

“YOU KNOW, WHAT IS OVERSPENDING?”, WORKING WITH COMPULSIVE BUYING, A CRITICAL DISCURSIVE ACCOUNT

A thesis submitted in partial fulfilment of the Doctorate in Counselling Psychology at
London Metropolitan University

by

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May 2019

Declaration:

I hereby declare that the work submitted in this dissertation is fully the result of my own investigation, except where otherwise stated

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Acknowledgements

I would like to thank my supervisor Dr Angela Loulopoulou for her unflinching support and encouragement over the past three years. Prior to that thankyou to Dr Isabel Henton for guiding me on the beginnings of this path. Thank you to some lovely friends from the course cohort who have empathised and listened to the struggles of writing a thesis along the way. Thank you to my family for their patience and understanding when I needed to work and for helping me relax when I needed a break. Finally, a huge thankyou to the people who so kindly gave their time to participate in this study, I couldn't have done it without them!

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Abstract

Background: There is increasing research into compulsive buying (CB), much of which has focussed on its aetiology, epidemiology and treatments from a positivistic and quantitative viewpoint. Reviewing the extant literature yielded conflicting discourses over its similarities to other substance and behavioural addictions, and its absence from the DSM-5's 'behavioural addictions' section.

Rationale: Opposing discourses of addiction may be taken up by therapists and can serve to both empower and victimise addicts and are thus thought to effect therapy. Reports suggest increasing prevalence of CB and social and cultural factors play a significant role in its aetiology and how it is perceived yet no research was found to date that investigated therapists' constructions of CB. This research sought to address this gap.

Method Semi-structured interviews were conducted with six therapists who had worked with clients who talked about issues with CB. The transcripts were analysed using critical discursive psychology, a branch of Discourse Analysis.

Findings: Four main discourses were elicited from the data: *'it's self medicating'*, *'how should I work with this?'*, *'we must all shop but not too much'* and *'is it a problem?'* The interpretative repertoires, subject positions and ideological dilemmas employed within these discourses were considered in relation to the extant literature and found to highlight the many tensions that surround this topic for therapists, particularly around addiction and culture. Implications for clinical practice and future research as well as limitations were outlined.

Introduction

'Retail therapy', 'shop till you drop' and 'keep calm and go shopping' are well-worn phrases that attempt to light-heartedly depict the act of shopping as a pastime or a means to lighten mood. Though for many this is a harmless pursuit or functional necessity, according to Maraz, Griffiths & Demetrovics (2016) for an estimated 5% of the population it is a behaviour that has become unmanageable and damaging. In developed countries shopping experiences and visits to the mall have become embedded in the culture (Farrell, 2003) but for those who cannot control the urge to shop, commonly referred to as compulsive buyers, there can be calamitous financial, emotional, psychological and occupational consequences as well as difficulties in relationships (Benson, 2000).

Compulsive buying (CB) is a relatively new area of research but one that has kindled a surge of interest in recent years. Despite the vast amount of studies conducted, it still remains a complex, contentious issue both in terms of its classification and treatment (Muller, Mitchell & de Zwaan, 2015; Lee & Mysyk, 2004). Given its reported increasing prevalence (Neuner, Raab & Reisch, 2005) especially within the adolescent population (Maraz, Griffiths & Demetrovics, 2016) and the high occurrence of co-morbidities, it is thought to be a phenomenon that many therapists and counselling psychologists will encounter.

It has been described in numerous ways, from compulsive consumption, to spendaholism (Murali, Ray & Shaffhuilla, 2012). Compulsive buying (CB) was chosen for the current research as it seemed the most frequently used in the literature. CB has been constructed in a way that has become generally accepted (though not formally validated), as maladaptive spending behaviour that leads to personal distress which can include problems with finances, social, marital and occupational functioning, as well as shame, guilt, general dysphoria and anxiety (McElroy, Keck, Pope, Smith and Strakowski, 1994; Konkoly Thege, Woodin, Hodgins & Williams, 2015). Whilst some claim it is a valid mental illness, worthy of inclusion in the Diagnostic and Statistical Manual of Mental Disorders 5 (5th ed; DSM-5, American Psychiatric Association, 2013), Hollander & Allen, (2006), others reject this as a

medicalisation of what is deemed a ‘moral’ problem (Lee & Mysyk, 2004). For counselling psychologists (CoP’s) diagnostic categories pose a dilemma since they propose a pathologising stance which antagonises the humanistic underpinnings of the profession, (Larsson, Brooks, and Loewenthal, 2012). However, therapists working in community mental health teams (CMHT’s) are required by the National Institute for Health and Care Excellence (NICE) to employ a stepped-care model, which is based on severity of diagnoses. This medicalised construction is consistent with the demands for CoP’s to be ‘scientist-practitioners’, that is to seek out evidence-based treatments (Albee, 2000).

Given such tensions, this lack of recognition in the DSM-5 would no doubt impact how therapists and NHS practitioners construct CB. Neurobiological studies have been scarce and there is no treatment offered by the NHS, yet some argue similar processes are apparent with gambling disorder, which was included in the most recent DSM-5 under a new section ‘behavioural addictions’ (Black, 2010; Potenza, 2014; Granero et al., 2016). Much of the research around CB is split between the biomedical, medicalising perspective and a more socio-political standpoint that assesses the influences of media, marketing and promotion of materialistic values. But where do therapists sit amongst all these conflicting messages? How do they navigate such nebulous terrain when working with CB?

The scope of treatments is varied, therapies proffered in the literature include cognitive behavioural therapy (CBT), psychodynamic, cue exposure, psychopharmacology, mindfulness and dialectical behavioural therapy (DBT). The most success and research has been represented with CBT, perhaps because it is briefer, manualised, more outcome-focussed than longer-term therapies and more widely accepted within NHS services (Mansell & Taylor, 2012).

Often CB has been constructed as having shared comorbidities, including anxiety, depression, hoarding, substance abuse, eating disorders, impulsive control disorders and behavioural addictions (Black, 2010; Granero et al., 2016). This can make treatment approaches more complex and

commonly CB is not the presenting problem, but will emerge further into therapy (Benson & Gengler, 2004).

This thesis will begin with a review of the literature on the topic; chapter two, the methodology, describes the epistemological and ontological positioning, how the data was gathered, the analytical method employed (Critical Discursive Psychology), the ethical considerations and the researcher's reflexive comments on this. Chapter three lays out the analysis, outlining the discourses and interpretative repertoires found with examples from the data. A discussion of these findings in relation to the critical literature review, their implications for counselling psychology practice, future research and my own reflexivity and learning from the whole research process follows in chapter four.

The literature review aims to give an overview of the different ways compulsive buying has been constructed in the psychological literature, its historical context, definition, etiology, epidemiology and treatments available. Though there is much research across the topic, most clinical research studies CB from the individual's point of view, there is a paucity of qualitative research and none found that contemplates the therapist's perspective. With so many divergent views and a strong sociocultural element that can be seen as stigmatising and denigrating the phenomenon (Dittmar, 2004), it is thought that how therapists talk about and construct CB is important. Though, as therapists, we strive to be impartial, open and non-judgemental (Strawbridge & Woolfe, 2010) opinions, beliefs and attitudes will inevitably have an impact on the way we are with a client and the approach we choose. The British Psychological Society's guidelines for Counselling Psychologist's professional practice highlight the importance of taking into account the context of client's experiences as well as being both client-centred and informed by theory (BPS, 2005). The inextricable contribution the wider social context has upon client's experiences is valued as integral to assessment, formulation and interventions. It is hoped that examining the use of subject positions, dilemmas and the discursive resources used can reveal something about their bearing and convictions around CB. For instance, do they construct it as addiction, compulsion, a moral problem, a social

problem, a diagnosis, do they feel their training prepared them for working with it, how do they position the clients? Are their constructions constant or fluid?

The literature was searched using keywords including ‘compulsive buying’ , ‘shopping addiction’ , ‘behavioural addictions’ , ‘addiction’ , ‘compulsive behaviour’ , ‘shopaholism’ , ‘uncontrolled buying’ , ‘compulsive consumption’ , and ‘construction’ using the academic search engines PsycInfo, Wiley Online and EBSCO.

Reflexive Statement

Reflexivity urges us to explore how our involvement in a study ‘influences, acts upon and informs’ the research (Nightingale & Cromby, 1999, p.228). As a researcher I will automatically have tacit assumptions about the subject matter I am interested in (Kasket, 2013). It is important to explore and become aware of these presuppositions as they will inevitably colour my research. This subjectivity and reflexivity are intrinsically linked in counselling psychology research. Being attentive to subjectivity is one of the key values of counselling psychology (Orlans & van Scoyoc, 2008) and this is also fundamental to counselling psychology research. Being aware of our own subjectivity and how this can affect the research process is important so that we understand and reflect on the potential biases this may bring to the research and consequently we can attempt to ‘bracket’ off (Spinelli, 2005) as much as possible, any partiality. In writing this section, I will endeavor to review what drew me to the topic in the first instance, my beliefs and assumptions about it and how I think these beliefs effect my approach to the research process, and reading of the literature.

I have long found the similarities between behavioural addictions and substance addictions fascinating, as evidenced by my choosing to do a dissertation on this topic at undergraduate level and working in placements in both a clinic for drug and alcohol and a pilot NHS one for behavioural addictions. At the latter I worked with clients who were seeking help for internet gaming, porn, kleptomania and compulsive shopping. Though we had a CBT based manual, which was a modified version of the pathological gambling protocol, it was an innovative area for the NHS to work with specifically and so my supervisor was open to discussing novel approaches and trying new techniques. I was surprised that there were no NICE guidelines or NHS provision for any of this client group other than the pilot clinic and despite no advertising of the service the waiting list was growing. I found the compulsive shopping clients really engaged with the work and were eager to change but I got a sense that this was a multifaceted and complex issue that could benefit from deeper, long-term work. This rendered me with the uncomfortable feeling that I was overwhelmed and unable to help. Shortly after I left the clinic it was closed down after a disparaging report on it in the tabloids complaining that NHS funds would be better spent elsewhere. I pondered about public

attitudes to mental health, the effect of stigma and the notion that there could be a hierarchy of suffering, with compulsive shopping ranking low in the public's empathy. I wondered where this came from, was it just from ignorance about the condition or was there a wider, social political aspect stemming from the fundamental role materialism and consumerism plays in prosperous western nations? It was this bigger picture aspect which I wanted to explore as well as the more micro, detailed analysis of how therapists work with CB, since it is not as 'established', well understood or researched as others conditions.

I also have a more personal attachment to the subject, as a close family member of mine suffers from depression, issues with anger, hoarding and compulsive shopping. Though they have never had this diagnosed or been to therapy for it, I have seen at close hand the symptoms, patterns of behaviour and consequences of their actions and how distressing it can be. This person is not hugely wealthy and their purchases are on their own not very expensive but they are excessive, costly and mostly made via a tv shopping channel. For them, I think the act of purchasing evokes a fleeting sense of self-worth, efficacy and control. Witnessing their inability to control this behavior (and sometimes being the recipient of unwanted gifts, which gives me a sense of collusion) is both frustrating and upsetting. Like my clinical work in this area, I am often left feeling powerless to help or effect profound change, realising that this is part of a much more complex problem.

Though these experiences have of course motivated me to look deeper into this topic, they will undeniably influence my research. Already by choosing to use a discursive analysis I have guided my attention in a certain way, listening to the way it is talked about and the stakes and positions brandished. I am assuming it is a construct with many social and political influences. I believe the social and political contribution to this phenomenon has been mostly underestimated and agree with Benson, et al. (2010) that materialism, overconsumption and the diminishing of personal and spiritual well-being are at the root of this problem. We exist in a quick-fix culture, where we are bombarded with inescapable messages from birth to buy in order to improve our lives. Sophisticated marketing, that draws on neuroscience and psychological techniques can prove irresistible, especially for those

with low self-esteem or indeed any mental health issue. I also see the rise of social media and its 'influencers' endorsing products as a growing area of concern that is as yet unregulated. Government is not disposed to help since encouragement of buying boosts the economy, so scarce, if any resources are put towards education or indeed regulation, as there is for instance with healthy eating, in order to combat obesity. This seems unfair and I wonder if the minimizing of this problem is in part a feminist issue as it is reported as mostly effecting females, whereas gambling, a behavioural addiction which is comparatively better funded and recognized, effects mostly males (British Gambling Prevalence Survey, 2010). I also feel I have a political stake since I am frustrated that the clinic was closed down and wonder where and how these clients get help now. From reflections in personal therapy I know a trigger for my anger has been not being 'heard' as a voice and this is something I am sensitive to in my clinical work. In taking on this topic I wonder if I have been personally motivated by this sense that CB is left under the radar, unheard and not being taken seriously.

Such strong opinions are accepted as integral to critical discursive psychology (Willig, 2013), the researcher is not seen as a neutral observer, but a subjective one, giving one reading of the data. However, I also have attempted to give voice to the more medicalized, biological discourses as these are also relevant to counselling psychology and working with CB. I will endeavour to have an open mind but suspect I will feel affronted if therapists that have worked with CB are disparaging of it but at the same time I am eager and interested to find out how their experiences of working with CB have been. I appreciate that probably there will be some similarities and some differences to mine and as a researcher I should embrace and not be hostile to these differences.

CHAPTER 1

CRITICAL LITERATURE REVIEW

1.1 Historical context

Compulsive buying behaviour was first constructed by Kraepelin (1909), a German Psychiatrist who sought to classify all psychiatric diseases by looking at common patterns of symptoms. He named it 'oniomania', from the Greek 'onios' meaning for sale and 'mania' meaning insanity, effectively labelling the population as 'buying maniacs', implying a pathological and vilified behaviour. The Swiss psychiatrist Bleuler (1930), later depicted the oniomaniac as impulsively insane, female, pleasure-seeking, 'frivolous debt makers', despite a 'good school intelligence' (p.540). Such language and discourse positions women as lacking willpower and shows the influence of historical and cultural context on how a diagnosis is constructed, providing 'hegemonic' ways of understanding the world (Gramsci, 1971).

Oniomania was given little attention again until the late 1980's when the American media focussed on self-help groups that were trying to address this emerging issue (Holmstrum, 1985, Mundis, 1986), in a culture of relaxed credit and shopping as a pastime (Black, 2007). Consumer behaviourists started to understand the problem as widespread (Elliot, 1994, Magee, 1994, O'Guinn and Faber, 1989). Several clinical cases were reported in America and Europe and corroborated similar presenting factors – mostly females with extensive comorbidities, indicating a definable, persistent clinical disorder (Dittmar, Long & Bond, 2007; McElroy et al. 1994, Schlosser, Black, Repertinger & Freet, 1994; Black, 2010).

1.2 Definitions

Compulsive shopping has been referred to in numerous ways, as shopping addiction (Murali, Ray & Shaffiula, 2012), compulsive consumption (O'Guinn & Faber, 1989), compulsive buying disorder

(Black, 2010), compulsive shopping disorder (Aboujaoude, Gamel & Koran, 2003), shopaholism (Shulman, 2011), uncontrolled buying, spendaholism addictive buying and consumption (Lee & Mysyk, 2004). This abundance of terms hints at the divergence in how CB is constructed.

1.2.1 Compulsive or impulsive behaviour?

The terms ‘compulsive’ (d’Astous, 1990, Faber & O’Guinn, 1989) and ‘uncontrolled’ (Lejoyeux, Ades, Tassain & Solomon, 1996) highlight a lack of control, synonymous with other compulsive behaviours (eg obsessive compulsive disorder). Dittmar (2004) contends that ‘excessive buying’ is a more appropriate term as it is less assumption-laden, whereas ‘compulsive’ is misleading as this signifies negative emotions, intrusive thoughts and actions that are ego-dystonic.

Some researchers have emphasised the impulsive character of CB, stressing it’s similarities to other impulse-control disorders such as kleptomania (Koran, 1999; Black 2001; Lejoyeux, Mc Loughlin & Ades, 2000),. Others maintain there are elements of impulsive and compulsive features in CB since there is both an impulsive element (gratification) which initiates the cycle and a compulsive element which leads it to persist (Hollander & Allen, 2006; Benson 2001; Joo & Kim; 2004; Kim & Hyun, 2005; Sohn & Choi, 2014)

1.2.2 Diagnosis and the DSM-5

Despite much attention in the past few decades CB has not been included in the DSM-5 (Muller, Mitchell & de Zwaan, 2015). Provisional operational measures for diagnosis were proposed in America from a study of twenty clinical cases by McElroy et al. (1994) which have since become standard in CB research. These included cognitive and behavioural factors, distress, financial or legal problems, impairment to social, occupational functioning and family life and ensuring the behaviour is not part of a manic episode. Focussing on such criteria could be seen as ignoring the role that fantasizing (as promoted by consumerist, cultural imagery) plays in CB (Featherstone, 1990), how

social reality can be constructed through purchases (McCracken, 1990) or the consumption of goods as a vehicle for renovation of the self (Belk, 1991).

Some strongly advocate the merits of inclusion in the DSM (Hollander & Allen, 2006; Muller, Mitchell & de Zwaan, 2015; Granero et al., 2016), as it aids advancements in research, tracking of prevalence and ensures CB is neither trivialized nor disregarded by clinicians. Others claim the evidence for its inclusion is still insufficient (Piquet-Pessoa, Ferriera, Meica & Fontenelle, 2014). Vanheule (2012) asserts the DSM-V is incompatible with psychotherapy practice as it fails to take into account the personal experiences associated with symptoms, it assumes that neurobiological disturbances cause mental disorders. Yet a diagnosis can give an individual a sense that their pain and identity is authenticated (Lafrance & McKenzie-Mohr, 2013). Such tensions around the diagnosis of CB could be seen as affecting counselling psychologists as their training emphasises formulation and valuing what is person-specific about a problem, yet they are often working in NHS settings where diagnosis and medical discourse are advocated.

1.2.3 Behavioural addictions

CB has been portrayed as analogous to addiction (Elliot, 1994, Scherhorn et al., 1990), with the National Institute on Drug Abuse (NIDA) describing behavioural addictions such as CB as cleaner versions of addiction, which share similar clinical features and brain circuitry that is not affected by external substances (Hollander & Allen, 2006). The latest DSM-V has a new section 'behavioural addictions', for diagnoses such as pathological gambling, which are said to demonstrate similarities to substance addictions in terms of increased physical arousal before the act, pleasure or high associated with the behaviour followed by decrease in arousal and feelings of remorse and guilt afterwards and sometimes tolerance and physiological withdrawal. It has been argued these criteria fit with CB (Hollander & Allen, 2006; Elliot, 1994; Scherhorn, Reisch & Raab, 1990).

1.2.4 Phenomenology

The debate around the classification of CB rests partly on an understanding of its phenomenology. CB has been defined as a frequent preoccupation with buying and shopping or impulses to buy that are irresistible, frequent buying of more than is needed, more than can be afforded, or for longer than is needed (McElroy et al., 1994). This will cause marked distress, be time consuming and have negative social, occupational and financial consequences (McElroy et al., 1994). During the shopping experience individuals experience short-lived relief and excitement followed by guilt and regret over the inappropriate purchases (Black, 2007). Items bought are often given away or left unused. Objects bought for the self often have significance for the individual's self-esteem and signify ways they attempt to improve their own identity to be more in line with their 'ideal' or 'better' self (Dittmar, 2004). Some people with CB will prefer to shop secretly, either alone or anonymously via the internet or TV (Muller et al., 2015), perhaps because of feelings of shame around their behavior (Black, 2010). Others enjoy the interaction and attention they receive from sales staff or from TV hosts complementing them and giving permission cues for the behavior, as well as increasing their self-esteem and reducing loneliness (Workman & Paper, 2010).

Krueger (1988) chooses not to differentiate between shopping (emphasising the importance of the process) and buying (stressing the significance of the purchase and ownership) whilst Campbell (2000, p. 58) maintains there can be individuals for whom either the shopping or the spending are the most salient. It seems the most detrimental consequences come from the actual excessive purchases (eg. financial debt and unwanted consumption) therefore this should be integral to the nomenclature, however it perhaps is not a dichotomous case of a normal or abnormally compulsive behaviour. Dittmar (2000, p. 106) suggests an inclusive, continuum perspective, with buying ranging from normal to excessive. The view of compulsive buyers as just 'extreme cases of a generalized urge to buy' has been adopted by other researchers (d'Astous, 1990, p. 17). However, this construction in which consumerism ranges from 'good' to 'bad' hints at the compulsive buyer's immoral position in society, (Campbell, 2000).

1.2.5 Comorbidity

CB is frequently linked in the literature with low self-esteem. Antecedents include negative emotions such as anger, boredom, anxiety and self-critical thoughts (Mittenberger et al., 2003) with shopping binges compared by some to bulimia, a means of purging depressive feelings (Lejoyeux, et al., 1996). Eating disorders, particularly bulimia and binge eating as well as obesity are often reported as co-morbid with CB, (Schmidt, Korber, de Zwaan & Muller, 2012). Other common co-morbidities include anxiety disorder, obsessive-compulsive disorder (OCD), impulse-control disorders such as personality disorder (Black, Repertinger, Gaffney & Gabel, 1998) and substance abuse (Christenson, Faber & Mitchell, 1994). It is estimated that half of those living with CB also are compulsive hoarders (Mueller et al., 2007) and it has also coincided with other addictive behaviours: pathological gambling (Grant & Kim, 2003), internet use (Mazahari, 2012), exercise dependence (Lejoyeux, Avril, Richoux, Embouazza & Nivoli, 2008). Parkinsons patients treated with dopamine agonists have also reported increased levels of CB (Weintraub & Nierenberg, 2013). Reports suggest that a co-morbid complaint is usually the presenting issue rather than CB (Muller et al., 2015) though some comment that comorbidity figures are biased as they are derived from psychiatric populations (Dittmar, 2004).

(Lee & Mysyk, 2004) note the difficulty in tethering out CB as a separate entity from other disorders, suggesting the literature could look at CB in a more holistic way, a vision that sits more congruently with counselling psychology values, which strive to look at problems and individuals phenomenologically and pluralistically (Strawbridge & Woolfe, 2010).

1.3 CB Profile

1.3.1 Scales

The most widely accepted scale of measurement is the Compulsive Buying Scale (CBS) (Faber & O'Guinn, 1992) which is used to distinguish normal from pathological buyers through a twenty-nine item questionnaire based on characteristics of CB. Others include Lejoyeux, Tassian and Adas (1997)

nineteen item questionnaire, though its psychometric validity was not reported (Black, 2010). Ridgeway Kukar-Kinney and Monroe (2008) developed the Compulsive-Impulsive Buying Scale which accounted for impulsive and obsessive-compulsive components. Monahan, Black and Gabel (1996) created a shopping version of the Yale Brown Obsessive-Compulsive Scale (YBOCS-SV) which probes for interference, distress, resistance and control related to CB. The Edwards' (1993) scale is less widely used but was advocated by Manolis and Roberts (2008) as more suitable than the CBS for identifying compulsive buyers from the general population. The use of diaries which record frequency of shopping, feelings, antecedents and outcomes help to monitor awareness and progress during treatment (Black, 2010).

1.3.2 Prevalence

Prevalence reports of CB have varied enormously from 1.8% (Faber & O'Guinn, 1992) to 44 % (Dittmar, 2005). Based on the results of a mail survey using the CBS, prevalence was estimated at around 1.8-8.1% of the general population in USA (Faber & O'Guinn, 1992). Koran, Faber, Aboujaoude, Large and Serpe conducted a USA phone survey (2006), using the same scale that found prevalence at 5.8%. In general, higher percentages are reported for college students and adolescents (Magee, 1994) (Roberts, 1998). It has also been claimed that prevalence of CB is rising in Germany (Neuner et al., 2005), though no other countries have done similar studies. CB has been highlighted in studies worldwide, (Korea, USA, Israel, UAE, Brazil, UK etc.) but unsurprisingly seems to be limited to developed, high income countries where credit and consumer-led societies are established (Murali et al., 2012). There are mixed reports on the income levels of those with CB. D'Astous (1990) suggests that middle class citizens are most likely to suffer from CB, whilst others surmise there is no significant difference across class (O'Guinn & Faber, 1989). However, it is acknowledged that the financial burden of CB will be felt most by those on a low income (Black, Monahan, Schlosser & Repertinger, 2001). The most recent metanalysis puts the prevalence rate at 5% of the population (Maraz, Griffiths & Demetrovics, 2016).

1.3.3 Age

Age of onset seems to occur around late teens to early twenties (Dittmar, 2005) (d'Astous, 1990). Black (2010) suggests it is no coincidence that this is a time when adolescents are becoming more independent and beginning to use credit cards. This pattern of excessive buying has been linked to other disinhibitions in adolescents such as smoking, drug use and early sex (Roberts & Tanner, 2000).

1.3.4 Gender

Most research has identified the majority (80-94%) of the CB population as female (Christenson et al., 1994; Faber & O'Guinn, 1989; Schlosser et al. 1994). However, some research has disputed this, finding CB is more equally spread across both genders (Koran et al., 2006). Dittmar (2004) argues that there are three main dimensions to motivations to shop; functional, socio-emotional and identity related and that for men only the first is salient, whereas for women all three factors are fundamental. Campbell (2000) claims men see buying as work that they have to do, whereas women associate it more positively with leisure. Black (2007) contends that men who compulsively shop interpret it as collecting, suggesting denial. This bias could result from women being more willing to seek treatment and respond to surveys. Fischer & Gainer (1991) assert that shopping is more integral to women than men as traditionally gender roles convey the act of buying goods as a female construct and thus it has become more emotionally, psychologically and symbolically attached to women, as well as contributing to the development and maintenances of their identity construction. These findings could be seen as a feminist issue, influenced by ways of talking about gender, and one which may change, should cultural norms around gender roles and shopping evolve (Dittmar, 2004).

1.3.5 Features of the Compulsive buyer

It has been argued that CB is just an extreme form of normal shopping behavior that is no qualitatively different, a kind of continuum conceptualization (Woodruffe, 1996; d'Astous, 1990). Such theories assume a homogenous group that shares causal and maintaining factors. DeSarbo and Edwards (1996) challenged this view, they found compulsive buyers demonstrated diverse manifestations that tended to two clusters. One driven by psychological factors such as

impulsiveness, low self-esteem, dependence and anxiety and the other more environmental factors such as isolation and coping. Perhaps looking at CB more holistically, as suggested by Lee & Mysk (2004) would make connections between the psychological and environmental factors. Eccles (2002) interviewed 46 women about CB and unfurled four clusters or ‘types’ of CB: revenge, existential, mood repair and serial buyers. Some studies have suggested that CB runs in families and also that families of origin of those with CB have higher levels of mood, anxiety and substance use disorders than the general population (Black, 2010). Materialism, depression, perfectionism, decision making difficulties, cognitive impairments and narcissism have also been highlighted as related to CB (Dittmar, 2004; Derbyshire, Chamberlain, Odlaug, Schreiber & Grant, 2014; Rose, 2007).

