ADVERSE CHILDHOOD EXPERIENCES IN THE TREATMENT OF GAMBLING DISORDER: A CLINICAL CASE REPORT APPLYING COGNITIVE BEHAVIORAL THERAPY

Phan Tuan Vu, MD[1]
Vietnam Women's Academy
Phanvu.vmmu@gmail.com

Nguyen Khac Dung, MD, MSc
Mai Huong Day Psychiatric Hospital - Vietnam Women's Academy
Dr.ngkhacdung@gmail.com

Abstract: Gambling disorder is a behavioural addiction associated with serious adverse consequences. Adverse childhood experiences (ACEs) increase the risk of gambling disorder through impaired emotion regulation and maladaptive core beliefs; however, they are rarely integrated into Cognitive Behavioural Therapy (CBT) protocols. This study illustrates the case conceptualization and implementation of an integrated CBT intervention for a client with a history of ACEs. The case involved client. B., a 40-year-old male accountant with recurrent gambling behaviour since adolescence and cumulative gambling debts reaching VND 4 billion. The intervention consisted of 10 sessions (approximately 60 minutes per session), with standardized assessments conducted at Sessions 5 and 10. The case conceptualization identified gambling as a compensatory coping mechanism driven by the core belief, "I am worthless," which had developed in the context of an emotionally unavailable father and a mother who enabled the behaviour through financial support. The intervention comprised four phases: (1) use of the downward arrow technique to identify the client's core belief; (2) Socratic questioning to challenge maladaptive cognitions; (3) cognitive restructuring to develop healthier alternative core beliefs; and (4) family systems intervention to interrupt the cycle of enabling behaviour. Over the course of treatment, the client progressed from limited insight into his disorder to recognising his maladaptive core belief and actively engaging in therapeutic change, while his family committed to discontinuing enabling behaviours. The therapeutic outcome suggests that integrating childhood trauma-informed case conceptualization, core belief restructuring, and family systems intervention into CBT may enhance treatment effectiveness for gambling disorder in individuals with a history of ACEs.

Keywords: *Adverse childhood experiences; cognitive behavioral therapy; core beliefs; family system intervention; gambling disorder*

Code: JHS-339 **Received:** 01st June 2026 **Revised:** 15th June 2026
Accepted: 20th June 2026

1. Introduction

Gambling disorder is defined in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) as a behavioral addiction characterized by persistent and recurrent gambling behavior that leads to clinically significant impairment or distress (American Psychiatric Association, 2013). It is the only behavioral addiction formally recognized in the DSM-5, with an estimated prevalence of approximately 2.4% among adults (Williams et al., 2012) and is associated with

[1] *First author/Corresponding author*

substantial adverse consequences for financial well-being, social relationships, and both mental and physical health (Kessler et al., 2008; Lorains et al., 2011).

Against this background, growing evidence indicates that Adverse Childhood Experiences (ACEs) play an important role in the development of gambling disorder. Since the seminal study by Felitti et al. (1998), ACEs have been defined as potentially traumatic events occurring before the age of 18, including physical, emotional, and sexual abuse, as well as household dysfunction, such as domestic violence, substance misuse by family members, mental illness, parental divorce, and family involvement with the criminal justice system. This framework was subsequently expanded to include poverty, parental gambling, and peer violence (Afifi et al., 2017, 2020a, 2020b).

The association between ACEs and gambling disorder has been consistently demonstrated across numerous large scale studies (Afifi et al., 2010; Black et al., 2012; Bristow et al., 2022; Goodrich et al., 2023; Lane et al., 2016; Lotzin et al., 2018; Moxey et al., 2025; Poole et al., 2017; Richard et al., 2024; Sharma & Sacco, 2015; Tucker et al., 2021). The principle proposed to explain this relationship is emotion dysregulation, whereby gambling serves as a means of avoiding negative emotions rooted in childhood trauma (Moxey et al., 2025; Poole et al., 2017). However, an important clinical gap remains. Although Cognitive Behavioral Therapy (CBT) is currently the most evidence-based treatment for gambling disorder (Okuda et al., 2009; Petry et al., 2006), most existing CBT protocols focus primarily on restructuring cognitive distortions related to probability and stimulus control, while giving limited attention to addressing childhood relational trauma and restructuring maladaptive core beliefs.

This report argues that, unless CBT incorporates interventions targeting childhood relational trauma and restructuring core beliefs about self worth, the risk of relapse is likely to remain high, particularly when the family system continues to enable gambling behavior. The case of client B. was selected to provide a clinical illustration of this argument because it presents multiple characteristic ACEs, a clearly conceptualized psychological mechanism, and a well documented course of CBT treatment.

Building on the clinical gap identified above, this case report pursues three objectives: (1) to examine the relationship between ACEs and the development and maintenance of gambling disorder through a clinical case in the Vietnamese context; (2) to describe and analyze the implementation of an integrated CBT model that combines standard cognitive - behavioral techniques with the restructuring of core beliefs rooted in childhood relational trauma and intervention at the family systems level; and (3) to draw implications for clinical practice and future research on the treatment of gambling disorder in Vietnam. Accordingly, the study addresses two research questions: (i) Through what psychological mechanisms do adverse childhood experiences contribute to the development and maintenance of the client's gambling behavior? and (ii) What changes in the therapeutic process and treatment outcomes result from integrating interventions targeting childhood relational trauma, restructuring core beliefs, and family systems intervention into the CBT protocol?

