Vietnamese Problem Gambling Treatment Program

Therapist Manual

Prepared by Statewide Gambling Therapy Service (SGTS), in conjunction with the Vietnamese Community in Australia (SA Chapter Inc.) (VCASA)

Flinders UNIVERSITY

CLUBS S.A. Community way of life!

aha|sa Australian Hotels Association (SA)

ADELAIDE CASINO

Government of South Australia
Department for Communities and Social Inclusion

Funded through the Gamblers Rehabilitation Fund

VIETNAMESE COMMUNITY IN AUSTRALIA SA CHAPTER INC

Key team members responsible for the development of this manual are:

- Ms Sue Bertossa, MMHSc, MSW, BA/BSocW,
- Ms Lan Nguyen BSW
- Mr Ben Riley MMHSc, BSW, BMus
- Ms My Phuong Sramek BHSc
- Professor Malcolm Battersby PhD, FRANZCP, FAChAM, MBBS
- Associate Professor Peter Harvey PhD, Dip T, Bed

The authors would also like to acknowledge the input of Mr Vinh Le and Mr Trung Tran, who work as Gambling Support Officers within their community.

This manual was funded by the Office for Problem Gambling, Department for Families and Communities, Government of South Australia, through the Gamblers Rehabilitation Fund and forms part of the Vietnamese Therapy Resource Kit.

Introduction

This Manual provides a basic description of how to conduct a behavioural treatment program for problem gamblers, with particular relevance for people of Vietnamese background who are living in Australia. The primary focus of the treatment is based on exposure methodology, similar to that applied by Isaac Marks (Marks, 1987) to treat phobias or other anxiety disorders. The therapy is based on the premise that many problem gamblers experience psychophysiological arousal in the presence of gambling cues, which prevents them from maintaining control over gambling behaviour. Therapists apply graded cue exposure with response prevention to help reduce the level of arousal the person experiences when in the presence of situations or cues that would normally trigger their urge to gamble. This approach has been adopted by the Statewide Gambling Therapy Service team in South Australia for more than a decade in their treatment of pathological or problem gamblers.

The Manual is designed to be used by therapists treating problem gamblers of Vietnamese background and there is a specific section which provides information on Vietnamese culture in Australia for those less familiar with people from this culture. It is expected that clinicians planning to conduct therapy based on this Manual are professionally trained and experienced in applying psychotherapy in other fields.

This project has taken into account the fact that there is no concept of counselling or therapy in traditional Vietnamese culture as is found in mainstream culture in Australia. There is a history of people of Vietnamese background generally not utilising mental health services in Australia. The methodology described here has now also been successfully applied to people from this cultural group.

Contents

Vietnamese people in Australia

Waves of refugees from Vietnam started to arrive in Australia in the mid-1970s when the Vietnam War drew to a close, and after the United States of America, Australia was the second-most common destination for Vietnamese refugees (Australian Government, 2011).

The refugees left a nation marked by decades of war and poverty. Although Vietnamese immigrants have demonstrated enormous resilience in re-establishing lives in Australia, evidence of trauma and Post Traumatic Stress Disorder (PTSD) has prevailed for many and there has been a general failure to respond with culturally accessible mental health care (Phan, 2000, Wagner et al., 2006, Silove et al., 2007).

Similar to other groups compelled to leave their homeland, Vietnamese refugees have contended with insecurity and uncertainty, separation from family, loss of money or property, and change in status and role. Living in Australia, they have also been subject to racism, and experienced language barriers and intercultural difference.

Vietnam has demonstrated significant growth since the liberalisation of the market and removal of sanctions that had prevented trade between Vietnam and US allies from the mid-1970s until the 1990s. Despite strong economic growth in recent years within Vietnam, people have continued to seek opportunities abroad, with most recent arrivals in Australia being accepted as part of family reunification schemes (Australian Government, 2011) Department of Immigration and Citizenship, 2011)

In Australia, Vietnamese people have been able to retain some cultural traditions, and are one of the largest Culturally and Linguistically Diverse (CALD) communities based in South Australia, ranked third when differentiated by language spoken at home (Australian Bureau of Statistics, 2006).

Gambling and culture

Acceptance of gambling within Vietnamese culture is mixed. People traditionally gambled on card games, cock and water buffalo fighting. These activities were conducted in the home or village and were widely accepted as a form of entertainment.

However, traditionally gambling has also acquired a less desirable reputation. The four vices for men are identified as 'womanising', 'drunkenness', 'drug-taking' and 'gambling', with gambling noted as "the uncle of poverty" (Delfabbro and Zysk, 2003). Gambling was more commonly associated with men than women, and games of luck (such as Bầu Cua Cá Cọp — Winter melon, Crab, Fish, Tiger) and card games featured as part of New Year celebrations. Horseracing was popular in Vietnam under French rule, but all gambling was banned under Communist rule.

Contemporary Vietnamese governments have sought to raise revenue through province-based lotteries and casinos. Vietnamese locals are not permitted inside casinos which have been designed principally to capture the tourist dollar. There are a number of casinos situated just over the Cambodian border, which offer incentives such as food and accommodation packages for Vietnamese people who gamble in their establishments.

The Adelaide Casino is a popular destination for visitors from Vietnam; this may prevent some people who experience gambling problems from barring themselves from the facility, because they would not be able to accompany guests to the venue.

In Vietnam today, there is an active black-market in lottery games across the provinces; and it is less clear whether unregulated gambling opportunities have infiltrated Vietnamese culture in Australia.

Games of luck feature as part of New Year celebrations in Australia as they do in Vietnam. Gambling outside of this period is viewed less favourably and excessive gambling is frowned upon at any time (Delfabbro and Zysk, 2003).

The Vietnamese community seems concerned about the increased accessibility of legalised gambling opportunities in Australia and the impact of these facilities on families and the community (Delfabbro and Zysk, 2003). An increase in the participation of women in gambling has also been observed.

A life in harmony

Traditional Vietnamese culture places emphasis on achieving a balance between two distinctive ways of thinking. On the one hand people strive to observe the more rigid expectations of reasoning, conformity, honesty and duty, while also observing the more egalitarian principles of compassion, fairness, generosity and benevolence on the other (Jamieson, 1995).

There is a hierarchical structure, with women subordinate to men and their husband's family, younger siblings respectful of their elders, and children of their parents. Acculturation in Australia has challenged the traditional role structure, potentially causing tensions within families.

Although there has been a traditional expectation that women will be submissive to their husbands, women are not regarded as inferior and there is abundant evidence of strong, decisive females in Vietnamese literature and recorded history (Jamieson, 1995) as well as evidence of men and women working alongside each other to great success.

Women gain respect through not being disruptive, and are to be admired for their cleverness in running a household or business, while maintaining harmony within the family unit. Similarly, a younger sibling attracts admiration for being respectful to their older siblings. Children are highly regarded, but taught from a young age that they are indebted to their parents. A 'good child' is one who respects and obeys their parents, and is mindful of their parents' needs ahead of their own. Children growing up under the influence of Australian culture may express conflicting values to those of their parents.

Traditional Vietnamese culture is characterised by a collectivist mentality, where the needs of the family or community are regarded as more important than those of an individual (Jamieson, 1995). Learning and other achievements are admired, but goals based around self-fulfilment, typically espoused in Australian culture, may be incongruent with traditional Vietnamese values and beliefs.

Excessive display of emotions or evidence of excessive behaviour, are also signs of imbalance. Vietnamese people are expected to be able to demonstrate control of both emotions and behaviour; a significant challenge for a person experiencing problems with gambling.

