disorder into Finnish: the term "gambling dependence" *("rahapeliriippuvuus")* has been chosen instead of directly translating the psychiatric term "disorder" (Castrén et al. 2014).

We therefore conclude that the Finnish non-medical model of addiction acts as a counterforce against the medicalization of problem gambling. In the Finnish context, the GPs' institutional framework concerning addictions is twofold: a) they are not involved in the everyday treatment of addictions, nor are they the leading profession in that area. They are, furthermore, b) practicing in a clinic organization, which hampers obtaining a holistic view of the patient, but which nevertheless assigns them with a societal responsibility in the Finnish arrangement of primary healthcare. This institutional context regarding addictions, with its distinct dispositions of acting, serves GPs as a blueprint for the conceptualization of problem gambling in a social framework. This turns the commonly expected progression of medicalization around. The GPs do not proceed from first establishing the correct medical terminology and then institutionalizing the medical understanding into everyday practice. Instead, both the position of general practice in the Finnish welfare state and the institutionalized non-medical approach to addiction are used as a *framework to make sense of upcoming new issues,* such as problem gambling. One reservation to this conclusion is the weak position of the profession of social work itself. Social workers might feel more of a need to struggle in the name of their profession in general than GPs, whose profession is already firmly established.

Our aim in this study was not to decide on the appropriateness or the functionality of the medicalization of problem gambling, but to suggest a new reading of the medicalization thesis. In the area of addiction, E. Morton Jellinek (1960) and Kettil Bruun (e.g. 1971) have supported the disease concept of alcoholism. However, they did so not because they considered alcoholism to be a disease, but because the disease concept can remove shame and responsibility from the alcoholic. Bo J. Bernhard (2007), for his part, remains sceptical of whether the medicalization of problem gambling has really eliminated moral judgements about gamblers. Furthermore, this study does not aim to and cannot predict the future of problem gambling as a medical matter in Finland. Pia Rosenqvist and Kerstin Stenius (2014) have identified a shift towards a more medical and individualized conceptualization of drug problems in Finnish addiction treatment. The conceptualization of a behavioural addiction such as gambling may follow a different route, but progress in pharmacological medication of problem gambling could indeed boost its medicalization. The pharmaceutical industry has, indeed, become a major engine for medicalization (Conrad 2005). Furthermore, the ability to prescribe medication fits well into everyday medical practice. Then again, Finnish GPs have been rather reluctant to be involved in the treatment of alcohol dependence (e.g. Egerer 2012), despite the availability of pharmacological measures.

Our practical advice from the results of this study is to exercise caution when adopting the dominant Anglo-Saxon medicalization discourse of problem gambling into the Finnish discourse. This is because the usage of medical terminology risks limiting social workers' efforts to address problem gambling, while GPs are unable and/or unwilling to deal with the problem.

Acknowledgements

This study was funded by the Finnish Foundation for Alcohol Studies and the Academy of Finland

(decision no. 140304). The article is part of the Alice Rap project, work-package 3.

References

ABBOTT, ANDREW. 1988. *The System of Professions. An Essay on the Division of Expert Labor.* Chicago: The University of Chicago Press.

ABBOTT, PAMELA & CLAIRE WALLACE. 1990. "Social Work and Nursing. A History." In *The Sociology of the Caring Professions,* eds. Pamela Abbott & Claire Wallace. London: The Falmer Press, 10–28.

AHONEN, J. 2007. "Treatment as Adaptation. A-Clinics in Post-War Finland." In *On the Margins. Nordic Alcohol and Drug Treatment 1885–2007,* eds. Johan Edman & Kerstin Stenius. Helsinki: NAD, 139–167.

ALEXANDER, BRUCE K. 2000. "The Globalization of Addiction." *Addiction Research* 8:6, 501–526.

BAKER, RICHARD. 1997. "Will the Future GP Remain a Personal Doctor?" *British Journal of General Practice* 47, 831–834.

BARTHES, ROLAND. 1977. *Image, Music, Text*. Glasgow: Fontana.

BECKER, HOWARD. 1970. "Field Work Evidence." In *Sociological Work. Method and Substance,* ed. Howard Becker. New Brunswick: Transaction Books, 39–62.

BERNHARD, BO J. 2007. "The Voices of Vices. Sociological Perspectives on the Pathological Gambling Entry in the Diagnostic and Statistical Manual of Mental Disorders." *The American Behavioral Scientist* 51:1, 8–32.