2. Literature review and theoretical background

2.1. Adverse childhood experiences and gambling disorder

Large scale epidemiological studies have consistently demonstrated an association between ACEs and the risk of gambling disorder. Using data from the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC), Sharma and Sacco (2015) identified significant lifetime associations between physical, sexual, and emotional abuse and gambling disorder. In a study of more than 1,000 parents in Canada, Bristow et al. (2022) found that most ACEs significantly increased the risk of problem gambling, with parental gambling showing the highest adjusted odds ratio (AOR = 3.37). Similarly, Tucker et al. (2021) reported that individuals with three or more ACEs had a 69% higher likelihood of frequent gambling (AOR = 1.69) in a population-based study conducted in Nevada.

Within treatment settings, Moxey et al. (2025), in a study of 195 individuals receiving treatment for gambling disorder in the United Kingdom, found that 81.1% reported at least one ACE and 40.5% reported four or more ACEs, representing a prevalence approximately five times higher than that estimated in the general population and indicating an exceptionally high prevalence of ACEs among clinical populations. Goodrich et al. (2023) likewise confirmed that ACEs increased the risk of problem gambling in a study conducted in New Mexico, with significant odds ratios reported for sexual abuse (OR = 1.64), having an incarcerated family member (OR = 2.08), and childhood maltreatment overall (OR = 1.36). From a developmental perspective, Richard et al. (2024), in a study of 6,314 adolescents aged 10 to 19 years in the United States, found that ACEs increased the risk of problem gambling during adolescence. Child maltreatment exerted a stronger influence than household dysfunction, while externalizing problems served as a mediating mechanism.

2.2. Mediating mechanisms: Emotion dysregulation and core beliefs

Poole et al. (2017) provided empirical evidence that emotion dysregulation mediates the relationship between ACEs and gambling disorder. In a community sample of 414 individuals who engaged in gambling, most categories of ACEs were significantly associated with gambling disorder, and emotion dysregulation

mediated the majority of these associations. Individuals who had experienced three or more types of ACEs were approximately three times more likely to develop gambling disorder. Within this context, gambling may function as an emotion avoidance strategy used to alleviate emotional distress rooted in childhood trauma (Moxey et al., 2025).

Bristow et al. (2022) also found that good mental health generally did not protect against the association between ACEs and gambling severity, suggesting a deeper underlying mechanism involving core beliefs and early-formed cognitive schemas.

The compensatory mechanism is directly relevant to the present case. Kemnitz et al. (2014) proposed that when parents compensate for the absence of time and emotional connection by providing money or material resources, children may develop distorted beliefs about the relationship between money and self worth. Family boundary dysfunction, particularly financial enabling, may further exacerbate the consequences of childhood trauma and contribute to the maintenance of addictive behavior.

2.3. Cognitive Behavioral Therapy for gambling disorder and the intervention gap

Cognitive Behavioral Therapy (CBT) is the psychological treatment with the strongest empirical support for gambling disorder (Okuda et al., 2009). Okuda et al. (2009) described a CBT protocol based on a relapse prevention treatment manual consisting of ten sessions that focused on functional analysis to identify the sequence of triggers, thoughts, emotions, and behaviors; cognitive restructuring of erroneous beliefs about probability and control; development of alternative coping skills; and stimulus control strategies. The clinical case reported by Okuda et al. (2009) illustrated the adaptation of CBT to a specific cultural context, particularly through an indirect approach to culturally and religiously rooted beliefs, rather than confronting such beliefs directly.

In Vietnam, CBT has been formally recognized within the national healthcare system through Decision No. 2531/QĐ-BYT, issued by the Ministry of Health on 8 August 2025, promulgating the professional guideline entitled "Technical Guidelines for Psychiatry, Volume 1" (Ministry of Health, 2025). On page 518 of this guideline, the CBT protocol is described in detail, including its theoretical framework, implementation procedures, therapeutic techniques, and clinical indications. Notably, under this guideline, the indications for CBT extend beyond emotional and anxiety disorders to include behavioral addictions, including gambling disorder (Ministry of Health, 2025), thereby providing an official clinical and regulatory framework for the implementation of CBT in the treatment of gambling disorder in Vietnam.

However, as identified in the research gap, although numerous studies have applied CBT to the treatment of gambling disorder, most have focused primarily on restructuring erroneous beliefs about probability and implementing stimulus control techniques. Based on the literature on ACEs and cognitive schemas, if CBT does not integrate the resolution of childhood relational trauma and the restructuring of core beliefs about self worth, the risk of relapse is likely to remain high, particularly when the family system continues to enable gambling behavior. The clinical case of client B. presented below provides a concrete illustration of this argument.

Approaches to addressing this gap have been more clearly articulated in the recent international literature through two complementary developments that extend conventional CBT. First, trauma informed CBT approaches emphasize the role of early traumatic experiences in the development and maintenance of addictive behaviors. Accordingly, they prioritize establishing psychological safety, processing trauma related emotions, and avoiding direct confrontation with the client's defensive processes during the early stages of therapy. This perspective is consistent with evidence identifying emotion dysregulation as a mediating mechanism linking ACEs to gambling disorder (Moxey et al., 2025; Poole et al., 2017). Second, schema therapy, developed by Young et al. (2003), extends Beck's cognitive model (Beck, 2011) by directly targeting early maladaptive schemas that arise from unmet core emotional needs during childhood, a framework that is particularly well suited to cases of behavioral addiction rooted in core beliefs about low self worth and disconnection. Integrating the principles of these two approaches into the standard CBT protocol for gambling disorder provides the theoretical foundation for the integrated intervention model described in the Methods section and illustrated through the clinical case presented below.

