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Rethinking the Approach to Gambling Disorder: The Case of the Italian Healthcare Services[1]

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Abstract

In a cultural context where ludopathy is a social phenomenon built through normative and medical definitions, how are healthcare services approaching the treatment of gambling disorder? The purpose of this study is to examine the Italian healthcare service approach to pathological gambling disorder (PGD), with the aim of formulating proposals for action. Italy is chosen as a crucial terrain of investigation to understand the challenges posed by the growth of the gambling market in Europe and its consequences on its healthcare systems.

The empirical material underpinning the analysis includes the latest official statistical data regarding the socio-medical treatment of people with addictions in Italy as well as qualitative interviews conducted with social-sanitary structure managers responsible for therapeutic activities combating dependencies. Through a social construction perspective, gambling and PGD are understood as social phenomena whose meaning and definition comes as a result of a process of negotiation.

Accordingly, principal findings are related to the respondents' visions of PGD and how they perceive the activities of social and health services, the impact of changes in legislation on the organisation of services, and the ongoing changes regarding this process.

Keywords: gambling disorders, ludopathy, gambling policies.

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Research highlights

- Gambling and gambling disorder are social phenomena whose meaning comes as a result of a negotiation.
- The consequences of pathological gambling are at once social, health, economic and relational in nature.
- The care and treatment of pathological gamblers is generally undertaken by persons with clinical training.
- The increase in demand for treatment services depends also on the wider range of services offered and a more common awareness of the problem.

An agenda of interventions, based on the experience of professional involved in treatment, is necessary to rethink the approach to PGD.

1. Introduction: the evolution of gambling and the Italian context

In a cultural context where ludopathy is a social phenomenon built through normative and medical definitions, how are the healthcare services approaching the treatment of gambling disorder? This research question, which forms the basis of this article, is becoming of increasing interest not only for gambling studies, but also for researchers and policy makers who critically question medicalised modes of dealing with excessive or compulsive gambling.

Italy is, for many reasons, a crucial point of departure in understanding the challenges posed by the incessant growth of the gambling market in Europe. According to a H2 Gambling Capital report quoted in *The Economist* of 9 February 2017, Italy, with expenditures of $US19bn (stakes minus payouts excluding expenses), had the highest losses of any European state in 2016 and ranked fourth globally after the United States, China and Japan. Italy was ninth in the world for losses per resident adult at just under $US400, half of which was spent in gaming machines not located in casinos. The data relating to the annual financial inflows from bets placed is even more impressive. Approximately €96bn was spent in 2016, an increase of 8% over the €88bn of 2016, with tax earnings of €9.2bn and gross total revenues within the gambling industry of approximately €10bn (Avviso Pubblico, 2017).

But the factor which makes Italy an international landmark in gambling is the type of regulation it applies to the sector. In general, three main models of public gambling regulations currently exist, corresponding to the three levels of State presence in the management of public activities. Gambling may fall under direct governmental agency control. Alternatively, the State may control the sector by applying an entrepreneurial approach whereby the managing body functions as a private enterprise not constrained by public administration regulations regarding salary levels and the procurement of supplies and services.

The third model, fully developed in Italy, is where the State maintains regulatory control but the gambling activities are organised by private concessionaires within a competitive market. In this model, the State is in effect a monopolist and promoter of a market which generates or favours excessive or pathological behaviours, with important implications for its concurrent role of guarantor of public health.

Gambling Compliance, a research organisation servicing the gambling industry, demonstrated in an analysis of a three-year period of particularly intensive market growth (2009-2012) that most European countries have chosen to move from a stance of monopoly or total prohibition towards a competitive market run by private dealers. The Italian 'Abruzzo' Decree-Law passed in 2009 is in line with this development. The model also foresees the monitoring and blocking of illegal sites, an area where Italy has been a pioneer. The wide arc of prohibitionist European states which in 2009 stretched from Berlin to Athens had by 2012 shrunk to involve only Bosnia, with Germany and Lithuania showing signs of favouring a partial legalisation of gambling, and most countries of continental Europe migrating to the Italian model.

2012 was additionally a very significant year in Italy for the 'social construction' of gambling in public opinion. A period of gradual legalisation of gambling had been initiated at the end of the 1980s, sometimes mistakenly referred to as a deregulation, where the State in fact maintained its role as a monopolist, increasing the number of concessions. This was followed in 2012 by the first regulatory intervention, a Decree designed by the incumbent Minister of Health, Renato Balduzzi, which foresaw restrictive measures controlling gambling and the recognition of addiction to gambling as a pathology that the national health system must treat (Pedroni, 2014). Contemporaneously, the so-called 'revolt of the municipalities' began: local and regional authorities challenged the State by pronouncing a series of territorial norms to combat the proliferation of gambling. The new laws focused in particular on limiting the opportunities to gamble by, for example, restricting premise trading hours or gaming machine access, or applying distance minimums of 300 to 500 metres between newly opened gambling premises and sensitive sites such as schools, churches and hospitals. Prevention programmes directed especially at the population sectors most in need of information and awareness-raising were also initiated.

2. Aim and methods

This article takes a social construction perspective (Berger, Luckmann, 1967) on gambling and gambling disorder, understood as social phenomena

whose meaning and definition comes as a result of a process of negotiation. The normative and medical definitions, object of this construction (Reith, 2007), are not static. They are under continuous redefinition through the practices of the social agents involved and the language they use to refer to such phenomena. For the purposes of this text we consider the point of view of social-sanitary personnel as absolutely relevant, and we have analysed it by referring to the way their opinion is verbalised (language) and the specific national context where the negotiation takes place.

Over the past decade, the cash prize game system in Italy has undergone significant changes due to the combined effect of the entry into force of new regulations at national, regional and local levels, public opinion movements hostile to the proliferation of gambling and its pathological tendencies, a stagnation of incomes and consumption (indicated at times as a contributing cause of increased spending on gambling), the introduction of new types of games, particularly online, and of internal competition in the world of distributors (Pedroni, 2014; Fiasco, 2010; Rolando, Scavarda, 2018).

The so-called Balduzzi Law, Decree Law 158 of 2012 converted into Law 189 of 2012, established an updating of the essential levels of assistance in order to set up therapeutic interventions against gambling addiction. In 2012, as noted above, Italian regional governments began to introduce regulations concerning the establishment and operation of gaming rooms, and began to formally combat gambling addiction. To date, almost all the Regions have approved and promulgated laws which, with varying intensity and via diverse measures, impose limits on the legal cash prize game markets within their respective territories.

Within the framework of a public opinion which is very sensitive to the issue and grassroots movements both lay and Catholic which decry the growth of Pathological Gambling Disorder (PGD) and fight the proliferation of gaming machines in places frequented daily such as bars and tobacconists (Pedroni, 2014), the complexity of the situation for the Italian national health system becomes obvious. It involves the identification of an effective and unified approach to the treatment of PGD within a system where health care is the responsibility of 21 different authorities. Italy has 19 Regions and the two autonomous provinces, Trento and Bolzano, with 18 different regional laws regarding gambling. The treatment of pathological gamblers was entrusted soon after their initiation to local services specialising in the treatment of substance dependence (Addiction Services).

Against the background of a critical analysis of the definition of gambling as a disorder, the changes introduced by the Diagnostic and Statistical Manual of Mental Disorder, fifth edition (DSM-V) and recent regulatory action in the

Italian context, this article examines the Italian healthcare service approach to gambling disorders with the aim of formulating proposals for action.

Regional and municipal regulations emphasise intervention where the subjects are most fragile and at risk. In line with this approach, both the monitoring of ludopathy or compulsive gambling and its diffusion as well as the therapeutic activities organised by the national and local health services or private and public agencies have gained in social relevance. Starting from this consideration, and within the framework of the social constructionist approach explained at the beginning of this Section, our research question is: how have the health services responded to the twin pressures of regulation and the changes introduced by the Balduzzi Law, and of classification changes with the updating of the definition of the pathological gambler introduced by DSM-V?

