Meeting the needs of a culturally diverse nation: An evaluation of a behavioural program adapted to treat Vietnamese Australians experiencing gambling problems

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The effectiveness of cognitive behavioural therapy (CBT) to treat mental health problems is extremely well documented, and CBT is largely regarded as the primary choice of treatment for a wide range of mental illnesses. The relevance of CBT to diverse cultural groups is still being established (Hays, 2014). However, there has been demonstrable interest in exploring the efficacy of CBT with a broader spectrum of cultures, including individuals of Asian ethnicities (Rathod et al., 2015). Problem gambling (PG) is a recognised mental health disorder (American Psychiatric Association, 2013), with well-established treatment interventions. Although aspects of this disorder may be universal across diverse cultural groups, PG may also feature cultural attributes (Raylu & Oei, 2004) that potentially affect the effectiveness of mainstream treatment interventions for these groups. Scant evidence exists of culturally informed interventions to treat this disorder within diverse culturally marginalised groups. Nearly 25% of the Australian population was born overseas (Department of Immigration and Citizenship, 2018), and people of culturally and linguistically diverse (CALD) backgrounds comprise a significant proportion. Thus, it is critical to consider how health services can better meet the needs of a culturally diverse nation through the integration of culturally specific perspectives into evidence-informed practice. This paper will explore the acceptability and effectiveness of CBT to treat PG within the Vietnamese Australian population based on the development and evaluation of a culturally tailored pilot program.

Background

PG is now recognised as a serious health issue in Australia, with an estimated 2–3% of the population directly affected (Social Research Centre, 2013). Individuals presenting with PG commonly experience financial hardship; psychological distress; and relationship, employment and legal problems (Blaszczynski & Nower, 2002). Aside from the devastating consequences for each person experiencing gambling problems, it is estimated that a further seven people connected to that individual are adversely affected (Productivity Commission, 1999). Historically, Vietnamese people have participated in gambling through traditional games using cards and dice or through betting on activities, including cockfighting (Zysk, 2003). It is also evident that the potential harm of gambling has long been recognised by Vietnamese people; traditional sayings identify gambling as the “uncle of sin” or as “one of the four deadly sins”, along with adultery, alcoholism, and drug abuse (Ohtsuka & Ohtsuka, 2010).

Before 1970, few Vietnamese had immigrated to Australia. However, years of civil conflict in Vietnam and the transition to communist rule in 1975 fuelled a mass exodus of Vietnamese seeking refuge in other countries (Ben-Moshe & Pyke, 2012). By the late 1980s, Vietnamese immigrants became Australia’s largest refugee community (Ben-Moshe & Pyke, 2012). At that time, Australia hosted the fourth largest intake of Vietnamese refugees, following the United States, Cambodia, and France. Under communist rule, gambling was ostensibly prohibited in Vietnam, contrasting with more liberal opportunities to gamble in Australia.

The influx of Vietnamese refugees coincided with the rapid expansion of the gambling industry in Australia: the introduction of electronic gaming machines and casinos into most major cities. More than ever before, gambling was exceedingly accessible and attractive to a broader cross-section of the community than prior to these changes (Delfabbro & LeCouteur, 2005). Vietnamese immigrants reported casinos to be a welcoming and non-discriminatory environment and a comfortable place in which to socialise e.g., through the attenuation of language barriers (Chui, 2008; Tran, 1999; Zysk, 2003). The welcoming nature of gaming venues also proved to be an inducement to others migrating to Australia who were experiencing difficulty navigating or integrating into the majority culture (Dickins & Thomas, 2016). Since gambling is a prominent and attractive constituent of Vietnamese Australian culture, it can be reasonably expected that a portion of this community would be directly affected by PG. For example, Delfabbro and King (2012) noted, “not all people who gamble are necessarily able to gamble at a benign level” (p. 1556).

