Shopping for an Addiction

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The human animal is a beast that dies and if he's got money he buys and buys and buys and I think the reason he buys everything he can buy is that in the back of his mind he has the crazy hope that one of his purchases will be life everlasting! - Which it never can be ... (Tennessee Williams 1955, pp. 61-2)

INTRODUCTION

This chapter discusses some of the possible reasons that people shop addictively, its effects on individuals who practice this form of shopping, its relationship to family and gender issues, and its links to other types of addictive behaviours. The chapter also includes material from the author's work as a psychotherapist treating addictions and concludes with a case study which describes one woman's experience of and treatment for addictions.

In the play Cat on a Hot Tin Roof, the character 'Big Daddy' describes how his wife has ‘... bought more stuff than you could haul in a couple of boxcars ...’ (Williams 1955, p. 59) in a vain attempt to avoid her fear of death and the emptiness of her life. In the same play, Big Daddy's son uses alcohol to avoid his sense of disappointment with his life and his daughter-in-law spends her time fantasising about sexual encounters in order to avoid facing the break-down of her marriage.

Like Williams's characters, some people use addictive behaviours as a way of avoiding painful feelings. Not confronting uncomfortable issues can result in practising not just one addiction, but multiple addictions at the same time or in substituting one addiction for another at various times. Shopping to excess, as well as the abusive use of alcohol, drugs or food, can increase the sense of alienation and desperation which the behaviours are initially meant to relieve. Shopping excessively can also
create secondary problems, such as unmanageable debts and marital or family conflicts (Wilson Schaefer 1987).

People who use activities or substances excessively may come from families with patterns of addictions which go back several generations. Within such a family, patterns of addictive behaviours may be linked to gender-role expectations; it is still more common for men to abuse alcohol and drugs and for women to overeat and to shop to excess. Moreover, families whose members practice addictive behaviours seem to have other commonalities, such as denial and dishonesty regarding family members’ addictions, difficulty with expressing feelings appropriately, unrealistically high expectations of themselves and others, a need to control their own and other people’s behaviours and colluding to protect each other from the consequences of their addictions. Kasl (1987) describes the addictive family as a system which serves to perpetuate and evoke addictive behaviours amongst its members.

For women particularly, shopping can move beyond an everyday necessity or a pleasurable activity and become a focal point of their interest and/or an expression of their identity. At the point where shopping begins to impact negatively on an individual’s emotional well-being, relationships, or finances, it becomes an addiction (Johnson 1980).

SHOPPING IN RELATION TO WOMEN’S ROLE AND SELF-IDENTITY

Some authors describe the ‘modernity of the late nineteenth and early twentieth centuries as a public stage from which women were excluded’ and suggest that life in middle-class Victorian England existed in ‘separate spheres’ for men and women which resulted in ‘the social and material exclusion of women from public life and urban areas’ (Falk and Campbell 1997, p. 60).

Victorian social roles were challenged as increasing numbers of unaccompanied women began to travel freely in public. Whereas ‘respectable’ women had previously been confined mainly to their homes and to domestic activities, they began to pursue and experience greater social and personal freedom. As women’s freedom of movement increased, shopping became central to the experience of many ordinary women. Department stores in particular were appealing because they provided a safe environment in which women could spend time and enjoy a variety of services such as supervised areas for children, restaurants and powder rooms (Falk and Campbell 1997, p. 67).

Shopping came to be seen as a ‘pleasurable social activity’ and a way to enhance women’s social status. The home furnishing available in
department stores became 'visible indicators' of status and, increasingly, reflected the shopper's identity. Shopping provided women with an anonymous, safe and socially acceptable public place where they could spend unsupervised time and exert financial control. Shopping was an acceptable domestic activity which allowed women relative freedom of movement and became an important aspect of modern female identity. Partly because of the shopping experience, women developed a new sense of the possibilities of modern life and began to discard the previous view of themselves as dependent, passive and retiring. Shopping helped women form a new definition of themselves and created 'a space for individual expression similar to men' (Falk and Campbell 1997, pp. 64–70). Since the beginning of the twentieth century, shopping has increasingly become a major leisure activity and '... significant form of self expression' and '... an important element in the construction ... of their self identities' for many women (Elliott 1994, pp. 159–60).

Shopping gave women increased freedom to spend money; it also fostered, in many women, a sense of identity, which could be expressed by buying fashionable clothes, available in shops. This experience came to be associated with an increased freedom to explore their sexuality. Women's pleasure in touching and trying on expensive material goods was seen as a kind of sensual experience. At the same time, men were experiencing a loss of authority over women's spending habits which came to be associated with a loss of control over women's sexual desires. As men felt more threatened and displaced by the advent of a mass culture and women's expanding independence, the balance of power within the family was gradually transformed (Falk and Campbell 1997, pp. 76–9). For many women, an increasing sense of their own power was closely linked to spending power; to shop for and purchase clothing and household goods gave them a sense of individuality which was otherwise lacking in their lives.

SHOPPING AS AN ADDICTION

For most people, shopping remains a normal and culturally acceptable behaviour. For a small percentage of the population shopping behaviour has become dysfunctional. Recent studies carried out in the USA, Canada, Germany and the UK identify a group of people who 'buy for motives which are not directly related to the actual possession of the goods'. Faber and O'Guinn (1992) maintain that 1–2 per cent of the population practice a pathological form of shopping behaviour. This group of people persistently repeat the behaviour despite its
leading to severe financial and social consequences (Elliott, Eccles and Gournay 1996, pp. 355–6). This type of shopping is described as an irresistible urge to buy despite attempts to curb or inhibit the behaviour. Elliott believes that within this context, shopping 'is an addiction because it involves the extension of normal behaviour into a pathological habit' (1994, pp. 159–60).