3. Methods

3.1. Study design

This study employed a case report design, a qualitative approach that is well suited to providing a detailed description of case conceptualization, intervention, and treatment outcomes in an individual case. This design was selected because of the nature of the clinical problem, namely the complex interaction among ACEs, core beliefs, and family system dynamics in the development and maintenance of gambling disorder, aspects that are difficult to capture comprehensively in large scale quantitative studies.

3.2. Participants

The participant was client B., a 40-year-old man who received treatment at a clinical psychology clinic. The case was selected according to the following criteria: (1) meeting the diagnostic criteria for gambling disorder as

defined in the DSM-5; (2) having a clearly documented history of characteristic ACEs; (3) agreeing to participate in a structured course of Cognitive Behavioral Therapy (CBT); and (4) providing informed consent for the use of anonymized clinical information for academic purposes. All potentially identifying information was anonymized to ensure confidentiality.

3.3. Data collection

Data were collected using the following methods: (1) semi structured clinical interviews conducted across multiple therapy sessions; (2) assessment of developmental and family history; (3) screening for ACEs based on the conceptual framework proposed by Felitti et al. (1998) and its subsequent extensions (Afifi et al., 2017, 2020a, 2020b); (4) clinical observation of the client's behavior, emotional responses, and interpersonal interactions during and between therapy sessions; and (5) systematic therapy records documenting session content, intervention techniques, and the client's responses to treatment.

3.4. Analytical framework

The study employed an integrated analytical framework comprising three components. First, the ACEs model (Felitti et al., 1998) served as the framework for analysing childhood traumatic experiences. Second, Beck's cognitive model of core beliefs, automatic thoughts, and cognitive schemas provided the framework for conceptualizing the client's psychological structure. Third, the financial–emotional compensation model (Kemnitz et al., 2014) was used to analyse the role of the family system in maintaining gambling behaviour. The intervention followed the standard CBT protocols for gambling disorder developed by Petry et al. (2006) and Okuda et al. (2009), with additional techniques integrated to address core beliefs and incorporate family systems intervention.

3.5. Intervention procedure and outcome measures

The intervention was delivered as individual therapy over ten sessions, each lasting approximately 60 minutes. The intervention was organised into four phases of the integrated CBT model (described in detail in section 4.2): establishing the therapeutic alliance and enhancing illness awareness; identifying and challenging core beliefs; cognitive restructuring; and behavioural intervention together with family systems intervention.

To enhance the transparency and replicability of the intervention process, treatment outcomes were assessed using a standardized battery of instruments administered at three time points to quantify changes in gambling urges, gambling disorder severity, and symptoms of depression, anxiety, and stress. Specifically, at Session 0 (baseline assessment), baseline measures were established by administering all five instruments: the Gambling Urge Scale (GUS), the Gambling Disorder Identification Test (GDIT; Molander et al., 2023), the Patient Health Questionnaire-9 (PHQ-9), the Generalized Anxiety Disorder-7 scale (GAD-7), and the Depression Anxiety Stress Scales-42 (DASS-42). At Session 5 (mid-treatment), the assessment was abbreviated to monitor changes in core gambling behaviour and mood using the GUS and PHQ-9. Finally, at Session 10 (post-treatment), the client completed the full assessment battery again, including the GUS, GDIT, PHQ-9, GAD-7, and DASS-42, to enable quantitative pre- and post-intervention comparisons and comprehensively evaluate the effectiveness of the therapeutic intervention.

4. Results and discussion

4.1. Case presentation

4.1.1. Demographic information and presenting complaints

Client B. was a 40-year-old man (all identifying information has been anonymized to ensure confidentiality). He was employed as an accountant at a public hospital, was married, and had three children (two daughters and one son).

The client presented for treatment after repeated involvement in gambling had resulted in substantial financial debts for his family. Notably, at the initial assessment, he demonstrated little awareness of the severity of his gambling problem or the need for psychological intervention. His attendance at therapy was largely passive and was primarily motivated by pressure from his wife. As he stated, he attended therapy "to make his wife happy" rather than out of intrinsic motivation to change.

4.1.2. History of gambling behaviour

The client's gambling related behaviour began during adolescence and progressed over several developmental stages.

During lower secondary school, he first engaged in betting soft drinks while playing electronic games. During high school, the wagers progressed to cash. At this stage, his motivation was not financial gain but rather the desire to assert himself and derive satisfaction from defeating individuals toward whom he harboured resentment. In his third year at university, he incurred his first substantial gambling debt of approximately VND 30 million. He subsequently deliberately inflated the amount to VND 80 million when informing his mother in order to appropriate the difference and also suspended his university studies during the same year.

Two years later, the client married and opened an electronic gaming business, where he was introduced to poker and began playing it frequently. Three years after his marriage, he informed his mother that he had incurred a second gambling debt of VND 400 million, which was again fully repaid by his mother, despite the fact that he already had his own family. Four years later, during the Covid-19 social distancing period, he expanded his gambling activities to include online gambling and sports

betting. His gambling debt reached approximately VND 4 billion, and this debt was once again fully repaid by his mother.