1.4 Theoretical explanations

1.4.1 Psychodynamic

Psychoanalytic theories have posited early life events, the absence of a stable self-image and castration-anxiety in women (Black, 1996). Sansone, Chang, Jewell & Rock (2013) examined five types of childhood trauma before the age of twelve (witnessing violence, physical neglect, emotional abuse, physical abuse and sexual abuse) and found all correlated significantly with CB. Krueger (1988) considered four CB case studies, and posited two main psychodynamic themes. Firstly, the ruptured self or self/object bonds to an important other person motivates CB in an attempt to mend the depleted sense of self and feelings of emptiness. Secondly, a developmental arrest of the body-self and psychological self, and a vulnerable reliance on the perceptions of others. In both instances the emphasis is on buying possessions as a means to gain approval of others through appearances and regain control. Drawing on psychodynamic theory, rather than case studies, Lawrence (1990) proposed female compulsive shoppers had experienced a form of object loss as a child resulting in identification with the father and compulsive purchasing of symbolically phallic objects. Like Krueger (1988), Lawrence viewed the object as an attempt to fill an emptiness, and soothe feelings of low self-worth, sustaining the unconscious dialectic that by giving something to the self, they are worthy of love. Lawrence (1990) points out that ‘the period of wanting the object with the knowledge

of its attainability is what is most fulfilling and therefore most frequently repeated' (p. 67), suggesting that possessing the object is not driving the compulsion but the feelings generated in the process of purchasing.

Benson (2006) notes typical familial patterns have included the physically abusive or negligent parent, the neglectful parent who demands good behaviour in return for love, the absent parent who has little time for the child and parents who become preoccupied with lost fortune. She claims the individual turns to possessions in an attempt to feel soothed, improve their self-esteem and social status.

1.4.2 CBT

Kellett and Bolton (2009) created a cognitive behavioural model for CB, that proposed four stages; antecedents such as family environment and early developmental experiences, internal emotional and external triggers, followed by the act of buying, and finally post-purchase emotional, behavioural and financial consequences. CB is constructed as losing control of overspending, failure to self-regulate and associated with high-level impulsivity (Kellett & Bolton, 2009). Their formulation acknowledges the contributing effect that external cues such as advertising, credit availability and promotional events can have on self-regulation processes.

1.4.3 Neurobiological

Neurobiological and genetic studies of compulsive buyers are scarce and inconclusive. One fMRI study (Raab, Elger & Neuner, 2010) found that non-compulsive buyers responded more negatively to loss of money through purchases than compulsive buyers. More generalised studies of behavioural addictions' neurobiology (though not specific to CB) have demonstrated variations in levels of serotonin, dopamine, endogenous opioids and cortisol suggesting an imbalance between overaroused drives and faulty inhibition or reward processing (Grant, Brewer & Potenza, 2006) (Murali et al., 2012).

1.4.4 Cultural

Social and environmental factors are often underemphasised in the more positivistic literature (Black, 2010). However, CB is only found in countries where there is a market based economy, easy access to credit, an abundance of consumer goods on offer, disposable income and significant amounts of leisure time (Lee & Mysyk, 2004). Some studies do stress the role of culture as culpable (Scherhorn et al.1990), depicting CB as a ‘desperate search for meaning in a disintegrating social order’ (Elliot, 1994, p.163). Benson, Dittmar & Wolfsohn (2010) review the growing disconnect between what is produced in industrialized societies and what is needed to live, exacerbated by advertising and media persuading society that buying will make us feel better. They also maintain the shift in aspirational figures over the last fifty years from our local peers to celebrities with affluent lifestyles has contributed to a more materialistic society.

1.5 Therapies

1.5.1 Pharmacological

Pharmacological treatments have shown mixed results. Some limited success has been demonstrated with citalopram (used to treat OCD, anxiety and depression) (Koran, Chuong, Bullock & Smith, 2003) and SSRI anti-depressants (Black, Monahan & Gabel, 1997). However, later studies have contradicted these findings, showing a placebo effect (Koran, Aboujaoude, Solvason, Gamel & Smith, 2007; Black, Gabel, Hansen & Schlosser, 2000; Ninan et al. 2000). Limited reduction of urges to shop was found with three cases using naltrexone, (Grant, 2003).

1.5.2 Psychodynamic and psychoanalytic

Psychoanalytic treatments have reported some success but they are limited to case studies (Winestine, 1985, Lawrence, 1990). Psychodynamic work is varied and has been said to depend on the orientation and preference of the therapist (Benson & Gengler, 2004). It has focussed on areas such as the need for nurturing the fragile sense of self that depends on the approval of others (Krueger, 2000), repairing ruptured emotional bonds and the need to appear attractive (Goldman,

2000) and family therapy to heal communication and self-differentiation issues that resulted in anxiety, depression and tension, (Tai-Young, Sung-Hui & Seo, 2006).

1.5.3 CBT

Probably the most widely used and researched therapy is group and individual CBT. Mitchell, Burgard, Faber, Crosby and de Zwaan (2006) developed a protocol in America of twelve sessions over a ten-week period trialled on twenty-eight individuals with CB. Sessions included the following topics :

1. treatment overview,
2. identifying problem behaviours and reasons for and against changing behaviour,
3. cues and consequences,
4. cash management and cancelling credit cards,
5. responses, thoughts feelings and behaviours
6. restructuring thoughts
7. cues and chains
8. self-esteem
9. exposure and response prevention
10. stress management and problem solving
11. relapse prevention and relapse plan
12. summary.

Improvements in CBS and Y-BOCS-SV scores were sustained at six-month follow up.

Mueller et al. (2008) used a similar manualised CBT 12 week protocol with thirty-one individuals who met the criteria for compulsive buyers as developed by McElroy et al.(1994). Practising and developing coping skills and healthy buying habits were also covered. Again, improvements were maintained at six-month follow up compared to a waiting-list control group. Both papers noted the reported salience of credit card management for the participants.

Kellet and Bolton (2009) also constructed a comprehensive CBT model in four phases (antecedents, triggers, buying and post-purchase) which they used to guide assessment and intervention in a trial on a single case study in the UK, generating positive outcomes at six month follow-up. It embraced the position that there are multiple explanations for CB, maintaining this approach was broad enough to be clinically appropriate to the heterogeneity of those seeking treatment for CB. Interventions focussed on the cognitions and behaviour and included planned avoidance of the shopping and exposure to the anxiety this provoked, distraction techniques and challenging negative beliefs. A further trial was performed by Filomensky and Tavares (2009) in Brazil focussing on cognitive restructuring of thoughts specific to shopping through group therapy with nine individuals who demonstrated significantly reduced YBOCS-SV scores at the end of treatment. Twenty sessions included the cognitive behavioural model, stages of change, misconceptions about shopping, compulsive versus regular shopping, various maladaptive patterns of thoughts and feelings about the compulsion to shop as well as financial and debt management. Mueller, Arikian, de Zwaan & Mitchell (2013) compared group CBT, phone-guided self-help (GSH) and waiting list control group and found the group CBT showed the most improvement after six months, but GSH tended to show more improvement compared to waiting lists. Session topics included motivation, stimulus control, alternative behaviour techniques, response prevention techniques, cognitive restructuring, money management, material values, stress management and problem solving.

1.6 CB In Practice

There are currently no NICE guidelines and direct treatment for CB is not offered under the NHS. A small NHS pilot clinic for behavioural addictions was trialled in London from 2013–2015 utilising a CBT manualised eight week programme based on the National Problem Gambling Clinic's protocol, but was closed due to lack of funding. Several private UK clinics such as The Priory offer psychotherapy, with the type of therapy usually unspecified. The Nightingale Capio hospital, describes their treatment program for behavioural addictions (including CB) as a bio-psychosocial approach using CBT, Motivational Enhancement Therapy, Interpersonal Therapy and Twelve Step

Facilitation, which aims to ‘motivate, educate, support and promote positive thinking’ (<http://www.nightingalehospital.co.uk/condition/addictions/>). No UK charities or non-profit organisations were found to date that offered direct specific help for CB. However, some charity websites such as The Living Room in Hertfordshire, offer structured day treatment group sessions for substance and ‘general’ addictions, that is based on CBT and solution-focussed therapy and a foundation in the Twelve Step tradition (<http://thelivingroom.me.uk/about/our-approach/>).

CB therapy is offered privately in USA through various organisations and therapists, e.g. Benson’s Stopping Overshopping website, which offers access to private therapy from her clinic in New York or therapists she has trained across the US. Benson and Eisenbach (2013) developed the Stopping Overshopping approach, a twelve-week group programme which draws on psychodynamic, CBT, DBT, motivational interviewing, mindfulness, and acceptance and commitment therapy. Attending to triggers, feelings, dysfunctional thoughts, behaviours, consequences and meaning of the compulsive buying and spending plans. Individual treatment is also available and may include, couples therapy, counselling, debtors anonymous, drug treatment, group therapy (<http://www.shopaholicnomore.com/complusive-shopping-treatment/>).

Many self-help books are available (Catalano & Sonnenberg, 1993; Shulman, 2011; Benson, 2008), online forums (e.g. <http://www.dailystrength.org/c/Shopping-Addiction/support-group>) as well as Debtors Anonymous which runs on the premise of the twelve steps, though this isn’t only applicable to CB, it can help with taking control of the financial management aspect.

1.7 Conclusions and identified gap in the research

The majority of research into CB has been quantitative and has focussed on identifying its key features, aetiology, epidemiology and clinical trials of treatments, (Mueller et al., 2015; Black, 2010; Murali et al., 2012) with some attention given to the societal and cultural contributing factors (Benson et al., 2010; Workman & Paper, 2010). Qualitative research is relatively sparse and tends to focus on

the experience and understanding of the compulsive buyer. There was no research found that looked at CB from a social constructionist perspective, discursively or from the therapist's perspective.

1.7.1 Qualitative research in CB

One of the earliest investigations into the experience of compulsive shoppers was by O'Guinn and Faber (1989) in America. They initially observed group therapy with fifty compulsive buyers, interviewed therapists treating the disorder, conducted several individual and group interviews and read over one thousand letters from compulsive buyers. The study consisted of a mail survey comparing CB with other shopping, and five in-depth interviews with compulsive buyers that were analysed phenomenologically to elicit emergent themes of compulsivity, self-esteem, fantasy, purchasing versus possessing and consequences. They noted the shame and embarrassment individuals felt since CB was not recognized as a compulsive disorder, the knowledge that they were not the only ones lent them some relief, leading the authors to suggest giving a label to CB could be beneficial. Though this study reaped much information around motivations and the lived experience of CB it did not report directly on the findings from the interviewed therapists, nor did it consider the way CB was constructed discursively or the resources used in talking about it.

Riddy (2000) investigated the role early family life may play in CB by using semi-structured interviews of twenty-seven self-proclaimed addictive shoppers in the UK. She aimed to explore what the shopping was expressing for the shoppers consciously or unconsciously. Her study suggested that shopping was a narcissistic search and found that in all participants there had either been 'a family imbalance in childhood or the mother had been an obsessive shopper' (p.173). Her thematic analysis similarly suggested themes of low self-worth, attempting to fill a gap and escapism, but also issues around control, shame, appearance and shopping as an acceptable addiction. Such themes hint at how socially constructed CB is (eg 'acceptable addiction').

Two studies were found using the grounded theory approach which looks at data to generate theory and processes. Tai-Young et al. (2006) studied a Korean female student who experienced CB and

was in family therapy. They observed issues with communication, sibling relationships, mothers parenting and communication style, inter-parental relationships, stress and compulsive buying and credit card usage. Clark & Calleja (2008) interviewed eight Maltese students who qualified as compulsive shoppers to assess if it could be understood as addiction. Themes highlighted included loss of control, negative consequences, mood regulation and addiction cycle.

Sohn & Choi (2014) used content analysis to study the phases of shopping addiction in compulsive buyers in Korea, deriving five themes; filling up emptiness with shopping, ignoring overconsumption, ran out of money, driving oneself to hasty buying, it is crazy but I cannot stop. Again the focus in the rich data received was on categorizing the phenomenon, drawing similarities it has with addiction, compulsive and impulsive behaviours. Eccles (2002) interviewed forty-six UK women who identified as compulsive buyers, using interpretative phenomenological analysis (IPA). A strong emergent theme was that the shopping evolved as a means to feel in control, making their own decisions, they described buying as as a type of 'freedom' allowing them space and empowerment not realised in other aspects of their lives.

Whilst all these studies have generated an understanding of the lived experience and processes underlying CB, it could be argued that thinking about the language, positioning and discursive resources used could tease out other perspectives pertaining to communication, identity, family and how the phenomenon is constructed and positioned.

1.7.2 Relevance to Counselling Psychology

All of these qualitative studies have generated knowledge and deepened our understanding of how CB is experienced, its features and processes. However there was little research found that looked at CB discursively, and none that regarded this from the viewpoint of the therapist. Why is this important?

As counselling psychologists we are asked to emphasize the subjective experience of clients, engage with them as equals and attempt to immerse ourselves in and understand their ‘inner worlds and constructions of reality’ (Strawbridge & Woolfe, 2010, p.10). However, in order to do this we, as therapists, need to be aware of the constructs and understandings we inevitably bring to the process, intended or not, we need to understand our own ‘histories, attitudes and emotional defences’ (Strawbridge & Woolfe, 2010, p.11). Though this is generally thought of as a rationale for undertaking personal therapy, in a broader sense it is applicable to the theories we adopt and approaches we choose. From a social constructionist perspective, our own attitudes and intentionality as therapists will be constructed from the fabric of our social and cultural interactions. Bailey (2005) maintains that discourse theory could be useful in helping us re-conceptualize the relationship between addiction and agency in addict’s accounts. In exploring the different discourses of addiction, she notes the importance of popular discourses as a powerful and subversive counter to more expert discourses of addiction, lending the addict an agency and control. She also notes how discourses are situated in time and place, for example in the nineteenth century consumption of opiates was considered a habit and in the 1950’s cocaine was seen as safe and non-addictive (Davies, 1992). Bailey (2005) claims the addict may find empowerment in the interweaving of apparently competing discourses of addiction constructed as both acceptable and pathologised, and she calls for more research examining this interplay of multiple discourses. She sees popular addiction discourses as making the individual less victim to all powerful chemicals and more actively engaged in their behaviour and therefore able to stop eg the ‘chocaholic’, the ‘shopaholic’. These may be in opposition to more disempowering discourses of helpless addict and expert therapist (Davies, 1992). Though she was looking from the addict’s perspective, the discourses identified would have been available to therapists too and it is argued here that exploration of how therapists manage this interplay would be equally valuable.

It is thus useful and important to increase our understanding of how we perceive CB as this will affect how we practice, the interventions we choose or don’t choose and how we interact with the client. Exploring therapist construction of CB should survey the complex relationships between

theoretical orientation, personal values and beliefs and actual therapeutic practice, an area that has been signposted for further research (Navajits, 1997; Pozanski & McLennan, 1995).

Shinebourne and Adams (2007) used a Q methodology (Brown, 1980; Stainton Rogers, 1995) to investigate therapists' understandings and experiences of working with addiction, noting many divergent factors and influences on their construction of addiction creating 'a worldview which is a composite of various perspectives' (p.215). They suggest that this is a valuable and important area for further study and may contribute to training. It has been observed that clients tend to assimilate their therapist's values (Kelly & Strupp, 1992) thus the construct a therapist holds of CB could effect engagement in the therapeutic relationship. They also called for supervision, training and agencies to take the beliefs and values of therapists into account, though their research was with therapists working with substance addictions, it could be argued that this would be even more relevant for CB, where there is so much in flux. Hemmler (2013) describes CB as being in a liminal status, that is through its medicalization it is on the threshold of becoming a 'disorder' moving from 'whimsical behaviour to psychiatric pathology' (p.134). Since it is not currently classified in the DSM-5 she sees it as in hazy territory, 'partly sanctioned' as a medicalized illness and partly disbelieved (Hemmler, p.134). CB is pictured in this way as on the margins of psychology and not taken seriously.

Lee & Mysyk (2004) decry the dangers of categorizing CB as an illness as it deflects attention from societal issues, focussing instead on the individual as the source of the problem resulting in the use of pharmaceuticals as the preferred treatment. Indeed many researchers maintain that sociological, political influences and media play a large part in CB. In their paper on the diagnosis of schizophrenia, Larsson, Loewenthal and Brooks (2012) examined the way the diagnosis was talked about in counselling psychologists work and the tensions this portrayed in working with a medicalized diagnosis yet coming from a non-pathologising underpinning. It could be contended that similar, if not more complex tensions should arise from therapists working with CB, since it is unclear how it should be diagnosed, classified, constructed and treated. No literature to date has been found that looks at CB in this way from the therapist's point of view. Though much of the

research is of course generated by clinicians and specialists from the field they are mostly attempting to produce theories and classifications, or to look at case studies and the lived experience from the individual's perspective. This depicts the experience of CB and attempts to map it out for clinicians to try to navigate.

There are clearly many conflicting theories, positions and discourses around this topic: how it should be defined, who it effects and how it can be treated have been constructed in many ways. Therapists working with CB, not just counselling psychologists, are in a pivotal position as they assimilate information from the psychological literature, their training and theoretical position, society, culture and most importantly from their experience with clients. This will inevitably lead to 'constructions' of CB, informed by their work, experience and attitudes which I hope to distill and investigate in this research. It is hoped that this will inform future practice and training for those working with CB. Therefore, the research questions I propose to ask are:

How do therapists construct CB in the context of their work?

How do they negotiate it in their talk?

What resources are they drawing upon to shape these constructions?

How does their discourse position CB in relation to other psychological phenomena?

CHAPTER 2

METHODOLOGY

This section will look at the methodology used to investigate the research questions highlighted by the literature review in chapter one. It will also summarise the epistemological and ontological underpinnings of the methodology and how this fits with the researcher's CoP values. The procedures used, ethical considerations taken and analysis steps will also be described. The reasons why this methodology was deemed more appropriate than others for this particular research question will also be discussed. Lastly, the researcher will share some reflections on the methodology.

2.1 Epistemological Position

2.1.1 Social constructionist epistemology

Discourse analysis assumes a social constructionist epistemology (Burr, 2003). Such a stance takes the view that there is no absolute truth but that everything (people, places, objects) exists in language. This postmodernist movement regards language as the generator of reality and as such all knowledge is socially and culturally derived (Alvesson & Deetz 1999). The aim of this type of research is not to understand the lived experience but to appreciate how reality and knowledge is constructed through language around the topic.

Social constructionism urges us to be skeptical of 'assumptions about how the world appears to be' (Burr, 2015, p.3). It does not assume that we are progressing to a more refined way of knowing but that our knowledge is a product of time and place (Burr, 2015). Social interactions expressed through language are active, yielding power dynamics and positions. The discursive study of psychological constructs (such as CB) can change them from being an explanatory source to a topic to be explored in itself (Wetherell, 1994). For example, a therapist may describe someone as 'addicted to shopping' or they may describe the same person as 'materialistic' or 'depressed' or having 'poor impulse control'. Each of these descriptions conjures different positions and identities for the compulsive buyer as well as the therapist. All such labels are symbolic and have an effect on the client, how they see themselves, how they are treated by other medical professionals and what may be 'done' in terms

of their treatment. In this sense the language constructs a new reality for them, it is 'doing something'. This aspect of compulsive buying can be explored through the lens of discourse analysis, examining the action orientation of the language, what discursive resources are available, the positions taken and power relations invoked.

2.2 Ontological considerations

Social constructionism encompasses differing ontological viewpoints (Stam, 2001) and these are reflected in the different theories of discourse analysis. Within social constructionism there are those who adhere to the pure relativist view that there are multiple truths, denying the view that language is neutral and simply reflecting activity rather than activity itself (Edwards, 1997). Discursive psychology (DP) adopts such a stance, seeing individuals as 'agentic and as continually in the process of construction and reconstruction built from the voices of others, from interactional patterns of early family life and other (life-long) socializing institutions' (Wetherell, 2007 p.672). This relativist position, has been described as 'ontological constructionism' (Edwards, 1997).

Such a stance rejects completely the critical realist position that there is a truth but that it can only be imperfectly, critically understood, (Ponterotto, 2005; Parker, 1999a; Bhaskar, 1975). Some approaches to DA such as Foucauldian Discourse Analysis (FDA) assume a critical realist ontology, arguing that discursive constructions of reality are grounded in social and material structures such as institutions and their practices (Parker, 1992). This demands an ontological realism that is anchored in time and by social, political and cultural forces (Burr, 2003). Whilst these two views may seem divergent it has been suggested that they can be combined to acknowledge both the social and material structures apparent and the dynamic and fluid constructions of identity and subjectivity within a context (Potter & Wetherell, 1995). From this framework, many aspects will be seen as contributing to the constructive and constitutive nature of the interactive talk between researcher and participant around CB. These may include clinical training, family values, personal experience's of shopping, the setting, etc *as well as* the wider social and institutional frameworks within which they are produced and which shape their production, (such as the NHS).

This position was chosen on the basis that the literature review found much positivistic, quantitative research which seemed too narrow in depicting the ideas that surround CB. The qualitative research found mostly took a critical realist position which has produced some interesting and valuable findings in this area pertaining to the lived experience of those dealing with compulsive shopping. Such a phenomenological approach attempts to interpret the individual's experience of CB but does not unearth any alternative perspectives. Examining CB instead through a lens that can capture what discourses and objects are made available and how this is managed socially in interpersonal interactions and to what end, could help understand why CB is arguably a nebulous and taboo topic.

2.3 How does this approach sit with my Counselling Psychology values?

This approach spoke to me not just for its appropriateness to the research question, but also personally and as a counselling psychologist. On a personal level, I am attracted to ideas that challenge the norm, that defy complacency and acceptance of the obvious. From a feminist perspective, for example, I believe women's position is socially and culturally constructed through discourse, that our expectations of women could be different in a different civilization (Elder-Vass, 2012). I am always curious of alternative theories, and social constructionism encourages us to think about and probe such possibilities (Elder-Vass, 2012). What contributed to me choosing counselling psychology as a profession was just such a curiosity for uncovering the individual's story, whilst acknowledging that this can be a changeable truth that depends on the interactions in time and place, including the interaction with a therapist.

2.4 Method of analysis (Critical Discursive Psychology)

Within the social constructionist approach there are many methodological strands and options, including FDA, Critical Discourse Analysis (CDA, Parker, 1992), Discursive Psychology (DP, Edwards & Potter, 1992) and Conversation analysis (CA). Some, such as FDA and CDA, choose to focus on the macro power dynamics in language, looking at the dominant discourses present, which can also limit what speakers can say (Willig, 2008). CDA sees discourses as socially constructed, perpetuated and able to create inequalities (Fairclough, 2013), therefore it seeks to understand

powerful ideologies (van Dijk, 2001). CDA has been criticized for ignoring the fine-grained aspect of talk and thus lacking validity (Schlegoff, 1997). DP answers such criticisms by concentrating on this in-depth analysis of talk and patterns of conversation such as turn-taking, subject positions and the performative nature of language (Willig, 2013), analysing the ‘micro’ aspect of language (Parker, 1997). DP has been criticised for solely concentrating on the specific conversation context and discounting the wider influences on the fine-grained talk, such as the extended social context, and how the talk may ‘reflect and enact social and material structures’ (Willig, 2013, p.125). It has also been criticised for being too limited in its focus on language as a negotiation of psychological processes rather than subjectivity such as intentionality, sense of self etc (Langdrige, 2004).

In order to explore how therapists construct CB through their talk, a synthesis of the two approaches, Critical Discursive Psychology (CDP) (Wetherell,1998), will be used. CDP looks at both the local organization of talk as well as the broad social and culturally resonant interpretative resources the participants employ (Edley & Wetherell, 2001). As such it sees language sequences as embedded in a historical context which will limit the lexicon of terms available to them (Edley, 2008). Reviewing the literature it became apparent that there was plenty of detailed research adopting a medicalized, positivistic perspective for example looking at diagnosis or comparisons to addictions, and others that embraced a more phenomenological, experiential analysis, looking at for example the lived experience of those who shop compulsively or themes in the process. Some assumed a more cultural, political perspective: critically analyzing the role of media, business and government on compulsive buying. What emerged was a lack of discursive analysis which takes into account the broader landscape of discourse around the topic at the same time as the more close-up scrutiny of the interactions in context. This viewpoint was considered pivotal in understanding the topic as it is arguably both a culturally embedded and psychologically motivated act.

It is hoped that by analysing the action-orientation, dilemmas, subject positions and stakes occupied by therapists talking about this topic, new understandings about how the information and knowledge that’s available for CB has been absorbed will be produced.

CDP arguably allows examination of tensions which can take into account both how CB is positioned by therapists in society (the macro) and how it may or may not be spoken about within the therapy room (the micro). For example, on a micro level the therapist may be wanting to show themselves as empathetic, knowledgeable and competent, yet on a macro level they may take up a medicalised discourse that sees ideal treatment for CB as anti-depressants. Though complex, CDP seemed the method that was most able to encapsulate the dilemmas around constructions of this topic which the research aimed to explore.

2.5 Design

2.5.1 Recruitment and selection

The selection criteria for the presented study comprised therapists and mental health professionals professionally registered in the UK who had worked therapeutically with compulsive buying in some capacity. This could be either from a specialist addiction clinic or as something that emerged in their work with a client, not necessarily as the presenting issue since this is frequently reported as the way CB emerges (Black, 2007). Taylor (2001) maintains that the nature of the data used for discourse analysis should be shaped by the broader topic or argument of the study and can be as broad and inclusive as possible such as population categories like gender or more limited such as same class and ethnicity. In choosing therapists, rather than solely counselling psychologists, the researcher hoped to maintain the emphasis on the topic of CB, how this is constructed and worked with, rather than tensions or reflections on how this sits specifically with counselling psychologists. As Taylor (2008) states, selection for discourse analysis is about samples of a certain perspective, that is about the language use reflecting the culture or genre, the culture inferred here is broadly the therapeutic profession and the language use around the topic of CB. Also, the view was taken that counselling psychologists do not exist in a vacuum or solely learn from research based on other counselling psychologists and counselling psychology theory but rather from the broader gamut of therapeutic proficiencies.

Ethical approval was gained for this research from London Metropolitan University to recruit participants. A flyer was produced (see Appendix A) outlining the basic premise of the research question and requirements for participants (ie that they had come across compulsive buying in some capacity in their therapeutic work with a client, whether this was the presenting issue or not). Several general addiction clinics, private addiction centres such as Nightingale Capio which deal with behavioural addictions, as well as NHS specialist addiction clinics were contacted. An advert was placed on the Facebook page of the London Counselling Psychologists website, as well as on the web page of a London therapy rooms company. Several addiction specialist therapists, alumni from the past ten years of the London Metropolitan Counselling Psychology course and old placement contacts were contacted using a snowballing technique to recruit participants.