The empirical material underpinning our analysis includes the latest official statistical data regarding the socio-medical treatment of people with addictions as well as interviews conducted with 13 social-sanitary structure managers responsible for therapeutic activities combating dependencies. Central to the purposes of this article is an exploration of the practitioners' visions of PGD and their perception of the activities of social and health services, including the impact of changes in legislation on the organisation of services.

The interviews with these key informants took place from June to October 2016 and explored the following thematic areas: an introductory framework of pathological gambling (a critical evaluation of DSM-V, similarities and differences with other behavioural disorders, the profile of a pathological gambler, the impact of pathological gambling on the community, families and individuals); service activities (types and spread of entities providing benefits, actors involved and their relationships, intervention strategies); the impact of changes in legislation on the organisation of services (benefits granted, human and financial resources involved); a trend analysis of the last 5 years (numbers of persons involved, their socio-demographic and clinical characteristics, game types and patterns of the pathological user, co-morbidity); an evaluation of outcomes (clinical and social outcomes, criticality of interventions undertaken, suggested improvements, total activity levels). The interviews applied a non-directive question strategy (Bichi, 2005) and aimed at capturing elements useful for a critical evaluation of the intervention programmes (Patton, 1987). The interviews lasted on average 60 minutes. They were audio-taped and transcribed in full. The interview transcriptions were subjected to hermeneutic analysis, aimed at an interpretation and an in-depth understanding of meanings of the responses. The interviewee list resulted from a snowball sampling which considered as eligibility criteria: (1) occupation of a manager/expert role in social and health services offering interventions specifically addressed to pathological gamblers; (2) at least 3 years professional experience in addiction

services; (3) employment in one of the three Regions included in the research, Lombardy, Apulia, Liguria.

The research team considered these regional contexts to be of particular interest because of the strict legal frameworks applied by the local authorities to govern gambling, a signal which may be read as an attempt to stem a phenomenon considered widespread and worrying. Despite the fact that restrictive norms have gradually been extended to cover the entire national territory, the three Regions chosen seemed, at the initiation of our study, to be particularly important for our objectives. The characteristics of the respective regional laws, i.e. the comprehensiveness of the laws in Lombardy, the timing of those in Liguria and the retroactive powers of the legislation in Apulia, are relevant for our research not so much and not only for an examination of the norms, but above all because they constitute a tangible signal of the public and political debates on gambling in the relevant Regions (Rovati, Pedroni, 2016). These debates bring to maturation the conditions allowing a process of legislative production and involve, consequently and among others, the health services.

Regional Law 8/2013 in Lombardy, amended by Law 11/2015, is frequently referred to in public debate and by policy makers as the legislative banner of those opposing a further expansion of gambling, and its related risks. It is applicable in a range of diverse environments and has become the inspiration for the emanation of a series of similar laws in other Regions. The Law:

- Bans the opening of new gambling establishments and the installation of gambling apparatus connected to data transmission systems within 500 metres of locations considered sensitive; in addition, local municipalities are empowered to define further 'sensitive' locations;
- Bans advertising promoting the opening or availability of gaming establishments and the installation of gambling apparatus in commercial or public sites;
- Provides for the establishment of a regional centre to study dependencies and monitor gambling;
- Creates the *No slot* branding for entertainment locations which do not install gambling machines;
- Allows for the contribution to associations involved in increasing the awareness of the risks of gambling and supporting responsible gaming;
- Projects the areas of competency of the municipalities and health service providers in the provision of information related to the risks of ludopathy;
- Obliges managers of gambling establishments to inform their clientèle and instruct their employees on the dangerous of pathological gambling;

- Creates a toll free number operating regionally to offer aid to players;
- Reduces the regional tax on production activities (IRAP) for establishments which cease to use gambling apparatus and increases it for the remaining locations;
- Assigns the results of sanctions to programmes combating ludopathy;

Liguria represents an interesting case because it was the first Region to take steps to control gambling. The Regional Laws 17 and 18 promulgated in 2012:

- Ban the opening of new gambling establishments within 300 metres of locations considered at risk, and provides for municipal powers to determine other sensitive locations;
- Ban advertising promoting the opening or availability of gaming establishments;
- Provide for the establishment of a regional centre to monitor gambling dependencies;
- Assign the responsibility for the treatment of ludopathy to the local public health authorities, to be carried out by specialised dependency units located within the Departments (this point is of particular relevance for our study);
- Provide for information programmes within the education system and gambling establishments.

Apulia is the final gambling 'hot spot' in our study. Regional Law 43/2013 may be the most severe of the laws to control gambling, when the effect of the laws on the locations is measured. It also establishes a five-year period for the application of the distance ban for establishments already in existence prior to the promulgation of the Law. In addition, the law:

- Bans the opening of new gambling establishments within 300 metres of locations considered at risk, and provides for municipal powers to determine other sensitive locations; the renewal of licences previously issued became subject to the distance regulations for five years.
- Provides for the establishment of a regional centre to monitor gambling dependencies;
- Creates the *Slot free - Region of Apulia* branding for entertainment locations which do not install gambling machines;
- Provides for the creation of ludopathy information spaces within gambling establishments;
- Determines the municipal and health services responsibilities in ludopathy prevention programmes;
- Creates a toll free number operating regionally to offer aid to players;
- Provides for information courses for establishment operators, employees and managers to be managed by the municipalities, interested actors and the third sector;

- Bans any advertising promoting the opening or availability of gaming establishments;
- Assigns funds for the prevention and cure of gambling pathologies;
- Established a day dedicated to combating the diffusion of gambling.

The persons interviewed in this study were in the main principal figures employed in the public services. Private service operators were included in the study in only one Region, Liguria. These were selected because of the particular relevance of their activities locally and their on-going collaboration with the public service operators interviewed. The theoretical research design initially foresaw the selection of four suitable participants from each Region, chosen from among the managers and operators of the local public social health services. As is often the case in qualitative studies, the subsequent performance in the field suggested a revision of the theoretical design (Merriam, Tisdell, 2016) to one capable of capturing the concrete experience of the practitioners and taking into account the practical difficulties and opportunities which arose during selection of the participants. Several points should be noted here. Firstly, the public social health services contacted offered the collaboration of figures who were in the main from upper management. We had originally sought interviews with operators in order to investigate the problems involved in the day-to-day contact with clients. In many cases, however, an operator was required to have the permission of their management to participate in the interviews, and/or be interviewed in the presence of the manager. After the completion of the first interviews, we remained convinced that the principal figures were also able to inform the study of daily problems, and we therefore interviewed operators only when they were expressly indicated as relevant by the services (Interview No. 13, Apulia). Secondly, the specifics of the local contexts within our snowball sample suggested that we should evaluate the experiences of nonprofit and private entities where these are strongly integrated with the public services. The Ligurian selection therefore includes two representatives (Interviews Nos. 8, 9). The third point involves the availability of a supernumerary participant considered key in the explanation of certain themes not treated in full by previous interviewees (Interview No. 5, Lombardy).

Snowball sampling is a convenience sampling method: the researcher accesses key informants through contact information that is provided by other informants. The most evident advantage of the snowball method is the time saved. However, the atmosphere of trust generated also provides the researcher with the opportunity for an improved communication between the interviewer and interviewee (Bieranacki, Waldorf, 1981). Although snowball sampling can introduce an expert bias, it is particularly useful for capitalising on expert wisdom (Suri, 2011).

Every person contacted agreed to be interviewed. Interviewees were advised that they could terminate the interview at any point. In addition, they were informed of the research objectives and received assurance that the data would remain confidential. The final sample consisted of 13 individuals as detailed in Table 1.

TABLE 1. Socio-demographic characteristics of the professional experts interviewed.