Pathways to therapy

There is no concept of counselling or therapy in traditional Vietnamese culture; a fact which has served as a significant barrier in the provision of services to Vietnamese-Australians. A person experiencing difficulties will usually try to sort things on their own to begin with and then turn to their family for assistance and support. Families may be reluctant to discuss the problem outside the home due to their concerns about 'losing face' in the community.

The goal is to make health promotional material available to the community, educating people of Vietnamese background in recognising the signs of problem gambling, but more importantly demonstrating that therapy can be effective in countering this.

Given the family structure, it is likely that a member of the family will refer the client for assistance. The therapist should consider suggesting to the client to include family members in the therapy process but respect their choice if they decline to do so.

Excessive gambling behaviour is likely to be a major source of embarrassment for the client. As they have probably not experienced counselling previously, it is important to reassure them about the confidentiality of the service, and to demonstrate compassionate understanding around their inability to control their gambling.

The client will gain confidence in your ability to help when you are able to demonstrate professional knowledge and experience in treating gambling disorders. Given the stigma that attaches to mental illness in the Vietnamese community, it is inadvisable to label 'problem gambling' as a mental health disorder.

Some clients may appear to be forthright but be prepared to allow them time to reveal the full extent of their problem. Personal declarations or revelations should be treated with upmost sensitivity. Once the client has demonstrated their trust through being able to speak more candidly, it will become easier for the therapist to negotiate the graded exposure aspect of therapy with the client.

Clients may be concerned about the level at which they react to triggers presented in the initial stages of therapy. Reassure them that their reaction is the purpose for providing this type of treatment and revisit the treatment rationale with them.

As the clients develop trust in the therapist, they may also develop a sense of obligation to them and to the others in their family who are affected by their gambling and as a result, will be highly committed to engage in the therapeutic tasks (Riley et al., 2011).

Cultural tips, in brief

- Many Vietnamese people have little experience or knowledge of the counselling process
- There may be a high level of shame associated with their gambling behaviour
- A client is more likely to practise personal resistance strategies or turn to their family for assistance and not seek external help
- Families may shy away from seeking external assistance, as an admission of a problem within the family reflects on the family as a whole
- Vietnamese people tend to be polite. Disagreement is more likely to be expressed in non-compliance than confrontation
- Maintaining control is important to Vietnamese people; revelations of excessive gambling would be associated with 'loss of face'
- Vietnamese people tend to be modest and private. Reassurance around confidentiality of the service is essential
- Vietnamese people respect learning, so therapists should demonstrate their professionalism and specialist experience for treating problem gambling as a means for engaging the client.

Approach to treatment

The primary focus of this treatment program is 'Cue Exposure with Response Prevention', which involves staged exposure to triggers associated with gambling. The treatment rationale is based on the therapy more commonly applied to overcoming phobias, whereby the person is encouraged to confront their source of fear in a graded fashion (Marks, 1987). The successful application of this process by the Statewide Gambling Therapy Service with the general population is demonstrated in Riley, Smith and Oakes (Riley et al., 2011).

Similar to the development of a phobia, it is understood that some people experiencing problems with gambling have developed a conditioned response to a range of gambling triggers and exposure to these generates a strong urge to gamble (Battersby et al., 2008)

The treatment aims to reduce the level of arousal experienced by the clients when exposed to triggers. The reduction in response to triggers is likely to reduce the compulsion to gamble and it also provides them with increased capacity to address other factors which have contributed to the development of their problem with gambling.

Key principles of cue exposure with response prevention

Clients are exposed progressively to a graded hierarchy of triggers that relate to their gambling behaviour. At each stage, the client is asked to abide by the following principles:

FOCUS	The client is taught to expose themselves to a trigger and to focus on their emotional response to the trigger.
PROLONG	The client is encouraged to focus on their urge to gamble until it dissipates, i.e., until habituation is attained.
GRADE	The exposure tasks are graded in order of increasing difficulty, commencing with the least difficult.
REPEAT	Clients repeat exposure usually daily, to the same trigger, until the urge to that trigger is extinguished.

Assessing the client

Through working with Vietnamese clients, we have witnessed two contrasting styles of presentation. Some clients are reserved initially; they will gradually reveal more personal information at each session but are at risk of withdrawing after the first meeting. Others become very emotional, particularly if they have been worried about their gambling for a long time and have not been able to disclose the problem to anyone else. The client may speak with great intensity, cry or even wail, and may be embarrassed by their emotional outburst, given that a display of high emotions is culturally frowned upon. A sensitive response from the therapist at this time can help establish a strong bond with the client and the release of emotions may prove to be quite cathartic.

In either case, the amount of information collected as part of assessment may need to be modified to suit the client's initial capacity to share.

The initial meeting

Essentials

- To gain an understanding of the problem from the client's perspective, use the 'Vietnamese Gambling Brief Assessment' form for recording
- An assessment of risk and provision of information regarding the client's rights and responsibilities
- A brief explanation of what the program entails and expected duration of treatment.

Desirables

- Perform a more in-depth assessment of gambling. Use the 'Vietnamese Gambling Screening Assessment'
- An analysis of a recent gambling episode, as a basis for providing a treatment rationale
- Completion of measures
- Introduction to cash restriction strategies to support the treatment approach.

Conducting a brief assessment

The form 'Vietnamese Gambling Brief Assessment' has been designed to provide a starting place for either the referrer or treating therapist to collect basic information and data about the client.

Most of the session should be dedicated to examining the presenting issue from the client's perspective by preceding with open-ended questions, such as: "Can you tell me a little bit about yourself, for example if you are married, whether you are working or not?" followed

by: "I understand that you have some concerns about gambling, perhaps if you could tell me a little about that."

If the client is having difficulty describing their problem with gambling, it may be helpful to talk about how and when they started gambling. This may be followed by questions to determine the time and circumstances of when they became concerned about their gambling behaviour.

The form also allows a space in which to record details of the client's cultural background. The purpose of the questions is to help you engage with the client while also assessing their level of acculturation. The therapist should bear in mind that Vietnamese-born people may be sensitive to questions about their personal experiences in their birth country, as many of them left Vietnam for political reasons.

For more information about the history and culture of Vietnamese people living in South Australia, refer to the culturally specific section contained within this guide, commencing on page 4.

The final question in the assessment form enquires about the status of the client's relationship with their family. Maintenance of the family unit is an important aspect of Vietnamese culture and isolation from family may be very distressing to them. It also indicates the level of support that may be available to the client while they are involved in treatment.

A copy of a map of Vietnam may be useful to have on hand, especially if the client would like to share more information about where they originated. It is probably not advisable to have a map of Vietnam on display though, due to political sensitivities.

A more comprehensive assessment

If the client is indicating that they are interested in engaging in the treatment program, a more in-depth appreciation of the presenting issues is required. The following provides a step-by-step guide to completing a comprehensive assessment. The form 'Vietnamese Gambling Screening Assessment' can be used to collect this information.

The 5 Ws

The purpose of the 5Ws is to obtain a general description of the problem. Using open-ended questions followed by closed questions will determine general, then more specific aspects of the problem.

Addicted (problem) gamblers commonly experience an uncontrollable urge to gamble. The urge has physical components (sympathetic arousal, sweating, heart racing, dizziness, stomach churning), emotional and cognitive components. The urge is triggered by predictable external situations (money, gambling venue, bills, sounds of the machine) and internal situations (loneliness, boredom, anger, conflict). Seek information on a possible urge if the client does not volunteer it.

WHAT: Seek a brief statement outlining the presenting issue e.g.: "I've lost control of how much I spend on gambling". Also include here the types of gambling the client is engaged in and indicate which are problematic.