Table 1: Participants demographics

Participant	Gender	Age	Profession	Recruited via
Abby	F	45	Psychotherapist	London Therapy Rooms Advert
Marcus	M	64	Psychotherapist	
Tessa	F	53	Psychiatrist	Direct email to website
Adam	M	43	Clinical Psychologist	Direct email to Specialist clinic
Rob	M	38	Counselling Psychologist	
Bridget	F	46	Counselling Psychologist	Snowballing technique through email to previous LMU students

2.5.2 Research Instruments

Once potential participants made contact, an information sheet (Appendix B) was forwarded to them which further explained what to expect should they agree to take part. If they agreed to participate an interview was arranged at a mutually convenient time and place.

2.5.5 Semi-Structured Interviews

Discourse analysis tends to produce the richest data from naturally occurring talk, such as may be uncovered in a focus group, however ethical and practical difficulties in obtaining such data leads many researchers to use semi-structured interviewing as the next best option (Willig, 2013). It proved logistically unfeasible to arrange a focus group between the many participants busy schedules so six face-to-face, semi-structured interviews were instead conducted. The disadvantages of semi-structured interviews is that they can reveal more about the subject positions and stake management within the interview than about everyday discursive strategies used (Willig, 2013). One advantage of the semi-structured interview over naturally occurring talk is they allow for the exploration of topic themes across a number of participants (Potter, 1996), they have thus been used extensively in discourse analysis. Whilst some maintain the interview is more artificial than naturally occurring talk, this method permits the participant to pose issues that concern them, (Hutchby & Woofitt, 1998). Researchers must appreciate that the interview is essentially a conversation between two people and as such it is the interaction that generates the data, not the participant alone (Willig, 2013). Though focus groups can also elicit fruitful data collection and arguably more natural dialogue, they have also been criticized for being more about group relations than the topic and also the issue of confidentiality (given that therapists may want to talk about client work) can be more difficult to guarantee (Taylor, 2001).

2.5.6 The Interview Schedule

The interview questions (Appendix E) were developed carefully, sensitive to the influence of the researcher's own assumptions upon the participants' talk of working with CB. An attempt was made to design questions that were value-free and as non-directive as possible whilst still attending to the topic and themes to be explored, eg. 'Could you tell me, without breaking confidentiality, a bit about your experience of this (working with CB)?' The questions also started more generally, asking about the therapist's mode of practice, then lead to more specific talk about the construct of CB and diagnosis, so that the interviewee is allowed to acclimatize and grow comfortable talking to the researcher and around the topic.

Whilst generally sticking to the schedule of questions, at times a line of conversation was instinctively followed that required alternate follow-up or clarifying questions, as is permitted in semi-structured interviewing. It is recognized that the researcher will inevitably have a strong stake in the research bringing an agenda and expectations (Burman, 1996) and despite efforts to remain neutral, meaning derived from the interview will be co-constructed by both interviewer and interviewee (Holstein & Gubrium, 1995).

2.5.7 Ethical Considerations & Debrief

Participants were fully informed about the nature of the study, were under no obligation to take part and were informed that they had the right to withdraw up to two months after the interview. This was reiterated verbally at the beginning of the interviews. The individuals interviewed for this study were not considered vulnerable, no deception was employed and the questions were not expected to cause distress; however a debrief sheet was given post-interview (Appendix F). This provided reassurances around confidentiality and anonymizing of all materials, relevant websites and references on CB should they be further interested in the topic. Interviews did not lead to disclosure of any illegal or incriminating information and no potential conflicts of interest were noted.

2.5.8 Informed Consent

Informed consent (Appendix C) was obtained in-line with the British Psychological Society's Code of Human Research Ethics (BPS, 2014). All respondents were given or sent by email a document (Appendix B) that fully briefed them on the nature of the study, what it would involve for them, approximately how long the interview would be, what the topic to be discussed was, and that anything talked about therein would be anonymised and completely confidential. They were informed that any data collected was to be handled in line with General Data Protection Regulation (2018) and any contact details of participants destroyed once the thesis was passed. In line with chapter 29 of the Data Protection Act (1998), data would be stored in a secure locked cabinet in my home and anonymised data destroyed once no longer needed for analysing or kept for a period not exceeding five years after research submission in line with London Metropolitan University's (2014)

Code of Good Research Practice, whichever period is shorter. They were also informed that they had the right to withdraw from the study up to two months after data collection should they wish.

2.5.9 Health and Safety issues for the researcher

Four of the participants were interviewed at their place of work in working hours, with colleagues in the building (but not the interview room). Two participants were interviewed in a hotel in a private area of a reception lounge where the interview could not be overheard. In both instances safety of the researcher was not deemed a critical issue although a partner was notified of the whereabouts and duration of the interview and contact was made with them after each interview to verify security of the researcher, in line with recommendations (Craig, Corden and Thornton, 2000).

2.6 Analysis

The analysis steps were informed by Willig's (2013) procedural guidelines, however it should be remembered that the discourse analysis process is relatively open-ended and circular, it is not like following a recipe, the results are rarely exhaustive and there are always other possible readings (Taylor, 2001). Audio tapes of the interviews were transcribed using a method of notation set out by Parker(1992) which are reduced set of Jefferson's (2004), (Appendix E). The transcription in discourse analysis is itself said to be a reflexive act (Bucholtz, 2000) as it obliges a researcher to think about their own role in the interview and therefore the data.

After transcription there are three essential steps to discourse analysis: reading, coding and analysis. The initial reading of the text should be without analysis but with a view to experiencing it as a reader, noting only the general discursive effects, impressions and what it is *doing* (Willig, 2013), the analysis will then focus on how it achieves this action. Next, familiarity with the text, through reading and re-reading or re-listening to the recordings and making note of any patterns (Taylor, 2001). Attention was paid to construct, variability and context in the text (Willig, 2013). Coding of the transcript (see Appendix F for a sample) was directed by the research question, it was crucial at this early stage to include even loosely connected instances, so nothing was missed (Willig,2013).

Initial coding comments highlighted general observations of the nature of the talk relevant to the topic, which could be construed as themes (Potter & Wetherell, 1987). Comments and reflections were noted on the left-hand margin, highlighting discourses or subject positions noticed within these thematic units. Attention was paid to terminology, stylistic and grammatical features, preferred metaphors and figures of speech (Willig, 2013).

2.6.1 Rhetorical Devices (interpretative repertoires, ideological dilemmas, subject positions)

A more in-depth coding was then conducted with both the fine grain analysis of the text (the micro) and rhetorical devices used, the interpretative repertoires, ideological dilemmas and subject positions employed. At the same time notes were made on the broader contextual, social and cultural influences apparent and implicit in the text (the macro). Ideological dilemmas reflect the lived rather than intellectual ideology, and as such represent culture which is by nature fragmented and contradictory (Billig et al, 1988, Billig 1987). According to Edley, (2009) ideological dilemmas suggest there is no cohesive, communal common sense-making but rather people have to navigate the conflicting and competing ways of thinking about the world, which arguable leads to a rich and flexible lexicon of resources for interactions. Edley, (2009) suggests that interpretative repertoires or ‘relatively coherent ways of talking about objects and events’ (p.198) should reveal the links between what is spoken, the constructs and the cultural and historical constraints that limit them, what is possible and not possible to say, which is fundamental to CDP. They are well practiced or borrowed historically acceptable ways of talking about subjects, providing a shared, social understanding (Edley, 2008). The analysis thus attempted to navigate both the micro and macro understandings of the language used (e.g. Edley & Wetherell, 2001, Wetherell, 1998).

Subject positions (Althusser, 1971) refer to our identities that are located within a conversation or discourse, they affect the way we see or feel about ourselves and others and how this is expressed through the language we use (Edley, 2008). Subject positions are not static, they are mobile and fluid and may change depending on the context and intention. To better understand the interpretative

repertoires, subject positions and ideological dilemmas, a complete table was put together (Appendices I, J & K), describing each one with example quotes from participants. This helped to amalgamate and coalesce them and see which ones seemed strongest.

2.7 Methodology Reflexivity

As interviewer and researcher I knew I would have some influence over the data gathered and would have a role in the constructions and discourse (Brinkmann & Kvale, 2009) but this became especially evident when conducting the interviews. I became aware after the initial nerves subsided just how much was at stake in terms of wanting to get ‘good data’ concomitantly trying to stifle my own opinions, conduct a free-flowing interview that felt like a conversation rather than a stilted agenda and cover all areas of the topic that I wished to discuss. In this sense I was ‘striving for objectivity about subjectivity’ (Brinkmann & Kvale, 2014, p. 278).

Working within the social constructionism paradigm such tensions between objectivity and subjectivity made sense as I contribute to the construction through my presence and inevitable influence. Conducting interviews creates a power imbalance as the interviewer controls the questions, (Harper, 1999). I was particularly sensitive to such forces and positions as both myself and the participants were professionals working in the same domain. These power dynamics could be very different were I interviewing clients or clients’ partners or other professionals. Social constructionism takes these differing social expectations into account, it views theory as subjective, fluctuating maps of reality existing in a time and place, with subjects either supporting or opposing them, therefore having a stake (Owen, 1992). For example, the interviewees occasionally seemed defensive and cautious about how they conveyed their opinions, perhaps because they wanted to be perceived as ‘ideal’ therapists. Such social and cultural norms are scrutinized in social constructionism, to comprehend how these different constructions of reality can effect human experience (Willig, 2013). At other times they seemed to project a sureness of authority, perhaps as a counter to my position of power as researcher. Agenda-setting renders the interviewer the power to limit the interaction and oblige the participant to take a position they might not have done

otherwise (Potter & Hepburn, 2005, Wiggins & Potter, 2008). Both ways of being elicited anxiety for the researcher with concerns about not unearthing 'good enough' data or appearing inexperienced, a position often felt by novice discourse analysis researchers (Harper, Connor, Self & Stevens, 2008).

Reflecting on the interviews, it is hoped the data gathered is neither good nor bad but rather more comprehensive by viewing it through lens of CDP where the fluidity of the many subjective influences (eg myself, the setting, the cultural and historical context, the agenda, the professional norms, the participants experiences etc) can all be taken into consideration as playing a part. It is also noted that in writing this there may be a natural bias towards the chosen methodology and ontology which will inevitably colour the recollection of the interview process and motivate a need to justify and validate its use.

CHAPTER 3

ANALYSIS

3.1 Introduction

The analysis was arranged by reporting on the main five discourses that emerged from the data. Within each discourse, sub-categories were identified, with a keen awareness of the discursive concepts which are characteristic of critical discursive psychology; interpretative repertoires, subject positions and ideological dilemmas. Examples from the text were then used to illustrate and discuss these subcategories with consideration given to the fine grain patterns within the talk and the rhetorical devices used.

Eliciting and identifying the many repertoires from the data proved less problematic than editing and refining them into a few cohesive discourses. Many of the lines between the discourses were quite arbitrary, for example the *'how should I work with this?'* and the *'is it a problem?'* discourses were inter-related as both linked to questions around therapeutic guidelines. Other discourses were initially generated that were of keen interest to the researcher but had less comprehensive data from across the transcripts. For example, the gender driven discourse *'it's ok for females to shop'* particularly stood out for the researcher, but on further scrutiny perhaps had less available data than others. Whilst an objective, full view of the findings was attempted the analysis inevitably bore the fingerprint of the researcher. Cultural and corporate influences on shopping were something that initially ignited interest in this topic and unsurprisingly this was an area of the transcripts that the researcher was repeatedly drawn to. It was also noted that participants became more animated, informal or enthused when talking about this aspect. Some of the repertoires were eventually either discarded, or where appropriate, combined under another discourse heading, after a process of reflection and realization that perhaps these were stronger discourses. For example, *'shopping for a better self'*, which was originally part of the *'it's ok for females,'* discourse, was deemed a sufficient fit for the culture discourse.

This iterative process of compromise and overlap was achieved by an amalgam of discussion in supervision and reappraisal of the texts. Deliberate self-reflection on how my preconceived opinions and theories around what influences this topic may have prejudiced how I had observed these repertoires presence amongst the transcripts was also key. Keeping in mind that discourse analysis is often rich, involves repeated examination and noting but not settling too soon on prominent features (Taylor, 2001). In these instances, rather than just asking ‘what is this discourse doing?’ (Willig, 2013, p.119) I needed to also ask myself ‘what am I doing to the discourse?’ Therefore the findings presented here are not exhaustive, but rather a representative selection by the researcher of what was deemed most relevant to the research question ‘How do therapists construct CB in the context of their work?’.

3.2 Discourses and repertoires:

The overarching discourses identified are outlined below and broken down into repertoires that fell within that discourse. The table below also gives an illustrative quote for each repertoire. These discourses could be summarized further roughly into the headings process, diagnosis, professionalism and culture.

3.3 It’s self-medicating

This discourse constructs CB as similar to substance addictions from both a biomedical perspective and a psychological, interpersonal standpoint. CB is portrayed within this repertoire as being a quick fix that stimulates neural pathways to produce adrenaline or dopamine, helping to eradicate difficult emotions or fill a void. It equates CB with substance and non-substance addictions such as alcohol, cocaine, eating disorders and gambling.

Table 2 : Discourses and Repertoires with Sample Quotes

Discourses	Representative Quote
4.2 It's self-medicating	Process
4.2.1 Similar to other addictions	<i>Rob: I look at kind of compulsive behaviours as being very, very similar. I think that behaviours that can get picked up that can become kind of 'sticky'?</i>
4.2.2 Quick fix	<i>Tessa: So then they say, you know, they're feeling low, they're anxious <u>and</u> they're using shopping as a way of self-soothing, self-medicating their anxieties or their really, their low mood for a high, to get a high for the high, you know, that quick fix.</i>
4.3 How should I work with this?	Professionalism
4.3.1 Taking pause	<i>Bridget: You know just trying to slow it down and to pause and trying to observe the behaviour, you know trying to help the patient to, to kind of observe their own behaviour...maybe kind of a like mindfulness approach.</i>
4.3.2 Therapeutic uncertainty	<i>Bridget: Mmm, mmm, yeah I mean I don't think it's something that I knew much about, you know, I don't think it's something that was covered in any part of my training, this.</i>
4.4 We must all shop but not too much	Culture
4.3.1 Accessibility as a trigger	<i>Marcus: because it's so easy to do, you don't have to get out of bed to do it you can pick up your ipad (taps table), download an app, you know, you can download the Amazon app and you can buy everything you want, you can download a gambling app and you can clickclickclick.</i>
4.3.2 Shopping as a cultural norm	<i>Adam: Compulsive buying is what we're meant to be doing on a <u>daily</u> basis.</i>
4.3.3 Shopping for a better self	<i>Tessa: It's not just about the compulsive buying but it's about buying to feel better about a future where you will be thinner...it's all about self-esteem and image of who they wanna be or who they were</i>
4.5 Is it a problem?	Diagnosis
4.5.1 CB as a secondary problem	<i>Bridget: I mean issues with compulsive buying have usually presented themselves as part of another problem rather than, you know, being the main problem that somebody just wants help with.</i>
4.5.2 It's a maths issue	<i>Marcus: I think, I think the more economically fortunate you, are the longer it takes you to realise it's a problem, and also that's a maths issue, you know.</i>
4.5.3 Bottom of the pile	<i>Adam: In this country there's no reason for expanding the sort of likelihood because of funding. I don't think <u>politically</u> it's something you could say there's such a thing as spending too much money (.) with buying and then you'd look at the behaviour then you'd be saying realistically (2) umm and there's backing that up is a lack of evidence, and backing that up is a lack of funding for evidence, and backing up that lack of funding is erm there's not enough funding for the things that need it at the moment</i>
4.5.4 The need for momentum	<i>Rob: It's you know, <u>I dunno</u>, hhh, I think the, there will be more evidence, because, simply, you know, the, 'cause it's occurring,</i>

Discourses	Representative Quote
4.5.4 The need for momentum	<i>it has to <u>hit kind of a point</u> in culture where (1) <u>suddenly it</u> (2) (hhh), arrgh, I dunno how to describe it really, but where there'd be enough momentum for it to <u>then</u> start.</i>

3.3.1 Similar to other addictions

Talk of CB as similar to other addictions, both substance and non-substance, was prominent amongst most participants and the vernacular used was evocative of addiction talk, including vocabulary such as compulsive behaviours, triggers, conditioning, and ways to avoid or cope with difficult emotions. Therapists using this repertoire seemed to place CB on equal footing with other dependencies, recognising the addictive underlying processes evident from their work with compulsive buyers.

286 Rob: *I look at kind of (.) compulsive behaviours as being very, very similar. I think that*
 287 *behaviours that can get picked up that can become kind of 'sticky?' I, um, use sticky*
 288 *within the kind of ACT framework, yes, um, so something, you know, behaviour*
 288 *becoming very fused, attached to someone as we also kind of use the metaphor here of*
 289 *of it being a bit like a virus or a bit like malware, °or something°. I think, (.) it's kind of,*
 290 *it's changeable in a way, shopping could be an issue (.) umm as much as any other*
 291 *behaviour can become dominant*

Rob seems to emphasise the similarity and interchangeability between all compulsive behaviours using repetition and extreme case formulation (Pomerantz, 1986) 'very, very similar'. Extreme case formulations depict objects or views in the extremes as a means of persuasion and justification (Pomerantz, 1986). Here CB is categorised with all compulsive behaviours as something 'that can get picked up', this disease metaphor is built up using a three-part list (Jefferson, 1990) to include a virus, malware 'or something'. Such talk constructs CB as an aggressive, living entity and implies that it can afflict anyone, alleviating responsibility from the individual. Rob's language positions the compulsive behaviour as powerful, using vocabulary such as 'dominant', 'fused', 'sticky', which seems to take up an empathic position towards the compulsive buyer yet it could also perhaps be said this positions them as unfortunate and helpless. Using the plural subject pronoun in L288, 'we' to talk

about the virus metaphor Rob implies a unified view that includes other professionals within his place of work, giving his assertion endorsement and a professional subject positioning. Rob makes use of a communicative ecological phrase (Gumperz, 1999), that is a phrase that's derived from a particular community, in this case, the therapeutic community, by mentioning ACT (Acceptance and Commitment Therapy). This, along with the 'you know' on L288 is employed to gain consensus from the interviewer as a fellow therapist .

Though he appears to begin with a very assured statement on L286, his delivery as he expands on this idea becomes tentative, with phrases like 'kind of', and 'a bit like' being repeated, which allows delivery of his strong opinion without seeming dogmatic. His final sentence L290-2 brings in the shopping, rationalizing it's place alongside other compulsive behaviours with the phrase 'could be an issue...as much as any other behaviour can become dominant'. By including 'any other behaviour', Rob employs a concessionary element (Antaki & Wetherell, 1999) to his building up of shopping addiction by drawing on the 'similar to other addictions' repertoire, but then quashing it's importance with 'as much as any other'. Concessionary elements are used to protect the speaker from potential misunderstanding or attack, Rob perhaps uses this device to navigate his position away from advocating just for CB being 'an issue', by counting all behaviours as key.

Marcus also employs this repertoire by drawing on the comparison of alcoholics.

- 29 Marcus: *Mmm, it's something I see with any addiction, that one of my approaches is to*
30 *try and separate out the addictive behaviour from (.) any kind of pleasure that it*
31 *gives, so hhh (1) if it's, so if you've got an addiction to red wine rather than going*
32 *out to a nice restaurant or a pub or whatever it is that you sit at home and, and you*
33 *drink red wine out, that's warm out of a paper cup, not in the company of nice*
34 *people so that*
35 H: *So it's like a whole experience?*
36 Marcus: *Yeah, yeah the substance or behaviour that you're addicted to got it's hooks into*
37 *the good things in your life. You can still have the good things in your life, (.) you*
38 *can still have the substance, but you have to separate those two out and that's (.)*

39 *really what the approach has been with, with helping people over, you know,*
40 *compulsive buying, shopping addiction.*

Marcus here similarly groups CB with other addictions but takes ownership of the repertoire with quite equivocal language '*it's something I see with any addiction*', asserting his professional footing this statement seems to imply a breadth of knowledge and experience on the topic. Marcus uses an anecdote to illustrate the interchangeability of any addictive behaviour, and CB, this similarity is repeated when he alludes to '*the substance or behaviour*' in L36. The narrative of the alcoholic at home drinking red wine employs hyperbole to evoke pathos for the addict, positioning them as objects to be pitied, lonely and unable to enjoy the good things in life. Using contrast, Marcus constructs the substance or behaviour as something injurious and discrete from the individual, employing personification '*got it's hooks into the good things in your life*', which positions the addict as weak. This could be seen as a 'dividing practice' whereby, according to Foucault (1982), one social group objectifies the different other through science and power. Whereas Rob constructed CB as virus like, Marcus talks about the individual needing to '*separate*' the behaviour and the good things, perhaps implying the association between the two is problematic. Marcus shifts his footing from depicting the addict as victim to more empathic one with talk of '*helping people*', constructing them as perhaps less passive as he proposes a need to '*separate out*', suggesting agency and capability.

3.3.2 **Quick fix**

Many of the participants portrayed CB as a vehicle for clients to get a quick fix or high and engaged this repertoire when first discussing the topic, drawing on the reductionist, biomedical model, seeing the behaviour as merely a result of a physical urge driven by neurotransmitters and hormones. This repertoire mobilised the hegemony of science (Gramsci, 1971; Aronowitz, 1988) advocating biomedical and neurological explanations of addiction which have traditionally been heralded as more robust explanations than perhaps social or other perspectives (Fraser, Moore & Keane, 2014).

93 *Tessa:* *So then they say, you know, they're feeling low, they're anxious and they're*

94 *using shopping as a way of self-soothing, self-medicating their anxieties or*
95 *their really, their low mood for a high, to get a high for the high, you know,*
96 *that quick fix.*

In this extract Tessa constructs CB as being used by her clients to self-medicate and attain a high that will reduce their anxiety or depression, in the same way that a substance addiction might be used. Tessa seems to distance herself from her clients talk, taking up a professional, therapeutic footing with ‘*So then they say*’ and adding ‘*you know*’, ostensibly invites the interviewer to this professional footing. She adds weight to the importance of this process by repetition of ‘*high*’ three times in L95. Tessa’s talk of self-soothing takes an empathetic and compassionate turn as her interpretation considers not only the search for a high, but the motivation for it.

Marcus also constructs CB with the same biomedical talk here when discussing the ease of internet shopping versus high street shopping.

20 Marcus: *Immediate gratification, you click on it and you’ve bought it, you know,*
21 *you’ve set off the neurotransmitter’s running around your system*

By using a lexicon of speed with words like ‘*running*’, ‘*immediate*’ and ‘*set-off*’, Marcus constructs the addicted as having an urgency and need for a quick high which can easily be fulfilled by online buying. The imagery of the ‘*neurotransmitters running around your system*’ reduces the end result of the act of CB to a neurochemical, physical reward for the body. This draws on a purely biomedical discourse that might equally be heard to describe substance misuse, which perhaps takes a more punitive stance towards the impatient, addicted shopper.

Later on, when talking directly about the similarities between gambling and CB he expands further;

270 Marcus: *There's obviously differences between the two, (2) umm, significant differences*
271 *between the two, but it's the same mechanism, somebody's looking for their*
272 *dopamine {laughs}. That's what's going on isn't it? They want some feel good*
273 *chemicals, 'gimme a fix', snort some cocaine, go gambling and all the excitement that*
274 *goes with all that, or (1) you know, are they a dopamine junkie are they a serotonin*
275 *junkie, are they both, you know? Where's their balance in it all?*

Marcus acknowledges an ideological dilemma, commencing with a stake inoculation (Potter, 1997) that CB has significant differences from gambling, yet ending the statement by affirming that the mechanisms are the same. Stake inoculations are used to pre-empt criticism of the speaker's stake or position on a subject, in effect they deny the opposition to them by making a disclaimer and acknowledging the opposing view (Potter, 1997). By extending this similarity to include '*feel good chemicals*' as well as gambling he perhaps implies inclusion of all substance and non-substance addictions. Marcus uses amplification, and extreme case formulation (Pomerantz, 1987) '*obviously*' and repetition '*differences*' (L270-1) to accentuate the distinctions he sees but by not stating what these contrasts are and instead expanding and elaborating on the underlying, comparable mechanisms he is perhaps implying these obvious differences are less noteworthy than the underlying, shared mechanisms. Marcus's statement '*somebody's looking for their dopamine*', uses hyperbole and irony to generate a reductionist stance that imagines the addict as purely driven to search dopamine, nothing else. '*Somebody*' and the laughter that accompanies it are used for humorous effect but they also advance the dichotomy between sick and well (Pilgrim, 2000), therapist expert and addict.

Maynard (1991) describes how clinicians navigate delicate objects with expressive caution. Marcus navigates the risk of his humour being negatively received as unkind by employing the rhetorical question '*That's what's going on isn't it?*', a call for agreement from the interviewer that perhaps legitimizes his position. Marcus employs two more rhetorical questions across lines 275-6 to clarify his positioning and focus on the addict's drive for neurotransmitters. The second utilises a three-part list to give weight to his question that constructs the biomedical forces as being the biggest pull, '*are they a dopamine junkie...are they both?*' Marcus here groups compulsive buyers with gamblers and

cocaine addicts (even using the same slang words for it *'junkie'*), but separates the activity from the underlying addiction process which he constructs as being addicted to neurotransmitters. With his final rhetorical question *'Where's their balance in it all?'*, Marcus takes up an 'evaluative accent', (Volosinov & Bakhtin, 1986), which means that a judgement is implied through the language used, as the compulsive buyer is constructed as lacking balance. *'Balance'* though undefined by Marcus, is positioned as the norm, locating CB as abnormal, Marcus's use of third person *'their'* engenders a distance and infers he is differently situated as 'normal'.

3.4 How should I work with this?

3.4.1 Taking pause

Many interviewees considered the needs and motivations that underlie the biochemical drives and proposed ways to cope with the difficult emotions by taking pause before acting on impulses.

180 Abby: *You can't see the wood for the trees...If you look at the anxiety, if you look at*
181 *something you're making room for the mind, for the body to settle so they can look*
182 *at it calmly does that make sense? So when you're all like 'I've gotta buy it, I've gotta*
183 *go there, oh my god', but actually what is it, why is your head so cloudy what is the*
184 *need?*

Abby constructs CB as a frenzied act of escape from underlying anxiety, depicted with the idiom *'you can't see the wood for the trees'* and active voicing and exclamation on L182-3 *'I've gotta buy it...'*. Active voicing (Hutchby & Wooffitt, 1998) depicts dialogue from a different time and enacts it in the current conversation. As a discursive device it strengthens the impact and authenticity of what is being said. Abby uses more active voicing to create a narrative of how she might challenge this frantic state on L183-4 *'what is it...?'* that builds Abby's therapeutic position up as composed professional guiding the client to calmness by *'making room for the mind, for the body to settle'*. This creates a juxtaposition between poised, capable expert and agitated, *'cloudy'* client.