BESSON, DANIELLE. 2005. *En 25 ans, les français ont doublé leur mise.* INSEE première: Rapport n° 1016.

BOULDING, KENNETH E. 1956. *The Image. Knowledge in Life and Society*. Ann Arbor: University of Michigan Press.

BRUUN, KETTIL. 1971. "Finland. The Non-Medical Approach." In *Proceedings of the 29th International Congress on Alcoholism & Drug Dependence,* eds. L. G. Kiloh & D. S. Bell. Butterworths: Chatswood, 545–559.

CASTELLANI, BRIAN. 2000. *Pathological Gambling. The Making of a Medical Problem*. Albany: State University of New York Press.

CASTRÉN, SARI, ANNE H. SALONEN, HANNU ALHO & TUULI LAHTI. 2014. "Challenges in Translating DSM-5 Criteria for Gambling Disorder into Finnish." *Nordic Studies on Alcohol and Drugs* 31, 221–224.

CONRAD, PETER. 2005. "The Shifting Engines of Medicalization." *Journal of Health and Social Behavior* 46, 3–14.

CONRAD, PETER & JOSEPH W. SCHNEIDER. 1980. "Looking at Levels of Medicalization. A Comment on Strong's Critique of the Thesis of Medical Imperialism." *Social Science and Medicine* 14A, 75–79.

CONRAD, PETER & JOSEPH W. SCHNEIDER. 1992. *Deviance and Medicalization. From Badness to Sickness.* Philadelphia: Temple University Press.

DAVIES, CELIA. 1996. "The Sociology of Professions and the Profession of Gender." *Sociology* 30:4, 661–678.

DAVIS, JOSEPH. 2009. "Medicalization, Social Control and the Relief of Suffering." In *The New Blackwell Companion to Medical Sociology,* ed. William Cockerham. London: Blackwell, 211–241.

DEMANT, JAKOB. 2012. "Natural Interactions in Artificial Situations. Focus Groups as an Active Social Experiment." In *An Ethnography of Global Landscapes and Corridors,* ed. L. Naidoo. Rijeka: InTech, 57–88.

EGERER, MICHAEL. 2010. *Gate Keepers' Images of Addiction in Finland, France, and Germany. The Film-clips in the Group Interviews.* Helsinki: University of Helsinki, Department of Social Research.

EGERER, MICHAEL. 2012. "Alcoholism, Brief Intervention and the Institutional Context. A Focus-Group Study with French and Finnish General Practitioners." *Critical Public Health* 22:3, 307–318.

EGERER, MICHAEL. 2014. *Institutional Footprints in the Addiction Image. A Focus-Group Study with Finnish and French General Practitioners and Social Workers.* Helsinki: University of Helsinki.

EGERER, MICHAEL, MATILDA HELLMAN & PEKKA SULKUNEN. 2012. "Autonomy and Protection in the Welfare State. Finnish Social Workers' Views on Alcohol Problems." In *A Welfare Policy Patchwork. Negotiating the Public Good in Times of Transition,* eds. Matilda Hellman, Gun Roos & Julius von Wright. NVC, 203–222.

EGERER, MICHAEL & VIRVE MARIONNEAU. 2015. "And that is Where the Fun Ends. General Practitioners' Conceptualisation of the Line between Recreational and Problem Gambling." *Nordic Studies on Alcohol and Drugs* 32:1, 31–47.

EHRENBERG, ALAIN. [1998] 2004. *Das Erschöpfte Selbst. Depression und Gesellschaft in der Gegenwart.* Frankfurt/M: Campus.

ELSTER, JON. 1999. "Emotion and Addiction. Neurobiology, Culture, and Choice." In *Addiction. Entries and Exits,* ed. Jon Elster. New York: Russell Sage Foundation, 239–276.

FERENTZY, PETER & NIGEL TURNER. 2013. *A History of Problem Gambling. Temperance, Substance Abuse, Medicine, and Metaphors.* New York: Springer.

FINGARETTE, HERBERT. 1988. *Heavy Drinking. The Myth of Alcoholism as a Disease*. Berkeley: University of California

Press.

FISH, STANLEY. 1980. *Is There a Text in this Class? The Authority of Interpretative Communities.* Cambridge: Harvard University Press.

FLEXNER, ABRAHAM. 2001. "Is Social Work a Profession?" *Research on Social Work Practice* 11, 152–165.

FREIDSON, ELIOT. 1970. *Professional Dominance. The Social Structure of Medical Care*. New Brunswick: Aldine Transaction.

