

## An Examination of the Validity of Codependence

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**ABSTRACT:**

Examines the history and development of the concept of codependence, from Al-Anon through the self-help movement of the 1980s to present time. Reviews the various 12-step movements and other therapies for codependents. Questions whether codependency is a "disease", a "disorder", or other tangible entity, and whether Codependent Personality Disorder belongs as a new entry in the Diagnostic and Statistical Manual (DSM). Considers the many differing definitions of codependence and how they may or may not affect treatment and therapy.

## INTRODUCTION:

The recovery movement has moved from a seeming lifesaver in the first half of the 20th century to a target of ridicule in the present time. Comedians use it frequently as a source of material (I'm Good Enough, I'm Smart Enough, and Doggone It, People Like Me! : Daily Affirmations By Stuart Smalley (Franken, 1992) is a prime example), critics write best sellers attempting to destroy it (Peele, 1989), and people in general just do not seem to take it seriously.

The codependency movement is a major reason for this. Whether disease, disorder, bad habit, or moral shortcoming, alcoholism and addiction are tangible concepts. People can be observed ingesting substances in seeming defiance of clear consequences, and there is little question to those who observe them that they are out of control. Left to his or her own devices, the alcoholic or addict will continue onto his or her personal ruin, familial destruction, financial disaster, institutionalization, and/or death. This is a pattern seen repeatedly and few that observe it can question whether the alcoholic or addict proceeds willingly.

Codependency, on the other hand, is not a tangible concept. There is no clear cause of it, no one behavior (such as chemical ingestion) that defines it, no clear progression of it, not even a clear consensus of what it is or even what to call it (Literature refers to it alternately as "co-dependence", "codependence," "codependency," "co-alcoholism," or "co-addiction.").

The one agreement by those that promote the concept and offer treatments and therapies for it is that it is a disease. However, that is perhaps the primary reason for argument and dismissal of the concept, and by extension, dismissal of the 12-step

movement and the recovery movement as a whole. In calling it a disease, they compare it with clear and tangible entities such as cancer, arteriosclerosis, and HIV, a comparison that many find easy to dismiss.

Is codependency a disease? In order to come up with an answer, one must consider the definitions of codependence as well as what constitutes a disease or disorder. Without a clear understanding of what is being discussed, an answer is impossible to come by. Where codependence is concerned, the clear understanding of what is being discussed is currently lacking.

### HISTORY:

In 1935, a New York stockbroker (Bill Wilson) and an Akron proctologist (Dr. Bob Smith) met for the first time, the stockbroker peddling his radical ideas of one alcoholic working with another to promote their mutual sobriety. Thus began the fellowship of Alcoholics Anonymous (AA), and in 1939, their ideas were codified in a book Alcoholics Anonymous, and specifically, in the 12 Steps of Alcoholics Anonymous (Wilson, 1939). Remarkable changes were made in their households and in the households of others over the next several years.

It soon became clear, however, that the alcoholic was not the only person affected by the alcoholism. In 1951, Lois Wilson, the wife of the aforementioned stockbroker, met with Anne B., a friend of hers whose husband had also recovered through AA. They developed a fellowship for the families of AA members, and eventually alcoholics in general, so that the wives and children could deal with their own issues of living with an

alcoholic (Alateen and Alatot, 12-Step fellowships for children, are subdivisions of Al-Anon and their meetings are generally moderated by Al-Anon members). This gave primary recognition of the existence of issues around alcoholism affecting more than simply the alcoholic (Haaken, 1993).

While AA and Al-Anon helped a great number of people and healed many families, the fellowships were naturally limited to this one primary issue of alcoholism, and people who did not have that primary issue were excluded from their meetings, and presumably, from the benefits of working a 12-Step program. The first group to address this issue was illicit drug addicts and their families, who clearly had a similar addiction problem, though alcohol was not the source of the addiction. Beginning in 1947 various groups formed, using their own adaptations of the 12 Steps and receiving personal approval from AA founder Bill Wilson in 1954. They grew into the fellowships of Narcotics Anonymous (NA) and Nar-Anon (Scott A., 1991).

Other groups followed, each with their own issues (sexual addiction, gambling addiction, pharmaceutical addiction, etc.). In 1986, Co-Dependents Anonymous (CoDA) was formed, consisting of people who suffered from "co-dependency." A common criticism of Al-Anon and Nar-Anon is that they are "sister" fellowships, essentially subservient to AA and NA, and that their meetings are generally held at the same place and time as AA and NA, usually in a room in the back or down the hall. CoDA, on the other hand, was a primary fellowship, not affiliated with AA or NA and not expecting the spouses of its members to be in AA or NA (Incidentally, neither Nar-Anon or Al-Anon has such a requirement, and many of their members are spouses of people who continue to drink or the divorcees of active alcoholics or addicts).