No.	Region	Function	Gender
1	Lombardy	Addiction Department manager	Male
2	Lombardy	Addiction Observation Centre manager	Male
3	Lombardy	Addiction Department manager	Male
4	Lombardy	Addiction Department manager	Male
5	Lombardy	Lombardy Addiction Department manager	Male
6	Liguria	Addiction Department manager	Male
7	Liguria	Addiction Services manager	Male
8	Liguria	Representative from a private social group supporting the addiction services, spokesperson for an anti-usury centre	Male
9	Liguria	Representative from a private social group supporting the addiction services	Female
10	Apulia	Addiction Pathologies Department manager	Female
11	Apulia	Addiction Pathologies Department manager	Female
12	Apulia	Addiction Pathologies Department manager	Male
13	Apulia	Psychologist, Psychological Dependency Service	Male

The research was funded by the nonprofit Foundation for Subsidiarity and conducted by a ModaCult Centre research team at the Catholic University of Milan. The project was part of a larger project conducted in 2016 entitled *The social and health impact of national, regional and municipal regulations on the cash prize games system*. All procedures performed in studies involving human participants were in accordance with the ethical standards of our institutions and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

In the following Section, several approaches to pathological gambling as a disorder will be discussed and relevant data on the incidence of gambling addiction in Italy presented. In Section 4, empirical material extracted from interviews will be analysed in detail. We will focus on the vision of the PGD as

expressed by socio-health workers, the characteristics of users who access the services, health facility action and the impact of the new rules, in particular the Balduzzi Law, on the organisation of the services. The discussion in Section 5 underlines our support of the need to rethink the approach to PGD. We will highlight how the social construction of the problematic player leads to considering the disease as an exclusively individual problem. To close, we will propose an agenda of interventions relevant to the construction of a new policy for treatment of PGD.

3. Literature review: gambling as a disorder

Pathological gambling is a serious mental disorder showing high comorbidity with substance use, mood, anxiety, and personality disorders (Petry, Stintson, Grant, 2005). Scholars and policy makers have expressed concern about the impact of pathological gambling on the quality of life of individuals, families and communities (Williams, Rehm, Stevens, 2011).

The business of academic literature on gambling is booming. In 2017, Google Scholar registered approximately 26,100 contributions related to keyword 'gambling', 4,820 of which referred to 'pathological gambling'. The proportion of studies on gambling devoted to compulsive gambling reveals the strong presence in the scientific debate of a medical vision that reads games of chance as the (potential) source of pathologies. Existing studies classify gamblers under a range of criteria, often referring to dichotomies such as the excessive/normal gambler (e.g. Abbott, Palmisano, Dickerson, 1995), social/pathological gambler (e.g. Fisher, 1993), or a three-category classification such as social/problem/pathological (e.g. Gupta, Derevensky, 1998), non-pathological/in-transition/pathological (e.g. Shaffer et al., 1994) and recreational/low problem/high problem (e.g. Vitaro, Arseneault, Tremblay, 1999) along a scale ranging from social games – encouraged and approved due to the aggregative function – followed eventually by problematic gaming – an exaggeration ignored in its manifestations until it becomes excessive. The last measure is that of pathology. This dependency is not related to the massive and distorted use of a substance (drug or alcohol) but to a behaviour form which is repeated without control because it is driven by an urgent need requiring compulsory fulfilment (Pani, Biolcati, 2006: IX). The clinical characteristics are the compulsiveness or an irresistible impulse to gamble, loss of control and an inability to exercise limits, and the continuity of game behaviour, despite the problems it generates for the player.

Until the 1970s, investigative approaches to the phenomenon of gambling followed a dynamic which was principally clinical in type, with contributions

mainly from the medical, epidemiological and psychological fields. Freud, in his essay on Dostoevsky and parricide, linked a gambling dependency to a 'primal addiction', masturbation, as vices reliant on the movement of the hands. Excessive gambling is also discussed as masochistic and neurotic behaviour in psychoanalytic literature (see for example Bergler, 1957; Lindner, 1974).

Gamblers are heterogeneous in presentation. Psychology has extensively researched pathological gambling, focussing on predisposing factors such as the presence of other players in the family or a tragic event or loss. It has composed a profile of the gambler as an avid player, generally male, over thirty years in age, unmarried and with little formal schooling, who began gaming at an early age (Volberg, 1998). However, definitive conclusions are difficult to formulate because attitudes to gaming and gambling are deeply influenced by socio-cultural variables. Another area of equal interest to researchers has been the possible correlation between pathological gambling and substance abuse (Johansson et al., 2009; Wareham, Potenza, 2010), which seems to suggest gambling as a manifestation of pathological behaviours in persons predisposed to dependence, rather than a sector capable of generating problems of addiction in subjects otherwise unrelated to situations of dependency.

The set of risk factors that predispose to addiction is highly articulated, and they may be summarised by classification into three main areas (Inserm, 2008):

(a) factors related to the *object of the addiction* itself, such as the type of game (the narrower the interval between bet and payout, the higher the frequency of play and risk), the initial gain (a high initial gain leads to gambling problems), as well as the medium of gaming type (the asocial aspects of the Internet as a risk factor, such as anonymity and solitude) and the offer and availability of games;

(b) *environmental factors and contexts*, including cultural and religious (the influence of religious obligations and prohibitions), socio-economic and socio-educational (parents and family background, socio-economic status);

(c) *individual factors* such as gender and age, family and personal history.

Blaszczynski and Nower (2002), in response to the high number of studies on the factors playing a significant role in the addiction process, propose a conceptual model of three discrete pathways corresponding to distinct subgroups of pathological gambling. At the low end of the pathology are the 'behaviourally conditioned problem gamblers', followed by 'emotionally vulnerable problem gamblers' and, at the peak of the pathological dimensions, 'antisocial impulse-driven problem gamblers' characterised by impulsivity and antisocial personality disorder. The latter demonstrates a poor response to any form of clinical intervention.

The impressive mass of medical and psychological contributions to the study of gambling has encouraged an epidemiological orientation in sociology designed to identify the number and characteristics of the persons exposed to

the risk of gambling addiction. Aasved (2003) has noted that since the 1970s a series of surveys within the Anglo-Saxon context have led to three main conclusions:

(a) men have a greater propensity to gamble than women (*gender hypothesis*);

(b) the tendency is greater in highly urbanised areas than in rural areas and in small towns (*rural-urban residence hypothesis*);

(c) there is a directly proportional relationship between opportunities for gaming (number and frequency of competitions and gambling sites) and the volume of the population's spending on gambling (*availability and exposure hypothesis*).

However, it is precisely the number of these surveys which demonstrates that the study of gambling is too often reduced to its socio-statistical component, with two main consequences. The first is the social construction of the 'player with a problem' as the dominant figure in the gaming world. This view emerged in the second half of the 20th century after the expansion of the gambling industry and the consequent concerns generated in public opinion where games of chance are interpreted as an unproductive activity, structurally unable to create wealth, guilty of redistributing wealth without reference to merit and aiding in the moral degradation of the people (Lears, 2003), as well as an incentive to vice and intemperance. An addicted gambler ideal type emerged in the 1970s, where medical and psychiatric nomenclature was used to describe the characteristics and personality traits. Surprisingly, at the peak of a period of commercial proliferation and economic deregulation in the early 1980s, problem gambling began to be discussed not in terms of consumer behaviour but rather in a reductive and materialistic epistemology of disease and disorder (Reith, 2007: 37). In a significant move in 1980, the American Psychiatric Association introduced the term *pathological gambler* in its DSM-III. In the DSM-IV, pathological gambling was defined as a 'persistent and recurrent disorder' connoted by the presence of at least five of the following symptoms: concerns about personal gambling behaviour; the need to gamble with increasing amounts of money; gambling as a way of escaping problems or dysphoric moods; repeated unsuccessful efforts to control, cut back or stop; restlessness or irritability when attempting to cut down or stop; 'chasing' losses; lying to conceal the extent of the involvement with gambling; committing of illegal acts to finance gambling; jeopardising or losing a relationship or job; reliance on others to provide money to relieve a desperate financial situation (American Psychiatric Association, 1994). In this DSM edition, pathological gambling was classified under *Impulse-Control Disorders Not Elsewhere Classified,* along with compulsive stealing (kleptomania), fire starting (pyromania) and hair pulling disorder (trichotillomania) (Christensen et al., 2015).