GALLAGHER, EUGENE & MAUREEN SEARLE. 1989. "Content and Context in Health Professional Education." In *Handbook of Medical Sociology,* eds. Howard Freeman & Sol Levine. New Jersey: Prentice Hall, 437–455.

GOFFMAN, ERVING. 1961. *Asylums. Essays on the Social Situation of Mental Patients and Other Inmates.* Chicago: Aldine.

GRIFFITHS, MARK. 2013. "Gambling in Great Britain. A Response to Rogers." *Practice. Social Work in Action* 25:4, 251–262.

GRONOW, ANTTI. 2011. *From Habits to Social Structures. Pragmatism and Contemporary Social Theory.* Frankfurt/M: Peter Lang.

GROSS, WERNER. 2004. "Sucht ohne Drogen. Gibt es das?" *Soziale Arbeit* 2, 56–62.

HAKOSALO, HEINI. 2010. "Katsaus lääkäriprofession kehitykseen Suomessa. Lääkäri, yhteiskunta ja yhteisö." *Duodecim* 126, 1544–1551.

HELÉN, ILPO. 2002. "Lääketieteen lupaus ja elämän politiikka." *Sosiologia* 39:2, 104–115.

HELÉN, ILPO & MIKKO JAUHO (EDS.) 2003. *Kansalaisuus ja kansanterveys.* Helsinki: Gaudeamus.

HELLMAN, MATILDA. 2010. *Construing and Defining the Out of Control. Addiction in the Media 1968–2008.* Helsinki: Swedish School of Social Sciences.

HIRSCHOVITS-GERZ, TANJA, KARI HOLMA, ANJA KOSKI-JÄNNES, KIRSIMARJA RAITASALO, JAN BLOMQVIST, JOHN A. CUNNINGHAM & IRINA PERVOVA. 2011. "Is there Something Peculiar about Finnish Views on Alcohol Addiction? A Cross-Cultural Comparison Between Four Northern Populations." *Research on Finnish Society* 4, 41–54.

HJORTDAHL, PER. 1992. "The Influence of General Practitioners' Knowledge about their Patients on the Clinical Decision-Making Process." *Scandinavian Journal of Primary Health Care* 10:4, 290–294.

ILLICH, IVAN. [1976] 1995. *Limits to Medicine. Medical Nemesis: The Expropriation of Health.* London: Marion Boyars.

JAAKKOLA, JOUKO. 1994. "Sosiaalisen kysymyksen yhteiskunta." In *Armeliaisuus, yhteisöapu, sosiaaliturva. Suomalaisten sosiaalisen turvan historia,* eds. Jouko Jaakkola, Panu Pulma, Mirja Satka & Kyösti Urponen. Helsinki: Sosiaaliturvan keskusliitto, 71–161.

JELLINEK, E. MORTON. 1960. *The Disease Concept of Alcoholism*. Mansfield Centre: Martino Publishing.

KEARLEY, KAREN, GEORGE FREEMAN & ANTHONY HEATH. 2001. "An Exploration of the Value of the Personal Doctor-Patient Relationship in General Practice." *British Journal of General Practice* 51, 712–718.

KOHLER RIESSMAN, CATHERINE. 2003. "Women and Medicalisation. A New Perspective." In *The Politics of Women's Bodies, Sexuality, Appearance, Behaviour,* ed. Rose Weitz. New York and Oxford: Oxford University Press.

KOSKI-JÄNNES, ANJA, TANJA HIRSCHOVITS-GERZ & MARJO PENNONEN. 2012. "Population, Professional, and Client Support for Different Models of Managing Addictive Behaviors." *Substance Use & Misuse* 47, 296–308.

LIVINGSTON, WULF. 2014. "Towards a Comprehensive Typology of Knowledge for Social Work and Alcohol." *Social Work Education. The International Journal* 33:6, 774–787.

MAYNTZ, RENATE. 1970. "The Nature and Genesis of Impersonality. Some Results of a Study on the Doctor-Patient Relationship." *Social Research* 37, 428–446.

MESCH, R. 2011. "Glücksspielsucht. (k)Ein Thema für die Schuldnerberatung." *BAG-SB Informationen* 3, 164–167.

MILLER, M. M. 1996. "Medical Approaches to Gambling issues. I: The Medical Condition." *Wisconsin Medical Journal* 95:9, 623–634.

MILLER, PETER & NIKOLAS ROSE. 2008. *Governing the Present. Administering Economic, Social and Personal Life.* Cambridge: Polity.