Ample evidence suggests that gambling is common among Vietnamese Australians, and significant concerns exist within this CALD community about the negative impact of PG on people and families (Chui, 2008; Le & Gilding, 2016; Ohtsuka & Ohtsuka, 2010; Tran, 1999; Zysk, 2003). Although CBT has been found the most effective PG treatment, and is typically considered the therapy of choice (Cowlishaw et al., 2012; Smith et al., 2015), not only have national prevalence studies provided little insight into the rates of PG among specific cultural groups but even less is known about such groups' response to treatment (Raylu & Oei, 2004; Stevens & Golebiowska, 2013). Until recent years, studies have been lacking on the use of CBT with individuals of Vietnamese background in general, with only scant literature now emerging. In the absence of specific evidence, the program designers of the current study combined their expertise in the use of CBT and Vietnamese Australian culture to modify therapeutic practices and delivery of treatment to suit the needs of a diverse group. This is an example of how mainstream health services can partner with ethno-specific organisations to deliver a culturally tailored and effective response to a significant health problem.

Barriers to accessing gambling help services

Help-seeking rates for PG are generally low among Australians, with only about 10% of people experiencing PG pursuing formal assistance—despite the availability of free and specialist services in all states and territories (Delfabbro, 2008). Help-seeking is typically the last option following the exhaustion of other self-help strategies adopted by individuals following a crisis. It is realistic to hypothesise that those belonging to ethnically marginalised groups would experience additional barriers in accessing treatment owing to a range of culturally based inhibitors, such as language barriers and unfamiliarity with the use of Western-style treatment or counselling services.

Language barriers hinder people's access to services by precluding awareness (Henderson & Kendall, 2011; Murray & Skull, 2005). This is highly relevant, because adult Vietnamese Australians continue to use Vietnamese as their main language at home and commonly are not proficient in English (Department of Immigration and Citizenship, 2009). Studies of health services usage in Australia and other Western nations indicate that people of Vietnamese background are often unaware of the existence of services or are uncertain about the nature or potential benefits of accessing treatment (Clarke et al., 2007; Duong-Ohtsuka & Ohtsuka, 2001; Phan, 2000; Zysk, 2003).

Like people from other collectivist cultures, individuals of Vietnamese background have no pre-existing concept of counselling or professional therapy, since the family unit is viewed as the main source of support in times of need (Davis, 2000; Jenkins et al., 1996). Personal problems are viewed as a source of shame for the entire family (Tran, 1999; Zysk, 2003); thus, seeking help outside of the family group is not only contrary to cultural traditions but also risks disclosing (shameful) family problems to the family's community. Shame is also the emotional nexus between excessive gambling and greed, with greed viewed as a dishonourable personal attribute according to traditional Vietnamese cultural standards (Jamieson, 1993). Unsurprisingly, shame is commonly cited as a barrier to help-seeking among culturally specific groups. Hence, the absence of a deeper, culturally informed understanding of shame precludes the capacity of services to respond and promote help-seeking to a broad cross-section of the community.

Method

Participants

To aid recruitment into the pilot program, new in-language promotional resources were produced, including brochures, booklets, community presentations, and DVDs. Contrasting with previous recruitment methods consisting of community education on the signs of PG and available support services, a greater emphasis was placed upon explaining and promoting the specialist treatment to the community. This strategic variation was simultaneously effective in recruiting participants to attend the pilot program, while also increasing the recruitment of Vietnamese Australian clients to the mainstream service during the same period. Of the 33 Vietnamese Australian clients registered to receive treatment for PG over a 2-year period (64% men, 36% women, 0% non-binary; M_{age} = 42 years; *SD* = 10.0), 22 attended the pilot program and 11 the mainstream service. In the previous decade, only two Vietnamese Australians had registered with the mainstream treatment service. The decision was made to include the mainstream clients' data as part of the pilot analysis since any differences in treatment mode or process could provide insights into the various aspects that benefited (or hindered) treatment outcomes.

One participant did not grant research consent; consequently, their personal data were excluded. Southern Adelaide Human Research Ethics Committee granted permission to evaluate this program.

