The Medicalization of Compulsive Shopping:

A Sociological Analysis of a Disorder-in-the-Making

Jennifer R. Hemler°
Department of Sociology, Rutgers University

Abstract

"Compulsive shopping," a phrase often used to caricature women's spending or presumed preoccupation with material goods, has, within recent years, taken on a second meaning: that of a mental disorder, clinically referred to as "compulsive buying." Compulsive buying has not *officially* been defined as a "disorder," but it is being treated as such by psychiatrists and a growing segment of the general public. This emerging *perception* of compulsive buying as a mental disorder has only been possible because of larger cognitive and scientific shifts – one such shift being the preeminence now accorded to biological explanations for deviant behaviors. In the U.S., treating social problems as psychological problems, and psychological problems as biological problems, is, if not already the norm, quickly becoming so. The narrowing focus of critical and lay attention on individualized pathologies, particularly in the United States, has displaced broader social-structural analyses. My purpose in this paper, in attempt to offer a broader analysis, is to examine the disordering of compulsive buying, and discuss the role this disordering plays for American society.

Key words

Compulsive Buying, medicalization, deviance, consumerism, professional claims-making

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° DRAFT – please do not cite without permission from the author. Please direct correspondence to Jennifer R. Hemler, Dept. of Sociology, Rutgers University, 54 Joyce Kilmer Avenue, Piscataway, NJ 08854, or email jhemler@sociology.rutgers.edu.

Introduction

"Compulsive shopping," a phrase used to caricature women's spending or presumed preoccupation with material goods, has, within recent years, taken on a secondary meaning: that of a mental disorder, clinically referred to as "compulsive buying." While some reject the idea of shopping as a disorder, reports from many westernized nations,[1] in the popular press as well as academic journals, indicate that these countries – or special interest groups within them – have recognized compulsive buying as a growing problem. These reports rarely seriously address the social, economic and environmental conditions that have both facilitated and been aggravated by "compulsive buying"[2] (Roberts and Martinez 1997; Roberts 1998); rather, the narrowing focus of critical and lay attention on individualized pathologies, particularly in the United States, has displaced broader social-structural analyses. The emerging *perception* of compulsive buying as a mental disorder, however, has only been possible because of larger cognitive and scientific shifts – one such shift being the preeminence now accorded to biological explanations for deviant behaviors. In the U.S., treating social problems as psychological problems, and psychological problems as biological problems – e.g., genetic inheritance, "chemical imbalances," serotonin deficiency, and other kinds of brain dysfunctions – is, if not already the norm, quickly becoming so.

My purpose in this paper, therefore, is to examine the disordering of compulsive buying, and discuss the role this disordering plays for American society. To be clear, compulsive buying has not been *officially* defined as a "disorder,[3] although it is being treated as such. Some journalists have even reported, without revealing their sources, that

compulsive buying is expected to be incorporated into the next edition of the American Psychiatric Association's (APA) *Diagnostic and Statistical Manual of Mental Disorder* (DSM), the premier psychiatric diagnostic guidebook in the United States ("Science Watch," 2003; Brundrett, 2003; Chaker, 2003; Seligman, 2003; Thernstrom, 2002). While there is no word from the APA yet on this matter,[4] the repercussions of incorporating compulsive buying into the DSM would be immense: Inclusion in the DSM means compulsive buying would be recognized as a mental disorder by legal,[5] medical and health care professions, opening the door for pharmaceutical companies to market new drugs for the disorder (and, in addition, more and more health care providers are covering drugs at the expense of therapy and other behavioral treatments; see Conrad, 2005). In fact, university researchers have already conducted drug trials for compulsive buying – at least two of which were sponsored by pharmaceutical companies (Ritter, 1995; Krum, 2000).[6] Explorations for an "impulsive" gene are also underway (see Carey, 2006).

Testing a drug for a disorder that does not yet exist – even diagnosing a disorder without official criteria – are recent developments in the process of medicalization (Conrad, 2005; Conrad, IHHCPAR talk, Mar. 28, 2006),[7] making compulsive buying an interesting case for sociological analysis. In addition, compulsive buying is somewhat different from other, previously contested mental disorders: as a culturally encouraged activity, shopping/buying is not like drinking alcohol, taking drugs, gambling and, to some degree, having sex, where the "normal" counterpoint is already morally suspect; nor is medicalizing compulsive buying simply improving upon a human imperfection – like erectile dysfunction, or adult attention deficit. The closest comparison would be to

binge-eating or bulimia – eating and shopping/buying are both necessary activities; excessive amounts of either is problematic – but whereas bulimia is physically destructive to *oneself*, compulsive shopping destroys social bonds and credit histories. If a "true" compulsion, compulsive buying would have to be beyond one's control, the impulse to shop originating in a dysfunction of a psychological or biological mechanism. This is the tack being taken in medicalizing shopping; if successful, this development would reveal how powerful the drivers of medicalization have become, and how invested Americans are in buying the modern mental illness narrative. Other narratives are possible: compulsive buying could simply be cast as an extreme form of consumerism – one that only the rich can afford, like plastic surgery or McMansions – and/or a byproduct of reference group shifts and status anxiety. That these alternative explanations are overshadowed by the disorder narrative supports the theory that medicalization signals a lowered tolerance for deviant behavior (Conrad, 2005) and removal of the responsibility for deviance from the social sphere. Therefore, it is important to investigate compulsive buying not only for how it is being medicalized, but what its medicalization implies about society at large.

In the following sections of this paper, I aim to present such an investigation. First, I discuss theories and findings from the medicalization of deviance and social construction of mental illness literatures. Because both fields have vast literatures, a complete review is beyond the scope of this paper; my intent is simply to situate my work within the intersection of these larger frameworks. Second, I discuss the treatment of compulsive buying within the lay media (major newspapers) as well as the academic fields of consumer behavior and psychiatric research, which are responsible for current

knowledge of compulsive buying. My goal is to reconstruct the conversation within and between these literatures in order to highlight the particular movements and mechanisms that have contributed to the construction of compulsive buying as a mental dysfunction. There has not been a sociological analysis of compulsive buying from this perspective, although there has been one article on the medicalization of compulsive buying in Canada (Lee & Mysyk, 2004). The authors relate compulsive buying to the global economic crisis of the 1980s and 1990s, and Canada's "jobless recovery" (2004: 1716). I largely address the social construction of compulsive buying as a disorder, and offer insight into shifts in academia and public opinion that have enabled the medicalization of this form of deviance. Thirdly, I touch upon the insertion of the pharmaceutical industry into compulsive buying, which demonstrates that the biomedical "advancements" have altered public perceptions of human behavior and health and reshaped the idea of what significant academic research is. This is particularly relevant to sociology, as current trends jeopardize the importance of Mills' sociological imagination. In conclusion, I offer an explanation of why the medicalization of deviance is so critical at this moment in time, and why compulsive shopping is perceived to warrant a medical label.

I. The Social Construction of Mental Illness and the Medicalization of Deviance

While most often occurring in tandem, social construction of illnesses and medicalization of deviance are somewhat different processes, although the degree to which they differ may depend upon one's analytical perspective. A true social constructionist would say that all mental illness is constructed according to cultural context, and that this construction relies upon on judgments regarding how to classify deviance (see Szasz

1960, 1972; Sedgwick, 1982). Others may argue that there *are* real dysfunctions that produce harm, hence the symptoms are not constructed, but the lumping together of symptoms into a discrete disorder or the meaning attributed to that disorder is (Wakefield 1992, 1999, and Horwitz, 2002, are closer to this position).

Currently, mental illnesses are defined by the APA, with increasing help from the pharmaceutical industry (Conrad 2005). As such, they are necessarily "medicalized," but "mental illness" is meant to refer to a body of classifications based on how mental illness is conceptualized within a culture; which medical models are in place influence how classifications of characteristics are made. For example, our culture defines hallucinations as symptoms of mental illness whereas other cultures might define hallucinations as religious experience. Horowitz describes mental illness as "whatever conditions a particular social group defines as such…. [T]he concept…refers to the actual labeling processes in any group, and therefore cannot be true or false" (Horwitz 2002:15). One major categorization we make is diseases of the "mind," mental illness, and diseases of the "body," physical illness (Bruce, 1999). Western philosophical tradition, which emphasizes a mind-body dualism, certainly influences how we conceive of different diseases. We generally think physical illnesses are distinct from functions of cognition or organization of experience and mental illnesses are distinct from physical ailments. Obviously the line between the two is fuzzy: "psychosomatic" illnesses are defined as mental illnesses that produce physical ailments, and physical illness can produce changes in the mind and mental functioning. Traditionally, western medicine has tried to define the two as distinct categories, but current perceptions of fuzziness between the two may be a product of growing interest in neurobiology, and growing acceptance of the link

between neurobiology and psychological states; the more psychiatry embraces a this standpoint, the fuzzier the distinction between "physical" and "mental" will become.

As the deviance literature makes clear, what "symptoms" we cluster together to comprise particular diseases in addition to which symptoms or diseases we define as belonging to the mind versus the body result from deeply political and social processes. Wakefield (1992, 1999) proposes that mental disorders are, or should be, defined by whether they are harmful – a social designation – and whether they stem from an internal dysfunction of a psychological process. If we perceive the illness as stemming from other, particularly external, sources – depression due to death of a spouse, or chronic headaches from eyestrain – we would not perceive the behavior to be "mental illness." However, in this view, depression that lasts longer than most would expect might be said to have triggered psychological dysfunction: the mourning or resilience function is not working the way it is supposed to. "Longer than most would expect" is a social evaluation, a decision based on the assumption that what is normative is how mental processes have evolved to function.

More confusion arises when considering cases like compulsive buying. It is not clear that compulsive buyers have a "mental" dysfunction. Furthermore, it is not clear how to measure such a dysfunction. It is obvious that someone who cannot stop spending money and obsessing over shopping has some kind of "problem," but is this problem a manifestation of a mental dysfunction, or a legitimate reaction to external circumstances (see Horwitz, 2002: Ch. 1)? If the reaction to external circumstances is not normative, does that necessarily mean the person is experiencing a mental dysfunction? A coping mechanism, for example, is not a mental dysfunction – the mind is still functioning

adequately; even using “unhealthy” ways to moderate duress (assuming again that the duress should, in majority opinion, provoke a reaction of appropriate severity) should not provoke mental dysfunctions. *Choosing* an unhealthy coping mechanism would seem to be deviant, particularly if the choice is “misguided” and harmful. Yet, even so, choosing to harm oneself could be construed as an illustration of a psychological mechanism gone awry.

Szasz’s (1972) concept of “problems in living” is germane to this discussion. Szasz proposes that mental illnesses are really metaphors because we are applying the same construct that we use for physical disorders onto mental disorders, and the construct does not map appropriately – psychological problems cannot be explained by defects in the brain or nervous system. Szasz also holds that we “invent” mental illness through classification schemes. While current critics would argue that there is a biological basis to psychiatric problems (Kandel, 1998; also see Wakefield, 1992), or argue that the “defect” is there but has yet to be discovered, Szasz’s observation that many mental illnesses are problems in living is justifiable. Depression may be a problem in living, as anxiety and social phobia may be: cross-cultural research suggests that the U.S. has higher rates of mental disorders than less developed nations (James, 2000; Weiss, 2005), and even schizophrenia has been found to be less problematic in more collectivist or community-oriented countries (Kirmayer, 1989). Culture shapes disorder behavior as well as perceptions of disorder; if people in westernized countries are more likely to have depression, or compulsive buying disorder, perhaps the dysfunction is in the social structure and not (exclusively, at least) in the brain.

While Wakefield's conception of mental disorder as a harmful internal dysfunction is a practical and useful definition, his definition does not protect against abuses of power in making decisions about what constitutes "harmful" or "internal." Traditionally, those making decisions about what constitutes mental illness and what does not have their own interests in mind rather than the interests of less powerful groups (Becker, 1991 [1963]; Quinney, 1975). An oft-cited example of abuse of power is the Soviet Union's institutionalization of political dissents in mental asylums in the early 80s, but less "intentional" abuses of power include clinically treating homosexuality or premenstrual dysphoric disorder as psychological dysfunctions. In a recent talk at the Institute for Health, Health Care Policy and Aging Research (IHHCPAR) at Rutgers University, Dr. Robert Spitzer, Head of the Task Force for DSM-III, said he thought premenstrual dysphoric disorder should be added and homosexuality should still be included in the DSM,[8] but then reconsidered – society has become more tolerant of homosexuality, so it may not be dysfunctional anymore (IHHCPAR talk, March 9, 2006). The norm is presumed to be what is good, natural, healthy – "the golden standard" – and hence the norm defines what the proper functioning of an internal mechanism is.