In May 2013, the DSM-V introduced a series of changes to the previous versions, as discussed in other contributions (Petry et al., 2014; Stinchfield et al., 2016; Goudriaan et al., 2006; Blanco et al., 2013). Problem gambling, now referred to as gambling disorders, was recognised to be similar in neurological, genetic, and behavioural terms to substances addictions. It was consequently included in the *Substance-related and Addiction Disorders* section, notably as the sole behavioural addiction in this group, rather than in the section on impulse control disorders. The threshold for diagnosis was lowered from five to four. It was also specified that symptoms must be present during past 12 months. A severity index was introduced, distinguishing between three levels of dependence: mild – 4-5 criteria met; moderate – 6-7 criteria; severe – 8-9 criteria. The changes included the removal of the presence of illegal acts such as forgery, fraud, theft, or embezzlement to finance gambling from the diagnosis criterion because they did not appear to be a decisive symptom for most people with gambling disorders (Strong, Kahler, 2007; Petry, 2010).

According to a 2018 study conducted by the Italian Istituto Superiore di Sanità (2018) referring to 2017, 36.4% or 18,450,000 residents of Italy had gambled for cash prizes at least once in the previous 12 months. Gambling had affected almost one in two men (43.7%, over 10,500,000 residents) and one in three women (29.8%, 7,900,000 residents). The researchers applied the Canadian Problem Gambling Index (CPGI), a scale developed by Ferris, Wynne (2001a, 2001b) and validated in its Italian version by Colasante et al. (2013), to estimate the percentage of persons with a gambling problem in the population, i.e. those who demonstrate risk behaviours but who have not yet developed an addiction, and pathological gamblers, subjects displaying the symptoms of a disorder associated with gambling. The study revealed that 26.5% of the adult population, about 13,435,000, gambles socially, with significant differences between males at 30.2% and females at 23.1%. 4.1% of the players, approximately 2,000,000 residents, were considered to be at low risk, with 2.8% or around 1,400,000 at moderate risk. 3% were considered to be pathological gamblers, and of these approximately 1.5 million persons the largest group at 35.5% is aged 50-64.

Estimating the number of subjects in treatment is problematic because no exhaustive, accredited and representative studies currently exist. According to the study conducted by Serpelloni (2013), in the year 2011 4,544 persons sought treatment, of which 82% were males and 18% females. The largest male age group was of subjects 35-54 in age, while the females were aged 45-64. However, the figure is greatly affected by the lack of data from the various Regions. According to the latest data transmitted by the Narcotics Department (2015), 12,376 persons were treated in 2014.

Gambling as a disorder has been the principal characteristic of the wide range of studies produced to date. It is, however, not the only approach considered useful for the purposes of this article. At least two other areas of analysis should be considered, although neither falls within the scope of our work. and cannot be given the attention they deserve. The first of these is gambling as a form of improper consumption (Reith, 2007). Gambling is seen as a form of non-productive expenditure, and it is particularly unacceptable in a capitalist society favouring a cult to utilitarianism when it becomes an excessive behaviour (Bataille, 1985) because excess gambling is seen as a destroyer of capital, not a creator: '[W]inning is merely a result either accidental or statistically unlikely action whose expected consequence is losing' (Pedroni, 2017: 67). Seen as such, the definition of what is excess or pathological is functional in the stigmatisation of the gambler as a citizen who has failed in their role as a consumer. Secondly, a study of gambling as a pathology cannot ignore the role of the State, a unit which has historically acted as a defender of public health in Italy since at least the 1980s by limiting a citizen's exposure to opportunities to gamble, and which has since transformed itself to become a neoliberal agent following the dictates of the market by promoting the expansion of gambling through its role of monopolist and regulator, proposing itself as a benefactor through the distribution of tax revenues gained from gambling activities, and the provider of prevention and curative services for pathological cases (Pedroni, 2014).

4. Findings

The shortcomings highlighted so far not only suggest the need for more targeted quantitative studies, but also a need for qualitative research aimed at an analysis of the Italian national health system's perception of gambling as a disorder, and the practices which result from this view. Our social constructionist approach and a focus on the language and standpoints of the social-sanitary personnel involved in the treatment of pathological gambling in our view aids the exploration of the respondent's visions of PGD and how they perceive the activities of the social and health services, the impact of changes in legislation on the organisation of services, and the ongoing changes observed in this process.

4.1 How compulsive gambling is viewed

It is the opinion of all the respondents that the consequences of pathological gambling are at once social, health, economic and relational in nature. The pathological gambler will invest disproportionate amounts of time

and economic resources to gambling. This tends to erode the time spent on other activities, relationships and daily commitments, to drain finances, create problems and family conflicts. In addition, it results in considerable costs to the community, including expenditure on the suppression of lawlessness, treatment, public order and decorum, and problems within families.

The high social and economic costs of this problem mean that PGD has become the only form of behavioural addiction recognised by psychiatry and for which formalised services for addictions (AS) exist within the Italian public services.

The field experts agreed nevertheless that it is not gaming or gambling itself which should be considered pathological, but rather the associated uncontrolled craving which creates important repercussions on life and relationships. It is the presence of a compulsion which represents, at a pathogenic level, the main common factor between pathological gambling and an addiction to psychotropic substances. In the words of interviewees Nos. 4 and 5:

> Addictions are characterised by impulses that the subject experiences as calming. When one has a desire to eat chocolate or pastries, in a way it feels as if the need has an internal origin. The person's will, their consciousness clings to this need. The same happens with a need to smoke, for sex or compulsive shopping, one of the most common dependencies. (...) You see, a gambling problem is similar to a pathogenesis through the mechanisms by which it develops. That which happens in the brain when you win at gambling is no different to what happens when you drink alcohol, smoke nicotine, during sex and so on. (...) An aetiological pathological symmetry exists. (...) Gambling produces effects in our nervous system similar to those of drugs. It stimulates the gratification system, inducing conditioned reflexes and the development of brain circuits such that when the addiction has developed, the brain of a person who has developed an addiction is profoundly different from that of a person who has no addiction. (Interview No. 4).

> There is an aetiopathogenical, phenomenological and clinical symmetry between pathological substance dependence and a pathological dependence on games of chance. (Interview No. 5).

The aetiology of the disorder, according to study respondents, defines pathological gambling as form of addiction influenced by individual factors such as emotional fragility, personal vulnerability and poor social resources (Interviews Nos. 3, 5, 11, 12) and structural variables including economic crisis, conflicts within families, but also factors directly dependent on regulatory and commercial decisions of the regulator and the concessionaires. of principal

importance among these is the increased exposure to opportunities to gamble through the proximity of gambling sites and the commercialised publicity of game types (Interviews Nos. 1, 4, 9, 13). In the words of the interviewees,

> The problem is that PGD is not a pure pathology, because it is influenced by many factors. The most relevant are definitely depression and then fragility. That is to say, if you find yourself with one of these two conditions, it is easy to develop PGD. (Interview No. 5).

> I believe that the major risk factor is exposure. The demand for interventions has increased because the offers have increased. You can play everywhere. There are people who are individually more vulnerable, weaker, have personal or family problems… Or there may be contingent factors: a death, a separation, a job dismissal (...) If a person does not have adequate resources, these problems are not overcome. They seek consolation in gambling, a way to escape from reality, an emotion. (Interview No. 11).

> To summarise, the environment facilitates and the game develops the biological mechanisms of addiction, individual factors predispose to a greater or lesser extent both to gambling and to the development of addiction. (Interview No. 4).

> Apart from fragility there is another aspect, the availability of [gambling], how easy it is to find somewhere to gamble. The availability on one hand and the fragility of the individual on the other are two aspects which complement each other. (Interview No. 9).

> We mustn't ignore the technological evolution and the commercial offers available because as soon as we determined that slot machines were the danger, the danger was already being shifted to another source. And this is one of the market's mechanisms aiding sales, isn't it! (Interview No. 1).

