A 50-year-old single man came into the therapist's office for a first session. The therapist looked at the man, noticing his shaking hands and downcast eyes. He also couldn't help but observe that he was immaculately dressed in an Armani jacket—easily worth $1,500. The therapist was impressed. It was way more than he could afford, but he felt a twinge of pride that he would even recognize Armani when he saw it.

"Ronald" introduced himself with a rather shaky voice. Every time his hands moved, the therapist could hear the jangling of a gold bracelet attached to a very expensive watch. The therapist took all this in, still surprised to see such an affluent, successful client in this clinic that generally served working-class people who could only afford to pay on a sliding scale.

"I hate to tell you," Ronald began, "but I feel a bit humiliated to be coming to a place like this." He gestured with his arms to take in a sweep of the

Marilyn Montgomery and David Shepard contributed equally to this chapter.

"Ronald" and other case examples in this chapter are composites of clinical cases of the authors. All identifying information has been changed to preserve individual anonymity.
building. “But I just cannot afford to pay for a therapist in private practice right now.” Ronald pulled down the sleeve of his cashmere jacket and adjusted the crease on his worsted wool slacks.

The therapist felt a sting but quickly righted himself by making the clinical observation that the client was devaluing him. Already a diagnosis was beginning to form—the symptoms, the expensive jacket and watch, the negative transference—all pointed to a narcissistic man suffering from an agitated depression, probably caused by the loss of some external support that shored up a fundamentally weak sense of self-worth.

The man’s story confirmed the therapist’s speculations. Ronald had grown up with few material pleasures; his father was a mediocre physical education teacher, forcing the family to move from town to town as his alcoholism continually got him fired. His mother was a sour, bitter woman, preferring to complain about her husband’s ineffectualness rather than leave the marriage. Ronald’s description of his childhood was succinct: “I hated it.” Determined to transcend his unhappy beginnings, Ronald had become a successful real estate broker, ultimately selling houses to the wealthiest clientele in the community. As the local housing market boomed, Ronald had luxuriated in the trappings of success. Ronald’s eyes lit up as he told how his house was once photographed for *Architectural Digest* and as he described his collection of vintage Cadillacs. The therapeutic alliance was solidified once the therapist slipped in the fact that he, like Ronald, knew the value of a 1978 El Dorado.

Ronald then related how everything had collapsed. The housing market had gone bad and his spouse had left him. He had lost his house and all but one of his cars. The worst of it, Ronald told the therapist, was his reaction to all of this—the sense of impending doom, the inability to stop his hands from shaking, and the feeling of humiliation so intense that he became afraid to socialize with any of his friends.

The therapist was aware of his uncharitable feeling of satisfaction that Ronald probably now had less net worth than he did. And for all his devaluing of therapy and the humiliation of being at a mental health clinic, Ronald needed him. Feeling confident and a little bit powerful, the therapist devised and proceeded with his treatment plan: (a) address the anxiety through cognitive–behavioral interventions, (b) explore the childhood roots of Ronald’s low self-worth, and (c) support him in taking steps to reduce his social isolation. Within a few months, Ronald’s mood improved significantly and his agitation abated. He returned to his normal activities.

“You’re a wonderful counselor,” Ronald told the therapist enthusiastically, “and you’ve helped me really understand myself.” On that happy note, therapy ended.

About a month later, the therapist received a desperate call from Ronald. “Everything was going great. Couldn’t be better. I even bought another El Dorado. It’s a car you’d love, too. But then the IRS caught up with me. I don’t
want to tell you how much I owe. And I'm being sued. I did some things that
I shouldn't have done, but I needed the money. I owe a lot. I'm in big trouble.
I want to see you, but I have to tell you . . . I'm basically broke."

What stunned the therapist the most was the realization that he had
never thought to ask Ronald concrete questions about how much debt he
owed or whether he could pay his taxes. The therapist had done a thorough
job assessing Ronald's mental status, but he had completely ignored his finan-
cial status. No wonder Ronald was agitated and depressed! His compulsive
acquisition habits had brought him to the brink of bankruptcy and the IRS
was breathing down his neck. The therapist had failed Ronald in some impor-
tant ways, even though he believed he was doing solid therapy and using
interventions grounded in theory and research data.

The therapy had been a "Band-aid" and had ultimately failed for a num-
ber of reasons. First, by focusing on Ronald's psychological distress and its
probable familial derivations, the therapist neglected the true root of the
client's problems: his desire to acquire status and expensive belongings so
much so that his financial, and therefore emotional, health was imperiled.
Second, the therapist's countertransference issues around acquisitive desire
(AD) had blocked him from engaging in a conversation with Ronald about
the personal costs of his compulsion to purchase status-enhancing luxuries.
Because the therapist had not resolved his own shame about working in a low-
fee clinic, he avoided the pain of talking about the things Ronald had that he
himself could not afford. The therapist envied his client too much. Also, the
therapist liked the fact that Ronald saw him as someone able to appreciate the
finer things, and he did not want to interfere with their communal basking in
the glow of knowing the value of an Armani jacket or a vintage car.