Conrad (notably 1992, 2000; and with Schneider, 1980) has spent his career investing the medicalization of deviance, what he aptly describes as the movement of specific behaviors (and people) from "badness" to "sickness." In the 80s and early 90s, Conrad saw the prime shapers of "sickness" being the medical profession, social movements and interest groups, and power disputes between and amidst professions. Definitions of illness were constructed in similar ways as definitions of deviance: moral entrepreneurs, claims-makers, and pressure groups (see Adler and Adler, 2006: 135-8) all

played key roles. Conrad (2005; lecture, 2006) has recently argued, however, that medicalization has progressed into an advanced phase, such that the pharmaceutical industry, genetic research, patient-consumers and managed care have become the primary drivers of medicalization. Unlike Clarke et al. (2003), he sees this new phase of medicalization as a shift in processes, not a complete transition to new and different mechanisms.[9] Conrad argues that these emergent engines were present in earlier phases of medicalization, but just were not dominant. Recent advancements in biotechnology and the increasing power of the pharmaceutical industry have turned health care into a marketing campaign for human perfection, and individuals into carriers of preventable or treatable abnormalities. Whereas once pharmaceuticals targeted sickness, now they target "normal" conditions, convincing the public in direct-to-consumer advertising that almost any bothersome aspect of humanity can be "fixed" through medical, i.e. drug, treatment. Carr (IHHCPAR talk, March 21, 2006) touches upon a similar topic in her work on aging, noting that responsibility for health care has shifted onto the individual, but, moreover, the individual is expected to work on improving the self through health care, not simply maintaining decent levels of healthiness. Conrad and Carr suggest that normal behaviors – or what we considered normal not so long ago – are now unacceptable, such that abnormality is actually becoming the norm. Individuals are now encouraged to be smart consumers and ask their doctors for information about new drugs and treatments for previous non-problems in order to attain new standards of acceptability.

The Sociological Challenge

Conrad (2005) challenges sociologists to focus on these processes born of the new

engines of medicalization. He does not intend to imply that definitional processes are not important – they remain the center of medicalization – only that medicalization is driven more by market interests than physicians, lay interest groups, and professional boundary drawing. While I agree that he has identified the major mechanisms of medicalization for the early 21st century, I cannot, however, completely address these issues within compulsive buying as it is still in its infancy as a disorder: Managed care is not yet involved in compulsive buying, at least overtly; pharmaceutical companies have only just begun to assert their many talents; and compulsive buyers are, ironically, not yet able to be "consumers" of medical products directed at compulsive buying, although some are already consumers of psychiatric and self-help services and medications for other disorders. Rather, the unfolding narrative of compulsive buying parallels the historical shifts in medicalization that Conrad discusses**:** in the 80s, professional and public interests were drivers in defining compulsive buying, kicked off by publication of the DSM-III and the proliferation of mental disorder that ensued. These drivers were overpowered in the 90s by the biologized perspective and the entrée of pharmacology into psychiatry. Perhaps in the 2000s, compulsive buying will fully arrive – receiving an official definition in the DSM, and becoming the darling of pharmaceutical companies. At this moment in time, though, the discourse surrounding compulsive buying is still being set in place. This discourse is the product that ultimately needs to be consumed by public and professionals.

I want to emphasize here that psychiatrists and psychiatric researchers can be considered an arm of the pharmaceutical industry. Active in their support of drug therapy and developing neurological/biological links to psychology, psychiatrists work with

pharmaceutical companies, sometimes in unethical ways, [10] either to reap the benefits bestowed upon them by these companies or to protect their profession from obsolescence. Kandel (1998), writing from within psychiatry, claimed that we are "in the midst of a scientific revolution – transforming our understanding of life's processes" (467). Worrying about the declining rates of medical students interested in psychiatry, presumably because they were being enticed by the excitement of neurology and biomedicine, he urged psychiatrists to revitalize the field by studying "brain processes…[and] to encompass mental and emotional life within a biosocial framework" (467). He also asserted that all mental illnesses are biological, and that people recover through therapy because "psychotherapy is successful by bringing about changes that alter gene expression that produce new structural changes in the brain" (466). While Kandel's interest in having psychiatry move into neurological and biological study is genuine, this shift created an opportunity for the pharmaceutical industry to assert power over the field – by funding university and private research, aggressively encouraging the prescription of certain drugs and other such methods. Conrad (2005) also makes the point that doctors in general are hampered by managed care due to what procedures and therapies are covered by insurance. Psychiatrists are directed by the pharmaceutical industry, constrained by managed care and hounded by patient-consumers for what they think is the best treatment, usually surmised through watching TV ads and surfing the Web (Conrad, IHHCPAR, all of which are responsible for the emergence and dominance of the current biologized perspective on mental health.

A point made by Horwitz (1999) is worth repeating here: the legitimacy we give to disorders that we think originate in the brain is not because they actually originate in

the brain (or because we think they do), but because we belong to a culture that privileges biological explanations for mental illness (70). Ultimately the evaluation we need to make is whether including certain harmful dysfunctions under the category of mental illness is useful (Horwitz 2002: 10), and whether it is actually helpful to the afflicted

The line between illness and deviance has been tenuous, at best (see Foucault, 1965). Medicalizing problematic behavior is a form of social control, but, looking on the "bright side" of medicalization (Conrad, 1992), medicalizing compulsive buying could actually help people with this problem, giving them a label and possibly treatment covered by health care (see Thoits, 1985). Thus, there is an inherent tension in setting forth a definition of compulsive buying as a disorder. By making a distinction between the disorder and less problematic forms of buying, like impulse shopping, compulsive buying necessarily becomes pathological and extreme – and even if the disorder is linked to genetics or serotonin levels, the individual would remain somewhat stigmatized (see Martin, Pescosolido and Tuch, 2000). In addition, it would seem to benefit people to seek help before sinking themselves into unrecoverable debt, destroying their professional credibility and personal relationships; yet, by clinical definition, compulsive buying can only be recognized by its full-blown symptoms: if moderate cases were to be diagnosed, the question then would be what is really being presented, compulsive buying disorder or problematic buying behavior. Ultimately, whether compulsive buying becomes a "true" disorder or not will be negotiated by the pharmaceutical companies, health care companies and public opinion,[11] hopefully with sociologists, health care policy makers, and concerned doctors present as watchdogs.

II. Compulsive Buying and the DSM

Originally defined within the consumer behavior literature (Faber and O'Guinn, 1987; O'Guinn and Faber, 1989; Valence, d'Astous & Fortier, 1988), psychologists have redefined compulsive buying based on the criteria for impulse-control and obsessive-compulsive disorders within the third and forth editions of the Diagnostic and Statistical Manual of Mental Disorder (DSM-III and DSM-IV) (American Psychiatric Association, 1980, 2000). The "clinical" definition emphasizes preoccupation with buying; extreme buying behavior (e.g., buying more than one needs, several of the same item, or more than one can afford) provoked by uncontrollable urges; and buying behavior which interferes with the individual's functionality or causes distress (occupational, financial or personal) (McElroy, 1994). The condition appears to be highly correlated with other impulse-control, obsessive-compulsive, and mood disorders – which should provoke questions about whether compulsive buying can be considered a discrete disorder[12] – but for the most part it is considered a bounded syndrome. Thus far, etiology and prevalence rates have only been estimable since studies have been based on non-representative samples. Despite the inconclusiveness of these studies as to the prevalence of, pathways to, and distinctiveness of compulsive buying as a disorder, these researchers seem to be in agreement that it is, in fact, a disorder, and a predominantly female one at that.

Most of the psychiatrists[13] who have worked on compulsive buying have traced its lineage back to Emil Kraepelin and Eugene Bleuler, prominent psychiatrists at the beginning of the 20th century. Kraepelin in particular is an important anchor for compulsive buying**:** He is generally credited with being the founder of modern *scientific* psychiatry, although his work has largely been overshadowed by Freudian psychoanalytic

theory. A contemporary of Freud, Kraepelin's diagnostic system is surprisingly antithetical to psychoanalytic theory, which is based on individualistic interpretations of symptoms. Instead, Kraepelin emphasized symptom *patterns* as diagnostic criteria, not the symptoms themselves, and proposed that diseases are distinct entities, having distinct symptom patterns (Horwitz, 2002; lecture notes, 2006).

Kraepelin identified oniomania – buying mania – in the eighth edition of his textbook of psychiatry, Psychiatrie, in 1915. This is important not only because his textbook was widely used, but also because it was the first to feature diagnoses of mental disorders. Classified as a "pathological impulse" (Kraepelin 1915, as cited by Lejoyeux, Ades, Tassain and Solomon, 1996), its connection to today's impulse control disorder category in the DSM is relatively straightforward. It is noteworthy that compulsive buying's link to Kraepelin has resurfaced after being buried by Freudian psychoanalysis or, more generally, dynamic psychiatry for so long. Dynamic psychiatry was the dominant medical perspective on problems of the mind since the beginning of the 20th century, becoming more mainstream in America post-WWII. Its uncontested position could explain the "disappearance" of compulsive buying from public and scientific knowledge since the model did not provide criteria for diagnosis of particular mental disorders; practitioners tended to blur distinctions between "normal" and "abnormal" behaviors in offering analysis (Horwitz, 2002: 41). Psychoanalysis, in both the past and present, would treat compulsive buying as a signifier of a deeper psychic problem, and what exactly that problem was perceived to be would change person to person, depending on his or her particular neuroses and experiences.

The reemergence of the concept of compulsive buying as a disorder can be linked to the displacement of dynamic psychiatry by diagnostic psychiatry. Dynamic psychiatry began to lose favor in the 1960s and particularly the 1970s, at which time the task force for the DSM-III was assembled. This shift to a more scientific, symptom-based organization of mental disorders occurred in part because of demands from within the psychiatric research community for a more reliable diagnostic system. The task force assembled to reconstruct the DSM also happened to intellectually identify with Kraepelin, calling themselves "neo-Kraepelians" (Horwitz, 2002: Ch. 3; Wakefield, 1999). The new diagnostic system, presented formally in the DSM-III, is based loosely on Kraepelin's classification system. Perhaps not coincidentally, the first version of the DSM-III was published in 1980, about the time when compulsive buying began to reemerge in the popular press as a serious psychological problem.

The publication of the DSM-III enabled "new" definitions of mental disorders to emerge. Although many of the actual symptoms of these disorders were present before, and attended to by dynamic psychiatry, they were reorganized and given distinct disorder labels by the new classification system of diagnostic psychiatry. This reclassification also led to the absorption of many deviant behaviors into mental illness (Horwitz, 2002: 67-73). This was in part possible due to how the DSM-III, and now –IV, classifies "mental disorder":

> **[A mental disorder is a]** clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress … or disability … or with a significantly increased risk of suffering …. [I]t must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the individual. Neither deviant behavior … nor conflicts … are mental disorders *unless the deviance or conflict is a symptom of a dysfunction in*

> *the individual*, as described above (The American Psychiatric Association, 1987: xxii; 2000, online introduction; italics mine).

While this definition includes a clause to prevent deviance from being diagnosed as illness, as I mentioned earlier, deviance has and can be defined as behavioral or psychological dysfunction because this classification is dependent upon current norms.

This definition is also at odds with the criteria presented in the DSM for diagnosing disorders, and how the DSM is ultimately used by clinicians and health care organizations. Every diagnosis rests upon a set of symptoms for which the individual is tested. Horwitz (2002: 73) explains, all that would be necessary to convert a behavior like compulsive buying – the example he gives is "compulsive television watching" – into a disorder is criteria by which that disorder can be named and reliably tested. Thus, to meet the DSM definition, a dysfunction within the individual that causes sufficient distress, all that is really needed is a checklist of distressing symptoms: do preoccupations with shopping prevent you from conducting your normal activities? Do you feel out of control when you shop? Have others commented on your inability to focus on your job or family because of your preoccupation with shopping? Using screening questionnaires and clinical judgment, a person would be labeled a compulsive buyer if they meet a certain cut-off point for the necessary number of symptoms or severity of those symptoms. Establishing the cut-off point for diagnosis is ultimately somewhat arbitrary – a person with four out of six symptoms is a compulsive buyer, a person with three and a half is not; likewise, if scales are used, how a person decides the extent to which they feel out of control on a scale from one to six is subject to current context and a personal interpretation about what those numbers actually mean. While diagnostic screeners and

criteria attempt to account for variation in severity and symptoms, they ultimately produce dichotomous categories: one is defined as a compulsive buyer or one is not.

