Journal of Gambling Issues
Issue 36, September 2017
http://igi.camh.net/doi/pdf/10.4309/jgi.2017.36.7
DOI: http://dx.doi.org/10.4309/jgi.2017.36.7

The Social Construction of the Pathological Gambler's Identity and Its Relationship With Social Adaptation: Narratives From Members of Italian Gambling Anonymous and Gam-Anon Family Groups

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Abstract

According to a socio-constructionist perspective, pathological gamblers' "subjectivities" emerge out of social networks and networks of meaning-making in which scientists, politicians, health services, and common people take an active part. We are interested in showing how a legitimated view (socio-cultural model) of problem gambling as a disease affects the way in which the members of Gamblers Anonymous (GA) self-groups understand and present their identity and talk about their problem and the help they have received. The work is based on a qualitative analysis of 35 in-depth, semi-structured, open-ended interviews, 25 with gamblers who attend Italian GA self-help groups and 10 with gamblers' relatives who attend Gam-Anon family groups. The main themes arising from the interviews show how a dominant view of problem gambling as a lifelong chronic illness opens the door to reconciliation with oneself and one's relatives. This work provides insights into the close relationship between acculturation to a pathological identity, moral reconciliation, and "social belonging" that occurs through conforming to the GA group.

Keywords: culture, problem gambling, identity construction, Gambling Anonymous groups, Gam-Anon family groups, pathological identity, social adapting

Résumé

Selon un point de vue socio-constructiviste, les «subjectivités» des joueurs pathologiques émergent des réseaux sociaux et des réseaux de création de sens dans lesquels les scientifiques, les politiciens, les services de santé et les personnes ordinaires participent activement. Nous sommes intéressés à montrer comment une vision légitimée (modèle socio-culturel) du jeu problématique en tant que maladie affecte la façon dont les membres des groupes autonomes de Gamblers Anonymes (GA) comprennent et présentent leur identité et parlent de leur problème et de l'aide qu'ils ont reçu.

Le travail est basé sur une analyse qualitative de 35 entrevues approfondies, semi-structurées et ouvertes, 25 avec des joueurs qui fréquentent des groupes d'entraide italiens de GA et 10 avec des parents de joueurs qui fréquentent des groupes familiaux Gam-Anon. Les principaux thèmes découlant des entrevues montrent comment une vision dominante du jeu problématique en tant que maladie chronique tout au long de la vie ouvre la voie à la réconciliation avec soi-même et avec ses proches. Ce travail donne un aperçu de la relation étroite entre l'acculturation à une identité pathologique, une réconciliation morale et une «appartenance sociale» qui se produit en se conformant au groupe GA.

Introduction

Drawing from a socio-constructionist perspective (Berger & Luckman, 1966; K. J. Gergen, 1999; McNamee & Gergen, 2000; Sharf & Vanderford, 2003), discourses about gambling (addiction) as a disease can be regarded as a kind of "cultural device" (Cain, 1991). This label does more than just describe: it suggests a particular "form of life" (Wittgenstein, 1953), communicates "a view of the world" (Reith & Dobbie, 2012), and prescribes thoughts and actions that are consistent with it (Strong, 2011). In this paper, we emphasize how pathological gamblers' "subjectivity" is a process embedded in a social system of meaning that also influences how people communicate about their health problems, how they make sense of them, how they represent the goals of clinical management, and how they try to reconstruct their social adaptation.

We start by recognizing the power of scientific discourses in concretizing the existence of the disorder and by emphasizing the role of social and politic processes, health services, and family and other groups in constructing a sick identity. The social network of Gamblers Anonymous (GA) and Gam-Anon family self-groups is then explored as one of the biggest arenas in which people become acculturated to particular ways of describing, understanding, and evaluating experiences associated with problem gambling. Based on a qualitative analysis of 35 in-depth, semi-structured, open-ended interviews—25 with gamblers who attend Italian GA self-help groups and 10 with gamblers' relatives who attend Gam-Anon family groups—the work highlights the close relationship between acculturation to a pathological identity, moral reconciliation, and "social belonging" that occurs through conforming to the discourses of the self-help group.

The Social Construction of the Sick Individual

Most social science explanations emphasize idiosyncratic or individual motivation for human social behaviour; inner states are supposed to cause one's response to the world and determine people's social adaptation or their failure to cope with their day-to-day life according to principles of normal, healthy, goal-oriented behaviour.

The psychological theorization on pathological gambling reflects this approach to the understanding of human behaviours and is one of the ways of instantiating it (Venuleo & Marinaci, 2017).

Many scientific publications have aimed to define the risk factors responsible for its most extreme forms, which are treated mostly as a manifestation of the disease (Castellani, 2000; Rossol, 2001). In the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-IV*; American Psychiatric Association, 1994), the essential feature of pathological gambling is a "persistent and recurrent maladaptive gambling behaviour… that disrupts personal, family, or vocational pursuits." In the current edition, pathological gambling is moved to a new classification titled "Addiction and Related Disorders" (5th ed.; *DSM-5*; American Psychiatric Association, 2013). The rationale for this change is that the growing scientific literature on gambling disorder reveals common elements with substance use disorders, not only in the external consequences of financial problems and destruction of relationships, but increasingly from the point of view of the biological and psychological process identified as underlying the addictive behaviour (Reilly & Smith, 2013).

In the diversity of etiological factors investigated (affective, cognitive, biological, etc.), the different theoretical models seem to share two kinds of assumptions (Venuleo, Salvatore, & Mossi, 2015):

1. The absence of an expected behaviour (rationale, suitable to gaming) is treated as an expression of emotional or irrational subjectivity on the part of the individual (his or her disease, its distorted cognitive patterns, etc.).
2. This component is the result of a specific intrapsychic configuration.