Co-Dependents Anonymous states that it is "a fellowship of men and women whose common purpose is healthy relationships" (Co-Dependents Anonymous, 1998a). However, even in their own literature, there is a murkiness to the actual definition of codependency. Asked the question "what is codependency," they answer:

If you are new to CoDA you may be wondering, "Am I codependent?" At CoDA, we offer no definition or diagnostic criterion for codependence.

What we do offer is a list of patterns and characteristics as a tool to aid in self-evaluation. (Co-Dependents Anonymous, 1998b).

The list of patterns and characteristics is fairly lengthy, but are grouped under "Denial patterns," "Low self esteem patterns," "Compliance patterns," and "Control patterns," so one can conclude that codependents have difficulties with denial (inability to identify feelings), low self esteem, compliance (compromising their own needs to meet someone else's'), and control (insisting on helping and providing for others even when such help is unwanted). Examining all these together should give a prospective CoDA member an idea of whether they qualify for inclusion into CoDA (Co-Dependents Anonymous, 1998c).

Codependency came to the forefront with the 1987 publication of Codependent No More (Beattie, 1987) and its follow-up Beyond Codependency (Beattie, 1989). Several other books came thereafter, various authors such as John Bradshaw (1988), Bob Earll (1989), and Pia Mellody (1989) writing about the effects of living in households dominated by alcohol and drug use. Codependency became the pop-psychology buzzword in the late 1980s, a period of time dominated by buzzwords. People flocked to CoDA meetings, as well as Adult Child of Alcoholics (ACoA/ACA), a fellowship

specifically for codependents who lived as children in alcoholic homes and now feel the effects of it.

#### DEFINITION AND ISSUES WITH DEFINITION:

A search into Beattie's groundbreaking work for a clear definition of codependence is possibly more futile than searching the literature of CoDA. Under "What is Codependency?", Beattie (1987) begins "I have heard and read many definitions of codependency" and finishes "There are almost as many definitions of codependency as there are experiences that represent it. In desperation (or perhaps enlightenment), some therapists have proclaimed: 'Codependency is *anything*, and *everyone* is codependent'" (emphasis in original).

This is the crux of the issue. If codependency is an issue that everyone suffers from, it is not a disease, but a common characteristic. If codependency is anything, if it cannot be defined and identified, how can it be diagnosed and treated? If it is considered to be a disease, and yet "codependency is anything, and everyone is codependent" (as quoted in Beattie, 1987, above), how can it be taken seriously by people not so keen on self-diagnosis and skeptical of popular psychology?

At this point it may be wholly appropriate to conclude that codependency is an invalid concept. Two key proponents of the concept--Melody Beattie and Co-Dependents Anonymous--have completely failed to offer so much as a rudimentary definition of what they propose to treat.

However, Beattie is not a clinician; neither is the leadership of Co-Dependents Anonymous. Like any 12-Step group, CoDA is nonprofessional and its leadership (to the extent that any 12-Step program has leadership) consists of laypeople. Beattie, herself, is a recovering drug addict who saw codependent personality traits in her own life as an obstacle in her recovery (Beattie, 1987). Beattie can report that codependence has affected her life, much as an alcoholic can report the effects alcoholism has had in his or her life without being able to give a clear definition of alcoholism.

Fortunately, there have been definitions offered by clinicians in an attempt to clarify the concept. One champion of the construct, Timmen Cermak, developed a Diagnostic Criteria for Codependence with the intention, unsuccessful in the end, to have it included as "Codependent Personality Disorder" in the DSM-IV. The criteria were to be as follows (Zetterlind & Bergland, 1999):

(A). Continual investment of self-esteem in the ability to influence / control feelings and behavior in self and others in the face of obvious adverse consequences.

(B). Assumption of responsibility for meeting others' needs to the exclusion of acknowledging one's own needs.

(C) Anxiety and boundary distortions in situations of intimacy and separation.

(D) Enmeshment in relationships with personality-disordered, drug-dependent, and impulse-disordered individuals.

(E) Three or more of the following symptoms:

(1) Construction of emotions with or without dramatic outbursts.



- (2) Depression
- (3) Hypervigilance
- (4) Compulsions
- (5) Anxiety
- (6) Excessive reliance on denial
- (7) Substance abuse
- (8) Recurrent physical or sexual abuse
- (9) Stress-related medical illness
- (10) A primary relationship with an active substance abuser without seeking outside support.

Cermak's criteria may be a little strict (Zetterlind & Berglund, 1999, found a very low incidence using Cermak's criteria, but stated that two or more of the A-D criteria plus three or more of the E criteria would be appropriate), but compared with the popular conception that codependence is grossly over-diagnosed, it probably needs to be. Zetterland & Berglund compared Cermak's scale with the Coping Behavior Scale, Hardship Scale, Symptom Checklist (SCL-90), Trait Personality Questionnaire, and The Interview Schedule for Social Interaction (ISSI) in order to find the actual prevalence of codependence in their study of relatives of alcoholics and to validate Cermak's scale. They determined the prevalence to be approximately 44%, 17% in males and 83% in females.