A checklist of symptoms and a definition seems to be enough for compulsive buying to be considered a disorder, even without the formal classification (McElroy et al., 1994). A few academic articles posit that compulsive buying already *is* "classified in DSM IV as an impulse control disorder not otherwise specified" (Black, Repertinger, Gaffney and Gabel, 1998); "currently classified in DSM-IV as an impulse control disorder" (Grant, 2003: 223); "included in the residual category 'Disorders of Impulse Control Not Otherwise Specified' [of the DSM-IV-TR]" (Dittmar, 2005a: 468); "still listed under the residual DSM category of Impulse Control Disorders Not Otherwise Specified" (Dittmar, 2005b: 833); or, more ambiguously, that it "lies within" (Koran et al., 2002: 704) or "falls within" (Hartston & Koran, 2002) the DSM-IV category of Impulse Control Disorders Not Otherwise Specified (ICD-NOS) (also see Goldsmith & McElroy, 2000: 219).

The ICD-NOS category in the DSM is actually a catch-all category for "disorders" that "do not meet the criteria for a specific impulse control disorder" (APA, 1987: 328) or are not a manifestation of another disorder (APA, 2000). For example, compulsive buying cannot be diagnosed with borderline personality disorder, because impulsive shopping is characteristic of that disorder. Impulse Control Disorders Not Elsewhere Classified (ICD-NEC) is the larger, "residual diagnostic *class* for disorders of impulse that are not classified in other categories, e.g. Psychoactive Substance Use Disorders" (1987: 321; italic mine), under which the ICD-NOS category falls. The ICD-NEC category does have specific criteria – in brief, failure to resist an impulse, escalating

tension before committing the act, and ultimate pleasure, gratification, or relief through committing the act – and does classify specific disorders, like kleptomania or pyromania, but the ICD-NOS category *could* be used to "classify" anything else that fits the above description according to the individual psychiatrist or physician.

Enough misstatement about compulsive shopping's status in the DSM-IV prompted Harold Alan Pincus, vice chairperson of the DSM –IV taskforce and the deputy medical director of the American Psychological Association at the time, to write the Washington Post to set a journalist who had erred in explaining the classification of compulsive buying straight:

> We're all in favor of stimulating the economy through more consumer spending ["Stop me before I Shop Again," op-ed, Sept. 14] but not at the expense of trivializing psychiatric diagnoses. Although "compulsive shopping" may be a problem for some people, it is not listed, nor was it even formally considered, in the new fourth edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM), as Daniel Greenberg humorously said it as. The task force of psychiatrists that assembled the new manual set a high scientific data standard for inclusion of additional disorders, and 'compulsive shopping," had it been proposed, would not have been accepted.
>
> The DSM-IV recognizes that many symptoms and behaviors occur across a wide severity spectrum and often do not imply the presence of a psychiatric disorder. The DSM tries to define reliably the clusters of symptoms at the far end of this spectrum that do have a clinically significant impact on an individual's ability to function.
>
> And now, if you'll excuse me, there's a big sale at the mall….
> (Pincus, 1994)

With the psychiatric community's failure to correctly cite the DSM-IV, it is not surprising that journalists also erroneously claim compulsive buying to be a disorder

recognized by the American Medical Association. These errors show a tendency to jump the gun on the part of the public and some researchers within the psychiatric community. Pincus' response is interesting because he is defending the DSM from attack by demeaning compulsive buying as a possible disorder – contrary to the tone other psychiatrists had been trying to set. The role of the DSM is to legitimize disorders, not only define them; in order for the DSM to maintain its authority, it needs to present itself as *scientific*. Pincus says that compulsive shopping would have been rejected based on the data, and there had not been many "scientific" reports published by 1994, date of the first edition of the DSM-IV. There had only been discussion by private practitioners in the mainstream press and studies published by consumer behavior researchers by that time, neither of which are scientific. However, Pincus' willingness to mock compulsive shopping in a major U.S. paper shows that public opinion on compulsive shopping was ambivalent. If public opinion and practicing psychiatrists had garnered more power in pushing for compulsive shopping as a disorder, it would be taken more seriously as a possible consideration.

The source of the confusion over compulsive shopping, however, is not necessarily about conflicting professional opinions, but more so about legitimation rights and conflicting guidelines for diagnosis. The DSM leaves a loophole for individual psychiatrists to interpret new disorders, the ICD-NOS category, however does not give psychiatrists the right to legitimize disorders on their own. Jumping the gun about asserting compulsive buying as a disorder necessarily has to be done before the public will accept the label, and in this case, before the psychiatric research community will scientifically investigate a new phenomenon. The effect of circulating this discourse has

in part been to influence public opinion, priming the public to accept eventual certification, but also, it seems, to force the larger psychiatric community to seriously take notice of emerging behavioral problems. Defining compulsive buying as a disorder ahead of time has most likely conditioned expectations that it be included in the upcoming version of the DSM, the fifth edition, which began development in 1999 and is set to be published in 2011 (DSM-V Prelude Project, 2006).

III. Constructing a Discourse of Disorder

Setting the Tone: Early Newspaper Reports on Compulsive Shopping

Reports presenting compulsive shopping[14] as a serious problem emerged in the popular press in the early 1980s. The Washington Post (Krucoff, 1980; "Buyer's Guide," "Are You a Compulsive Shopper?," 1985), Newsweek ("Compulsive Shopping," 1985), The New York Times ("Shopping Addiction,"1986), The Toronto Star (Fruman, 1986; "Compulsive Shopping," 1986), and the Australian Telegraph (Koopman,1987) were all front-runners, preceding academic publications on the topic and presenting a picture of an insidious and growing epidemic. A typical article would open with an example of a woman who had shopped herself into severe debt, or a paragraph about how shopping is a pleasurable activity for most of us – but for some, a serious addiction. While later reports could mock the notion of compulsive shopping as a disorder outright – at that point, compulsive buying had been more established, hence there was a position to react to – early reports present some unease but generally accept compulsive shopping as a mental health problem. Newsweek's hook conveys the general idea:

> Compulsive shopping? You've got to be kidding, Is that the answer to the latest trivia-game question on trendy addictions? It may sound absurd, but to the shopper who can't stop at the hosiery counter without blowing a cold $100, the obsession is no joke. Thousands of Americans are caught in the grip of shopping madness, flocking to malls and boutiques across the land. Mental health experts acknowledge that the problem is still relatively unexplored, but many believe it is widespread ("Compulsive Shopping," 1985: 81).

The tone is sensationalist, but the theme common: you won't believe it, but this is a serious mental problem. The subtext: women are spending money like mad. The proof: healthcare professionals agree. This set-up intends to draw the reader into the author's confidences (I share your skepticism), recognize how ridiculous this disorder sounds (women cannot control their impulses, but a disorder?), and create panic while evoking patriotism (thousands of Americans are rushing out to malls; we should be concerned and do something). Variations on this theme dominated the popular press, but ultimately formed a "campaign" to take compulsive shopping seriously.

The trendiness noted above in labeling excessive behaviors "addictions" can be attributed in part to the 1980 publication of the DSM-III, which marks a major shift in how mental illness is perceived and diagnosed. Instead of the previous psychodynamic model, the DSM-III set forth symptom-based criteria for diagnosing mental illness. This change in models, which I previously discussed, led to the proliferation of mental illness, labeling "abnormal" behaviors and mood states "disorders" (Horwitz, 2002). At this point in time, the public had recently witnessed deviant behaviors such alcohol abuse, compulsive gambling, anorexia and certain sexual dysfunctions morph into mental disorders. On one hand, this set the stage for compulsive shopping to emerge as a disorder; on the other, as suggested above, the public was growing somewhat weary of

"trendy addictions." Compulsive shopping, with its connotations of female frivolity, could have been a difficult sell.

For the most part, though, compulsive buying was not seriously challenged as a potential disorder. However, there had not yet been an event to catalyze dissent, such as known consideration for inclusion in the DSM. Journalists' interviews with prominent area psychiatrists, psychoanalysts and/or credit counselors predominantly lent legitimacy to the claim, demonstrating that the condition was not a product of newspaper sensationalism. Despite acknowledging public skepticism, few early articles offered scrutiny of compulsive shopping as a disorder nor of the experts solicited, but instead provided a forum within which professionals could vie for prospective clients – and ownership of the problem. Some experts even provided simple self-tests[15] so readers could evaluate their own likelihood of being a compulsive shopper, followed by where and how to seek treatment – usually at their own facilities.

Not surprisingly, psychiatrists, as represented within these articles, described compulsive shopping as an outcome of low self-esteem, feelings of emptiness, anxiety, or depression – traits targeting individuals, particularly women (e.g., see "Shopping Addiction," 1986; Blashki, 1988; Busmer, 1991; Weese, 1994). Somewhat contradictorily, psychiatrists and researchers at this early stage also claimed that men were as likely to be compulsive shoppers as women, only less likely to seek treatment and more likely to buy big-ticket or collector's items (Nemy, 1985; Blashki, 1988; "Compulsive Shopping Growing," 1986; Gentry, 1991). Since men were not typically seeking treatment, substantiating whether or not there were actually moderate numbers of male compulsive shoppers was rather difficult. Furthermore, most of the examples the

press and psychiatrists used were female; words like “shopaholic” or “spendaholic,” mostly associated with women, were used to appeal to the public; and comparisons to “masculine” disorders were made in attempt to legitimize the disorder: “It’s a compulsive disorder – it's a syndrome much like gambling and alcoholism. It’s a build up of anxiety that needs to be released,” said one psychotherapist (“Shopping Addiction,” 1986). Conceptually, compulsive shopping cannot be frivolous if it is lumped into the same category as stigmatized, and masculinized, behaviors. These presentations did little to disrupt the collective schematic conflation of shopping and women – perhaps even reinforced it. However, positing compulsive shopping as the female counterpoint to compulsive gambling and alcoholism may have been the more advantageous strategy in the long run. Convincing people to take compulsive shopping seriously relies on making it believable: “male compulsive shoppers” produces a cognitive disconnection for most Americans and since gambling had just been entered into the DSM-III, compulsive shopping had more of a chance of being taken seriously by riding on its coat-tails.

The other group of experts commonly solicited in the early stages of defining compulsive shopping was credit counselors. It is difficult to gauge how much credit counselors accepted psychological explanations that compulsive shopping is a mechanism to compensate for lack of love or self-esteem. Credit counseling services existed before the compulsive shopping epidemic and were accustomed to seeing large numbers of people who could not maintain financial health. With the right criteria, many of these people probably could be classified as compulsive buyers, but credit counselors on average tended to situate spending problems in a different context. As one credit counselor claimed, if 99% of people seeking help from credit counselors simply spend

more than they earn, the problem, then, for them, is not defined by individualized psychic states, but by cultural conditioning: "It is a habit that is built up over time, and it's a difficult one to break" ("Shopping Addiction," 1986).

Debt-forming habits, credit counselors stress, are encouraged by easy access to credit and having multiple credit cards at one's disposal, in addition to the policies of credit card companies themselves: giving cards to people with bad credit histories, "handing out special cards giving clients a sense of prestige" ("Compulsive Shopping Growing," 1986), upping credit limits and offering minimum payments with high percentage rates. Identifying social acceptance of debt as the problem more than individual (female) pathology, they warned that compulsive shopping would only increase: "We have a whole generation that has been brought-up in a credit-card society. They grew up with dept and use it freely" ("Shopping Addiction," 1986).[16] This approach still displaces the blame from the individual consumer, only instead of to psychological problems, to the credit card companies. This approach also infantilizes the general consumer by suggesting credit is too powerful a force for many consumers to manage prudently. For some, perhaps it is.[17]

Both perspectives have some validity, but pitching compulsive shopping as a female disorder is somewhat more "concrete" than warning about the ill-effects of consumerism. In addition, there are benefits to disordering compulsive buying. While these two perspectives appear compatible – treating compulsive shopping as a disorder does not seem antithetical to claims against consumerism – the process of medicalizing compulsive shopping inherently protects current norms of consumerism. Whereas an "abnormal" behavior can still exist on the fringe of group boundaries (Erikson, 1966), a

"pathology" is clearly outside the bounds of normal group behavior; Erikson claims that groups need potential deviants to reinforce group boundaries, if simply by pointing out where those boundaries are, but serious transgressors are ousted from the group altogether. As capitalism and consumer society depend upon people shopping impulsively and even excessively at times, these forms need to remain within "normal" group behavior,[18] which depends upon compulsive shopping jumping categories from "badness" to "sickness" (Conrad & Schneider, 1992). Compulsive buying has to be pushed beyond the realm of normalcy to keep these other forms of buying from suspicion or else they too might be considered "sick" and, consequently, the entire shopping enterprise or consumer culture pervious to moral and/or rational scrutiny. Medicalizing compulsive shopping thereby substantiates the integrity and rationality of American consumerism – and the ordinary American consumer – by offering an oppositional category.[19] As I will discuss shortly, early consumer researchers attempted to treat compulsive shopping as a mental disorder *and* locate possible causes of the disorder within consumer industry but soon found this relationship cognitively unsustainable.