The gambler is portrayed as a free agent who is in no way coerced either by the force of material conditions or by the thoughts of other people (Reith, 2007). How the problem is defined and explained determines the policy response to it. The predominant view of problem gambling as a disease prompts strategies of intervention centred on the individual (typically psychotherapy in its various manifestations: psychoanalysis, cognitive behavioural therapy, family therapy) rather than, for example, on the settings and systems within which the encounter between the individual and problem gambling takes place (Reith, 2007; Venuleo & Marinaci, 2017).

In recent decades, different theoretical perspectives, with different emphases, assumptions, and concepts, have favoured a radical critique to the view of mental disease as a state of the world, encapsulated in the head of the individual. From the constructionism perspective,[1] the individual's action and identity is viewed as inherently social, more specifically, as deriving from shared meanings (Sugiman, Gergen, Wagner, & Yamada, 2008). Applied to psychopathology, socio-constructionism emphasizes how psychopathological categories, which over time took on a privileged ontological status in the lives of patients, professionals, and public health officials (Gone & Kirmayer, 2010), are not the by-product of specific modalities of the mind's

functioning, placed in the individual; rather, they are socially connoted scripts placed within the sphere of social discourse, to which some individuals identify with (K. J. Gergen, 1985). The emphasis is on the construction of social identity (also of a sick identity) through shared meaning, achieved through social interdependence, within a wider historical and socio-symbolic universe.

In this light, pathological gambling is not simply out there, available for observation. To speak of pathological gamblers is to participate in a textual genre, "to draw from the immense repository of intelligibilities that constitute a particular cultural tradition" (K. J. Gergen, 2001, p. 805). This is not say that pathological gambling does not exist outside linguistic practices. However, the emphasis is on the power of linguistic practices to have value of life for people. Once one begins to describe or explain what pathological gambling is, one inevitably proceeds from a fore-structure of shared intelligibility that organizes the way people (gamblers as well as relatives and social network) feel and act, including the manner in which they present their symptoms, the reason they go for care, and how long they remain in care (Conrad & Barker, 2010; Kleinman, Eisenberg, & Good, 2006).

Broader contextual dimensions—cultural models, ideologies, shifting frameworks of knowledge, structures of power (Ratner, 2008; Venuleo et al., 2015)—are just as constitutive of the dialogical nature of the way people think and communicate about problem gambling and the gambler's identity as the here and now of the systems of activities where people experience their life. Social and political processes (e.g., the media, scientists, health and economic policies, social stigma) influence how people make sense of their outer and inner realities and how people come to describe, explain, or otherwise account for the world (including themselves and their behaviours; Muehlenhard & Kimes, 1999). The ways in which conceptions of gambling have changed over time illustrate this process (McMillen, 1996): It has been condemned as a kind of sin, encouraged as a form of entertainment, recognized for its health and social benefits, and, finally, seen as a serious health problem.

The meanings offered by the historic-cultural heritage emerge within relational transactions; they are triggered and carried out by people as they are engaged in activities that involve intersubjective engagement. Family, peers, the media, and health care services (Binde, 2012), as fields of social and discursive exchange, play a major role in providing group members with ready-made cultural texts or rationales for feelings and behaviours related to problem gambling and for the elaboration of hypotheses about the cause of pathological gambling and its treatment (Borrell & Boulet, 2005; Luck & Bond 1992). "Forms of negotiated understanding of people problems are of critical significance in social life" (K. J. Gergen, 1985, p. 268), since they are not simply a way of interpreting a problem, but a way of experiencing oneself, which regulates the relationship and the way people act and react within the social world (Charmaz, 2000; Venuleo, Rollo, Marinaci, & Calogiuri, 2016).

Some important methodological implications follow the socio-constructionist view of the illness. One concerns the role of sufferers in the identification and

understanding of their problem. Whereas, in the *DSM* models, "the patient is viewed as a poor historian, oblivious or misinterpreting the true nature of his/her condition" (Gone & Kirmayer, 2010, p. 90), the socio-constructionism perspective takes the subjective experience of illness seriously. The patient's presentation is recognized as being more than a mere source of error; rather, it is a powerful semiotic organizer of the mind, orienting the way the patient feels and thinks about his or her problem, making sense and relating to the health services (Venuleo & Marinaci, 2017). This acknowledgment in turn orients research toward a method of analysis that favours the exploration of the patient's experience of his or her illness (typically via focus groups, in-depth interviews). Narratives are important not only because they permit one to furnish an accurate picture of what actually happened, but also because they are the means by which people understand and live their lives (K. J. Gergen, 1985) and because they are ways to participate actively in the practice of a particular culture.

A second implication concerns the attention to the interpersonal and social environment that offers the meaning and the criteria to understand and talk about one's own experience. If we assume that it is through the context of discourse and interaction that the frame of meaning suggested by an actor comes *alive* (Linell, 2009), we must also recognize how productive it might be, for researchers, to examine how illness is managed in the social network that sufferers inhabit (Conrad & Barker, 2010). What we need to do is look more closely at the way that individuals interact with each other when they construct their beliefs about health and illness, and how certain social and cultural environment enable certain discursive and behavioural practices. These processes cannot be studied only locally in the circumstance in which they unfold.

This article is focally concerned with GA self-help groups as one of the social arenas in which one becomes acculturated to particular ways of describing, understanding, and evaluating experiences associated with gambling (Strong, 2011, p. 71). Like other illness-defined organizations (Sharf, & Vanderford, 2003), GA groups share a socially constructed reality shaped by common interests, rules of operation, metaphors, norms, and vocabulary generated by the sharing of individuals' stories and experiences. We are interested in showing how a legitimated view (socio-cultural model) of gambling as a disease affects the narrative produced within GA self-help groups and the way that GA members understand and present their identity and talk about their problem, the "reasons" to go for care, and (the goal of) recovery. This research also describes how people struggle to make sense of their experience and reclaim a sense of self within the context of their personal and social relationships, through the view of problem gambling as a disease. More specifically, the work provides insight into the way that a dominant view of problem gambling as a lifelong chronic illness opens the doors to reconciliation with oneself and one's relatives. Managing problem gambling comes to acquire the meaning of developing socially appropriate ways of being and behaving.