The majority of the respondents find DSM-V to be a useful tool for diagnosis (Interviews Nos. 1, 2, 4, 5, 6, 7, 8, 10, 11, 12). The V version did not completely change diagnostic practices, but improvements were made in (a) the recognition of PGD as a form of addiction rather than an impulse control disorder; (b) greater appropriateness of diagnostic criteria (especially regarding the elimination of the illegality criteria); (c) the possibility of identifying different levels of severity of PGD (mild, moderate, severe).

> The main contribution is in terms of a greater standardisation. The most significant difference between DMS-V and DSM-IV was the deletion of illegality as an element. (...) The DSM-V particularly improved the situation

> by listing PGD (...) among addictive disorders. The integration of the severity levels was another significant step. Users cannot be generalised because the disorder develops through various stages, making it important to understand at what stage in the evolution of the pathology the patient finds themselves in order to be able to offer an effective and personalised intervention. As a result, it is a guide for diagnosis, but also for intervention. (Interview No. 11).

> DSM-IV diagnosed problem gambling behaviours as a lack of impulse control, whereby a particular condition makes it almost impossible to control the desire to gamble. Players were criminalised, and judged morally. DSM-V, however, clearly defined problem gambling as a dependency with specific symptoms, as in the case of substance dependencies. (Interview No. 8).

Three interviewees observed that DSM-V also presents problems (Interviews Nos. 3, 12, 13). Respondents pointed out particular limitations not closely related to edition V but rather to the syndromic type of nosological approach characterising the American Psychiatry manual and requiring an integration with other tools. Among these are (a) the clinical-anamnestic interview; (b) the personality rating scales; (c) other diagnostic tests and clinical trials, such as the ICD-10 (International Classification of Diseases, 10th edition, a medical classification list by the World Health Organization-WHO) or the SOCS (South Oaks Gambling Screen as proposed by Lesieur and Blume, 1987).

> DMS-V has critically impoverished the culture of psychiatrists. (...) The DSM is a phone book. The only correct thing the DSM does is speak of ailments, and not of disease. PGD is not a disease, it is a collection of ailments. I prefer to speak of ludopathy. After the DSM-V, nothing really changed. We refer in any case to the DSM criteria, because we have to use a precise language in defining the problem. When we treat people, we react in a broader manner, we consider all aspects of the person, their feelings, their problems. (Interview No. 12).

> For us, DSM-V has always been only one of several instruments [available for use]. Especially if we talk about the game, we always had a range of psycho-diagnostic, clinical, diagnostic tools, to use. (Interview No. 3).

> I prefer to refer to the ICD-10 of the WHO. (...) In my opinion anyone who asks for help needs help. The criteria are useful, but what matters is helping those in need, regardless of diagnosis. I prefer personality tests. (Interview No. 13).

4.2 The number of persons receiving care from the services

Over the past 5 years, the number of subjects in the care of the services has increased enormously. According to field professionals, this growth has been due to the increase in service possibilities from sources involved in the treatment of persons addicted to gambling as well as to a greater awareness of the problems involved, rather than an increase in pathological gambler numbers in absolute terms (Interviews Nos. 1, 2, 10, 13). There has been an increase in the demand for treatment from female and young gamblers. Foreigners have on occasion requested help. In almost all cases, these are subjects who have developed an addiction to slot games. To a lesser extent, the addiction is to betting and scratch card games. These are forms which are played in isolation, or in the absence of other players, and which allow an immediate payout when successful. As one interviewee summarised,

> Pathological gamblers are solitary individuals... Addictive games are individual games. There is no game, there is only the player. (Interview No. 10).

The effects of online gambling are unknown to date, a concern to some professionals who predict that it will be a more widespread problem in the future (Interviews Nos. 1, 5, 8). Online games are in the main attractive to the younger player (Interviews Nos. 1, 8). The fact that fewer subjects have so far contacted the services is assumed to be associated with the longer latency period of gambling addiction, compared to the latency periods of other forms of addiction. Online trading and illegal and underground casinos are another source of concern.

As evidenced by the literature (Narcotics Department, 2015; Serpelloni, 2013), socio-demographic variables influence the choice of the type of game. Young people prefer online gambling, the elderly tend to instant lotteries, and women prefer Lotto and SuperEnalotto.

Service users affected by PGD are often the subjects of a variety of psychiatric and psychological problems. Above all, for some experts there is a modest correlation with alcohol, tobacco and, more rarely, cannabis and cocaine consumption (Interviews Nos. 2, 3, 7, 13).

4.3 Service activities

Gamblers have a variety of services which they may call upon. However, most pathological gamblers seeking help are aided through the various public substance abuse agencies, often entitled addiction services, whose operators have traditionally focused on treating forms of addiction to psychotropic

substances. The care and treatment of pathological gamblers is generally undertaken by persons with clinical training, for example, doctors, psychiatrists, psychologists and, in some cases, nurses. Services involving professionals with socio-educational training (social workers, in rare cases, educators) are less common. This, in the opinion of area professionals, constitutes a possible limit because the treatment is often in clinical terms only, whereas the addiction problem should be addressed through a socio-psycho-educational approach offered by a multidisciplinary team (Interviews Nos. 3, 9, 13).

A common problem is that these professionals are also involved in activities connected with drug addiction. Their involvement in PGD cases means a subtraction of human resources from the area of services for alcohol and drugs dependants, and that intervention models tailored to substance abuse are extended to pathological gambling addictions (Interviews Nos. 1, 7, 11, 13).

Self-help groups play an important role, in particular Gamblers Anonymous (Interviews Nos. 7, 13).

These groups often work hand-in-hand with the addiction services. The private social services make an additional contribution, both in terms of awareness-raising initiatives and through services such as the provision of support aimed at managing the debt of the person in treatment. These are mainly facilities affiliated with the national health service and provide a particular service to a specified standard. However, several service managers believe the private social services should play a subsidiary role relative to public services due to the public relevance of pathological gambling as a phenomenon.

Unlike the case of an addiction to psychotropic substances, residential services for PGD are not widespread, although several projects in Liguria and Lombardy have been documented (Interviews No. 2, 7). The lack of these services can be explained, on the one hand, by the need not to separate the player from their network, where there is instead a need to invest in the rebuilding of ties. It is also important that daily living routines, first and foremost work obligations if present, are not interrupted. However, several area professionals speculate on the utility of residential services, especially for severe cases of gambling addiction.

The network approach, understood as a system of alliances between the different professionals and entities present in a given territory, is positively evaluated by many respondents (Interviews Nos. 2, 3, 4, 8, 9, 11, 12), who nevertheless believe that this approach is still too sparsely spread in practice. Forms of collaboration with anti-usury agencies[2] often exist (Interviews Nos. 8, 12). In particular, a more integrated cooperation with general practitioners,

[2] Associations that provide legal, psychological and financial assistance to the victims of usury and to those in conditions of over-indebtedness.

social services, municipalities, the police and the juvenile courts is needed (Interviews Nos. 3, 12).

Treatment forms are mainly psychological and psychiatric. The preferred form of intervention is the clinical interview. In all of the cases examined, an individual therapy was combined with a group therapy. Often a family therapy is foreseen, as mentioned by this interviewee:

> In our treatment, we work a lot through group therapy. (…) They are groups organised systemically or ecologically, their families are also involved. On one hand we have to tackle the suffering of the individual concerned, but we must also correct the community, otherwise relapses are and will remain frequent. The old motto 'mens sana in corpore sano' should be 'mens sana in corpore sano in comunitate sana'. (Interview No. 12).

The clinical interview is geared primarily to: (a) developing an awareness of having a problem which has a significant impact on their personal social, economic and relational state (Interviews Nos. 1, 3, 4, 7, 8, 9, 11, 12); (b) discrediting the mythology related to gaming practices (Interviews Nos. 1, 2, 4, 12,13); (c) strengthening the personality, especially in terms of resilience and, more generally, of personal resources (Interviews Nos. 2, 3, 5, 6, 8, 12, 13); (d) improving relations with primary networks (Interviews Nos. 3, 4, 6, 9). Addiction is in fact not considered a problem of will.