The medical discourse surrounding compulsive shopping deters investigating the social conditions that may be contributing to the problem while also protecting the individual from ultimate responsibility. As psychiatrists became more dominant in academic discussions, moving the discourse from external to internal mechanisms, they also became more vocal in the press, displacing the perspective of debt and credit counselors. I surveyed 250 general news articles from major newspapers from 1985 to 2006,[20] and, of these, the articles that solicit experts to discuss compulsive shopping or buying reference psychiatrists nearly four times as often as credit counselors. If I add the

vaguely described “researchers” addressed in some articles (as in, “researchers say….”) to the psychiatrist category (most were psychiatrists at universities, but were not named as such, or were other kinds of professors), then psychiatric and academic professionals would have been referenced over fives times as often as lay experts.

Somewhat contradictory, however, self-help groups like Debtor’s Anonymous and other credit counseling groups were often listed as resources in these articles, rather than or in addition to psychotherapy, and were deemed successful in providing services to compulsive shoppers (e.g., see “Shopping Addiction,” 1986; Gentry, 1991; Webb, 1992; Wasco, 1992; Weese, 1994; Siskos, 2002). Psychiatrists did gradually spread into traditional lay territory, becoming part of the self-help book market (e.g, Damon, 1988; Wesson, 1990; Aronson, 1991; Coleman and Hull-Mast, 1992; Grant and Kim, 2003), but other non-psychiatric experts popped up as well, filling a “new” entrepreneurial niche as “money managers” (Thernstrom, 2002).

From the proportion of references to psychiatric professionals in these articles, it is clear that the public and the media have accepted psychiatrists as the chosen experts – at least in America. This is not to say that there were not pockets of resistance to medicalization, but that objections did not make any sizable impact in the development of compulsive shopping’s disorder narrative.

Initial Definitions: Consumer Research

Consumer research today is considered a subset of marketing, found on college campuses mostly within business, advertising and marketing departments. While the field has interdisciplinary roots, now it predominantly uses soft versions of psychology and

sociology in the service of retail or product marketing (see Kassarjian, 2005, for a short history of the evolution of the field; a separate treatment of consumerism, more akin to cultural studies, is what scholars like Juliet Schor do). On one hand, it makes perfect sense that consumer researchers would have "discovered" compulsive buying, as they are the ones most attuned to that social world; on the other hand, psychologists with private practices and other self-help groups had also noted this behavior. The initial lack of academic interest by research psychiatry enabled consumer behavior's prowess in this area, but, ironically, consumer behavior's work in this area attracted attention by psychiatric researchers.

Compulsive buying became a hot topic within consumer research mostly due to the work of two American consumer behavior researchers – Ronald Faber, a professor of journalism and mass communication at the University of Minnesota, and Thomas O'Guinn, a professor of advertising and business administration at the University of Illinois, Urbana-Champaign. A team of Canadian researchers – initially led by Gills Valence, but continued by Alain d'Astous, professors of marketing at the University of Sherbrooke, Québec – was also instrumental in producing compulsive buying as a subject area for academics. Starting off on common ground, both sets of researchers proposed similar models of compulsive buying, based on a variety of social, psychological and biological causes. The two research groups soon diverged, however, on the issue of whether or not compulsive buying is distinct from other forms of buying. The decision as to whether compulsive buying is quantitatively or qualitatively distinct from other forms of shopping is important for the reasons referred to above in the former section. If only quantitatively different, compulsive buying remains within the realm of "normal" human

behavior. If qualitatively different, then compulsive buying becomes pathological. This decision is pivotal in enabling or rejecting the medicalization of compulsive shopping and in determining which academic field can legitimately study it. The American team ultimately claimed that compulsive buying is a pathological condition, merging with the psychiatric perspective; the Canadian team warned of the loss of knowledge this perspective could entail and encouraged another path for future consumer researchers. Viewing the behavior as "distinctive" and not "excessive" forces compulsive shopping into the "sickness" category rather than allowing it to remain in the "badness" category (Conrad and Schneider, 1980).

In their early articles, the American team of Faber and O'Guinn worked with the definition of "compulsive consumption" as a consumer behavior that is "inappropriate, typically excessive, and clearly disruptive to the lives of the individuals who feel impulsively driven to consume" (Faber, O'Guinn, and Krych, 1987: 132). They initially proposed the topic important for *consumer researchers* to study because of its impact on consumer patterns: "buying has an abuse potential" which could lead to debt, "create economic and emotional problems for [compulsive buyers] and their families... [and] adversely affect their creditors" (O'Guinn & Faber, 1989: 147). Moreover, they claimed studying compulsive buying was an "exploration of abnormal consumer behavior … [with] potential to further our understanding of more typical buying behavior" (1989: 156). At this point, they maintained a connection between compulsive and normal buying behavior, defining them relationally; they naturally assumed that consumer researchers, as studiers of people's buying behavior, were the appropriate people to investigate this behavior.

This language is important because it shows that Faber and O'Guinn (with Krych, 1987; O'Guinn & Faber, 1989) initially framed compulsive buying within constructs of deviance, not mental illness, even though they did use psychological explanations and classifications to aid their analyses. They suggested that compulsive buying works in ways similar to other compulsions and addictions – first an uncontrollable urge, then heightened emotion, then relief, then regret – but, as of yet, they did not detach the urge, or the compulsion, from its manifestation, buying; thus the buying urge is not about a vague, underlying, psychological state, looking for any attachment object. Rather, the uncontrollable urge to buy products marks compulsive buying as something different from normal buying but does not divorce the behavior from the consumer realm. Insofar as Faber and O'Guinn addressed the psychological components of compulsive buying in their early articles, they focused on the psychological functions buying performs, which necessarily invokes social context; buying would perform different functions in a different social context. They focused less on the seemingly socially-isolated causes of compulsion, like neurological dysfunctions.

Similarly, Valence et al. (1988) were careful to use psychological mechanisms to explain compulsive buying as an excessive buying behavior – not as a symptom pointing to the existence of a compulsive trait or disposition. They constructed typologies of consumer behavior based on differences in emotional and cognitive states (421), and created a measurement scale for compulsive buying that incorporated levels of psychological tension and emotional reactivity[21] (426); yet they clearly linked compulsive buying behavior to consumer culture and advertising, appealing to the "macro-marketing responsibility on part of the industry in general" (431).

Thus, at the inception of compulsive buying research, consumer researchers did relate compulsive buying to other compulsive disorders for explanatory power – by simply labeling a behavior "compulsive," the link is unavoidable – but in setting up advertising, family relations, consumer culture, bank cards and the like as largely responsible for the behavior, they made it clear that this problem was not solely the product of mental dysfunction. They retained the possibility that compulsive shopping could be a natural response to external stimuli or an outlet for other "normal" frustrations.

Maintaining the balance between psychological explanations for compulsive behavior and social explanations for abnormal consumer behavior, however, proved difficult. As they progressed in their explorations, Faber and O'Guinn became convinced that compulsive shopping is *qualitatively* different from "normal" shopping, not just quantitatively, as Valence and d'Astous and colleagues believed (Valence, d'Astous and Fortier, 1988; d'Astous and Tremblay, 1989; O'Guinn and Faber, 1989). Claiming that compulsive buying is distinct from excessive or impulsive shopping carved out "new" territory for them to investigate; no one else had determined that this was a distinct form of consumer dysfunction. It also enabled them to explain a conundrum: a lot of people have low self-esteem, are depressed and want higher social status – three of the main rationales for why people shop compulsively – but the majority of these people do not become compulsive shoppers (or compulsive eaters, drinkers or gamblers, for that matter). By differentiating compulsive shopping from "normal" behavior (and "normal" levels of low self-esteem, depression, and status seeking), they could pose that compulsive shoppers have radically different orientations to spending -- but this

assessment necessitated proposing that these spending orientations were based on radically different psychological make-ups.

Segmenting compulsive buying into its own, discrete category out of the normal-to-abnormal continuum distinguishes a behavior as qualitatively different, but it would also seem to be a dangerous step for consumer researchers to make: it precipitates labeling compulsive buying a disorder, which then removes the topic from their jurisdiction. As in many cases of deviant behavior, avoiding the transition from "inappropriate" to "pathological" is difficult, especially when the behavior appears morally incomprehensible[22] to a majority of people. Buying compulsively to such an extreme level – sinking oneself tens to hundreds of thousands of dollars into debt by shopping, rather than through buying a house or paying for college, for example – becomes unconscionable, immoral, and incomprehensible; it offends our latent Puritan values of self-control and hard work, but also exposes our ambivalence about those values (Hewitt, 1989; Reinarman, 2006). Ultimately, it may be easier for people to accept compulsive buying as disorder/illness rather than moral failing or egregious irresponsibility because pathologizing a behavior means that "normal" people are protected from incurring it – only "sick" people are susceptible.

Interestingly, Faber had written to another consumer researcher in Germany, Gerhard Scherhorn, asking if compulsive buying should be considered part of a continuum or a departure from normal buying (Scherhorn, Reisch & Raab, 1990). Scherhorn did not date this exchange but reported that he had responded that it is both: he proposed that the tendency toward compensatory buying is present within the consumer populations of westernized countries, but when this tendency becomes a dependency on

buying, the behavior becomes “addictive buying,”[23] his preferred terminology.[24] Scherhorn et al. also claimed that the addictive buyer is not controlled by his or her urge, nor perceives the urge to buy as foreign to the self. The individual experiences this urge as his or her own need or want (Scherhorn, 1990: 383). This characterization of will fundamentally clashes with the clinical definition of compulsion. Faber and O’Guinn did not adopt this perspective, instead concluding that compulsive buying is different from other forms of buying and that the compulsion is often against one’s will, or is at least not controlled by it.

In doing so, Faber & O’Guinn (1992; O’Guinn and Faber 1989) accept the clinical definition of “compulsion,” rendering social context a subordinate if even necessary explanation. They began to frame the behavior within a larger group of “compulsive consumptions,” like binge-eating, hypoactive sexual desire, gambling, hair-pulling and kleptomania. Linking compulsive shopping to other impulse-control disorders embeds it within a discourse of disease and mental dysfunction, not one of problematic consumer behavior. This move aligned Faber & O’Guinn with the dominant psychiatric framework at the expense of the interests of the larger consumer research profession, as illustrated by responses within the field to their shift in position.

d’Astous (1990), writing on his own, specifically objected to Faber and O’Guinn’s new position, instead defining compulsive buying as the extreme end of the normal spectrum of consumption behaviors. He also modified his earlier view (Valence et al., 1988), agreeing with Scherhorn et al. (1990) that “a generalized urge to buy” is present in the general population and that compulsive buyers are particularly high on this dimension (d’Astous, 1990: 17; Nataraajan & Goff, 1991: 309). Furthermore, in an article

entitled “An Inquiry into the Compulsive Side of ‘Normal’ Consumers,” d’Astous (1990) called Faber and O’Guinn’s position “extreme” (15), and warned, “by dichotomizing the world into compulsive and normal consumers, we may be missing an important aspect of consumer behavior” (16). Perhaps more defensively – or sarcastically – d’Astous and colleagues wrote in a later article, “Without denying the interest of adopting a quasi-pathological orientation to study compulsive buying behavior,” their approach “has much to offer” because it “is driven by the belief that less excessive forms of dysfunctional consumption behavior are also important and must be studied” (d’Astous, Maltais & Roberge, 1990: 311). This perspective exemplifies the “pure” consumer research approach, and, ironically, mirrors Faber & O’Guinn’s original position.