WHEN A BEHAVIOUR BECOMES AN ADDICTION

In exploring shopping as an addiction, it seems useful to explore the term 'addiction'. Much early literature focused on alcoholism, as it was the first behaviour to be widely studied as an addiction. According to current thought, a person may become addicted to a substance, including alcohol, drugs, caffeine and nicotine, or may become addicted to an activity, such as shopping, exercising, eating, gambling or working. Wilson Schaef believes that

An addiction can be any activity over which we feel powerless ... the behaviour has taken control of us, ... causing us to do and think things that are inconsistent with our personal values and leading us to become progressively more compulsive and obsessive. (Wilson Schaef 1987, p. 18)

In considering shopping as an addiction, it also seems useful to draw distinctions between normal activities and excessive behaviours and to identify points at which normal behaviours can become problematic and eventually be classified as an addiction. Craig Nakken describes behaviours as occurring on a continuum, which can progress from patterns and habits to compulsions and addictions. According to this model, a pattern of behaviour is a practice or activity which helps us to structure our lives and is not destructive or harmful. A pattern remains flexible; we may, for example, say that we like to have breakfast at 9.00 a.m., but we are not upset or bothered if it is necessary to have breakfast at a different time. A habit is a more individualised behaviour and is frequently associated with words such as always or usually. Thus, when I say that I like to eat breakfast at 9.00 a.m., I am describing a pattern, and when I say that I always have toast for breakfast, I am describing a habit. Patterns are fairly easy to change, while habits are more difficult to alter. Giving up a habit may cause a temporary sense of discomfort, but the feeling is usually short-lived (Kasl 1987).

Behaviours which are damaging to us go beyond patterns or habits and, depending on their severity or the damage they cause to our health, finances or relationships, may be defined as either a compulsion
or an addiction. A compulsion is different from a pattern or habit in that it is based on a need to reduce tension or anxiety, often brought about by feelings which the person wants to avoid or control. Compulsions are usually associated with a sense of urgency or need and words such as 'have to' or 'must'. When I say that I have to eat breakfast at 9.00 a.m., I am describing a compulsion. According to Nakken,

There is often a frantic feeling associated with the behaviour until it is completed. When a person is unable to carry out the compulsive behaviour, feelings of agitation and distress may continue for hours or days, until the compulsive urge is met ... (Kasl 1987, p. 31)

Such behaviours are often carried out in a trance-like state. Compulsions are more difficult to discard or alter than habits, but they can usually be managed or accommodated without causing undue disruption to a person's life. Compulsive behaviours may be harmful but do not seriously impair functioning. Compulsions may damage but do not usually destroy relationships (ibid.)

Addictions are seen as more destructive than compulsions. The damage which an addiction can cause to our emotional or physical health, our relationships and to our financial or professional functioning is denied. 'Addiction involves the words powerlessness and unmanageability, both of which the person denies' (Kasl 1987, p. 31). It is at this point that the addictive shopper spends money beyond his or her means and denies the consequences of the behaviour. According to Wilson-Schaef, 'A sure sign of an addiction is the sudden need to deceive ourselves and others – to lie, deny, and cover up. An addiction is anything we feel tempted to lie about' (p. 18).

Another definition of addiction focuses on the impact of the behaviour on the person's life. Vern Johnson (1980) suggests that an addiction involves behaviours which negatively affect any one or more of the following areas of functioning: the person's physical, emotional, spiritual, personal, or professional existence. This definition of addiction was formulated to describe substance abuse; although a behaviour such as shopping doesn't directly affect a person's health, it can cause serious damage in other areas of life. Shopping behaviour can have a negative impact on emotional functioning, interpersonal relationships and economic circumstances.

TWO KINDS OF ADDICTIONS

Addictions can be divided into two major categories: substance addictions and process addictions. Both are said to function similarly
and to produce essentially the same results. Substance or ingestive addictions involve taking alcohol, drugs or nicotine, among other substances, into the body in order to avoid or deny painful feelings or to induce pleasant feelings. This kind of addiction may lead to increased physical dependency on the substance. A person who becomes addicted to a process does not experience the physical dependency associated with a substance addiction, but may become addicted to a set of behaviours. An addiction to a process is similar to a substance addiction in that both serve to help people look for solutions to their problems outside themselves and to avoid or deny painful feelings. This kind of addiction can involve excessive shopping, gambling, exercise, work or sexual activity. According to Wilson-Schaef, 'The characteristics and dynamics of any addiction are similar to those of any other addiction' (1987, p. 26).