First, a picture of the GA group is offered to present the cultural and organizational context of our inquiry. A qualitative study primarily based on semi-structured

interviews with gamblers ($N = 25$) and their relatives ($N = 10$) is then presented to gain deeper insight into how group members describe their experience of problem gambling and the help they received.

Gamblers Anonymous

The self-help organization GA was founded in the 1950s in the United States along the lines of Alcoholics Anonymous (AA), and its emergence is often quoted as a key moment in the recognition of gambling as a pathology (Dixon, 1991, p. 318). Like AA groups, GA self-help groups use the disease model of addiction. This medical template, which has great scientific support in problem gambling research (Potenza, 2006), suggests that gambling addiction develops predictably; an individual who has once been genuinely addicted to gambling will never be able to play moderately. For this reason, total abstinence is recommended. The GA approach, in its efforts to promote a disease model of gambling, imposes a lifelong, chronic illness on all its patients—even those who are fully compliant and who successfully stay away from problem gambling. As we will see, this view appears to be a powerful semiotic organizer of the narrative offered by GA members, orienting the way they feel and think about their problems, make sense of them, and relate to the group meetings.

As in AA, the GA recovery program is articulated into "12 steps" (http://www.gamblersanonymous.org/ga/content/recovery-program). These first steps require that individuals honestly admit their powerlessness when faced with gaming. Individuals are then invited to make a list of their character flaws and to work on eliminating them day by day, to identify all the parties who were injured during the gaming experience and make amends toward them, to take stock of their lives every day, to improve their conscious contact with a "higher power" (as each individual conceives it) through prayer or daily meditation, and to practice the 12 steps in everyday life, one day at a time (Giocatori Anonimi Italia, 2007, p. 115).

An account of recovery in GA with a focus on the 12 steps and GA's main text is offered by Ferentzy, Skinner, and Antze (2006). The program urges members to acquire some spiritual values, such as honesty, openness, good will, humility, and empathy, thus called because they are intangible. Although there is no "deadline" in putting them into practice, GA argues that by applying these principles to everyday life, players can not only reduce their desire to gamble, but can improve all other aspects of their life. The practice of the 12 steps thus promotes not only abstinence from gaming, but also personal growth.

GA's principles are promoted through the weekly meetings of the group. The meeting is supposed to focus both on financial aspects (how to budget one's money and how to deal with loan sharks and institutions to which one owes money with a manageable repayment plan) and on emotional support to stop gambling and to achieve a "normal" way of life by sharing experiences, with the hope of being able to handle the problems related to gambling. A good part of the meeting is always dedicated to the "witness," during which the members are encouraged to talk about

their experience with gaming. It serves both as catharsis for the individual and as a means of sharing the members' various experiences; it also serves to keep alive the memory of their destructive behaviour and so to hinder the return of old habits (Giocatori Anonimi Italia, 2007, p. 3).

The Italian GA website describes GA as a fellowship of men and women who share their experience, strength, and hope with each other that they may solve their common problem and help others to recover from compulsive gambling (Giocatori Anonimi Italia, n.d., para. 1). The only requirement for membership is a desire to stop gambling. Because there are no dues or fees, GA is self-supporting through member contributions. The site further states that GA is not allied with any sect, politics, organization or institution, nor does it intend to engage in any controversy, or to support or oppose any cause. Their primary purpose is to abstain from gaming and help others to recover from compulsive gambling (Giocatori Anonimi Italia, n.d., para. 1).

GA is related to another association: Gam-Anon (http://www.gam-anon.org/), a group for family members affected by compulsive or pathological gamblers, also focused on 12 steps. Gam-Anon provides a supportive environment for spouses, relatives, or close friends of problem gamblers to share their experiences. GA and Gam-Anon have specific meetings, often weekly, to discuss organizational aspects of the associations or to celebrate special events, such as the anniversary of one or more years of abstinence from gambling by a GA member.

It is generally acknowledged that GA groups provide valuable help to many problem gamblers (see Binde, 2012; Petry, 2003). The number of GA groups has grown significantly in the United States and Europe (Petry, 2005). In Italy, the number of GA groups increased from three in 1999 to 48 in 2006 (Focardi, Gori, & Raspini, 2006) and to 95 in 2016 (http://www.giocatorianonimi.org). Despite the large number of people receiving and giving support in GA groups, the academic literature on the subject is limited (Ferentzy & Skinner 2003). As far as we know, no studies have been published on GA in Italy. One main reason for this is that the groups are hard to study, since the principle of anonymity is honoured and GA mutual support group meetings are in principle closed to those without a gambling problem.

Narratives From Members of Gambling Anonymous and Gam-Anon Family Groups

According to the conceptual frame provided earlier, gamblers and their relatives interpret the self-group setting they are part of on the basis of a defined system of meanings negotiated and shared in that context (Salvatore & Zittoun, 2011). Such negotiated and shared meanings can be conceived as the symbolic terrain for their own (and reciprocal) identity, which guides and constrains their way of interpreting their own participation in the self-help group.

Open-ended interviews were collected from members of three GA and Gam-Anon mutual support groups of Southern Italy to explore how gambler identity is

constructed within this social network. The study was guided by the following research questions:

- What kind of identity emerges and is suggested by the way someone talks about his or her own problem with gambling?
- What meaning is constructed for the problem gambling experience?
- How is the decision to ask for help explained?
- How is the change and the goal of attending groups depicted?

