Abnormal Consumer Behavior: A Model of Addictive Behaviors
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I have been asked to speak about abnormal consumer behaviors specifically from an addictions model. My comments will attempt to pull the four papers in this session together, but I also hope to present some information about commonalities across a wide spectrum of addictive behaviors, including such things as compulsive collecting and compulsive spending.

One of the presenters this morning defined deviant behavior as "any behavior which differs from the normal standard". I submit that we would be hard pressed to defend this definition due to the difficulty in defining the term "normal". Many definitions of deviant behavior are very subjective and emotionally laden in nature, and often the term "deviant behavior" arises whenever someone else is doing something we ourselves don't like or approve of. For example, in the not-so-distant past people who indulged in consumption of a drug or engaged in some other form of activity to the point of social or physical harm, and continued with such behavior despite expressed intentions to stop, and despite recommendations from others, were said to be suffering from a form of mania, such as dipsomania, narcotomania, kleptomania, or pyromania, to name a few. They were often seen to be in the grip of "morbid appetites" or "diseases of the will". Although such language is largely outdated, the phenomenon to which this language referred have continued unabated, and the repertoire of addictions has even expanded. Addiction to alcohol and drugs is well known, of course. Compulsive gambling is another well known addiction. In recent years various eating disorders have been conceptualized as types of addictions to food. We are also hearing and learning more about sexual addiction, addiction to work ("workaholics"); some people are examining addiction to video games. We also hear of addiction to spending (as mentioned in this conference), exercise addicts, people addicted to religion, and others. Currently there are many researchers attempting to examine and understand these phenomenon more completely.

History teaches us that the same behavior can be viewed from totally different perspectives depending on the fashion of thought at the time, and the orientation of the observer. For example, some addictive behaviors have been viewed as non-problematic overindulgence (in the early days of the United States, drinking to the point of drunkeness was common, but was seen as non-problematic overindulgence), sinful behavior, criminal activity, as a disease, as maladaptive behavior, and as deviance. Many of these perspectives lose their objectivity in emotionality and value laden beliefs and attitudes.

What I would like to do this morning is to discuss various addictive behaviors, looking for patterns and commonalities across addictions.

All addictions externalize themselves in compulsive behavior. Addictions are characterized by repetitive loss of predictable control of the addictive behavior, which results in adverse consequences (i.e., life problems) for the individual, and in many cases, for the family members and friends of that individual as well.

An operational definition of "loss of predictability": On any given occasion, once the addictive behavior begins, the individual cannot reliably predict where it will stop for that occasion. For example, an alcoholic may plan to drink only three drinks and stop, and may do that on several occasions. However, he may find that sometimes but not always (unpredictable but repetitive) he plans to drink three drinks and ends up drinking many more than that, and suffers negative consequences as a result, (e.g., DWI). Similarly, a compulsive consumer, once a spending binge begins, may or may not stop when or where he or she planned to on that given occasion. This phenomenon also holds true for gamblers, compulsive overeaters, sex addicts, and others.

Therefore an operational definition of an addict is someone who (a) engages in the addictive behavior, (b) has problems because of that behavior, and (c) keeps doing it again and again anyway in spite of destructive consequences. These "problems" can fall into many categories along the biopsychosocial continuum: for example family problems (arguments, physical and/or psychological abuse, separations and divorce, homicide in extreme cases, affecting spouse, children, parents, and other relatives); monetary problems (cost of engaging in the addictive behavior itself; secondary cost, for example, cost for treatment, fines, restitution, etc.); health problems (this is especially notable with alcohol and/or drug addiction, eating disorders, and sex addiction); emotional-health problems (low self-esteem, guilt and remorse over engaging in the addictive behaviors, depression, despair, a sense of failure for being out of control, irrational resentments, etc.); legal problems (including arrests and fees); job problems (impaired performance, loss of job, underemployment due to instability, etc.); social problems (including loss of friends, social withdrawal and isolation).