Ronald's case is an illustration of a psychological disorder that may be
termed acquisitive desire (AD; Kottler, 1999). Like substance-abuse and eat-
ing disorders, problems of AD represent a multifaceted cluster of enduring
cognitive, behavioral, and social factors that are linked with other symptoms
such as anxiety, depression, and impulsivity. Although AD is not strictly a
discrete condition that manifests itself in a single way, AD disorders have in
common an intense desire to acquire, possess, or hoard objects. We see AD
as an overarching construct that may include features such as compulsive
shopping, hoarding, greed, purchasing or collecting objects, and the neurotic
pursuit of possessions. A final symptom of AD is the common phenomenon
of clients regarding their therapist as a personal possession.

ACQUISITIVE DESIRE IN THE LIVES OF CLIENTS
AND THEIR THERAPISTS

Because AD often appears with symptoms of other disorders, therapists
may treat the other symptoms (e.g., Ronald's depression and narcissism)
without connecting the symptoms to the underlying, long-term hold that AD has in the lives of clients. Assessment and diagnosis of AD problems are often complicated because of the different processes and meanings involved in the various so-called ADs. For some people, AD is “self-medication” for depression or anxiety; for others, it is a symbol of success or status; it can also be a manifestation of obsessive-compulsive disorder. When the therapist is not aware of the ways that symptoms can be indications of a deeper AD, the treatment may not be as successful as it could be.

Another factor to consider is that we therapists live in the same material world as our clients. We are exposed to the same advertising, the same attractive shops in our local malls, and the same alluring cars in our neighbors’ driveways. We feel the same pressures to be successful and to own the same symbols of this success. For some of us, it may be an expensive car, jacket, or watch; for others, it may be a particular university diploma or office address. In academia, many of us may “collect” acquisitions such as grants or publications in prestigious journals. We feel the same needs to compete with our colleagues, the same desire for symbols of success. We therapists thus have our own issues with acquisition, and these can impair our ability to interpret the meaning and consequences of AD in the lives of our clients.

The purpose of this chapter is to provide clinicians with a roadmap for recognizing and treating all types of AD, using clinical examples from our own practices. We also address countertransference issues therapists face because of their own ADs.

**RESEARCH ON AD DISORDERS**

What motivates people to consume? Is this a universal (and normal) psychological drive? If so, why do some people cross the line between a healthy desire to be materially comfortable and an unhealthy preoccupation or compulsion to acquire? What processes or states are associated with AD getting out of hand? Are the various manifestations of AD distinct from one another in ways that might have implications for treatment?

**Recognizing Acquisition-Related Disorders**

During the Great Depression (another time when the material world was strongly in focus), some writers for a British medical journal sought to understand the psychological processes underlying desires for property and motivations for possessiveness (Ginsberg, Isaacs, Marshall, & Suttie, 1935). Their explanations for why people consume included the following, summarizing the psychological thinking of the time: (a) Acquisition is a way of assuaging social anxiety; (b) acquisition represents a desire for security and
status gained by having more than one's neighbors; (c) acquisitive tendencies result when self-assertive tendencies are weak; and (d) the desire for an object rarely represents a desire for the object itself, but rather is a symbolic triangulation between the object, the person desiring it, and a hoped-for effect on another person.

Despite this auspicious presentation of a number of hypotheses that could have provided the springboard for further study, psychological attention to AD waned to virtually nothing until fairly recently. Perhaps this is because the decades of affluence that ensued (the 1950s, 1960s, 1980s, and 1990s) convinced psychologists that chasing after possessions was so common as to be unremarkable goal-directed behavior (Csikszentmihalyi, 1999, 2000). Congruent with this thinking, an area of psychology termed consumer psychology has grown over the last decade, investigating various aspects of people's purchasing behaviors and experiences. From this body of work comes the idea that people purchase many objects out of a measurable "need for uniqueness"—a kind of counter-conformity motivation that varies in strength across individuals (Tian & McKenzie, 2001). These studies offer insights into how people shop for, and why they value, their prized possessions, but generally do not draw attention to the dysfunctional aspects of the desire to consume and acquire. Indeed, research on the various dysfunctional forms of AD, and its treatment, is sparse (though see chap. 10, this volume).

Impulse Control

Many forms of AD, and certainly compulsive buying, appear to be closely related to impulse-control disorders. People with impulse-control disorders display three characteristics: (a) they cannot resist an impulse to do something, even though they think it may be harmful to themselves or others; (b) they experience a rising sense of tension (often described as "restlessness," "anxiety," or "pressure") that becomes unbearable as they contemplate the deed; and (c) they experience a strong sense of relief, satisfaction, or gratification as they give in and commit the act. The aftermath may or may not include remorse, guilt, and regret (Maxmen & Ward, 1995). Often, people with an impulse-control disorder have (or have family histories of) mood disorders and substance-abuse disorders (McElroy, Hudson, Harrison, Keck, & Aizley, 1992). Kleptomania is an impulse-control disorder with some features in common with AD, but it is distinct in that it involves the theft of things that are meaningless and without value to the thief after they are acquired.

