Problem gambling and compulsive spending by religious ministers are increasing concerns among religious leaders and mental health professionals who work with religious ministers. Stories abound, but a brief search of the Internet reveals numerous news reports of ministers embezzling anywhere from a few hundred to several million dollars to support their gambling or spending habits.\(^1\),\(^2\),\(^3\) Ministers are human and will forever be subject to human failings such as these; unfortunately, problem gambling and compulsive spending may also bring with them severe negative consequences for faith communities and the mission they serve, and even result in criminal consequences for the individual minister.

In The War of the Gods in Addiction, David Schoen suggests that “the addictive substance, activity, or behavior must ultimately take over complete and total control of the individual psychologically... [and] take control in an inherently destructive and ultimately life-threatening way.”\(^4\) Clearly, he sees the adverse consequences as an integral part of addiction/compulsion. Ultimately, the all-consuming nature of gambling/spending addiction results in the devotion of more and more time just to keep up; good money is thrown after bad. Relationships, career, financial situation, and social standing are destroyed in the bargain.

Research suggests two distinct types of problematic gambling: the action gambler and the escape gambler. Each has its unique developmental path.\(^5\)

Action gamblers are more often male; they tend to be egotistical, controlling, competitive, confident, and persuasive. These negative characteristics are glossed by their social skills and intelligence. They seek out excitement and prefer games of skill such as poker, sports betting, and dice games; betting on the horse races is a classic image. These gamblers often begin in pre-adult years. Their passage through four developmental phases may unfold over decades. In the winning phase, which lasts a few short years, they win more often than they lose; there comes the belief that they are superior gamblers. Time and money spent in gambling activities increases until they eventually begin to lose consistently; the losing phase can persist for five or more years during which action gamblers begin to bet more just to cover their losses. Despair begins to build, commensurate with the growing losses. The desperation phase is evident to the observer: the gambler is no longer in control. This phase may be relatively short or go on for decades. In the all-consuming preoccupation with gambling, there may be concession to the demands of others to enter treatment, but the commitment is superficial. The real boss or loved one is the gambling itself. Finally, action gamblers enter the hopeless phase wherein all that remains is to seek help or die.

Conversely, escape gamblers are more often, but not exclusively, women. Onset is at a much later age, as early as 30 and as late as 80 years of age. These individuals are not generally egotistical or outgoing; rather, they have often been nurturing and caring persons throughout their lives. More deeply, however, they carry the burden of low self-esteem. There may be depression and/or a history of trauma. Escape gamblers enter the gambling world first for the social experience; they begin with friends or family, but become addicted almost at once. In the gambling itself, Continued on Page 2
rather than in the social experience, they find the escape from their emotional difficulties. Escape gamblers are drawn to games of chance such as slot machines and bingo. They, too, pass through four phases, though they do so much quicker than the action gamblers; treatment becomes a desired option as soon as a few months to three years following the time when gambling becomes problematic. The introductory phase is marked by a sense of social acceptance and belonging in the gambling environment; emotional problems and the demanding needs of significant others are kept at bay. In the losing phase, rather than trying to win back their losses, the escape gamblers ignore them and view any winnings as the means to gamble more. Inevitably, however, losses mount and relationships/career suffer from neglect. In the desperation phase, escape gamblers clearly have lost control; gambling is the only relationship of importance. Only in the hopeless phase does the escape gambler, now struggling with suicidal ideation and emotional exhaustion, recognize the need for help.

Compulsive spenders are similar in many respects to the escape gamblers.6, 7, 8 They are typically, but not exclusively, women. Onset ranges from 18 to 30 years of age. Spending/shopping is used primarily as a means of escape from uncomfortable feelings including sadness, anger, anxiety, loneliness, and low self-esteem. The experience provides a temporary rush of excitement, sense control or power, and feeling of happiness. Women typically make numerous small purchases such as clothes, shoes, jewelry, and beauty supplies; men typically make less frequent but more expensive purchases such as electronic, automotive, or hardware products. Unlike gambling, there are no winnings to extend the shopping spree so the individual’s financial situation quickly becomes precarious; credit card balances can be tremendous.

