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The Implementation of a Telephone-Delivered Intervention for Asian American Disordered Gamblers: A Pilot Study

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Abstract

This report will discuss the implementation and preliminary results of a community-based telephone-delivered gambling treatment program specifically designed for Asian Americans. The intervention was implemented by the NICOS Chinese Health Coalition, a nonprofit community organization based in Northern California, overseen by the UCLA (University of California, Los Angeles) Gambling Studies Program and the California Office of Problem Gambling, and launched in December 2010. It consisted of six 1-hr long telephone-delivered sessions conducted by a mental health provider using a translated version of the Freedom from Problem Gambling Self-Help Workbook. In the current study, 6 providers completed a 30-hr training program for gambling related disorders. One-hundred and 40 callers inquired about the intervention within the first 6 months of its launch, 19 clients expressed interest in participating, and 8 enrolled into the program. The results show that the majority of clients who enrolled into the program did not report any gambling behavior after baseline and improved on self-reported measures of overall life satisfaction, gambling urges, and self-control. This study suggests that the implementation of this type of intervention is feasible at a small community-based organization and may be effective in treating gambling-related disorders for Asian American populations. The low rate of clientele enrollment is addressed and potential remedies are discussed.

Keywords

Asian Americans; gambling; telephone-delivered interventions; community mental health services; implementation

Although a number of current theories, assessments, and interventions attempt to explain and treat disordered gambling, there is an urgent need for empirically supported interventions specifically tailored to individuals of Asian descent (Loo, Raylu, & Oei, 2008). This report will attempt to address this need by describing the development and utilization of an intervention program for gambling disorders in the Asian American community.

Disordered Gambling

Gambling in the United States is a widespread and socially acceptable activity. Although most U.S. adults gamble without incurring problems, 4% of the population currently has a gambling disorder, and 6% will experience one at some point in their lifetime (Shaffer & Hall, 2002). The *Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition (DSM-IV)* defines *pathological gamblers* as those who gamble despite serious social and

personal consequences and who meet five out of 10 criteria encompassing withdrawal from, tolerance of, and preoccupation with gambling (American Psychiatric Association [APA], 2000). *Problem gamblers*, who are at an increased risk for developing pathological gambling, have less severe gambling issues and meet one to four criteria (Shaffer, Hall, & Vander Bilt, 1999). Experts in the field use the term *disordered gambling* to refer jointly to problem and pathological gambling (Shaffer et al., 1999).

The National Gambling Impact Study Commission has estimated the economic cost of disordered gambling in the United States to be \$5 billion per year (Gerstein et al., 1999). However, recent research suggests that the prevalence of disordered gambling is trending upward (Kessler et al., 2008; Shaffer & Hall, 2002), as the accessibility, affordability, anonymity, and convenience offered by online gambling has increased (Griffiths, 2003) and the casino industry has expanded (Richard, 2010; American Gaming Association, 2012). These values therefore may underestimate the true cost of disordered gambling, in addition to its adverse social, vocational, and personal consequences (Fong, Reid, & Parhami, 2012).

Disordered gambling comes with an array of negative physical and psychological repercussions (Morasco et al., 2006a; Morasco, vom Eigen, & Petry, 2006b; Potenza, Fiellin, Heninger, Rounsaville, & Mazure, 2002). Individuals with disordered gambling incur headaches (Pasternak, Andrew, & Fleming, 1999), cardiovascular problems (Morasco et al., 2006a; Pietrzak, Morasco, Blanco, Grant, & Petry, 2007), physiological stress (Goudriaan, Oosterlaan, de Beurs, & Van den Brink, 2004; Meyer et al., 2000), fatigue (Bergh & Kühnhorn, 1994), and sleep disturbances (Parhami, Siani, Rosenthal, & Fong, 2012a; Parhami et al., 2012b), and they have comorbid psychiatric or substance related disorders (Lorains, Cowlishaw, & Thomas, 2011; Petry, Stinson, & Grant, 2005). Disordered gamblers also utilize more medical services (Morasco et al., 2006a), are at a higher risk for suicidal ideations and attempts (Ledgerwood & Petry, 2004; Petry & Kiluk, 2002), and report a decreased quality of life (Lin et al., 2010). Socially harmful repercussions include a higher incidence of domestic violence, child abuse, divorce (Liao, 2008; Shaw, Forbush, Schlinder, Rosenman, & Black, 2007), arrests, and incarceration (Błaszczynski, McConaghy, & Frankova, 1989; Brown, 1987; Ledgerwood, Weinstock, Morasco, & Petry, 2007) in disordered gamblers as compared with the general public.