The aspects of AD that appear to be related to impulse control are not clearly distinguishable from some compulsive, AD-related disorders. For example, Faber and colleagues have developed a program of research on identifying (but not treating) compulsive buying (see chap. 10, this volume).
They sought to identify the attitudes and behaviors (O'Guinn & Faber, 1989) as well as demographic profiles and psychiatric co-morbidities (Christenson, Faber, de Zwaan, & Raymond, 1994) of the compulsive buyer, and they developed a clinical screener for compulsive buying (Faber & O'Guinn, 1992). The typical compulsive buyer, according to this research, is a midlife female who began compulsive buying in late adolescence and whose buying usually results in adverse psychosocial consequences. When compared to matched controls, compulsive buyers have a higher lifetime prevalence of anxiety, substance use, and eating disorders, and they are more depressed, anxious, and compulsive. Additionally, 96% of their compulsive buyers described buying behaviors that resembled an impulse-control disorder (Christenson et al., 1994).

Compulsive gambling is another example of an acquisition-related impulse-control disorder. Whereas compulsive buyers are typically women, male compulsive gamblers outnumber women 2 to 1 (Volberg & Steadman, 1988). Compulsive gambling conjures up images of a haggard desperado unable to leave a smoke-filled casino, but the Diagnostic and Statistical Manual of Mental Disorders (4th ed.; DSM-IV-TR; American Psychiatric Association, 2000) criteria also capture the socially acceptable gambling of the wheelers and dealers who get involved in business scams, as seen in the following case:

He had been in for a few weeks with his wife for couples therapy, and it was one of those cases that never seems to get off the ground. They presented as an attractive, well-groomed couple—the kind you might envy—with the usual communication troubles about money and stepchildren and perhaps some sub-clinical levels of anxiety and depression. After a few weeks, they "no showed" and never came back or returned follow-up phone calls. About a year later, his picture was on the front page of the newspaper; the story headline read, "Money at the core of lifestyle that led to jail, charge of attempted murder." The story depicted the shock of all who knew him as a kind and wonderful man, an active parent in the PTA who, beneath the surface, was caught in a web of financial dealings and property acquisitions that had gradually become more and more illegal. "It was greed," confessed one of his business partners of their fast-and-loose business dealings, "we all went in on greed." The authorities got involved when the man and his wife got into a more vehement argument than usual and he knocked her unconscious. "They argued over money," reported the detective assigned to the case.

This case illustrates how compulsions and impulse-control problems can exist concurrently. In addition to a compulsive acquisition style reminiscent of compulsive gambling, several failures of impulse control are evident, including the physical aggression that came to characterize the couple's conflicts. The differential etiology and phenomenology of poor impulse control and impulse-driven compulsions directed toward acquisition are, as yet, poorly understood.
Obsessive Compulsions

AD sometimes manifests itself as an anxiety-related compulsion. Many compulsive buyers (67%) describe a phenomenology of buying that also closely resembles obsessive–compulsive disorder (Christenson et al., 1994). Obsessive–compulsive behavior differs from impulse-control disorders in that with compulsions, the actual act is ego-dystonic and the person does not get relief by following through with the urge to acquire. These individuals know that their behavior is inappropriate, but they feel helpless to stop it. Compulsive hoarding is the disorder that best fits this category. Compulsive hoarders, unlike avid collectors, have trouble discarding objects that they recognize as worthless, such as old newspapers or mail (Frost & Hartl, 1996). They recognize that their cluttered living spaces interfere with their lives and often their social goals, but they feel helpless to alter their acquisitive patterns. Recent research has revealed that compulsive hoarders often experience depression and anxiety, and they experience social and familial impairment, much more so than with other anxiety or obsessive–compulsive disorders (Frost & Hartl, 1996).

Existential Identity Problems

The “existential crisis” that seems to characterize some clients with AD probably best fits the DSM-IV-TR category of identity problem, which falls under the unceremonious distinction of “other conditions that may be a focus of clinical attention” (American Psychiatric Association, 2000, p. 731). Affluent, consumer-oriented societies such as ours insist that people distinguish themselves with self-made identities (Erikson, 1956/1980). Optimally, young people emerge into adulthood with a sense of personal identity that includes “a sense of psychosocial well-being” and “a feeling of being at home in one’s body, a sense of ‘knowing where one is going,’ and an inner assuredness of anticipated recognition from those who count” (Erikson, 1956/1980, pp. 127–128). However, when society is diverse, diffuse, and rapidly changing, it is easier for some “emergent adults” to sort out the coming-of-age question of “who am I” with an answer of “I am what I own” (Arnett, 2000). Currently, there are many social influences that discourage traditional, thoughtful, or moral approaches to answering the existential questions of life and instead encourage quick-fix, postmodern, material answers (Côté, 2000). Under these circumstances, wrote Josselson (1994):

identity then tends to be phrased not in terms of what the individual will stand for, be faithful to, or try to become or generate in the world, but instead what the individual will purchase. For such young people, the burning issues are those of consumption: for example, which are the best stereo speakers? (p. 23)
By midlife, most adults find that these kinds of answers to life’s questions have begun to wear very thin. However, individuals who have spent their early adulthood “shopping for identity” may not have developed inner resources for discovering and constructing a life that represents a commitment to the core values of one’s self.