At the time of referral, the client was on unpaid leave to care for his newborn third child. His current psychological state was characterised by feelings of discouragement and emotional exhaustion resulting from the burden of outstanding debts and persistent harassment from creditors. He expressed a desire to seek a new work environment because of feelings of inferiority associated with his past failures and his fear that contact with former friends might expose him to gambling opportunities and increase the risk of relapse.

4.1.3. Family history and adverse childhood experiences

The client's parents were financially well established but were consistently occupied with work. Throughout his childhood, he experienced a lack of communication and emotional connection within the family, particularly with his father. The client clearly perceived that his father showed affection and closeness only when he achieved outstanding academic results. Outside those occasions, there was little meaningful connection between father and son. Differences in personality further widened the emotional distance between them over time.

This emotional absence was compensated for by excessive material indulgence. Every request made by the client, including those for expensive possessions, was readily fulfilled by his parents. This permissive parenting fostered a habit of inflating the actual value of requested items in order to retain the difference, a behavioural pattern that was later repeated when he reported his gambling debts. This behavioural pattern has continued to the present day because his mother has consistently been willing to accept responsibility for and repay virtually all of his gambling debts immediately, regardless of their amount.

From the perspective of ACEs, the client presented with two prominent categories of ACEs: (1) emotional neglect by his father, reflected in the absence of unconditional emotional connection, with affection being contingent upon academic achievement; and (2) household dysfunction in the form of excessive financial enabling by his mother, creating a family environment lacking healthy boundaries regarding financial responsibility and behaviour.

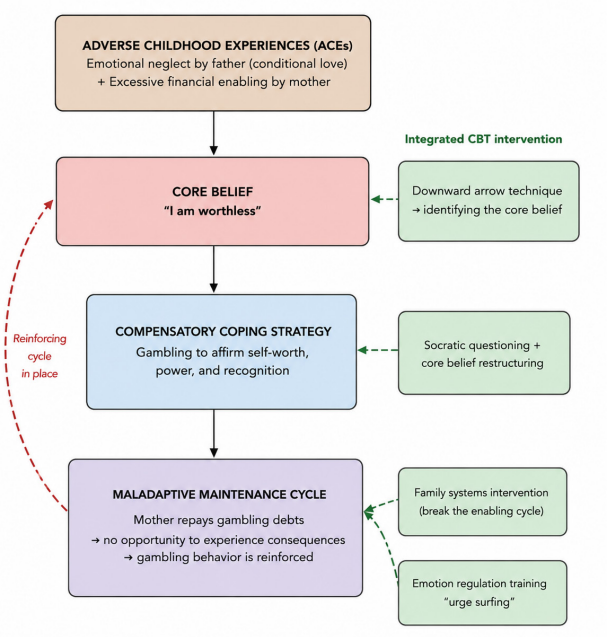
4.1.4. Case conceptualization

The clinical case conceptualization indicated that the client's gambling behaviour did not arise primarily from financial need but rather represented a compensatory coping strategy rooted in a family system characterised by emotional deprivation. Specifically:

The father's emotional absence, combined with a pattern of compensating through material provision, contributed to the development of a maladaptive core belief in the client - that he was not worthy enough for his father to spend time with him - leading money to become "a measure of his self-worth". To counteract his feelings of inferiority, the client developed a compensatory coping strategy characterised by a persistent need to outperform others, to be the best, and to defeat those around him. Gambling became a "stage" that provided an illusory sense of power and temporary validation.

This maladaptive cycle was reinforced by two factors. After each disclosure of his gambling debts, feelings of shame and remorse quickly disappeared because his mother repaid the debts, including the debt of VND 4 billion, thereby preventing him from learning responsibility and from accurately evaluating the real consequences of his gambling behaviour. The relationships among these components are summarised in Figure 1.

Figure 1. Case conceptualization and key components of the integrated CBT intervention



Source: Developed by the Authors

4.2. Cognitive Behavioral Theraby intervention process

4.2.1. Treatment objectives and overall approach

The CBT intervention followed the general framework of standard cognitive - behavioural techniques for the treatment of gambling disorder (Okuda et al., 2009), while integrating additional work on maladaptive core beliefs and the family system based on clinical case conceptualization. The treatment objectives were to enhance the client's awareness of the harmful consequences of gambling behaviour; identify and challenge maladaptive core beliefs related to self worth; develop healthier alternative core beliefs; strengthen emotion regulation and frustration tolerance; and intervene in the family system to disrupt the cycle of enabling.

4.2.2. Phase 1: Bringing core beliefs from outside awareness into conscious awareness

Because the client entered treatment with limited awareness of his gambling problem, having attended therapy primarily at his wife's request, the initial phase focused on using the downward arrow technique to identify the underlying core beliefs beneath his automatic thoughts.

The therapist asked: "What went through your mind at the very moment you decided to place a large bet?" The client replied: "I had to win this hand to show them who I am". The therapist continued: "If you didn't win and couldn't prove yourself, what would be the worst thing that could happen?" The client answered: "Then I'd be a loser, and people would look down on me". The therapist asked further: "And if people looked down on you, what would that mean about you?" The client responded: "It would mean that I'm worthless. Nobody really cares about someone who is worthless".

The final response addressed the client's core beliefs namely, the fear of abandonment and feelings of worthlessness rooted in childhood which were associated with a pattern in which the father showed closeness only when the client achieved success, while money became the primary means of interaction between the client and the family.

