Women who gamble. A group clinic experience through the circus metaphor and other stories

Fulvia Prever – Psychologist Psychotherapist, Member of staff of **ALEA** association

Valeria Locati – Psychologist Psychotherapist

AND association - Azzardo e Nuove Dipendenze, Varese, Italy

Address your communications to:
Dott.ssa Fulvia Prever, Via Cascina Barocco, 24 – 20152 Milano
email: fulviaprever@tiscali.it; tel. +39 331 9215627

9th European Conference on Gambling Studies and Policy Issues

Loutraki, Greece, September 19, 2012

1. **Introduction**

Gambling has always been considered a male habit, because not appropriated, not suitable for a good mother, wife or daughter; it's a spare time activity only for men and so, eventually, a male pathology. (C. Guerreschi, 2008)

In the past and nowadays, the gambler is represented by a young male, fascinating... in love with risk taking, money, nice women and “dolce vita”. He is a “nice and damned guy” (Dostoevsky, Pupo, Baldini)

On the other hand, more recently, we've been noticing that the gambler often is a lady, not even too young, a housewife, a simple woman with a sad regard…not well dressed up, without any light in the eyes and not at all looking for adventure!

We know that the possibility to develop a gambling problem is twice higher in men than in women (La Barbera 2010);on the other hand, prevalence is influenced by the offer of gambling, which is spreading all over in the last few years (in Italy it's especially related to the government involvement) and by overwhelming advertising which has more and more women as a specific target ; the result is that women with a gambling problem are growing so much to get close to male pathological gamblers population.

An interesting study describes, in a casual sample of female population, age 18-72, a prevalence of 5,1 % of pathological gambling and a 9,7% of problematic gambling. (Cesare Guerreschi 2008)

In analogy to what Lavanco and Varveri (2006) describe, what we observe as clinicians, is that the more women are approaching gambling, the more the amount of women with problematic or pathological gambling increases and the more they start coming to clinical services; however, since women asking for help are however very few, even if constantly increasing , this may not be sufficient to demonstrate a real growth of the phenomenon "problematic gambling among women" if not associated with the direct observation of gambling venues. This shows us an incontrovertible reality: women are there, they gamble and are almost half the population concerned by gambling; if we go into the “gambling cathedrals”, the Bingos, the percentage rises up to 80%, as evidenced by AAMS data (State Monopoly Agency). Gambling venues has been spreading more widely in everyday life places and led women to approach gambling without being noticed by others and without giving up their daily tasks: to go shopping, to bring their children to school, to look after their old grandparents. The post office, the supermarket, the subway, the bar for the cappuccino in the morning, have become all potential “gambling sellers”, available to the most efficient housewife, sometimes even if she's together with her children. Not to mention the growing phenomena of internet gambling: it allows women to gamble without even leaving home, escaping neighbours' sight, avoiding their gossip and curiosity. Computers, smart phones, interactive TV, etc. lead ladies not only to compulsive shopping, but also to gambling. In Anglo-Saxon countries, on line gambling sites as Cashcade have already achieved 80% of the female world and this path is also closely followed by Italian operators, involving in gambling activity a new different female target, younger than the one who gamble on slots, bingo, lotteries and scratch cards (Rangone and Mangiaracina, 2012).

Women, as well as it happens to them with other addictions (smoking, alcohol, drugs), take longer than men to cross the bounds of transgression, but when they go beyond the limit, they have a very rapid escalation; for women, gambling is today another "broken taboo" (Prever, 2011).

The evolution of the symptom is often much faster than it is for men, leading women, in a short time, to the stage of despair (Custer, 1982); at the same time, it is more difficult for them to have access to help, because symptoms are underestimated or totally denied by the family, or

simply not accepted ; then, for a woman, who usually manages the family economy, it is difficult to ask for help because it is likely that she will encounter attitudes of denial of the problem and blame; furthermore, when finally a woman gets to our clinical services, often she rarely find appropriate times and settings: when the elective intervention is group therapy (Croce and Zerbetto, 2002), they have to do with an overwhelming majority of male players, and this does not allow the exposure in the group of feelings connected to more intimate relationship issues, that only women are able to listen to and to prove empathy (Prever and Locati, 2010; Locati and Tadini, 2010).

Women with a gambling problem represent for the clinician a major challenge which requires a very deep and articulated therapeutic project; dealing with gambling addiction for women means also dealing with emotional dependency, the crucial question with its historical and cultural significant connotations (Guerreschi, 2011).