Procedure

To devise better prevention and treatment strategies for diverse sub-populations, PG needs to be understood within the relevant cultural context (Okuda et al., 2016; Raylu & Oei, 2004). The partnership between an ethno-specific welfare association and a specialist gambling treatment service is fundamental to building a culturally appropriate response to the Vietnamese Australian community. This partnership spans promotion of help-seeking among people experiencing PG to devising a culturally adapted approach to treatment. The Vietnamese Gambling Help Service has a long history of providing information about PG and counselling support for both individuals experiencing problems with gambling and their families. This cultural expertise–informed treatment forges strong connections with community, thereby aiding the recruitment and support of participants throughout the pilot. Although the partnering specialist gambling treatment service had only limited experience treating Vietnamese Australians, its therapeutic expertise in addressing PG was an essential component in developing CBT-based treatment and providing clinical input to the trial.

Development of the program and its associated resources was overseen by a reference committee comprising Vietnamese Australian health and welfare professionals, gambling support workers from culturally diverse backgrounds, and specialist gambling treatment providers. Both cognitive and behavioural treatment approaches were considered in the early stages of the pilot, with graded cue exposure with response prevention (GERP) being the preferred option, owing to its task-oriented focus. The active nature of the tasks was viewed as appealing to the work ethic of people of Vietnamese background, but also advantageous in reducing the need for lengthy verbal discussions between the therapist and client where language complexities were present. GERP also targets a core feature of PG behaviour: the uncontrollable urge to gamble. This sensation can be of concern for anyone experiencing PG but may be particularly worrisome to people of Vietnamese background because self-control is a highly desired personality trait within Vietnamese culture (Jamieson, 1993; Purnell, 2008).

GERP involves evoking a range of cues used to trigger the desire to gamble. Standard cues may consist of card dealing, listening to gaming venue sounds, or arriving in the carpark of a venue. Recipients are instructed to confront each cue, being mindful of their psychological, emotional, and physical responses to a given stimulus, without attempting to relax or contain their urge to gamble. Cues are presented in order of increasing difficulty, with people repeating each task until each cue no longer arouses a gambling urge. An important aspect of GERP in the treatment of addictions is to prevent relapses that reinforce the unwanted behaviour (Byrne et al., 2019). For an individual with gambling problems, money is an enabler of this behaviour but may also act as a gambling cue. In a randomised controlled trial comparing the use of cognitive therapy with behaviour therapy to treat PG, participants undergoing cue exposure were required to adopt temporary cash restriction measures as a means of relapse prevention during treatment (Smith et al., 2015). The study's intervention schedule indicates that access to money was gradually introduced towards the end of treatment, with progression to independent money management only encouraged once participants had become less reactive to gambling stimuli. Cash restriction has featured in other PG cue exposure treatment regimes (Tavares et al., 2003).

Treatment consisted solely of progressive face-to-face therapy sessions. The treatment team consisted of CBT-trained therapists based at the mainstream service, a Vietnamese-speaking trainee practitioner, and two Vietnamese-speaking social workers. The latter were available to provide language and cultural guidance to the non-Vietnamese-speaking therapists. Over the course of the pilot, the trainee therapist received postgraduate training in CBT. Before commencing work with Vietnamese Australian participants, the trainee consulted people from non-Vietnamese backgrounds to broaden her PG treatment experience, external to the pilot. Throughout the pilot, cultural insights of the trainee contributed to the development and tailoring of the PG resources and treatment manual.

Modifications to treatment

In contemporary psychotherapy, a consensus maintains the benefits of modifying treatment to meet the needs of the client, particularly the idiosyncrasies of their context (Norcross & Wampold, 2011b). Variations to standard treatment protocols were employed during recruitment, screening, assessment, and treatment to improve accommodation of the characteristics of Vietnamese Australian clients. To promote initial client engagement and further continuance, a screening tool was applied in the first session, with the standardised assessment process deferred until subsequent sessions. This allowed people time to think over their decision to participate in treatment or engage in discussion with others before embarking on therapy. During screening, participants were provided with an in-language DVD describing the proposed treatment and key elements of Western-style counselling, including reassurance about confidentiality. A full assessment had normally been completed by the second session, with a set of bilingual measures applied. The assessment tool was adapted to include views on luck in relation to gambling, providing the therapist an opportunity to enquire about culturally specific beliefs and practices involving luck, and to help gauge clients' readiness to make

changes to their gambling behaviour. The Vietnamese support workers played an active role in supporting participants in sessions and were also available to provide case management support or follow-up between sessions. Outreach services were provided, including delivery of treatment in prison settings.