4.2.3. Phase 2: Challenging maladaptive core beliefs through Socratic questioning

Once this maladaptive core belief had been identified, the therapist did not challenge it directly but instead used Socratic questioning to help the client recognise the inconsistencies in his own reasoning. The therapist asked: "You said that you gamble to prove your status and maintain control. But when you accumulated a debt of VND 4 billion, were constantly harassed by creditors, and had to rely on your mother to repay your debts, who was actually in control of your life?" and "How long does the pleasure of winning a bet last? How long do the shame and discouragement after admitting your gambling debts last? Is the price of this 'illusion of power' causing you to lose the real authority you have as a father and a husband?".

The objective of this phase was to challenge the client's illusion of control, one of the core cognitive distortions associated with gambling disorder (Okuda et al., 2009), while simultaneously linking it to the deeper maladaptive core belief concerning his self worth. The client was encouraged to recognise that gambling did not conceal his feelings of inferiority but instead reinforced them.

4.2.4. Phase 3: Developing more adaptive core beliefs

Once the client's original maladaptive core belief began to weaken through cognitive work, the third phase focused on developing more adaptive core beliefs. Cognitive restructuring addressed two interrelated issues simultaneously: the client's feelings of inferiority regarding his self worth and his habitual avoidance of responsibility, which had been maintained by his family's enabling behaviour. The client was guided to recognise that self worth is not determined by gambling outcomes or financial wealth but is built through responsibility, honesty, and the ability to stand on one's own without relying on a financial safety net provided by others.

4.2.5. Phase 4: Behavioural intervention and family system intervention

The fourth phase was regarded as an essential condition for achieving sustainable CBT treatment outcomes. The therapist recognised that if the client's mother continued to repay his gambling debts, cognitive changes alone would not be sufficient to maintain the therapeutic gains.

Family system intervention. The therapist conducted several sessions with the client's mother and wife, helping the mother recognise that repaying her son's gambling debts did not represent an act of love but rather an enabling behaviour that perpetuated the maladaptive cycle. The objective was to establish a behavioural commitment to completely discontinue accepting responsibility for and repaying the client's gambling debts.

Exercises to strengthen frustration tolerance. Because the client had developed an expectation of immediate gratification from childhood as a result of an indulgent family environment, a tailored homework assignment was introduced. Whenever he experienced an urge to gamble in order to escape the stress of caring for his infant child, he was instructed to practise urge surfing by remaining with the uncomfortable feelings and recording them in an emotion diary for 30 minutes without accessing any gambling applications.

Confronting responsibility. The client was required to develop his own financial repayment plan or to face pressure from his creditors without seeking financial assistance from his mother. Although this process was emotionally painful in the short term, it provided an opportunity for psychological maturation and for developing a genuine understanding of the consequences of his behaviour.

4.3. Treatment outcomes

4.3.1. Qualitative changes throughout the therapeutic process

At the qualitative level, the therapeutic process demonstrated several notable changes. At the beginning of treatment, the client attended therapy reluctantly, primarily "to please his wife," and showed little awareness of the severity of his gambling problem. Through the application of the downward arrow technique and Socratic questioning, he gradually identified the underlying maladaptive core belief, "I am worthless", that lay beneath his gambling behaviour. He also came to recognise both the illusory nature of the sense of "power" associated with winning and the way in which gambling reinforced, rather than alleviated, his feelings of inferiority. During the later

stages of treatment, the client became increasingly willing to engage in emotion regulation exercises and gradually began to confront his financial responsibilities instead of avoiding them.

At the family system level, the sessions conducted with the client's mother and wife resulted in a critical change. The client's mother came to recognise that repaying his gambling debts constituted an enabling behaviour rather than an expression of parental love, and she committed to discontinuing any future assumption or repayment of his gambling-related debts. This change was regarded as a fundamental condition for maintaining the client's cognitive and behavioural gains following treatment.

4.3.2. Changes in standardized assessment measures

The quantitative assessment results obtained using standardized instruments at Session 0, Session 5, and Session 10 are presented in Table 1. The measures were used to monitor gambling urges and gambling disorder severity (GUS, GDIT), as well as depressive symptoms, anxiety symptoms, and stress (PHQ-9, GAD-7, and DASS-42).

Table 1. Assessment results at Sessions 0, 5, and 10

Assessment measure	Construct assessed	Session 0	Session 5	Session 10
GDIT	Gambling disorder severity	40	–	13
GUS	Gambling urge severity	37	9	6
PHQ-9	Depression severity	12	2	2
GAD-7	Generalized anxiety severity	9	–	0
DASS-42	Depression – Anxiety – Stress	13 – 8 – 15	–	0 – 0 – 0

Source: Data collected by the authors from the clinical records of client B.

The results showed that gambling urge severity (GUS) decreased from 37 at Session 0 to 9 at Session 5 and further declined to 6 at Session 10. From Session 5 onward, measures of mood and anxiety remained within the normal range.. PHQ-9 scores remained stable at 2 at both Session 5 and Session 10, while the GAD-7 score was 0 and the DASS-42 scores were 0-0-0 (Depression-Anxiety-Stress) at Session 10. A GDIT score of 13 at Session 10 reflected the client's level of gambling disorder severity at the completion of treatment. The symbol "–" indicates that the corresponding assessment measure was not administered at that time point.

Monitoring both gambling-specific measures and measures of depression, anxiety, and stress enabled the concurrent evaluation of the core symptoms of gambling disorder and its commonly associated psychological symptoms, thereby providing a comprehensive assessment of the effectiveness of the integrated CBT intervention across multiple domains of the client's psychological functioning.