The individual interviews were begun by asking for standard biographical information, followed by a more open-ended portion in which the subjects were asked to describe the way they choose their gambling stories, their personal view of problem gambling, the reasons that motivate the search for help, the meaning of group membership, and what makes GA effective. The interviews were exploratory, allowing respondents to touch on any topic that was meaningful to them, but the topic guide ensured that all relevant topics were covered.

Because of the anonymity principle, all participants were recruited on a voluntary basis. Unfortunately, we do not know the total number of members of each group because GA does not have a record of participants. There were about 10 gamblers present at each meeting, but the number can change from one meeting to another because of the entrance of a new gambler or the temporary absence of some members.

The initial contact was made with the contact person in each group. The contact person had informed the group and obtained consent for an information session. In each GA context, at the opening of a weekly meeting, the members were informed by the research group about the general aim of the research, the voluntary nature of participation, and the anonymity of responses. No incentive was given.

In each GA group, about 80% of the participants gave their consent, as did about 50% of their relatives. Participants had all been members of GA or Gam-Anon for at least 2 months. None of the newcomers agreed to take part in the individual interviews. We collected 35 in-depth, semi-structured, open-ended interviews in all, 25 with gamblers who had managed to abstain from gambling and 10 with their significant others. The socio-demographic characteristics of the participants are described in Table 1.

Most of the gamblers interviewed were male and, conversely, most of the relatives were female (mainly partners or mothers). This distribution reflects the composition of groups we met and, more generally, that of GA groups. It can be argued that women gamblers become “the absent present” (Ward & Winstanley, 2003) in our research within GA and that male gamblers’ relatives become “the absent present” in Gam-Anon. This can reflect a major diffusion of problem gambling among men, but it can also reflect a major difficulty for women to ask for help and receive support from their family.

The interviews were conducted by the authors with a team of research assistants. Each interview was conducted individually and took place in a room for GA groups

Table 1
Socio-Demographic Characteristics of the Participants

Characteristics	Problem gamblers (n = 25)	Relatives (n = 10)	Total (n = 35)
Sex			
Male	24	1	25
Female	1	9	10
Age, years			
28–36	1	0	1
37–44	5	2	7
45–53	8	4	12
54–62	2	2	4
63 +	6	2	8
Missing values	3	0	3
Education			
No qualification	0	1	1
Primary school	1	0	1
Middle school	14	6	20
High school	6	3	9
Missing values	4	0	4
Marital status			
Single	1	1	2
Married	22	8	30
Separated	1	1	2
Cohabitant with partner	1	0	1
Job status			
Employee	9	5	14
Freelance	6	1	7
Jobless	1	0	1
Retired	3	2	5
Other	2	2	4
Missing values	4	0	4

(only the interviewer and the interviewee were present in the GA room during the interview).

Interviews lasted between 20 and 60 min and all were tape-recorded. Before each individual interview, in accordance with the ethical code of the Italian Psychology Association (http://www.aipass.org/node/11560) and the Italian Code on the protection of personal data (Legislative decree No. 196/2003), each participant signed an informed consent form for the interview itself and for audiotaping.

The interviews were transcribed verbatim and then analyzed qualitatively for the specific purpose of grasping the implicit theories of the interviewees about the topics of the research agenda: who the gambler is, how problem gambling can be explained or understood, what motivates the request for help, and what makes participation in GA groups effective. In contrast with analytic techniques such as content analysis, which emphasizes informational content, narrative analyses take on "the discontinuity

between story and experience and focus on discourse: on telling themselves and the devices individuals use to make meaning in stories" (Sandelowski, 1991, p. 162).

We began the analytical work by reading the material in its entirety and listing the themes that the interviewees talked about. We then grouped themes and related content according to the topics of our research agenda. For each point, the focus was on the meaning and the basic assumptions emerging throughout the discourse, namely, the symbolic frame giving sense to the ways that the interviewees talk about their experience. The map of the symbolic frame is a matter of abductive reconstruction (Salvatore, 2016). It has to be performed in terms of inferential reconstruction from the abductive logic of interpretation of the relationships among representational contents. This approach leads to placement of the semantic contents of the topics within brackets in order to interpret them as the contingent expressions of super-ordered meanings conveyed by the discourses and as underpinning the representational contents. Believing that managing gambling is a "spiritual endeavour" is an example of generalized meaning that does not concern a specific aspect and that is not conveyed by a specific content but can encompass what all the interviewees say about their attempt to deal with the gambling problem.

Shared basic assumptions and meaning does not mean that participants think and feel in the same way. Therefore, our analyses were also aimed at identifying dissimilarities in the subjects' ways of connoting their experience. However, the interviews reflect homogenous understandings of problem gambling and what makes the groups effective, either among gamblers or among gamblers and their relatives. We interpret this similarity as a further sign of how GA and Gam-Anon self-groups work as a shared context to negotiate the meaning of the problem gambling experience.

Findings

Five main themes were identified from the way that gamblers and relatives relate to the research topic suggested by the interview:

- the recognition of oneself as an inherently sick individual;
- the symbolization of one's problem with gambling as a rupture with one's "peaceful" past experience;
- the use of a social "lens" to describe one's decision to ask for help;
- the symbolization of the cure as a spiritual endeavour, in which the "true" identity of the addict needs to be recovered; and
- the symbolization of the change in terms of becoming a better and more well-adjusted person.

The main themes and assumptions underpinning them are presented below; we then discuss them in order to highlight how a biomedical view can paradoxically favour adjusted forms of relationships with the environment.