WHERE: Finding out where the client gambles e.g. local hotels, gives you a picture of where the client is most at risk.

List any venues the client may be barred from and note whether they have been compliant with this.

WHEN: Help the client estimate how often they gamble, and identify any times when they find it hardest to resist gambling e.g. on their day off.

WHY: Ask the client why they think they gamble. It may be when they are bored or need 'time out' or when they are looking for a win, either for the excitement or to supplement their finances.

WHOM: Many problem gamblers gamble alone, although they might have started out in the company of others.

If they are not gambling on their own, explore the relationship they have with others with whom they gamble. This will provide insight into any social pressures that may make it harder for them to stop gambling in the future.

Other assessment factors

Onset: Most clients respond well to these questions as it allows them to tell their story about when they started gambling and how their gambling has evolved over time. You may have already covered this while completing the Brief Assessment; however, the Comprehensive Assessment provides an opportunity for you to cover this in more depth.

There is also an opportunity for the client to identify periods where they were not gambling as much, or where the problem has been worse. They might be able to identify factors that contribute to better management of their gambling.

Other help: In some cases, the client may have sought help for their gambling previously. Once again, this gives them the opportunity to talk about what they have already tried, and the effectiveness of their previous efforts.

Impact: This section examines the impact that gambling is having on the client's life. The information collected here is important in establishing a range of meaningful therapeutic goals.

Vietnamese people tend to be reserved and find it hard to disclose information about themselves that they are ashamed of. Many Vietnamese people have had minimal contact with counselling services. The non-judgemental perspective demonstrated by therapists may be unexpected but appreciated as they become more familiar with the process.

It can be expected that a Vietnamese client will be guarded at first, and responses to questions regarding finances and family relationships may not reveal the full extent of the hardship they are experiencing. These questions may be asked again when establishing goals for therapy.

Cognitions: It is common for a problem gambler to believe they are able to control, predict or influence gambling outcomes, and many of these thoughts may be quite erroneous. Some therapeutic approaches to problem gambling attempt to redress distorted beliefs held by the gambler. This practice is not encouraged with gamblers of Vietnamese background, as the beliefs may have a cultural basis. Challenging these beliefs may take a therapist who is unfamiliar with Vietnamese culture into areas where they risk offending the client early in therapy.

The purpose of enquiring about 'luck' specifically is to assess the client's beliefs and how these relate to their gambling and to assess current perceptions of luck in relation to themselves. Therefore, the focus is on asking whether they believe they have luck and to explore anything they might have done to try to improve their luck.

Goals: This is only a brief statement, such as: "I want to stop gambling altogether" or: "I want to get control back over my gambling". A more comprehensive establishment of goals is planned for the next session.

Mental health: There is a significant stigma attached to admitting to mental health issues amongst the Vietnamese population, which prevents many people from seeking assistance. Although the client may meet the criteria for Pathological Gambling as listed in the Diagnostic Statistical Manual of Mental Disorders), it is probably inadvisable to suggest that a gambling problem might be interpreted as a form of mental illness.

'Nervousness', 'sadness' or 'worries' are terms commonly used to describe anxiety or depression by Vietnamese people and those experiencing mental illness may not have sought help for this or only requested help for the somatic symptoms associated with mental disorders. Even if diagnosed, the client may be unsure of the correct diagnosis, as is the case with many others with mental illness, with language and culture presenting a further barrier to understanding.

Medication: The therapist should be aware of any prescribed medications and should ask about compliance with these. Some medications may affect the ability of the client to engage in exposure therapy, e.g. diazepam or alprazolam. Clients who use these drugs regularly may need to reduce their usage if they want to participate in exposure therapy. If the therapist believes the dose of medication may affect therapy, the client should be advised to discuss this with their treating doctor and encouraged to consent for the therapist to liaise with the doctor.

Alcohol/Drug use: This section should assess the use of caffeine, tobacco and alcohol as well as illicit substances, and the relationship between their use and the client's behaviour with gambling. If the two activities are associated, they may need to be addressed simultaneously during the therapy process.

High level and frequent use of alcohol and illicit substances is likely to affect the client's ability to engage in therapy and referral to an external agency may be required. Even where the client plans to attend treatment regularly, the influence of current substance use may affect their ability to focus on exposure tasks and they may be unable to habituate to a gambling trigger. Alternative therapy may be needed until their drug use is reduced or resolved.

Where clients have a history of substance abuse, mindfulness strategies may be helpful to assist them to regain their ability to maintain focus during exposure if they are having difficulty completing exposure tasks and achieving habituation to triggers.

Mental State Examination: Only a brief examination of the client's mental state is required, with usually only 5 to 10 minutes devoted to this part of the session. For further information regarding mental state examinations, please refer to general texts on this.

Risk: Problem gambling is commonly associated with suicide ideation and has the potential for increasing the risk of conflict between the gamblers and others. This can be a sensitive issue to raise with anyone, but as Vietnamese people tend to be very private, extra care should be taken to ensure that the client is providing adequate information regarding risk.

Pathological Gambling Disorder (312.31), DSM-IV

Below is a list of the criteria: the client needs to exhibit at least 5 criteria in order to meet diagnosis:

- Preoccupation
- Tolerance
- Loss of control
- Withdrawal
- Escape
- Chasing losses
- Lying
- Illegal acts
- Risking significant relationship and/or job
- Reliant on bail-out

People experiencing problems with gambling may meet the criteria for a diagnosis of Pathological Gambling Disorder. As you conduct the assessment, a number of criteria are likely to become self-evident. You may need to ask further questions at the end of the assessment to establish whether the client meets the diagnosis. The following section describes these criteria in more detail:

Preoccupation

Problem gamblers may find themselves thinking about gambling even when they are not engaged in playing. The thoughts are typically triggered by negative emotional states, being under financial pressure and needing a win or when opportunities to gamble are pending. Ask: "Do you find yourself thinking about gambling, even when you aren't playing?"

Tolerance

Over time, gamblers may place higher bets and feel less satisfied when gambling with smaller amounts of money. This indicates that the client is developing a gambling dependency. Ask: "Have you found yourself betting more or higher amounts than when you first started gambling?" This is a less commonly identified symptom of pathological gambling and is borrowed from the alcohol and drug abuse phenomenon of tolerance and withdrawal. The more common experience is that positive feelings of excitement are replaced by uncomfortable tension from the uncontrollable urge to gamble. This urge is relieved once the gambler places a bet.

Loss of control

This is a common indicator of problem gambling, and is often revealed in the course of the assessment process without targeted questioning. However, there is significant 'loss of face' for a Vietnamese person to admit to loss of control over their behaviour. Sensitive handling of revelations of this nature represents an opportunity for rapport building between the therapist and client. Ask: "Have you tried to stop or cut back, and found that you couldn't?"

Withdrawal

Some problem gamblers find that they feel restless or agitated if they are unable to gamble. Ask: "Do you miss it when you can't gamble? Are you ever restless or frustrated if you can't gamble?" As with tolerance, withdrawal is not always commonly experienced by problem or 'addicted' gamblers. The restless feeling is attributed to the psychophysiological urge to gamble.

Escape

Gambling may have developed as a coping mechanism in some people, providing them with the means of escaping from negative emotions or situations. At times of distress, sadness, loneliness or boredom, they may experience a strong urge to gamble. Ask: "Do you gamble to help you forget other problems?"