This brings up another issue in the area of codependency: it is considered a "woman's disease." Opponents of the concept see it as a way to pathologize accepted female roles of supporting and deferring to the husband, taking responsibility for the

family without usurping the husband's image of control, and attempting to correct and / or cover for inappropriate behavior from the husband. The question becomes how frequent would these same traits come up in families where no addiction or dysfunction is present. This is a difficult question to answer, in that families who have no dysfunction do not end up in clinical research on dysfunction and many of Cermak's criteria (A, D, E-6, E-7, E-8, and E-10) are based specifically on addiction or dysfunctional relationships.

In other words, if someone assumes responsibility for others' needs at the expense of one's own, exhibits anxiety and boundary distortion during separation from or intimacy with the spouse, and has problems of constricted emotions, depression, anxiety, and stress-related illness and does not attribute it to a dysfunctional relationship, is that person codependent?

Many people assume responsibility for others' needs at the expense of their own. They may be altruistic, they may be caregivers for ill people in their own family, they may be healthcare workers, clergy, teachers, or even parents. It is not uncommon for newlyweds or married people who are still very much in love to have anxiety over separation or during moments of intimacy. Many people have constricted emotions due to cultural and familial norms of expression of emotion. Depression, anxiety, and stress-related illness are very common occupational hazards--would we declare all air-traffic controllers codependent because they suffer from these symptoms almost ubiquitously?

Indeed, a certain degree of codependency is healthy and necessary for some occupations. It would be difficult, for example, to be a psychologist, counselor, or social worker and not be codependent. It would be the drive to help others that would lead one to the profession, the concern for their needs over one's own that would allow one to be

empathetic. One has to acknowledge the necessity to maintain boundaries, but those boundaries will be stretched, bent, and crossed at times to make for effective work; otherwise, the professional may be too hard, cold, and cynical to be helpful.

Yet while it may be a mistake to pathologize these situations as codependent, it would be equally fallacious to ignore the possibility that true codependence exists. In fact, there are people whose lives have been affected greatly by living with or being raised by an alcoholic, addict, mentally ill person, or abuser. These people may exhibit the symptoms that Cermak lays out, and these people are the people who may benefit from identification of the problem, the causes, and the appropriate treatments.

Though he does not include it in his diagnostic criteria, Cermak describes codependence as involving a secretly willful and manipulative nature in the codependent's relationship to the world (Haaken, 1993). In other words, the codependent has been so out of control over life in the past, he or she will fight to maintain every possible degree of control. This occurs whether the lack of control stems from a family of substance abuse, the codependent's own substance abuse, or dysfunctions of another sort (physical abuse, neglect, poverty, etc.; Haaken, 1993).

Indeed, the overwhelming subject of codependence would have to be control. Springer, et al (1998) state that codependents "continually invest their self-esteem in the ability to control and influence behavior and feelings in others." This fits in with the commonly described tendency of people from dysfunctional families to not feel emotions and to become uncomfortable around others who show emotional expression. When emotion begets chaos (as in the explosive anger of an alcoholic), rejection (parents admonishing their children to not cry and act tough because another expectation or

promise was unfulfilled), or punishment (the oft-repeated "Don't cry or I will give you something to cry about"), then expression of feelings, and eventually the feelings themselves, become a source of problems. It is far better to completely extinguish the feelings and deny them than it is to risk everything that acknowledging feelings brings.

For someone raised in such a situation, there may be no realization that the world outside his or her family does not operate this way. Parents teach children not to feel, older siblings teach younger siblings not to feel, and these people as adults wonder why others have not learned the same lessons. The person may be attempting to live life normally with no realization that he or she interprets reality from an entirely different basis than most everyone else.

That is the pathology of codependence. There is little about codependent behaviors in and of themselves which, absent of the distorted reality and the obsessive need for control, makes it pathological. Cermak's Codependent Personality Disorder criteria, above, fails to make that distinction, and measuring that distorted reality and the obsessive need to control is indeed extremely difficult.

The Millon Clinical Multiaxial Inventory-II (MCMI-II; Millon, 1992) has been considered as a possible diagnostic instrument for codependence (Loughead, et al, 1998). The MCMI-II is a 175 true/false item test that yields information relating to both personality and clinical issues, giving scores on 14 personality scales corresponding to the DSM-IV personality disorders, as well as 10 clinical scales and four validity indices (Cohen & Swerdlik, 1999). Because of the correspondence between the DSM-IV and the MCMI-II, the intention was that the MCMI-II would be able to translate results directly into a diagnostic category (Millon, 1992), something that is far more difficult to do with

the similar Minnesota Multiphasic Personality Inventory (MMPI).