The Purposes of an Addiction

When a person is 'practising' an addiction, he or she knows at one level that the behaviour is harmful or damaging. In order to continue the addiction, the person must feel that he or she is experiencing a reward or benefit; the addiction must serve a purpose. The purpose of an addiction can be an attempt to fill a void or avoid painful feelings and to feel better about ourselves. Wilson Schaef (1987) sees the addicted person as experiencing loneliness or emptiness in his or her everyday life; the addiction is meant to provide a magic panacea to fill the void and to remove painful feelings. Kasl describes this experience as a person 'searching for something to help her feel complete, but she doesn't know how to find it' (p. 5). Frequently, the sense of emptiness is experienced as feeling unloved. According to Kasl,

The underlying intention of addictive behaviour is to find love and to feel good. Such behaviour actually comes from a desire to fill a profound emptiness, anesthetize pain, and stay away from feelings. (p. 12)

The attraction of shopping, as with other addictive behaviours, is that the effect is immediate; the emotional pain stops at once. As is the case with other addictions, 'We do not have to deal with our anger, pain, depression, confusion, or even our joy and love, because we do not feel them, or we feel them only vaguely' (Wilson Schaef 1987, p. 18). Although the initial relief is eventually replaced by the original painful feelings, the immediate relief reinforces the behaviour. 'It is so seductive because it works immediately' (Kasl 1987, p. 96).
Some believe that addictive behaviours are driven by an underlying sense of shame on the part of the individual (Bradshaw 1988). Feeling ashamed of one's normal, human failings can slowly become a generalised sense of shame which takes over our self-identity. According to Bradshaw (pp. vii–viii), 'To have shame as an identity is to believe that one's being is flawed, that one is defective as a human being.' It is this core sense of shame which Bradshaw believes drives all compulsive/addictive behaviours and is an attempt to heal a ruptured sense of self; to avoid feelings of loneliness and hurt. He believes that, 'Each addictive acting out creates life-damaging consequences which create more shame' (p. 15). The persistent sense of shame fuels a cycle of addictive behaviours.

The person whose sense of self is shame-based is in constant pain. Bradshaw believes that this feeling is experienced as chronic loss and mourning for the authentic self which, in turn, creates a need for relief. Any behaviour which takes away the ‘gnawing discomfort’ will become the individuals' only priority and their most important relationship. He says that, 'Whichever way you choose to mood alter will be the relationship that takes precedence over all else in your life' (Bradshaw 1988, pp. 95–9).

THE COSTS OF AN ADDICTION

An addiction may temporarily help someone deny painful feelings or avoid facing uncomfortable issues, but the long-term effects of the addictive behaviour are damaging. An alcohol addiction may cause individuals to experience severe, irreparable damage to their health and may harm their professional functioning; these are consequences which the addictive shopper is unlikely to experience. Like the alcoholic, however, the addictive shopper may experience harmful consequences such as a loss of contact with the self. According to Wilson Schaeff,

As we lose contact with ourselves we also lose contact with other people and the world around us. An addiction dulls and distorts our 'sensory input' and costs us the 'ability to become intimate with others'. (1987, pp. 18–19)

The person 'practising' an addiction often experiences a sense of alienation not only from his or her significant others but from the self. Addicts may feel intense and contradictory feelings which they are incapable of expressing in appropriate ways. Eventually, many addicted people lose the ability to differentiate among feelings which may all
begin to feel the same. By this point, the addict may experience no feelings except numbness or generalised anxiety. The experience of any feeling can seem threatening and can trigger the addictive behaviour (Wilson Schaef 1987; 1990).

For many addicted people, the experience of losing touch with a deeper self results in chronic, mild depression. Kasl (1987, pp. 150–1) believes that the depression associated with an addiction covers a cluster of feelings and attitudes about the self which include ‘learned helplessness, anger turned inward, loss of self-esteem, lack of connectedness to others, and negative, inaccurate, self-defeating beliefs’.

The depression which is often associated with addictions may also be linked to the addict’s need for control. Wilson Schaef believes that

The illusion of control is a setup for depression. When we believe that we can and should be able to control our world and it turns out that we cannot, we experience failure, and this is depressing. We then try even harder to gain control and fail even more miserably. (1987, p. 45)

The addict’s attempts to control the addiction may be seen as an attempt to avoid painful thoughts and feelings by focusing on attempts to control the addictive behaviours rather than on the self (Wilson Schaef 1987, p. 43). People who are addicted often believe that they should be perfect and are unable to live up to their own expectations of themselves. At the core of the addict’s view of the self is a belief that they are failures and that nothing they do can ever be good enough. The desire for perfectionism can serve to both trigger and reinforce the addictive behaviour (p. 68).

People who believe that they should be perfect experience any failing as proof of their inadequacy. Their thinking becomes dualistic; either I am perfect or I am worthless, completely good or bad, either in control or totally out of control. Their view of the self becomes black or white with nothing in between. Addicts experience themselves as ‘bad’; regardless of their accomplishments or achievements, they never see themselves as good enough or worthwhile as people (Wilson Schaef 1987, p. 112). In describing this process, Kasl says that

When a person becomes addicted, the personality splits into two distinct parts, each denying the existence of the other. It is as though the person has two sets of values. Addiction is like having two sides – the addict side and the healthy side – engaging in a life and death struggle to control the inner world. While people derive temporary feelings of pleasure through their addictive behaviour, harmful consequences are sure to follow. She falls more and more under the control of an unknown force within. (1987, pp. 29–32)
MULTIPLE ADDICTIONS

An addiction may be an attempt to deny painful truths and multiple addictions may become a way of life. Kasl describes this process as

a constant state of strife, split between our perceived reality and the buried reality. Because addiction is the psyche’s way of seeking escape from buried feelings and easing the inner strife, the addictive agent can be almost anything, alcohol, sex, cigarettes, religion, caffeine, TV, anger, depression, shopping, cleaning, eating ... (1987, pp. 2218–19)

Some people practice serial addictions and substitute one addiction for another, such as replacing smoking cigarettes with overeating. Others practice addictions simultaneously, such as shopping and overeating, or drinking and smoking. Kasl believes that two addiction can be ‘ritualised’ together; most commonly sex and alcohol or drugs, and almost as frequently, sex and food (1987, p. 197).