Chasing losses

On the realisation that they are losing while playing, some gamblers will become intent on chasing the money they have lost. The client will strive to find further sources of money to gamble with, falsely believing that their luck must be due to turn around. Gamblers may be so intent on regaining money lost, they will source money from wherever they can. There may be a strong cultural basis underlying the expectation that money can be won back, based on the Vietnamese philosophy of life being in balance (Ohtsuka and Duong, 2000). Ask: "When you lose do you feel the need to return and try to win your money back?"

Lying

Admitting loss of control over gambling is embarrassing for many, particularly when the client is letting down others as a result of their gambling. It is not unusual for a problem gambler to lie about their gambling or feel forced to cover up their behaviour.

Illegal acts

Some people experiencing problems with gambling have committed illegal acts in order to source money to gamble with. This is the intention of this criterion; it is not related to involvement in gambling for money laundering purposes. Ask: "Have you ever done anything illegal, or felt like doing anything illegal, in order to access money to gamble with?" It is not necessary for the therapist to pressure the client into disclosing details of illegal acts. The information is simply being collected to help form a diagnosis.

Risking relationship or job

Problem gambling commonly affects others who are dependent on the gambler in some way. Continued gambling can be a major source of

tension within relationships and families. A preoccupation with gambling can lead to the client neglecting obligations to others they are close to, or may affect their motivation to work or study; the client may behave in a way that is highly uncharacteristic for them and not in keeping with their personal values. Once again, this may be embarrassing for the client to admit to, but provides an opportunity for the therapist to demonstrate sensitivity and understanding. Ask: "Has your gambling ever placed your job at risk?" or: "Has gambling affected your relationships with others who are close to you?"

Reliant on bail-out

Problem gamblers may rely on others to bail them out financially. In some cases, gamblers are perpetually borrowing from others or seeking support around finances, with the potential for causing conflict with people important to the gambler or a loss of reputation, leading to social isolation.

Analysis of a specific gambling incident

In standard cognitive behavioural assessments, this is called a functional or behavioural analysis. When clients initially request help, they are often confused about why they are incapable of controlling their level of gambling. Many have stopped for periods of time but struggle to sustain their efforts. This exercise is designed to help the clients recognise what happens to them before, during and after they gamble.

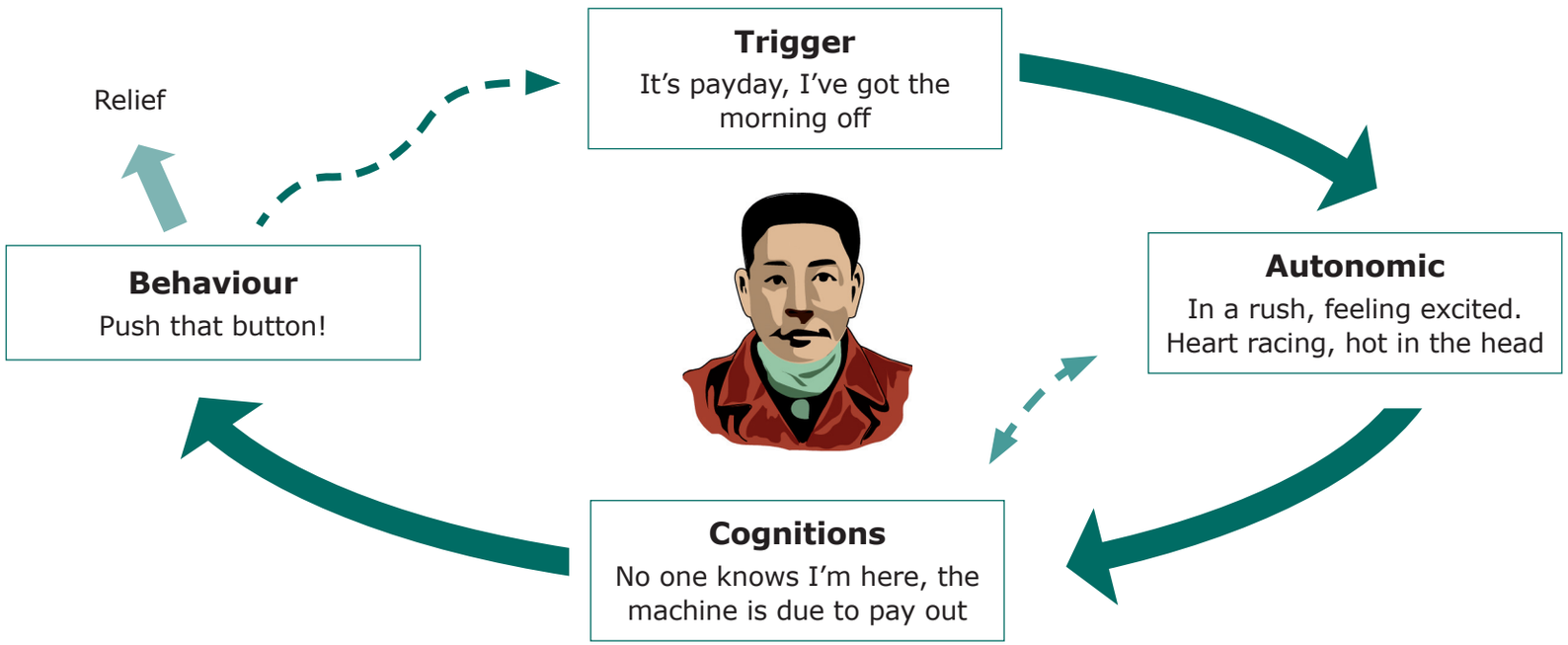
The table below provides a brief summary of a completed analysis:

Specific incident	Autonomic	Behaviour	Cognitive
Before	"Felt as if I'm rushing, felt excited, positive, you know"	"Told others I'd been called into work", "turned off my mobile"	" I've got a couple of hours before anyone will notice, I've got time"
During	"I get more and more agitated, sometimes I can feel my heart racing, I get hot in the head"	"Tried a few coins, tested the machine out", "went back to the ATM over and over"	"Should I change machines, I'm not winning", "hope no one comes in, I've got to be close to a win"
After	"When I've played for a long time, when I walk out I feel worn out"	"Head into work, try to act as if everything is OK"	"I should've walked out" "my family will find out, not sure how to cover up"

Depicting the gambling cycle

As the client recalls details of a recent or significant episode of gambling, they can become upset or embarrassed about their behaviour. Talking about their gambling in this way can also generate an urge response, adding to their discomfort. The therapist should persist with gaining more detail through questioning, as this is an important basis for the planned therapeutic approach. It is also an opportunity for the therapist to develop rapport by demonstrating acceptance and understanding of the client's predicament with gambling.

The next step is to transfer the client's information into diagrammatic form. This can be done on the whiteboard or if it is more comfortable for the client, on a blank sheet giving them something they can take away with them.



Treatment explanation

Clients who have lost control over their gambling experience a strong desire to gamble which cannot be dismissed easily. They may be less aware of the early signs of wanting to gamble or what transpires while they are gambling. Composing a cycle of the clients' gambling helps them to recognise the components governing their urge to gamble: any physiological arousal, emotional changes, ambivalent or distorted thinking, and how each of these feed off each other, culminating in them gambling.

At the time, gambling can feel good — pressing that button or placing a bet provides temporary relief from the heightened state of psychophysiological arousal, reinforcing their urge to gamble again in the future.

Presenting it to the client

Ask the client what they think would happen if you deliberately triggered their urge to gamble but they were prevented from being able to gamble in response. Persist with this enquiry until the client recognises that over time the urge must eventually lessen. You can acknowledge that the urge is likely to come back: however, for a short period there will be a reprieve.