Ethnicity and Disordered Gambling

Studies suggest that the rate of gambling-related problems may be higher among certain populations (Binde, 2005; Raylu & Oei, 2004). For example, the 2001–2002 National Epidemiological Survey on Alcohol and Related Conditions found the prevalence of gambling-related disorders to be almost double for African Americans (2.2%), Native Americans (2.3%), and Asian Americans (2.3%), as compared with Caucasians (1.2%) (Alegria et al., 2009). Other studies with smaller convenience samples have demonstrated higher rates of gambling disorders in certain minority groups, including Southeast Asian refugees (Petry, Armentano, Kuoch, Norinth, & Smith, 2003), Iranian Americans (Parhami, Siani, Campos, Rosenthal & Fong, 2012), Australian Aborigines (Wardman, El-Guebaly, & Hodgins, 2001), and Native Americans (Zitzow, 1996).

Culture, or a group's distinct ideas, customs, social behaviors, products, or way of life (OED, 2011), may account for the varying rates of problematic gambling within different ethnic groups, and may even play a role in their preference for gambling activities and susceptibility to develop problems related to particular forms of gambling (Barry, Steinberg, Wu, & Potenza, 2009; Welte, Wieczorek, Barnes, & Tidwell, 2006).

For example, gambling can provide a relatively easy way to achieve financial success for immigrant groups facing financial hardship (Fong et al., 2010). Gambling can also provide a sense of relief and achievement to compensate for the nostalgia one feels for their motherland (Parhami et al., 2012). Furthermore, some immigrant communities may use gambling to cope with the psychosocial stressors related to immigration, such as racism, discrimination, and difficulties with acculturating (Petry et al., 2003; Raylu & Oei, 2004). In addition, children within some cultures may be exposed to gambling at earlier ages at frequent family gatherings (Parhami et al., 2012), thereby increasing the risk for developing gambling disorders (Dickson, Derevensky, & Gupta, 2008; Jacobs, 2000). Culture therefore has an important impact on the management of disordered gambling (Raylu & Oei, 2004). These factors become significant in the clinical assessment and treatment of patients (Alarcón, Westermeyer, Foulks, & Ruiz, 1999; Sue & Sue, 1987), and play an important role in the cultural modification and adaptation of interventions (Benish, Quintana, & Wampold, 2011; Okuda, Balan, Petry, Oquendo, & Blanco, 2009).

Asian Americans, Gambling, and California

In California, over 5.6 million people (i.e., 3.2% of the population), are of Asian descent (United States Census Bureau, 2010). Prevalence estimates for disordered gambling in Asian populations is increasing (Loo et al., 2008), as social gambling is a preferred form of entertainment for many Asian communities worldwide. A recent California gambling prevalence study found that 10.7% of Asian Americans in California displayed a problem with gambling (Volberg & Nysse-Carris, 2006). Additionally, an informal study of 1,808 Chinese American adults in San Francisco identified 21% of the Chinese community as pathological gamblers (NICOS, 1997). This survey also found that 70% of Chinese immigrants identified gambling as a problem in their community, thereby making it the leading social concern for this population.

Several community studies have demonstrated a higher prevalence of disordered gambling among Asian groups, as compared with Whites (e.g., Kim, 2012; Blaszczyński, Huynh, Dumlao & Farrell, 1998; Marshall, Elliot, & Schell, 2007; Loo et al., 2008). Other than the cultural factors noted in the literature (Loo et al., 2008; Raylu & Oei, 2004; Oei & Raylu, 2010), societal factors may also increase vulnerability to develop problematic gambling patterns for this group. For example, some gambling venues create friendly environments for Asian descendents by minimizing cultural or linguistic barriers, and some casinos specifically target this population by placing culture-themed advertisements and marketing strategies within their communities (e.g., free bus transports to the casino from Chinatown; Fong et al., 2010).