Narcissism and Greed

A final type of disorder associated with AD is narcissistic personality disorder. Newspaper tabloids revel in publishing splashy stories about the bank president who was discovered to have a gold-plated toilet installed in his private chambers, paid for with bilked investors’ funds, or about the school superintendent who was discovered to require a leased island condo for “business meetings.” Sensational and far-fetched as these stories may seem, they are about real individuals whose neurotic greed has gotten so far out of hand that they get caught. When forced to seek help, they are usually diagnosed with a narcissistic personality disorder, which is characterized by self-aggrandizement paired with extreme reactivity to failure (Rodewalt & Morf, 1998).

People with narcissistic personalities often develop lifestyles of grandiosity. Material culture offers many opportunities for people to express grandiosity and to solicit admiration through the use of possessions. Many highly successful people display personality traits that could seem narcissistic. However, narcissistic personality disorder is indicated only when competitive acquisition of the biggest and best house, car, office, suit, laptop, or boat is accompanied by excessive pride, disdain for others, and by an insistence on admiring attention. When preoccupation with success becomes inflexible and maladaptive and causes impairment—in other words, when the individual crosses the line between living with an impressive, sweeping style and living exploitatively—then AD-related narcissism is considered a psychological disorder (American Psychiatric Association, 2000).

PRELIMINARY ASSESSMENT AND DIAGNOSIS

Because American culture tends to deny problems related to ADs, clinicians tend to misidentify AD problems and misconstrue the role they play in other disorders (e.g., mood disorders). Clinicians who want to be effective in this area must make a conscious decision to assess clients’ psychosocial well-being in the area of acquisition and possessions.

Before asking any specific questions, the therapist can listen for acquisition-related themes as clients describe the circumstances that brought them to therapy. For example, clients with impulse-related acquisitive disorders often come to therapy because they are overwhelmed with problems in many
areas of life such as work, career, and family, similar to clients with substance abuse. Clients with anxiety-related acquisitive disorders such as compulsive hoarding or collecting usually reveal other impairments in social and familial areas of life. Clients with narcissistic greed may reveal an exploitative or manipulative style, as well as jealousy and competitiveness, without even realizing the social inappropriateness of their boastfulness. Clients with a narcissistic sense of entitlement may speak with disdain for others, use score-keeping metaphors, mention social isolation, reveal a concern with impression management, or talk about their lack of satisfaction despite their success. Any of these patterns suggest working hypotheses for a therapist to explore in more depth after an initial assessment is made and rapport has been established (Kottler, 1999).

Even when an AD disorder is not immediately suspected, it is helpful to ask routine, concrete questions about money and possessions in the initial clinical assessment. It is also useful to inquire about clients' cognitions, behaviors, and affect related to possessions and to follow up with concrete questions about clients' vague allusions to problems with money or possessions. Because clients, like therapists, experience shame and ambivalence about their possession-related behavior, they may initially cloak acquisition problems by talking about their other concerns.

In one case where the client presented with typical "midlife crisis" issues, the therapist extensively discussed with the client the life goals he regretted not reaching and his hopes and plans to begin bettering himself. It was only when the client and therapist stood up to conclude the intake session that the former said, "Oh, by the way, sometimes I have a hard time getting rid of things, and that's probably affecting why I'm having trouble selling the house." The therapist laughed sympathetically, "Sure, a lot of us have that problem." "No, I mean I really have trouble letting go, like letting the water out the bathtub. You never know when you might need it, you know?"

The therapist realized that she had missed something big. To avoid similar clinical faux pas, we suggest therapists ask their clients specific questions, such as the following: What are some of your prized possessions; when and how did you acquire them; how do you go about finding things that you might want to buy; how do you feel when you are able to buy something you've wanted for a long time; what do you do with possessions you no longer need; who owes you money; to whom do you owe money?

Honest answers to these questions depend on the initial rapport established, and many clients require a more firmly established therapeutic alliance before disclosing their deepest concerns about acquisition and possessions. Nevertheless, the answers to these questions in the intake and the manner in which the client reacts to these questions may suggest possible problems and areas for future exploration.
After the therapist suspects that AD in one of its forms is operating in the client's life, the second step is to determine the degree to which this is true and how entrenched the problem is in the person's symptomatology and life context. A few additional questions can be used to determine the degree of a client's emotional attachment to his or her possessions (Belk, 1992). These might include the following: do you have strong feelings about [object or acquisition activity]; can something else be substituted for [the object or acquisition activity]; could you sell the object for its fair market value or quit the acquisition activity?