Next, ask the client what they think would happen if they were continually presented with the same trigger, over and over, each time focusing until the urge goes down. With encouragement, most clients recognise that eventually they would no longer find that particular trigger arousing.

Let the client know that they will be presented with triggers of increasing difficulty, but will be able to apply what they have learned at each stage as they progress onto the next. The aim is to reach the point where the client has money and opportunity to gamble, is unaccompanied and in a venue familiar to them, but no longer experiences any uncontrollable urge to gamble.

Graded exposure, with response prevention

The key principles to effective exposure therapy, coupled with response prevention are:

- Achieving **FOCUS**
- the experience is **PROLONGED**
- the tasks are **GRADED**
- process is **REPEATED** until extinction.

Clients need to demonstrate that they have restricted their access to ready cash before commencing therapy. This is a temporary measure only to allow therapy to proceed. For further information on developing effective cash restriction strategies, see page 18.

Achieving FOCUS

On presentation of a gambling trigger, the client is asked to focus on the trigger and to note their response to this. Enquire about any thoughts or arousal generated by the trigger.

People respond very differently to triggers: some are more responsive to visual triggers, such as an image of a horse or a favourite poker machine; others, to audio triggers such as recorded sounds of being in a casino or listening to a race being called.

The task of the therapist is to find a trigger that generates a moderate response from the client. If the response is too high, the client is likely to avoid focusing on their response.

Before presenting the trigger, check on the client's willingness to be exposed to a gambling trigger, and their understanding of the purpose behind achieving focus rather than responding with their customary avoidance strategies.

Understanding the reason for confronting the trigger usually promotes willingness in the client to experience the discomfort associated with the task.

In some cases, the task generates little or no response. The therapist should be aware that the client may 'block' their response due to embarrassment or unwillingness to experience loss of control.

If the client is experiencing little or no response, it may also be that the trigger is not relevant to them. The therapist will need to introduce an alternative trigger.

PROLONGING the experience

The client is encouraged to focus on their response to the trigger, and to sustain the response for as long as it takes for their urge to be extinguished. It is normal for it to take up to 40 minutes in the first instance. The urge may not always disappear completely; clients should be encouraged to prolong the task until the urge is reduced by at least 50 per cent from their peak rating.

Throughout the process, the client may start to think about other things. Encourage them to notice when this happens and redirect their focus back to noticing any urge they have to gamble or any frustration that they cannot.

GRADING the tasks

Grading tasks is an important part of setting up a treatment plan. Ideally, the initial task should provide the client with a level of arousal of between 3 and 6 out of a possible 8.

As the urge to each trigger is extinguished, the client is presented with a trigger of increasing difficulty, and the process is repeated until extinction of urge to each trigger is achieved. The client is asked to repeat the same task each day until there is no or minimal urge, before they progress to the next task.

As the clients progress through the series of tasks, they usually become more competent at achieving focus, as they gain confidence that the urge will dissipate without them needing to distract themselves.

If the urge generated by the trigger is too high, the client is unlikely to be able to maintain the focus required to achieve habituation to the trigger.

REPEATING tasks

Essential to the therapy is achieving repetition of exposure to the same trigger daily or at least four days per week, until extinction is achieved. As the client progresses through the tasks, it is not uncommon for habituation to be achieved more rapidly. It is as if the client's mind and body have become retrained to allow the urge to dissipate more quickly.

Practitioners may prefer to present the principles in a different order. For example, it may be less threatening for clients who are uncertain about treatment if the therapist opens with the principles of grading and repetition before discussing the need to maintain focus throughout exposure exercises.

Formulating tasks

Remember, you are aiming for the client to rate the initial task at around 3–6 out of 8. If the urge is more than 6, the client is unlikely to be able to maintain focus, rendering the task unsuitable.

Initial tasks may involve visual images that relate to the client's preferred gambling activity. Examples of images that may be used are:

- an image of their favourite poker machine
- a still image captured from a horse or dog race
- a copy of an on-line gaming site
- photos of the exterior of a casino or hotel
- scenes from sports events.

Progression through tasks

The next step may be to use audio triggers, such as recorded sounds from gaming venues. In turn, these can be combined with the images introduced earlier.

Some people may be more responsive to tangible triggers; therefore, the therapist may bring in a handful of coins or gaming chips, a receptacle or dice.

Where available, some gaming experiences may be replicated artificially. PowerPoint presentations comprising a rotating series of images relating to the client's gambling may be a useful next step or a DVD rendition of a poker machine game. These can be introduced without sound, and then the client may proceed to a version that includes an audio component.

Introducing *in-vivo (live)* tasks

Once the client has demonstrated use of correct technique and experienced extinction of trigger arousal to a series of graded tasks, it is advisable to move onto tasks that more closely resemble the client's gambling activity.

At this stage, it is recommended that the client is encouraged to not carry cash or have access to money while completing the exposure tasks. Otherwise, this places them at risk of gambling, negating the purpose of the exercise, or interferes with their ability to maintain focus without concern about controlling for relapse.

An ideal first task may be to sit outside a gaming venue in the car park, without any access to money. Gradually the client can progress to being inside the venue, perhaps in the foyer or a side room to begin with. Eventually the aim is to have the client replicate their gambling activity as much as they can, short of actually gambling, while focusing on any urge they may still have to gamble.

A race punter may practise placing mock bets and then watching the race. Initially the punter practises leaving the race without knowing the result and remains focused on their urge to gamble until it recedes. Watching the race to its end after placing a mock bet is also a valuable exercise. Some people respond more strongly to experiencing a loss; others to having a win. The aim is to extinguish the urge across all contexts. A similar approach may be adopted for those engaged in sports betting.

In time, the client should be encouraged to carry small amounts of money as well. The tasks can be extended by asking them to change money inside the venue. You may ask a poker machine player to place coins in a gaming machine, refunding them at the end of the task.

Alternative approaches

Other triggers may occur to the therapist through discussions with the client. For example, the client may have items or behaviours that they normally use to increase their luck as a gambler, and these can be incorporated into the therapy process as gambling stimuli.

Payday is often a strong trigger for a problem gambler, and therefore tasks associated with accessing money might be replicated as part of therapy. The therapist may ask the client to practise walking to the bank, then past gaming venues at which they usually play.

Completion of homework tasks

Ideally, the client undertakes their first task in the presence of the therapist, where they can receive guidance around maintaining techniques. This also provides an opportunity for the therapist to ensure that the task is well matched to the client.

Clients are provided with a sheet to record their responses to the task ('Homework Sheet — Recording Planned Exposure Tasks'). A copy of a completed homework record is presented on the next page.

Repetition of tasks is essential for the treatment to work; therefore, the therapist needs to assess the client's potential for completing tasks independently. Common factors that influence the completion of homework tasks are:

- the client's ability to manage their time and plan tasks around their normal life
- the support of others close to them
- the privacy to complete tasks, particularly if the client has not disclosed to others that they are attending therapy
- the level of motivation or energy of the client around engaging in therapy.

Information for the client

A set of instructions has been prepared to assist the client while they are working on tasks independently of their therapist. See 'Instructions for Confronting Gambling Triggers'.

Responding to spontaneous triggers

As they graduate through the triggers, clients should be able to adopt the same practice with gambling triggers that are not planned as tasks. This increases their ability to confront gambling triggers they are likely to encounter in the normal course of their life.

Example of a completed homework sheet:

Exercise: Listening to the sounds of being in the Casino

Date	Time		Urge Ratings			Comments
	Start	Finish	Before exercise	During exercise	After exercise	
27/2	10.00	10.25	2	4	1	Noticed a tightening in the chest, made me want to be there but that went away
28/2	9.30	9.45	1	3	0	Went OK this time, urge went away faster.
1/3	9.30	9.40	0	1-2	0	Not very exciting.
3/3	10.00	10.10	0	1-2	0	Same as above.
3/3	10.00	10.10	0	0	0	Boring, no response at all.