Clinical practice teaches us that women with a gambling problem have a much heavier burden within the family, because often they have no support from the partner,(just the opposite of what happens to a man who gamble), isolation and stigma are greater, and they have to face anyway family tasks and fit their role. Because of all this, a woman feels more oppressed and overloaded than a man, often she can't manage to find time and space to express her despair in a social care clinic ; on the other hand, she lives constantly a tearing contrast between the role of woman / mother / wife / daughter and her disease.

The way in which more easily women have access to their deepest emotions is within a gender group; feminine looks for feminine to give voice to her own soul, her own suffering, daily frustrations, suffered violence, love denied / sought, her repressed sexuality. Women need other women to regain their own identity and strength. This allows them to identify themselves, to project, abandoning the false "safety" that gambling activity represents in favour to experience their weakness, within the room, supported by the therapeutic frame and the protection of the group (Karter, 2010).

Our project, first and unique in Italy, was born to give an answer to these needs; this group includes only problematic gamblers in consideration of the absence of a specific therapeutic intervention, women oriented, in Lombardy and even on the national territory. It takes place in a large city of northern Italy, Milan, where the power of money on one hand and poverty and marginality on the other, live in perfect harmony; a city where female population affected by this problem seems to increase rapidly, cause an urban reality with too many bars and bingo halls: it's a variegated population by age, social class and national identity.

In support of a clinical intervention as much as possible effective and adapted to the needs of pathological gamblers, we made reference to Italian literature (Croce and Zerbetto, 2002). In particular, an interesting research conducted by Guerreschi (2008) provides significant information about the women players:

- they seem prefer certain types of game like lotteries, Superenalotto, Lotto and scratch cards;
- most of them have a gambler in the family;
- the more they are involved in gambling, the more they live negative internal states such as nervousness, sadness, anger, confusion and guilt.

With regard to the clinical course, they tend to start later than men, usually around thirty years, and the interval of time that passes between when they start to play and the moment in which it is recognized the existence a gambling problem seems to be shorter, perhaps because of the rapid escalation of symptoms, called "telescoping effect" (Grant and Potenza, 2004).

Usually for women the entrance into the world of gambling has little or nothing to do with money, but means the access to a world free from external control, where the passion for numbers and statistics is almost none and suddenly there's a transition to a state of despair (Guerreschi 2008). Only in the beginning the economic value of the game is present in women, but always with a relational meaning: they start gambling in the hope of giving practical help to family's budget. Women feel relationship as the focus of their life, where centrality is not only that of love and affections, of the maternal role, but has now become that one of the economic support, the role of helping or substituting the spouse in family's economic survival (Prever, 2011). The passion for gambling usually comes as a result of an occasional visit in a gambling venue, in company of friends or family: the game is initially seen as a social event that allows to temporarily move away from the problems or to break the monotony of everyday life. It only takes a few visits and the woman will go alone to the gambling venue, she will gamble as much as possible, she will begin to lose and she will play to recover the money she has lost, and she will be lying to her family, until her life will be deeply compromised (Guerreschi, 2000).

To trigger the gambling behaviour is very often the desire to avoid or escape difficult situations, personal or health traumas, or other painful circumstances; through the game, women try to minimize *loneliness,* escape mentally and emotionally to *daily traumas* or cancel *past unresolved grief,* avoid *physical pain* or *chronic* disease, win money, avoid *conflicts or family abuse,* relieve stress and tension in some *life turning points* (e.g. retirement, separation or divorce, death of a loved one) (Guerreschi, 2008).

Among the most significant *risk factors* that make women more vulnerable to the possibility of becoming pathological gamers we can therefore briefly mention:

- *presence of problematic parents:* women with a family history of gambling-alcohol, drugs-psychiatry or gambling problems are more at risk (Guerreschi, 2008);
- *level of education and social class:* the incidence of pathological gambling is higher in less educated and less affluent social classes (Lavanco, 2001);
- *marital status:* women who gamble are often single, separated or divorced;
- *trauma and child abuse:* some studies have shown the presence of child abuse, particularly sexual abuse, in the history of many women with pathological gambling (La Barbera, 2010; Guerreschi, 2008);
- *presence of neurotic traits.*

With regard to the type of game, women prefer non-strategic forms of gambling, more oriented to flee (such as lotto, scratch cards, slot machines, video poker or bingo), unlike men who prefer action-oriented and sensation-looking ones (such as sports betting or blackjack) (Grant, Power 2004). Escape, therefore, has a hypnotic effect, serves as a tranquillizer and numbs the senses; in addition, to go to a bingo hall makes a woman feel safe, competent, welcomed and treated politely, so that she can feel less alone, and get a new feeling of belonging.