Analysis

A case note audit was conducted with a modified clinical audit checklist to assess treatment outcomes and identify any salient features of treatment affecting subsequent outcomes. The checklist comprised an amalgam of existing clinical checklists devised to guide CBT practice and its application to PG (Abbott et al., 2017; Blagys & Hilsenroth, 2002; Haddock et al., 2012; Moyers et al., 2016; Smith et al., 2015). The program's checklist (Table 1) was further modified to test the fidelity of applying motivational interviewing (MI) techniques. MI is effective in building therapeutic alliance across a range of domains (Miller & Rollnick, 2012; Moyers et al., 2016) and is a standard adjunct to many therapeutic approaches; it is commonly applied in cross-cultural settings and treatment of addictions. The clinical audit checklist was administered by the leading clinician to identify evidence of compliance and non-compliance. Treatment retention is regarded as an important indicator of treatment success; therefore, the case notes were then subdivided into completer and non-completer groups. The case notes were then revisited, one group at a time, generating a new list of observations. Similarities and differences within and between each group were documented.

Table 1. Clinical Audit Checklist for Problem Gambling Behavioural Treatment

Behavioural treatment aspects	
Case conceptualisation	Linking autonomic responses with behaviour, eliciting feedback from client regarding validity and usefulness
Sharing conceptualisation with client	Use of meaningful examples
Eliciting client's experience of urge	Evoking autonomic symptoms, thoughts, and behaviours related to client's gambling
Cash management	Effective plan established with and agreed upon by client
Setting and conduct of exposure tasks	Tasks are appropriate in terms of difficulty and relevance, and agreed upon by client
Key issues addressed	Key issues raised in relation to urge and behaviour
Habituation	Evidence that client can extend learning to spontaneous urges
Use of alternative behavioural techniques	Techniques are appropriately selected and applied, relevant to therapy goals
Motivational aspects	
Cultivating change talk	Eliciting client's motivations for change
Expressing empathy	Understanding or making the effort to understand client's perspective
Collaboration	Acknowledging expertise and wisdom of client while giving information and educating client based on professional expertise. Allowing time to build trust and rapport

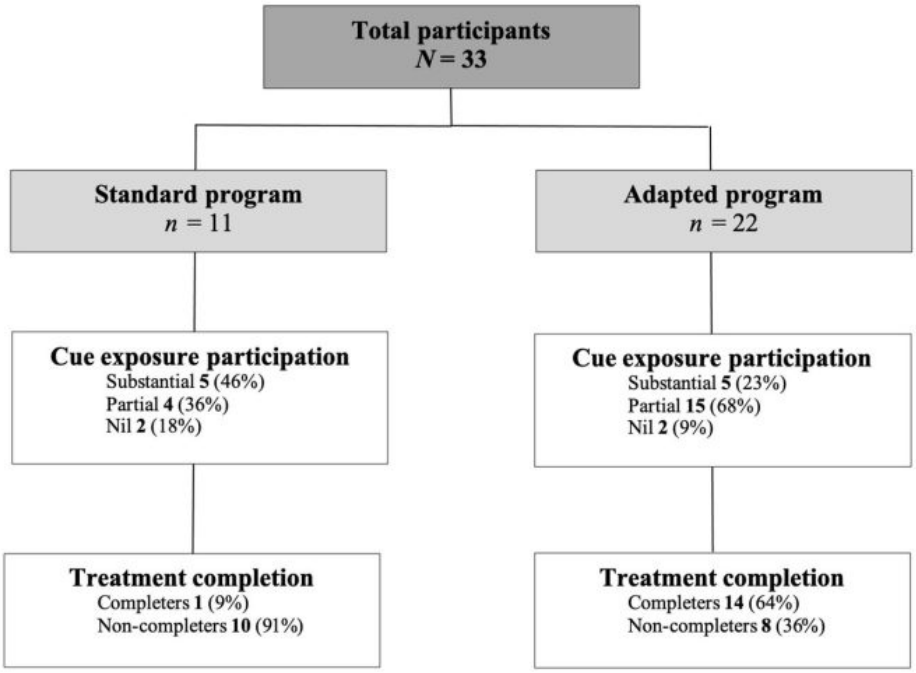
Rolling with resistance	Highlighting client's sense of control, involving client in decision-making. Adapting pace to suit client
Developing discrepancy	Identifying differences between client's goals and values and their current behaviour
Cross-cultural modifications	
Language assistance	Using interpreters or bilingual resources
Proactive support	Implementing active follow-up and contact between treatment sessions, providing outreach
Cultural support	Enlisting cultural guides, developing shared understanding of client's situation from a cultural perspective, tailoring treatment to cultural needs