As more researchers entered the field, the debate widened but remained centered around core issues of definition and measurement (Nataraajan and Goff, 1991, 1992; Cole and Sherrell, 1995; DeSarbo and Edwards, 1996; Hassay and Smith, 1996; Elliott, Eccles, Gournay, 1996). Faber (1992), however, branched out from strictly consumer-oriented researchers and published a solo article in *American Behavioral Scientist*. In this article, he openly labels compulsive buying an impulse control disorder and embeds the new disorder within psychiatric lineage, starting with Kraepelin and Bleuler (Faber, 1992: 809). This device swiftly (re)asserts psychiatric ownership over compulsive buying and strips “new” cultural factors of their causal poignancy as we now see that this disease existed before recent social conditions came into play.[25] With the publication of this article, Faber throws in his lot with the psychiatric profession, citing McElroy et al.’s (1991) study of antidepressants on compulsive buyers; other psychiatrists working with pathological gambling (Jacobs, 1989; Lesieur, Blume and Zoppa, 1986), hair pulling

(Christenson, Mackenzie and Mitchell, 1991), substance abuse (Levison, Gerstein & Maloff, 1983), kleptomania (Goldman, 1991; McElroy et al., 1991); and others with whom he had recently collaborated (Faber, Mitchell & Fletcher, 1992; Christenson et al.,1992). Furthermore, while entitling his article "Money Changes Everything: Compulsive Buying from a Biopsychosocial Perspective," the social aspect of this perspective is unsatisfactory. Faber only presents a cursory explanation of gender socialization into particular pathologies, mostly focusing on the relative acceptability and easy accessibility of shopping for women. The "bio" and "psycho" parts of the perspective are more developed, leading one to make the assumption that they are more significant to his model. As Peterson (1999) says, the "biopsychosocial" model is "just a slogan until one can fill in its details for specific instances of abnormality" (105).

After this article, Faber and O'Guinn published their clinical measurement scale in 1992, which is still widely used in psychiatric studies. Donald Black (2001), a well-published psychiatrist in the fields of compulsive buying and gambling, acknowledged, "The scale is now considered an important tool by researchers in identifying and diagnosing compulsive shopping" (20). Consumer behavior research has thus become scientifically relevant despite being previously overlooked by psychiatric researchers (McElroy, 1991; Christenson et al., 1994 – which includes Faber as an author; McElroy et al., 1994; Schlosser, Black, Repertinger & Freet, 1994). After the publication of their scale, O'Guinn stopped working in this area and Faber published a couple more articles with psychiatrists (Faber, Christenson, de Zwaan & Mitchell, 1996; Faber and Christenson, 1996; Mitchell et. al, 2002), except both have contributed to the occasional book chapter (Faber, 2000; O'Guinn & Faber, 2006; Faber and Vohs, 2004). What

appears to have happened was that Faber and O'Guinn handed off their work to the psychiatrists entering the field at this time, while other consumer researchers continued working in this area but with less notice from psychiatry and the mass media.

American consumer research into compulsive buying started to return to its roots in the late 90s, after Faber joined forces with the psychiatric field and the psychiatric field moved in the direction of pharmacology. Consumer researchers returned – or were relegated – to exploring topics more directly associated with "consumer behavior." James A. Roberts from Baylor University, Texas, with his colleagues, has frequently published on materialism, family structure, and cross-cultural comparisons of compulsive spending tendencies (Roberts and Martinez 1997; Roberts 1998; Roberts, Cesar and Sepulveda, 1999**;** Roberts, Gwin and Martinez, 2004; Roberts & Manolis 2000; Roberts 2000; Roberts and Jones, 2001; Roberts, Manolis and Tanner, 2003; Roberts and Pirog, 2004; Gwin, Roberts and Itesm, 2005), becoming one of the most prolific writers in the consumer research of compulsive buying. While his work directly states that compulsive buying is a negative by-product of a world-wide consumer culture, it still relies on quasi-psychological measures such as "materialist-value orientation" to gauge issues such as how much self-esteem has been replaced by materialism. However, his work has not been cited by any psychiatric study, while Faber and O'Guinn's continues to be. Other works include Kwak et. al's cross-cultural comparisons between the U.S. and Korea (Kwak, Zinkham and Dominick 2002; Kwak, Zinkhan and Crask 2003) and Kyrios, Frost and Steketee's (2004) cognitive approach to compulsive buying.

These studies are important inquiries into more "concrete" constructs, but their claim to compulsive buying as a field has been overpowered by the media attention

psychiatric articles and drug trials have garnered (see p. 48 of this paper). Because of the strength of the biomedical turn in the scientific community, and the ability of "science" to trump "soft" disciplines, consumer research has been demoted, directed to study topics like materialistic value-orientations instead of "real" psychological functions. The material realm has once again become subordinated to the psychic realm.

Early Psychoanalytic Articles

Movement toward formalizing a definition and diagnostic criteria by the academic psychiatric community was relatively slow-coming, considering the interest of private practices, as presented in the mainstream press, and early publications by consumer researchers. A few academic publications by psychiatrists did appear between 1985 and 1991, but consistent, numerous publication did not occur until 1994. These early publications did not present a cohesive perspective on compulsive shopping, despite all utilizing a psychoanalytic framework. This lack of unified presentation of what compulsive buying "is" might be one reason why the larger psychiatric research community did not take notice.

The first psychological article appeared in 1985 in *Psychoanalytic Quarterly*, entitled "Compulsive Shopping as a Derivative of Childhood Seduction" (Winestine, 1985). This two-page article described a case study in which compulsive shopping was purportedly used as an attempt to rectify feelings of powerlessness and shame stemming from childhood sexual abuse. The compulsive shopping was not directly treated, nor diagnosed as the subject's illness, but rather presented as "an adult symptom" of "the interdigitation of such an experience [childhood molestation] with the development of

intrapsychic conflict" (72). Another two-page case study appeared in the *British Journal of Addiction* in 1987 (Glatt & Cook, 1987). This time presented as an addiction, the authors suggested "pathological spending" be recognized as a "syndrome": their case study subject had developed a "psychological dependence" on spending, using the activity and the goods she bought to compensate for feelings of parental deprivation, to gain social status and to experience "highs." Another set of case studies was published in the *American Journal of Psychotherapy* in 1988 (Kreuger, 1988), presenting yet another analysis but moving closer to establishing a working definition of compulsive buying as its own psychological problem. Describing it as "an overpowering urge to buy items, especially clothing, in a pattern of 'shopping binges'," Kreuger distinguished the "impulse disorder and the addictive process of compulsive shopping and spending" (574) from other forms of spending or other compulsions. At the same time, though, the author concedes, "The basic disorder is the absence of a stable internal self-image" (581); compulsive buying is used to repair narcissistic injuries, regulate negative affect and restore wholeness – it is not the underlying problem. While presented as a disorder, the more psychiatrists define its functions the more compulsive shopping sounds like a coping mechanism and not a disorder.

These three articles represent different categorizations of compulsive shopping – a symptom, and addiction, an impulse disorder and addictive process – as well as different causes – childhood molestation, status desire and revenge fantasy, and inchoate self. They are similar in trying to inscribe compulsive buying in psychoanalytic terms, distinguishing it from mere mismanagement of money or selfish indulgence; but, in not presenting a united vision or noticeable trend, forming a view of "compulsive shopping"/

"pathological spending" as a distinct disorder based on these articles would have been difficult. In addition, academic psychiatrists may not have paid much attention to compulsive buying as an emerging condition *because* it had been presented in psychoanalytic terms; psychoanalysis had been losing favor to a more rigid medical model, culminating in the publication of the DSM-III a few years earlier (Horwitz, 2002).

Compulsive shopping did not gain sufficient interest by the academic psychiatric community until the mid-90s, before which consumer researchers had begun carving out the domain. In effect, consumer researchers had been using psychological explanations and terminology, capitalizing on the tools of the psychiatric field and the advice of experts without being psychiatrists themselves. When psychiatrists entered the field, they claimed there had been few if any systematic studies as of yet and no scientific data; they set out to establish the terms of the "disorder" themselves (McElroy et. al, 1991; Christenson et al., 1994; McElroy et. al, 1994). Contestations between and within fields are nothing new; yet it is important to notice the way in which psychiatry came to dominate the field: by reducing the complex interplay between psychological and cultural forces to biology. By creating a disorder of compulsive buying, psychiatry not only took ownership away from consumer researchers and set the terms for future inquiry – but cast inquiries that were not biomedical, even psychological ones, as illegitimate.

Psychiatric Research – Clinical Studies

McElroy et al.'s 1991 article, "Treatment of Compulsive Shopping with Anti-depressants," appeared in the *Annals of Psychiatry* and awoke the interest of others in the psychiatric community. Although they stated compulsive buying was "recognized as a

significant psychiatric problem" (p. 199), no one within psychiatry had yet published suggested diagnostic criteria or made a clear case that compulsive buying is a disorder to be investigated within the psychiatric realm; McElroy and colleagues, in fact, are responsible for setting working diagnostic criteria in 1994. This 1991 study, however, is unusual in that it is the first published scientific study on the subject – the psychoanalytic articles are not regarded as "scientific" nor are the consumer research studies – and it begins its inquiry into compulsive buying by testing various drug treatments before an official diagnosis or even informal criteria had been set. While off-label prescribing is not unusual, publishing results on drug trials for an undefined (even ill-defined) disorder is. Yet, this approach proved not to be so unusual. Other drugs tests were to be conducted before an official definition was set, or even a consensus as to what diagnostic category compulsive buying fit into. Beginning research with the assumption that compulsive buying is a distinct psychiatric problem that is prevalent and harmful, researchers plowed through compulsive shopping at an incredibly fast pace, arriving at conclusions and drug trials before adequately studying the phenomenon.

McElroy et al.'s (1991) study provided psychiatric researchers with enough evidence to suggest that compulsive buying was indeed a disorder, however this study has serious limitations. McElroy's three clinical subjects, each seeking help for compulsive buying, had myriad other psychological conditions as well: one patient had dysthymia, somatization and panic disorder; another had bi-polar disorder, characterized by massive depression and short periods of mania, panic disorder and alcohol and drug abuse; and the last patient had a history of obsessive-compulsive disorder, major depression, anorexia and bulimia. McElroy et al. ensured that each patient met criteria for

the DSM-III-R category, Impulse Control Disorder Not Otherwise Specified (ICD-NOS) (see p. 17 of this paper) in order to attest that each had severe problems with compulsive buying, but with the variety of other disorders these study subjects had, they most likely would have met the criteria regardless of the compulsive shopping. In addition, the ICD-NOS diagnosis is catch-all category for use at the clinician's disposal and really demands no official recognition of the condition it is being used to diagnose.

Treating the subjects with different combinations of anti-depressants and drugs for their other ailments (fluvoxamine, used for OCD and major depression; clonazepram, used for panic disorder; trazodone, used for depression; bupropion, an anti-depressant and anti-smoking drug usually marketed as Wellbutrin; nortiptyline, a tricyclic anti-depressant; and fluoxetine, an anti-depressant, anti-obsessional, and anti-bulimic drug best known as Prozac), McElroy at al. reported that all three subjects demonstrated full or partial remission of their compulsive shopping. While the authors acknowledged the possibility that the patients' compulsive shopping might be linked to an underlying disorder, which might have been what actually improved through treatment, they resisted this interpretation because "[a]ll patients … described their shopping symptoms as quite distinct … and all had experienced periods of depressive symptoms … in the absence of compulsive shopping" (McElroy et al., 1991: 203). They do not state that these patients experienced compulsive shopping in the absence of their other symptoms, which would be more convincing evidence to suggest that compulsive buying is a discrete disorder and less a side-effect or manifestation of other disorders.

Despite these limitations, this study opened the gate for future research. In 1994, three other influential articles were published: Christenson et al's "Compulsive Buying:

Descriptive Characteristics and Psychiatric Comorbidity," McElroy et al.'s "Compulsive Buying: A Report of 20 Cases" and Schlosser, Black, Repertinger and Freet's "Compulsive Buying: Demography, Phenomenology, and Comorbidity in 46 Subjects." These articles established the foundational knowledge of compulsive buying within psychiatry, and quickly led to more drug testing.