Use of validated measures

A range of measures can be employed to quantify the impact of gambling on the client and the effectiveness of treatment. It is advisable to establish at least a baseline measure and a final measure at discharge, but interim measures may be useful in assessing the progress of treatment.

Most of the listed measures have been developed for the non-Vietnamese community and only some have been translated into the Vietnamese language or adapted to suit Vietnamese culture.

It should also be noted that Vietnamese clients are likely to be concerned about how their information may be used and who can access their file.

If there is an intention to use the information for research, all information should be de-identified and the client needs to sign consent.

Gambling-specific measures

Measures applied in Australia have been the South Oaks Gambling Screen (SOGS), the Victorian Gambling Screen (VGS), the Canadian Problem Gambling Index (CPGI 9-item) and the Eight Screen. SOGS had been adapted for Australian conditions and translated into Vietnamese (Ohtsuka and Ohtsuka, 2000) but this measure has not been trialled extensively with clinical populations. A Vietnamese-language version of the CPGI is available from the Centre for Addiction and Mental Health website, http://www.camh.net/.

Additional measures may be applied to assess other aspects of problem gambling but unless there is a specific purpose underlying their use, they should not be added to the set. The selection of measures should be purposive and the number of measures applied kept to a minimum.

Assessing impact on mental health

Once again, there is a selection of possible measures; those commonly used in Australia are:

- The Kessler Psychological Distress Scale (K10) which is a measure of psychological distress relating to anxiety and depression.
- The Depression Anxiety and Stress Scale (DASS21), which also assesses the severity of symptoms of anxiety and depression.

There have been various Vietnamese-language versions of the K10 made available by government organisations but the accuracy of the translations in use in these communities is yet to be validated.

It is acknowledged that people of Vietnamese background are likely to have a different understanding and appreciation of mental health conditions. The Phan Vietnamese Psychiatric Scale (Phan et al., 2004) is lengthy but has been specifically developed for the Vietnamese community in Australia, and makes use of cultural descriptions of symptoms of anxiety and depression.

Alcohol and substance use

Alcohol and substance use can be established through clinical assessment, negating the need for further measures. Excessive use of alcohol and other substances may impede the client's ability to participate in graded exposure therapy.

It may be necessary to refer the client for external assistance around reducing their use of alcohol or other substances prior to commencing gambling treatment. The therapist can suggest strategies to reduce the harm caused by gambling in the interim, such as cash management techniques or self-exclusion from gambling venues.

Measuring progress

Problem and goal statements

A well-prepared problem statement can help encapsulate the problem that gambling poses for the client. The statement should contain these components:

- a brief description of the problem
- the antecedents to gambling
- a description of the gambling behaviour
- the impact of gambling.

An example of a constructed problem statement is:

"My main problem is **uncontrollable gambling***, whenever I* **have money and I'm bored***, which leads me to* **spending more than I can afford to***, resulting in* **arguments with my partner, not being able to pay bills and feeling bad about myself***.*

The client rates the severity of their problem on a scale of 0 to 8, with 0 being no problem and 8 representing a severe problem.

Development of goals

Goals need to be clear and measurable. Given that the client is engaged in graded exposure therapy to counter their urge to gamble, a primary goal should focus on reducing their response to gambling triggers. The goal is an end-of-treatment goal constructed using the SMART principles, i.e. specific, measurable, action-based (a behaviour), realistic, time-based i.e. how often, how long. For example, the client needs to formulate a goal such as:

"Be able to sit in front of a poker machine for circumstances, one hour, with $200 cash, on my own and have no urge to gamble".

As gambling often impacts on finances, a secondary goal may be set around reducing debt or developing a savings plan. Other goals may be suggested from the problem statement such as spending time with family, revitalising a hobby or making social contact if the client has become socially isolated as a result of their gambling.

Each of the goals should also be rated on a scale of difficulty from 0 to 8, with 0 being easy and 8 extremely hard.

Both Problem and Goal statements should be rated at least at assessment and discharge, but it is advisable to attempt to repeat measures at four-session intervals once exposure therapy has commenced.

Sessional progress

Treatment sessions are usually conducted weekly, with sessions 2–5 focused on exposure to artificial triggers or imaginal tasks, and sessions 6–10 on in-vivo tasks. This serves as a guide only, with some clients able to complete full exposure in fewer sessions. A risk assessment should be routinely conducted.

At each session the therapist will explore any gambling activity or urge to gamble that has occurred since the last session, review homework and set new tasks for the client to complete independently.

Key questions would be:

Q1. Have you gambled since we last met, and if so,

a) how often have you gambled?

b) how much money have you spent?

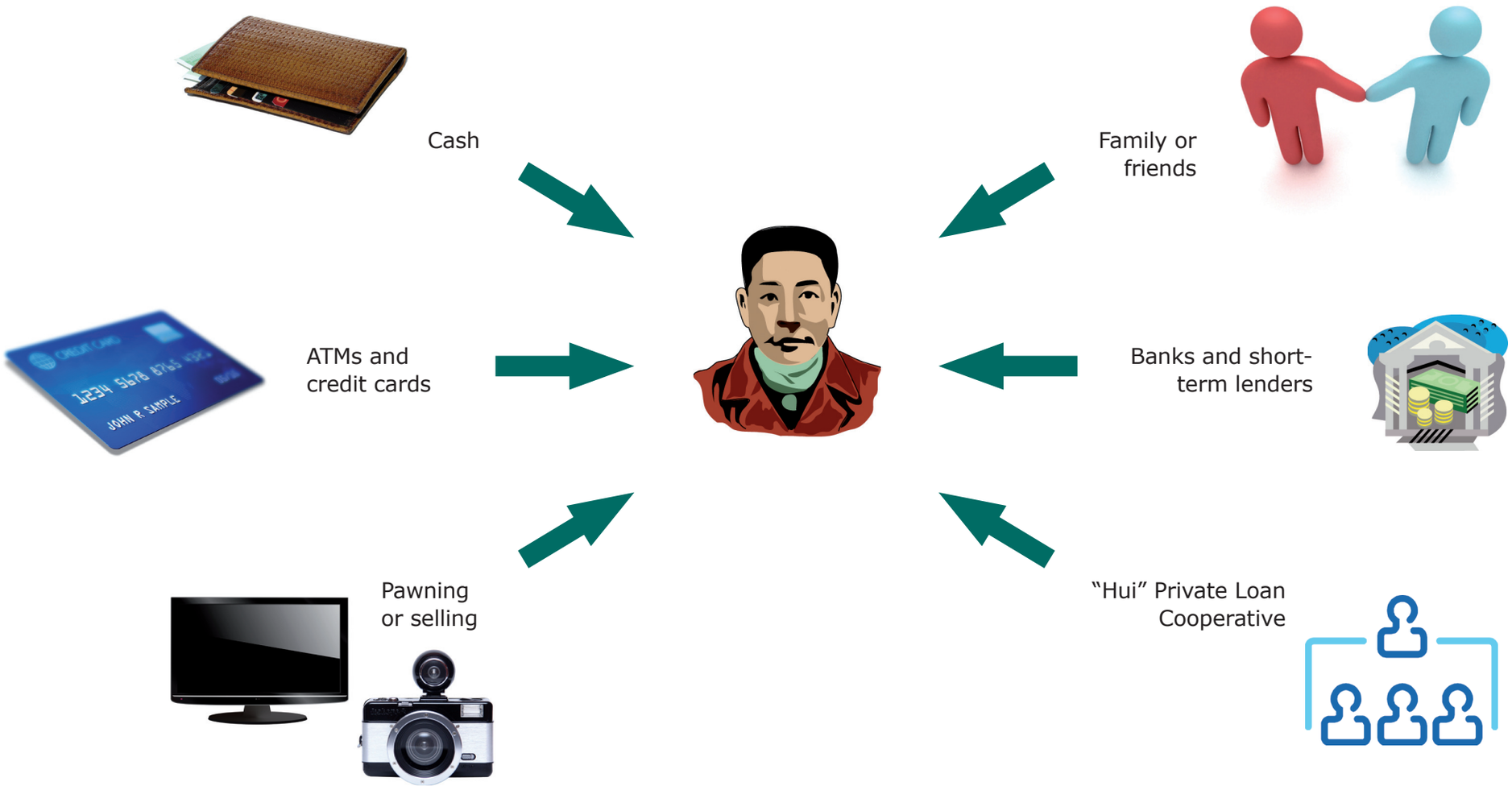
Even where the client has not gambled since the last session, they should be asked to rate the strength of their urge over this period, using the usual scale of 0 to 8.