Asian Americans and Treatment Utilization for Gambling-Related Disorders

Even though these Asian American communities are generally aware of gambling disorders and their ramifications (Papineau, 2005; Fong et al., 2010; Wong, Leung, & Lau, 2009; Dhillon, Horch, & Hodgins, 2011; Liao, 2008), treatment is not utilized by most (Kim, 2012). This is consistent with emerging literature demonstrating that Asian Americans are less likely to seek mental health and substance abuse treatment services than their community counterparts (Matsuoka, Breaux, & Ryujiin, 1997; Abe-Kim et al., 2007; Sakai, Ho, Shore, Risk, & Price, 2005).

Asian Americans may be hesitant to seek treatment for a variety of reasons. First, there may be a stigma associated with mental disorders, and receiving professional help may be experienced with shame (Dhillon, Horch, & Hodgins, 2011; Kim, 2012). Second, Asian Americans may prefer discussing an adverse situation with people close to them or dealing with it independently, rather than seeking professional help from strangers (Blaszczyński et

al., 1998; Fong & Tsuang, 2007; Kim & Keefe, 2010; Papineau, 2005). Other possible barriers include differences in language and culture between providers and clients, or economic setbacks such as lack of insurance or transportation to treatment (Kang et al., 2010; Fong & Tsuang, 2007; Fong et al., 2010).

Some believe that members of this community who utilize professional treatment do so because they have developed a severe disorder and have exhausted all other paths for help (Fong & Tsuang, 2007; Loo et al., 2008). These gamblers may have hit “rock bottom” (have lost everything including financial assets and social relationships) and are at higher risk for suicide (Fong et al., 2012; Pulford et al., 2009). There is literature to support this belief; in a sample of telephone gambling helpline callers, Asian Americans were significantly more likely to have suicidal tendencies, as compared with Whites (Barry et al., 2009).

Short-Term Interventions for Disordered Gambling

Several empirically supported short-term interventions are available for gambling disorders, including self-help workbooks, brief motivational interviewing (one session), and short-term cognitive-behavioral therapy (eight sessions; Gooding & Tarrier, 2009; Fink et al., 2012). Because the effectiveness of these interventions is comparable (Leung & Cottler, 2009) and low in cost, many are feasible to implement by community organizations with limited funding and workforce.

Telephone-delivered interventions are becoming increasingly popular mode for treating mental health disorders that are not immediately life threatening, especially within community organizations with limited resources (Muller & Yardley, 2011). This type of delivery method is particularly beneficial for clients in hard to reach areas devoid of specialized programs, as well as communities that have a stigma associated with mental health services typical of certain ethnic communities (Hart & Hart, 2010), such as Asian American. Most important, recent literature has demonstrated that these interventions tend to be as effective as traditional therapy, while costing significantly less (Young, 2012; Mistry, 2012).

Current Study

This report will discuss the implementation of a community-based telephone-delivered gambling treatment program specifically designed for Asian Americans. The primary objective of this report is to discuss the development and implementation of this program. The secondary objective is to examine its potential effectiveness in an Asian American community. This report will help other culturally themed intervention programs deal with the limitations and challenges associated with community-based intervention efforts for treating gambling-related disorders; doing so will aid in the development and implementation of optimal treatments for similar populations.

Methods

Setting

The NICOS Chinese Health Coalition, a non-profit organization based in San Francisco, California, oversaw the implementation of this intervention. In 1985, five of the largest health care organizations in Chinatown (North East Medical Services, Independent Practitioners Association at Chinese Hospital, Chinese Hospital, On Lok Senior Health Services, and Self-Help for the Elderly) united to form NICOS. Today, NICOS is a public-private-community partnership of over 30 health and human service organizations. The mission of NICOS is to enhance the health and well-being of San Francisco's Chinese

community through research, training, advocacy, coalition building, and health care program implementation (<http://www.nicoschc.org>). In 2000, the California Office of Problem Gambling (OPG) funded NICOS to launch a toll-free community help-line (1- 888 -968 - 7888) for Asian American communities in California.