Christenson joined Faber and other colleagues to publish an overview of compulsive buying, consolidating the results from the few previous studies that had been conducted, including the psychoanalytic case studies and the body of work produced by consumer researchers (Christenson et. al, 1994). They used this information to inform their own study of 24 compulsive buyers, matched according to age and sex with 24 "normal" subjects. Using structured interviews as well as screeners for other disorders, notably depression, obsession-compulsion and anxiety, they compiled the following profile:

> Compulsive shoppers are likely to:
> • have irresistible urges followed by mounting tension, resulting in buying
> • be motivated to shop by negative mood states (sadness, loneliness, anger, frustration, feeling hurt, and irritability) but also positive ones (happiness, elation);
> • feel more positive mood states during shopping (happiness, power), but also negative ones (out of control, frustrated, irritable, depressed, hurt and angry)
> • buy products associated with appearance and self-image, particularly clothing
> • return items bought, give them away, or store them; but never use them
> • have a history of other disorders, particularly anxiety, depression, and sometimes substance abuse disorders

Christenson et al. (1994) concluded from these results that "compulsive buying is a definable syndrome that causes significant personal, social, and economic disability and is often associated with psychiatric comorbidity … [and] shares features of both OCD and impulsive control disorders" (1994:10). However, the findings they present are ambiguous: almost any emotion can act as a trigger or outcome, and almost any mood disorder has been found as a comorbid condition. In addition, one-third of their subjects reported that they did not have irresistible urges. The lack of specificity and conclusiveness of these findings – they only interviewed 24 compulsive shoppers – does not suggest discovery of a unique, discrete illness with reliable diagnostic criteria; yet this study proposed to outline the characteristics and comorbidities of compulsive buying.

Based on the same body of literature as Christenson et. al's study, and including it as well, McElroy et al. (1994) also found that "available evidence suggests that compulsive buying may be prevalent (present in 1.1% to 5.9% of the general population) and that it may be a significant psychological problem…" (242). These figures are derived from Faber and O'Guinn's 1989 screening of 270 "normal" consumers with their first measurement scale (their second scale, published in 1992, revises that number to 1-2% of the population. Some reports claim a 1-10% range or as high as 16% [see Dittmar, 2005]). The questions for this scale were derived from their pilot study of 19 female and four male members of a self-help group (Faber and O'Guinn, 1987). Basing their screener questions on a self-selected group of female compulsive shoppers, Faber and O'Guinn encountered major methodological problems; not only can they not generalize from this study, but because they started off with the assumption that more women were compulsive buyers than men, all future studies relying upon this scale may be skewed to

identify female compulsive buyers. In addition, the self-selection of study subjects could also bias the screener and subsequent results in unapparent ways. This study and all others based on it, including the McElroy et al. 1994 study, cannot be viewed as reliable sources.

To address the situation, McElroy et al. (1994) conducted their own "systematic study" in which they detail "the demographics, phenomenology, course, psychiatric comorbidity, family histories, and treatment responses of 20 consecutive psychiatric patients with compulsive buying" (242). They recruited these study subjects by having clinicians at two mental health facilities refer patients to them whom they thought could be compulsive shoppers (in addition to their other mental health problems, for which they were presently being treated). Screening was based on whether the patient described his or her own buying as uncontrollable, distressing, time consuming and not part of a manic episode. All patients described their buying as uncontrollable, driven by senseless and intrusive impulses; most reported relief after shopping, due to mounting tension beforehand; and most said the urge to buy caused them distress and that their shopping increased when they were depressed. All patients displayed psychiatric comorbidity, which is not surprising considering they were being treated for a different disorder when referred to McElroy and colleagues. McElroy's team found similarities between these patients' testimonies and obsessive-compulsive disorder, impulse control disorders and the urges of substance disorders, leading them to query, along with Christenson et. al (1994), if compulsive buying could be part of "a larger family of obsessive-compulsive spectrum disorders" (McElroy et al., 1994: 247).

Upon the findings from this clinical, highly comorbid sample, McElroy et al. proposed diagnostic criteria for compulsive shopping referring to DSM-III-R criteria for obsessive-compulsive disorder, impulse control disorder and substance abuse disorders. Their model remains the clinical criteria used for "diagnosing" compulsive buying today:

> Diagnostic Criteria for Compulsive Buying
> A. Maladaptive preoccupation with buying or shopping, or maladaptive buying or shopping impulses or behavior, as indicated by at least one of the following:
>
> 1. Frequent preoccupation with buying or impulses to buy that is/are experienced as irresistible, intrusive, and/or senseless.
>
> 2. Frequent buying of more than can be afforded, frequent buying of items that are not needed, or shopping for longer periods of time than intended.
>
> B. The buying preoccupations, impulses, or behaviors cause marked distress, are time-consuming, significantly interfere with social or occupational functioning, or result in financial problems (e.g. indebtedness or bankruptcy).
>
> C. The excessive buying or shopping behavior does not occur exclusively during periods of hypomania or mania.
>
> (McElroy et al., 1994: 247)

This list of criteria does not resolve the issue of what compulsive shopping "is," but proved to be enough of a definition for other psychiatrists to use in doing research or treating patients (or performing drug trials). Again, the criteria depend on determining what is "maladaptive," "frequent," "irrepressible," and "functioning." The reliability of diagnosis depends upon the same interpretation of these words by practitioners, yet psychiatrists are encouraged to interpret their clients' problems somewhat "intuitively" (Spitzer, IHHCPAR talk, March 9, 2006). The fact that the studies upon which these criteria were founded are methodologically unsound is not mentioned.

After McElroy et al's diagnostic criteria was published, Schlosser et al. published their (1994) study based on interviews with 46 self-identified compulsive buyers who had responded to an advertisement and met their diagnostic criteria – they used Faber and O'Guinn's (1992) screener and practically the same structured interviews, inventories and questionnaires that Christenson et al. (1994) used in their study. They found 60% of their subjects met criteria for a personality disorder, differing from Christenson et al. (1994) and McElroy et. al. (1994), who reported higher rates of depression and/or anxiety. Schlosser et al. also differed in reporting much lower rates of OCD within their sample than both McElroy et al. and Christenson et al. Although noting that the differences between these studies could be due to methodological techniques, Schlosser et al. did not find a clear relationship between obsessive-compulsive (OCD) and impulse-control disorders (ICD), and instead proposed that compulsive buying has more in common with ICDs -- most of their subjects met criteria for one or more ICDs. This finding contradicts the basis of the diagnostic criteria that McElroy et al. posed above, the assumption that compulsive buyers belong to an obsessive compulsive-impulse control disorder spectrum. Admitting that "work needs to be done to better characterize the disorder, define its boundaries, and explore treatment," they also concluded, once again, that "the data do suggest that a significant number of persons have similar problems with spending, and that compulsive buying is a definable syndrome" (1994: 211). They also reported that they were currently conducting an open-label study of fluvoxamine, an SSRI, in the treatment of compulsive buying (to be reported by Black, Monahan & Gabel, 1997).

The publication of McElroy et al.'s (1994) definition of compulsive shopping and diagnostic criteria seemed to be what psychiatrists were waiting for: it was enough to legitimate future inquiries into compulsive buying. Yet, it is difficult to reach any conclusions by comparing most of these studies as they use different screening and interviewing tools, focus on slightly different research questions and report different findings. In addition, because all of the studies have their limitations and methodological flaws, generalizing to a larger population is practically impossible. The nature of the clinical trials is that they cannot be representative samples; yet, because these studies test what are perceived to be biologically based disorders, the individual's genetic make-up is assumed to be representative. However, in these studies, participants have several different disorders in addition to the compulsive buying, making it is difficult to tease out what belongs to the compulsive buying and what belongs to the other disorders. Viewing these studies together, they render compulsive buying more mysterious than definable and even implicitly suggest that it is more of a manifestation of another disorder than its own.

For instance, McElroy et al. (1995) reviewed kleptomania, binge-eating and compulsive buying, and proposed that all three conditions could be viewed as ICDs belonging to a family of compulsive-impulsive spectrum disorders; this spectrum disorder could exist within a larger family affective spectrum disorders and could possibly share a "common pathophysiologic abnormality," such as "deranged central serotonergic neurotransmission" (1995: 23). Lejoyeux, Tassain, Solomon and Ades (1997) proposed a link between depression and compulsive buying as 32% of his sample of depressed, hospitalized patients (N=119) screened positive for compulsive buying

using McElroy's criteria and their own screening tool. This finding is supported, they argued, by McElroy's finding that compulsive shopping responds to antidepressants. Black, Monahan and Gabel's (1997) ten compulsive buying subjects for their fluvoxamine study also had histories of other disorders: depression, substance abuse, eating and panic disorders; and all but one had a family history of mental illness. Black, Repertiner, Gaffney and Gabel (1998) found that of 33 compulsive buyers, 9.5% of their relations were also compulsive shoppers, but since none of the family members or subjects had OCD, it was unlikely that compulsive buying was related to OCD. Not only is compulsive shopping being seen as an impulse control disorder, and hence a manifestation of a psychological and most likely neurological dysfunction, but it is now being posited as genetic; in looking for family members with compulsions, they are not testing for environmental conditions or learned behavior, but genetic inheritance. More studies can be compiled here, but the one consistency across the board is that none of these studies, despite various findings, question the accuracy of defining compulsive buying as a type of disorder.

Drug Trials and Media Attention

Without any conclusive evidence, Black et al. (1997) had begun their clinical trial of fluvoxamine, a selective serotonin reuptake inhibitor (SSRI) used mainly for obsessive-compulsive disorder. Considering the high rates of other disorders most subjects with compulsive buying have, moving into a drug trial for compulsive shopping without being able to differentiate it adequately from other disorders or symptoms is a bold move, albeit one that had been already attempted. What made this trial even bolder

was the fact that fluvoxamine, at both the time they initiated the trial and at the time of the publication of the 1994 article in which they announce they had been working on this trial (Schlosser, Black, Repertinger and Freet's, 1994), had not yet approved for use in the U.S. but was legal to administer in Canada and Europe (fluvoxamine was approved in the U.S. in December 1994; this article was published in May 1994. See Anderson & Hustak, 1994).

Black et. al's (1997) study of fluvoxamine was funded by Solvay Pharmaceuticals of Marietta, Georgia, and The Upjohn Co. of Kalamazoo, Michigan (see Ritter, 1995), which raises questions about these companies' stakes in the drug trial: they jointly own fluvoxamine, whose brand name is Luvox in the U.S. In addition, the media attention Black was getting further promoted the idea that pharmaceutical treatment is acceptable for the emerging problems that people have. While Black consistently states that drug treatment is only necessary for a very small percentage of extreme cases, viewing therapy and other support groups helpful for most (see for example, Mestel, 1994; Ritter 1995; McFarling 1999), his presence in the media helped to normalize the use of pharmaceuticals for conditions like compulsive shopping – and helped the public perceive compulsive shopping as a psychiatric problem. After the open-label trial suggested fluvoxamine was effective in treating compulsive buying, Black became somewhat of a media star within the field, often quoted in the mainstream media (Anderson & Hustak, 1994; Mestel, 1994; Ritter, 1995; Harvey, 1995; Gifford-Jones, 1995; Day, 1997a, 1997b; Edwin, 1997; McFarling, 1999, 2000; Jones, 2000; Siskos & Burt, 2002; Ethridge, 2002; Chaker, 2003; Earle-Levine, 2005). Despite the fact that Black, Gabel, Hansen and Schlosser's (2000) second fluvoxamine study, a double-blind

comparison of the drug to a placebo, showed no significant differences between fluvoxamine and the placebo, the idea that drugs could treat compulsive buying was already circulating in the public sphere.

Dr. Lorrin Koran and colleagues at Stanford had begun their open-label study of another SSRI, citalopram, before Black et al.'s (2000) results were published (Koran, Bullock, Hartson, Elliot and D'Andrea, 2002). New York-based pharmaceutical company Forest Laboratories sponsored the trials of citalopram, brand name Celexa, which had been approved by the FDA in 1998. Koran asserted in the press that if compulsive buying is related to depression, and drugs help depression, then drugs should help compulsive buying as well; he speculated that increasing serotonin levels could help control compulsive shopping (Krum, 2000: 6).