Q2. How would you rate the strength of your urge to gamble during the last week?

There should also be the opportunity for successes to be highlighted and barriers to treatment discussed, with the therapist helping the client to develop problem-solving skills to overcome obstacles.

Cash restriction strategies

During the early stages of therapy, it is important that clients put in place measures that prevent them from having ready access to money they can use for gambling. The following diagram depicts the usual sources of money available to people:



Achieving compliance with cash restriction

The cash restriction strategies are designed to restrict ready access to money that could be used for gambling while the client is undergoing treatment. As part of the treatment process, access to money will be gradually re-introduced.

The reasons for applying these strategies while they are undergoing treatment is to protect the client from further gambling, which would reinforce the client's urge to gamble.

Understandably, many clients are reluctant to forego their access to money. Careful planning allows them to operate as independently as possible in managing their life and finances during the initial stages of therapy.

Tips for motivating the client to use cash restriction practices

- Cash restriction brings immediate benefits to the client as it prevents them from unrestrained bouts of gambling.
- Money serves as a significant trigger for most clients. Therefore, not having ready access to money can reduce the urge to gamble immediately.
- Cash restriction allows the client to engage fully with exposure tasks, confident that their risk of gambling has been minimised.
- Cash restriction strategies are temporary measures only. As part of therapy, access to money will be re-introduced, re-establishing the client's ability to manage their finances independently in the future.

Successful cash restriction

Clients will have their own methods for gaining access to money for gambling. These are some of the methods that clients have employed in order to restrict availability of funds:

1. Only carry minimal amounts of cash during the early stages of therapy.
2. Arrange for income to be transferred into an account without a card or phone banking facilities. This means the client can only withdraw money from the account during bank hours.
3. Some banks allow the withdrawal level on their ATM cards to be reduced. This restricts the amount of money that can be withdrawn while the card is still available for making purchases.
4. Store gift vouchers from the major supermarkets can be used for shopping, petrol outlets, etc. Currently some outlets sell VISA Gift Cards, available in $50, $100 and $200 denominations, which can only be used for making purchases. These can be redeemed at most outlets where a VISA card is accepted.
5. Arrange for bills to be paid via direct debit. Be careful about any delay between the day money is credited into the account and the day money is to be debited. This is where a second 'holding' account can prove useful. If the client is a Centrelink recipient, it may be easier to automate payments through Centrepay.
6. Any savings can be protected by either putting these into long-term accounts or by setting up a joint account with someone whom the client can trust. This way the client can only withdraw money with the permission of the other person.
7. Involve the client's partner, family or someone else they trust to help keep their money safe. They can help by holding onto bankcards or accompanying the client when they transfer money into accounts or purchase gift cards.

Review of cash management

The therapist should also make a point of checking whether the client has had opportunities to access money, although tight cash restriction should be in place early in the therapy process. At a later stage in therapy, the therapist may suggest that the client starts to carry small amounts of money, and gradually work their way towards independent management of finances. Once this process has commenced, the therapist should check how the client is responding to increased availability of money in terms of their urge to gamble.

Q. Have you made any changes to the way in which you are managing your money? If so,

a) what money can you access?

b) has this influenced your urge to gamble?

Relapse prevention

The purpose of relapse prevention is to provide the client with the skills to identify, anticipate and cope with circumstances where they may be tempted to gamble in the future. Discussion of relapse prevention strategies should be introduced towards the end of therapy, ensuring that the client is building capacity towards being able to manage independently of the therapy process.

The final session of treatment should include the development of a clear plan by the client, taking into account the following considerations:

Normalising the desire to gamble

People who have gambled for a long time will have a storehouse of gambling memories, not all of them negative, and the thought of having a small gamble may be appealing. It is useful to differentiate between experiencing a 'memory' as opposed to an 'urge' to gamble.

Identifying risk factors

Relapse may be associated with situations where the client is experiencing negative emotions, such as feeling stressed, angry or depressed. A chronic health condition or other physical health problems may re-ignite problematic gambling behaviour. Encourage the client to explore other ways of dealing with these situations.

The client may also be exposed to regular social situations that involve gambling. In these circumstances, the client may be tempted to return to gambling in a small, controlled manner. Encourage the client to practise abstaining from gambling in these situations over a period of time before returning to gambling in a measured fashion if they so choose.

Responding to lapses

Isolated lapses sometimes occur, and learning from this can assist the recovery process. Encourage the client to develop a plan around re-engaging in tasks they found helpful in the first instance. If they are unable to quell their urge to gamble, advise them to seek professional assistance. It may require minimal appointment time with their treating therapist to help them get back on track.

Recognition of progress

A therapist may help the client revisit their motivations for addressing gambling, and identify the changes they have made. The following diagram provides a template for exploring the advantages and disadvantages of gambling:

Advantages of Gambling	Disadvantages of Gambling
Advantages of NOT Gambling	Disadvantages of NOT Gambling

The client may like to record a personal story of their recovery that can be transcribed for their own use or shared with others. They may also like to be considered for peer worker or volunteer opportunities, to assist others recovering from problem gambling.

Supports

Ask the client to identify the people and places they may seek out for further support if they need it.

Practising the learned skills

Clients who have completed a substantial component of graded exposure to gambling triggers should be encouraged to continue to expose themselves to situations and places where they could gamble. This is both to consolidate the extinction process and to test their reaction to a variety of gambling contexts. Intentionally avoiding gambling triggers following the treatment program, limits clients' opportunity to discover any 'burning embers' that can easily be extinguished.

Any urge experienced in these contexts should be countered through employing the same techniques learned during therapy.

Common challenges

The client remains unconvinced about the treatment

- Demonstrating control is highly regarded in Vietnamese culture. It may take considerable effort to persuade a Vietnamese client that exposure to gambling stimuli will be helpful, as the task usually induces a sense of lost control. After revisiting the treatment rationale, it may help to point out that being prepared to experience the discomfort of being exposed to a gambling trigger is a sign of strong character.
- Applying the Vietnamese philosophy of life balance, the exposure tasks can be explained as a means to restore balance between mind and body, with rational thinking matched to a reduced physiological response to gambling triggers.