133 Bridget: *You know just trying to slow it down and to pause and trying to observe the behaviour,*

134 you know trying to help the patient to, to kind of observe their own behaviour... maybe
135 kind of a like mindfulness approach and you know, I think maybe also kind of ideas
136 around umm distress tolerance, can I (laughs) can I just maybe stay with this emotion
137 and maybe it will go away? Yeah maybe it won't just keep on getting worse, you know
139 maybe I won't give in to it, maybe there's consequences of carrying on getting into it
140 you know, yeah

Bridget also constructs the client as needing to take pause and observe their behaviour, as her talk aligns her with the scientifically recognized and popular third wave approaches of distress tolerance and mindfulness, which seems to work up a position of credible expert. Bridget refers to 'the patient' and then lists various actions that she, the therapist would help them to do, this could be seen as what Sacks (1992) terms a 'membership categorisation device', that is, a means of allocating a person to a certain category, which at the same time excludes them from others, setting up 'standard relational pairs' in this instance, CB patient and therapist. Within these contexts it is proposed there are set 'category-bound activities' (Sacks, 1992). For Bridget as therapist, these activities are constructed as guiding the patient through distress tolerance, which she portrays with active voicing, 'can I just maybe stay with this emotion?'. Yet her delivery is hesitant 'I think, maybe', 'kind of,' which signifies what Nofsinger (1991) terms repair work, perhaps demonstrating a lack of conviction in the effectiveness of the approach.

3.4.2 Therapeutic uncertainty

Therapists expressed uncertainty about which approach or interventions might work best. Whilst most relied on CBT-led interventions many expressed doubts about this approach engaging with the root problem.

61 H: How did you work with the issue, you know did you formulate it or what kind of
62 intervention?
63 Adam: Tended to very brief intervention uh, umm (.) I didn't want to look into, I mean I didn't
64 look into what involved, why the behaviour, err, has I think there was, there was a
65 suggestion that it could be formulated, but the mother was, was always very well turned

66 *out, very well presented (2) err her clothes and her dress and err, the daughter was*
67 *following that so I didn't get into the dynamics of was this, was she the least favoured*
68 *child and was she trying to carry favour with the mother? Was she trying to get her*
69 *mother's love through copying her behaviour? But would edit it to her in a brief six or*
70 *seven sessions about the motivation the (2) 'how are we going to move forward? What*
71 *are you going to do in terms of how are you going to manage your life in terms of the*
72 *money?'*

Adam's reaction to the question seems to place him on an unexpectedly defensive footing. This is conveyed through his initially hesitant and indecisive language, using several pauses, 'umm' and 'errs' and negative statements declaring what he didn't do rather than what he did. This apologetic position, seems to position the CBT work used as potentially inadequate compared to psychodynamic work with a phrase such as '*was she the least favoured child?*'. Adam's footing seems to shift to a more positive, confident one as he details the CBT approach he took. He uses the third person active voicing to express this in question format, '*how are we going to move forward?*', a narrative device that gives a glimpse of how Adam interacts in session with his client, granting him a more professional, assured footing. Adam moves from using 'we' in L70 '*how are we going to move forward?*' taking a collaborative position, a key element of the CBT approach (Mansell & Taylor, 2012) to 'you' on L71, '*what are you going to do?*' This subtle shift in footing creates more distance from the CB client and at the same time is a call for action from them, a position that could evoke both a professional, expert who is able to challenge the client but also perhaps constructs the client as capable of meeting such challenges.

Bridget answered the same question regarding how she worked with the issue by openly admitting there was a lack of knowledge about it:

109 *Bridget: Mmm, mmm, yeah I mean I don't think it's something that I knew much about you*
110 *know I don't think it's something that was covered in any part of my training, this, so*
111 *I guess I'm just going from first principles, you know, thinking about what's the function*
112 *of this behaviour, you know, what are the associated feelings, you know, before and*

113 *after, you know, what are the triggers? (2) I actually I did feel a bit out of my depth.*

Though Bridget articulates some irritation with the lack of training for such a presentation, portraying her footing as uninformed and inexperienced, in L111, she reclaims her professional footing by talking about using *'first principles'*. Such language draws on a professional, therapeutic discourse and by using *'you know'* assumes the researcher's own professional understanding, inviting corroboration. She emphasizes this with the use of a three-part list (Jefferson, 1990) on L111-113, talking about behavior, associated feelings and triggers, all of which have strong links with CBT theory. Bridget's shifting footing seems to convey an ideological dilemma through her fluctuating conviction. Her talk manages the troubled position of being *'out of her depth'* by building up her adaptability of her professional knowledge of first principles and CBT. She expanded on this later when asked how the interventions worked.

180 *Bridget: I think sometimes patients come to therapy hoping for some kind of magical solutions*
181 *to their problems, you know... Sometimes we can help people a little bit but often we,*
184 *we don't have anything new to say or we don't have anything that's gonn-gonna make*
185 *a difference for them and I feel with these patients that perhaps that might have been*
186 *the case, that it was some you know maybe I could make them, you know, help make*
187 *some smaller changes some improvements to how they're coping with things.*
188 *H: So, was there somehow a sense that their interventions that had limitations and would*
189 *only do so much?*
190 *Bridget: Yeah, I guess so, yeah, I guess so. I guess, the reinforcement is so entrenched*
191 *that it can be quite hard for them to change it.*

Bridget commences with a stake inoculation statement (Potter, 1997) depicting some patients as having too high expectations from therapy, *'magical solutions'* constructs these expectations as unrealistic, positioning the therapist's skills as insufficient and the patient as perhaps unreasonable lazy, relying solely on the therapist to evoke change. This prefaces Bridget's ambivalence around her own capability to deal with some of these clients, apportioning some of the blame with the patient, she thus manages her stake from inadequate to competent enough practitioner, able to *'make some*

small improvements'. Bridget also navigates a 'helpless expert' position in L184-5 '*we don't have anything...*' as she despairs on a more general note that some clients can only be helped so much. This more apologetic footing perhaps signifies an ideological dilemma (Billig et al. 1988) that Bridget feels she has failed these clients *and* they have expected too much. Bridget's admission becomes more personal and direct as she moves from third person, (we), implying the whole profession, to first person as she admits that she may not have been able to help her CB clients make great changes. I attempt to help her navigate this difficult terrain by referring to the interventions being limited, rather than her own therapeutic abilities. She hesitantly agrees but shifts the responsibility to the strength of the reinforcement, constructing a more empathic understanding for the clients struggle in L191, '*It can be quite hard for them*'.

3.5 We must all shop but not too much

This discourse positions the speaker as political defender of the CB victim by censuring corporations, advertising and government for driving, encouraging and inciting the need to shop. These hegemonic forces are seen as preying on individual's insecurities by promising a new improved self and endorsing the lust for more things to achieve this, yet vilifying and judging those who shop 'too much'.

3.5.1 Accessibility as a trigger

Adam, Rob, Tessa, Marcus and Bridget all talked about the widespread accessibility of shopping being problematic, whether internet or high street based. This interpretative repertoire positioned the CB as vulnerable to external triggers which are portrayed as powerful and controlling.

Tessa, reflects on how the accessibility has affected her personally:

274 Tessa: *The shopping online is fascinating. And I, from a personal perspective actually, I had*
275 *an interesting experience where, umm, you know when you're really busy, you know*
276 *, you don't go out to shops as much as you would like and would enjoy doing. So a*
277 *couple of times I've sort of clicked on things and realised I'd ended up on mailing lists*
278 *and when the mailing list arrived I would be scrolling through clothes (.) and then*

279 *suddenly* start thinking ‘oh well I could buy this’, and then you get involved into that
280 whole transaction thing (1) and it was only recently that I thought you know what?
281 I’m sure I’m looking at far more clothes than I would ever want to or need to (.) and so
282 I started unsubscribing from lists from which I had not really subscribed to in the first
283 place, I don’t know what happened, I think you just look at something and then, so, but
284 I thought ‘oh my goodness!’ (.) how must it feel (.) to suddenly in your inbox everyday
285 get these things?’ And so the exposure is really vital in this field.

Making a personal disclosure around her own experience with the lure of online shopping Tessa risks compromising her position as professional expert. She manages this troubled position by maintaining attributional distance (Clayman,1992), a form of protecting her footing that is achieved through a professional, non-emotional tone, (as would perhaps be expected given this was a non-therapeutic interview) that employs minimizing and understatement, ‘a couple of times’, ‘sort of clicked’, and by prefacing her story with a rationale for why she, someone ‘*really busy*’ would look at these emails in L275-7. Her repetition of ‘*you know*’ helps build consensus and corroboration. Tessa also omits from her depiction key parts of the process, ‘*when the mailing list arrived I would be scrolling through clothes*’, overlooks any thoughts or feelings that perhaps led to this, and ‘*I don’t know what happened!*’ hints at an internal process for Tessa which she is reluctant to explore. She repairs this troubled position by choosing to orient her talk back to the clients, exclaiming ‘*oh my goodness how must it feel?*’ With the use of this rhetorical question and her emphasis on feel she seems to pivot herself back to an expert footing that both empathises with and detaches her experience (as professional, in control of her emotions) from that of the emotion-laden clients. This ‘us and them’ narrative serves as a ‘dividing practice’ (Foucault, 1982), that is, it subjugates and objectifies the ‘other’ (addict). Tessa’s return to expert position is cemented by her follow up statement which forms a conclusion to her narrative ‘*and so the exposure is really vital in this field*’ which works her identity up as a torchbearer shining the light on what needs to be focused on and constructs the triggers as perhaps more culpable than the individual.

285 Marcus: *You have to understand that without, without sounding dramatic we’re in the middle*
286 *of an anxiety epidemic in the Western World and that’s driven by lots of things, you*

287 *know, media, aspirations, expectations, we can be talking about that for hours,*
288 *but generally more and more people are less and less happy in their own skin (2)*
289 *some sense that whatever it is we've been chasing for a long time be it material*
290 *wealth, economic good fortune, love, lust, you know all those things have less value*
291 *than they thought they might have and so there's a bit of a vacuum, it's like, well*
292 *what now, what next? And part of that has driven behaviour like gambling addiction,*
293 *°shopping°, because it's so easy to do, you don't have to get out of bed to do it you*
294 *can pick up your ipad (taps table), download an app, you know, you can download*
295 *the Amazon app and you can buy everything you want, you can download a*
296 *gambling app and you can clickclickclick and you can switch between the two and*
297 *multitask it and you're sat in bed and you haven't put a foot out of bed and you're*
298 *getting all this reward ...but you haven't made any effort.*

Marcus commences with a direct imperative 'you have to understand' and disclaimer (Hewitt & Stokes, 1975) 'without meaning to sound dramatic', followed by hyperbole 'we're in the middle of an anxiety epidemic' which grabs the listener's attention and pre-emptively avoids criticism through stake inoculation (Potter, 1996). This imagery constructs the problem as widespread, unmanageable and like a sickness, which positions all of the 'Western World' (an overgeneralisation, which includes himself) as vulnerable to this anxiety and hence the triggers that drive it. He employs a three-part list (Jefferson, 1990) on L287 'media, aspirations, expectations' and extreme case formulation (Pomerantz, 1987) 'we could be talking about that for hours' to elevate the persuasiveness of his argument. Marcus then distances himself from this position of vulnerability by switching to third person plural on L291 'they' as he describes the disappointment this pursuit brings leading to a 'a bit of a vacuum' L291-2.

The wide availability of gambling and shopping online is constructed as the easy, but wrong answer to his rhetorical question on L292 'what now, what next?'. He positions the ubiquitous access and by inference (though they are not directly mentioned) the companies that are behind them as injurious to the compulsive buyer (or gambler) who is powerless to resist the draw of the 'app'. Marcus depicts this with a vivid catalogue of evidence that builds corroboration and consensus and uses anaphora (repeating clauses across L294-7 'you can') to build up a positioning of the internet shopper as lazy 'you haven't put a foot out of bed' and undeserving of the instant gratification 'all this reward'. He

animates the gravity of his narrative with amplification and physical demonstration (tapping table) in L296 'clickclickclick'. Marcus seems to position this means of gaining reward as inferior to other, more effortful means, a perhaps ambiguous shift in footing from his original position that pursuit of such rewards by any means is unfulfilling.

3.5.2 Shopping as a cultural norm

When asked about what influences how compulsive buying is constructed, Adam explores the omnipresence of adverts and the influence this has on society as a whole.

283 Adam: *Compulsive buying is what we're meant to be doing on a daily basis. I mean there's,*
284 *I was walking in the tube yesterday, and I'd seen a photo of this before and there's*
285 *a tube tunnel in Victoria with no adverts on it (2) it was just bizarre! And it had been*
286 *put on twitter because people had looked at this and it's like a hundred yard walk or*
287 *something wall to wall, no adverts and it just makes you think, well, hang on a minute*
288 *you know, the degree to which we are bombarded at every step, everywhere, we go you*
289 *know, up and down the tube, you know, pictures on the tube, everywhere you go, you're*
290 *bombarded with 'buy this, buy this, buy this'. And we're driven to doing this and the*
291 *goal of the adverts seems to be it's socially acceptable to buy as much as possible you,*
292 *keep spending, err, but that's the contradiction in society, that if you're going to*
293 *overstep the mark then they're going to come down on you hard.*

Adam uses scene-setting in L283-5 a device which prepares the listener (Horton-Salway, 2001) in this case for his working up of the omnipresence and power of adverts (recounting a stretch of tunnel in Victoria tube station with no adverts in) over the public. Adam uses a 'binary contrast structure' (Edwards, 1997) to highlight the paradox of the advert-free stretch versus the everyday, taken for granted, bombardment of adverts using rhythmic, lyrical repetition, L288-90, 'up and down...everywhere you go' and active voicing 'Buythisbuythisbuythis'. Adam aligns himself as sympathetic to the compulsive buyer from the outset with humour, irony and hyperbole, 'Compulsive buying is what we're meant to be doing on a daily basis' and positions himself as shocked by the proliferation of adverts with the exclamation, 'it was just bizarre!'. Adam's invective seems to

construct the advertisers as powerful, pervasive, able to invoke social norms, judge and punish the compulsive buyer whom they consider pliable, lacking self-control, paradoxically deserving to be punished for the thing they were encouraged to do. His tone in this extract becomes more impassioned and colloquial than scientific with phrases like *'hang on a minute'* suggesting this is something he has personal agency in.

He widens his critique to include society and social norms in L292-293 employing an if-then formulation (Edwards, 1997) to create a troubled position and a dilemma for individuals who are at once implored to buy more yet vilified by society if they shop too much *'they're going to come down on you hard'*.

325 Marcus: *I guess, I mean, I could get on my political orange box about it...a lot of the*
326 *ills of the Western World are driven by corporate greed and I think much like*
327 *gambling, for example, this whole idea of internet shopping, whilst it might be*
328 *very convenient, is driven by the muse of the directors of companies to*
329 *maximise the financial benefit of their shareholders of those companies (2)*
330 *there are laws in place that says that if you are a director of a company you*
331 *have to act in a way that is for the financial benefit of that company so I can't*
332 *blame the directors of Amazon or ASOS or any of these big online shopping*
333 *things and it's part of a, a wider problem (1) I think that it's interesting that*
334 *there's a movement afoot and its really only gone nursery steps and it's to get*
335 *people to live minimally, it hasn't really got traction yet to have less, buy less*
336 *stuff, buy less things that you don't need (1) that's fascinating.*

Marcus provides a two-sided argument (Abell & Stokoe, 1999) in this extract presenting the corporations (Amazon etc) as on the one hand driving the *'ills'* of the Western World, and on the other just doing their job. This throws up an ideological dilemma yet also positions Marcus as a kind of intermediary commentator and judge who understands the bigger picture, at once apportioning blame and exoneration (Horton-Salway, 2001) on the corporations. Here Marcus constructs the CB as part of a wider-ranging problem *'the ills of the Western World'*. Whilst much of Marcus's polemic could be heard as condemning, he employs disclaimers (Hewitt & Stokes, 1975) to manage his stake and maintain a level of neutrality both towards the corporations *'I can't blame*

the directors' and the shoppers, *'whilst it might be very convenient'*. He also ascribes himself permission *'I could'*, to take a more political footing with his opening statement in L325, the idiom of getting on his *'orange box'* at once prepares the listener and apologises for his forthcoming diatribe.

Marcus builds up an almost prophetic position of political observer of society, *'there's a movement afoot'* and suggests a personal stake and a call for consensus from the listener with the phrases *'I think that it's interesting'* and *'that's fascinating'*. Marcus uses the contrast between the movement to live minimally with the *'greedy'* corporations (which are constructed as the problem) to signify that living minimally is a good thing. Marcus seems to struggle with the *'politics of representation'* (Wetherell, 2001) as he works up the position of power of this new movement yet uses caution to manage this sensitive declaration, at once using exaggeration and understatement *'it's really only gone baby steps'*.

3.5.3 Shopping for a better self.

Several of the interviewees talked about image as a key motivation for CB and shopping and the lure of self-improvement through purchases was portrayed as an integral part of this process.

When asked what else he would like to add at the end of the interview Marcus began to talk about how advertising motivates our need for more things:

352 *Marcus: It's driven by, you know, the salesmen's best weapon is fear or loss. "if you*
353 *don't buy this then you won't look like Kim Kardashian" or "if you don't buy*
354 *this pension then you won't be looked after when you're grey and old" and*
355 *they've got really good at that you know.*

The imagery of our *'fear or loss'* being used as a weapon against us tells the listener they should be against or in combat with the salesmen constructing them as bullies preying on the susceptible shopper. Marcus constructs corporation's sales techniques as manipulating and exacerbating people's insecurities using extreme case formulation (Pomerantz, 1987) drawing on popular, iconic

images of wealth and glamour ‘*if you don’t buy this then you won’t look like Kim Kardashian*’, active voicing to engage the listener depicting the sales pitches and using if-then formulations (Edwards, 1997), anaphora and hyperbole. Marcus’s talk negatively constructs sellers as inscrutable and greedy but also clever ‘*they’ve got really good at that*’, positioning the buyers as shallow (for valuing such superficial attributes) and perhaps naïve for being drawn in by such tactics.

112 Tessa : *The compulsion is really there and you realise it when they tell you that they’re*
113 *buying, you know, four versions of the same thing...that they’re buying two or*
114 *three sizes or not buying their own size at all you know, it’s not just about the e*
115 *compulsive buying but it’s about buying to feel better about a future where you will*
116 *be thinner, it’s all about self-esteem and image of who they wanna be or who*
117 *they were.*

Tessa talks up a position of compassionate professional with her assertion on L112 that the compulsion is ‘*really there*’ an extreme case formulation that at once affirms her belief in her clients plight but by following it up with ‘*you realise this when they tell you*’ she perhaps implies there are ‘others’, not in this position of confidence who might doubt it. Her talk perhaps implies a taken for granted scepticism for the legitimacy of the compulsion. The use of the third person imperative ‘*you realise this*’ serves to distance her from the clients and to include the listener into a collusive professional footing. Tessa’s dramatizes the CB’s actions ‘*or not buying their own size at all.*’, by emphasising ‘*at all*’ she positions the CB’s actions as absurd, and perhaps unthinkable to Tessa,. Tessa softens what could be a ridiculing stance by referring to the motivation behind these actions in L115-7, this positions the CB as someone to be empathized with and perhaps pitied. Her talk works up her identity of understanding, professional, expressed through the phrase ‘*it’s not just about...it’s about*’ whilst the shopper is constructed as lacking self-esteem, foolishly yearning for ‘*a future where you will be thinner*’.

3.6 Is it a problem?

This discourse embodies the professional uncertainty around whether CB should be given the status of ‘problem’, often positioning CB as subordinate to other ‘more serious’ conditions whilst acknowledging that it may appear as a co-morbidity alongside them. Therapists navigate the dilemma of taking it seriously but at the same time saluting the hegemony of science and evidence-based approaches which do not yet recognize this diagnosis.

3.6.1 CB as a secondary problem.

This repertoire constructs CB as less significant than or driven by other issues.

Abby takes up this repertoire when talking about what the presenting issue has been for these clients.

44 Abby: *Yes exactly it hasn't been their primary no it's it's like, it's like a bypass it's a, it's,*
45 *it's, it's a package, like an addiction. Some people just have anxiety or just try not to*
46 *feel that energy too so it's what's going on at that moment for that moment to be out*
47 *of control? Does that make sense? That, err feeling out of control (2) what is it that*
48 *is causing it like the anxiety could be a way of enhancing their self-esteem by looking*
49 *good or? What's going on for them? Are they compensating?*

Here Abby positions CB as a secondary concern ‘it hasn’t been their primary’ or part of a greater problem ‘*it's a package*’ for her clients. She also constructs it as a means of evasion ‘*it's a bypass*’, using a series of rhetorical questions that suggest what might be causing this avoidance; anxiety, self-esteem and compensating. She works the problem up as being ‘*out of control*’ with the rhetorical question ‘*what's going on at that moment, for that moment to be out of control?*’ This seems to convey there are other forces at work that are driving this behavior, reiterating CB as secondary to these more powerful dynamics. Abby’s language conveys an explorative, tentative stance from L44-45, suggesting she is attempting to make sense of where CB fits with the presenting issue. This stance is further conveyed in L47-50 with the use of rhetorical questions that check-in with the interviewer ‘*does that make sense?*’, and hesitation ‘*errm*’.

158 Tessa: *The underpinnings of this as a behavioural addiction are not as powerful in*
159 *terms of the addictive nature of the action as the gaming or the gambling and*
160 *so or some of the other internet activities like porn, I think therefore that you*
161 *need the psychological vulnerability from a psychological perspective to be*
162 *there far more than for the other more powerful behavioural addictions.*

Tessa positions the compulsion to buy as '*less powerful*' than other addictive behaviours such as gambling and porn but considers the underlying drives or '*psychological vulnerability*' are constructed as needing to be more potent for the CB to take place, whereas the other addictive behaviours are already '*more powerful*' therefore they don't need such severe psychological vulnerabilities. Tessa seems to express a dilemma here as in one sense this positions CB as lower down in a hierarchy of addictive behaviours, yet for it to be present there needs to be a more enduring psychological vulnerability, which implies a worse underlying issue.

27 Bridget: *I mean issues with compulsive buying have usually presented themselves as*
28 *part of another problem rather than, you know, being the main problem that*
29 *somebody just wants help with.*

Bridget seems to construct CB from the outset as not the '*main problem*', but a '*part*' of it. This positions it as contributing to their presentation, but perhaps not enough on its own for some to come forward with. Bridget's use of '*just*' on L29 suggests an inadequacy, that perhaps somebody would not come forward with '*just*' an issue with CB. This accentuates her positioning of CB as not aggregate enough in itself and implies an '*other*' or '*others*' that could be instead considered as '*main problems*'.

3.6.2 It's a maths issue

This repertoire grapples with ideas around financial boundaries and parameters with questions and uncertainty about how to know when and if CB is a problem.

When I asked what he made of CB being called the smiled upon addiction, Marcus pondered the role of money.

313 Marcus: *I think, I think the more economically fortunate you are the longer it takes*
314 *you to realise it's a problem, and also that's a maths issue, you know.*

Marcus here considers the financial thresholds as a key marker for whether CB is seen as problematic by the individual, proposing that if you are richer it will take longer to become a problem. It could be argued this constructs the compulsive buyer as having an external locus of control, since the determinant of their perception of the problem is money rather than any inner psychological factors. This is perhaps interlinked with the cultural discourse above that we must all shop but not too much, assuming that shopping is accepted and encouraged by society, consequently an individual would not perceive there is a problem until their money runs out or they go into debt. Marcus ironic statement, *'That's a maths issue, you know'*. Marcus employs what Sacks (1989) has termed two-class sets, constructing a binary contrast of rich (who would not perceive the problem) and poor (who would).

Bridget also refers to money when talking about one of her clients and how they would buy items they didn't necessarily use.

90 Bridget: *He would buy a lot of stuff that he didn't really need but it wasn't causing him*
91 *a lot of distress, err we did try to work with it a little bit but it wasn't the main*
92 *thing that was kind of causing him a lot of distress because he wasn't getting*
93 *himself into debt. He wasn't buying really high value items, he was a guy with*
94 *a good professional job so, you know, he had money, so he could fritter, to a*
95 *certain extent, he could fritter without it causing any particular damage.*

Bridget's narrative constructs CB as something that can perhaps go unnoticed or ignored by a client as *'not causing any particular damage'* if they are wealthy enough *'you know, he had money'*, yet perceived as more of a problem by the therapist who highlights the purchasing of lots of things he

doesn't *'need'*. Bridget utilizes the inference *'he had money, so he could fritter'* suggesting money is to blame as the activator and arbiter of CB, but also the benchmark for whether it is a problem or not. Such logic could also assume that without money, he would not have *'frittered'*, locating the client, similar to Marcus, as less in control of his actions. *'Fritter'* depicts the client as wasteful and perhaps having poor judgement whilst L90-1 *'it wasn't causing him a lot of distress'* suggests a lack of awareness. The dilemmatic nature of CB as a problem is again built up as it both causes little *'distress'*, yet was also worked with *'a little bit'*. This perhaps links to the earlier repertoire about CB being a secondary problem *'it wasn't the main thing'*, positioning other agents of distress as more powerful or significant for him.

221 Tessa: *To try to set some guidelines as to what it is being a shopping addict might look*
222 *like (2) but it's really hard to quantify because everyone earns different money*
225 *and spends different amounts of money to spend and so you know maybe reaching*
226 *some sort of understanding as to what it is really quite wrong in terms of percentage.*
227 *You could get the norm pretty easily and then you could apply it to problem shoppers.*

Here Tessa constructs the problem of diagnosis of CB as being about money and proportion of income, by calling for an arbitrary means of finding a *'norm'* versus *'what is really quite wrong'*. Tessa's call for diagnosis and her professional position could be expected as a psychiatrist, yet such binary terms can serve to decontextualize and pathologize a group from mainstream (Gremillion, 2004). Language is described as constitutive and constructive of worlds (Wetherell, 2001) in this instance it perhaps notable what markers are not considered constitutive (eg psychological) as well as those that are.

3.6.3 Bottom of the pile

For many of the participants there was an issue around lack of funding and research which was constructed as politically motivated.