The therapist may want to note what happens when negotiating the fee and requesting payment for the session. A sudden excuse such as "Oh! I forgot my checkbook! Gosh, can I pay you next week?" or a sheepish request for you to hold the check a few days before cashing it is probably more than a coincidence and may offer a good bridge into discussing specifics about a clients' financial debt structure in the next meeting. Long-time therapeutic wisdom indicates that what happens in the session is a reflection of the client's life in the "real world," and the business of paying for sessions is no exception.

It is important for therapists to recognize that the desire to acquire, in and of itself, is not a disorder or evidence of some emotional problem; indeed, the process of shopping and collecting can be satisfying and meaningful without being a compulsion. Likewise, there is an undeniable pleasure in owning objects, for their intrinsic beauty or utilitarian value, or as a reflection of one's identity and accomplishments. The decision about whether AD is a problem must depend on the same criteria that therapists use to assess the mental health impact of any behavior (Kottler, 1999): It diminishes quality of life; it interferes with reaching important goals; it acts as a distraction from close personal relationships or as a substitute for intimacy; it results in other negative consequences, either overt or subtle; it is excessive and out of balance with other life priorities; there is diminished impulse control; and owning or pursuing this object or these objects creates significant suffering.

TREATMENT REGIMEN

After thorough and comprehensive assessment procedures are undertaken to identify issues related to AD, the next step is to plan a treatment program that addresses the multifaceted and multidimensional nature of these problems. Kottler and Stevens (1999) have developed a general treatment plan for most forms of AD disorders. The plan is flexible and can be adapted to deal with the specific features of the AD problem, be it anxiety, compulsion, narcissism, or neurotic greed. The following sections outline the steps that we find helpful in the treatment of AD. After the therapist and client have established a firm collaborative therapeutic relationship, the steps can be followed in any order that suits the individual case.
Establish a Solid Therapeutic Relationship

Regardless of the therapist’s theoretical orientation, the treatment of AD begins with developing a strong working alliance. Because issues surrounding AD can be threatening to the client's core identity, it is important to find a therapeutic stance that enhances the comfort level of the client and engages him or her in the treatment process. For example, with highly successful and wealthy clients, the therapist may want to adopt a businesslike, consultant-type relationship because it is a collaborative, credible style familiar to these clients.

Frank had formed an investment banking company in the mid-1990s, had sold his company before the market nose-dived, and now found himself with more money than he could spend in a lifetime. Reaching 40, he still wanted the one thing that had eluded him—a lasting intimate relationship, leading to marriage and children. In the first session, Frank was quite specific about what he wanted out of therapy: “I know my problem,” he asserted in a calm, confident voice. “I have a fear of abandonment, resulting from my mother’s going back to work when I was two. So I abandon women before they abandon me. I have to break this pattern. But since I’ve figured this much out already, I’m thinking we can have this solved in a couple of weeks, right?”

The therapist felt the urge to say something like, “Well, from my experience, this kind of problem may take longer than a few weeks,” but she also knew that challenging Frank’s need to be in control might drive him from therapy. Instead, she praised Frank for his insightful self-analysis, took out a notebook, and worked out with him a sequential treatment plan, as though they were creating a strategic plan for starting a business. As they went through each step of the therapeutic process, Frank could immediately see, on paper, that treatment might require at least several months, and he was comfortable with the plan. He also appreciated the therapist’s willingness to grapple with his deeper issues early in treatment. “It felt like we were rolling up our sleeves and getting down to business.”

Understand the Cultural Context of the Behavior

It is important to explore with the client the socialization processes that influence the role of acquisitions in the client’s life. Clients begin to hear messages about the value of acquisitions from early childhood, and advertising, peer pressures, family traditions, and cultural-ethnic beliefs reinforce these messages (see chap. 2, this volume). Helping clients understand how these messages impact their ADs can help them to see these desires as learned values that can therefore be unlearned.

Katherine grew up in Britain, to parents with an aristocratic lineage but, secretly, cash-poor. Her parents devoted their lives to maintaining the façade of wealth and remaining accepted in exclusive society circles.

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Katherine internalized the value that the appearance of wealth was critical to self-worth. As an adult, Katherine continually bought haute couture dresses well beyond her financial means. In therapy, she explored her family’s long tradition of connecting outward appearance with internal dignity and ultimately recognized that she did not need to uphold this destructive family legacy.

Explore Unfinished Business

Regardless of theoretical orientation, it may be necessary to explore “unfinished business” with the client, including traumas, deprivations, and other childhood wounds. Acquisitions may be a means of self-soothing or a substitution for love and attention not received in earlier life. Muensterberger (1994) suggested that many collectors have suffered emotional or physical trauma in early life; the objects they collect provide a solace for the lingering pain from these experiences or a vehicle to help cope with unfulfilled needs and longings.

Attachment issues are also implicated in A.D. Riddy (2000) conducted a qualitative study of 27 British self-reported addictive shoppers. She found that about half reported major trauma during childhood that involved a disruption of the mother–child bond, such as the mother leaving home, suffering from depression, or being hospitalized for extended periods.