MOMPER, SANDRA. 2010. "Implications of American Indian Gambling for Social Work Research and Practice." *Social Work* 55:2, 139–146.

MORGAN, DAVID L. 1988. *Focus Groups as Qualitative Research*. Newbury Park, California: SAGE.

MURTO, ANTTI. 2010. "Rahapeliongelma ja sosiaalityö." In *Sosiaalityön käsikirja,* eds. Aulikki Kananoja, Martti Lähteinen & Pirjo Marjamäki. Helsinki: Tietosanoma, 244–250.

MURTO, LASSE. 2005. "Käytäntörelevanssi. Haasteita sosiaalityön koulutukselle ja tutkimukselle." *Janus* 13:3, 316–328.

NYE, ROBERT. 2003. "The Evolution of the Concept of Medicalization in the Late Twentieth Century." *Journal of the History of the Behavioural Sciences* 39:2, 115–129.

OLDMAN, DAVID. 1974. "Chance and Skill. A Study of Roulette." *Sociology* 8:3, 407–426.

PARKE, JONATHAN & MARK GRIFFITHS. 2007. "The Role of Structural Characteristics in Gambling." In *Research and Measurement Issues in Gambling Studies,* eds. Garry Smith, David C. Hodgins & Robert J. Williams. London: Elseviewer, 217–250.

PASTERNAK, A. V. 4th & M. F. Fleming. 1999. "Prevalence of Gambling Disorders in a Primary Care Setting." *Archives of Family Medicine* 8:6, 515–520.

PEELE, STANTON. 1989. *Diseasing of America. Addiction Treatment Out of Control.* Lexington: Lexington Books.

PENNONEN, MARJO & ANJA KOSKI-JÄNNES. 2010. "Päihdealan ammattilaisten käsityksiä aineriippuvuuksista." *Janus* 18:3, 208–224.

PETERSEN, ALAN & DEBORAH LUPTON. 1996. *The New Public Health. Health and Self in the Age of Risk*. London: SAGE.

PÖYSTI, VIRVE & MAIJA MAJAMÄKI. 2013. "Cultural Understandings of the Pathways Leading to Problem Gambling. Medical Disorder Or Failure of Self-Regulation?" *Addiction Research & Theory* 21:1, 70–82.

REITH, GERDA. 2006a. "The Experience of Play." In *Sociology of Risk and Gambling Reader,* ed. James Cosgrave. London: Routledge, 255–290.

REITH, GERDA. 2006b. "The Pursuit of Chance." In *Sociology of Risk and Gambling Reader,* ed. James Cosgrave. London: Routledge, 125–141.

RISKA, ELIANNE. 2003. "Gendering the Medicalization Thesis." In *Gender Perspectives on Health and Medicine. Advances in Gender Research, Volume 7,* eds. Marcia Texler Segal, Vasilikie Demos & J. J. Kronenfeld. Emerald Group Publishing Limited, 59–87.

ROGERS, JIM. 2013a. "Gambling and Social Work. Response to Griffiths." *Practice. Social Work in Action* 25:4, 263–267.

ROGERS, JIM. 2013b. "Problem Gambling. A Suitable Case for Social Work?" *Practice. Social Work in Action* 25:1, 41–60.

ROSE, NIKOLAS. 2007a. "Beyond Medicalization." *Lancet* 369, 700–702.

ROSE, NIKOLAS. 2007b. *The Politics of Life Itself. Biomedicine, Power, and Subjectivity in the Twenty-First Century.* Princeton & Oxford: Princeton University Press.

ROSECRANE, JOHN. 1985. "Compulsive Gambling and the Medicalization of Deviance." *Social Problems* 32, 275–284.

ROSENQVIST, PIA & KERSTIN STENIUS. 2014. "Medicalisation of the Social Perspective. Changing Conceptualisations of Drug Problems in Finnish Social Care and Substance Abuse Treatment." *Nordic Studies on Alcohol and Drugs* 31:5–6, 551–568.

SALONEN, ANNE H., SARI CASTRÉN, HANNU ALHO & TUULI LAHTI. 2014. "Concerned Significant Others of People with Gambling Problems in Finland. A Cross-Sectional Population Study." *BMC Public Health* 14, 398–416.

SASSEN, MONIKA, LUDWIG KRAUS & GERHARD BÜHRINGER. 2011. "Differences in Pathological Gambling Prevalence Estimates. Facts or Artefacts?" *International Journal of Methods in Psychiatric Research* 20:4, e83–99.