Adam expands on this when asked why he thinks it's not in the DSM-5

379 Adam: *In this country there's no reason for expanding the sort of likelihood because*
380 *of funding. I don't think politically it's something you could say there's such*
381 *a thing as spending too much money (.) with buying and then you'd look at the*
382 *behaviour then you'd be saying realistically (2) umm and there's backing that*
383 *up is a lack of evidence, and backing that up is a lack of funding for evidence*
384 *and backing up that lack of funding is errm there's not enough funding for*
385 *the things that need it at the moment errm so are they, you know, err you have*
386 *a funding panel, perhaps, and you have five studies and it's probably not going*
387 *to go to compulsive buying err until you find someone who's err got an element*
388 *of (1)*
389 H: *...So you're not going to get funding for?*
390 Adam: *Of course you're not.*

Adam constructs the omission from the DSM-5 as having a political dimension, *'I don't think politically it's something you could say...'* this reflects Boyle's (2005) contention that discourse operates through social and institutional practices. Such institutions, are positioned by Adam as co-producing what we can and can't say about spending too much money in L380-1. Following on from a discussion earlier in the interview around a culture of spending he implies that the government do not want to label this as they would not want to discourage spending. Such talk seems to legitimize CB as a possible diagnosis were it not for the lack of funding and government backing. Repetition of *'funding'* and anaphora (repeating the phrase *'backing that up'*) with a three-part list (Jefferson, 1990) that traces the lack of evidence and funding for evidence, creates persuasive emphasis. Adam seems to take up the footing of cynical professional who understands the complex mechanics of the institution, and the impossibility of campaigning for more funding for CB. Speakers are said to criticize more effectively when they appear to do so from a neutral stance (Wetherell, 2001) and Adam seems to negotiate this troubled position by shifting his footing, asserting there's not enough *'funding for the things that need it at the moment'*. He uses aposiopesis at the end of his speech, that is the conclusion of his thought is left unsaid for emphasis *'until you find someone who's got an element of....'*. I respond with a yes-no interrogative (Raymond, 2003) for clarification on L389 to which Adam makes his final footing clear with the extreme case formulation *'Of course you're not'*.

Adam's final statement suggests a finality and authority in its tone the 'of course' proposing any counter argument would be absurd.

Rob also responds to the same question around its omission from the DSM-5 drawing on similar discourses of politics, science and money:

420 Rob: *Ummm...it, I guess that's kind of a bit contentious, so I've a little bit I've*
421 *errm. If I was very pragmatic I'd say that just simply not enough evidence,*
422 *and of course there's reasons why there isn't you know, there isn't the*
423 *evidence there and it was the same with gambling it think it took a while for*
424 *gambling to come till it was acknowledged and if you look at cultural forces in*
425 *terms of err with gambling I mean if you can look at it today where there's*
426 *just a lot of forces that say you know that power dynamics within a society*
427 *where gambling has significance and there's a lot of money and there's*
428 *a lot of people can lobby umm to protect the status quo, right?*

Rob construct's this topic from the outset as 'contentious' framing it as a 'delicate object' (Silverman, 1996), he manages some neutrality in this delicate position with tentative language 'I guess' and hesitations 'erm' and the stake inoculation (Potter, 1996) 'If I was very pragmatic'. He builds a two-sided argument (Abel & Stokoe, 1999) to expand on this, that both acknowledges the scientifically-endorsed view that there is not enough research to support its entry to the DSM, 'simply not enough evidence', yet also questions the acceptance of this paucity 'of course, there's reasons why'. This works up a position of challenging and suspecting motives behind this omittance, the 'of course' assumes the listener corroborates with this and needs no further explanation. Rob substantiates this position with comparison to the history of gambling's entry to the DSM, describing the obstructions it faced in L424-8, employing repetition and extreme case formulations (Pomerantz, 1986), 'a lot of forces'. His comparison constructs CB as confronting the same centripetal forces (Bakhtin, 1986) of culture, power and money, driving it CB to the bottom of the pile to safeguard their interests 'a lot of people can lobby umm to protect the status quo, right?'

3.6.4 The need for momentum

This repertoire signposted the hegemony of scientific evidence-base for diagnoses and the influence of cultural, social norms on the momentum required in order for something to be acknowledged as an addiction.

- 151 H: *How do you think or do you think it sits alongside other diagnoses, so behavioural*
152 *addictions, or do you see similarities?*
153 Tessa: *I really believe that to be an expert at something and to really make a pronouncement*
154 *on things you need to see about a thousand cases, I really believe that and I haven't*
155 *seen that many so it's hard for me to give you a really clear opinion.*

Tessa's reluctance to give an opinion is delivered through the robust stipulation that she would need to see a thousand cases to be an expert, drawing on a scientific discourse of expertise and collating evidence before one can make a '*pronouncement*'. Tessa underscores her position here by repeated extreme case formulation (Pomerantz, 1986) '*I really believe*'. Though the question was delivered more tentatively and did not necessarily intend to invite such a definitive pronouncement but more of a general opinion. It was not clear if such a strong caveat would also be utilised for other addictions or diagnoses that perhaps Tessa also hadn't seen a thousand cases of. CB seems to be constructed here as in need of the weight of science, evidence and scale of cases behind it before it can take up the biomedical nomenclature of diagnosis. Such talk seems to position CB as still ambiguous and nebulous and thus not meriting a diagnosis in comparison to 'other' addictions.

When asked about its potential place in the DSM Rob also explored similar ideas around evidence and public perception.

- 436 Rob: *It's you know I dunno, hhh, I think the, there will be more evidence, because,*
437 *simply, you know, the, 'cause it's occurring, it has to hit kind of a point in*
438 *culture where (1) suddenly it (2)(hhh) arrgh, I dunno how to describe it really*
439 *but where there'd be enough momentum for it to then start.*
440 H *[Yeah, so it's on a roll..]*

441 Rob: *Yeah it's like, you know a kind of snowballing effect where then enough*
442 *people feed to into it and then it's the idea of a new idea will become accepted*
443 *the, 'actually, it could be an addiction', umm and then it can be a problem for*
444 *people and then it's not something that's to be dismissed because it's yeah, you*
445 *know as much as any other behaviours it's, it's the behaviour, you know, that's*
446 *the issue. And that's, that's the key thing and that's the problem I think a lot of*
447 *people have with it, it's difficult to grasp*

Rob constructs CB here as on the verge of public acceptance 'it has to kit a kind of point' and legitimizes this with 'cause it's occurring', positioning himself as believing CB is something that is out there happening. His talk seems to convey expressive caution with tentative language, 'and it's', 'I dunno', his talk also creates protective layers between himself and the ideas, what Goffman (1981) refers to as 'embedded relationships' eg 'it's the idea of a new idea', suggesting Rob constructs this as a delicate object (Clayman, 1992). His sigh and pause on L438 conveys to the listener Rob is taking up a reflective, personal stance that needs to be heard. Rob works up the idea of social momentum of acceptance of CB with active voicing on L443 'actually it could be an addiction' this imagery helps the listener imagine the process happening with Rob and builds consensus. Rob's footing becomes more assured at the end, stressing 'and that's the key thing', highlighting the dilemma that it could become something that's not dismissed but it's status as something that is difficult for people to 'grasp' is constructed as a barrier to its acceptance as a problem.

When asked about how seriously CB is taken, Adam highlighted the similarities between gambling and CB and added:

417 Adam: *I don't see much difference between them and compulsive gambling but there's*
418 *not enough stories out there that warrant it's...*
419 H: *Do you think that's because it's not as prevalent or that people don't really, I*
420 *don't know, come forward with it as much?*
421 Adam: *Well, I mean, no-one's gonna come forward with umm, there's not gonna be*
422 *much discussion of it with umm, like I said, it comes back to money and there's*
423 *always comes back to the problem of how much is compulsive behaviour and*

424 *not compulsive behaviour? You know, what is overspending? You know, how*
425 *many people believe, how many people overspend, or are spending over their*
426 *means? There's people spending or spending more than they need, hundreds*
427 *and thousands on their credit card debts, car, spending out, is this compulsive*
428 *behaviour? As I say, overspending is encouraged by the government. Is it*
429 *compulsive behaviour when it's socially encouraged?*

Adam constructs CB as similar to gambling but having '*not enough*' evidence suggesting that if there were more, it would merit it being taken more seriously. Adam accounts for this lack of evidence with the strong assertion and extreme case formulation (Pomerantz, 1986) '*no-one's gonna come forward*', which could suggest it is stigmatized or shameful. He blames government '*as I say overspending is encouraged by the government*', suggesting that if there was less encouragement and acceptance more people would come forward. Adam takes an almost philosophical position and invites the listener to this reflective footing as he poses several rhetorical questions across L423-9 that position defining CB as problematic '*You know, what is overspending?*'. Adam constructs this problematic position as built up by the hegemonic, dominant forces of government and '*money*' which subjugates '*people*' to '*spend hundreds and thousands on their credit card*'. Adam's final dilemmatic footing (L428-9) seems to question this norm and at the same time concede that whilst this is the cultural norm, CB will not be acknowledged.

CHAPTER 4

DISCUSSION

This research analysed the talk of six therapists about their work with CB. Investigating the research on CB it was found much focussed on the etiology, epidemiology and measurements but very little that considered it from a discursive frame or from the perspective of the therapists. It also appeared to be a contentious topic with many conflicting theories and positions taken up, particularly around its 'addiction' status. Thus this research set out to explore the use of language to construct objects and take positions, such as 'expert' and 'addict', using widely available ways of talking or repertoires, and negotiating ideological dilemmas. This discussion will consider how these findings might relate to extant literature as set out in the review as well as its limitations. It will also reflect on the possible implications for clinicians and counselling psychologists as well as suggest some areas for future research and the researcher's final thoughts and reflections.

4.1 It's self-medicating

The self-medicating discourse which related CB to other addictions in terms of its mechanics was drawn on strongly by all therapists (see Appendix I). The behaviours, biochemical reactions and underlying processes were talked up as similar in nature to other substance and non-substance addictions.

Addiction as a disease metaphor is seen as a dominant discourse in current science literature (Reinarman, 2005) and this representation was mobilised by the therapists. This was in one respect unsurprising as constructions of CB as similar in features to other addictions both substance and non-substance was also a dominant concept from the literature review, with many arguing for its place in the DSM (Hollander & Allen, 2006; Elliot, 1994; Scherhorn, Reisch & Raab, 1990) alongside other addictions.

Perhaps feeling legitimized by the hegemony of this medical model, the therapists taking up this repertoire seemed to exhibit a confident and assured professional position. It is wondered whether this came through so strongly because of the wealth of literature found supporting this discourse or

whether there was felt a need to compare to other addictions in order to legitimize CB's place or existence since their working with it suggested their own professional acknowledgment of it as an addiction. This need to legitimize CB could explain the use of concessionary elements in the talk (Antaki & Wetherell, 1999) employed to evoke consensus and protect their professional footing. It has been argued that these biomedical and neurological explanations of addiction are afforded a superior status to more social or systemic accounts (Fraser, Moore & Keane, 2014). This bias constructs addiction as an individual or group's issue rather than a societal one and has been said to fuel the pathologization of problems and the dichotomy between sick and well (Campbell, 2012). The addiction as disease construct can thus serve to excuse bad behaviour, absolve blame, explain irrational behaviour or legitimise treatment or punishment (Davies, 1992; 1997). Though the concept of addiction as a disease is now a taken for granted discourse it is a relatively recent construct and one that's scientific basis has been contested as vague and unfounded; a cluster of variable behaviours that are only interpreted as symptoms under certain circumstances (Reinarman, 2005; Zinberg, 1984).

4.1.2 Quick fix

The quick fix repertoire constructed CB as being a means of self-soothing much like a drug, with talk of the biochemical high, and neurotransmitters used as a speedy reward and addiction as a disease metaphor. Biomedical and neurological explanations of addiction have been labelled the 'dominant lexicons' of this era (Campbell, 2012, p.203). Yet some dispute the purely biochemical power of addiction, constructing it as sociologically contingent rather than physiologically inevitable (Morgan & Zimmer, 1997; Waldorf, Reinarman & Murphy, 1994) . However, therapists talk drew on the hegemonic, biomedical discourse referring to 'dopamine' and getting a 'high', yet interestingly there were scarce neurobiological studies found to support this that directly related to CB, though some exist that relate to other substance and non-substance addictions (Grant, Brewer & Potenza, 2006) (Murali, Ray & Shafiullha, 2012). However the extant literature supports the construct of CB being used as a way of achieving short-term relief from co-morbidities such as anxiety, depression, anger etc (Miltenberger et al., 2003). It seems that despite the paucity of research and the conflicting

literature therapists draw on hegemonic discourses, their knowledge and professional experience of the process of addictions in general and build this up when employing this repertoire.

This quick fix repertoire positioned the addict as out of control and driven by chemical urges, suggesting responsibility lying with the individual (fundamentally the same as with other addictions) whereas therapists were seen as taking up professional positions of knowledge. Maintaining a professional footing seemed important for therapists, but with the minimising caveat that CB could become addictive like any behaviour could.

It has been argued that this discourse of addiction as a ‘disease’ is too cognitivist and vague, since it depends on how disease is defined (Wallace, 2004), it also fails to view addiction in the more discursive light as something functional and system-specific. A drug addict may talk up the hedonistic aspects of drug taking whilst a professional may stress the extent of the addiction (Davies, 1992). Likewise, were we to interview compulsive buyers about their addiction, there may have been no mention in their talk about their addiction as a ‘disease’. Wallace (2004) argues individualistic approaches to addiction are too narrow and that, situational aspects of addiction should also be considered such as the environment in which it takes place (Graham, 1985; Becher et al., 2000). These taken for granted discourses around the strength of such chemical processes in addiction have been challenged as a growing corpus of research suggests addiction is less about chemical ‘hooks’ and more about the surroundings and environment of the addict (Alexander, 2010; Hari 2015). Alexander (2010) proposes addiction is not the result of addictive drugs, peer pressure, genetic predispositions, or incurable brain dysfunctions but rather an adaptation to a fragmented society where individuals feel increasingly dislocated, a construct that is adopted in the ‘*we must all shop but not too much*’ discourse below.

4.2 How should I work with this?

Therapists constructed their CB clients as needing to pause and observe their behaviour in order to gain insight and agency, portraying the individual as responsible for and needing to change. Such

repertoires positioned them as agitated and frenetic in contrast to the calm, guiding therapist. Therapeutic approaches which embrace elements of CBT, ACT and mindfulness for CB are touched on in the extant literature (Kellet & Bolton, 2009; Benson & Eisenbach, 2013) and offered in practices. Such approaches are used for addictive behaviours in general and presuppose the construction of CB as compulsive behaviour that is plagued with impaired gratification delay, a construct also reinforced in the literature (Horvath, Buttner, Belei & Adiguzel, 2015; Sohn & Choi, 2014; Billieux, Rochat & Rebetez, 2008).

The therapists expressed a sense of uncertainty about what could work best for their CB clients. Therapists' shifting footing and ideological dilemmas conveyed this troubled position of being out of their depth, unprepared and unsure if their approach or any approach is 'right'. Concurrently they also worked up their ability to adapt their knowledge and skills adequately, emitting a stance of 'authoritative doubt' and 'safe uncertainty' (Mason, 1993), that is approaching CB with a sense of curiosity that refuses to jump to conclusions and is open to new ideas. Thus they were able to fend off a position of helpless expert working with the reliability of CBT and 'first principles', as opposed to more psychodynamic methods, which were portrayed as perhaps less useful. A similar bias in approach can be seen from the literature, though there is little specific guidance on therapeutic methods, most advocate a CBT protocol (Kellet & Bolton, 2009; Filomensky and Tavares, 2009; Muller et al., 2008; Mueller et al., 2013), with few investigating psychodynamic treatments (Krueger, 2000; Goldman, 2000). This inclination to rely on CBT or its third wave derivatives as a preference to psychodynamic modalities could be dictated by the NHS settings, the fact that there are no NICE guidelines for its treatment and the hegemonic, scientific discourses supporting CBT as the evidence-based 'go-to' approach (Butler, Chapman, Forman & Beck, 2006; Pilgrim, 2009). It is notable that therapists also drew attention to the accessibility and the potency of the omnipresent reinforcements often thwarting treatment gains, at once excusing the inadequacy of the treatment and criticising its limitations, but also perhaps countering any fragility perceived in their therapeutic abilities and standing.

4.3 We must all shop but not too much

It was observed that the therapists became most animated and passionate when taking up this discourse in the interviews. Whereas the more scientific discourse saw them take up a professional footing, this seemed to elicit more of a personal voice from the therapist and a more liberated delivery.

4.3.1 Accessibility as a trigger:

This repertoire positioned the wide accessibility of shopping both online and on the high street as problematic and exacerbating the problem. Whilst one therapist pondered a personal experience with being drawn into shopping online more than she needed to another cogitated on the wider impact of too much accessibility on society as a whole and what he described as the '*anxiety epidemic*' (Marcus, L286). Though both employed stake inoculation (Potter, 1996) and attributional distance (Clayman, 1992) to protect their footing as professionals, they also seemed to disclose a more impassioned and introspective stance. Such a stance was reflected in their use of personal narrative and hyperboles, yet at the same time courting consensus and corroboration from the listener. This courting was most evident in the interviews as their voices and mannerisms became more animated when taking up this discourse, for example Marcus vigorously tapping the table when talking about downloading the amazon app. Though the influence of culture, media and advertising is assessed in some of the literature as culpable in encouraging CB (Elliot, 1994; Benson, Dittmar & Wolfsohn, 2010), it is perhaps minimized in the more positivistic research (Black, 2010), which is more plentiful.

Hartston (2012) maintains that the widespread accessibility of shopping since the rise of the internet has had an aggregate effect on its potential for addiction, both in the frequency of triggers (adverts) present and the encouragement of impulses to be acted on immediately – via reduced steps to complete a purchase and the ability to purchase anywhere, anytime. She argues this creates an equally or even more addictive draw than psychoactive substances like heroin (Hartston, 2012).

4.3.2 Shopping as a cultural norm.

Therapists constructed the advertisers and corporations as actively encouraging people to buy, yet society and culture chastising those who shop too much, employing the repertoire '*shopping as a cultural norm*'. Such positioning of consumerism on a scale from good to bad in the extant literature builds up the compulsive buyer as immoral (Campbell, 2000). A cultural landscape is constructed in this repertoire of a constant barrage of adverts and corporate greed powering and facilitating the urge to buy and hence many '*ills of the Western World*' (Marcus, L326) . Therapists constructed the CB as suggestible and weak, and the corporate bosses as simultaneously reproachable and just doing their job. Within this repertoire a rebellion away from this hyper-materialist panorama is tentatively alluded to, positioning living minimally as an emerging and positive movement, versus the evils of shopping.

Whilst much historical and current literature discourses have cautioned impulsive and compulsive behaviour, forewarning its negative consequences, corporations and marketers have actively encouraged and promoted such behaviour in terms of excessive buying (Workman & Paper, 2010). This focus on the cultural contribution to the problem of CB is championed by Lee & Mysyk (2004) who point the blame at societal issues rather than solely individuals as the source of the problem. It is interesting that most of the positivistic or science-led papers ignore or give little credence to these influences.

This discourse seems to mobilise the debate around what is addiction and who is responsible for it. These tensions are reflected in the therapists shifting positions and constructions. Historically most of the positivistic literature and discourses have pointed to the individual as responsible for their addiction. This is understandable since scientific research tends towards evidence-based experiments that can measure behaviours and actions. However this repertoire seems to take a more macro, holistic view that looks at other influences as responsible or at least significantly contributing to the problem, i.e. cultural influences, big business, government interests.

4.3.3 Shopping for a better self

Therapists took up this repertoire when considering the compulsive shopper's motivations to buy, constructing it as being about wanting to enhance their self-image. Therapists talk acknowledged the widely accepted scepticism towards the authenticity of CB as at odds with their clinical experience of extreme buying behaviour in the vain pursuit of an improved self. This idea of buying to improve self-image, bolster self-esteem, or gain approval of others is in accord with much of the psychodynamic theoretical explanations in the literature (Black, 1996; Krueger, 1998; Benson, 2006). The construct of a quest for a better self through material purchases, could signify what Elliot (1994, p.163) constructs as a 'desperate search for meaning in a disintegrating social order'. Addiction has been constructed as a way that needy people respond to what is missing or traumatic in their own lives and communities (Hart, 2013; Lewis, 2015, Thompson, 2016), this repertoire depicts shopping as driven by this void.

Responsibility for the materialism driving CB was constructed as lying with media, influencers and corporations promoting images of wealth and glamour through advertising which persuades society that buying will make us feel better and more like these idealized images. Indeed, this need to appear attractive has been cited in the current literature as a motivation for CB (Goldman, 2000). Benson et al.(2010) maintain that our aspirational figures have changed over the last fifty years from our neighbours and peers to celebrities with affluent lifestyles, contributing to a more materialistic society.

De Graaf, Wann & Naylor (2005) described this paradox of western societies erroneously urging freedom and happiness through consumerism as 'affluenza', 'a painful, contagious, socially transmitted condition of overload, debt and waste resulting from the dogged pursuit of more' (p.2). Therapists talk drew on this sociocultural discourse of corporations training consumers to heal difficulties with material goods encapsulated by De Graaf, et al. (2005, p.2) 'shopping has become our programmed response to joy and sorrow, good fortune and bad, and despair and hope. It is thus considered substance abuse'.

4.4 Is it a problem?

4.4.1 CB as secondary

Much of the existing literature links CB with various co-morbidities including low self-esteem, negative emotions such as anger, boredom, anxiety and self-critical thoughts (Miltenberger et al., 2003) anxiety disorder, obsessive-compulsive disorder (OCD), impulse-control disorders such as personality disorder (Black, et al., 1998). It has also been suggested that a co-morbid complaint is usually the presenting issue rather than CB (Muller et al., 2015) In line with the discourse from this corpus of literature, therapists talk drawing on this repertoire constructed CB as a secondary issue, often not the primary presenting concern and also less potent than other addictions, or having a more enduring underlying issue, a construction that seems to conflict with the '*similar to other addictions*' repertoire above. That it is perceived and positioned as 'secondary' may contribute to client's reluctance to come forward with this as a complaint, which in turn feeds into the perception that it is a minor or secondary difficulty, creating a self-perpetuating cycle.

Discourses on addiction can be said to be co-produced between the media, the public and the scientific community through actions, experiences, contexts and meanings (Winter, 2016). One of the most influential objects in defining addiction is the DSM-5. Lack of recognition in the most recent edition and the bias towards biomedical and neuropsychological explanations for addiction in research (Vrecko, 2010a) distil into these collective narratives. Given the scarcity of biomedical research in this area, no clear scientific endorsement as a 'diagnosis' and the lack of obvious treatment options, client's willingness to bring up the topic would understandably be diminished. If something is not constructed as a having potential to be a problem or addiction, then how can it be talked about or understood by a client as treatable?

4.4.2 It's a maths issue

This repertoire both questioned and described how CB is identified and understood in terms of money. Therapists talk assumed a lack of funds or percentage of income spent to be the significant marker for whether the shopping reached the status of being problematic. This positions the shopper

as reckless and unaware, content to continually shop until their funds run out or reach unacceptably low levels. Some therapists noted their client's lack of concern due to possessing greater funds and wondered at their avoidance of the problem. Others drawing on this repertoire constructed it as a more binary issue; if you have the money to feed such a habit, then it is not a problem. Prevalence rates from the extant literature yield conflicting results regarding income levels, some suggest it is most likely to afflict middle income earners (D'Astous, 1990), others see no significant difference across class (O'Guinn & Faber, 1989). This construction of the 'amount' as a marker for addiction is problematic if we consider substance addictions, would it be talked about as a problem only if you ingest a certain amount or should other factors that may be affected by the activity be taken into account (psychological, work, time spent, family etc)? Scales devised thus far for CB consider many factors: psychological, financial, time spent, shame, distress, impulsive, compulsive and obsessional behaviour (Faber & O'Guinn, 1992; Ridgeway et al., 2008; Monahan et al., 1996).

It is worth wondering why therapists talk within this repertoire seemed to overlook these features. Perhaps the materialistic ethos prevalent in the '*we must all shop but not too much*' discourse has filtered into therapists consciousness making it difficult to see buying as potentially dysfunctional other than financially. We are primed to think if you are wealthy and have all the trappings this provides, you must be ok. In this respect how does CB differ from gambling, where large amounts of money are spent in the process? Perhaps there is something in the accumulation of 'stuff' that is both abhorrent and entices envy whereas gambling and drug addiction tend to evoke images of loss and destruction through debt and physical afflictions and thus more empathy?

4.4.3 Bottom of the pile

Therapists who have worked with this presentation seemed to face a dilemma as they constructed CB as unfairly marginalised yet also not necessarily warranting further funding or research. Therapists shifted positions between a neutral and challenging stance when considering the political hegemonic forces and discourses that create a barrier to research and funding. Hemmler (2013, p.28) pointed out the 'liminal status' of CB, constructing it as on the outskirts of acceptance as a medical

disorder and this is reflected in the therapists ambiguous positioning on this point. Despite estimated prevalence rates at 5% (Maraz, Griffiths & Demetrovics, 2016), CB seems to be constructed as in a vicious cycle, exclusion from the DSM-V is put down to a lack of sufficient evidence (Potenza, 2014) yet calls for more investigations are opposed by the same hegemonic forces that seem to support diagnostic recognition (science, government, culture).

4.4.4 Need for momentum

CB was ultimately constructed as nebulous, lacking the weight of scientific backing and being difficult for people to comprehend. Therapists talk in the current research also predicted CB eventually becoming more widely accepted as a diagnosis and as a legitimate addictive behaviour, constructing it as needing momentum. Thus therapist's footing was hazy, with use of expressive caution, suggesting CB is perceived as a delicate object (Clayman, 1992) and calling for consensus. It was constructed as something potentially shameful, since not enough people have come forward with it, yet at the same time its understood that this shame relates back to the culture of encouraging people to spend, creating a no-win situation.

4.5 Findings and clinical implications

The current study seems to illuminate many of the confusing and contradictory ways CB is constructed. One of the key tensions seems to be around its similarity to other addictions, yet it is not acknowledged in scientific discourse as such. Therapists thus seem to be unsure how to treat it and also unclear about whether or not it is or should be seen as a problem, positioning it as minor in comparison to other more 'plausible' psychological problems and addictions. Though they recognise and at times challenge this lack of research, funding and recognition as being driven by cultural and governmental powers, there is also a tendency to acquiesce to these hegemonic forces and the discourses they allow. Thus it seems important that therapists cultivate an awareness of just such tensions in their workings with clients in this domain. As has been discussed, addiction is a nebulous and changing construction, influenced by culture and historical context.