Results

Two-thirds of the 33 participants attended the culturally adapted program (n = 22, 66.6%), while the remaining 11 clients received standard treatment through various CBT practitioners providing treatment within the standard program. Distinct differences were evident between clients attending the adapted versus the standard program. The adapted program group spoke Vietnamese as their primary language (Fisher's exact, $p < .001$), and were older: adapted, M (SD) = 46.0 (1.93); standard, M (SD) = 34.4 (2.07); $t(31) = 3.74$, $p < .001$. There was no gender disparity (Fisher's exact, $p = .471$). Most adapted program clients' first point of contact was the Vietnamese Gambling Help Service (n = 9; 41%) or they were referred by the Department for Corrections (n = 9; 41%). Other participants were encouraged to attend by family or friends (n = 3; 14%) or a casino (n = 1; 5%). Those registering with the standard program came from more diverse referrers, including health practitioners (n = 3; 27%), other gambling help services (n = 3; 27%), family and friends (n = 2; 9%), and other sources (n = 3; 27%).

Of those participants engaged in treatment, nearly half (45%) completed their therapy. The case note audit revealed three major themes governing treatment completion, namely, engagement in treatment, use of adjunct supports, and the application of MI. Those attending the adapted program were found to have a significantly higher rate of treatment completion relative to the standard program (Fisher's exact, $p = .004$; Figure 1).

Figure 1. Participant Flow and Outcomes



Clients attending the culturally adapted program were as likely to engage in exposure-based therapy as part of their treatment, as were mainstream clients (Fisher's exact, p = .068). Participants in the adapted program attended more sessions (z = 2.44, p = .015), indicating greater treatment retention. The number of sessions attended by people experiencing PG in the adapted program was 76% greater than the number of sessions attended by participants in the mainstream program. To determine gambling status at discharge, case notes were examined in detail, as reported in Table 2. These results illustrate that, at discharge, those attending the adapted treatment program achieved a greater level of resolution to gambling-related problems (Fisher's exact, p = .002), and achieved more of their gambling-associated goals (Fisher's exact, p = .003).

Table 2. ***Treatment Outcomes, Adapted Versus Standard Program (N = 33)***

Gambling status at discharge					**Goal achievement at discharge**				
Program	No change *N* (%)	Not gambling *N* (%)	Reduced gambling *N* (%)	Unknown *N* (%)	Program	No change *N* (%)	Partial achievement *N* (%)	Substantial achievement *N* (%)	Unknown *N* (%)
Adapted	0 (0)	13 (59)	8 (36)	1 (5)	Adapted	0 (0)	9 (41)	12 (54)	1 (5)
Standard	2 (18)	2 (18)	2 (18)	5 (46)	Standard	4 (36)	4 (36)	1 (9)	2 (19)

Discussion

This pilot study sought to explore the outcomes and potential benefits of modifying standardised PG treatment for use with Vietnamese Australians experiencing gambling problems. Results were compared across the culturally adapted and standard PG treatment programs and indicated that the culturally adapted program (i.e., for Vietnamese Australians) was more effective at retaining clients in treatment. In the cue exposure component of treatment, participant engagement was equivalent across the adapted and standard programs. Comparative analysis of case

notes between treatment completers and non-completers provides insight into the barriers to attending therapy by participants. Three main themes were identified in the case note audit: (a) facilitators of treatment engagement, (b) role of adjunct supports, and (c) application of MI, discussed, point-wise, below.