Wilson Schaeff describes addictions to alcohol, drugs, nicotine, food, relationships, and sex as secondary addictions; the primary addiction is the person’s sense of ‘powerlessness and nonliving’ which the addictive process both masks and perpetuates (1987, p. 16).

Another view of addictions, whether to a substance, process or relationship, suggests that all addictive behaviours represent a core issue in the addict’s life. Lefevre believes that,

We suppress our natural feelings by using something artificial in order to overcome the human response of feeling emotional pain when we do damaging things to ourselves and to our relationships. (Lefevre 1988, p. 4)

Lefevre also believes that addictions are a symptom of the ‘addictive disease’, which is in the person, and not just about a substance or a behaviour. In order to treat the underlying disease, he stresses the need to recognise the commonalities among all forms of addictions, regardless of the particular addiction being practised at any given time. Treating one addiction on its own usually results in the substitution of yet another addiction and fails to address or treat the root problem underlying the addictive process (Lefevre 1988).

PEOPLE AT RISK OF BECOMING ADDICTED

People who practise addictions as adults often experienced abuse or neglect as children. Kasl (1987, p. 83) reports that between 50 and 80 per cent of the women she treats for chemical dependency were
survivors of abuse and that within her therapy groups for incest survivors, almost half of the groups' members have also been treated for drug or alcohol abuse. Although the divergence between 50 and 80 per cent is unaccounted for, other therapists also describe the high incidence of clients who have experienced abuse as children and who, as adults, practise multiple addictions. In treatment programmes for eating disorders, 80 per cent of women treated described themselves as survivors of sexual abuse (Kasl 1987, p. 214). Robin Norwood makes the link between eating disorders and family patterns when she says that '... nearly every woman I have seen with an eating disorder has been the daughter of either one alcoholic, two alcoholics, or an alcoholic and a compulsive eater' (Norwood 1985, p. 165). In describing possible links between childhood abuse and multiple addictions, Kasl says that

In many instances, misuse of food, sex, alcohol, work and money either occur together or interchangeably as an individual desperately tries to quell an inner emptiness created by some form of childhood abuse or neglect. (1987, p. xiii)

ADDICTIVE FAMILY SYSTEMS

Individuals who practice addictions frequently come from families whose members have been addicted to substances or activities, sometimes over the course of several generations. Therapists who describe the family as a system believe that the principle of homoeostasis is at work within families, causing its members to seek balance over change in their interactions with each other, even when the balance is harmful or destructive and change could be positive (Satir 1972). Change in one member of a family 'will lead to a compensatory change in another family member' (Stafford 1992, p. 68). In disturbed families, change of any sort is often seen as threatening, and family members strive to restore or maintain equilibrium through the maintenance of rigid patterns of behaviour. According to Bradshaw, 'a dysfunctional family uses the members to maintain its equilibrium. The more dysfunctional the system, the more closed and rigid are the roles it assigns' (1988, p. 59).

When one person is addicted, he or she may be expressing or acting out the distress of the family. Fossum and Mason believe that addiction is always a 'family disease' and is the 'central organising principle of the system - maintaining the system as well as the shame' (Bradshaw 1988, p. 96). Within an alcoholic system, the patterns and behaviours
used to hide the addiction also serve to maintain it and eventually affect all its members. According to Wilson Schaefer, 'Any addictive system is contagious, and those who live within it become infected with the disease sooner or later. The dynamics and patterns are the same for those infected as they are for the alcoholic' (1987, p. 13).

Families whose members practice addictions frequently deny that they are experiencing difficulties and, simultaneously, feel deeply ashamed of their underlying problems. Describing alcoholic families, Stafford says that, '... shame and denial dovetail to become guardians of the addiction, and how roles are created to maintain the stability of the family' (1992, p. 84). Bradshaw calls this sense of shame 'toxic' and believes that it is multigenerational; passed from one generation of addicts to the next. He believes that

Shame-based people find other shame-based people and get married. As a couple each carries the shame from his or her own family system. Their marriage will be grounded in their shame-core. The major outcome of this will be a lack of intimacy. It's difficult to let someone get close to you if you feel defective and flawed as a human being. Shame-based couples maintain non-intimacy through poor communication, nonproductive circular fighting, games, manipulation, vying for control ... (Bradshaw 1988, p. 25)

This sense of shame, according to Bradshaw becomes the basis of the family's dealings with each other. He states that

Shame has been called the master emotion because as it is internalised all the other emotions are bound by shame. Emotionally bound parents cannot allow their children to have emotions because the child's emotion triggers the parents' emotions. Repressed emotions often feel too big, like they would completely overwhelm us if we expressed them. (1988, p. 54)

Attempting to avoid or deny the addictive family's feelings of shame may create characteristic patterns of communication. Such families may develop rules which stifle open communication in order to maintain the illusion that the family is 'normal'. 'Unwritten rules keep communication rigid. Family members do not talk about anything which draws attention to the alcoholism, they deny or ignore strong feelings' (Stafford 1992, p. 75). This type of communication circumvents open, honest discussion which could confront the alcoholic with the consequences of his or her behaviour and disrupt the system's homeostasis. 'So long as the family remains in denial, illusion and shame, the drinking continues, and the happy family facade is maintained in the face of overwhelming contradictory evidence' (ibid.).
Family members may also lie about the addictive behaviour to protect each other from outside sanctions, such as one person’s lying about another person’s drinking to protect the alcoholic from losing his or her job. Over time, persons within this system may find it easier to lie ‘gratuitously’, even when telling the truth would have no negative repercussions (Stafford 1992, p. 91).