Provider Training

Therapists interested in providing this telephone-delivered intervention service for disordered gamblers were required to attend the California Problem Gambling Treatment Services Program (CPGTSP) Provider Training. The UCLA Gambling Studies Program (UGSP), led by author T. F., designed and implemented the CPGTSP Provider Training in collaboration with OPG. The purpose of the training was to educate California mental health practitioners on the effects of problem gambling and train them to treat problem gamblers and their families. Licensed mental health providers (MFT, LCSW, PsyD, PhD, MD, DO) in good standing with active malpractice insurance were eligible to participate in the CPGTSP training.

Experts in the field of gambling disorders conducted the 30-hr training curriculum. Trainees were provided with a comprehensive overview of gambling pathology, including topics such as assessment and evaluation, screening tools, impact/consequences of gambling, motivational interviewing, cultural competency, gamblers anonymous, working with affected individuals, and relapse prevention. In addition to this training, telephone providers received training from author T. F. on utilizing a specific translation of the Freedom from Problem Gambling Self-Help Workbook (<http://problemgambling.securessites.com/ccpgwebsite/help-available/publications.aspx>) as well as delivering telephone therapy.

Telephone-Delivered Intervention

This telephone-delivered intervention for disordered gambling included a native-language translated workbook and guidance from a mental health treatment provider fluent in the client's preferred language. This program was intended to be a weekly intervention with six sessions that are 50 minutes each. After the sixth session, the provider either recommended six more sessions or referred the client to a local mental health practitioner. Providers were urged to review one chapter during each session but were free to decide the relevancy of each chapter to a particular session.

This empirically tested workbook consists of 36 pages and six short chapters intended for individuals with at least an eighth grade reading level (Campos, Rosenthal, Parhami, & Fong, in preparation). The workbook is available in 20 different languages and is accessible online at no cost. The workbook contains sections on the definition of problem gambling (including diagnosis, course, and outcomes), self-assessment tools, relapse prevention techniques, and a list of available resources in California. The workbook used in this program includes several components from different treatment modalities that have demonstrated effectiveness in research, namely motivational enhancement (Hodgins, Currie, & el-Guebaly, 2001), treatment of cognitive distortions (Toneatto & Gunaratne, 2009), and cognitive-behavioral therapy (Petty et al., 2006).

The motivational interviewing technique used in this workbook posits that some individuals with addictive disorders are ambivalent about their addictive behavior and seeks to work through their ambivalence in a nonconfrontational manner, with the intention of increasing the client's motivation for change. The behavioral technique used in the workbook helps the client limit their access to money, making it more difficult to act on the desire to gamble. Cognitive-behavioral approaches address distorted gambling-related thoughts that are presumed to be central to pathological gambling. Finally, relapse prevention tools educate

clients about internal and external triggers for gambling and teach them skills for managing their actions in response to these triggers. Overall, it is designed to help individuals understand how gambling affects their lives and offers strategies to stop or reduce gambling.

Targeted Clients

Individuals with gambling problems who called the NICOS Chinese community helpline were targeted for this intervention. Recruitment for these individuals took place through advertisements in the local media (e.g., ethnic newspapers and magazines, radio and television programs, etc.), community gatherings (e.g., ethnic fairs and events), and information packets distributed to community leaders and organizations (e.g., churches, community centers, etc.). Once the client called the helpline, NICOS assigned them a specific case manager who provided information regarding this program. If the client was interested in receiving this treatment, they were given the following items either by mail or in person: a registration packet which included a consent form to participate in the telephone-delivered treatment, a declaration of clients' rights and responsibilities, the terms and conditions of service, a request to revoke the consent form, and the Freedom from Problem Gambling – Self-Help Workbook (in their preferred language). After delivery of the packet, the case coordinator attempted at least one follow-up call within five business days instructing the client to complete the forms and return them in the prepaid return envelope provided. Upon receipt of signed paperwork, the case coordinator assigned the client to a NICOS provider based on a rotating schedule and the clients' preferred language. Within one business day, NICOS providers contacted the client to begin the intake and treatment process. Clients also received contact information for UGSP and the California OPG to report any concerns or complaints.