As the Stanford study garnered more media attention, Koran replaced Black as the media's point person (Grey, 2000; Krum, 2000; Avery, 2000; Sibley, 2000; Thomas, 2000; Jones, 2000; Bowman, 2000; "Help for CS," 2000; Le Fanu, 2000; Stryker, 2002; Chaker, 2003; "Popping a Pill," 2003; "Cure Found, 2003," Wood, 2003; "Out of Context, 2003; Batya, 2004), practically burying Black's unsuccessful results with fluvoxamine. Koran et al. reported that they found significant improvement (and significant comorbidities) within their first study and proceeded to conduct another, more rigorous study, this time an open-label followed by a double-blind discontinuation (Koran, Chuong, Bullock & Smith, 2003). Many of their subjects had active comorbid conditions – depression and dysthymia were prevalent; social phobia, trichollomania, kleptomania and pathological gambling were each present in one study subject – which they noted may require longer or more complex treatment; regardless, they found "rapid,

marked, sustained improvement or remission" (793) in 15 to 18 of the subjects, depending on measurement tool used. They also reported that of the eight people given the placebo, five relapsed. Koran is reported in several news articles saying, "Patients improved within one or two weeks. No disorder I have treated has reacted like this," or similar remarks ("Cure Found," 2003). In a year follow-up report of their first open-label study (Koran et al., 2002), Aboujaoude, Gamel and Koran (2003) found that 81% of the responders to citalopram within study group remained in remission at three months (13 out of 16 respondents), 71% at six months (10 out of 14), 71% at nine months (10 out of 14), and 73% at 12 months (11 out of 15). They concluded "a good response to three months of citalopram treatment predicts a greater likelihood of continued remission over one year" (950). A follow-up on the 2003 double-blind study has not been published yet.

Koran, however, received some flack for this trial: "There are assertions in the US that drug companies, eager to expand the use of their products, fund research into a 'new' disorder for which they, conveniently, have a cure," reported Sharon Krum (2000: 6) of The Guardian. "Koran says he approached a drug company, not the other way around. 'Critics suggest drug companies are creating the disorder to market their drug. But these people are truly suffering. We didn't create the problem - they are compulsive spenders and we are looking to help them.' " Krum also reported that in response to these allegations, Paul J. Tiseo, a director of clinical development at Forest Laboratories, claimed, " 'We funded the trial because it's an interesting question…. But no one thinks these types of trials are hard science' "(6). Interestingly, Tiseo claims that these trials are not hard science, yet these trials often lead to more trials to legitimize the drug for treatment of a particular disorder. Even if not "hard science," these trials have hidden

benefits for drug companies. “Clinical trials are often a company’s first opportunity to ‘educate’ the public about a disease or disorder,” wrote Maggie Jones of the New York Times (2000: 6), paraphrasing David Healy, the author of “Listening to Prozac” and renowned critic of the pharmaceutical industry. Healy, echoing Conrad’s (2005) earlier point about the driving engines of medicalization, told Jones: “Compulsive shopping is novel; it catches the media’s interest. A lot of therapists and lots of people who think they have this problem will get together, seeking treatment or seeking to provide treatment – without a pharmaceutical rep ever coming through the door” (Jones, 2000: 6).

The Resistance

While there was little protestation in the early stages of compulsive shopping’s public campaign, more people have been reacting negatively to talk about its formalization as a disorder, and about possible treatment by drugs (Stryker, 2002; Seligman, 2003; Derbyshire, 2004). For example, Paula Caplan of Brown University told a reporter, “There is an absurd and frightening proliferation of labels for alleged mental illnesses, and that proliferation is greatly fueled by drug companies’ profit motive.” (Chaker, 2003). Darrel A. Reiger, director of research at the APA, said, “I don’t think there’s been enough evidence to warrant consideration of compulsive shopping as a mental disorder” (Chaker, 2003), and Dr. Robert Lefever of the Promis Recovery Centre in Kent, told the BBC, “[Drugs] are simply another addiction. It’s the same relation as methadone to heroin” (“Popping a Pill,” 2003). Dr. Elissa Benedek, past president of the APA, added that many compulsive shoppers do not have the neurobiological symptoms, so it is unclear whether the problem is medical or personal (Seligman, 2003).

Many voices in the popular press bemoan the medicalization of compulsive shopping as well, but complaints tend to be more anti-drug than anti-disorder. Daly and Palmer of the Toronto Star (2004: A01) situate compulsive buying in "a long list of illnesses being treated by anti-depressants," warning that drugs are becoming "the cure-all for everything from physical ailments to what some might simply call life." Chaker of the Wall Street Journal (2003: D1) proclaims that while antidepressants may help people, "much of this is a tendency in the psychiatric community to view as treatable a variety of problems that were once life's quirks." Derbyshire of the Daily Telegraph (2004:18) reports, "As diseases get pushed into the history books, new conditions pop up to fill the gaps… The latest chapter in the relentless 'medicalization' of human behavior was announced last year, where scientists announced a cure for compulsive shopping disorder." Others protest the use of drugs instead of behavioral treatments (Martin, 1999; Reihill, 1996), the labeling of disorders and use of drugs as a way to hike up insurance premiums ("Try Shopaholics Anon.," 2003), and the lack of personal responsibility encouraged by medicalization (Sibley, 2000). These voices are present, yet it is difficult to gauge how strong sentiment against the medicalization and the pharmaceutical industry is becoming, or how strong it would need to be to counteract the power of the pharmaceutical industry, health care organizations, and even the general public, many of whom are major consumers and proponents of drugs for depression, anxiety and similar conditions.

Few have published academic articles disclaiming compulsive buying as a disorder, but Dittmar (2004, 2005a, 2005b), a social psychiatrist, defends the argument made by Valence, d'Astous & Fortier (1988) and d'Astous (1990) that compulsive

shopping lies on a continuum with “ordinary, psychologically motivated buying,” (2005a: 833). She also resists using the term ‘compulsive buying,’ because “it seems questionable whether this behavior conforms to a strict conceptualization of compulsive, characterized by intrusive thoughts, uncontrollable urges to perform the behavior, and negative affect” (Dittmar, 2005a: 833). Similar to the current consumer research literature, in particular, a German follow-up of Scherhorn’s 1990 study which shows increases in rates of compulsive buying tendencies (Neuner, Raab & Reisch, 2005), Dittmar identifies the problem of compulsive shopping with increasing material values; she argues that compulsive buying “is embedded within the major changes that have transformed consumer behavior in Western developed countries” (2005a: 835). Some of the changes Dittmar identifies are increased disposable income, credit, the greater significance of goods in people’s lives, and attempts to shrink the distance between real and ideal selves though the symbolic meaning of goods (835-6). Dittmar’s finding that gender differences in compulsive buying tendencies are less strong in adolescent samples, while material values are higher, as compared with adult samples, suggests to her that compulsive shopping could be a rite of passage, but could also suggest growing materialist orientations (2005b).

Lee and Mysyk (2004) present a more sociological perspective in criticizing the compulsive buying literature in that “the social context of consumerism, i.e. that individuals are encouraged to buy an array of desirable items, tends not to be addressed” (2004: 1709). They also point out that the labeling of compulsive buying as a “problem” is not addressed; they want compulsive buying to be called an addiction rather than a compulsion because they feel that that term can include social causation. If compulsive

buying were considered an addiction and not a compulsion, treatment options would focus more on consumer education, not reductionist, biomedical treatments. Focusing on Canada's "jobless recovery," they blame economic recovery efforts for dependence on consumption, keeping interest rates high to generate eventual surpluses, but not increasing jobs or wages.

In general, those resisting the medicalization of deviant behavior – or even "normal human behavior" (Derbyshire, 2004: 18) – are reacting to its recent strengthened force; they mostly attach blame onto the psychiatric field or the pharmaceutical industry, but as Conrad (2005) and Clarke et al. (2005) have discussed, the engines of medicalization have become much more powerful, and larger, because they now include biotechnological advances that are wrapped up in commercial interests. Many note that "disorders" have become less stigmatizing with the promotion of drug treatments and direct-to-consumer advertising (the "bright side" of medicalization, Conrad & Schneider, 1980), however the perceived benefits of pharmaceuticals masks its encroachment into areas that are not technically disorders. While drug treatment may make life "better," the question is really how they are transforming life so that we perceive it as "better."

IV. Conclusions

In this paper, I set out to investigate the processes by which compulsive shopping is being medicalized into compulsive buying disorder. I aimed to look closely at the conversations occurring within the consumer behavior and psychiatric literatures and the popular press in order to ascertain how "compulsive buying" was constructed as a psychological problem possibly worthy of the disorder label. While academia and the public certainly contribute to the creation of the discourse of disorder, the psychiatric

community's mounting focus on biological sources of abnormal behaviors has helped to construct a social context within which genes are pathologized and blamed for problem behavior. This process somewhat spares the individual from blame, but it also reduces the person's sense responsibility and agency. In addition, the recent intervention into this process by the pharmaceutical industry clearly demonstrates the power that the pharmaceutical industry has in defining disorders.

If compulsive shopping is deemed a biological deficiency, this implies that debt counselors cannot resolve the problem and consumer culture cannot be a cause – nor altering it a cure. Therapy cannot be of much use either unless in connection with medication. The condition becomes unsolvable except through medication. This process obviously benefits the drug companies, who do sponsor the drug trials, but it benefits the psychiatric community as well, by securing tight boundaries around the discipline; outsiders may be fluent in psychological concepts, but they cannot write prescriptions. This process also benefits those in political power by distracting individuals from addressing the social conditions that are implicated in compulsive shopping. While I did not address sociological causes of compulsive shopping in this paper (see Hemler, forthcoming), I did discuss some of the mechanisms by which social problems become reduced to personal issues. When social problems become perceived as personal issues only, individuals lose their sense of connection to the social fabric, as well as their sense of mastery over the conditions that frame their lives. Ultimately what is at stake is the power to define social conditions.

Whether or not compulsive buying will be officially defined as a disorder in the upcoming DSM-V remains to be seen. Drug trials have not been overwhelmingly

successful in proving that compulsive buyers respond to antidepressants or anti-compulsive drugs, and the scientific research behind compulsive buying is limited, to say the least. The perspective that compulsive shopping is a disorder has become part of public discourse, and, as the public is becoming increasingly reliant on biological explanations to more complex problems, perhaps the public will support compulsive buying disorder. Conrad (2005) sees the major players in medicalization being the pharmaceutical industry, genetic research, patient-consumers and managed care, but it is too soon to tell how these forces will play out within this specific case. As of now, the research behind compulsive buying needs to be convincing enough for the DSM-V to accept it as a legitimate, discrete disorder. Whether the pharmaceutical industry, psychiatric researchers or patient-consumers can promote compulsive buying to the DSM committee is unclear, but several journalists hinted of its inclusion. However, recent lawsuits against pharmaceutical companies and growing weariness regarding the disordering of "normal" human traits, in addition to mainstream publications by doctors and other health experts denouncing the pharmaceutical industry, may produce a backlash. Yet a backlash is unlikely to reverse the trends of medicalization and the growing acceptance of genetic explanations for behavior.

The growing strength of bio-medicine and the infiltration of pharmaceutical companies into the medical community reduce complex systems of meaning making to the biological agents within ourselves. In this paper, I have shown how psychological explanations of compulsive buying overruled consumer research explanations that emphasized consumer culture. I have also shown how biological and neurological explanations trumped psychoanalytic explanations. At the present moment, medicalizing

compulsive buying serves several interests: the psychiatric profession, the pharmaceutical industry, but also political interests. Treating compulsive buying as a disorder – solely – prevents critique of a capitalist system that produces rampant desires and needs, of an economy that relies upon massive consumption for growth, and of a debt-culture where most Americans live on credit. Treating compulsive buying as a disorder – solely – directs our attention toward microscopic sources of disorder, which remain outside the realm of our control, and outside the realm of social responsibility. Our intolerance of deviance is redirected to our nervous system or genetic make-up at the expense of other legitimate sources of social disorder.