When family members consistently avoid direct communication, the family becomes a ‘closed system’, whose members avoid spontaneous or genuine communication and become rigid, both in responses to each other and to the outside world. A closed system may intensify and reinforce addictive behaviours. According to Virginia Satir (1972), troubled families use four characteristic patterns of communication in their interactions with each other: by blaming others for their problems, by excessively apologising or placating others, by responding to others’ feelings in a cold, rational, logical manner, or by distracting others from serious issues by changing the subject.

Bradshaw describes the addictive family as needing to control communication among its members by enforcing a ‘no talk’ rule which ‘prohibits the full expression of any feeling, need or want ... no one speaks of his loneliness and sense of self-rupture’ (1988, p. 40). This becomes a major defence strategy which both protects and stifes family members.

The need to control in others can extend beyond controlling communication among family members and can become generalised into other aspects of the family’s interactions. An individual’s inability to control one’s own addictive behaviours can be denied by focusing on controlling the behaviours of other family members. What we cannot control in ourselves may become the basis for a need to control others. According to Bradshaw,

We need to control because our toxic shame drives us outside ourselves ... We objectify ourselves and experience ourselves as lacking and defective. Therefore, we must move out of our own house. The striving for power flows from the need to control ... Achieving power is a direct attempt to compensate for the sense of being defective. When one has power over others, one becomes less vulnerable to being shamed. (1998, p. 89)

In addictive families, spontaneous behaviour may become so inhibited that all interactions, communications, and behaviours become rigid and controlled, reflecting the family’s need to present a ‘perfect’ front to the outside world, masking the flaws within the family. The need for perfectionism is pervasive in addictive families, and becomes a way of coping with and avoiding a deeper sense of failure.
and imperfection. Family members develop a sense of shame around addictive behaviours and learn to deny ‘normal’ human failings and limitations. According to Bradshaw, ‘Perfectionism is a family system rule ... which denies healthy shame ... by assuming we can be perfect. Such an assumption denies that we will make mistakes’ (1998, p. 61).

Family members taught the need for perfection experience a sense of being measured from the outside by an externalised source and of never being able to measure up.

Attempts to present a perfect image to outsiders may result in the addicted family’s need to conform to and enforce rigid role expectations. The family’s expectations of its members may be based on gender; men may be expected to be decisive and unemotional, while women may be expected to be acquiescent and caretakers for others (Bradshaw 1998). Other family therapists who work with addicted families believe that children are assigned roles by their parents which both protect and perpetuate the dysfunctional system. One child may take on the role of ‘family hero’ who is expected to solve the family’s problems, while another child takes on the role of the ‘enabler’, who covers up the addictive members’ behaviours and protects the addicts from the consequences of their behaviours. Addictive families may also include a ‘mascot’, who acts cute or helpless to attract attention, a ‘scapegoat’, who is blamed for the problems in the family, and a ‘lost child’, who withdraws from the family completely (Wegscheider-Cruse and Cruse 1990).

The roles learned by children raised in addicted families often become the basis for their adult behaviour and affect their relationships as adults. Speaking about alcoholic family systems, Stafford believes that

... the roles that it assigns to its members and how these roles are carried over into adult life ... [affect] the quality of life and the capacity to achieve fulfilment. The characteristics which adult children of alcoholics develop are, in fact, a function of the family system and an attempt to maintain stability within that sick system. (1992, p. 68)

Whether the addiction is to alcohol or shopping, the addict is unable to take care of his or her own unmet needs and often marries someone who holds out the promise of meeting their partner’s sense of emptiness. When this happens,

Each looks to and expects the other to take care of and parent the child within him or her. Each is incomplete and insatiable. The insatiability is rooted in each person’s unmet childhood needs. When two adult children
meet and fall in love, the child in each looks to the other to fill his or her needs. (Bradshaw 1988, p. 44)

Being unable to meet a partner's needs may result in parents projecting their own needs and expectations onto their children. Such children experience themselves as not having their own childhood and as having been expected to function as adults from an early age. Bowlby, writing in the 1940s, said that

in alcoholic families, the alcoholic parent is seeking the care and attention which was lacking in her childhood and attempts to obtain the missing parenting from her own child. Thus she is ... 'inverting the normal parent–child relationship by requiring the child to be the parent figure and adopting the role of child herself'. (cited in Stafford 1992, p. 82)

Bradshaw also describes this process when he says that

By taking on the role of supplying his shame-based parents' narcissistic gratification, the child secures love and a sense of being needed and not abandoned. This process is a reversal of the order of nature. Now the child is taking care of the parent's needs, rather than the parents taking care of the child's needs. (1988, p. 44)

The process of children parenting their parents is handed down to the next generation as the adult children of alcoholics seek to fulfill their own needs either by taking on addictive behaviours themselves and/or by creating relationships based on being useful to others at the cost of their own needs and feelings (Norwood 1985).