Ministers are not immune from these syndromes; however, the processes of screening, formation and ongoing engagement by leadership provide the opportunity for early identification and resolution of personality traits that are often associated with action gamblers.

There are three categories of risk factors for escape gamblers and spenders, that formation personnel and consulting professionals might recognize and address.9 10

The first risk factor relates to individual vulnerabilities. Candidates or ministers with a history of unresolved traumatic experiences, or faced with a current distressing situation of loss or illness, can be more vulnerable to using gambling or compulsive spending as a means of coping. These histories or current situations will certainly be uncovered in a competent screening process and leaders can assist current members by being aware and involved with their ongoing experiences. If a leader suspects a minister’s coping resources may be overwhelmed by current events, reaching out pastorally and perhaps referring for medical and psychological assistance will help in the development of alternative strategies for emotional regulation.

The second risk factor involves social and environmental dimensions. For instance, gambling may have a strong cultural/historical association if it was often present at family and church gatherings. Likewise, shopping may be associated with fond memories. Thus, gambling or shopping may ease nostalgic emotional pain for some persons; identification of the behavior as a problem is complicated by the early modeling of family and respected others. Additionally, gambling establishments and successful retail stores are built to compensate for the longing for social support and sense of connectedness by providing warm and welcoming environments in which the cares and stress of ministry can be left behind for a time. Religious leaders and communities can make a healthy response to the unhealthy lures by building supportive environments for ministers in which social networks are encouraged and interesting activities are available. When geographical distance makes such connections more difficult, religious leaders can encourage the use of electronic social media to facilitate such interaction.

The third category is behavioral dysregulation. Particularly in an aging population, the impact of medications, illnesses, or brain injuries can contribute to increased impulsivity and decreased self-control and self-awareness, possible precursors to the development of addiction of any type. Religious leaders should be cognizant that if a minister begins to make uncharacteristically poor decisions or judgments or starts taking risks that previously would have been eschewed, medical and mental health professionals should be consulted to assess the problem and assist in the intervention.

For ministers who desire to stop gambling or compulsive spending, the optimal treatment program integrates cognitive-behavioral therapy with the twelve-step model of addiction recovery. With regard to the latter, Gamblers Anonymous or Debtors Anonymous, which follow a twelve-step program similar to that of Alcoholics Anonymous, can be very helpful.10, 11 They address spiritual issues as well as social. The cognitive-behavioral treatment also should infuse the scientifically-based psychotherapy with a willingness to embrace the minister’s inherent spirituality. Therein one finds the opportunity for the minister to reconnect with God, community and the virtues that resurrect meaning and hope. Self-loathing can be put aside in favor of compassion and forgiveness. As Gerald May said in Addiction and Grace (reviewed elsewhere in this issue), “[This] understanding will not deliver us from addiction, but it will … help us appreciate grace where our hope lies.”12
I am considering a weight loss treatment program for one of our community members. The story is familiar: numerous “diets” over the years, initial success to the tune of 20-30 pound weight loss and ultimate failure by regaining all and more of that weight within two years. How can the Program for Psychology and Religion’s weight management program help with this type of “chronic” weight problem?

The key to our approach is the multidisciplinary team. Clients cannot overcome chronic weight management issues with physical means alone; diet and exercise are essential but not sufficient. At SLBMI we treat the mind, body, and spirit as one. We begin with an assessment to determine the root of the problem. Does it stem back to poor childhood eating habits? Is food being used to self-soothe hurts associated with traumatic life experience? Does the person have poor stress management and/or coping skills? Clients must identify and understand the cause of their unhealthy eating behavior before they can effectively work toward personal healing and positive behavior change.

The multidisciplinary evaluation consists of psychiatric, psychological, spiritual, physiological and medical elements. The results are presented and processed before treatment goals are planned. The resulting treatments are precise and focused, but when we treat the “parts” we keep in mind the “whole” person. Communication among all professionals and the client is at the heart of ongoing assessment and adaptation of treatment.