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ENDNOTES

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[1]For example, academics have researched compulsive buying in Canada (Valence, d'Astous, and Fortier 1988; D'Astous 1990; d'Astous, Maltais and Roberge 1990), Belgium (Vlerick, 1998), the UK (Elliot, 1994; Dittmar and Drury 2000; Dittmar, Helga. 2005a; Dittmar, Helga. 2005b), France (Lejoyeux, Ades, Tassain and Solomon 1996; Lejoyeux, Tassain, Solomon and Andes 1997; Lejoyeux, Haberman, Solomon and Ades 1999; Lejoyeux, McLoughlin and Ades 2000; Lejoyeux, Bailly, Moula, Loi and Jean Adès 2005), West Germany (Scherhorn, Reisch and Raab 1990; Neuner, Raab and Reisch 2005), Korea (Kwak, Zinkham and Dominick 2002; Kwak, Zinkhan and Crask 2003), Japan (Hama 2001), and Mexico (Roberts and Martinez 1997; Roberts, Gwin and Martinez 2004). Compulsive shopping has also hit Japan's (e.g., Matsumaru 2000) and Australia's (e.g., Koopman 1987; Wilson, 2000; Garth 2000, and Fynes-Clinton, 2000) popular presses. Newspapers in Israel (Ludman 2004), Malaysia (Edwin, 1997; Mustapha, 2003) and Singapore ("Popping a Pill," 2003) have also featured stories about compulsive buying. As I have focused my search on the U.S. and on literature in English, I am sure there are others. In general, as nations become more westernized, i.e., more global and capitalist, they seem to arrive at this problem (Earle-Levine 2005; Dittmar and Drury 2000). Less developed nations do not seem to have this problem, perhaps because their peoples do not have as much disposable income, but perhaps also because they are not exposed to the same kinds of pressures or desires as more "developed" nations. This is not to argue that the west is a "corrupting" force, but perhaps there is a more nuanced relationship here between capitalist creation of desires, global reference groups, access to goods, and new, disposable income than can be reduced to economic power.

[2] In attempt to make the reading of this paper less cumbersome, I will refrain from using quotations around compulsive buying. As Barker (2005:14) says in her book on the social construction of Fibromyalgia, "the reader needs to be mindful that when sociologists study 'reality,' they are," quoting Berger and Luckmann (1967:2), " '[l]ogically, if not stylistically…stuck with the quotation marks.' " I do not intend to argue that compulsive buying is "really" a disorder or not. I use "disorder" without the quotes – instead of "problem," "syndrome," or other terms of lesser degree – because others in the psychiatric field do label it a disorder, and the phrase "compulsive buying disorder" has entered common parlance.

[3] Some articles have actually stated compulsive buying *is* listed in the DSM-IV-TR -- see Black, Repertiner, Gaffney and Gabel 1998: 960; Grant 2003: 223; Dittmar 2005a: 468, Dittmar 200b: 833 -- while others have merely inferred that it is there -- see Koran, Bullock, Hartston, Elliot and D'Andrea 2002; Hartston & Koran, 2002; Goldsmith & McElroy, 2000.

[4] According to Dr. Michael First, editor of the last two editions of the DSM, the DSM-IV and the DSM-IV-TR and Director of the DSM-V Prelude Project, "The DSM-V process is just now getting underway. I'm sure that the OCD [obsessive-compulsive disorder]

work group [a group of specialists who confer on each disease heading in the DSM] will need to consider whether or not to include compulsive buying as a new disorder based on the data but they have not even begun their deliberations" (personal correspondence, April 13, 2006).

[5] Compulsive buying has been used to justify embezzlement and other like crimes within courts of law. In one case, that of Elizabeth Roach, a psychiatrist testified to her condition. She was granted a lighter sentence due to her condition, but after an appeal, she was re-sentenced according to normal guidelines (Bullock, May 25, 2001; Broughton, May 26, 2001; Gray and Whitaker, June 6, 2001; Hall, Aug. 4, 2001; "Daylight Robbery," Aug. 15, 2001; Stryker, July 21, 2002).

Rosemary Heinen, an employee who embezzled money from Starbucks, also used compulsive shopping as part of her defense (Ko, Nov. 23, 2002).

[6] Solvay Pharmaceuticals of Marietta, Georgia, and The Upjohn Co. of Kalamazoo, Michigan, sponsored trials of fluvoxamine, brand name Luvox, run by Dr. Donald Black and colleagues of the University of Iowa (Black, Monahan and Gabel 1997; see Ritter, 1995); and New York-based pharmaceutical company Forest Laboratories sponsored trials of citalopram, brand name Celexa, at Stanford by Dr. Lorrin Koran and team (Koran, Bullock, Hartston, Elliot and D'Andrea 2002; see Krum 2000). Both drugs are SSRIs. The U.S. Food and Drug Administration (FDA) approved Luvox in 1993 for obsessive-compulsive disorder, and in 1997 for treatment of OCD in children and adolescents.[6] Celexa was approved by the FDA for the treatment of depression in 1998.

[7] Conrad defines medicalization as a definitional process by which something previously outside a medical framework becomes defined within that framework. Clarke et al. (2005) argue for use of the term "biomedicalization," under which they describe a broad range of developments and technological advancements. "Genetization," (Lippman, 1991) is probably more accurate for what is actually happening – attributing behaviors to genes rather than the socialized individual – however this term, as Conrad (1992) says, has "not taken hold" (328).

[8] Homosexuality was dropped from the DSM in 1973, although Sexual Disorder Not Otherwise Specified remains, one diagnostic criteria of which is "Persistent and marked distress about sexual orientation" (APA, 2000). Premenstrual dysphoric disorder is currently listed in "Appendix B: Criteria Sets and Axes Provided for Further Study" of the DSM-IV-TR (APA, 2000).

[9] Clarke et. al (2005) view medicalization as a process of modernity, and "biomedicalization" as the process of postmodernity. I do not agree that we can call our present time period postmodernity, but do agree that biomedicine and all that the biomedical industry entails is permeating important aspects our lives. I do not doubt their research, but agree with Conrad that their presentation is too broad and all-consuming, at least to be useful for my purposes here.

[10]Benefits not only include conferences in Hawaii, but professional prestige; many of the top psychiatrists are hand-selected by pharmaceutical companies to sign their reports, which are then submitted to the most prestigious medical journals. Often these signers are not involved in writing the report. For those who do, the data they receive on the drugs is given to them in tables, already formatted and "cleaned." They may sign these reports trusting that the data is correct, or sign their name to a long list of other doctors who have already signed the report (Healy, notes from talk at Presbyterian Hospital, Oct. 20, 2005).

[11] The drug companies may need to work against a public who may be beginning to grow weary of big business, corporate scandals and increasing litigation against pharmaceutical companies for a variety of dangerous and dishonest practices. A slew of books by doctors, health reporters, and policy makers have exposed the crimes of the pharmaceutical industry:

• Valenstein (Ph.D.) *Blaming the Brain: the Truth about Drugs and Mental Health*, 1988.
• Moynihan & Cassells (medical writer & policy researcher) *Selling Sickness: How the World's Biggest Pharmaceutical Companies are Turning us All into Patients*, 2005.
• Whitaker (Pulitzer Prize-nominated and Polk-winning journalist), *Mad in America: Bad Science, Bad Medicine, and the Enduring Mistreatment of the Mentally Ill*, 2002
• Abramson (M.D.), Overdosed America: the Broken Promise of American Medicine; How the Pharmaceutical Companies are Corrupting Science, Misleading Doctors, and Threatening Your Health, 2004.
• Kassirer (M.D.),*On the Take: How Medicine's Complicity with Big Business Can Endanger Your Health*, 2005.
• Angell (M.D.), *The Truth about the Drug Companies: How they Deceive Us and What to Do about It*, 2004.
• Barlett & Steele (Pulitzer Prize-winning journalists), *Critical Condition: How Health Care in America became Big Business – And Bad Medicine*, 2006.
• Barker (Ph.D. sociology), *The Fibromyalgia Story: Medical Authority and Women's Worlds of Pain*, 2005.

In addition, the Vioxx case seems to have caused concern for pause. Perhaps the new engines of medicalization are powerful enough to steamroll through lawsuits, but what I think will enable medicalization to carry on, and for compulsive buying to be accepted as a disorder, is the public's refusal to see its role in perpetuating these socially destructive forces. Alienation from the abstract – biotechnology, consumer culture, mammoth health care structures, corporate scandals – encourages public dis-involvement, anger, and subsequent apathy.

[12] Horwitz (2002) argues that discreteness is necessary for inclusion in the DSM, but Spitzer denied this claim at his talk.

[13] McElroy et al. (1991), Faber (1992), Christenson, Faber, deZwaan et al.(1994), McElroy et al. (1994), McElroy et al. (1995), Black (1996), Lejoyeux et al. (1996; 1997),

Lejoyeux et al (1999), Black (2001), Miltenberger (2003), Aboujaoude, Gamel & Koran (2003), and Koran et al. (2003).

[14] Shopping, spending and buying are all considered part of the problem, but the problem, of course, is only identified when someone slips into debt or is so obsessed he or she fails to meet life's other commitments.

[15] A side-bar in the Washington Post features "Are You a Compulsive Shopper?" According to Richard Greenberg, Washington psychiatrist, as reported by the Post, "Affirmative answers to the following questions may mean you are a compulsive shopper."

> Do you feel:
> Happiest when you can spend your free time shopping?
> Let down after a day at the mall?
> Anxious if you haven't been to a store in a week?
> Also, do you:
> Buy a dress, shirt or shoes in eight different colors …?
> Select things that don't match anything in your wardrobe?
> Go to work late, leave early or take extra-long lunch breaks to shop?
> Buy a greeting card or a pack of gum rather than go home empty-handed?
> Shower gifts on acquaintances even when it is not appropriate?
> Hang around car show rooms when your own new auto had done less than 1,000 miles?

Notice how general these questions are; anyone could be a compulsive shopper – which both increases self-anxiety and de-stigmatizes the disorder.

[16] Interestingly, this report refers to an increase in credit card debt by $4.1 billion from March to April in 1986 (total debt then = $555 billion), saying that no figures exist on what percentage of this debt is by compulsive spenders. There is no reference to social conditions that may be linked to the rise in credit card debt.

[17] It has not been possible to weed out the "irresponsible" users of credit from the truly desperate credit users; during the 80s, credit debt was presented as the fault of the former: keeping up with the Jones in a time of yuppie expansion. Today's press represents the situation differently. With the release of the Plastic Safety Net report, and the all-time-low personal savings figures, credit debt is starting to look more like a structural issue, but not completely addressed as such; still somewhat addressed as Americans spending beyond their needs in a time of recession.

[18] After 9/11, Mayor Guiliani of New York told people the way they could help NY was to go shopping. Shopping became patriotic. People are also told that spending money is necessary to sustain the economy. These messages rely on people spending more money and encourage excessive and impulsive shopping.

Marketing plays a huge role in encouraging excessive and impulsive behavior. As well as store design and promotions, TV commercials are the most obvious form of promotion: a recent TV commercial for Las Vegas depicts a woman talking about how practical she has become in middle age, but since she's in Vegas she's going to reclaim her youth and throw caution to the wind by making an impulse purchase that her husband probably won't approve of.

[19] As does highlighting the alleged femaleness of the behavior. Despite the fact that women are still responsible for most of the household shopping, they are still deemed irrational decision-makers (see Zelizer, 1995).

[20] I surveyed major newspaper articles across time, using Academic Search Premier and the "general news" category of LexisNexis and the search terms "compulsive shopping" and "compulsive buying." This search resulted in 250 articles that contain one of the search terms. Some articles used the terms in a facetious or mildly self-deprecating manner, and the others discussed compulsive buying as a disorder or recent developments in the psychiatric field. These news articles were generally from the U.S. but the search did include international newspapers deemed "major" by LexisNexis,

[21] Valence et al. (1988) proposed a 16-item scale based on four dimensions: tendency to spend, reactive element (psychological tension), post-purchase guilt, and family environment (this was eventually dropped).

[22] Viewing something as abnormal means you are still framing it in relation to normality; pathology connotes something beyond comprehension.

[23]"The tendency to succumb to compensatory buying is based on societal values which put an emphasis on the symbolic content of consumer goods, and of consumption as a way of addition to one's own standing and self-worth. …[T]hose values are transmitted to everybody; but they will have the biggest impact on those individuals who are or have been subject to influences distorting their autonomy and hence impairing their self-esteem.

"The propensity for addictive buying, together with other addictive tendencies, is another significant feature of Western society – to the extent that some authors even speak of an 'addictive society'…" (Scherhorn et al., 1990: 382).

[24] Scherhorn et al., do not view the behavior as obsessive-compulsive: "Like some drugs, buying can function as a stimulant, but the excitement it effects can function as a depressant as well, like certain other drugs. In some cases it even causes hallucinations, like a third kind of drugs. We therefore regard buying as a universal drug. This may explain its ubiquitous and increasing significance – not only to addicts. Addictive buying is certainly no more than the tip of the iceberg (d'Astous and Tremblay, 1988)" and "Normal buying is not addictive, but to a large extent compensatory (Gronmo, 1988)" (373).

[25] This explanation does not explain why compulsive buying "disappeared" from psychiatric history for so long – but the history of the psychiatric analytical models can perhaps explain this magical disappearance and reemergence, which I discussed earlier in this paper.