Quality Assurance

The UGSP leads periodic quality assurance checks and ongoing supervision to ensure fidelity and completeness of the program. The NICOS providers must submit weekly progress reports to the UGSP, providing their number of intakes, discharges, and active patients. In addition, the UGSP affords two site visits per year to NICOS to review files and client forms, and answer any concerns from providers. Each individual provider is also required to undergo 10 hours of regular supervision from an experienced clinician working in the gambling field.

To assess the effectiveness of treatment, providers collected information using standardized questions during the initial intake process and throughout the course of treatment. Intake forms consisted of demographic questions, inquiries about the clients' gambling behavior (e.g., preferred type of gambling, duration, amount, frequency), and 10 questions corresponding to the *DSM-IV* criteria for pathological gambling. These questions asked about preoccupation, tolerance, withdrawal, loss of control, escape, chasing, lying, illegal acts, and risky relationships as they pertained to gambling (APA, 2000). Current evidence supports using the aggregate number of *DSM-IV* criteria met as a way to classify gambling behavior on a spectrum of severity (Strong & Kahler, 2007; Toce-Gerstein, Gerstein, & Volberg, 2003). In-treatment forms consist of questions regarding gambling behavior and additional questions inquiring about life satisfaction, gambling urges, and self-control with 100-point Likert scales. The UCLA Institutional Review Board for Human Subject Research approved all study procedures.

Results

Program Execution

Execution of the Problem Gambling Telephone Intervention began with provider training in July 2010. Six NICOS providers completed the CPGTSP training and one additional training related to the telephone-delivered adaptation of the language-specific translated workbook. These providers consisted of five women, four licensed Marriage and Family Therapists, a licensed Clinical Psychologist, and a licensed Clinical Social Worker. They had between three and 18 years of experience speaking Cantonese, Mandarin, Teo-Chow, Vietnamese, and Taiwanese. Client enrollment and telephone counseling were initiated after NICOS finalized the program policies and procedures in December 2010.

Client Enrollment

Between December 2010 and June 2011, 140 callers inquired about gambling treatment for themselves or someone close to them. Callers learned about this program through advertisements on culturally themed radio stations (38%), newspapers (22%), Chinese television shows (18%), and through referral (22%) sources such as family members and friends, as well as through the Internet, community agencies, and outreach events. Out of the 140 callers, 19 were interested in participating in the program and eight clients completed the necessary intake forms to enroll. Those who failed to complete the required paperwork and/or respond to telephone calls, or were simply not interested to continue participating in the intervention were removed from the program ($n = 11$).

After an initial intake, clients completed an average (mean, M) of 4.25 out of six possible initial sessions (range = 1–6; standard deviation [SD] = 2.19). Four out of eight disordered gamblers completed six initial sessions after intake, with two clients receiving an extension on their treatment (six extra sessions), as per the providers' discretion. There were an average of 7.63 days between intake and first session for the disordered gamblers and an average of 12.61 days between each treatment session (range = 5–101; SD 17.62; see Table 1).

Client Characteristics

The majority of the eight disordered gamblers (average age = 48 years old, $SD = 6.5$) were male ($n = 7$), reported Chinese ethnicity ($n = 7$), spoke Cantonese ($n = 6$), worked full time ($n = 6$), lived in the San Francisco County ($n = 5$), were referred by family members or friends ($n = 6$), and were currently married ($n = 8$; see Table 2). Disordered gamblers met an average of eight *DSM-IV* criteria for pathological gambling ($SD = 1.4$), gambled an average of 4.13 hours per episode ($SD = 1.6$), averaged \$38,188 losses in the past year ($SD = \$67,108$), and had an average of \$12,562 gambling debt ($SD = \$18,615$; see Table 3).

Outcomes

NICOS did not report any client complaints or problems with their staff or the treatment program. There were no adverse effects reported that may have jeopardized the safety of the disordered gamblers participating in this telephone-delivered intervention. In addition, OPG, UGSP, and NICOS did not receive complaints or concerns regarding the NICOS providers. However, one problem encountered consistently was the clients' unwillingness to complete the consent forms.