**BREAKING THE CYCLE**

Effective treatment of one addiction may involve the individual's recognition of other addictions. Treating someone for a shopping addiction is only successful if it addresses the underlying needs and feelings which trigger the addictive behaviour. Failing to do so often results in giving up one addiction and replacing it with another. Successful therapy involves first identifying the person's addictive tendencies. One instrument used to identify addiction is 'The PROMIS Questionnaire' (Lefevre 1988) which was designed to identify a range of potentially addictive behaviours. This questionnaire asks respondents to answer questions involving their behaviours in relation to eleven categories: alcohol, nicotine, recreational drugs, caffeine, gambling and risk taking, work, relationships, sex, shopping, spending or stealing,
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exercise, prescription drugs and food. Each category contains thirty questions related to the particular substance or behaviour. In interpreting the results of the questionnaire, one to nine positive answers in any one category are said to indicate a possible addiction, which may not be of great concern, an area with ten to nineteen positive answers indicates a cross-addiction, and an area with twenty or more positive answers indicates a primary addiction. Lefevre recommends that treatment should first address the primary addiction or addictions and eventually address minor cross-addictions. Failure to identify and treat all of the person's addictions is seen as treating symptoms or behaviours rather than the root addiction and may result in relapse or substitution of another addiction for the original addiction.

Lefevre (1988) describes this as treating the addict, rather than the addiction, and sees treatment recovery and relapse prevention as consisting of three stages: beginning with an initial state of actively practising an addiction, entering treatment for the addiction and entering recovery. In the initial stage, the addict has an overriding sense of emptiness, a need to and an inability to control his or her addictive behaviours, a preoccupation with the addictive substance or behaviour, difficulty in focusing on other people's needs or feelings, and a tendency to blame personal difficulties on external events or circumstances, rather than taking responsibility for his or her own actions and decisions.

According to Lefevre's model (1988), when an addict enters treatment, he or she needs to practice full abstinence from the addictive substance, or behaviour, and learn to face and accept personal responsibility for his or her choices and actions. Lefevre also believes that successful treatment involves active participation in a Twelve Step Programme, which follows the steps and principles originally laid out in the Alcoholics Anonymous Programme. Successful recovery, according to this model, includes accepting one's inability to control the addiction through will-power and logic and accepting a higher power outside or greater than one's self (Johnson 1980).

Treating addictive behaviours also involves facing the denial surrounding the behaviour and addressing the underlying needs that the addiction is meant to compensate for. Part of the work involved in breaking addictive patterns also involves the person facing his or her own 'humanness' and acknowledging parts of the self which have been disowned. Not accepting a less desirable part can reinforce an addictive pattern. Wilson Schaef believes that

If we flee from our shadow side, judge it, or hate it, it will come back to haunt us ... Under every addiction is a longing for self and for love. Facing
rather than avoiding our flaws can help to release the needs which fuel addictive patterns. (1987, p. 35)

According to Kasl,

We break through the addictive miasma by connecting with our truths and releasing our buried feelings and healing our tired bodies. We must recognise and heal the inner split. Anger, directed at the appropriate source, is often the wakeup call ... When we connect with ourselves deeply, we calm the conflict that leads to addictive and compulsive behaviour. (1987, p. 219)

The original sources of the addict's pain may be out of his or her awareness. Helping the client to recognise and acknowledge the pain he or she experiences in the present often serves as the starting point. This process allows the person to begin experiencing and integrating the deeper feelings which trigger the addictive behaviours.

Psychotherapy frequently involves changing addictive patterns by confronting feelings which have been denied as well as learning to let go of the need to be perfect and to demand perfection from those around us. Ironically, letting go of the need to control ourselves as well as others creates a stronger sense of being in control of one's life. Wilson Schae (1987, p. xv) describes this as '... restoring one's relationship to oneself and others'.

Reconnecting with one's self in the present means learning to recognise and respond to a current need rather than reacting addictively to an unaddressed need from the past. Addicts describe the point where the addiction takes over as a feeling almost like an hypnotic state and speak of coming out of a 'trance' to realise that they have been practising their addiction/s. In treatment, they gradually learn to identify the feeling which the addiction masks and learn better ways of coping. Wilson Schae describes this when she says, 'When you are sleepy, sleep; when you are hungry, eat; when you are sad, cry', and adds, 'When you need comfort, find someone to comfort you; when you are lonely, learn to experience your loneliness as one of many human emotions' (1987, p. 4).

Some current treatments for addictions stress the need not only to connect with a deeper level sense of self, but to learn to distance ourselves from our sense of attachment. One tradition advocating this stance is Buddhism which sees peace and contentment as an outgrowth of relinquishing attachments. When this attitude is applied to psychotherapy, according to Wilson Schae,
We are advised not to purge our desires from our lives, but to let them pass through our awareness and to observe the experience of them, without madly seeking them or becoming bound to them. (1987, p. 18)

Recovering addicts often find that learning some form of meditation helps them to let go of the addictive needs and describe connecting, at this point in treatment, with a spiritual part of themselves which assists them in letting go of their addictive drives. Wilson Schaefer describes this when she says,

We can become attached to substances, wealth, ideas, opinions, theories, beliefs, sense pleasures and even the concept of nonattachment ... When we become enslaved by our 'thirsts', we lose our connection to our spiritual center. (1987, pp. 17–18)

Learning to disengage gradually from attachments such as addictions involves accepting the inevitability of life's disappointments without needing the artificial highs and lows which addictions can temporarily provide.