Fiona Murray is a self-described shopping addict who eloquently wrote about how a legacy of family emotional deprivations influenced her adult addictive behavior (Murray, 2000). Murray’s grandmother died when her mother was born, and “It was inevitable that my mother, without the nurture and connectedness with her mother, was emotionally unavailable to me” (p. 222). As she grew up, Murray’s mother repeated the pattern of leaving home for several days at a time, and upon returning, would give her daughter presents:

My mother seemed to be saying, “I love you. Forgive me.” . . . Throughout my adult life I would seek reparation for myself in the form of alcohol or shopping whenever I felt hurt, isolated or abandoned. I also understand why I once felt compelled to buy others presents when I felt that I had displeased or hurt them. I was looking for absolution in the same way that my mother had once sought it from me. . . . I experienced the euphoria of shopping at the early age of eight or nine for it represented one of the few occasions where I was the recipient of some meaningful female attention, even if it was only the sales assistant fussing over me. (p. 223)

Explore the Family System

The notion that the family may inadvertently “enable” the behavior of one of its members in order to maintain system homeostasis is useful in treating the shopping or collecting addict. Riddy (2000) described a hypothetical
example of a “feedback loop” wherein a husband and wife support each other’s addictive behaviors. An alcoholic husband, rather than facing his own problem, scapegoats his wife. She turns to shopping as an escape from the husband’s blame, distancing herself further from the family, which causes the children to misbehave. The husband responds by drinking more and putting more blame on his wife, who, in turn, increases her shopping. An actual example can be illustrated by a case from our clinical work.

Susan and Roger came for couples counseling in order to break their cycle of fighting. In the session, Susan nastily denigrated Roger’s acquisitive behaviors and attacked his “shallow materialism,” which she claimed to abhor. Susan was starting a business and feared that Roger’s need for “toys” like big-screen TVs and high-end sound systems placed impossible demands on her to succeed. Roger argued that she was making him so miserable that he had to have “the best of everything” in order to feel better about his life. At one point he exclaimed, “You say you hate what I buy, but you sure seem to enjoy watching that TV!” As the therapy progressed, it became clear that Susan was unconsciously supporting Roger’s purchasing habits despite her constant attacks. Her barrage of criticisms enabled her to have impressive things without feeling personally responsible for their excessive spending. When the therapist helped Susan to see the part she was playing in the system, she stopped attacking Roger, who, in turn, stopped spending more than they could afford.

Unearth the Cognitive Patterns and Narratives Related to the Behavior

For some clients, using cognitive and narrative therapy interventions can expose underlying dysfunctional beliefs as well as external messages that influence the client’s AIDs. For example, one woman was told by her parents when she was a little girl that her birth was an unwanted “accident.” She developed the core belief, “I am worthless” and interpreted most of the negative experiences in her life as confirmation of this. As an adult, she became an obsessive collector of expensive antiques in a futile struggle to bolster her self-esteem. The therapist helped the client see how buying valuable antiques served to counteract her maladaptive assumption that she had no value as a person.

Find Leverage to Secure a Commitment to Change

Because some AD problems are functionally similar to addictions, techniques used in treating addictive disorders can be borrowed and applied to these problems. Exploring with clients the consequences and functional uses of symptoms can increase their motivation for change. Miller and Rollnick (1991) have described an interactive process that is effective for helping clients with tenacious addictive disorders to explore both their desire for change and their ambivalence about making changes. Specifically, they advocate the use of ques-
tions to invite clients to describe the origins and course of problem development and their broader life circumstances. By listening nonjudgmentally and highlighting both the positive and negative aspects of the client’s problem, a therapist can elicit self-motivational statements from clients. The therapist can affirm, reinforce, and reflect back to clients their self-statements that function as arguments for change, such as problem recognition, expressions of concern, intentions to change, and expressions of optimism. Follow-up questions directed to clients can help to secure a commitment to change and subsequently to direct the focus to short- and long-term goals. These strategies, used skillfully by the therapist, often immediately increase client motivation to change (Miller & Rollnick, 1991; Rollnick, 1998).

Suzanne’s compulsive shopping habit engaged her emotionally like nothing else in her life did. She was overweight and lonely, and longed for companionship that she could rarely find. Despite daily resolutions to attend exercise class and meet people at community activities, Suzanne found herself in the mall after work, seeking solace by impulsively buying hot fudge sundaes and small trinkets for herself and her home. Although she felt better when doing these things, and when bringing home and unwrapping her new purchases, by the next morning she felt guilty, weak, and determined not to give in to herself again. Suzanne’s therapist used questions to highlight the decisional balance that Suzanne weighed out every day, and gently persisted until Suzanne could articulate for herself how her self-indulgent shopping was working against her larger hopes and dreams for herself.

Deal With Guilt and Shame Issues

We have discovered that when clients do alter their acquisitive patterns, residual feelings of shame and guilt often surface. Recent research lends some support to our clinical experiences. In Riddy’s (2000) study, all but three of the 27 addictive shoppers interviewed described feelings of self-disgust, guilt, and depression shortly after making a purchase. In Elliott’s (2000) qualitative study, using a sample of 50 British addictive shoppers, all the participants reported feelings of guilt and remorse after the shopping experience, including a desire to keep their purchases a secret from others. Additionally, we have found that some clients experience shame and guilt when they become aware of how their behaviors may have adversely affected their intimate partners and families.