4.4. Discussion

4.4.1. The significance of ACEs in this clinical case

The clinical case of client B. clearly illustrates the relationship between ACEs and the development of gambling disorder, particularly through ACEs involving emotional neglect and family dysfunction, two categories that have consistently been identified in the literature as being associated with gambling disorder (Black et al., 2012; Bristow et al., 2022; Lane et al., 2016; Lotzin et al., 2018; Poole et al., 2017).

Notably, this case highlights the role of the family from a different perspective. Rather than parental gambling itself, it was the family environment that facilitated the client's gambling behavior from an early age. This finding is consistent with Bristow et al. (2022), who reported that parental gambling had the highest adjusted odds ratio (AOR = 3.37) for problem gambling in adulthood.

This case also illustrates the proposition advanced by Moxey et al. (2025) that gambling functions as an emotion avoidance mechanism. The client's gambling behavior did not arise from financial need, as his family was financially secure, but rather from a desire for recognition and a sense of self-worth rooted in experiences of emotional disconnection during childhood.

4.4.2. The role of core beliefs and the compensatory mechanism

This clinical case extends the mediating mechanism of emotion dysregulation proposed by Poole et al. (2017) by examining the underlying cognitive structure in greater depth. Specifically, it highlights the core belief, "I am worthless," together with a compensatory strategy expressed through behaviors aimed at demonstrating superiority, suggesting that an emotion dysregulation model alone may not be sufficient to explain more complex cases. Consistent with the compensatory mechanism model (Kemnitz et al., 2014), when money became the primary medium of family interaction, the client developed a distorted belief about the relationship

between money and self-worth. This distortion was continually reinforced by his mother's repeated financial rescues, which consistently shielded him from the financial consequences of his gambling behavior.

4.4.3. Clinical implications: toward an integrated CBT approach

This clinical case demonstrates that treating gambling disorder in individuals with a complex history of ACEs requires an integrated CBT approach that goes beyond restructuring cognitive distortions related to probability and stimulus control. Three implications for clinical practice emerge from this case. First, ACEs should be assessed during the initial evaluation to identify the origins of the client's core beliefs and to guide the development of appropriate interventions. This recommendation is consistent with Moxey et al. (2025), who advocated routine ACE screening in gambling treatment. Second, family systems intervention should be considered an essential component of treatment rather than an optional addition. If enabling behaviours within the family are not addressed, cognitive and behavioural changes achieved during therapy are unlikely to be sustained. Third, treatment should adopt a trauma informed approach. Therapists should avoid confronting core beliefs directly during the early stages of therapy and instead use Socratic questioning to help clients discover and re-evaluate their own maladaptive beliefs, as illustrated by Okuda et al. (2009).

4.4.4. Novelty of the study, factors contributing to therapeutic success, and challenges encountered during treatment

Compared with most previous case reports and CBT protocols for gambling disorder, which have focused primarily on restructuring cognitive distortions related to winning probabilities and stimulus control (Okuda et al., 2009; Petry et al., 2006), the present report offers three notable contributions. First, the study places the assessment and treatment of ACEs at the centre of the case conceptualization process rather than viewing gambling as an isolated behaviour that simply requires behavioural control. Second, the intervention model simultaneously targets three interrelated levels: childhood relational trauma, the core belief "I am worthless," and compensatory gambling behaviour. Third, the study identifies family systems intervention, particularly the interruption of financial enabling, as an essential component of the treatment protocol rather than an optional element. This integrated approach differs from the conventional "single-layer" CBT approach and translates the recommendation for routine ACE screening in gambling treatment (Moxey et al., 2025) into an intervention process that may serve as a reference for clinical practice in Vietnam.

Several factors were considered to have contributed to the effectiveness of the intervention. First, the use of the downward arrow technique and Socratic questioning enabled the client who initially lacked intrinsic motivation to identify his own core beliefs rather than having them imposed by the therapist, thereby reducing resistance to therapy. Second, the involvement of the family system, particularly the mother's commitment to stop repaying the client's gambling debts, provided the practical conditions necessary to reinforce behavioural change. Finally, incorporating specific emotion regulation exercises, such as the "urge surfing" technique, equipped the client with an alternative coping strategy during periods of heightened risk of relapse.

The therapeutic process also revealed several challenges. The client's initial motivation for treatment was largely extrinsic, as he attended therapy primarily to please his wife, requiring considerable effort during the early phase to develop insight into his gambling disorder and establish a therapeutic alliance. The expectation of immediate gratification, shaped by an overindulgent family environment, contributed to the client's low frustration tolerance, thereby increasing the risk of relapse when confronted with stress. In addition, modifying the mother's long-established enabling behaviour proved challenging and required sustained therapeutic work with the family system rather than with the client alone.

4.4.5. Study limitations

As a single clinical case report, this study has inherent limitations regarding generalizability. The conclusions are derived from one individual case and therefore cannot be generalized to the broader population of individuals with Gambling Disorder. From a methodological perspective, the study did not include a comparison or control group. Although standardized assessment instruments were employed to monitor treatment outcomes, measurements were collected only at three time points (Sessions 0, 5, and 10), which may not fully capture the continuous progression of symptom change throughout therapy. Moreover, the study did not include a long-term follow-up after treatment completion. Consequently, the durability of the therapeutic effects and the risk of relapse could not be systematically evaluated. In addition, most clinical information was obtained through the client's self-report, which may be subject to recall bias, particularly regarding childhood experiences, as noted in the ACEs literature (Bristow et al., 2022). Finally, although anonymization of identifying information was ethically necessary to protect the client's confidentiality, it inevitably reduced the transparency of certain aspects of the clinical data.