THE AUTHOR'S EXPERIENCE OF ADDICTIVE CLIENTS

As a psychotherapist who has worked with addictions in both clinical and private settings, my experience both confirms and contradicts current therapeutic beliefs and practices. The clients who have come to me wanting treatment for their addictive behaviours often have much in common with each other. The treatment which seems to be effective with one person, however, may not be helpful for another person; some individuals seem capable of stopping their addictive behaviours with little or no psychotherapeutic support, while others continue practising an addiction regardless of its negative effects and in spite of therapeutic interventions.

In my experience, people who seek treatment for an addiction, whether to a substance or a behaviour, come from families with a history of addictions. Clients who come for treatment often initially deny or fail to recognise the presence of an addiction, either in themselves or relatives. Admitting that a behaviour has become out of control in their own lives is often coupled with the discovery that several generations of family members both practised and denied practising various forms of addictions. I remember asking a client who had come to me for treatment of alcoholism whether there were any alcoholics in her family. Her initial response was a firm no, followed, when she returned the next week, by her statement that she had
realised in the intervening week that twelve of her relatives had also been alcoholics. Such insights are painful but necessary in helping clients begin taking responsibility for and changing their own addictive behaviours. I have also found that addictive behaviours can often 'skip' a generation: clients may discover that their own parents are free from addictions, but that their grandparents were addicted to a substance or a behaviour.

Addictions also seem to be influenced by gender factors. More men than women come to me for treatment for alcoholism, while more women than men seek treatment for excessive shopping, eating disorders, and addictions to prescription drugs. Several female clients have described addictive shopping as offering them a sense of revenge in response to feeling powerless in their marriages. One woman came to therapy initially for help in coping with her alcoholic husband. In therapy, she realised that she had used tranquillisers for years to avoid painful feelings and often swallowed her feelings of frustration by overeating. For her, successful change meant focusing on her own feelings and gradually learning to express her needs, rather than trying to help her husband with his addictions.

Clients seeking treatment for addictions often realise that they have practised several addictions simultaneously or have given up one addiction in favour of another at various times in their lives. The client who has stopped smoking may begin addictive shopping. The need, in this case, is to explore the underlying causes which the addiction helps to mask. I worked with a client who described that, when she was not involved in a romantic relationship, she starved herself and shopped for clothes additively, in order to attract a man. Once in a relationship, she overate and drank excessively until the relationship ended; a pattern which she had repeated for years. In her case, therapy involved exploring the feelings underlying her need for and fear of an intimate relationship which the addictions help her to avoid facing directly.

Much of the initial work in therapy involves clients recognising and admitting the role that addictions have played in their lives. Clients describe how addictions both protect them from and, at the same time, reinforce their sense of inadequacy and pervasive feelings of sadness. One of the core beliefs that they describe is an internal judge, telling them that they should be perfect and reminding them, each time they resort to the addiction, that they are failures, and unable to curb the behaviour through the use of will-power alone. One of my clients described herself as a devout Christian; she often talked about her inability to tolerate other people's shortcomings. For her, being able to stop addictive behaviours came about as she explored the idea of forgiving herself for not being perfect.
People in treatment for addictions also describe parents who were often critical in spite of or perhaps because of their own inadequacies and addictive behaviours. Needing to prove their own worth, such parents taught their children that they were worthless. Clients describe the effects of years of physical, emotional and sexual abuse as children, which their own addictions help them to deny.

Clients in treatment for an addiction invariably describe never having been able to discuss their deeper feelings within their families and the fear that showing their feelings will cause them to be ridiculed. Talking openly and non-defensively about feelings is often experienced for the first time in the safe environment that therapy provides.

For some clients, successful treatment for addictions does involve years of painful exploration of childhood trauma in individual therapy; others have learned to change addictive patterns in therapy or self-help groups. I no longer believe that the client has to hit rock bottom, or join a twelve-step group or to accept a Higher Power in order to change, although for many clients, all of those may be effective. I now believe in using an integrative approach to therapy. For some clients, successful therapy involves catharsis and insight; for others, effective treatment involves cognitive and behavioural approaches. Help and change take different paths for each person. What is needed is to explore the hidden pain and sense of shame which the addiction masks and perpetuates. Each client needs to find a way of working towards a healthier goal as opposed to focusing on curbing an unhealthy practice. Stopping smoking is possible, for example, by focusing on an increased ability to breathe rather than focusing on not being able to have a cigarette. Permanent change is accompanied by a shift in self-worth and acceptance, rather than by using force or will-power which focuses on an addictive behaviour by itself.

I have also given up trying to predict which clients will succeed at mastering their addictions. I remember working with a man who had tried to quit drinking alcohol for most of his adult life; he had gone to individual and group therapy and Twelve Step Programmes for years. I initially felt pessimistic regarding the likelihood that, this time, he would succeed. And yet, he did just that; eight years after his last drink, he said that he was finally ready to quit.

**Case Study**

The following case history is not unusual for people who experience shopping as an addiction. The woman presented in this case study, although not a client of mine, agreed to be interviewed regarding her
addictive behaviours. She describes herself as having been addicted to alcohol and a compulsive over-eater, in addition to shopping addictively. She also describes several generations of her family members as having multiple addictions and as exhibiting many of the characteristics of 'troubled' families discussed in this chapter. In my work with compulsive shoppers, clients often describe their shopping behaviour as one of several addictions and relate family patterns similar to those discussed in this case study.