Although intensive treatment may last up to six months, plans for continued growth after treatment are just as critical. The skills developed during the intensive period of treatment must be maintained day by day over the long haul to prevent a relapse to old, poor, eating and exercise habits. As a community leader, you play a very important role in arranging for monitoring and supportive feedback. We are here as well; monthly phone consultation and periodic “renewal weeks” are available.

I am truly amazed and grateful for the positive changes we see in clients who enter this program. Of course, the reduction in risk for medical disease is the result many clients and community leaders notice most, but we also bask in the positive changes in personal confidence, spiritual trust and energy for ministry. I hope you will give it a try!

If you have any more questions, please call Dr. Christopher Grimes at 314-289-9407.

In his short life of sixty-five years, Dr. Gerald May contributed mightily. He was a teacher; as an integral member of the faculty of the Shalem Institute in Bethesda, Maryland he accompanied many along the spiritual path. He influenced medicine, spirituality and psychiatry through his many articles and books, which continue to be widely taught and referenced.

Although the present book is not a fast read, it is an intriguing look into his understanding of the essence of addiction. Particularly important is his insight into the relationship of attachment and addiction. To understand that relationship is to begin the path of spiritual awareness and recovery.

Expanding on this foundation, May argues that we all are addicted to something—alcohol, food, relationships, work, gambling, responsibility, sex, performance, perfection, to name a few—because we all struggle with attachment to transient things.

We are attached because we long “for God and for love,” but seek to fill this longing with the tangible. The tangible soothes but does not satisfy and therefore “limits the freedom of human desire.” Once begun, it is difficult to stop. The consequences are many, but include depression, anxiety and even sickness.

Yet, the emptiness, even the addiction itself, once recognized and accepted, can become doorways through which the power of grace can enter our lives.

This book is an excellent spiritual reader for anyone who is struggling with addiction but is trying to believe in and surrender to the power of grace. It is just as powerful for those who seek in their ministry to understand and accompany others on that journey.
From the Director’s Desk

Have you ever wondered why we selected such a lengthy name for our program? I mean, really “The Program for Psychology and Religion at St. Louis Behavioral Medicine Institute” is quite a mouthful, but it carries significant meaning. When we say proudly that the Program for Psychology and Religion is part of the Saint Louis Behavioral Medicine Institute, we base that assertion on the fact that we are an academic affiliate of Saint Louis University and that in addition to treatment we provide academic training for advanced students. In this issue, we are proud to introduce the Psychology and Religion post-doctoral resident, Dr. Theta Gribbins, and her insightful article on the troubling and complicated syndromes of compulsive gambling and spending. You will find there much about the dynamics of these syndromes and the most effective methods of addressing them in treatment. I trust you’ll find her insights and suggestions helpful.

In the last edition of the UpDate, I wrote about our ongoing effort to keep fresh our understanding of the needs of ministers and to adapt our educational and treatment programs to meet those needs. The recently completed needs assessment survey of religious leaders was most interesting.

Perhaps the most urgent need expressed was for briefer and less expensive treatment programs, with the option to use insurance to cover some of the cost. In response to that need, I am pleased to announce that the Program for Psychology and Religion is now offering an intensive outpatient therapy service, which is covered by most insurance plans, for ministers who are suffering from depression or anxiety disorders. This means that clergy and religious who are suffering from depression and/or anxiety and meet insurance criteria for intensive outpatient therapy can be enrolled in a treatment program that will be covered by insurance, while at the same time remaining confident that the treating clinicians understand the dynamics of religious life and ministry and remain able to offer integrative treatment that addresses spiritual as well as medical and psychological dimensions of the whole person.

Please look for a brochure explaining this covered treatment option to arrive in your mail within the next few weeks. It will explain how this focused treatment option adds yet another dimension to the services offered by the Program for Psychology and Religion and make clear how it complements the current six-month intensive program that is geared toward growth and transformation.

In the meantime, as always, if you have any questions about the new treatment option or about any issue addressed in this newsletter, or if you would just like to talk over a behavioral or medical issue, give me a call. I will be glad to hear from you and I will put you in touch with the member of our team who can best answer your question.

Warm Regards,

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