Interesting is the study of cognitive distortions and erroneous perceptions in women who gamble (Bowden-Jones et al., 2011) compared to men, distortions that are the basis of the dynamics of gambling addiction: in group sessions, it's easier for women to talk about the meaning and the illusions related to gambling (gambling as a friend, as a lover, as a way not to be alone) than about winning strategies due to cognitive distortions (Prever, 2011).

The group "Women who gamble" gradually took shape, starting from these considerations, in November 2010.

2. **Methods**

2.1. Setting, frequency, gratuity

Group sessions took place twice a month, in the late afternoon, carried out according to a systemic relational approach, and were held in a room of a central church in Milan, outside of traditional care services. Therapy is free, and the participants were asked, if they could, a minimum contribution for the cost of rent (up to 5 Euros) a small amount of money taken from the gambling for a useful activity for oneself.

2.2. Patients selection and treatment network

Participants were selected from November 2010 and the group intervention took place from January to December 2011.

More than 15 women (age 34 - 67) were involved into the project through preliminary interviews, in order to exclude psychosis, *borderline* disease or heavy depression, as not suitable for a group work.

All women were given a battery of tests (Capitanucci and Carlevaro, 2004) with the aim to investigate the relationship with gambling, the impairment in certain areas of the functioning of the person, and the relations with their parents in an evolutionary phase. During the selection process, results were integrated with other assessments, including the use of diagnostic categories (Blaszczynski, 2000 and 2005) (Bellio and Fiorin, 2009).

Most of the participants were sent to us by public services as an alternative or integration with individual work (Prever, 2008, 2008). In some cases, before including women in the group, public services have made meetings of psycho - education on the subject to assess the feasibility of group work. Other patients have come to us through direct contact, thanks to the dedicated phone number put on the website of the association, or addressed by the operators of the toll – free number for addiction active in Italy.

In all cases, has never been requested withdrawal from the game, nor it was placed as a condition to continue participating to the group.

For the duration of the treatment was maintained contact with the network of care of women gamblers, where this exists, and we made all the possible to activate it, in order to support the person with psycho - social, health and financial help.

In summary, in relation to the accesses, the characteristic is that of an open group with a deadline, which involved 8 women continuously.

2.3. Theory and practice

As mentioned above, the theoretical framework within which this group intervention was designed and created is the systemic - relational model, based on the concepts of relationship and connection among the elements of the considered system and of the most important retroactive aspect that clinical intervention generates in people.

The potential of the systemic approach is the simplicity with which you come close to this way of thinking, suggesting a new vision of things. It deals with working with everyday matters, events in society, suffering experienced by families, to respect them by a warm welcome and a proposal of a new connection matrix of relationships and data.

The main clinical practices used by the authors were the following:

• Hypothesizing, circularity and neutrality (Palazzolo, Boscolo, Cecchin and Prata, 1980): they deal with the process of care, with the possibility to connect data that emerge from patients and that are posed to the others in terms of new points of view, with attention to each individual and, at the same time, collective situation.

• Continuous oscillation between "here and now" and "there and then", in a recursion of the concept of time (Boscolo and Bertrand, 1993).

• Constant oscillation from a part to the whole and from the whole to a part, in a network of systems and subsystems.

• Connection of the meanings at different levels in different stories at different times, with one and only "here and now".

• Ability to get involved and change the personal, social and interpersonal dimensions.

3. **Achievements**

It is hard to think of a linear description of the therapeutic process of this women group, both for the quality of the process of the intervention and for the desire not to consider the group as the sum of its individuals but as a stand-alone system, with independence and interdependence with the environment. We will therefore refer to some specific phases of the process, inviting the reader to consider all parts of a circle.

3.1. The beginning: the individual and the rigidity of his "pathology"

During the first meetings the participants got to know each other, but also test themselves in a new context, check their centring with respect to work and test the therapist if really trustworthy. The narration of their personal stories has brought all their attention to the description of gambling behaviours and to the symptoms of what they would define their pathology. In many cases the narrative belonged to the semantic field of medicine, with particular attention to diagnosis that had been made by clinicians they met before us. The label of *pathological gambler* has determined the choice of words used to tell about herself to others: to be a pathological gambler means to be able only to think about it and be in a group designed to treat this disease, and to address the issue in terms of symptoms, money lost debts.

This was the initial thought, that is a static and linear thought with which we immediately clashed. The expectations of the participants were of symptoms' remission; their hope was to regain the trust of loved ones, to stop feeling guilty and shame and to find a solution to economic problem. The eyes of patients were always seeking therapists' eyes, meaning they believed us to be the only ones able to help, to define the seriousness of the situation and the steps towards to the "redemption."