Linda (not her real name) describes both her parents as having been alcoholics who managed to function successfully in spite of their frequent drinking bouts. From an early age, Linda learned to 'parent' her own parents, protecting them from the consequences of their drinking from the outside world, as well as 'parenting' her younger sister, by preparing meals for her and bathing her when their parents had been drinking.

Linda recalls that her paternal grandfather died when her father was three. Her father recounts that his mother abandoned him several times during his childhood; once, he claimed, leaving him by himself in an hotel room for several days when he was eighteen months old. Linda describes her grandmother as a compulsive over-eater who, according to her father, sexually abused him by arranging and watching friends engage in sexual activities with her young son.

According to Linda, her father grew up to become an alcoholic and, in Linda's words, a 'sexual addict'. She describes him as having had frequent extramarital affairs and sexual liaisons. Linda remembers the 'sexual energy' surrounding her father and the sexual innuendoes and comments which made up his interactions with her and her younger sister. He made his living writing and publishing pornographic books.

Linda says that her maternal grandfather sexually abused his daughter, Linda's mother, and later sexually abused both Linda and her younger sister. Her maternal grandmother, according to Linda, dealt with her husband's sexual behaviour by compulsive overeating and compulsive shopping.

Linda described herself as having felt empty and lonely for most of her life. When she went to university, she sought to avoid the pervasive sense of loneliness by drinking excessively and having frequent sexual affairs. At that point in her life, she restricted her eating behaviours to the point of anorexia and restricted spending money by buying second-hand clothing. Although she could have afforded new clothing, she felt driven to hoard food and money, out of a fear of 'having nothing left' if she spent any money. After leaving university, her first job paid enough money for her to have credit cards. She describes a 'switch' in her attitude about spending at this point. She
could afford to buy expensive clothing and, shopping on credit, she could avoid thinking about her mounting debts. Shopping made her feel really good about herself during and after clothes-buying sprees; she felt powerful and attractive.

Linda describes the next several years of her life as revolving around addictive sexual and alcoholic behaviours and periods of over-eating and severely restricting her eating in order to lose weight. At this point, compulsive shopping was not the primary addiction in her life, although she sometimes went on 'shopping binges' when she had been drinking. During these times, shopping gave her a sense of freedom and made her feel 'exhilarated'; the feelings of guilt and anxiety came later when faced with mounting credit-card debts. Shopping itself was 'fun' and gave her a 'high' without the 'hangover'.

Linda's drinking eventually caused her to seek inpatient treatment for alcoholism. She says that the initial treatment addressed her alcohol addiction, but not the underlying issues which had caused her to drink to excess or to practise other addictions. Although she managed to stop drinking, she continued to overeat and her shopping addiction intensified. She began to feel as out of control around her spending patterns as she had previously felt in regard to drinking. She describes her shopping as 'binges' which occurred when she went out intending to buy 'one practical item for the house', usually groceries, and ending up buying dozens of items, usually of clothing, which she didn't need, feeling 'unable' to stop herself.

Linda recounts that the binge shopping often consisted of buying items of clothing which were too small, planning on dieting to be able to wear them. She often bought the same item, two sizes too small, in every available colour and ended up eventually discarding the never-worn clothing. She sometimes shopped by herself and, at other times, went shopping with friends who 'enabled' her out of control shopping behaviour. She also 'binged' by mail, ordering some items of clothing in several different sizes and all the available colours, which she either returned or kept without ever having worn. She describes one 'shopping binge' which lasted for six months. By not looking at or paying the bills on her credit cards, she was able to avoid facing the enormous debts she was incurring.

Finally, Linda's GP suggested that she consider getting treatment for the 'stress' and 'exhaustion' which had begun to affect her health. Entering inpatient treatment for a second time, she was able to identify the multiple addictions which she practised at times simultaneously and at other times alternating between one addiction and another. She reports that she began to see herself as being addicted to compulsive shopping as well as alcohol, nicotine and over-work. At this point, she
explored the addictions which she practised as a pattern which she had seen modelled by her parents and grandparents, and gradually learned to identify the ‘secondary gains’ which the addictive behaviours afforded her. She became more aware of using addictive behaviours to avoid experiencing painful feelings and using one addiction to help her avoid facing the consequences of another.

Over the next several years, Linda recounts that she participated in individual therapy and attended Twelve Step Programmes on a regular basis. As she learned healthier coping responses, she was able to recognise and express the feelings of emptiness, despair and the constant sense of ‘shame’ which triggered the addictive behaviours.

At this point in her life, Linda says that she continues working towards gradual, positive changes in her life, rather than expecting ‘immediate’ perfection in herself which, paradoxically, had often led to her out-of-control behaviour around shopping, drinking and overeating. Although she has not drunk alcohol in a number of years, she still sometimes eats and spends ‘too much’. She is, however, now able to recognise the feelings and events which trigger these behaviours as they come up and is able to stop herself much sooner without experiencing the shame which accompanied previous relapse. Progress, for her, lies in reducing the problematic behaviours and in feeling better about herself. The emptiness and shame which she used to experience frequently are slowly being replaced by contentment.

REFERENCES