The following are commonalities across addictive behaviors:

1. The individual engages in the behavior and finds it pleasurable and rewarding.
2. There is an increase in preoccupation with the addictive behavior or activity.
3. There is an increase in the frequency of the addictive behavior, accompanied by loss of interest in other activities.
4. The addict begins to demonstrate defensive reactions, either overtly or covertly, to family members and others concerned about his or her overindulging in the addictive behavior.
This defensiveness is an early manifestation of the psychological mechanism of denial. Denial is a primary characteristic of all addictions. Denial is a psychological defense mechanism which serves to block the addict's awareness that continued participation in the addictive behavior has become destructive, that these behaviors are now causing additional life problems. Denial is extremely subtle and extremely powerful in helping the addict to continue to engage in the addictive behavior and feel justified in doing so. In fact, the addict truly believes that he or she engages in the addictive behavior to obtain relief from all other life problems and stressors. It is common for addicts to describe engaging in the addictive behavior as the only source of relief from their perceived stress. In actuality, however, although the addictive behavior provides some measure of temporary relief from the perceived stress, it is short-lived and the stressors subsequently re-emerge. This then triggers another cycle of the addictive behavior, and so on in a downward spiral of addiction. This cycle generally continues until the addict experiences a major life problem which forces the issue into the open.

5. Addicted individuals periodically experience a craving, or a longing to engage in the addictive behavior, coupled with an unrealistic expectation of anticipated relief or escape from physical discomfort or emotional distress.

6. Addicted individuals continue to engage in the addictive behavior, defending it and justifying it through excuses in spite of increasingly adverse consequences. Early in the course of the addiction, these are generally situation-specific (and, typically, plausible) excuses to justify an episode of addictive behavior to others. Later, however, these excuses and justifications become increasingly more global and nonspecific in nature. They involve an increasing distortion of reality to minimize the addict's awareness of the harmful consequences directly resulting from the addictive behavior.

7. As the life problems escalate, the addicted individual becomes aware, at some level, that the addictive behavior is causing life problems. The individual then makes repeated and varying attempts to control the addictive behavior, which invariably fail after only a short time. (Examples of these attempts to control the behavior include: making promises to oneself or to others to stop, or to engage in the behavior only at certain times; attempt to regulate the duration of the episode or the frequency of the episodes; attempts to regulate the place where it occurs; repeated (broken) promises to quit altogether).

8. The function of the addictive behavior in the person's life changes. That is, initially, the addictive behavior is pleasurable, rewarding in and of itself. In later stages, however, the addictive behavior is engaged in to provide relief from perceived discomfort, pain, and distress. In a sense, the addicted individual engages in the addictive behavior in an effort to essentially self-medicate, that is to do something to help himself/herself feel better quickly, to gain relief from perceived stress. The problem of course is that the relief is only short lived, and is often destructive, causing additional problems for the person and his or her family members and friends in the long run.

9. The individual's tolerance to anxiety and other unpleasant emotions is diminished, and the person's repertoire of alternate adaptive coping skills, responses, and mechanisms to deal with these negative states are gradually extinguished through lack of use. Engaging in the addictive behavior becomes the addict's only perceived option for relief when under stress. (This, of course, is the key to intervention in the initiation of change in addictions treatment. The addicted individual learns that there are many alternative choices, and gains practice utilizing them.)

10. "Enabling" is common in families of addicted individuals. In their efforts to help, family members very often assume responsibilities that should be shouldered by the addict (for example, they cover a bad check, make excuses for the addictive behavior, etc.). This contributes to the addictive spiral of short term immediate gratification at the expense of long term problem resolution. This "enables" the destructive addictive process to continue in spite of everyone's best intentions to help.

11. Finally, there is a continuation and escalation of this cycle, with an increase in the number and types of major life problems, as well as a decrease in coping skills until a major life crisis occurs. This crisis usually brings the addict to the attention of a social agency, and possibly, to treatment (for example, the addict has a medical crisis as a result of the addictive behavior, he or she comes to the attention of the legal system, the addict's family threatens to leave unless the addictive behavior stops, etc.).

The above described patterns seem to be common to all addictive behaviors. I will now address the issues of incidence and causation.

The incidence and etiology of addictions is gaining increasing attention. In terms of our most obvious national addiction, alcoholism, it has been well documented that between 7 and 10% of users of alcohol in the United States develop alcoholism (NIAAA). The National Institute on Drug Abuse has reported similar incidence rates for addiction to drugs other than alcohol. Research on the prevalence of other addictive behaviors is still limited. Current estimates of the prevalence of pathological gambling range from 2% to approximately 6% (Sommers, 1988). In this conference, Faber and O'Guinn found that as much as 5.9% of the population may be at risk for becoming compulsive buyers. Research on the incidence of eating disorders as well as
the incidence of sexual addiction is still in its early stages, and findings are inconclusive at this time.