With regard to gambling behavior outcomes, five out of eight disordered gamblers did not report any gambling behavior after baseline (see Table 4). Out of the combined 28 treatment sessions completed after the first session, disordered gamblers reported abstinence from gambling 79% of the time ($n = 22$). Using the baseline and last reported score on the

following Likert scales for the eight disordered gamblers, six reported improved scores on overall life satisfaction (two reported a decrease in life satisfaction), six reported decreased gambling urges (one reported no change and one reported increased urges), and six reported more control over gambling (one reported less control and one reported no change; see Table 5).

Discussion

While this telephone-delivered intervention for disordered gamblers was challenging in terms of its utilization by Asian American community members, the present study found that its implementation was feasible and necessary at a small community-based organization. With 140 calls to NICOS Chinese Gambling Helpline in 6 months, this report demonstrates the necessity and demand for intervention services in this community. Moreover, preliminary results revealed that this telephone-delivered intervention was beneficial for the majority of the disordered gamblers. They showed a decrease in gambling behaviors (days gambled, hours gambled per episode, and dollar amount gambled) and improvement in negative associations (lifetime satisfaction, cravings, and self-control). The clients who agreed to participate in this treatment had severe gambling problems (indicated by their number of *DSM-IV* criteria met for pathological gambling), gambled a significant proportion of their stated income, and had incurred a gambling debt. The preliminary benefits of this intervention, along with the popularity of the program and its utilization by severe gamblers warrant the need for its continued support, further funding, and possible inclusion of other Asian American communities.

An important area of improvement for this program involves increasing its client enrollment. Although interest was high among the community, a large number of clients ($n = 121$) declined to participate in this treatment. In hindsight, it would have been beneficial to record clinical demographics and gambling characteristics for the callers who did not enroll. Unfortunately, it was not ethically possible to record data from these callers. The greatest barrier for the utilization of this treatment by interested participants may have been the requirement to complete the necessary consent and information forms. Many immigrants, especially immigrants from Asia, are suspicious of research in general and thus hesitate to release personal information (Chao et al., 2011). In addition, individuals of Asian descent may feel shame when asked to disclose information about their mental health (Shea & Yeh, 2008).

One potential remedy for this low enrollment rate (13.5%) is to minimize the necessary information required at intake and enroll callers who decline to complete the mandatory forms, since telephone-delivered interventions are fairly new and the ethical and legal policies regarding confidentiality and privacy are still emerging (Brenes, Ingram, & Danhauer, 2011). The American Psychological Association and the majority of states do not have such guidelines regarding telephone psychotherapy (Brenes et al., 2011). Nevertheless, client feedback forms may undoubtedly assist with components that are especially important for pilot programs, such as program development and evaluation. Client feedback forms would also help to determine challenges within the program and identify areas that may need improvement to ensure optimal delivery. Research has also demonstrated that therapist–client feedback tools may enhance treatment outcomes (Anker, Duncan, & Sparks, 2009; Harmon et al., 2007; Miller, Duncan, Brown, Sorrell, & Chalk, 2006; Reese, Norsworthy, & Rowlands, 2009).

Another solution for the low enrollment rate may be to have providers, rather than case managers, connect with the interested callers immediately and be held responsible for collecting all necessary forms. This would build an instant relationship and familiarize

clients with their provider earlier, perhaps leading to a stronger therapeutic alliance. Recently, the California Problem Gambling Helpline began to directly connect callers to potential providers during business hours; preliminary analyses have shown a significant increase in initiation of treatment for these callers.

Although retention rates in this study correspond to typical retention rates in gambling treatment research (Grant, Kim, & Kuskowski, 2004), it was expected that a culturally geared treatment would help improve retention (Miller et al., 2006; Okuda et al., 2009; Raylu & Oei, 2004). Research also suggests that individuals receiving a telephone-delivered intervention would be less likely to drop out due to its ease of utilization (Muller & Yardley, 2011). Although both a culturally geared treatment and a telephone-delivered intervention were used in this study, it is surprising that retention rates were not higher for this population. This suggests the need for further exploration of retention among gamblers in treatment.