The client is not able to focus

- The task may be too difficult. The client needs to be able to experience their urge to gamble without feeling compelled to avoid or distract themselves. Select an easier task.
- The client is overly anxious. Some people experience pervasive anxiety or they may be very uncomfortable meeting with the therapist. Switch to an easier task and encourage them to take small steps and gain self-confidence.
- The client is restless and normally experiences problems with maintaining concentration. Encourage them to practise deep breathing and other mindfulness techniques in and out of session. It may be that the client always needs to apply techniques to centre themselves before undertaking exposure tasks.

Homework is not done or is unrecorded

- The client may be in an unsupportive environment. The client may invite others to the meeting with the therapist, enabling those close to the client to develop an understanding of the therapy and be more supportive.
- The client may not have the privacy to undertake tasks without revealing to others that they are engaged in treatment for problem gambling. Assist the client to find solutions, taking into account any restrictions and suggesting alternatives. Reiterate the need to practise for the therapy to work.
- Depression is commonly associated with problem gambling, and as a result, the client may not have the motivation or energy to complete the tasks properly. Apply brief behavioural activation strategies, combined with cash restriction strategies, at the start of therapy. The client may need further medical advice around medication.

- Some clients perform the tasks but may not record their efforts. Check literacy competency and if appropriate, provide exemplars of completed records. If the client persists in not recording, set time aside in the session to explore in as much detail as possible the extent of their participation in the homework tasks.

Urge not recognised

- In some cases, clients are so overwhelmed by their emotions associated with gambling that they are not aware of their thoughts or the physical reactions they are experiencing. If an initial exposure task fails to arouse any significant urge to gamble, the therapist may provide a brief description of common symptoms, and ask the client to keep a record of their own responses before the next session. (Provide a copy the 'Urge Diary' template). One useful strategy for a therapist presenting a picture to a client that fails to elicit any urge is to ask: "Does it feel any different looking at a blank piece of paper (neutral trigger) than the gambling picture?" And if so, ask: "In what way?"
- A client may be encouraged to explore further their experience around gambling through completing an imaginal exercise. Additional directions for this task are provided in 'Imaginal Exposure Task'.
- Where no urge is elicited, it is possible that the client is blocking the experience. Once again, discuss the purpose of the task, the client's expectations and promote willingness by the client to experience discomfort.

Constant lapsing

Where a client continually lapses throughout the therapy, it is worthwhile checking the circumstances around each lapse and problem solve around this. In particular, the therapist should encourage:

- Tighter cash restriction strategies, encouraging the client to involve others if need be.
- Explore the client's motivation to stop gambling. Apply Motivational Interviewing (MI) techniques (Moyers, 2002) to explore any ambivalence around making changes.

Irregular attendance

There may be circumstances in which it is harder for the client to attend regularly.

- Where it is difficult for the client to attend regularly due to other commitments, explore the possibility of more intensive treatment options by extending duration of treatment sessions ((Tolchard et al., 2006)) or by booking multiple sessions in a period where the client may be able to attend more frequently.
- The client may need assistance with problem solving around transport or managing other commitments in order to be able to attend regularly. Explore possible barriers to regular attendance.
- If the client is forgetful, text or phone reminders the day before may be helpful until they are in the routine of attending.
- Some clients need the support of others to be able to attend sessions. Encourage them to seek support.

Other issues

- Some prescription medications may affect the client's ability to focus. Particularly where the client is not using the medication as advised, encourage them to reduce their use and discuss with their treating doctor.
- Excessive substance and alcohol use may also affect the client's ability to engage in this style of therapy. Encourage reduction and refer externally for further support. Treatment may need to be suspended until the client has addressed their excessive use.

- Gambling behaviour may act as a form of self-destructive behaviour, particularly in clients with poor emotional regulation. Although this should not restrict the client's access to gambling treatment, referral to psychological or other counselling support may be appropriate.

Becoming financially independent

At the close of treatment, clients may not be fully independent in their financial management. Where others have been involved in supporting the client with financial management, they may be reluctant to hand control back to the client.

This is an important issue at the closure of treatment and during follow-up. Where necessary, the therapist should help couples or families develop a staged plan towards independent financial management.

It can take significant time for people to re-establish their trust in the person who has been gambling. Although it is easy to understand why this has occurred, it can adversely affect the recovery of the person who has undergone treatment.

As the ex-gambler grows in confidence in their ability to be self-managing around money, they may come to resent the control others have over them. The therapist may be able to help the client negotiate with others around this.

It is important that the therapist is not seen to be influencing this process, and they should clearly acknowledge to the client that with changes there are risks involved.

References

AUSTRALIAN BUREAU OF STATISTICS 2006. Cat. No. 2068.0. *2006 Census of Population and Housing*.

AUSTRALIAN GOVERNMENT 2011. Country profile: Vietnam. *In:* DEPARTMENT OF IMMIGRATION AND CITIZENSHIP. (ed.). Canberra.

BATTERSBY, M., OAKES, J., TOLCHARD, B., FORBES, A. & POLS, R. 2008. Cogntive Behavioural Therapy for Problem Gamblers. In: ZANGANEH, A., BLASZCZYNSKI, A. & TURNER, N. (eds.) *In the Pursuit of Winning: Problem Gambling Theory, Research and Treatment.* New York: Springer.

DELFABBRO, P. & ZYSK, A. 2003. Gambling in a multicultural society: A study of Vietnamese-Australains in South Australia. *In:* SERVICES, D. O. H. (ed.). Adelaide.

JAMIESON, N. 1995. *Understanding Vietnam*, Berkeley, University of California.

MARKS, I. 1987. *Fears, Phobias and Rituals*, New York, Oxford University Press.

MOYERS, T. B., ROLLNICK, S 2002. A motivational interviewing perspective on resistance in psychotherapy. *Psychotherapy in Practice*, 58, 185-193.

OHTSUKA, K. & DUONG, T. 2000. Vietnamese Australian gamblers' views on luck and winning: a preliminary report. In: MACMILLEN, J. & LAKER, L. (eds.) *Developing strategic alliances: Proceedings of the 9th National Association for Gambling Studies Conference*. Gold Coast, Queensland 1999.

OHTSUKA, T. & OHTSUKA, K. 2000. The Vietnamese-language South Oaks Gambling Screen for the Australian context. In: MACMILLEN, J. & LAKER, L. (eds.) *9th National Association for Gambling Studies Conference*. Gold Coast, Queensland.

PHAN, T. 2000. Investigating the use of services for Vietnamese with mental illness. *Journal of Community Health*, 25, 411-425.

PHAN, T., STEEL, Z. & SILOVE, D. 2004. An ethnographically derived measure of anxiety, depression and somatisation: The Phan Vietnamese Psychiatric Scale. *Transcultural Psychiatry*, 41, 200-232.

RILEY, B., SMITH, D, OAKES, J 2011. Exposure therapy for problem gambling in rural communities: A program model and early outcomes. *Australian Journal of Rural Health*, 19, 142-146.

SILOVE, D., STEEL, Z., BAUMAN, A., CHEY, T. & MCFARLANE, A. 2007. Trauma, PTSD and the longer-term mental health burden amongst Vietnamese refugees: A comparison with the Australian-born population. *Social Psychiatry Psychiatric Epidemiology*, 42, 467-476.

TOLCHARD, B., THOMAS, L. & BATTERSBY, M. W. 2006. Single-session exposure therapy for problem gambling: A single-case experimental design. *Australian Academic Press*, 23, 148-155.

WAGNER, R., MANICAVASAGAR, V., SILOVE, D., MARNANE, C. & TRAN, V. 2006. Characteristics of Vietnamese patients attending an anxiety clinic in Australia and perceptions of the wider Vietnamese community about anxiety. *Transcultural Psychiatry*, 43, 259-274.