"I Am a Sick Person"

As in other 12-step fellowships, GA members give their first names and acknowledge their addiction before speaking in their meetings. The standard presentation is "My name is …, and I'm a compulsive gambler." Such a presentation is given every time a member takes the floor and thus also many times in a single meeting. In this way, a specific view of their problem is conveyed and restated. Problems with gambling are related to an ontological state of being: "a condition that is fixed and unchanging, and is core to one's sense of self" (Reith & Dobbie, 2012, p. 519). In the interactive process of group discussion, the recognition of oneself as an inherently sick individual is promoted as the first step to face the powerful force of gambling addiction. In the narratives collected among the members, the idea that problem gambling is a chronic disease ("I am a compulsive gambler and I will be so for life"), which one can only manage, is a common and dominant assumption:

> Yesterday I did not play, I hope not to play today, and I hope it goes well for life, because this is a disease and I have to take care of it day to day; I must not think about being healed, because if I think I am healed, I am back in the abyss. (Gambler, 52-year-old male, attending GA for over 1 year)

> Now, since a year ago, I can say that it is a disease and I am sure that I cannot heal; I can only stop gambling, I can only take it away (Gambler, 44-year-old male, attending GA for 6 months to 1 year)

> Unfortunately, this is a degenerative disease; the adrenaline which arises from it never stops growing. (Gambler, 53-year-old male, attending GA for over 1 year)

> Then, I think that my husband has inherited from his father; they are predisposed to get this disease. I used to say it was a vice, then, since I've been attending the association I've understood it is a disease. (Wife of a gambler, 63-year-old female)

Problem gambling is not something one has, but rather a gambler is something one is, a fixed content of identity with brain deficits (biological, neurological) and mind deficits (cognitive or affective) working as sources of origin. The "problem gambling" persona is the core of their sense of self, defining who they are, both in the present as well as in the past and future (Reith & Dobbie, 2012, p. 518).

Notably, the disease formulation, which implies a genetic or hereditary disposition, leads to externalizing of the problem, a monster placed outside intentionality and control, as well as outside family and the interpersonal network within which gambling unfolds. In so doing, the disease view frames gamblers and relatives as victims, not playing any role in the construction of the problems they are dealing with: It is problem gambling, depicted as a sort of infective agent acting inside the body by itself, that has the power to define actions and change people's identity.

The narratives of gamblers and their relatives allow us to grasp the social value of this process of internalization of an "addiction identity." They point out that within

the view of problem gambling as a disease, the gambler's behaviour, thoughts, and feelings have become understandable. The disease view counters a "moral" or "criminal" representation of problem gambling and related feelings of guilt and anger. The "monster," as problem gambling is defined by a member, acts without the will of the gambler (as something outside oneself); thus, what has happened can be interpreted not as a sign of moral weakness and disregard for rules and affective bonds, but of predisposition to an "addiction identity," for which people have no responsibility.

This kind of renegotiated meaning of problem gambling, as is the case with most diagnostic labels (Quosh & Gergen, 2008), provides individuals and their relatives with reasons for prior actions and a means to render their suffering intelligible; this, in turn, opens the door to the (re)shaping of the relationships that the disease disrupted:

> For years I thought that my husband was a criminal and that gambling was a vice... I discovered that it is a disease and by attending these groups I am accepting that it is a disease. (Wife of a gambler, 44-year-old female)

> […] in the first meeting, I didn't understand anything because I had so much anger in me...a lot of anger…and I couldn't understand anything…but then I began to understand the steps, the first step about the acceptance of the disease and the second step, that tells us that we are powerless against the gambling problem. I began to fall in love with the [Gamblers Anonymous] program from there onwards. (Husband of a gambler, 67-year-old male)

> Before I wasn't able to give my testimony because I cried immediately when I tried to speak. Now I have become a strong person, I have to accept that I have a sick person close to me and I have to take care of him as if he had cancer. (Wife of a gambler, 60-year-old female)

> Today, I know what problem gambling is, I know where it leads, I know what pain it brings, what pain. Today I also understand his pain; at the beginning, I did not understand it. (Wife of a gambler, 52-year-old female)

Making sense of something that appeared unintelligible and unjustifiable gives relatives relief. Above all, even if in some paradoxical way, the acknowledgment of one's own powerlessness against problem gambling has a healing power (Binde, 2012). The sick individual and their loved ones can now see a solution: The GA group suggests in which direction to proceed and what to do to avoid "temptations":

> […] It is a disease that doesn't depend on substances used but it has similar consequences. I can say this because now I believe I have the right tools to understand what the problem is and what the consequences are. (Wife of a gambler, 60-year-old female)

> The GA group has taught me that I must not bring money with me, I must not manage the money. I have to trust. Even though I have a salary, I have given

> everything to my wife and I'm happy because now I have no more temptations. (Gambler, 53-year-old male, attending GA for 6 months to 1 year)

Above all, people reconstruct a symbolic land for their relationship, grounded on the role of the sufferer and sick individual, who must be understood and accepted in his "human weakness" and guided, and who must be cared for. The family and the self-group itself (symbolized as a salvation) has the power of control and imposes rules for the gambler, symbolized as a needy and vulnerable child. The gambler, in turn, has the duty to be grateful and to act responsibly toward his or her relatives and the other members.