Notably, the implementation of this intervention at NICOS demonstrates that collaborating on research activities with a community-based organization not focused on research is achievable, and allows for an empirically supported treatment to be delivered and culturally sensitive data to be collected. Four previously discussed important components were enforced to ensure that NICOS had the capacity to launch and maintain this program (Collins, Phields, & Duncan, 2007). First, and most importantly, NICOS's organizational environment, governance, and programmatic infrastructure were necessary to provide the leadership and management of resources to organize this program with minimal cost and labor. Second, UGSP's continued instructive support and OPG's financial support were necessary to train the work-force in delivering optimal care. Third, individual motivational forces and readiness by the NICOS team were necessary to overcome the burdens of conducting an innovative pilot intervention program at an organization with limited resources. Lastly, the quality assurance system, provider supervision, and continued program evaluation were necessary for the advancement of this program.

There are several benefits of administering a telephone-delivered intervention for gambling disorders at a community organization. This may be especially true of an organization knowledgeable and fluent in the clients' cultural values and language; this may have explained the high number of interested callers to the helpline. In addition, these interventions are cost-effective for both the providers and clients (Mistry, 2012). Clients do not have to spend the time and money to receive specialized therapy, and providers can treat a larger geographic area without multiple treatment sites. Also, the clients' concerns about the stigma related to receiving mental health treatment may be reduced because of the privacy with which the telephone therapy sessions are conducted.

Aside from these benefits, there are still some concerns related to telephone-delivered interventions for disordered gamblers, especially within populations that are at increased risk for suicide, such as treatment-seeking gamblers (Battersby, Tolchard, Scurra, & Thomas, 2006). This is partly because providers conducting telephone-delivered interventions do not have control over their client's environment (Young, 2012) and need to be especially mindful of the possibility for suicide. Strict regulations should be developed to deal with such crises, even one that entails excluding clients who express suicidal ideation at intake.

The chief limitation of the current study is the sample size of clients who enrolled into the intervention, rendering it difficult to appropriately examine its effectiveness. Although the recruited number of participants is similar to other published reports of telephone-delivered interventions, this study has a lower rate of enrollment (Muller & Yardley, 2011). Most

other intervention studies include a financial incentive given to clients for their participation and continuation in the study; this possibly introduces a confounding variable when translating the intervention into a community setting, where there is usually no monetary incentive to begin or continue therapy (Halpern, 2011). One particular study found that participation in a telephone-based continuing care program for cocaine dependence was notably higher in clients who received incentives as compared with the nonincentivized clients (67% vs. 39%, $n = 195$) (Van Horn et al., 2011). Recent reports of pilot community interventions have had comparable sample sizes and enrollment rates (e.g., Bonevski, Baker, Laura, Paul, & Bryant, 2012; Bricker, Mann, Marek, Liu, & Peterson, 2010). Thus, as a preliminary study that sought to describe the introduction and facilitation of this pilot program, these results still carry substantial weight. In conclusion, this report demonstrates the feasibility of this telephone-delivered intervention for disordered gambling at a community-based organization geared toward Asian Americans and the challenges associated with its utilization. Continued funding is necessary for this telephone-delivered intervention for Asian American disordered gamblers and special attention is needed to improve enrollment rates more effectively and efficiently.

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Table 1**Number of Days Between Sessions**

	Number of clients	Mean number of days	SD	Minimum	Maximum
Initial intake to first session	8	7.63	8.98	1.00	28.00
First to second session	8	20.63	32.58	7.00	101.00
Second to third session	6	8.00	3.10	5.00	14.00
Third to fourth session	5	11.20	3.83	7.00	14.00
Fourth to fifth session	5	9.80	3.83	7.00	14.00
Fifth to sixth session	4	8.75	3.50	7.00	14.00

Note. Clients completed an average of 4.25 sessions (*SD* 2.19, range 1–6). Overall, there was an average of 12.61 days between each treatment session (*SD* 17.62, range 5–105).