5. Conclusion and recommendations

5.1. Conclusion

This clinical case report presents the case of Client B., an individual with severe gambling disorder and a history of characteristic ACEs, including paternal emotional neglect and maternal financial enabling. The case illustrates a developmental pathway in which early

relational trauma contributed to the formation of a core belief of personal worthlessness, ultimately leading to gambling behavior as a compensatory coping strategy.

The most important conclusion drawn from this case is that effective CBT for gambling disorder in individuals with complex ACEs cannot be limited to restructuring cognitive distortions related to probability estimation or stimulus control alone. To reduce the high risk of relapse, treatment should integrate (1) direct therapeutic work on maladaptive core beliefs rooted in early relational trauma, and (2) intervention targeting the family system that maintains gambling behavior through enabling patterns. This integrated therapeutic approach represents the principal clinical contribution of the present report to the treatment of gambling disorder in Vietnam.

5.2. Recommendations

Clinicians working with individuals with gambling disorder are encouraged to routinely screen for ACEs during the initial assessment, develop integrated Cognitive Behavioral Therapy protocols that incorporate trauma-informed interventions and schema-focused cognitive work, and consistently consider involving key family members in the treatment plan. Future research should conduct randomized controlled trials (RCTs) to compare the effectiveness of traditional CBT with integrated trauma-informed and family-based CBT in the treatment of gambling disorder among individuals with ACE histories in Vietnamese clinical settings.

Ethics statement and Acknowledgements

This clinical case report was conducted in compliance with the ethical principles of research in clinical psychology. This study was approved by the Ethics Committee of Mai Huong Day Psychiatric Hospital (Approval No. 130/BVMH-HĐĐĐ, dated 03 June 2025) and was conducted in accordance with the ethical standards of the Declaration of Helsinki. The authors obtained the client's voluntary informed consent for the use of clinical information for academic and publication purposes; all participants signed a written informed consent form. Participants had the right to withdraw from the interview at any time, and this did not affect their continued access to healthcare services in any way. All potentially identifiable information was coded or altered to ensure the confidentiality of the client's identity and privacy. The Authors declare that there are no conflicts of interest related to the content of this article and would like to express sincere gratitude to Client B. for agreeing to share clinical case information for academic purposes.

REFERENCES

Afifi, T. O., Brownridge, D. A., MacMillan, H., & Sareen, J. (2010). The relationship of gambling to intimate partner violence and child maltreatment in a nationally representative sample. *Journal of Psychiatric Research, 44*(5), 331-337.

Afifi, T. O., Ford, D., Gershoff, E. T., Merrick, M., Grogan-Kaylor, A., Ports, K. A., MacMillan, H. L., Holden, G. W., Taylor, C. A., Lee, S. J., & Bennett, R. P. (2017). Spanking and adult mental health impairment: The case for the designation of spanking as an adverse childhood experience. *Child Abuse & Neglect, 71*(24), 31. https://doi.org/10.1016/j.chiabu.2017.01.014

Afifi, T. O., Salmon, S., Garcés, I., Struck, S., Fortier, J., Taillieu, T., Stewart-Tufescu, A., Asmundson, G. J., Sareen, J., & MacMillan, H. L. (2020a). Confirmatory factor analysis of adverse childhood experiences (ACEs) among a community-based sample of parents and adolescents. *BMC Pediatrics, 20*(1), 1-14. https://doi.org/10.1186/s12887-020-02063-3

Afifi, T. O., Taillieu, T., Salmon, S., Davila, I. G., Stewart-Tufescu, A., Fortier, J., Struck, S., Asmundson, G. J., Sareen, J., & MacMillan, H. L. (2020b). Adverse childhood experiences (ACEs), peer victimization, and substance use among adolescents. *Child Abuse & Neglect, 106*, 104504. https://doi.org/10.1016/j.chiabu.2020.104504

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders: DSM-V* (5th ed.). Arlington.

Beck, J. S. (2011). *Cognitive behavior therapy: Basics and beyond* (2nd ed.). Guilford Press.

Black, D. W., Shaw, M. C., McCormick, B. A., & Allen, J. (2012). Marital status, childhood maltreatment, and family dysfunction: A controlled study of pathological gambling. *Journal of Clinical Psychiatry, 73*(10), 1293-1297. https://doi.org/10.4088/JCP.12m07800

Bristow, L. A., Afifi, T. O., Salmon, S., & Katz, L. Y. (2022). Risky gambling behaviors: Associations with mental health and a history of adverse childhood experiences (ACEs). *Journal of Gambling Studies, 38*(3), 699-716. https://doi.org/10.1007/s10899-021-10040-3

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The adverse childhood experiences (ACE) study. *American Journal of Preventive Medicine, 14*(4), 245-258.