Problem Gambling as Rupture

Gamblers' narratives are consistent with what is commonly approved or disapproved of within GA culture. Talking about gambling as a legitimate leisure pastime or putting emphasis on aspects that might justify one's heavy involvement with gambling would raise eyebrows, if not reproach, at a GA meeting (Strong, 2011). Through the interviews, such a tacit norm appears to be maintained. Pleasant experiences related to the recent past are not mentioned. Feelings of shame, guilt, and self-contempt related to problem gambling are recurrent. The dominant story offered in response to the question, "What has problem gambling meant for you?" is the confessional narrative of an individual "out of his mind," for whom life began and ended with the thought of gambling and who gave no thought or feeling to loved ones. Problem gambling could only be something wrong and destructive for oneself (one's own identity) and for family life, an inherently destructive agent of moral decline (cf. Keane, 2002) that prompts subjects to neglect relationships and to spend too much time and money on games that could be spent on family, work, or more socially acceptable forms of consumption:

> […] it's something really bad [to gamble] because more than anything you don't realize, at that time I was no longer the mother who had taught them the rights and the duties of a good citizen, and therefore I repeat, what I did was shameful. (Gambler, 68-year-old female, attending GA for over 1 year)

> […] I no longer saw anything good in myself or in people who were close to me. Problem gambling had brought me to the destruction of my family. (Gambler, 44-year-old male, attending GA for over 1 year)

> I was not at the hospital [when my child was born]. I arrived afterwards. This is something that hurt me, touched me (Gambler, 53-year-old male, attending GA for over 1 year)

> I'd rather have another surgical operation than face his disease. It destroyed me. It stole my life, it stole it from me. (Wife of a gambler, 51-year-old female)

Problem gambling appears to be like a calamity that befalls one out of the blue, something external, out of control, but able to overwhelm any aspect of one's life. It is worth noting two aspects of this way of depicting problem gambling as rupture.

First, the "rupture" by definition points to a deep discontinuity between what happened before—the peaceful experience of the past—and what happened after, the destructive scenario that problem gambling made. Second, as a related aspect, consistent with a biomedical view, the role of psychological and socio-cultural issues in understanding why one became excessively involved in gambling is downplayed. Problem gambling is a rupture that, in the view of the interviewees, has no relationship with one's own biography, feelings, or financial and social situation, nor is it explained by what happened before or is happening around them:

> We of GA do not care about gambling, we don't have to fight against gambling, we should not say it is the fault of the state, that it's the fault of the shops that are full of machines, we don't have to fight any battle, we have to think only about not playing. (Gambler, 64-year-old male, attending GA for over 1 year)

> I did not have any problems, neither with the family of my mother nor with the family of my father. (Gambler, 71-year-old male, attending GA for over 1 year)

The Request for Help and the Foregrounded Role of the Interpersonal Environment

How is the decision to ask for help explained? On the one hand, the role of the interpersonal and social environment in the onset or maintenance of problem gambling is neglected within GA culture and members' narratives, whereas, on the other, the social "lens" reflecting society's viewpoint is used to describe the kinds of problems related to one's own problem gambling and to explain one's decision to ask for help; the request appears to be a process strongly intertwined with and responsive to the reaction of the gambler's interpersonal environment.

GA members often talk about a low point when they feel that they simply cannot go on in the future as they have in the past. Some authors (Reith & Dobbie, 2012; Stall & Biernacki, 1986) refer to these low points as "rock bottom" experiences. GA narratives focus more on the interpersonal impact of problem gambling (the threat of divorce by the wife if he did not stop playing; the loss of an important love relationship) than on the economic costs or legal consciousness. The rock bottom experience is related to the feeling that gamblers were at risk of losing their loved ones because of their failure to meet family needs and obligations:

> I got to the point that I was losing my wife and my daughter. (Gambler, 44-year-old male, attending GA for over 1 year).

> The frustration that you can move on knowing that you have, somehow, a family, a little girl you are at risk of losing, your job and everything you've tried to build in 10 years […]. Clearly, I can't take it anymore. (Gambler, 40-year-old male, attending GA for 1 to 3 months)

Feelings of guilt, shame, and disgust are associated with memories of faults and damage done to relatives. Gambling problems are recognized by respondents themselves largely as an inability to satisfy social obligations toward parents, partners,

and children above all. The request for help involves recognition of these social and cultural roles and expectations and an attempt to reshape behaviour in ways that affirm them.

Change as Spiritual Endeavour

How are the change and the goal of attending GA and Gam-Anon groups defined?
In many narratives, the encounter with the association is depicted as the encounter with hope and forgiveness—as an antidote to anger, hostility, and bitterness—and with rebirth:

> GA offered me this great, great joy. GA gave me the chance to restart to live. Starting to live again means having faith in something good, and healthy. In this way, I got my wife back, my home, my daughter, my job, my serenity, my life. (Gambler, 53-year-old male, attending GA for over 1 year)

A secular concept of conversion and salvation is promoted within GA and Gam-Anon groups and restated during the interviews: Gamblers are not sinners, they are "sick"; they are not victims of the devil, they are victims of a pathology. It is addiction that suspends people's control and morality; it is an addiction that leads to wrongdoing (Hammersley & Reid, 2002). Yet, as in the religious approach, the disease model promotes a spiritual solution: Gamblers can metamorphose from being "wrong" to being "right" and can even lead their brethren to redemption.

GA indicates a program for individual discipline—a set of social and conceptual techniques for organizing everyday life. The chance for individuals to change depends on their loyalty and personal devotion toward the group, namely, on their commitment to the spiritual values (kindness, generosity, honesty, and humility) and codes of conduct prescribed within GA. Managing the illness comes to acquire the meaning of becoming a better person, willing to recognize one's own limits and mistakes and to develop or restate "appropriate" ways of being and behaving:

> Today, I find myself in this association, it's 2 months since I gambled, and above all I'm trying to improve my character, presumably improving my character to be able to be a better person. (Gambler, 40-year-old male, attending GA for 1 to 3 months)

> It all depends on the will that one puts into it. (Gambler, 64 years, attending GA for over 1 year)

> You have to believe, if you do not believe you do nothing. (Gambler, 59-year-old male, attending GA for 6 months to 1 year)

> I can feel the seriousness of my mistakes and learn from my mistakes only through sharing with the other brothers. (Gambler, 53-year-old male, attending GA for over 1 year)

> I have many defects of character and I should improve. In fact, during the testimony all these defects are coming out. (Gambler, 40-year-old male, attending GA for 1 to 3 months)

Along with abstinence from gambling, many narratives (those of the members attending GA groups for more than a year) feature a change in character as a result of members' participation in GA meetings and a related change in the quality of their relationships.