> To ask a person who has an addiction to quit through sheer willpower is paradoxical. Because if they were able to stop through will-power they would not have a dependency, which by definition is the inability to stop even when one wants to control their own behaviour. It is a loss of control over personal behaviour. (...) It must be aided through a number of tools that we call therapeutic interventions. (Interview No. 4).

Family involvement is very important for several reasons. Firstly, the majority of the patients who seek help from the services do so at the request of their families, and almost always because household economic resources have been exhausted. Secondly, many players are immersed in family situations marked by conflicts and difficulties which are important to address. Finally, family members play a crucial role in the control forms set in place to prevent the individual continuing to play.

In some cases, in the presence of comorbidities and especially if psychiatric, a pharmacological treatment course is foreseen in order to, for example, control anxiety states or other manifestations of distress such as anger (Interviews Nos. 1, 5, 12).

Elements contributing to the success of treatment include (a) minimising the wait for treatment after the initial request for help (Interviews Nos. 1, 13), (b) the continuity of care (Interviews Nos. 3, 4, 7, 8, 12), (c) the cooperation of the family (Interviews No. 3-4-6-9), (d) periodic follow-ups (Interviews Nos. 9-12); (e) the implementation of an interdisciplinary approach (Interviews Nos. 3, 9, 13). However, relapses are common and represent the real challenge during the treatment follow-up period (Interview No.12).

4.4 The impact of changes in legislation on the organisation of services

Gambling in Italy, as noted above, is governed by Decree Law No. 158 of 2012, known as the Balduzzi Law. The regulations, in the opinion of the respondents, contain several strong points, related primarily to the recognition of health and political concerns. After its enactment, the requests for help from the addiction services increased. These agencies, however, were required to respond to the growth in clientèle without adequate increases in economic and staffing resources. It should be noted that five years after the passing of the Balduzzi Law, ludopathy or pathological gambling was included in the health system's basic levels of care list (Livelli essenziali di assistenza, LEA), the services considered to be the responsibility of the national health service. However, the territorial public services have not concurrently received the required increase in financial aid, although they have seen a significant increase in demand for services as a result of the regulatory steps.

Several respondents noted that the increase in demand for treatment services did not depend simply on the increase of pathological gamblers in absolute terms (even though some concede the influence of the rise of game types and exposure), but rather on the wider range of services offered and a more common and widespread awareness of the problem (Interviews Nos. 1, 3, 5, 7, 10, 11, 12).

> The Law brought us more patients. However, it did not give us any resources. (...) The plus point is that the Decree acknowledged the problem. As a result of the Law, a hunt for financial resources for services was launched, without the development of a culture of ludopathy. (...) We started out by making the same mistake made in the 70s-80s, when we had to cope with drug addiction. As then, we were caught up in a passion to 'do something'. A time of reflection was needed. The Balduzzi Law encouraged action, but it was an unorganised attack. Everyone involved wants to impose, loudly, their own vision. Commonly accepted scientific articles are required and then we can act as the law requires (Interview No. 12).

> It is not that pathological gamblers didn't exist before, it is simply that, since gamblers may have had more than one problem, among them PGD, they were perhaps treated for something else (Interview No. 2).

The extension of services demanded changes in their general organization. Several were broken up into sub-service areas, mainly to prevent gamblers accessing the same services available to drug addicts (often subject to stigmatisation and therefore limiting in terms of access) or due to the areas of specialisation of the operators of the new services (Interviews Nos.1, 3, 6, 10, 12, 13).

However, this distinction was not always possible, either due to a lack of facility and staff resources or because service managers, in recognising more similarities than differences between pathological gambling and a substance addiction, deemed the separation unnecessary (Interviews Nos. 2, 10, 11).

5. Discussion: rethinking the approach to PGD

PGD has been traditionally considered a purely individual problem and addressed through a clinical (medical-epidemiological) approach. Our interviewees, while emphasising the social consequences of disorder gambling, recognise the individual nature of the diagnostic tools and the pathway from addiction to treatment. The DSM makes a decisive contribution to the social construction of the problematic player, legitimising an approach that emphasises individual responsibility along with the need of an addiction detox treatment (Volberg, Wray, 2007). This mindset, even in the presence of population segments whose gender, age, racial or status characteristics make them more vulnerable to problem gambling, pays less attention to how cultural and economic differences in the actual practice of gambling reflect broader social domain and marginalisation mechanisms. However, it can be shown that the members of social minorities and subaltern groups, besides being more vulnerable to the risk of excessive gaming, are less likely to seek help in escaping the web of gambling because they suffer the threefold condition of a 'sick, stigmatised and ignored' person (Volberg, Wray, 2007: 57).

In addition – and this is the most worrying aspect – to consider and treat gambling as an individual pathology rather than as a social problem implicitly releases the State from any responsibility (Suissa, 2005). This means the State supports steps to counteract individual addiction while remaining a promoter and beneficiary of legalised gambling – and it does so by supporting the development of the gambling industry (Pedroni, 2014) and by accumulating fiscal revenues (Eadington, 1999; Beckert, Lutter, 2009). It would be more useful, from a sociological perspective, to see the emergence of gambling within

the context of transformations of Western societies and, in particular, the transition from an ethic of production to one of consumption where, as Zygmunt Bauman (2002 [1998]) notes, the individual's desire for self-realisation is achieved through their purchasing behaviour. Purchasing becomes a method to construct personal and social identity instead of a way of accumulating possessions. Sociology during the last two decades has recognised the ability of the citizen of late-modernity to assemble consumer goods in a basket which reproduces and communicates their lifestyle. Within this context, normal gambling may be read as a tile in the consumption mosaic, and that excessive consumption is a form of inappropriate consumption (Reith, 2007) in which self-control and awareness are replaced by irresponsibility, economic dependence and a loss of control over their own lives and relationships. This means that a behaviour which may be assessed without bias as a form of consumption and a means of communication becomes in its pathological variant alienating, paradoxically external to the ethics of consumption despite the vast sums of money expended. The gambler with a problem is 'immoral' because they at once violate the ethics of production (the gambler is non-productive, destroying rather than creating resources), and those of consumption (the gambler is not a creative, conscious consumer, they are irresponsible and media dependent) (Reith, 2007: 51). The gambler in the context of this article becomes the subject of remedial action sponsored by a State which assists the growth of the gaming market yet also supports the national health service's efforts to contain the effects of gambling.

The key informants interviewed, moreover, clearly recognise that PGD is a social problem, influenced by social contexts such as economic crisis, the 'crisis of values', evolutions in the offers, variations related to social acceptability, etc. This perception, combined with clinical practice and the evaluation of the expansion of the phenomenon, has led them to a set of conclusions, which we list here in the form of an agenda, one to be understood as a proposal by the authors built on the empirical findings collected through our research:

(a) the DSM (clinical tool) is an important device for diagnosis (Interviews Nos. 1, 2, 4, 5, 6, 7, 8, 10, 11, 12), but it is not sufficient and not free from limits/criticality (Interviews Nos. 3, 12, 13);
(b) the increased demand for treatment is due both to the spread of service possibilities and a greater awareness of the negative consequences associated to pathological gambling (Interviews Nos. 1, 2, 10, 13);
(c) an intervention approach involving the network and other territory actors is necessary (Interviews Nos. 2, 3, 4, 8, 9, 11, 12);
(d) family involvement is important (systemic-relational approach) (Interviews Nos. 3, 4, 6, 9);

(e) a multidisciplinary team intervention is essential (the problem of PGD is a psycho-socio-educational as well as clinical) (Interviews Nos. 3, 9, 13);
(f) the importance of acting within the service offer context (Interviews Nos. 2, 3, 4, 8, 9, 11, 12).

The latter point, while being beyond the sphere of possibilities for health service managers, forms the basis for a rethinking of the approach to PGD, a complex phenomenon that requires not only legislative, but also socio-educational and health intervention.