3.2. The formation of the group: female solidarity, the presentification third parties, creativity hypothesis of therapists

Aware of this situation, the therapists have widely made use of the techniques described previously, especially using "hypothesizing" to connect ideas and information that could make sense of the history of some of the light to what reported by others. Little by little, women have started to feel a strong sense of belonging to the group, feel part of it and feel the benefit of listening, discussion and sharing their gambling stories and their despair: Gradually, the role of woman, daughter and mother at the same time was making it possible for them to see things from a different perspective.

The therapists have offered the greatest number of options (Von Foerster, 1987), facilitating the group relations and connecting from time to time women stories with a multigenerational reconstruction (Bowen, 1980; Boszormenyi-Nagy and Spark, 1973).The typically feminine solidarity gave birth to a network which was not only supportive but also emotional, where they all could find respect and trust. The opportunity to share details of their family and personal history, to connect their sufferings of the past to their present discomfort was experienced as enriching by all the participants.

All women have always been collaborative, they talked weaving their experiences, sometimes creating some affinity with one and connecting with others in a special way, based on a special subject and their personal resonance. To make it possible, the conductors have always assumed and acted as if the therapy room, in a circle, there weren't only women described and physically present, but also their entire family, "significant others", all components of the systems described in their stories (Boscolo and Bertrand, 1996). In addition, the constant reference to the frame of the context made by the conductor and the importance of the "here and now" have increased the possibility of restructuring the initial diagnostic label to accommodate other point of views (Caruso, 2002)

3.3. The stalling of therapy

As often happens in family or individual therapy, women have been seeking therapist' confirmation in their attitude and have been trying to "shell out" a recipe for well-being. Far from obvious, this attitude so dangerous and hidden behind several demands that had to do with concrete, economic or organizational aspects (how to get a financial aid, how to manage children and group session, how to behave in some situations etc) all at once became an alarm-bell in the clinicians' mind.

The group seemed to regress, not referring anymore to himself, but linearly with the therapists and the system, with all its chairs for relevant others presentified (Boscolo and Bertrand, 1996), was locked: metaphorically, there was no more space to be creative in that crowd of people, the exchange of chairs that had been so fluid previously could not be done and the only reference figures perceived by the patients were the two conductors, from which they wished to receive a lifeline to fix well at the bottom of the sea.

3.4. The creative twist: the circus metaphor, the whole group and the resonances

Maybe we were trying to connect similar experiences among women without taking into account the nature of addiction that we were dealing with. We used to underline the inevitability of touching ground, we tried to understand their challenge with the machine as well as Bateson (1976) suggests in relation to the bottle for the alcoholic. But we were blind to the creative capacity of our participants, in front of their relational skills that are played in a non-obvious and not described world (Schinco, 2007). Then we began to disrupt the system, to *challenge it* in his new balance with ideas that had to do with this vision: we had in front of us women who were able to manage their busy time-schedule, to keep secrets, to balance the accounts in the family, to play uncomfortable roles. Many of the women in therapy had passions and creative hobbies: some of them use paint, or write poetry or make handicraft, but also had the extraordinary ability to imagine themselves in a love affair with gambling.

Most of them described gambling as a charming lover, as a friend who then betrays you, as a tempter who welcomes you in his arms and then drops you down. We put on stage the relationship with the gambling, simulating the extraction of the lottery, the sequence of slots and we had them play bingo; we analysed non-verbal communication of participants and connected the findings to their failures, to their behaviour in the family of origin, we have expanded the meanings that "losses" had for them till that point, using our experience of mourning and life.

We were, women and therapist, inventing reality (Watzlawick, 1987).

Our ideas have had an effect on the group in terms of movement, imbalance, and information: the participants have returned a new image of themselves; once they have been challenged, they have returned to us a particular structure, which has immediately brought us to a metaphor, the *circus*; suddenly every woman reminded us of a different artist, the knife thrower, the acrobat, the clown, the lion tamer, the trapeze artist. Each of them gave us back the idea of the risk of being in balance, between fun and danger, between balance and imbalance, to behave in an extreme way to feel alive, some of them in a more active and aggressive way, some through a mask or through the tears of the clown , some with more passive and hypnotic behaviour.