These tensions also seem to generate shifting positions available to the client from vulnerable addict, to lazy addict to lacking willpower, to having poor judgement, being shallow, naïve, lacking self-esteem, needing guidance, being victim to the will of corporations and government or even having too much money. The therapists position themselves as at times expert and inexperienced, but often relying on hegemonic scientific discourses to bolster their professional positions. Foucault describes discourses as ‘practices that systematically form the object of which they speak’ (1972, p.49) as such they limit what can and cannot be said or done within a topic. The therapeutic relationship permits such constructions and the interaction of knowledge and power as therapists construct the client’s problems through the lens of therapeutic knowledge, placing themselves as knowledge’s practitioner (Bird, 2004a), ‘its embodied representative, and seemingly its controller, manager and master.’ (Guilfoyle, 2006, p. 51). It thus seems important for therapists to be aware of the positions these repertoires dictate as they construct objects and ways of being for clients that may reinforce a wider delegitimised status for CB, which could produce implicit barriers to the work. Keeping a professional footing should not be maintained at the expense of sustaining an open mind, curiosity and a stance that is able to question the taken for granted. Therapists should critically reflect on their own conceptualisations of CB and how these may be affected by their wider constructs of addictions in general and how this may influence their practice, particularly in light of the inevitable power differential between client and therapist. It is noted that this data was garnered from research interviews *not* client dyads so conserving a professional stance could be seen as contextually influenced.

The analysis also suggests therapists be attentive to the pivotal role culture, businesses and government may play in creating such discourses, and whilst they may not be able to directly effect policy or commercial change, they can be mindful that their language can serve to challenge or perpetuate such discourses, rather than take for granted their scientific ‘truths’. Seeing the individual as a ‘container for disorders and pathologies’ serves to ignore the integral role of social processes and context (Lyddon, 1998, p. 215). Public policies have changed in recent decades towards addictions with government beginning to intervene and regulate in substances such as smoking

(Pierce, White & Emery, 2012), alcohol (Meier, Purshouse & Brennan, 2010), sugar (Gostin, 2018), and behaviours including gambling and online screen activity to effect change.

Whilst it isn't in the scope of this research to suggest what interventions might be needed or possible, one doesn't need to look far for inspiration of how public behaviours can be shaped. One of the strongest discourses that emerged from the analysis positioned advertising and culture as having co-produced public constructions around the need for more 'stuff'. If Western populations are so suggestible can such ideas then also be deconstructed or re-constructed? UK local governments now employ a spectrum of bioethical 'nudges' which include eliminating choice (banning), financial disincentives (taxation), changes to environment such as designing buildings with fewer lifts, provision of information, use of norms etc. to effect public behaviour (Quigley, 2013). Responsibility for public health moved from the NHS to local government in 2013, if prevalence rates of CB are averaging at 5% then it could be argued this constitutes a public health problem that might warrant such nudging strategies.

The discourses around living minimally that were alluded to in the '*we must all shop but not too much*' repertoire are showing signs of being echoed by the growing governmental discourses on environmental changes such as tariffs on plastic bags and the need for less waste (Department for Environment, Food and Rural Affairs, 2018). Such initiatives take into account the impact of overconsumption on the planet but do little to target the cycle of anxiety and low self-worth that such materialism can foster. If 'nudging' techniques are to be truly effective then they need to also target people's misconceptions that the acquisition of material goods can buy you happiness and a positive identity, a notion that has significantly grown rather than decreased over the last few decades (Dittmar, 2007; Richins, 2004). However, this drive to buy more than we need is inextricably linked with economic growth and thus it is not in most government's interests to discourage such materialism (Benson, et al., 2010). Perhaps this is where therapist work comes in?

The current study constructs responsibility as being situated with different parties, most often it is ascribed to the individual, in-line with many populist addictive narratives (around willpower, poor judgement etc), but as described earlier much research challenges such assumptions as too narrow, ignoring the cogent effect of culture, businesses and government in exacerbating the problem. When speaking more personally, therapists drew on repertoires that endorsed similar accountability for CB (to culture, materialistic society, government policy). Since there is no specialist provision within NHS practice nor any NICE guidelines for CB treatment and the repertoire '*therapeutic uncertainty*' reinforced this message, this perhaps constructs a cultural necessity for more expert support in this field.

4.6 Evaluation, limitations and suggestions for future research

Research is ultimately meant to offer meaningful and beneficial answers to the questions that directed it in the first place (Elliot et al., 1999). It is hoped that this research has provided some thoughts on the research questions around how therapists construct CB, the discursive resources they draw on and how they position it in relation to other psychological phenomena. However, the repertoires selected do not purport to elicit universal truths or positivistic validity, but rather to show which constructions appear more available than others, or easier to say (Edley, 2001), which are culturally dominant, taken for granted and whose interests do they best serve.

Using semi-structured interviews (e.g. Potter & Hepburn, 2005; Wiggins & Potter, 2008) generates a power dynamic whereby as researcher I control the agenda, questions and limit the interactions in a way that inevitably effects the participants positioning and talk (Potter & Hepburn, 2005). The epistemology and ontological framework for this study attempted to take this into account in being attentive to the many contextual features that might be affecting the interaction and discursive resources utilised. Using reflexivity and supervision to try to be conscious of the many ways my reactions to the data shaped and allowed certain insights and limited others was also central (Willig, 2012). Though focus interviews could not be arranged logistically, they may have elicited more naturalistic conversation which could better illustrates attitudes, co-construction of meaning and

positions taken up and how alternative positions can be influenced by others (Willig, 2013). This could be a target for further research and it would be interesting to see what different or similar repertoires, positions and dilemmas are mobilised.

Two areas that came up as slightly weaker discourses were around shopping as a female activity and shame. Though the scope of this research meant this aspect was not included in the final analysis, it could be an area for further exploration, perhaps interviewing females and males who identify as compulsive shoppers and using DA to see if there are differences in the way it is constructed and also exploring talk around shame and how explicit and implicit barriers around CB are negotiated through talk.

Given that some therapists constructed CB as a *'maths issue'* it would be interesting to explore the role of money and how it affects CB. The idea of CB as *'bottom of the pile'* and *'secondary'* seems to suggest an inherent bias in how we look at this particular issue in comparison to other addictions and psychological conditions so further investigation into how such a hierarchy might work, for whom and why could be of interest. Discursive analysis research that widens this discussion to the general population, media, arts and advertising, people who identify themselves as compulsive buyers, or therapists who work with addictions in general could all broaden our understanding of how it is perceived, and what can and cannot be said from the *'language culture'* (Edley, 2001, p.190).

There was much talk by therapists about *'accessibility as a trigger'* with particular mention made of internet access. Researching this area further, perhaps in comparison to non-online shopping and how this differs psychologically may contribute to differing treatment approaches.

From the literature review it was clear our understanding of neurobiological and etiological processes are limited and further investigations into this area may contribute to legitimising its status and allowing therapists and clients to speak about it more openly. Such research may serve to strengthen the *'quick fix'* repertoire that compared CB processes to addictive substances and the chemical high

they glean. Given the discourse of *'therapeutic uncertainty'* that was constructed by many of the participants more trials into different treatment options seem to be needed. The repertoire of *'cb as a secondary problem'* suggests research into such treatment options could also take into account different comorbidities.

Though there is some research on the lived experience of CB (eg, Eccles, 2002) more IPA research in this area, from different countries and cultures, particularly emerging economies, could expand our appreciation of how it develops and is experienced. Finally, the current research seems to call out for investigations that take into account the cultural and societal influences on CB, that perhaps looks at the problem more systemically rather than just individually. Taking a more unified, holistic lens that recognises the many influences on the topic.

4.7 Concluding comments.

In this research I hope to have made a worthwhile contribution to our understanding of how CB is constructed, particularly with therapists who have worked with it, an area that has hitherto been under-researched. Taking a social constructionist lens and utilising a CDP methodology has allowed for a fine grained analysis, as well as pondering the wider social and political context of the talk. The discourses that emerged in the analysis highlight the many tensions that surround this topic for therapists. CB is constructed as both like other addictions, with the same processes and comorbidities, yet seen as less important, delegitimised and unrecognised with little clarity around how it should be treated. The current research also constructs culture, media, and corporations to blame and the inescapable triggers that encourage self-improvement through material goods as exacerbating and reinforcing CB, yet it is mainly constructed as the individual's duty to regulate. Such uncertainties would ordinarily herald a call for more research, yet CB is also constructed as challenged by implicit barriers to further research and funding. Concurrently, a more positive stance was built up of CB as in need of 'momentum', suggesting that it will inevitably become more recognised and culturally accepted as something 'that's not dismissed' (Rob, L444). It is hoped that

this call for more research will be heard to generate evidence that may filter into the wider scientific and public discourses and may lead to NICE guidelines that could help dispel these ambiguities for therapists.

4.8 Reflexivity

This was one of the first pieces of research I have done that involved semi-structured interviews and I found this part of the process harder than I had anticipated. I felt a constant tension between staying on track with the questions and wanting to have a more free-flowing discussion. On reading the transcripts there were points where I wished I could have explored their responses more (eg around it being a female/male activity, around differences and similarities between CB and other addictions) and this was a cause of frustration. At the same time the most challenging aspect was editing out interpretations and deciding what *not* to include, as ‘interpretation always involves both the opening up and the closing down of possibilities’(Willig, 2012, p.165).

Counselling psychologists are expected to marry the oft opposing medical model with humanistic, phenomenological approaches and this topic seemed to embody similar tensions. Doing this research it became apparent that CB is a complex, human problem in a world that’s default is to provide a medical solution, a quick fix for a quick fix. Such a default position raises philosophical questions about what is an addiction and why are certain addictive behaviours more accepted than others and why do we tend to assess it from a positivistic viewpoint?

Reflecting on the methodology I was struck by its epistemological and ontological similarities to the way therapists, particularly counselling psychologists, work and view cases. The attention to the micro and macro influences on talk inherent in CDP seemed redolent of counselling psychology’s acknowledgement of a biopsychosocial approach that takes into account the individual’s phenomenological experience as well as their wider environment and context. This zooming in and zooming out is something I am aware of in my practice, as decisions to focus on one area inevitably seem to circumspect other areas.

Such dilemmas of what to focus on whilst holding an awareness of broader influences allows, I believe, a more enriched and profound construction of psychological distress. Such tensions and choices seem comparable to the process of analysis for the current research. It wasn't that certain areas were ignored but rather that others were foregrounded, as I chose what stood out as the most interesting, following what Wetherell and Potter describe as 'hunches' rather than 'rules or recipes'(1998, p177). As Counselling psychologists we are both in relation to and drawing on technical expertise (Strawbridge & Woolfe, 2010, p.19) and this melding of scientist practitioner with pluralism, humanist and an existential-phenomenological outlook is not without its tensions. The tensions within the analysis around biases toward the medical model and scientific constructions versus the messy reality of therapeutic uncertainty and the circularity of culture and government effecting behaviour which effects social norms is mirrored in the challenges of upholding evidenced-based practice whilst navigating what Schon describes as the 'swampy lowland', or the 'messy confusing problems that defy technical solution', (1987, p.3).

I have been asked many times what I am researching and I am aware of a defensiveness in my reactions, feeling I have to justify the topic as 'worthy' to others. I have had much time to reflect on this and wonder at why I have chosen a topic that I assume others find trivial or less 'weighty'. It seems that either I am not immune to the biases of the discourses I have identified (eg 'is it a problem?', 'it's a secondary issue'), or that I am so conscious of these discourses that I have fashioned them into my own analysis. At the same time I notice when I explain my research further I become invigorated by the discussion around culture and advertising and I think this has been a genuine motivation for me to explore the political and contextual effects. Having lived through the birth and explosion of the internet (and thus online shopping), the effects of two major world recessions, and the current drive towards greener fuels and reduced emissions I feel acutely aware of the effects of a cultural sea-change on our attitudes towards spending and needing more 'stuff'. Such 'acceptable' discourses perhaps make the wider discussion around this research more relevant and vindicate my position. Though it has been arduous learning a new methodology I am grateful for the

experience of researching this topic from this paradigm as it has heightened my sensibility in my professional and personal life to discourses drawn upon, positions taken up and dilemmas in talk. It has also increased my consciousness of the need to sometimes challenge these taken for granted frames.

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Appendix A.



Have you had any experience of clients coping with compulsive buying?

Would you be willing to take part in some research?

I am a Counselling Psychology Doctoral Student at London Metropolitan University and as part of my thesis I'm interested in talking to therapists about any experience they've had of working with a client who has shown some tendency to compulsive buy.

I am looking to speak to therapists who have completed their training and are now in practice. It would involve no more than one hour of your time at a convenient time and location to you and of course anything spoken about would be completely confidential and you would not be asked to in any way breach client confidentiality.

For more information please contact
XXXXXX on xxxxxxxx

Appendix B. INFORMATION SHEET

Introduction

You are invited to take part in a research study about how therapists who have worked with Compulsive Buying talk about, construct and experience the work. Please take the time to read the following information before you decide whether you would like to take part. If you would like more information please do not hesitate to get in touch.

Why is this research being done?

As previously mentioned, this research aims to understand how therapists that have worked with compulsive buying experience the work and construct and talk about the diagnosis

The research is being conducted as part of a Professional Doctorate in Counselling Psychology at London Metropolitan University (see below).

Who is conducting the research?

This research forms part of an accredited postgraduate qualification in Counselling Psychology. The primary researcher is a postgraduate student who has experience in conducting research. In addition, the study is fully supervised and all of the discussion topics and methods have been approved for use.

The research complies fully with the guidelines set out by the British Psychological Society (BPS) and has been approved by the London Metropolitan University research ethics committee.

What will happen if I decide to take part?

If you are willing to take part, please call Harriette, who will be pleased to make arrangements for the interview.

You will need to give your consent by signing the forms provided, keeping one yourself and bringing the other to the interview.

The interview can take place in your own home, place of work or at a local venue wherever you prefer, at a mutually convenient day and time.

The interview will last for approximately one hour.

The interview will be audiotaped and then a written transcript will be produced.

What happens if I decide not to take part?

It is completely your choice whether you take part in the research and whether you choose to continue once started.

What will happen to all of the information that I give?

The interview transcripts will not have any names attached to them, so anything you say will be anonymous. In addition any spoken names or other identifying markers will be changed. The taped interview will not be heard by anyone other than the researcher and research supervisor so that no one will be able to identify you.

Initially the information (both audio recordings and transcripts) will be stored securely at the home of the researcher and only the researcher and supervisor will have access to it. Both will be kept in a secure place for a period of no longer than 5 years.

A report will be produced at the end of the work, but again no information will be included which could identify who took part. Some quotes from the transcripts will be included in the analysis section of the report to show how the researcher has interpreted what has been talked about.

What if I change my mind about taking part in the research after I attend the interview?

You have the right to withdraw your consent to be part of this research at any time up until September 2017. If you decide to withdraw from the research project please make contact with the researcher who will then erase your interview audio recording and destroy the written transcript.

Where can I get more information about this research?

If you would like more information, you can either contact myself (Harriette) or alternatively you can contact my research supervisor

Here are our contact details:

Researcher:
XXXXXXXXXXXXXXXX@xxxxxxxxxxxx
Tel: xxxxx xxxxxx

Project supervisor:
XXXXXXXXXXXXXXXX@xxxxxxxxxxxxxxxx
Tel:
xxx xxxx xxxx

London Metropolitan University
Department of Psychology
London Metropolitan University
Tower Building
166-220 Holloway Road
London
N7 8DB

**Appendix C.
Participant Consent Form.**

If you would like to take part in this research project, please fill in and sign these consent forms, keeping one copy for yourself. Before you sign please read and tick the following statements:

- I have read the information sheet provided.
- I have had the opportunity to ask any questions I have.
- I understand I have the right to withdraw my participation at any time prior to the research being written up.
- I agree to the resulting data being used both in oral and written forms, for the purposes of distributing the research in a range of settings.
- I give permission for my interview to be audio recorded.
- I agree to take part in this research.

SIGNATURE OF PARTICIPANT

Name (PLEASE PRINT):

Date

Tel no:

When is the best time to contact you?

Appendix D.
Demographics form

It would be really helpful if you could answer the following questions.

1. Your age: _____ years old

2. Gender _____

3. Ethnic origin:

Ethnic Origin does not mean nationality but is normally defined in relation to a people or culture with which a person's forebearers are most strongly identified. Please tick one of the following that you most strongly identify with:

- White (e.g. British, Irish, or any other white background)
- Mixed (e.g. White and Black Caribbean, White and Black African, White and Asian, or any other mixed race background)
- Asian or Asian British (e.g. Indian, Pakistani, Bangladeshi, or any other Asian Background Black or
- Black British (e.g. Caribbean, African, or any other black background)
- Other ethnic group (e.g. Chinese or any other ethnic group)

4. How long post- qualification are you? _____ year/years

Appendix E.

Interview Schedule

1. How would you describe your therapeutic approach and training?
2. Have you had any clients who spoke about issues with buying or shopping? If so, could you tell me, without breaking confidentiality, a bit about this?
Possible Prompts : how many? how did the issues emerge?
3. Can you tell me about how that was for you? Probes: Thoughts, feelings, dilemmas
4. How did you work with this issue?
Possible prompts : What previous knowledge or experience did you draw on – if any? was there a 'diagnosis'? types of therapy or intervention? How did client react to the work?
6. How do you put this issue into words? What influences this?
Prompts: How do you see the diagnosis/concept of compulsive buying generally? Do you feel your opinion changed having experienced this clinical work directly?
7. Is there anything you'd like to say/add about this that we haven't talked about?

Appendix F.

Distress Protocol and Debrief sheet

Thank-you for your time. I would like to take this opportunity to remind you once again of the following:

Anything you have talked about will be made anonymous. The written transcripts of the interviews will not have any names attached to them and the names of any clients or places you have mentioned will be changed. The taped interview will not be heard by anyone other than the researcher and research supervisor so that no one will be able to identify you.

•

If you should decide that you want to withdraw your participation please make contact with me (Harriette) and I will then erase your interview audio recording and destroy the written transcript.

•

If you would like to know about the findings of the research please let either myself (Harriette) or my research supervisor (Isabel) know and we will be happy to send you a copy in due course.

Our contact details:

Researcher

xxxxx xxxxxx

xxxxxxxxxxxxxx

Project supervisor: xxx xxxxxxxx

Department of Psychology

London Metropolitan University

Tower Building

166-220 Holloway Road

London

N7 8DB

Should you wish to know any more about compulsive shopping or provide some further information for your clients the following websites may be of help.

<http://www.currentpsychiatry.com/home/article/compulsive-shopping-when-spending-begins-to-consume-the-consumer/674ab9a0d6ce256ffdb3f1ec6087d188.html>

<http://www.priorygroup.com/addictions/shopping>

<http://www.shopaholicnomore.com/>

Appendix G.

Transcription notation

<u>Underlined text</u>	Added emphasis placed upon word(s)
[]	Indicates overlap in speech
(.)	Audible pause in speech (untimed)
(other information)	Laughter, or explanation of non verbal events referred to within the interview.
‘ ’	Reporting speech of others, or use of active voicing
° quieter speech°	Encloses audibly quieter speech (not due to distance from microphone)
(xxx)	Signifies inaudible speech

Appendix H: Combined sample transcripts

- R: Ok so just to start How would you describe your therapeutic approach and training?
- Marcus: My therapeutic approach is probably a cross between cognitive behavioural therapy, dialectic behavioural therapy, the mainstay of it is probably brief solution focussed therapy, person centred counselling, clinical hypnotherapy, human givens approach and yeah they're approaches that I've learnt and been trained in over the years
- R: So how many years have you been practising
- Marcus: I was just thinking, 34 years, doesn't seem that long, seems more like yesterday you know if youd asked me id have gone 10years, but 1983.
- R: So quite a pluralistic approach
- Marcus: Yeah
- R: Umm, so you've obviously have some clients who've spoken about this issue in some form so could you just tell me a bit about that without breaking confidentiality or anything
- Marcus: Yeah, a number of people over the years I looked back at my notes to try and just see if there was common ground patterns and a flavour to it if tyou like over the years and I suppose it falls into 2 categories, that which has arised since the internet and pre internet days so 2 very different ways of looking at it so with th internet immediate gratification, you click on it and you've bought it you know you've set off the neuroetrnsmitter s running around your system, the other is about more about the whole experience of shopping about getting dressed up getting on the train tto the city centre going to the glitter of the um the shop and I guess it also comes back to gambling addcition which I've dealt with over the years. Is it somebody sitting there constantiyl clicking (taps table) or is it someone who goes to a casino and enjoys the whole experience?
- R: So is that something that you've seen a difference xxx
- Marcus: Mmm it's something that ive see with any addiction which that one of my approach is to separate out the addictive behaviour from any kind of pleasure that it gives so if its so if you've got addcition to red wine rathe than going out to a nice restaurant and have a glass of wine you sit at home and drink red wine out that's warm out of a paper cup not in the co[any of nice people so that
- R: So it's like a whole experience?
- Marcus: Yeah yeah the substance or behaviour that you're addicted to got its hooks into the good things in your life. You can still have the good things in your life, you can still have the substance but you have to separate those two out and that's really what the approach had been with helpjng people over compulsive buying
- R: And how many have you seen could you say roughly how many
- Marcus: I'm looked up um and theres about 34 and interestingly that's about an average of once a year in all the years ive been practising um but probably it's a lot more prevalent in the last few yeasers or so because its so much easier just to click click on the amazon one-click
- R: So are the cases that you've come across recently more internet based
- Marcus: [more internet based yeah]
- R: And how how did the issues emerge was it
- Marcus: It...I have to say that every single one that I've dealt with has been a female, I've never had a male with compulsive shopping to um either the physical shopping or

the internet shopping... I'm not being sexist in that remark it's just my experience of it, um, and very often it's brought to my attention because of a crisis or a further crisis in life and the husbands or boyfriends have brought their attention to the problem there's a few 'oh you don't buy any more or im off.' Crisis has forced some kind of intervention

R: So in that sense it has been the presenting issue rather than something that has emerged from therapy?

Marcus: Yeah, yeah part of a wider pattern and it in a couple of cases that stand out it came to me thought relationship counselling which I do you know on 2 of those occasions it was very much about the wifes compylsive spending yeah

Adam: she could see the damage that she'd done pretty badly and she was aware of everything had got out of hand and umm as I say over a hundred thousand in a couple of years and realising there was a problem and living with her husband who umm they had a really very strained relationship where there was a query about his behaviour towards her in terms of the relationship and what she was buying (...) err she hid some of the things from him that she was always working out how she could get rid of them she tended to slightly hoard as well so she had large numbers of handbags and he was aggressive largely (xxx) but I was always wondering how serious that was.

R: Ok, and how did you work with the issue, you know did you formulate it for her you know how was it formulated and what kind of intervention

Adam: Tended to very brief intervention uh umm I didn't want to look into I mean I didn't look into what involved why the behaviour err has I think there was, there was a suggestion that it could be formulated, but the mother was, the lady's mother was always very well turned out very well presented (...) err her clothes and her dress and err, the daughter was following that so I didn't get into the dynamics of was this, was she the least favoured child and was she trying to carry favour with the mother? Was she trying to get her mother's love through copying her behaviour? But would edit it to her in a brief six or seven sessions about the motivation the'how are we going to move forward? What are you going to do in terms of how are you going to manage your life in terms of the money? To stop your need to buy things without compulsively buying'. On a week by week basis it's quite interesting going through, you know what you've bought and actually having to look at 'ok you bought three pairs of tights there, did you plan to buy three pairs of tights there? Did you go in to just buy one?' So it's trying to tease out what was compulsive and normal behaviour which is quite interesting but it allowed her to trace her purchasing and her sort of processes of purchasing on which she bought something. So there were instances where she would buy a seventy or eighty pound dress and would think about that and reflect on it and think 'What do you think that was, did you go to buy that dress.... Well I didn't actually, but it was a bargain'

R: [Yeah]

Adam: 'Well that sounds a bit like previous behaviour as the problem was so what could you have done differently, what will you do differently next time if you go in to buy some err underwear' I think she was going to buy and err, 'if you see a dress that, How would you react differently?'. You're getting right into the moment that now and in the future so she can abstain to make bad decisions for her behaviour because compulsive behaviour, compulsive, probably it was very much the inability to see the consequences of her behaviour, the long term consequences not seeing the (...) it's a behavioural training perhaps

Bridget: Yeah, yeah she had her family giving her quite a hard time about it, really so she definitely brought that a bit to therapy 'well you know my family keep telling me not (laughs) to do it, you know I've got no money' you know she was on benefits got a really tiny flat so she hadn't got space for things and her family were always on at her to stop to kind of stop buying and to stop hoarding and she actually lost her home at one point because of these problems so yeah so she lost her home and then was just sort of staying with family. That was just before I started seeing her actually she'd just managed to get a new property and tiny little flat you know and so really wanted to try and keep it nice and stop filling it with useless (laughs) junk that she doesn't need.

R: And you mentioned there was another client

Bridget: Yeah

R: Was that a similar kind of case or?

Bridget: Yeah, umm not really no so this was a much more high functioning guy who was presenting with what we call generalised anxiety you know a lot of worry and anxiety and um sort of work relate stress umm you know a little bit of ocd umm that he was presenting with but we didn't really work with the OCD we worked more on the kind of worry and general anxiety umm but he had quite some sort of unusual behaviours around shopping and buying stuff and you know he would spend a lot of time you now on the internet surfing and spending and um not being able to resist buying stuff once the idea got into his head he would kind of do it and he, he would express no kind of interest in using these things once he'd placed the order

R: He didn't use them?

Bridget: Yeah so that was kind of a fix I guess yeah so that was umm you know something that relieved something that gave him that kind of seemed to give him some kind of relief you know giving into this urge and he would he would buy a lot of stuff that he didn't really need but it wasn't causing him a lot of distress err we did try to work with it a little bit but it wasn't the main thing that was kind of causing him a lot of distress because he wasn't getting himself into debt, he wasn't buying really high value items, he was a guy with a good professional job so you know he had money, so he could fritter to a certain extent he could fritter without it causing any particular damage. But he would sort of he had some odd, odd habits about clothes like he would always buy the shirt he would always buy several he would always buy lots of them so they were kind of stored away. I can't remember if they were different colours or all the same colour. That he would always want to have the same shirt and the same if he found a t-shirt that he liked he would always buy lots and lots of them yeah so quite an obsessive thinker if he was quite stressed at work he would sort of go to a shop and buy some really nice stationary (laughs) you know in particular colours and you know(...) yeah, and and quite buying a large number of toys for a children's party and he would spend a lot of time surfing on the internet looking for these toys and, and ordering them (laughs), yeah

R: So how would you work with these issues, like what kind of interventions did you use?