Goodrich, K. M., Trott, A., Rodríguez, M. N., Waller, M., & Lilliott, E. (2023). The impact of adverse childhood experiences on problem gambling in New Mexico. *Journal of Prevention, 44*, 309-324. https://doi.org/10.1007/s10935-023-00725-3

Kemnitz, R., Klontz, B., & Archuleta, K. L. (2014). Financial enmeshment: Untangling the web. *Journal of Financial Therapy, 5*(1). https://doi.org/10.4148/1944-9771.1063

Kessler, R. C., Hwang, I., LaBrie, R., Petukhova, M., Sampson, N. A., Winters, K. C., & Shaffer, H. J. (2008).

The prevalence and correlates of DSM-IV Pathological Gambling in the National Comorbidity Survey Replication. *Psychological Medicine, 38*(9), 1351-1360. https://doi.org/10.1017/S0033291708002900

Kroenke, K., Spitzer, R. L., & Williams, J. B. W. (2001). The PHQ-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine, 16*(9), 606-613. https://doi.org/10.1046/j.1525-1497.2001.016009606.x

Lane, W., Sacco, P., Downton, K., Ludeman, E., Levy, L., & Tracy, J. K. (2016). Child maltreatment and problem gambling: A systematic review. *Child Abuse & Neglect, 58*, 24-38. https://doi.org/10.1016/j.chiabu.2016.06.003

Lorains, F. K., Cowlishaw, S., & Thomas, S. A. (2011). Prevalence of comorbid disorders in problem and pathological gambling: Systematic review and meta-analysis of population surveys. *Addiction, 106*(3), 490-498. https://doi.org/10.1111/j.1360-0443.2010.03300.x

Lotzin, A., Ulas, M., Buth, S., Milin, S., Kalke, J., & Schäfer, I. (2018). Profiles of childhood adversities in pathological gamblers: A latent class analysis. *Addictive Behaviors, 81*, 60-69. https://doi.org/10.1016/j.addbeh.2018.01.031

Lovibond, S. H., & Lovibond, P. F. (1995). *Manual for the Depression Anxiety Stress Scales* (2nd ed.). Psychology Foundation of Australia.

Ministry of Health. (2025). *Decision No. 2531/QĐ-BYT dated August 8, 2025, on the promulgation of the professional guideline Technical Guidelines for Psychiatry, Volume 1*.

Molander, O., Wennberg, P., & Berman, A. H. (2023). The Gambling Disorders Identification Test (GDIT): Psychometric evaluation of a new comprehensive measure for gambling disorder and problem gambling. *Assessment, 30*(1), 225-237. https://doi.org/10.1177/10731911211046045

Moxey, M., Dennie, E., Rossi, R., Sallis, H., & Herbert, A. (2025). Exploring adverse childhood experiences (ACEs) among those seeking treatment for gambling problems: A mixed-methods study. *Addictive Behaviors, 173*, 108535. https://doi.org/10.1016/j.addbeh.2025.108535

Okuda, M., Balán, I., Petry, N. M., Oquendo, M., & Blanco, C. (2009). Cognitive-behavioral therapy for pathological gambling: Cultural considerations. *American Journal of Psychiatry, 166*(12), 1386. https://doi.org/10.1176/appi.ajp.2009.08081235

Petry, N. M., Ammerman, Y., Bohl, J., Doersch, A., Gay, H., Kadden, R., Molina, C., & Steinberg, K. (2006). Cognitive-behavioral therapy for pathological gamblers. *Journal of Consulting and Clinical Psychology, 74*(3), 555-567. https://doi.org/10.1037/0022-006X.74.3.555

Poole, J. C., Kim, H. S., Dobson, K. S., & Hodgins, D. C. (2017). Adverse childhood experiences and disordered gambling: Assessing the mediating role of emotion dysregulation. *Journal of Gambling Studies, 33*(4), 1187-1200. https://doi.org/10.1007/s10899-017-9680-8

Raylu, N., & Oei, T. P. S. (2004). The Gambling Urge Scale: Development, confirmatory factor validation, and psychometric properties. *Psychology of Addictive Behaviors, 18*(2), 100-105. https://doi.org/10.1037/0893-164X.18.2.100

Richard, J., Deng, J., Ivoska, W., & Derevensky, J. (2024). Adverse childhood experiences, problem gambling and disordered gaming: The mediating role of internalizing and externalizing problems among adolescents. *International Journal of Mental Health and Addiction, 22*, 3835-3858. https://doi.org/10.1007/s11469-023-01086-y

Sharma, A., & Sacco, P. (2015). Adverse childhood experiences and gambling: Results from a national survey. *Journal of Social Work Practice in the Addictions, 15*(1), 25-43. https://doi.org/10.1080/1533256X.2015.996502

Spitzer, R. L., Kroenke, K., Williams, J. B. W., & Löwe, B. (2006). A brief measure for assessing generalized anxiety disorder: The GAD-7. *Archives of Internal Medicine, 166*(10), 1092-1097. https://doi.org/10.1001/archinte.166.10.1092

Tucker, W., Garn, J. V., & Yang, W. (2021). Relationship between adverse childhood experiences and gambling in Nevada. *American Journal of Health Behavior, 45*(2), 246-255. https://doi.org/10.5993/AJHB.45.2.5

Williams, R. J., Volberg, R. A., & Stevens, R. M. G. (2012). *The population prevalence of problem gambling: Methodological influences, standardized rates, jurisdictional differences, and worldwide trends*. Report Prepared for the Ontario Problem Gambling Research Centre and the Ontario Ministry of Health and Long Term Care.

Young, J. E., Klosko, J. S., & Weishaar, M. E. (2003). *Schema therapy: A practitioner's guide*. Guilford Press.