SATKA, MIRJA. 1994. "Sosiaalinen työ peräänkatsojamiehestä hoivayrittäjäksi." In *Armeliaisuus, yhteisöapu, sosiaaliturva. Suomalaisten sosiaalisen turvan historia,* eds. Jouko Jaakkola, Panu Pulma, Mirja Satka & Kyösti Urponen. Helsinki: Sosiaaliturvan keskusliitto, 261–339.

SATKA, MIRJA. 1995. *Making Social Citizenship. Conceptual Practices from the Finnish Poor Law to Professional Social Work*. Jyväskylä: University of Jyväskylä.

SCOTT, W. RICHARD. 2008. "Lords of the Dance. Professionals as Institutional Agents." *Organization Studies* 29, 219–238.

SILVERMAN, DAVID. 2001. *Interpreting Qualitative Data. Methods for Analysing Talk, Text and Interaction.* London: SAGE.

STENIUS, KERSTIN. 2007. "In the Faint Shadow of Prohibition. The First Finnish Alcoholics Act of 1936." In *On the Margins. Nordic Alcohol and Drug Treatment 1885–2007,* eds. John Edman & Kerstin Stenius. Helsinki: NAD Publications, 97–120.

STRAUSS, ANSELM. 1987. *Qualitative Analysis for Social Scientists*. Cambridge: Cambridge University Press.

SULKUNEN, PEKKA. 2007. "Images of Addiction. Representations of Addictions in Films." *Addiction Research & Theory* 15:6, 543–559.

SULKUNEN, PEKKA & MICHAEL EGERER. 2009. *Reception Analytical Group Interview. A Short Introduction and Manual*. Helsinki: University of Helsinki, Department of Sociology.

SULLIVAN, SEAN, BRUCE ARROLL, GREGOR COSTER & MAX ABBOTT. 1998. "Problem Gamblers. A Challenge for GPs." *NZ Family Physician* 25:1, 37–42.

SZASZ, THOMAS. 1961. *The Myth of Mental Illness. Foundations of a Theory of Personal Conduct.* New York: Harper & Row.

TAKALA, JUKKA-PEKKA & JUHANI LEHTO. 1992. "Finland. The Non-Medical Model Reconsidered." In *Cure, Care, Control. Alcoholism Treatment in Sixteen Countries,* eds. Harald Klingemann, Jukka-Pekka Takala & Geoffrey Hunt. New York: State University of New York Press, 87–110.

THL, NATIONAL INSTITUTE FOR HEALTH. 2011. "Hoitopalvelut kunnittain." http://www.thl.fi/attachments/pelihaitat/hoitopalvelut_kunnat2011.pdf (Accessed 26 October 2015).

TIKKINEN, KARI, JANNE LEINONEN, GORDON GUYATT, SHANIL EBRAHIM & TEPPO JÄRVINEN. 2012. "What is a Disease? Perspectives of the Public, Health Professionals and Legislators." *BMJ Open* 2, 1–8.

TOIKKO, TIMO. 2005. *Sosiaalityön ideat. Johdatus sosiaalityön historiaan.* Tampere: Vastapaino.

TÖRRÖNEN, JUKKA. 2002. "Semiotic Theory on Qualitative Interviewing using Stimulus Texts." *Qualitative Research* 2:3, 343–362.

TURJA, TUOMO, JUKKA HALME, MARKUS MERVOLA, JOHANNA JÄRVINEN-TASSOPOULOS & JENNI-EMILIA

RONKAINEN. 2012. *Suomalaisten rahapelaaminen 2011.* Raportti 14/2012. Helsinki: THL.

WARPENIUS, KATARIINA, MARJA HOLMILA & KIRSIMARJA RAITASALO. 2012. "Pelin ei puututa. Alkoholin, tupakan ja rahapeliautomaattien ikärajavalvontaa testanneet ostokokeet vähittäisliikkeissä." *Yhteiskuntapolitiikka* 77, 375–385.

WILLIAMS, ROBERT J., RACHEL A. VOLBERG & RHYS M. G. STEVENS. 2012. *The Population Prevalence of Problem Gambling. Methodological Influences, Standardized Rates, Jurisdictional Differences, and Worldwide Trends.* Report Prepared for the Ontario Problem Gambling Research Centre and the Ontario Ministry of Health and Long Term Care. May 8, 2012.

ZOLA, IRVING K. 1972. "Medicine as an Institution of Social Control." *Sociological Review* 20:4, 487–504.