Table 2

Client Demographics

ID	Sex	Age	Ethnicity	Location (county)	Primary language	Education	Employment	Income (\$)	Marital status	Referral source
1	M	52	Chinese	San Francisco	Mandarin	College degree	Unemployed	35k–49k	Married	Family/friend
2	M	51	Chinese	San Francisco	Cantonese	H.S. diploma	Part time	<10k	Married	Helpline
3	M	42	Chinese	San Francisco	Cantonese	Lower than H.S. diploma	Full time	35k–49k	Married	Family/friend
4	M	46	Chinese	San Francisco	Cantonese	H.S. diploma	Full time	25k–34k	Married	Family/friend
5	M	55	Chinese	Orange	Mandarin	Some college	Full time	100k–149k	Married	Family/friend
6	M	52	Chinese	San Francisco	Cantonese	College degree	Full time	75k–99k	Married	Family/friend
7	F	49	Chinese	Los Angeles	Cantonese	Some college	Full time	50k–74k	Married	Family/friend
8	M	38	Chinese	Los Angeles	Cantonese	Lower than H.S. diploma	Full time	35k–49k	Married	Gam-Anon

Table 3

Gambling Characteristics for Disordered Gamblers

ID	Preferred gambling activity	Total gambling debt (\$)	Amount lost in past year (\$)	Average hours gambled per episode	Average amount gambled per episode (\$)	Aggregate DSM-IV PG criteria met
1	Blackjack	50,000	20,000	6	2,000	10
2	Poker	500	3,000	3	150	8
3	Cards	0	5,000	3	400	6
4	Blackjack	0	7,500	3	500	6
5	Sportsbetting	0	200,000	7	75,000	7
6	Sportsbetting	8,000	10,000	3	800	8
7	Blackjack	10,000	10,000	4	1,500	7
8	Poker	32,000	50,000	4	1,000	9
Total						
Average		12,562	38,188	4.13	10,169	7.63
SD		18,615	67,108	1.55	26,203	1.41

Note. DSM-IV criteria: indicate total number criteria met by each client for pathological gambling from the *Diagnostic and Statistical Manual of Mental Disorders – fourth edition* (APA, 2000).

Table 4

Gambling Outcome Measures

ID	Session	Days gambled since last session	Hours gambled per episode	Money gambled per episode (\$)	Total loss since last session (\$)
1	1	—	—	—	—
	2	0	0	0	0
	3	0	0	0	0
2	1	—	—	—	—
	2	0	0	0	0
	3	0	0	0	0
3	1	—	—	—	—
	2	0	0	0	0
	3	0	0	0	0
4	1	—	—	—	—
	2	0	0	0	0
	3	0	0	0	0
5	1	—	—	—	—
	2	0	0	0	0
	3	0	0	0	0
6	1	—	—	—	—
	2	0	0	0	0
	3	0	0	0	0
7	1	—	—	—	—
	2	0	0	0	0
	3	0	0	0	0

ID	Session	Days gambled since last session	Hours gambled per episode	Money gambled per episode	Total loss since last session (\$)
8	2	0	0	0	0
	1	—	—	—	—
	2	3	2	100	300
	3	2	30	50	100
	4	0	0	0	0
	5	2	2	50	100
	6	2	30	50	100

Note. Session numbers are not consistent among clients because some dropped out before completing six sessions.

Table 5

Gambling-Related Measures Based on Session Number Attended by Client

ID	Session number	Overall life satisfaction	Urges to gamble	Self-control
1	1	55	18	85
	2	70	15	85
	3	75	15	85
2	1	50	30	50
	2	40	40	30
	3	10	30	80
	4	50	40	70
	5	50	0	70
	6	50	0	80
3	1	50	70	70
	2	70	40	50
	3	75	40	70
	4	75	35	50
	5	80	35	60
	6	75	30	75
4	1	70	40	60
	2	48	10	85
5	1	45	25	80
	2	45	25	75
	3	55	25	75
	4	55	25	75
	5	15	40	25
6	1	40	50	50
	2	80	50	70
	3	80	50	70
	4	80	40	70
	5	80	40	75
	6	75	50	70
7	1	70	18	55
	2	85	15	85
8	1	50	80	30
	2	40	80	30
	3	65	70	40
	4	75	40	75
	5	70	70	50
	6	75	65	50

Note. Session numbers are not consistent among clients because some dropped out before completing six sessions. Clients reported gambling related measures using 0–100 Likert scales: overall life satisfaction (0 = *absolute worst*, 100 = *best ever*), urges to gamble (0 = *none at all*, 100 = *strongest ever*), and self-control (0 = *no control*, 100 = *complete control*).