Fill the Void That May Be Left

For some clients, the pursuit of material goals can provide a sense of purpose and focus to their lives. Stopping the acquisitive behaviors can remove the sense of direction around which they have organized their daily existence (see chap. 6, this volume.) For others, buying can be a distraction from exis-
potential guilt, the painful awareness of not living up to one's potential. Therefore, the therapist may want to find ways to help clients fill the void that will be left when the buying patterns stop; otherwise, clients may resort to previous acquisitive patterns to ward off emerging feelings of internal disorganization and meaninglessness. Ideally, the period when clients begin to face this void can be an opportunity to explore with them issues of personal meaning and values around which a more existentially satisfying life can be constructed. The therapist may also want to use this stage of treatment to explore the possibility of living a voluntarily simple lifestyle, perhaps based on spiritual rather than materialistic values.

Andres came to therapy because of a depression he attributed to his failure as a novelist. The therapist soon discovered that Andres easily spent 8 hours a day buying and selling Beatles paraphernalia on an Internet auction site. His closets were overflowing with album covers and John Lennon dolls. The therapist assumed that if she could get Andres to stop his collecting addiction, he would immediately channel his energies into his writing career. Shamed by her interpretation of his collecting as a defense against taking responsibility for his writing ambitions, Andres sold off his entire collection within a week. Without the shopping distraction, or some other means of organizing his daily life, Andres sat immobilized at his computer, experiencing in full-force the terror that he lacked the talent to write. Andres's depression worsened until the therapist realized that Andres needed some other sense of purpose while they addressed the underlying meanings of his writer's block. She suggested that Andres spend no more than an hour a day at his computer and that he instead focus the bulk of his time on cleaning out his garage and transforming it into a home-office. With this new structure to his daily life, Andres's mood brightened and he regained the ego strength necessary to examine in therapy his underlying fears.

Explore Fears of Failure and Intimacy

Our experience suggests that the fear of failure and the concern about intimacy frequently underlie self-destructive acquisitive behaviors. The case of Andres is an example of a client who avoided the shame of failure by engaging in nonstop collecting. Indeed, Andres's success at bargaining on eBay enabled him to cope with his otherwise intolerable feelings of inadequacy as a professional writer. Another client, married to an emotionally detached computer engineer, bought shoes to assuage her feelings of emptiness in a relationship devoid of genuine intimacy.

When core issues are addressed and resolved, buying or collecting patterns do not necessarily come to a complete halt. Rather, the nature of the acquisitive behavior shifts from being compulsion or impulse driven to being a pleasurable, choice-based activity and a pursuit that no longer impairs important areas of functioning.
Envision a Different Future

A critical treatment step is to explore what the client's life will look like when acquisitive behaviors are changed. The object of such an exercise is to help clients feel empowered enough to feel that they have choices about how they act in the future.

Anne was a compulsive shopper who was also neglecting to pay off her considerable school loans for college. Her situation had reached the point where she was receiving a weekly threatening letter demanding that she pay her debts or have her wages garnished. She went to work each day wracked by the fear that her employer would inevitably discover her addiction and fire her. Sadly, she responded to her ensuing stress by shopping even more. Anne's therapist suggested they do a guided visualization in which she imagined receiving a letter from the loan agency with a large "0" in the balance column. Anne then saw herself working productively at her job, secure in the knowledge that she would be able to keep all of her earnings. The visualization concluded with Anne walking into her favorite store, perusing an aisle of goods she could afford, and buying a single item with an ensuing feeling of pride.

Structure Ongoing Support

Part of a comprehensive treatment approach is to check to see what forms of affiliation may have been neglected as the client's problems with AD become more acute and what kinds of support systems are in place to help the client maintain the treatment goals of individual therapy. If necessary, the therapist may work on re-connecting the client with family, friends, or other forms of affiliation. As with other addictions, if the client's social networks reinforced his or her self-destructive behaviors, the therapist should help the client separate from these groups and develop more healthy means of support. For some clients, 12-Step programs may be helpful. For others, the demand that they stop all addictive behaviors may be an intolerable pressure in our consumer-oriented, materialistic world. We have found that referring clients to their community's Consumer Credit Counseling Service may help them get their financial lives in order, although this cannot address the underlying disorder.

THERAPEUTIC COUNTERTRANSFERENCE WITH ACQUISITIVE DESIRE

A number of countertransference issues arise when working with AD. Perhaps the most common is envy. As therapists, we may believe that we have somehow transcended ADs and that we adhere to the more enlightened
values we would like to reach to our clients. However, most of us are fooling ourselves. We want success, approval, wealth, and comfort as much as most upwardly mobile middle-class Americans.

Consequently, feelings of envy and jealousy are natural, perhaps inevitable, when we work with wealthy clients. We may even find ourselves resenting our wealthy clients, belittling them in our minds as shallow and superficial. By resenting them we may be denying our distaste for the parts of ourselves that wish we could live like our wealthy clients do.