In another arena, research examining the coexistence of more than one addiction within the same individual suggest that the phenomenon of dual addictions may be more common than previously recognized. For example, Lesieur and Associates (1986) found coexistence of pathological gambling and alcoholism and/or drug addiction in 19% of patients in treatment for chemical dependency. Washston (1988) reported that cocaine addiction and sexual addiction have a special relationship and have become a common dual problem that is best treated simultaneously. Other research indicates a high incidence of eating disorders (especially bulimia) among alcoholic women.

The question of etiology of addictions, especially alcoholism, has been under intense scrutiny in recent years. The growing body of research is indicating that genetic factors play a critical role in the etiology of alcoholism, and may be equally important in the etiology of all addictive behaviors. For example, Dr. Theodore Reich, in a presentation at the 1987 symposium sponsored by NIAAA's Alcohol Research Utilization System, identified 6 ways in which a predisposition towards alcoholism might be biologically transmitted to the children or grandchildren of alcoholics. He also notes that biological inheritance may not be specific to alcoholism at all, but instead, provide a general tendency that is transformed into alcoholism by the environment. A related growing body of literature is providing evidence suggesting that individual differences in brain chemistry, specifically in brain serotonin levels, may play a significant role in the etiology of addictive behaviors. For instance, in the last 10 years, scientists have identified three very specific neurophysiological and neurochemical abnormalities within the brains of young men genetically at risk for alcoholism. First, unusually fast EEG activity is often present in the sons of alcoholics, whether or not these sons are actually exposed to alcohol. Second, at risk young men often respond to external stimuli with less neurovoltage than their peers from non-alcoholic families. Thirdly, monoamine oxidase (MAO), an enzyme in the central nervous system, is found at abnormally low levels among male alcoholics and their relatives. Further research may reveal how these biological markers of alcoholism interact with environmental factors. Other studies provide further evidence that alcoholics differ from non-alcoholics in the content of serotonin in several brain regions. Regarding other addictive behaviors, a recent study indicates that pathological gamblers have different levels of cerebral spinal fluids, specifically those which affect brain serotonin levels, that result in gamblers high sensation seeking behavior. High risk behavior (e.g., gambling) creates increased levels of serotonin which at adequate levels produces a feeling of well being (Roy et al, 1988). Other studies have confirmed similar physiologic deficits in impulsive, aggressive, and hostile individuals. Overall, the literature points towards a neuropsychogenetic model of addictions. A biochemical predisposition to high risk behavior, regardless of the nature of that specific addictive behavior, may be mediated in part by either innate (genetic) or environmentally (stress) induced brain chemistry dysfunction. There may exist a spectrum of disinhibitory behavioral disturbances characterized by impulsivity, low frustration tolerance, and stimulus seeking behavior which manifest themselves as addictive behaviors that are mediated by reduced central serotonergic activity, and which have a genetic component, but which also are affected by environmental cues. The question of genetic predisposition versus environmental stimulus is still being examined. Enoch Gordis, director of the National Institute on Alcohol Abuse and Alcoholism, in 1987 stated "In emphasizing the role of genetics, it is important to realize that even the most articulate exponent of genetic research would be the first to say that influences other than genetic predisposition are still terribly important in the development of alcoholism, as well as in its manifestations. Ultimately our understanding of alcoholism will have to be based on an understanding of the relationship between genetics and the environment. In fact, many of the genetic factors in alcoholism may turn out to be specific genetic responses to different environmental stresses."

Dr. Gordis' comments apply equally to other addictive behaviors as well.

Research, of course, will continue to examine addictive behaviors in all their manifestations. Clearly, a comprehensive understanding of the etiology, incidence and course of addictions and addictive behaviors will lead to the identification of early warning signs of trouble, which can be addressed directly before the emergence of serious life problems. This more comprehensive understanding will also result in major social benefits. The harmful effects of addictions are not isolated to just the addict, but rather affect many others in harmful ways (family, friends, co-workers, employers, etc.). The social cost of addictive behaviors, both in personal expenditures and in costs to the public (for example health care, crime control, disability, etc.) are enormous if not immeasurable. A better understanding of addictive behavior can lead to more cost-effective and cost-beneficial treatment modalities. It has already been clearly demonstrated that the cost of alcoholism treatment is more than reimbursed by direct and indirect savings following treatment. Identification and intervention with people suffering from other addictive behaviors may result in similar beneficial effects to the individual, to his or her family, and to society as a whole.

REFERENCES