The empirical research we present here resulted in our formulation of an agenda of actions benefiting the containment and intervention of pathological gambling as a phenomenon:

(a) investment in prevention – and not just in reparative measures – through continuing interventions adopting consolidated methodologies and which are subject to constant evaluation (Interviews No. 10, 12, 13);
(b) move to improve the contact and early intervention processes in order to identify the grey zone of the phenomenon, the people who, despite developing pathological forms, do not appeal to the services for help (i.e. online gamblers) (Interviews Nos. 1, 5, 8);
(c) work towards avoiding relapses through periodic follow-ups (Interviews No. 9, 12);
(d) prohibit all forms of advertising supporting gambling (Interviews Nos. 7, 10);
(e) further limit exposure through the timely application of the legal norms (Interviews Nos. 7, 10);
(f) adopt a network approach in field utilising multidisciplinary teams made up of clinical figures (doctors, psychologists, psychiatrists), and social-educational figures (professional educators, social workers). In any case, the collaboration with other territory actors such as anti-usury centres, family doctors, private social institutions, police stations, public institutions and, as underlined often in the interviews, the industry operators (all the interviews);
(g) provide economic support; in addition to involving the anti-usury centres, support administration access should be strengthened (Interviews Nos. 8, 12);
(h) increase funding of public services, mainly to recruit personnel trained and experienced in contact with the profile of focus (Interviews Nos. 10, 12);
(i) create services exclusively for PGD, in locations separate from facilities for drug users, or with differentiated access times, for stigma reasons and the need to have personnel trained ad hoc (Interviews Nos. 2, 10, 11).

Although the contributions of individual units of the national healthcare system would benefit the major part of the actions proposed above, it is clear that broader institutional intervention is also necessary. This would require the support of the Italian State, in particular the collaboration of the Ministry of Economy and Finance which controls gambling licences through the Customs and Monopoly Authority, and the Ministry of Health. It is essential that the full powers of the Balduzzi Law be applied, and hopefully a further and more incisive decree responding to the challenges to socio-health workers posed by in field problems will arrive. These results are specific to the Italian context, but the relevance of the country in the worldwide gambling landscape suggests that the proposed agenda may be applied to raise similar issues within any construction of the gambling legislation process where the State maintains regulatory control but where the gambling activities are organised by private concessionaires within a competitive market.

6. Conclusions

We have demonstrated that Italy is a context of particular importance for understanding the challenges posed by gambling in the 21st century. The growth of the market, regulatory developments and the evolution of the international paradigm of treating gambling addiction today require a rethinking of the models and strategies on which the national health system has based its services for gamblers with a problem. Through in-depth interviews with leading figures from social-health structures offering therapeutic services for dependencies, we analysed the vision of PGD prevalent among operators, the characteristics of service users, health facility activities and the impact of the new rules (in particular the Balduzzi Law) on the organisation of services. The snapshot which emerges highlights the importance of rethinking the approach to PGD by challenging a social construction of the problematic player which leads to viewing the pathology as an exclusively individual problem, and widening the view of the context to include, for example, family members as co-causes and -resources, the local area as the base of a service network, and the excessive offers available in the gaming market as a pathology trigger. We present an agenda of priorities based on these statements to be considered in future national policies related to gambling.

This study suffers from several limitations which may hopefully be corrected through future research.

Firstly, although we have indicated the reasons for which Italy is a field of study of particular significance, the single national context represents in itself a limitation on our study. Future research could usefully focus on other countries

in comparative interpretations of both the intervention models of national healthcare systems as socio-cultural challenges posed by the global gambling market growth and, on a parallel level, the incidence of PGD.

Secondly, during our study, regional laws and municipal norms to combat gambling continued to be promulgated and issued in Italy parallel to a public debate on the costs and benefits of gambling. Our study was limited to three Regions which are very significant for the reasons stated in Section 2. It does not take into account the full range of recent regional normative changes nor the specific responses of the local social-health services. However, the significance of the regional experiences studied and the completeness of the accounts furnished by the interviewees did allow the formulation of an agenda of possible interventions. Extending the study to include further Regions could confirm the validity of the intervention agenda proposed, or apply it where opportune.

Thirdly, we interviewed principal managers of the public services actors in each of the Regions in our study (see Section 2). This choice represents a research limit which could be overcome through an expansion of the samples from each Region to include social-health services operators by in the public and private sectors with the aim of investigating the integration of the two sectors in cross-over areas.

Despite the exploratory nature of our work and the limits described above, we are convinced that our article may serve as a model and prompt similar studies of other Italian Regions.

We consider that, in any case, epidemiological investigations and quantitative analyses should be complemented by qualitative studies aimed at examining the practices and perceptions of health service operators', the people who are the front line of the State in the battle against the growth of ludopathy. Only with their help will a correct understanding of gambling be possible, one where the treatment of excessive behaviours is able to co-exist with gaming as a means to satisfy expressive-symbolic needs such as socialisation, personal fulfilment and enjoyment.

References

Aasved, M. J. (2003), *The Sociology of Gambling*, Springfield , Charles C. Thomas Publisher.

Abbott, M., Palmisano, B., Dickerson, M. (1995), 'Video Game Playing, Dependency and Delinquency: A Question of Methodology?', *Journal of Gambling Studies*, vol. 11, 287-301.

American Psychiatric Association (1994), *Diagnostic and Statistical Manual of Mental Disorders: 4th Edition*, Washington, DC, American Psychiatric Press.

American Psychiatric Association (2013), *Diagnostic and Statistical Manual of Mental Disorders: 5th Edition*, Washington, DC, American Psychiatric Press.

Avviso Pubblico (2017), *I dati ufficiali sul gioco d'azzardo nel 2016 in Italia*, retrieved at http://www.avvisopubblico.it/home/documentazione/gioco-dazzardo/i-dati-ufficiali-sul-gioco-dazzardo-nel-2016-in-italia/ (accessed 7 June 2017).

Bataille, G. (1985), *Visions of Excess: Selected Writings 1927-1939*, Minneapolis, University of Minnesota Press.

Bauman, Z. (2002) [1998], *La libertà*, Troina (EN), Città Aperta.

Beckert, J., Lutter, M. (2009), 'The Inequality of Fair Play: Lottery Gambling and Social Stratification in Germany', *European Sociological Review*, 25(4), 475-88.

Berger, P. L., Luckmann, T. (1967), *The Social Construction of Reality: A Treatise in the Sociology of Knowledge,* New York, Anchor Books.

Bergler, E. (1957), *Psychology of Gambling*, New York, Hill and Wang.

Bichi, R. (2005), *La conduzione delle interviste nella ricerca sociale*, Rome, Carocci.

Bieranacki, P., Waldorf, D. (1981), 'Snowball Sampling: Problems and Techniques of Chain Referral Sampling', *Sociological Methods & Social Research*, vol. 10, 141-63.

Blanco, C., Krueger, R. F., Hasin, D. S., Liu, S. M., Wang, S., Kerridge, B. T., Saha, T., Olfson, M. (2013), 'Mapping Common Psychiatric Disorders: Structure and Predictive Validity in the National Epidemiologic Survey on Alcohol and Related Conditions', *JAMA Psychiatry*, 70 (2), 199-207.

Blaszczynski, A., Nower, L. (2002), 'A Pathways Model of Problem and Pathological Gambling', *Addiction*, 97 (5), 487-99.

Christensen, D. R., Jackson, A. C., Dowling, N. A., Volberg, R. A., Thomas, A. S. (2015), 'An Examination of a Proposed DSM-IV Pathological Gambling Hierarchy in a Treatment Seeking Population: Similarities with Substance Dependence and Evidence for Three Classification Systems', *Journal of Gambling Studies*, 31 (3), 787-806.

Colasante, E., Gori, M., Bastiani, L., Siciliano, V., Giordani, P., Grassi, M., Molinaro, S. (2013), 'An Assessment of the Psychometric Properties of Italian Version of CPGI', *Journal of Gambling Studies*, 29 (4), 765-774.