Facilitators of treatment engagement

Case note entries indicated that many participants acknowledged an “uncontrollable” urge to gamble and expressed a keen desire to regain “self-discipline” over gambling behaviour as a primary motivator to participate in the treatment program. The pilot study found that participants more readily engaged in exposure therapy if therapists more carefully explained the rationale underpinning the treatment (i.e., checking participants’ understanding of cue exposure, inviting questions, or attending to participants’ reservations). It was apparent that some participants were not readily convinced that graded cue exposure would be effective in countering their urge to gamble. Hesitancy to engage in exposure tasks could be expected in any person presenting with PG. However, the inability to control psychophysiological arousal as involved in exposure therapy has been found particularly challenging for individuals experiencing gambling problems of Vietnamese background (Barry & Mizrahi, 2005).

The highly structured nature of CBT typically leads to therapist-directed communications (Bennett-Levy et al., 2015), and yet it is evident that patient-centred discussions were particularly valuable for exploring the cultural norms influencing Vietnamese Australians. This was especially the case when addressing the use of avoidant coping styles to manage gambling urges. Self-control is considered exceedingly important in Vietnamese culture (Fry & Nguyen, 1996; Jamieson, 1993); thus, allowing themselves to exhibit heightened emotions in response to a cue is inherently challenging for this population. The capacity to focus on task-stimulated urges appeared to be more impaired in men than in women and may be attributed to the dynamically opposing, enduring forces governing gender roles in Vietnamese culture, where “yin” traits associated with femininity are characterised by “softness” and “yang” traits associated with masculinity are characterised by “strength” (Nguyen, 1985). One man described how difficult it was for him to refrain from controlling the urge, as required by the program for the treatment to be effective. He did finally complete all scheduled exposure tasks, such that he could attend a venue on his own, with large sums of money. However, his tendency to resist the urge recurred each time he started a new task.

A greater emphasis on patient-centred discussions in the culturally adapted program compared with the standard program facilitated participants’ recognition (i.e., open admission in sessions) of the ineffectiveness of avoidance strategies to control their gambling behaviour. In turn, such recognition was associated with a willingness to attempt exposure-based tasks. Importantly, this willingness was apparent regardless of the extent participants were motivated to halt or reduce their gambling and had the added benefit of allowing time for participants to familiarise themselves with the therapist and the treatment expectations. In traditional Vietnamese culture, it is not usual to talk about your problems with others, and emotions are “typically kept to oneself”, at least until problems have reached a crisis threshold. The Western-style counselling model provides an opportunity for individuals of Vietnamese background to “step outside” their own culture and gain benefits that might not otherwise be available to them.

Role of adjunct supports

There was good evidence that social workers with bilingual capabilities were crucial in emboldening participants to engage in treatment. The availability and capacity of social workers to explain and discuss the merits of the therapy in participants’ first language were exceedingly important. As the social workers’ confidence and understanding of the therapy grew, they became “treatment advocates”, providing assistance with language while also addressing participants’ doubts about engaging in exposure-based therapy and, in turn, improving compliance.

Participants who completed treatment received assistance to address a broader range of associated problems. Common issues included homelessness, and medical and legal problems. Assistance simultaneously promoted and undermined engagement with the treatment program. For example, providing extra support helped reduce early withdrawal from the treatment program (increased motivation, resolved associated problems), but the resolution of these immediate problems or needs resulted in failure to progress to treatment of the underlying issue (gambling). Arguably, this is an acceptable risk when designing or delivering programs for difficult-to-engage communities.

Vietnamese Australian individuals with gambling problems have a tendency to request practical assistance first, only later divulging their gambling issue after trust has been established (Chui, 2008; Ohtsuka & Ohtsuka, 2010; Zysk, 2003). One participant made three points of contact with the pilot therapist team before revealing his gambling problem. The decision to offer him housing support afforded the opportunity for the therapist to make sensitive

enquiries about the gambling behaviour. Finally, the participant tearfully recounted his history of gambling and its impact on his life. The therapist's attendance to these practical matters demonstrated caring, which is recognised as an all-important characteristic when building rapport with Vietnamese Australian clients (Nguyen & Bowles, 1998).