Our women gave us a metaphor for the group: they didn't performed individually but converged to create this dimension playful and dangerous, they were part of the same big family and they were fundamental one for the other, as are the ball to the juggler, the gun to the woman, the hostess to the knife thrower, and the trainer for the lions themselves

We decided to tell the participants our thoughts, share our assumptions and offer our vision. The reaction was immediate; all participants shared this metaphor, comparing themselves to the various circus characters, sitting next to them on the imaginary chairs.

An image of the last session: *once, gambling was like giving up, feeling free, but also feeling adrift, as a nomad ... Now here I am, living a new life, happy as a gypsy, dancing with my long skirt that rotates in the air, happy*.

4. Discussion

One year after its opening, the group for women gamblers ended with a good result and a great satisfaction by the participants.

Specifically, the improvements have taken place on the affective, relational and physical sides, and especially regarding their families of origin and the current ones. All women continue to attend care services and to receive treatment or other forms of assistance they used to have. New social networks were activated for women who needed it.

The relational, psychological and social exchanges that took place within the framework of the group have been a source of knowledge for the patients, who now feel that they have learned other ways of relating and are able to know hidden or forgotten parts of themselves. The sense of trust and belonging developed during therapy consolidated their social skills, motivating them to do something for themselves beyond the search of gamble. They could leave the "safety" of the repetitiveness of the game and anaesthesia feelings, to voice their fears and frailties, and regain self-confidence and self-worth, with an increase in self-esteem.

The women, at the end of the intervention, had a total or almost total abstinence, as if having spoken of anxiety, pressure, heaviness and lightness, and having experienced their fears in a network of support, let them find the "winning strategies"**.**

The appeal for slot machines, scratch cards and bingo sometimes is still present, but much far away and less obsessive. For some of them, even if abstinent, remains a sense of loneliness that gambling was covering.

The therapeutic role of conductors has been welcomed, challenged, sought and often exploited in relation to the stage of the process of care considered: in general, sharing the same gender has allowed the establishment of a good climate of cooperation and trust from the very beginning, and this was functional to the process of change.

In the experience of the group of women gamblers, the parental role usually given in family therapy to conductors has here been replaced by the reference to the phases of the life cycle of the women themselves. The different age of the two therapists (30 and 55 yr.), has been instrumental in the reactivation of past memories and future projects among the participants, thanks to the possibility of multiple identifications. This fact had a great importance in therapy and allowed us to use successfully the *split-half* technique, that is the representation, made by conductors, of two different points of view, with the aim to suggest, once again, alternative views of the same problem.

During the last meetings we tried to introduce more and more elements external to the context of care, so to accompany the patients to the real world, far from the protected setting in which they became accustomed to be.

Some participants will probably continue with a second round of group meetings, in order to consolidate achievements made and chase new ones, continuing along this path with new women who gamble as travel companions. Others are planning to leave because they feel to have reached the goal; their change implies a different work activity or that the management of the children can no longer be delegated.

5. Conclusions

We can say that this experience has gone in the direction to improve therapeutic tools dedicated to female gambling; it has certainly confirmed the hypothesis that the gender group provide the ideal setting, for women with gambling problems, to bypass their defences and face their resistances.

We still have a lack of literature on the treatment of women with gambling problems and this is even more serious and surprising according to the impact of gambling addiction on women's family and society itself.

It’s therefore important to analyse the phenomenon in details with a scientific study, linked to the Anglo-Saxon ongoing research, to understand what the clinical intuition seems to suggest, that is the different experience of gambling in the world of women and the different cognitive approach. If the preference of skill or active games is highly correlated to the illusion of control (Myrseth, 2010) and to cognitive distortions, is this true for women in a lesser extent? If the game for women has the function to avoid any unpleasant emotional state and does not depend predominantly from erroneous thoughts, can this make systemic therapy more effective for them than cognitive behavioural approach?

Can metaphor in itself be a facilitating tool of change in female specific world?

May we think that the anxiety, so important in creating fertile ground for addiction, can be more and more present in today women and at the same time more likely to change due to the characteristics of the women themselves?

In conclusion we believe that these are the questions that will support our work, making us share with the patients’ anxiety, uncertainty and the search for new points of view.

6. Acknowledgements

We want to thank AND association that made this project possible in a highly qualified framework. In particular Dr. Capitanucci, Dr. Smaniotto and Dr. Biganzoli who took care of us and drove us not to give up when the group was hardly starting. We thank the Parish of San Pietro in Sala and Don Domenico Storri, for having welcomed us without prejudice and for being ready to help us on different concrete problems; we also thank all the professionals who contributed to the construction of the network.

The main thanks goes to the women in the group and their families for having accepted the challenge, for believing in this adventure, for giving us so much throughout the therapy and for having left us so many open questions.

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