Eadington, W. R. (1999), 'The Economics of Casino Gambling', *Journal of Economic Perspectives*, 13 (3), 173-192.

Ferris, J., Wynne, H. (2001a), *The Canadian Problem Gambling Index: User Manual*, Ottawa: The Canadian Centre on substance abuse, Ottawa, ON, Canadian Centre on substance abuse.

Ferris, J., Wynne, H. (2001b), *The Canadian Problem Gambling Index: Final Report*, Ottawa, ON, The Canadian Centre on substance abuse Canadian Centre on substance abuse.

Fiasco, M. (2010), 'Breve storia del gioco in Italia: tre epoche per tre strategie', *Narcomafie*, 9/10, 22-30.

Fisher, S. E. (1993), 'Gambling and Pathological Gambling in Adolescents', *Journal of Gambling Studies*, 9, 277-288.

Gambling Compliance (2012), *Market Barriers: A European Online Gambling Study 2012*, retrieved at https://gamblingcompliance.com (accessed 1 February 2019).

Goudriaan, A. E., Oosterlaan, J., de Beurs, E., van den Brink, W. (2006), 'Neurocognitive Functions in Pathological Gambling: A Comparison with Alcohol Dependence, Tourette Syndrome and Normal Controls', *Addiction*, 101, 534-547.

Gupta, R., Derevensky, J. (1998), 'An Empirical Examination of Jacob's General Theory of Addictions: Do Adolescent Gamblers Fit the Theory?', *Journal of Gambling Studies*, 14, 17-49.

Inserm (2008), *Jeux de hasard et d'argent. Contextes et addiction. Contextes et addictions*, Paris, Les éditions Inserm, retrieved at http://lesrapports.ladocumentationfrancaise.fr/BRP/084000697/0000.pdf (accessed 1 February 2019).

Istituto Superiore di Sanità (2018), *Gioco d'azzardo, Comunicato Stampa no. 30/2018 (18 October),* retrieved at https://ufficiostampa.iss.it/?p=1335 (accessed 22 October 2018).

Johansson, A., Grant, J. E., Kim, S. W., Odlaug, B. L., Götestam, K. G. (2009), 'Risk Factors for Problematic Gambling: A Critical Literature Review', *Journal of Gambling Studies*, 25 (1), 67-92.

Lears, J. (2003), *Something for Nothing: Luck in America*, New York, Viking/Penguin.

Lesieur, H. R., Blume, S. B. (1987), 'The South Oaks Gambling Screen (SOGS): A New Instrument for the Identification of Pathological Gamblers', *American journal of Psychiatry*, 144 (9), 1184-1188.

Lindner, R. (1974), 'The Psychodynamics of Gambling', in Halliday, J., Fuller, P. (eds), *The Psychology of Gambling,* London, Allen Lane.

Merriam, S. B., Tisdell, E. J. (2016), *Qualitative Research: A Guide to Design and Implementation* (4th edition), San Francisco, CA, Jossey-Bass.

Narcotics Department [Dipartimento Antidroga] (2015), *Relazione annuale al Parlamento sullo stato delle tossicodipendenze in Italia. 2015,* retrieved at http://www.politicheantidroga.gov.it/attivita/pubblicazioni/relazioni-al-parlamento/relazione-annuale-2015/presentazione.aspx (accessed 1 May 2017).

Pani, R., Biolcati, R. (2006), *Le dipendenze senza droghe. Lo shopping compulsivo, Internet e l gioco d'azzardo*, Turin, Utet.

Patton, M. Q. (1987), *How to Use Qualitative Methods in Evaluation*, London, Sage.

Pedroni, M. (2014), 'The 'Banker' State and the 'Responsible' Enterprises: Capital Conversion Strategies in the Field of Public Legal Gambling', *Rassegna Italiana di Sociologia*, LV (1), 71-97.

Pedroni, M. (2017), 'Extreme Losers: On Excess and Profitless Expenditure in Male Gambler Practices', *Journal of Extreme Anthropology*, 1 (3), 61-82.

Petry, N. M. (2010), 'Pathological Gambling and the DSM-V', *International Gambling Studies*, 10 (2), 113-15.

Petry, N. M., Blanco, C., Auriacombe, M., Borges, G., Bucholz, K., Crowley, T. J., O'Brien, C. (2014), 'An Overview of and Rationale for Changes Proposed for Pathological Gambling in DSM-V', *Journal of Gambling Studies*, 30 (2), 493-502.

Petry, N. M., Stintson, F. S., Grant, B. F. (2005), 'Comorbidity of DSM-IV Pathological Gambling and Psychiatric Disorders: Results from the National Epidemiologic Survey on Alcohol and Related Conditions', *The Journal of Clinical Psychiatry*, 66, 564-574.

Reith, G. (2007), 'Gambling and the Contradictions of Consumption: A Genealogy of the 'Pathological' Subject', *American Behavioral Scientist*, 51 (1), 33-55.

Rolando, S., Scavarda, A. (2018), 'Italian Gambling Regulation: Justifications and Counter-Arguments', in Egerer, M., Marionneau, V., Nikkinen, J. (eds), *Gambling Policies in European Welfare States: Current Challenges and Future Prospects*, Cham, Palgrave Macmillan, 37-57.

Rovati, G., Pedroni, M. (2016), *Analisi comparativa delle leggi regionali in Lombardia, Liguria, Puglia e mappatura dei regolamenti comunali*, Research Report, Milan, ModaCult-Università Cattolica del Sacro Cuore.

Serpelloni, G. (2013), *Gambling. Gioco d'azzardo problematico e patologico, inquadramento generale, meccanismi fisiopatologici, vulnerabilità, evidenze scientifiche per la prevenzione, cura e riabilitazione*, retrieved at http://www.politicheantidroga.it/media/587792/manualegambling_light.pdf (accessed 1 May 2017).

Shaffer, H. J., Labrie, R., Scanlan, K. M., Cummings, T. M. (1994), 'Pathological Gambling among Adolescents: Massachusetts Gambling Screen (MAGS)', *Journal of Gambling Studies*, 10, 339-362.

Stinchfield, R., McCready, J., Turner, N. E., Jimenez-Murcia, S., Petry, N. M., Grant, J., Welte, J., Chapman, H., Winters, K. C. (2016), 'Reliability, Validity, and Classification Accuracy of the DSM-V Diagnostic Criteria for Gambling Disorder and Comparison to DSM-IV', *Journal of Gambling Studies*, 32 (3), 905-922.

Strong, D. R., Kahler, C. W. (2007), 'Evaluation of the Continuum of Gambling Problems using the DSM-IV', *Addiction*, 102 (5), 713-721.

Suissa, A. J. (2005), *Le jeu compulsif: vérités et mensonges*, Montréal, Fides.

Suri, H. (2011), 'Purposeful Sampling in Qualitative Research Synthesis', *Qualitative Research Journal*, 11 (2), 63-75.

The Economist (2017), *The World's Biggest Gamblers*, retrieved at https://www.economist.com/graphic-detail/2017/02/09/the-worlds-biggest-gamblers, February 9 (accessed 7 June 2017).

Vitaro, F., Arseneault, L., Tremblay, R. E. (1999), 'Impulsivity Predicts Problem Gambling in Low SES Adolescent Males', *Addiction*, 94, 565-575.

Volberg, R. A. (1998), 'Il gioco d'azzardo negli Stati Uniti: studi sulla prevalenza del fenomeno', *Medicina delle tossicodipendenze*, 18, 23-27.

Volberg, R. A., Wray, M. (2007), 'Legal Gambling and Problem Gambling as Mechanism of Social Domination? Some Considerations for Future Research', *American Behavioral Scientist*, 51 (1), 56-85.

Wareham, J. D., Potenza, M. N. (2010), 'Pathological Gambling and Substance Use Disorders', *American Journal of Drug & Alcohol Abuse*, 36, 242-247.

Williams, R. J., Rehm, J., Stevens, R. M. G. (2011), *The Social and Economic Impacts of Gambling*, Final Report prepared for the Canadian Consortium for Gambling Research.