Application of motivational interviewing

Treatment completers' case notes indicated that their therapist dedicated time to prompt participants' motivation for making changes, as per MI practices. Therapist–participant discussions acknowledging therapy as challenging also helped build rapport. Resistance was evident among people withdrawing early from the program: common indicators from these participants were reluctance to engage independently with the tasks (outside treatment sessions) or failure to implement cash restriction strategies. When therapists reiterated the cue exposure rationale, rather than leading to an exploration of participants' personal barriers, withdrawal from treatment was the most likely outcome. While mainstream treatment requires a client to commit to cash restriction for the therapy period, in which the financial constraints reduce only towards program completion, such strategies proved quite problematic in this sub-population. Participants who were offered a more moderate cash restriction approach were more likely to maintain therapist contact, and therefore they engaged in the cue exposure tasks, a crucial component for successful outcomes.

Periodically, therapists' case note comments relating to resistance were evident; further exploration implicated cultural nuances. Furthermore, when clients were invited to unpack their reservations about cue exposure treatment in relation to Vietnamese cultural norms, overwhelming guilt and shame were prominent. These culturally linked emotional features governed participants' engagement in exposure therapy. Excessive and undiminished feelings of gambling-related guilt appeared to interfere with participants' ability to concentrate on gambling urges when presented with a gambling cue. Gambling cues appeared to elicit only negative emotions in these cases, which seemed to be linked to memories associated with the impacts of PG on important relationships. These circumstances compelled these participants to undertake cue exposure, perhaps for catharsis or as a form of self-retribution.

It was also evident that only participants in the culturally adapted program voiced their desire to be able to venture more safely into gambling venues to accompany a relative to a venue or take visiting family members from overseas to a casino, while maintaining their personal choice not to gamble. The therapist could then use this aspiration to persuade participants to undertake cue exposure treatment, since this would enable them to visit venues safely in the future.

Therapeutic alliance is regarded as a vital component of treatment outcome (Lambert & Barley, 2001; Meier et al., 2005; Norcross & Wampold, 2011a). Time and flexibility were clearly key to effective therapeutic partnerships and subsequent treatment engagement. Allowing more time in sessions (for dyadic discussions) and being prepared to extend the duration of treatment were important to the therapeutic influence. Longer sessions helped participants of Vietnamese background become familiar with the therapy mode and receive intensive support to complete exposure tasks guided by the therapist. Some participants took longer than the session to complete their tasks but were able to remain in the therapist's room or a neighbouring space to do so, which enabled them to check aspects with the therapist. The treatment was also made available to people in custodial environments. Conspicuously, only participants in the adapted program maintained contact following their release into the community, thereby providing further indication of the greater therapeutic alliance formed within the culturally adapted program.

Case note entries revealed a stark contrast between therapist–client exchanges across the adapted and standard programs: standard program participants were generally less open, and client–therapist discussions were more superficial and stunted. The openness and flexibility demonstrated by the therapists in the culturally adapted program appeared to lead to more open communication between clients and their therapists. This occurred despite the fact that participants attending the adapted program were less proficient in English and less acculturated to mainstream Australian culture. Hence, the adapted program practices appeared to provide a safe space for engagement and self-disclosure for Vietnamese Australians experiencing problems with gambling, which is a remarkable achievement among an infamously reserved cultural group.

Conclusion

This preliminary study explored the modest but strategic efforts undertaken to transform a standard treatment to possess greater relevance and cultural sensitivity to members of an ethnic group, who were otherwise unlikely to seek or receive treatment. The formalisation of this program with a therapist manual and bilingual outcome measures provides a solid foundation from which to test the short- and long-term effectiveness of behavioural treatment for Vietnamese Australian individuals experiencing gambling problems. Future therapeutic directions will focus on the modification of cognitive treatment and the potential for a combination of both.

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