Bridget: Mmm mmm, yeah I mean I don't think it's something that I knew much about you know I don't think it's something that was covered in any part of my training this so I guess I'm just going from first principles you know thinking about what's the function of this behaviour, you know what are the associated feelings you

know before and after you know what are the triggers, is it providing some sort of general relief and some sort of short term kind of decrease in distress and anxiety and kind of causing a reinforcing effect but then is it sort of of long-term causing problems. So, just kind of you know trying to go from first principles really kind of trying to build a formulation trying to understand this behaviour with the person ummm(12.04). with the lady that I mentioned I don't think we did an awful lot of work on it because as I mentioned she had more difficulty with discarding umm discarding items but with the guy um I actually I did feel a bit out of my depth I did go to the library that we have here, um its quite a good reference and umm they um they had a book about compulsive buying so umm I got that and I was hoping that sort of first there were useful exercises and things like that umm(...)

R: and did it help?

Bridget: Yeah I think it did help actually, I think it did help...you know just sort of a few ideas about different exercises really, sort of exploring you know the behaviour and kind of yeah I'm just trying to remember but sorry could be helpful but umm the yeah I think that was quite helpful

R: And was it quite CBT based interventions that were helpful?

Bridget: Yup, yup. Umm and I, I guess I work quite a lot with like mindfulness type approaches, so you know trying to pause trying to stop and think what am I thinking right now, you know what is it that I'm doing won't work, and 'why am I on this website(laughs) why am I feeling like I have to buy all these items?'. You know just trying to slow it down and to pause and trying to observe the behaviour, you know trying to help the patient to, to kind of observe their own behaviour.

R: [Yeah]

Bridget: Detach a little but from their thoughts, say 'ok you know how are we gonna, gonna compulsive buying (laughs) type thought, do I, you know do I need to react in the same way? Or can I just maybe just let that go, just see if it maybe comes back later and try and change my focus of attention so I think maybe kind of a like mindfulness approach and you know I think maybe also kind of ideas around umm distress tolerance, can I (laughs) can I just maybe stay with this emotion and maybe it will go away? Yeah maybe it won't just keep on getting worse, you know maybe I won't give in to it maybe there's consequences of carrying on getting into it you know, yeah

R: And um was there any kind of like diagnosis in terms of like compulsive buying or

Bridget: No, no, no I mean I'm not that keen on diagnosis I mean any way as an idea because it can tend to sort of lead us up the garden path to particular interventions which may or may not be useful you know so I'm very much of the type of you know try and create an individualised formulation you know in terms of what's going on for that patient you know what they want help with and what behaviours they wanna change, umm so yeah I mean there was no diagnosis made particularly you know I mean within our service I mean we do, it's it kind of part of the way the service is set up and the way the system is set up which is that people have to be given and primary and problem descriptor I think its called, which is the diagnosis, yeah yeah so for the for the man I was talking about that would have been generalised anxiety disorder I think which is about as close as you can get to what he was presenting with and I think for the other person I think she was umm there might have been down as OCD although we didn't do much work on (laughs) ocd, it might have been down as depression I don't know but the diagnosis that comes its therefore irrelevant it's something that we kind of have to put down umm yeah and that's it's kind of obviously important for the people who

are crunching the numbers but it's not massively important really cos it's just about a kind of you know it's more about doing your formulation I think isn't it ?(...) allowing your treatment to be kind of derived from that.

Abby : Err – with the shopping? Umm I can see that when I work with the feelings more like I said with the addiction of shopping its about the symptom so they wanna get rid of something like ‘oh my god I need this’ it’s an obsession it’s a compulsion at that moment so what is it again it is working with that underneath to kind of make room or space because when someones obsessed with something their head’s very cloudy.

R: [Yes, yes]

Abby: You can't see the wood for the trees, if that's the saying and if you look at the anxiety, if you look at something you're making room for the mind for the body to settle so they can look at it calmly does that make sense? So when you're all like ‘I've got it, I've got it, I've gotta buy it, I've gotta go there, oh my god’, but actually what is it why are you're head so cloudy what is the need

R: So is it kind of umm (xxxx)

Abby: [Yes and once you've uncovered], yes or there's heads like I've got it I've got it I've got it but actually once you relieve that anxiety you might feel calmer and more grounded because it's too much up here

Tessa: Or at home on line, now that's different because if you're on your own at home online and all you do is look at stuff, if you're just looking then obviously that doesn't fit in although that in itself would end up being in the internet uses side because then because if that's all your doing then that's not all that great either. Yeah I think one other thing that would be interesting for you to look at would be the availability because the shopping online is fascinating. And I from a personal perspective actually I had an interesting experience where umm you know when you're really busy you know you don't go out to shops as much as you would like and would enjoy doing. So a couple of times I've sort clicked on things and realised I'd got on mailing lists and when the mailing list arrived I would be scrolling through clothes and then suddenly start thinking oh well I could buy this and then you get involved into that whole transaction thing... and it was only recently that I thought you know what I'm sure I'm looking at far more clothes than I would ever want to or need to.. and so I started unsubscribing from lists which I had not really subscribed to in the first place I don't know what happened. You just look at something and then, so , but I then thought ‘oh my goodness’, I thought ‘ how must it feel to suddenly in your inbox everyday get these things . And so the exposure is really vital in this field

R: [Yeah]

Tessa: As much as anywhere else. And I think that protecting people by maybe making them aware that if you're exposed to images and images every day that you will be nurtured into wanting more things or even more but it was you know, an excellent experience to, to have because I was really, you know how many shirts do you need?

R: And also the power of data, you know that there's that the data bases and how they're shared and that's the kind of impact

Tessa: Yeah yeah. So if you have the right neuronal pathways what you start to feel is the equivalent of what you feel when you're full when you've eaten you know youre

satiated by this and so you know you feel sick, you see too many images you feel sick that's not giving you the surge of pleasure you see too much.

R: Yeah

Tessa: It's only when you don't have that ability to experience saturation that you uncover the vulnerability to the addiction. Yeah.

R: So that's how you know your addicted

Tessa: Yeah, I mean I could've I could have I don't think I mean I think I ended up buying one thing but I was open to the idea of buying them and to me that was just as bad because I was open to the idea of shopping and these emails were just coming and I was looking and I was open to the idea of shopping and it was only when it was just one morning when one too many came in and I thought 'huh you know I don't need more clothes' and I thought but if I hadn't had that moment of feeling saturated that's when actually you might go more and more emails and more and more clothes

R: and I suppose that's what builds that barrier for that saturations

Tessa: yeah and I suppose that is when if your life is empty that's how you fill it up – if you don't have your sports your hobbies or your job then you just fill it up and actually we look at these women that's exactly where they come – they might have a job but they're missing...yes.

Rob: Well it I it depends on what we had time to do, basically and sometimes it's not always apparent what the initial kind of umm you know if there is a primary drive or primary kind of issue umm it's not always clear what that is and sometimes that might be, comes about as a result of that behaviour it's not always the original... issue. Umm so but being with at least I found personally I found it very enlightening to focus on the urges to separate the urges from the behaviour umm, focus on what's, what's happening at that point with the urges. Seeing that as a signal and a way forward with what's, what else is going on and that's when I talk about bringin in the awareness of what's happening because often there, there is no awareness you know there's a reason for there not being an awareness

R: Because they're..

Rob: The avoidance yeah,

R: I just want to pick up on a couple of things which you mentioned

Rob: Ok

R: Ok so one is you mentioned um talking about shopping addiction that it, it can be joked about and that it's kind of xxx and I wondered if you could say a bit more about this

Rob: Ok well I guess it's it's, this is about the culture again, and the kind of social and it comes down to being acceptable kind of what's acceptable. I think it's kind of I won't go into this at the time but it can also connect to concepts of maybe shame as well. Shame and let's say guilt but basically mechanisms that are also occurring and often do a lot with, with addictions but probably less so to some extent I think with shopping because there's an idea of it being more accepted... umm so it's at least within certain um certain social groups I think and even if we're talking in terms of femininity here and masculinity I think there, there are surely men out there who are also addicted to shopping but might be less likely to express or, or to come forward and talk about it which could be part of a larger, you know *trend in* let's say toxic masculinity, but I won't go into that. But it's just you know masc, kind of cultural gender mapped behaviours and attitudes

R: Mmm

- Rob: So umm, so maybe that's where it's less accepted, but also shopping I guess has been you know there's been a lot of, its generally quite accepted, it seems to be more socially acceptable for more females shopping as an activity. Umm and in terms of addiction perhaps in expressing it and when we talk about joking about it we can say that joking's a defence in a way but it's still there's that ...I dont know it's...there's, it's something happening there which also encourages that kind of behaviour. And it makes me think of eating disorders kind of, in a way, in a slight way, where there can be a culture of enabling and facilitating and almost kind of being competitive umm I think, I was just gonna say I realise it's murky when I think about that so I'm so I won't comment too much on it.
- R: Is that around, you know people want to be thin and then kind of the extreme of that
- Rob: Well there can be, it could be that and when we talk about the ideal, kind of idealised sense of self, so that could be there and that could be playing into it. So we have kind of cultural norms where we come to an ideal self and what we would like and then we have the less desired self aswell. So that could be, those kind of social pressures could be active in the situation, some of those mechanisms of you know kind of joking about it so with the female or maybe even that kind of competitiveness when it comes to umm achieving that idealised self whether that's as another woman or whether XXX so it could be XXX low self-esteem on an individual level but getting acceptance on a larger level and that's where also I would maybe bring in or connect to narcissism a little bit, in the sense of getting approval, but also having that idea of attaining a solid sense of self...make sense?
- R: Yeah, and just finally why do you think that it's not in the DSM
- Rob: Ummm...it I guess that's kind of a xxx contentious, so I've a little bit I've erm. If I was very pragmatic I'd say that just simply not enough evidence, and of course there's reasons why there's isn't you know there isn't the evidence there and it was the same with gambling it think it took a while for gambling to come 'till it was acknowledged and if you look at cultural forces in term of err with gambling I mean if you can look at it today where there's just a lot of forces that say you know that 'power dynamics' within a society where gambling has significance and there's a lot of money and there's a lot of people can lobby umm to protect the status quo, right, so were saying it's not a problem, we can kind of bring in that stuff related to kind of video games as well, especially gambling recently kind of the new DSM has been gambling or not and so on. But with shopping it can either go the same way in terms of cultural forces and the idea of xxx, err, it's not a problem, or indeed being dismissive of it with shopping. And it's you know I dunno I think there will be more evidence, because, simply cause it's occurring, it has to hit kind of a point in culture where suddenly it (sighs) I dunno how to describe it really but where there'd be enough momentum for it to then start
- R: [Yeah, so it's on a roll..]
- Rob: Yeah its like it an out a kind of snowballing effect where then enough people feed into it and then it's the idea of a new idea will become accepted, it could be an addiction, umm and that it can be a problem for some people and then it can be something that's not dismissed because its **yeah, you know*** as much as any other behaviours its, it's the behaviour that's the issue. That's the key thing and that's the problem it think a lot of people have with it, its difficult to grasp that it can be that distinction between the person and the behaviour. Socially our way of thinking about things relaly is I cant remember the the name of it but its a very individualistic way of functioning within society, as oppose to more of a group. So, if theres something

wrong with someone 'its in the individual' as opposed to maybe the group where actually it's everyone, it's how we think as a society, and I think that part of that that cultural way of thinking still feeds into how we address problems with mental health and the larger picture. Ok?

R: Thankyou – is there anything this has brought up for you or is there anything you'd like to add?

Rob: Umm no not really umm I think it's it brings up ideas of roles of being a psychologist and being a therapist and indeed you know how to address issues and when is a problem a problem. And whether it's a case of just fixing a problem and putting them back into saying goodbye to them and umm so I think there is an argument for a much more kind of holistic, try to avoid sounding like a yoga teacher when I say that but that kind of looking at maybe systems would be a better word, so a systemic way of seeing well how did the problem emerge, and indeed if it's a problem for the person then it's a problem. But how does that fit into the individual elements and the social? When does the problem emerge? So that's the kind of fuzzy area if you like.

R: Is that for compulsive buying you think where its..

Rob: I think it's that's a bit more of a bigger picture than it is addictions but it is especially with compulsive compulsive behaviours but there looking at also this idea of swapping one behaviour for the next and it's obviously there's the small details in terms of what determines or the environmental details of what determines which kind of behaviour can become what's kind of (xxx). But there is always that tension between the individual and the group, we see that especially with addictions.

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	Interpretative repertoires	Abby	Adam	Rob	Tessa	Marcus	Bridget
1	CB as a quick fix/chemical reaction – dopamine and adrenaline	L223, it's like adrenaline, it's a need and it's a chemical reaction as well L318, It's like the responsibilities went out the window there was like a need for a fix	L434, certainly the ones I saw it fit really nice into the addictions and conditioning work	L146, L160 with CBT we might be more of a kind of a basicer thing the kind of adrenalin model theres a clear kind of clear habitual drive based on reward....so its getting that that kick that high(14.24) from making a purchase	L94, they're using shopping as a way of self soothing, self medicating their anxieties or their really their low mood for a high to get a high for the high you know that quick fix. L127, spending money was important it's like a fix if you, the gratification comes not just with the object but when you depart from the money	L21, you click on it and you've bought it you know you've set off the neurotransmitters running around your system L272 somebody's looking for their dopamine (laughs). That's whats going on isn't it? They're looking for their fix.	L87, yeah so that was kind of a fix I guess yeah so that was umm you know something that relieved something that gave him that kind of seemed to give him some kind of relief you know giving into this urge and he would he would buy a lot of stuff that he didn't really need L112, what are the associated feelings you know before and after you know what are the triggers, is it providing some sort of general relief and some sort of short term

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	Interpretative repertoires	Abby	Adam	Rob	Tessa	Marcus	Bridget
							kind of decrease in distress and anxiety and kind of causing a reinforcing effect but then is it sort of of longterm causing problems.
2	Interchangeability and similarity to other addictions eg drinking/cocaine/eating/gambling	L35, they wanna fix themselves sometimes shopping and like food for example L106, spending, gambling, shopping it's a kind of difficult to deal with emotional space they're in and it's an addiction L296, Like any addiction, it could be like 24/7 you know you're on it and	L409, certainly, you know you sit down look at their behaviour and the way they act and a bit err, you're looking at the similarities in the processes and the same conditioning and umm words that come out of their mouth very much and the same compulsive behaviour. But	L75 L287 I look at kind of compulsive behaviours and being very, very similar. I think that behaviours that can get picked up that can become kind of sticky. I um use sticky within the kind of ACT framework, yes um so something you know, behaviour becoming kind of fused, L294, I think kind of its changeable in a way, shopping could	L77, so it would be exercise that may have been something that in the past may have been something they were very good at they may have had eating disorders in the past with control issues and then they've just let go of everything and then compulsive shopping is just one extra thing they have an issue with,	L30, it's something that I've see with any addiction which that one of my approach is to separate out the addictive behaviour from any kind of pleasure that it gives L101, my approach with pretty much any kind of addiction is whether its behavioural or substance addiction is this: firstly you look at the	L270, it does seem to have something in common with gambling, L273, I think kind of getting into an urge to do something that's kind of being reinforced in some way, (...)yeah but I don't know ummm lots I mean people use the word addiction in quite a variety of ways you know so

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	Interpretative repertoires	Abby	Adam	Rob	Tessa	Marcus	Bridget
		you lose sense of self and relationships L304, And it could even trigger eating disorders aswell if you think about it. 'Oh my god I need I don't look that good in it, I need a smaller size, actually I look big in that' But actually you probably don't.	didn't have them before the triggers, has them afterwards and the come down so umm I don't see much difference between them and compulsive gambling,	be an issue umm as much as any other behaviour can become dominant	L300 So if you have the right neuronal pathways what you start to feel is the equivalent of what you feel when you're full when you've eaten you know youre satiated by this and so you know you feel sick L306, it's only when you don't have that ability to experience saturation that you uncover the vulnerabilty to the addiction.	foundation of their emotional health. 213, L272, snort some cocaine, go gambling and all the excitement that goes with all that or...you know are they a dopamine junkie are they a serotonin junkie are they both? Where's their balance in it all? What's a better healthier way of getting that need met, more sustainable, yeah?	people say 'oh addicted to a tv show or addicted to shopping an and stuff like that so err, umm so I suppose in cog yea sort of addiction could just be a strong kind of urge to do just about anything you know how we use that kind of word err
3	Difference of experience shopping versus internet shopping - ease of online immediate gratification			L61, there was online and offline shopping, so both were an issue for him but they were both very kind of situational I guess.	L268, or at home on line, now that's different because if you're on your own at home online and all you do is look	L19 I suppose it falls into 2 categories, that which has arised since the internet and pre internet days so 2 very	

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	Interpretative repertoires	Abby	Adam	Rob	Tessa	Marcus	Bridget
					<p>at stuff, if you're just looking then obviously that doesn't fit in although that in itself would end up being in the internet uses side because then because if that's all you're doing then that's not all that great either</p>	<p>different ways of looking at it so with the internet immediate gratification, you click on it and you've bought it you know you've set off the neurotransmitters running around your system, the other is about more about the whole experience of shopping about getting dressed up getting on the train to the city centre going to the glitter of the um the shop L305 - it can happen to anybody, in terms of how easy it can be to slide into that and how the internet has facilitated it,</p>	

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	Interpretative repertoires	Abby	Adam	Rob	Tessa	Marcus	Bridget
4	Availability & accessibility as a problem/trigger		L27, with shopping we were thinking well how do you stop someone from moving around but in way very different to gambling you know how do you get someone off the high street	L316 especially with internet shopping as well the accessibility has increased hugely	L282, only recently that I thought you know what I'm sure I'm looking at far more clothes than I would ever want to or need to.. and so I started unsubscribing from lists which I had not really subscribed to in the first place I don't know what happened. You just look at something and then so , but I then thought 'oh my goodness'. I didn't think of the compulsive shoppers, I	L44, probably it's a lot more prevalent in the last few years or so because it's so much easier just to click, click on the amazon one-click L294, its so easy like that (taps table) you can download an app you know you can down load the amazon app and you can buy whatever you want you can down load a gambling app and you can click clik and you can switch between the 2 and multitask it and you're sat in bed and you don't even have to get out of bed and	L192, I guess the reinforcement is so entrenched that it can be quite hard for them to change it.

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					thought of the gamblers and then I thought ‘ how must it feel to suddenly in your inbox everyday get these things . And so the exposure is really vital in this field	youre getting all this reward for little effort you know for your lunch across the bushfelt with a spear when you know you haven’t made any effort L305 - it can happen to anybody, in terms of how easy it can be to slide into that and how the internet has facilitated it,	
5	Assumed a ‘female activity’?? – prevalence or barriers to present – wealth?	L209, Umm I don’t know if gender makes a difference but some people are particular about having lots of shoes, what is it about shoes you know that I need an extra pair of shoes?		L44, looking back at the clients I saw umm and it was more generally in terms of demographics it was more women than men L381 - theres an idea of it being more accepted... umm so	L36, these people we are thinking of middle aged women who live alone who have jobs who’ve ended up in significant debt because of the shopping err and there are often very strong	L49, I have to say that every single one that I’ve dealt with has been a female, I’ve never had a male with compulsive shopping to um either the physical shopping or the internet shopping. I’m not being sexist	

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	Interpretative repertoires	Abby	Adam	Rob	Tessa	Marcus	Bridget
		<p>L361, are they denying their femininity or are they repressing their femininity or are they frightened of attracting the opposite sex or what is it?</p>		<p>its at least within certain um certain social groups I think and even if we're talking in terms of femininity here and masculinity I think the, there, there are surely men out there who are also addicted to shopping but might be less likely to express or, or to come forward and talk about it which could be part of a larger, you know *trend in* lets say toxic masculinity, but I wont go into that. But its just you know masc, kind of cultural gender mapped behaviours and attitudes</p>	<p>underlying factors er components to the presentation L54, its always women, aprt from the guy who was schizophrenic ive really only had female compulsive shoppers as you know if you look at the literature I think you see a lot of that.</p> <p>L326, it wouldn't surprise me in asia to see a higher male rate than that to be honest now...</p>	<p>in that remark it's just my experience of it um and very often it's brought to my attention because of a crisis or a further crisis in life and the husbands or boyfriends have brought their attention to the problem there's a few oh you don't buy any more or im off.</p> <p>313</p> <p>I think the more economically fortunate you are the longer it takes you to realise it's a problem, and also that's a maths issue, you know.</p> <p>L317 - im a bloke, im male brained.</p>	

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	Interpretative repertoires	Abby	Adam	Rob	Tessa	Marcus	Bridget
				L410, that could be, those kind of social pressures could be active in the situation, some of those mechanisms of you know kind of joking about it so with the female or maybe even that kind of competitiveness when it comes to umm achieving that idealised self			
6	Need for more research/more robust evidence		L415, but there's not enough stories out there that warrant it's... L419, Well, I mean, no ones gonna come forward with umm, there's	L421, kind of a contentious issue, so I've a little bit I've erm, If I was very pragmatic I'd say that just simply not enough evidence, and of course there's reasons why there isn't you know there	L154, I really believe that to be an expert at something and to really make a pronouncement on things you need to see about a thousand cases,		

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	Interpretative repertoires	Abby	Adam	Rob	Tessa	Marcus	Bridget
			<p>not gonna be much discussion of it with umm, like I said, it comes back to money andthere's always comes back to the problem is how much is compulsive behaviour and not compulsive behaviour</p>	<p>isn't the evidence there and it was the same with gambling it think it took a while for gambling to come till it was acknowledged and if you look at cultural forces in term of err with gambling I mean if you can look at it today where there's just a lot of forces that say you know that 'power dynamics within a society where gambling has significance and theres a lot of money and there's a lot of people can lobby umm to protect the status quo, right, so were saying its not a problem</p>	<p>I really believe that L174, as more studies get collected it may be that I just haven't seen enough cases, you know it may be that in china and I think it will be somewhere like that where they really start building up the cases L238, its about understanding more about their bhr, we don't really understsnd enough about their behaviour. We don't know whether it's always the same people always compulsive</p>		

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	Interpretative repertoires	Abby	Adam	Rob	Tessa	Marcus	Bridget
					buying through out their lives or if there are peaks and you know if people do it for a while in their lives and then what is the prevalence of this across countries ?		
7	Shopping as filling time/ gaps/ emptiness/ emotional need/ way of coping with difficult emotions	L32, it's like an emptiness L45, with some people it can be I need, I need it's just it's like, it's a, it's a sort of it fills them up		L76 there learning of structure there suddenly a bit of dead time where there's a case of sometimes there's difficulty of how to fill that time and there's a feeling of uncomfortableness L257 was only an issue really when she was single. Um so after a difficult break up this is when shopping became a problem for her, so we figured it out there was protective	L40, Sometimes people have had their relationships ending, sometimes lost their marriages, have been err, experiencing low levels of self confidence or self xxx often there are issues with their ex-partner of abuse or domestic violence, there are general marital	L188, What you're doing is you're taking an emotional short cut to getting your emotional needs there and you can either do that from snorting cocaine or drinking alcohol or buying things on amazon or whatever it is or you can put some effort in and when you put effort in it tends to be a more enduring and healthy reward	L144, maybe also kind of ideas around umm distress tolerance, can I (laughs) can I just maybe stay with this emotion and maybe it will go away? Yeah maybe it won't just keep on getting worse

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				<p>factors here the way it is sometimes these protective factors would be there for a long time and something would occur there's a rupture or kind of major life occurrence occurs and then I guess with anna and peter the old kind of coping mechanisms are triggered.</p>	<p>dissatisfactions and the part of shopping is to really get that immediate gratification or boost and so that's it umm it's a combination of all the kind of cbt techniques etc L70 I've seen a lot more high functioning but socially isolated err and using it as a as a reward L82, returning to a structured approach to life in general seems to really help and when you get rid of the shopping then I think that pragmatically speaking it can be very easy to keep</p>		

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	Interpretative repertoires	Abby	Adam	Rob	Tessa	Marcus	Bridget
					<p>away from the shopping L85, for them it was almost like a manifestation of rock bottom for their type of psychological make-up L319, if your life is empty that's how you fill it up – if you don't have your sports your hobbies or your job then you just fill it up and actually we look at these women that's exactly where they come – they might have a job but they're missing/...yes</p>		

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	Interpretative repertoires	Abby	Adam	Rob	Tessa	Marcus	Bridget
8	Need to replace addictive bhr with something 'better'			L474, especially with compulsive, compulsive behaviours but they're looking at also this idea of swapping one behaviour for the next and its obviously there's the small details in terms of what determines or the environmental details of what determines which kind of behaviour	L52, so you'd you can get people to feel better but unless you replace the activities with other better activities and there are lots so for these L72, what has worked well has been replacing the shopping with exercise, err <u>at the risk</u> maybe of them becoming addicted to exercise you know I totally understand, but on the other hand it does boost self-confidence and it is <u>the</u> most effective way I've found to get them through and to, to change tack	L146-148, so it's a matter of helping them design and build a life that works without that compulsive shopping, and that it's you are clever it's what do you do instead of the compulsive shopping L203, now let's try to replace that with instead well go for a walk somewhere, or you know well go for some kind of experience you know reconnect with some friends that you haven't seen for a long time, or take up ballroom dancing or church bell ringing or cake sales or something or being part of the community rather	

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	Interpretative repertoires	Abby	Adam	Rob	Tessa	Marcus	Bridget
						than the isolation that you're getting through by yeah does that make sense?	
9	Compulsive Buyers need to 'pause' before make 'bad' choice, controlling impulse – emotional vs rational brain		L371, that's where the CBT helps in terms of with getting down right to the moment, of imagining the next moment and looking back at the last moment and looking to the next moment. Using hindsight and foresight and seeing, right, whenever you're in a situation how're you gonna manage the situation			L116 Firstly to buy time to sit at the crossroads or the fork in the road and use their thinking brains to decide whether they're going down the left-hand side where they've been a thousand times before and they've always ended up back here, more addicted or whether to take the right hand path where they will end up with a lot better life	L132, I guess I work quite a lot with like mindfulness type approaches, so you know trying to pause trying to stop and think what am I thinking right now, you know what is it that I'm doing won't work, and 'why am I on this website(laughs) why am I feeling like I have to buy all these items?'. You know just trying to slow it down and to pause and trying

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	Interpretative repertoires	Abby	Adam	Rob	Tessa	Marcus	Bridget
			<p>getting people to really look</p> <p>L92, You're getting right into the moment that now and in the future so she can abstain to make bad decisions for her behaviour because compulsive behaviour, compulsive, probably it was very much the inability to see the consequences of her behaviour, the long term consequences not seeing the</p>				<p>to observe the behaviour, you know trying to help the patient to, to kind of observe their own behaviour.</p>