One way we may defend against our feelings of envy is to reinforce our wealthy clients' mistaken assumptions that we are as wealthy as they are. Because our wealthy clients are paying us high fees, they may assume that we have the kind of incomes they do, not realizing that no therapist gets rich from private practice alone. Many therapists can recall incidents when they indulged in a little passive impression management about their wealth. One therapist recalled a session where a wealthy client told her he had seen her driving a BMW, like his. “I did not disabuse him of the notion, telling myself I did not want to impede exploration of his fantasies or the development of a positive transference. But these were rationalizations of the fact that I wanted him to think I owned a BMW.” Another therapist recalled this story: “A client told of her vacation plans. It just so happened that she and her boyfriend were choosing between two very swanky resorts at the same time my husband and I had just booked reservations at one of those places. I self-disclosed that I had stayed at one of her choices—clearly, to make myself look like I was on her financial and worldly level.” Yet another therapist confessed, “I find myself thinking, ‘It’s a good thing I have an office in a high-rent part of town, so my wealthy clients will think I’m as financially successful as they are.’” She justified her expensive leather couch as a business expense, but admitted that there was something gratifying in being perceived, even mistakenly, as “one of them.” By creating impressions but not bringing up “money talk” as part of the therapeutic agenda, therapists may be complicit in creating an unhelpful setting where they pretend to be above mundane financial considerations, even though such considerations may be crucial to the case.

In fact, any conversation about money or possessions can stir up unpleasant feelings for the therapist. If we feel we have not put enough money away for retirement, it stings when a client tells us that she will retire at age 45. If we are fighting with our spouse about how much to spend on a new house or car, we may feel guilty when offering advice to a couple struggling with their own financial issues. If our caseload is dropping, it does not feel very good to listen to clients talk about their success. To the degree that we measure our self-worth according to our financial achievements, working with wealthy or successful clients is bound to stir up feelings of shame and inadequacy. We believe that, just as therapists are trained to think about issues of gender, race, and so on and how their stance on these variables influ-
ences their therapy, similar training is necessary to address the therapists' awareness of their own issues concerning money, social class, and materialism.

Personal Values and Nonjudgmental Acceptance

As much as we have been trained to remain nonjudgmental of our clients, holding this stance can be particularly difficult with clients whose ADs seem obviously self-destructive or destructive to others. We may feel the urge to exhort our clients to “stop buying things you cannot afford!” Alternatively, values we hold dear, such as working hard to earn what we get in life or seeing all people as equal, may present us with special challenges when clients are clearly enjoying advantages that they did not work for or when they communicate an air of superiority. One therapist was working with a single woman who was determined to have a child through insemination. She hated the fact that all of her friends were married and having babies and she was not. The therapist, who had strong values about appropriate circumstances for bringing a child into this world, was horrified that the client’s reason for having a child—to keep up with her friends—was so superficial. Aware of her strong judgmental reaction, the therapist feared that she would reveal her anger if she explored the issue with the client. Unable to work through this countertransference, the therapist avoided confronting the client about this issue altogether.

When the Therapist Is a Possession

Another common countertransference issue is dealing with the client who treats their therapist as a “possession.” We all have had clients who talk about us as “their therapist.” One psychologist described his experience this way:

You know, they [wealthy clients] try hard not to do this, but you sometimes get the feeling that to them, you’re really just one of “the help,” similar to other service professionals that clean the pool or manage their legal affairs or cater their parties.

Clients who treat us as one more thing they have acquired can provoke a variety of responses. We may feel an initial boost to our self-esteem that later turns to resentment. We may also feel used and exploited. A therapist described her reaction to a client who told her, “I’d like to refer people I know to you, but I want you all for myself.” She immediately thought of how much more money she might be making if she changed the client’s attitude. She attempted to engage in an objective exploration of the issue, but the results were disastrous. Her irritation with the client came through, and he was deeply wounded, setting back months of effort in building a working alliance.
CONCLUSION

As self-reflective practitioners we are in a unique position to aid our clients with acquisitive disorders because we contend with the same acquisitive pressures they do, and some of us have found healthy ways of coping with them. Treatment of AD can only be effective when we respect the intensity of these pressures on both our clients and ourselves. Thus, it is just as important to design an effective treatment plan for our clients as it is to acknowledge the normalcy and prevalence of our own ADs. When we pull out of our driveways in the morning, we may find ourselves noticing how our house compares with our neighbors. We may experience pangs of longing when we see a luxury car passing us on the highway. When we enter our offices each morning, we may wonder if we'd feel happier with our work if we replaced that well-worn couch with an expensive leather one. Becoming aware of our desires and evaluating the degree to which they impair or improve our lives is the critical first step if we are to help our clients cope with the same pressures. One of the oldest pieces of wisdom in our profession, going all the way back to Freud, is certainly relevant here: Discovering our desires and ultimately accepting them without judgment is the precondition—perhaps, even the source—of our power to heal.

REFERENCES


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