Spiritual engagement helped them to become a better and more "well-adjusted person." They talk about a new sense of self that is highly valued by themselves and their significant others. As observed by Binde (2012), the overall structure of the stories typically follows a single master template that emphasizes strength of character, personal maturation, emotional development, and the value of openness and trust in close relationships.

As in the addiction recovery narrative reported by Hurwitz, Tapping, and Vickers (2006), the quest to undo the illness and affliction of gambling appears to be shaped as a spiritual endeavour, in which the "true" identity of the addict needs to be recovered:

> The association has given me the strength to become a different person, a person who is talking now. I would never be able to do something like that, it gave me the opportunity to share also with colleagues. I was a person that never shared problems at work or the problems of other colleagues, or I never put in a word in a discussion. […]Now I can do it, now I can make my point and it is an important thing, even if it is wrong, I can say what I think, before I could not. This is the fundamental help that the association gave to me, that now I understand who I am really and what I was not before. (Gambler, 52-year-old male, attending GA for 1 to 3 months)

> Since I joined the association, I have regained the trust of my wife, I returned to my wife and my daughter, live a more peaceful life, both in the affective domain, and working with friends. I feel another person, I feel another person. (Gambler, 44-year-old male, attending GA for over 1 year)

This aspect is emphasized also by the gamblers' parents and partner. They may describe their relationships with excessive gamblers and how they have been hurt by the betrayal and lies, but then how they repaired their relationships by communicating more openly than before (Binde, 2012):

> In the end, it seems we broke through because we've attended this association for 1 year and 2/3 months and I must say that a miracle has happened. My husband has changed his attitudes; he's changed his ways of doing things and I am able to give him money and send him to pay the bills. He immediately gave me the bank card. He brings me the receipts. I am having second thoughts on the idea he was a criminal. (Wife of a gambler, 44-year-old male)

> Never before—it's been more than 4 years since we started attending the association. I see my son so different, completely different. He has always his problems but he is handling them great. (Mother of a gambler, 59-year-old male)

Why GA?. The definition of the problems influences the responses given to them and these responses in turn influence individual experiences (Conrad & Barker, 2010). Being labelled as a sick individual can be more comfortable than being labelled as an immoral person. In their study on the correlates of support seeking, Davison, Pennebaker, and Dickerson (2000) report that "having an illness that is embarrassing, socially stigmatizing, or disfiguring leads people to seek the support of others with similar conditions" (p. 213). Stigma has been suggested as a barrier to treatment for individuals struggling with disordered gambling. Consistent with this suggestion, the feeling of not being condemned and of being understood within GA is shared through the interviews, both by gamblers and by their relatives:

> […] surely the knowledge that we are all in this together and so you don't feel judged. I think that it is precisely the fact of feeling judged that leads people with addiction problems to not seek treatment. But here every single experience makes you relive those bad times and understand that the decision taken was the right one. (Gambler, 63-year-old male, attending GA for over 1 year)

> […] because in the association you're not judged, there is always someone that gives you a pat on the back and who understands your problem... maybe because they are people that have lived the same bad times and they know really how to help you, also by giving some advice or giving you a call ... the fact of sending a text means they are people who are close to you... and so you're aware that you have found the right place to fight this disease. (Gambler, 52-year-old male, attending GA for over 1 year)

Whereas the proximal or the wider social context appears judgmental (Rockloff, & Schofield, 2004), GA serves as a smaller, welcoming community, providing both a medical code to understand and justify moral transgression and the answers to the needs for sociability and identity (Ocean & Smith, 1993). People are rewarded by others for making changes and they feel they receive great social support in exchange for conforming to the GA group.

Discussion

In accordance with a socio-constructivist perspective, we have suggested that pathological gamblers' subjectivities emerge out of social networks and networks of meaning-making, in which common people, health researchers, practitioners, and policy makers take an active part.

Our study within GA self-help groups shows how an essentialist "deficit" model affects GA members' narratives by imbuing them with a medical vocabulary (Rossol, 2001) that homogeneously gives members with initially diverse identities a

fixed sick identity, that of pathological gamblers. Within this homogenizing class, each member is the same as every other member, and narratives appear to overshadow the idiosyncratic process underlying each member's personal story with problem gambling and the multiple trajectories that may have led to this equifinal point (Valsiner, 1986). The narratives of the members downplay the role of psychological and socio-cultural issues in understanding their own problem gambling. Space—as the cultural, symbolic, and emotional context that the individual is part of—and time—as the historical, synchronic dimension in which individuals are placed—appear to have no importance.

Focus groups with GA members highlight how even presenting oneself as an individual with a disease is, for some, the result of a troubling process of negotiation (Marinaci & Venuleo, 2016), but that, once actors achieve their reciprocal syntonization, the resulting shared representation—"we are sick individuals"—is established as a taken-for-granted reality, which organizes the way of defining one's identity and allows the actors to converge in a shared view of what is useful and what is not useful to manage the "evil."

Although GA is not committed to any specific religion, the GA story is clearly rooted in the Christian tradition (Bourgois & Hart, 2014): The prodigal son returns home and is accepted into the congregation. This is the same mechanism that Hanninen and Koski-Jannes (1999) underline in regard to AA groups. In M. Gergen's (1988) terms, the different story types could be classified as progressive narratives characterized by the protagonist's moving toward a valued end point: After and through the despair of one's own addiction disease, individuals have been able to become better, to rebuild their own relationships, and to receive solidarity.