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	Interpretative repertoires	Abby	Adam	Rob	Tessa	Marcus	Bridget
10	Not 'main problem' - secondary – CB as part of another problem	<p>L44[yes] exactly it hasn't been their primary no it's it's like a err it's like a bypass it's a it's it's it's a package its you know it's with some people it can be I need, I need it's just it's like, it's a it's a sort of it fills them up. R: so it wasn't the presenting issue? P1: No, cos I remember when you were saying um it is yeh it is problematic issue it was erm it was like an addiction that as a whole not to feel some people are just from</p>		<p>L345, often I see urges as well urges as well as a signal that something isn't quite right and that can be err with a huge amount of comorbidity, L356it's not always apparent what the initial kind of umm you know if there is a primary drive or primary...kind of issue umm its not always clear what that is and sometimes that might be, comes about as a result of that behaviour its not always the original... issue</p>	<p>L20, A lot of the other cases are patients of mine who have alcohol disorders or drug dependencies mainly cannabis though not any cocaine necessarily or heroin umm but people with depression or anxiety who present with the co-morbidity L142, in recent times maybe in the last year as I said I think there has been such a heavy emotional undertone to the presentations that you realise that the weight you carry for the patients is really in other realms</p>		<p>L27,issues with compulsive buying have usually presented themselves as part of another problem rather than you know being the main problem that somebody just wants help with L75, a much more high functioning guy who was presenting with what we call generalised anxiety you know a lot of worry and anxiety and um sort of work relate stress umm you know a little bit of ocd umm that he was presenting with</p>

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	Interpretative repertoires	Abby	Adam	Rob	Tessa	Marcus	Bridget
		<p>anxiety or just not to feel that energy to so it's what's going on at that moment for that moment to be out of control does that make sense? That, err feel out of control you what is the underneath issue what is it that is causing it like the anxiety could be a way of feeling or making themselves or enhancing their self-esteem by looking good or they're too much focus on the inside what's going on for them are they compensating?</p>			<p>not in the compulsive shopping which is just a manifestation of everything else that's going on</p>		

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		Yeah so what is it ahh..I wanna look good but actually whats going on inside? Whats the security in clothes?					
11	Highly motivated/ shame as motivator??		L36, was extremely motivated in that she had been umm was discovered by the family to have taken a hundred thousand pounds of her mother's money	is about the culture again and the kind of social and it comes down to being acceptable kind of whats acceptable. I think its kind of I wont go into this at the time but it can also connect to concepts of maybe shame aswell	L104, I always expected there to be maybe more shame involved but I think there is anxiety financially but not so much shame involved as maybe the other behavioural addictions that were familiar with like the sexual or porn watching		L61, she had her family giving her quite a hard time about it, really so she definitely brought that a bit to therapy 'well you know my family keep telling me not (laughs) to do it, you know I've got no money' you know she was on benefits got a really tiny flat so she hadn't got space for things and her family were

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	Interpretative repertoires	Abby	Adam	Rob	Tessa	Marcus	Bridget
							always on at her to stop to kind of stop buying and to stop hoarding and she actually lost her home at one point
12	Learning theory and CBT model as best fit /whats available				<p>L24, when I see these patients I either test the comorbid stuff and use stimulus control with the triggers but I don't enter into psychodynamic</p> <p>L49, so in terms of the interventions or what you've seen that works is very much the approach is CBT?</p> <p>P4: yes because umm anything that</p>	<p>L230, get them to weigh up the evidence and then there's no distress for their cravings or or anything like that and you've got something else for them to do instead of their destructive behaviour then it tends to work</p>	

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					isn't so pragmatic doesn't seem to work		
13	Behavioural addictions as 'contentious'			L32- behavioural addictions which are somewhat contentious in some ways in thinking well there is kind of growing evidence that other kind of behaviours might be eventually acknowledged in the same way that say gambles have been acknowledged so you know originally it was an impulse disorder now of course it's an addictive behaviour in the DSM L438, it has to hit kind of a point in culture where suddenly it (sighs) I dunno how to	L205, I think among serious researchers because it's not quite clearly defined I think it's an area people are quite tentative about I think like actually a lot of other behavioural addictions		

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				<p>describe it really but where there'd be enough momentum for it to then start</p> <p>R1: [Yeah, so its on a roll..]</p> <p>P3: Yeah its like it an out a kind of snowballing effect where then enough people feed into it and then it's the idea of a new idea will become accepted, it could be an addiction, umm and that it can be a problem for some people and then it can be something that's not dismissed because its yeah, you know* as much as any other behaviours its , it's the behaviour that's the issue. That's the key thing and that's</p>			

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	Interpretative repertoires	Abby	Adam	Rob	Tessa	Marcus	Bridget
				the problem I think a lot of people have with it, it's difficult to grasp that it can be that distinction between the person and the behaviour.			
14	Money as a 'problem'		L326 money addiction is the biggest problem we have I think in society, umm a lust for cash is across everything so if you look at every health service now it's been turned into a business, school are a business, at my child's school you have to pay a hundred and fifty pounds a year now for essential kit				L91, it wasn't the main thing that was kind of causing him a lot of distress because he wasn't getting himself into debt , he wasn't buying really high value items , he was a guy with a good professional job so you know he had money, so he could fritter to a certain extent he could fritter without it causing any

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			<p>and err if that wasn't spent on marketing and that wasn't spent on boosting their league tables you know because they're a business you know and they're seen as a business and they have to use their money in a certain way but if you think its complete insanity I always think in a thousand years you know it's the legacy on society. Money addiction and longing are probably the</p>				<p>particular damage.</p>

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			two things that will stand out.				
15	Weighing up evidence - consequences of behvr					229	
16	Corporate greed as driving and encouraging the culture of wanting more			<p>L303 certain level of acceptance there which makes it different and makes its etiology a kind of a little bit different from other addictions. Umm but its really the case of kind of whats in front of you as you develop, whats in your environment as you grow</p> <p>L451, its a very individualistic way of functioning within society, as oppose to more of a group. So, if there's something wrong with someone 'its in the individual'</p>	L292, I think that protecting people by maybe making them aware that if you're exposed to images and images every day that you will be nurtured into wanting more things or even more	<p>L325 - I guess I mean I could get on my political orange box about it.. a lot of the ills of the western world are driven by corporate greed and</p> <p>L352 - Yeah its more stuff and its driven by you know the salesmens best weapon is fear of loss..'if you don't buy this the you won't look like kim Kardashian or if you don't buy this pension then you won't be looked after when you're grey and old and they've got really</p>	

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	Interpretative repertoires	Abby	Adam	Rob	Tessa	Marcus	Bridget
				as opposed to maybe the group where actually it's everyone, it's how we think as a society, and I think that part of that that cultural way of thinking still feeds into how we address problems with mental health and the larger picture. O		good at that you know L360 - that's what advertisers and marketers prey on. So don't buy any stuff	
17	Anticipation and obsessing about purchases	L177, when someones obsessed with something their head's very cloudy. L183, So when you're all like 'I've got it, I've got it, I've gotta buy it, I've gotta go there, oh my god', but actually what is		L165, Umm in getting a purchase it could be getting a purchase of something that maybe, you know there there it could even be a a slow build up to this so with peter there was the implication he would obsess or ruminate about this item, something that would be really quite um, you know,			L101, so quite an obsessive thinker if he was quite stressed at work he would sort of go to a shop and buy some really nice stationary (laughs) you know in particular colours and you know(...) yeah, and and quite buying a large number of toys

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	Interpretative repertoires	Abby	Adam	Rob	Tessa	Marcus	Bridget
		it why are you're head so cloudy what is the need		something that would really improve him in some way. Umm and this I think is			for a children's party and he would spend a lot of time surfing on the internet looking for these toys and, and ordering them (laughs), yeah
18	CB as act to improve identity and image	L53, the anxiety could be a way of feeling or making themselves or enhancing their self esteem by looking good L203, its their self-worth and their self esteem and like I said they compensate what they don't feel inside so they want to feel good on the outside		L170, 197, 200 so in that sense yeah its its about identity...I think. And it is about self, so the construction of self, and the construction of self image. mean L248 hed buy things and then he'd get praise within his social , he was very outgoing, very um had lots of friends had a strong kind of firmeds network and part of this was kind opf building his	L112, the compulsion is <u>really</u> there and you realise it when they tell; you that theyre buying you know 4 versoons of the same thing but that all 4 versioons may remain int the packet you know in the wardrobe that theyre buying 2 or 3 sizes or not buying their own soze at all because its not		L221, he would tell some very kind of detailed stories about how he wanted to get a camper van and how he was obsessed about getting a camper van and how it was only a matter of time before he got a camper van and he kept thinking about it and um a lot of worry a lot of worry about whether it was going to be the

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	Interpretative repertoires	Abby	Adam	Rob	Tessa	Marcus	Bridget
				<p>repairing his self esteem and getting feedback from others saying 'ah you look great!'</p> <p>L281 she would very much get a high from her friends kind of saluting her on her sense of fashion</p> <p>L277 a sense of rebuilding and repairing something</p>	<p>just about the compulsive buying but its about buying to feel better about a future where you will be thinner.</p> <p>L122, very interesting theyre not, the patients I've seen were not buying you know technical equipment or you know if someone wants to spend money there are very easy ways of getting rid of a lot of money quickly you just like hitech stuff or what ever, no these were repeated out in clothes shops multiple items</p>		<p>right choice of camper van</p>

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	Interpretative repertoires	Abby	Adam	Rob	Tessa	Marcus	Bridget
					L. 132, it sounds a bit like identity as well <u>intrinsically linked</u> um and idealised version and a journey to thwat idealised self so you end up with 3 blue dresses and each sizre is smaller and you know you kind of you almost err its wishful thinkgni in and almost objectified way, yeah		
19	CB as act of entitlement						L248, I felt that, I felt that what she was saying was that shopping was about, it was about entitlement, you

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	Interpretative repertoires	Abby	Adam	Rob	Tessa	Marcus	Bridget
							know it seemed to be about you know I deserve these lovely thing I should have these things

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	Ideological dilemmas	Abby	Adam	Rob	Tessa	Marcus	Bridget
1	Same as gambling yet different		L324, 416	L40, I guess it's like my understanding or approach is really like within that framework of ok it's like gambling L424 the same with gambling it think it took a while for gambling to come till it was acknowledged and if you look at cultural forces in term of err with gambling I mena if you can look at it today where theres just a lot of forces that say you know that 'power dynamics within a society		L24 I guess it also comes back to gambling addiction which I've dealt with over the years. Is it somebody sitting there constantly clicking (taps table) or is it someone who goes to a casino and enjoys the whole experience? L212, I think there's subtle differences in causation but form my point of view as a psychotherapist there's not much difference in	L241, I mean you could position it as kind of impulse control umm, is that different to addictive addiction , yeah I think it is, but then is it very different from like a gambling addiction? Not really umm so so yeah I think its quite a complicated and I think its similar to other things L261, maybe I mean maybe it's been conceptualised as something you don't get

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	Ideological dilemmas	Abby	Adam	Rob	Tessa	Marcus	Bridget
				<p>where gambling has significance and theres a lot of money and theres a lot of people can lobby umm to protect the status quo, right, so were saying its not a problem, we can kind of bring in that stuff related to kind of video games as well, especially gambling recently kind of the new xxx has been gambling or not and so on.</p>		<p>the terms of how to do something about it L270 there's obviously differences between the 2 umm significant differences between the two but there's the same mechanisms, somebodys looking for their dopamine (laughs)</p>	<p>a reward from whereas gambling you can get a reward, I dunno but it doesn't make much sense to me err I think it can be like a little bit arbitrary as to what's kind of been put under that bracket like of an addiction or hasn't</p>
2	<p>Need for abstinence yet abstinence impossible – all have to shop</p>		<p>L26, a lot of the work is around not indulging in the behaviour which is really easy with</p>	<p>L132, Of course, this is the difficulty with compulsive</p>			

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	Ideological dilemmas	Abby	Adam	Rob	Tessa	Marcus	Bridget
			gambling and porn but with shopping we were thinking well how do you stop someone from moving around but in way very different to gambling you know how do you get someone off the high street but we still had to have people who were using money and going shopping whilst stopping the shopping L424	buying umm and treating it umm in comparison to gambling where we can look for complete abstinence. With buying of course it's very difficult			
3	Psychodynamic approach as unnecessary or unfunded, yet gets to deeper issues – <i>advocating CBT, yet unsure what works</i>	L242, Yeah, over time there's a lot of childhood work you go back over time and see, there's some past issues and some trauma as well	L69, so I didn't get into the dynamics of was this, was she the least favoured child and was she trying to carry favour with the mother? Was she trying to get her mother's love through copying	L82, there was a history of a fairly traumatic childhood and not a particularly secure base,...L90 we didn't really dig into it too much because			L109, yeah I mean I don't think it's something that I knew much about you know I don't think it's something that was covered in any part of

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	Ideological dilemmas	Abby	Adam	Rob	Tessa	Marcus	Bridget
			<p>her behaviour? But would edit it to her in a brief six or seven sessions about the motivation L107, It was a short period of time I mean she was a lady in her sixties, so I have my own set of beliefs about the utility of going into sort of um another formulation of her own life, umm I didn't see the sense in talking about it and I thought there'd be no utility to gain talking about it, umm and I think I was also motivated by umm wanting to see if the learning theory I</p>	<p>it's fairly short-term treatment but there was something very difficult for him to tolerate about being alone L185 evidence seems to suggest cbt is less effective when they're suffering or its connected to a developmental disorder or well, early trauma, yes. So that philosophy means that there's just something else happening you know it's not just you know it's not just a habit that's picked up whenever you</p>			<p>my training this so I guess I'm just going from first principles you know thinking about what's the function of this behaviour L328, you know psychologists aren't happy unless they've got an inventory for something are they? It was something like the, the savings inventory and then it's got 3 sub categories you know kind of three kind of clusters for it and I find it kind of</p>

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	Ideological dilemmas	Abby	Adam	Rob	Tessa	Marcus	Bridget
			<p>was working with was appropriate</p>	<p>get a dose of dopamine and its rewarding, it can be something else that's contributing to umm to that behaviour umm which can make it harder to shift. L202 I could see him in the CBT model but this is where it could have been quite useful to maybe have a bit more of an emphasis on...um his childhood, umm growing up and how that identity was developed. Umm and im thinking about</p>			<p>irritating that your kind of drawn to use those kind of tools you know? Because you're kind of thinking I suppose were stuck between trying to be scientific and measuring stuff and trying to kind of trying to just see what's going on you know and one of those measures was the excessive acquisition , the compulsive buying</p>

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	Ideological dilemmas	Abby	Adam	Rob	Tessa	Marcus	Bridget
				<p>tyat within a kind of um a I guess a framework that includes narcissism , im thinking of the psychodynamic defienintion, umm and I think well perhaps low self esteem as well L211-222 L240, thinking y'know the treatment pathways and is one any better than the other or maybe is it that split between the dopamine and adrenaline way of thinking about things or the relationship,</p>			

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	Ideological dilemmas	Abby	Adam	Rob	Tessa	Marcus	Bridget
				interpersonal and that maybe that's split was there with some of the clients, its certainly there with gambling L464, I think there is an argument for a much more kind of holistic, try to avoid sounding like a yoga teacher when I say that but that kind of looking at maybe systems would be a better word, so a systemic way of seeing well how did the problem emerge, and indeed if it's a problem for the person then it's			

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	Ideological dilemmas	Abby	Adam	Rob	Tessa	Marcus	Bridget
				a problem. <i>(also for 4. Below)</i>			
4	Not ‘main problem’ yet something clients wanted to work on – what makes something a problem/...validity??	L124, make conscious effort to, to minimise the spending or the, the overspending or they can catch the underlying feeling that’s causing it. If they’re in denial it’s very difficult to look at it and they have to be ready and to look at there was one there not even ready and if theyre not even ready like with any addiction its very difficult to break the defence mechanism. They have to be open to actually this is an issue.	L 80, So it’s trying to tease out what was compulsive and normal behaviour which is quite interesting	L375 - is about the culture again and the kind of social and it comes down to being acceptable kind of whats acceptable. I think its kind of I wont go into this at the time but it can also connect to concepts of maybe shame aswell L469 But how does that fit into the individual elements and the social, when does the problem emerge? So			L208, You know it probably brought up some thoughts for me about whether umm you know whether I’m being judgemental about you know calling something a problem, you know because I’m think it sounds problematic, umm. L212, you know like ‘hes describing a few things from his life and its not really

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	Ideological dilemmas	Abby	Adam	Rob	Tessa	Marcus	Bridget
				that's the kind of fuzzy area if you like			bothering him, its not kind of bankrupting him and just to try to be careful that were not kind of seeing it as kind of 'the' problem, hes not seeing it as kind of the main problem.
5	'Lack' of shame, yet motivated because family found out/ financial difficulties – spouse/ family. Also hid bought objects/ don't use/ wrong size – suggests shame					L54 Im not being sexist in that remark it's just my experience of it um and very often its brought to my attention because of a crisis or a further crisis in life and the husbands or boyfriends have brought their attention	L57, maybe she needed to gain my trust you know have my trust a little bit in the relationship before she revealed these things maybe there's a certain amount of shame around it you could speculate but,

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	Ideological dilemmas	Abby	Adam	Rob	Tessa	Marcus	Bridget
						<p>to the problem theres a few oh you don't buy any more or im off. Crisis has forced some kind of intervention</p>	<p>but um yeah she seemed to bring it up quite easily yeah, yeah she had her family giving her quite a hard time about it L309, he did feel quite awkward about talking about it , he did feel quite weird about it he was just like 'oh it's just really awkward to talk about it I remember that we'd do this oh just say it out loud that I've got six t-shirts that are the same so you know</p>

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	Ideological dilemmas	Abby	Adam	Rob	Tessa	Marcus	Bridget
6	Other addictions as 'more important' or stronger/taken more seriously		L389, there's not enough funding for the things that need it at the moment erm so are they you, know erm you have a funding panel perhaps and you have five studies and three on counts that one of them aren't it's probably not going to go to compulsive buying erm until you find someone who's erm got an element of ...		L158, I would say that the underpinnings of this as a behavioural addiction are not as powerful in terms of the addictive nature of the action as the gaming or the gambling and so or some of the other internet activities like porn, I think therefore that you need the psychological vulnerability from a psychological perspective to be there far more than for the other more		

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	Ideological dilemmas	Abby	Adam	Rob	Tessa	Marcus	Bridget
					<p>powerful behavioural addictions L166, I think you might be quite possible to find someone with shopping addiction someone who could manage their own credit cards a year down the line, whereas I can't say that about gambling I can't say that someone without restrictions and a serious history of porn addiction would be able to manage their own</p>		

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	Ideological dilemmas	Abby	Adam	Rob	Tessa	Marcus	Bridget
					<p>impulses...I think you know if there is a range of strengths this falls in the lower end so I think it's unlikely to properly end up in the DSM you know the next version of the DSM,</p> <p>L189, I think it's a self-limiting action the shopping what money they can spend and umm I believe that that has an inherent, acts as an inherent break to the</p>		

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	Ideological dilemmas	Abby	Adam	Rob	Tessa	Marcus	Bridget
					<p>addiction because there's only a finite number of goes you can have you can argue that with gambling, but potentially because you are buying <u>dresses</u> rather than you know £2 for a gamble the dopaminergic surges you get you might get 2 or 3 but it's not that constant you know gaming L209, if you look at the general population it's a term that is sometimes</p>		

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	Ideological dilemmas	Abby	Adam	Rob	Tessa	Marcus	Bridget
					<p>used in a fun-loving way for people who enjoy spending their money and there are people who define themselves as I'm a shopping addict and um the way that being an addict is used in general language err for fun as er describing someone who feels so strongly about something so so. L243 Err im really interested and I think there</p>		

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					is a whole load of work to be done and I think it's only when the work is done that I think we can start to take it seriously		
7	Not wanting to 'label' or diagnose yet diagnosis led service?					L153	L151, I'm not that keen on diagnosis I mean any way as an idea because it can tend to sort of lead us up the garden path to particular interventions which may or may not be useful you know so I'm very much of the type of you know try and create an

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	Ideological dilemmas	Abby	Adam	Rob	Tessa	Marcus	Bridget
							individualised formulation L157, within our service I mean we do, it's it kind of part of the way the service is set up and the way the system is set up which is that people have to be given and primary and problem descriptor I think its called, which is the diagnosis
8.	Similar to eg eating disorders – encouraged and facilitated yet disapproved of		L96, it's a behavioural training perhaps in the same way the gambling see's one, one bet 'well this isn't going to	L394, Umm and in terms of addiction perhaps in expressing it and when we			

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	Ideological dilemmas	Abby	Adam	Rob	Tessa	Marcus	Bridget
			<p>be harmful', well lets take this forward, 'so if you buy this, is this going to wake up a behaviour that's going to lead to a problem here</p>	<p>talk about joking about it we can say that jokings a defence in a way but it's still there's that ...I dont know, it's...there's, it's something happening there which also encourages that kind of behaviour. And it makes me think of eating disorders kind of, in a way, in a slight way where there can be a culture of enabling and facilitating and almost kind of</p>			

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	Ideological dilemmas	Abby	Adam	Rob	Tessa	Marcus	Bridget
				being competitive umm I think, I was just gonna say I realise its murky when I think about that so I'm so I won't comment too much on it			

Appendix K: Subject Positions

	Subject Positions	Abby	Adam	Rob	Tessa	Marcus	Bridget
1	CB's as gotten out of hand/ hiding activity - shame		L50, as well she could see the damage that she'd done pretty badly and she was aware of everything had got out of hand and umm as I say over a hundred thousand in a couple of years L56, she hid some of the things from him that she was always working out how she could get rid of them she tended to slightly hoard as well so she had large numbers of handbags				L81, you know he would spend a lot of time you now on the internet surfing and spending and um not being able to resist buying stuff once the idea got into his head he would kind of do it and he, he would express no kind of interest in using these things once he'd placed the order
2	Corporations and advertising as controlling behaviours and corrupting influence on societal values and mental health		L283, Compulsive buying is what we're meant to be doing on a daily basis. I mean there's, I was walking in the tube yesterday and I'd seen a photo of this before, and there's a tube tunnel in Victoria with no adverts on it ...it was just bizarre and it had been put on twitter	L102, there'd be some kind of very effective shopping marketing going on which would then land in his inbox and then so Saturday and Sunday he		L285- You have to Understand that without meaning to sound dramatic were in the middle of an anxiety epidemic in the western world and theats driven by lots of things, you know	

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			<p>because people had looked at this and it's like a hundred yard walk or something wall to wall no adverts and it just makes you think well hang on a minute you know the degree to which we are bombarded at every step, everywhere we go you know, up and down the tube, you know, pictures on the tube, everywhere you go, you're bombarded with 'buy this, buy this, buy this'. And we're driven to doing this and you could say the same about gambling and adverts and the goal of the adverts seems to be it's socially acceptable to buy as much as possible, you keep spending, err ,but that's the contradiction in society, where the let's say third attitude that if you're going to overstep the mark then they're going to come down on you hard.</p>	<p>might look at his emails and so that would trigger buying, L137, because of course this you know this is part of our society we have to buy so it's a very it is a bit more difficult to manage L296if we look at it culturally there theres an argument for kind of materialism and shopping , not shopping only really being an issue in a society or certain kind of societies (25.28). but that that I think introduces the idea of what</p>		<p>media, aspirations, expectations, we can be talking about that for hours and hours but generally people are less and less happy in their own skin, some sense that whatever it is we've been chasing for a long time, be it economic wealth, good fortune love, lust, you know all those things have less value than they thought they might have and so theres a bit of a vacuum and it's like well what now what next and part of that has driven bhr like gambling and addcitive bhr because it's so easy like that (taps table)</p>	

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			<p>R: So it's kind of accepted, but also if it's too much...</p> <p>P2: [It's acceptable], it's the, the general rule of or philosophy it's the general taboo of...sort of thing where everyone else does the same and everyone's born the same and that is a landban type of personal responsibility of everyone's responsible for their own behaviour, now that is umm that's walter mongay...had a fantastic way of describing it but I can't remember what it was umm but err it's the ability that everyone is responsible for what they do and therefore every capitalist entity is allowed to do what they want to do in terms of enticing people to behave in a certain way and all that means is it's not over the line the markers as the mild communist markers</p> <p>L419, Well, I mean, no ones gonna come forward with</p>	<p>cultural norms there are for very simple behaviours</p> <p>L479, there is always that tension between the individual and the group, we see that especially with addictions</p>			

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			<p>umm, there's not gonna be much discussion of it with umm, like I said, it comes back to money andthere's always comes back to the problem is how much is compulsive behaviour and not compulsive behaviour? You know, what is overspending, you know, how many people believe, how many people overspend, or are spending over their means? There's people spending or spending more than they need, hundreds and thousands on their credit card, debts, car, spending out - is this compulsive behaviour? As I say, overspending is encouraged by the government. Is it compulsive behaviour when it's a socially encouraged...</p>				
3	Therapist as expert/guide yet also unsure what is	L235, you've got to break down their denial. And it's, and it's you've kind of got	L73, how are we going to move forward? What are you going to do in terms of how are you going to manage your life in terms of the	from a psychiatric perspective err the stimulus control side that		L98, 105, 126 - 136 'in subtle, clever ways'	

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	working on a deeper level	to work with round we looked at their self esteem and they got it that working on the inside stuff building that resilience, building a sense of self building their confidence rather than a false sense of security around clothes, around this around the relationship it was like that	money? To stop your need to buy things without compulsively buying'	we would use here with other behavioural addctions is still hugely important so you still teach them how to err delay gratification how to be aware of environmental cues and triggers, how to a lot of the time cancel a lot of the cards that they've got, how to sometimes use even the same financial management techniques that we use for gamblers			
4	Therapist left wondering about more to the story –	L329, Why not food? What is it about the shopping that	L58, he was aggressive largely (xxx) but I was always wondering how serious that was.				

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	psychodynamic perspective	causes you that drives you to your primary. That's what I would question if, why not drugs, or why not alcohol what is it about shopping that creates this issue for you why don't you turn to something else					
5	Therapist as 'inexpert', not sure what works						L109, yeah I mean I don't think it's something that I knew much about you know I don't think it's something that was covered in any part of my training this L121, I actually I did feel a bit out of my depth I did go to the library that we have here, L184, Sometimes we can help

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							people a little bit but often we we don't have anything new to say or we don't have anything that's gonn gonna make a difference for them and I feel with these patients that perhaps that might have been the case, that it was some you know maybe I could make them you know help make some smaller changes
6	CB's 'cant be trusted'				L65, They will have a period of three months or 6 months and then they take things in hand, they decide you know		

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					I'm not that person		
7	DSM-V as business vehicle to get paid – cynicism about validity of diagnoses and DSM?					L238-250 ‘ its all about money’	