Weinberg (2002) observed that "although ostensible symptoms of pathological gambling consist in social or cultural transgressions, its underlying nature is generally located in one or another bodily pathology, deficit or vulnerability" (p. 1). The current study suggests that the individual explanation of this social failure only appears to be a contrast. People can choose to interpret their problem as an addictive disease, not because this interpretation best fits the observable facts, but because it is a view that serves useful purposes for themselves and for society in general (Davies, 1992). The medical template —the acknowledgment of gambling as a disease and of oneself as a sick individual—offers gamblers a welcoming community that promises to understand, to support the repairing of the social rupture, and to rebuild a more socially legitimate identity and adjusted life. The value of this promise has to be understood in light of the great stigma faced by gamblers, as reported in local qualitative research (Borrell & Boulet, 2005) and as also reported by many GA members who we interviewed. Goffman (1963) suggested that stigma is an "undesired difference" within a certain social environment, namely, a discrepancy between an individual's virtual and actual identity—or the expectations that others have of the individual and his or her actual self—"which spoils his social identity" (p. 31). Goffman said little about addiction per se, but his notion of "spoiled identity" has been taken up by others (Reith & Dobbie, 2012). Waldorf and Biernacki (1981),

for example, suggest that recovery from drug addiction is based on the management of a spoiled identity and aims to resolve the conflict between an "addict identity" and other conventional identities, such as those of parents and partners. The idea promoted within GA groups that problem gambling is a disorder beyond the will and control of the gambler has the advantage of counteracting stigmatizing connotations (irresponsibility, selfishness, insensitivity) and giving to the players and their families the power to reaffirm a social canon (the value of being a good, spiritual person) and to relate its rupture (a failure to meet family and social obligations) to something external to the individual's will. Gamblers appear to be helpless in the face of their physiological disorder and thus deserve to be included, embraced, and helped. The acculturation to a sick identity is crucial for mobilizing these resources and for reshaping the self in culturally appropriate ways (Reith & Dobbie, 2012).

If GA is effective, it is because it supports the need to resolve one's own relational and social failure and to allow moral reconciliation (McGowan, 2003); stopping gambling acquires its meaning within and in light of this purpose. Ironically, the change rests on continued reinstatement of pathology: the idea of "once an addict, always an addict" (Reith & Dobbie, 2012):

> I'm not a healed person, I do not feel like a healed person. I can only hold off (the disease), because gambling is a monster; if I can hold it off, I do not try again, but if I go and play even once that monster reappears to me and I feed it again. (Gambler, 44-year-old male, attending GA for over 1 year)

As an identity, addiction entails persistence, the idea of being always the same through the variability of time and space (Märtsin, 2014). This is the central assumption on which the permanent dependence on the self-groups is constructed. Because gambling is conceived as a chronic illness, gamblers will need the instrumental and affective help of the other members and relatives forever because their chronic illness, unlike an acute illness, lasts (Charmaz, 2000).

A final important consideration concerns the circumstances in which the gamblers' experience is listened to. The idea of dialogicality invites us to seriously consider the actual, socially situated conditions of the production of discourse (Marková, Linell, Grossen, & Salazar Orvig, 2007). From this perspective, we have to keep in mind that narratives are shaped by the intersubjective circumstances motivating their activation: the request from a research group to understand problem gambling from the point of view of those who need help and those who are trying to manage problem gambling within GA groups.

Often, the interviewers shared the feeling that they have listened to a sort of lay prayer or confessional account through which the interviewees were emphasizing not only their own remorse about problem gambling, but also their strong loyalty to GA culture and a feeling of acknowledgment toward the GA "brothers." It is possible that in this sphere, the trouble and conflict that accompanied entry into GA, as well as critical moments related to, for example, "relapses" of their own or those of other

members, were neglected. This is not to say that the process of change was simple, straightforward, and "blind" to any phenomena of ambivalence. It is not information of the past, but of the present in their relationship within the GA groups. We can say that it may be the story of a new, more legitimate dependence, this time on the group.

Limitations and Future Directions of Research

Further research is needed to understand the ways that GA members think about their identity and how their problem with gambling changes over time and to investigate more deeply the interindividual differences in this process. Certainly, the fact that none of the newcomers agreed to take part in the individual interview limits our understanding of the process of acculturation to the GA identity. Furthermore, the principle of anonymity and the absence of a record of members makes the effort to understand the reasons that some dropped out difficult. We cannot rule out that the disease model and its assumptions (such as the neglected role of subjectivity and/or the social environment) play a role not only in understanding why GA is felt to be effective by its members, but also why it is felt not to be useful for understanding or managing one's illness by those who left the group.

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Footnotes

[1]Here, according to Conrad and Barker (2010), the label of social construction is used to refer to various approaches to illness that "all share an eschewal of a strictly positivist conception of illness as the mere embodiment of disease," the emphasis being on "how illness is shaped by social interactions, shared cultural traditions, shifting frameworks of knowledge, and relations of power" (p. S69).

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Submitted August 29, 2016; accepted April 26, 2017. This article was peer reviewed. All URLs were available at the time of submission.

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Competing interests: None declared (all authors).

Ethics approval: None required. The study is based on a qualitative analysis of 35 semi-structured open-ended interviews, 25 with gamblers attending Italian GA self-help groups, and 10 with gamblers' relatives. In accordance with the ethical code of the Italian Psychology Association (AIP) (http://www.aipass.org/node/11560) and the Italian Code on the protection of personal data (Legislative decree No. 196/2003), each participant signed an informed consent form both for the interview itself and for audiotaping. The participants were informed about the general aim of the research, the anonymity of the responses, and the voluntariness of participation.

Acknowledgements: Special thanks to all the Gambling Anonymous and Gam-Anon self-help groups who allowed us to conduct the research. We are also grateful to the research team who helped us to collect the data: Francesca De Blasi and Alice Marchese Peluso.