Loughead, et al (1998) found that codependents show a distinct profile on the Dependent, Avoidant, and Compulsive Personality Disorder scales. This would fit in with the idea that the codependent's need to control feelings would involve avoidance of them, and that codependents' behaviors stem from compulsive dependence on others.

In addition, there was significant elevation on the Self-Defeating, Passive-Aggressive, Borderline, and Schizoid scales. Codependent behavior is characterized by these traits, passive-aggressive attempts at control, maintaining self-defeating relationships, emotional instability and distorted reality expectations.

The Holyoake Codependency Index (HCI; Dear, 2001)) is another measure intended to diagnose codependence. It is a 13-item 5-point Likert scale (strongly disagree-undecided-strongly agree). It is further divided into three subscales: self-sacrifice, external focus, and reactivity. This is consistent with the idea that codependents tend to be focused on the needs of others to the point of neglecting themselves and tend to have a great deal of internal emotional reactivity even if it is not outwardly expressed.

Though the results with both the MCMI-II and the HCI showed a significant tendency towards certain patterns in scores, the samples tested were previously identified as codependent and brought into the diagnosis (recruited from codependency support groups and treatment centers). The use of similar tests on people employed in "codependent" occupations (healthcare, counseling, or as personal caregivers) need to be examined as a control group to see if the same patterns occur with people who do not have problems relating to codependence.

The HCI is written with the questions indicating judgment (examples: "Because it is selfish, I cannot put my own needs before others," "I live too much by other people's standards," "I put on a show to impress people; I know I am not the person I pretend to be." Dear, 2001). If the questions were written without the inherent lean toward pathology ("I put others' needs before my own," "I follow other people's standards in my life," "I tend to portray myself in public differently than I consider myself in private,") the results could be different. By using judgmental questions and testing a population already diagnosed as pathological (either professionally or by self-diagnosis), the diagnosis is cemented, while in a non-clinical population there is the likelihood of a false-negative pattern (that is, people will disagree with the questions not because they disagree with the behavior, but with the judgmental wording). On the other hand, eliminating the judgmental wording opens up the possibility of the false-positive because altruistic behavior appears the same as codependent behavior without the consequences.

The MCMI-II, on the other hand, may be an effective tool for the diagnosis of codependence, in that it has been shown as a valid personality diagnostic tool in general (Millon, 1992; Loughead, et al, 1998). The only questions would be whether there is a significant pattern to codependence (which Loughead, et al, 1998 has hypothesized and demonstrated) and whether the pattern is not indicative of another personality disorder).

### CONCLUSIONS AND DISCUSSION:

Codependence appears to have some validity, but further research is needed. Popular psychology and the 12-Step recovery movement has made many aware of a

significant issue, but in promoting the self-diagnosis and self-treatment, has eroded the concept such that many cannot take it seriously. Using layman's terms such as "disease" and "addiction" do not help when professional clinicians have entirely different understandings of these terms (An addiction to what? What is the physical manifestation and prognosis of this disease?)

If codependence was like any other personality disorder--borderline, schizoid, avoidant--there would have been no popularizing of it prior to its introduction to the professional community. Researchers would have observed these traits in their subjects, come up with a set of criteria (as Cermak did), tested and revised the criteria, and developed some diagnostic testing for it (as Dear and Loughhead, et al, each did). This would be evaluated on its own merit and either accepted or rejected, likely revised several times. There are DSM-IV personality diagnoses that are likely less valid than Codependent Personality Disorder (Self-Defeating Personality Disorder comes to mind) and personality diagnoses that are equally open to criticism (Borderline Personality Disorder is also criticized as vague and pathologizing traits that are within the range of normal female behavior).

However, none of these diagnoses have the same public and professional perceptions that Codependent Personality Disorder has. Cermak was ridiculed by some of his colleagues for promoting a pop-psychology diagnosis that essentially was invented by the 12-Step movement and promoted by the popular psychology movement, and as such it is shelved next to Transactional Analysis. Transactional Analysis was a popular therapy of the 1960s and 1970s, but is now seen as a relic of the time and is rarely taken seriously

regardless of whether it was valid or not. Codependence is a relic of the 1980s and 1990s and will likely be forgotten as we move into the late 2000s and the 2010s.

One wonders if Transactional Analysis would be forgotten today if not for Harris' bestseller I'm OK, You're OK (1969), written for the masses to treat themselves from all neuroses, real and imagined. Likewise, where would codependence be today if millions had not read Codependent No More (Beattie, 1987) and seen Melody Beattie as being the guru with the cure to every neurosis of the 1980s? Would Eric Berne and Timmen Cermak have a little more respect from their colleagues? One can only speculate. The images have already been developed and their consequences seen.



REFERENCES:

- A., Scott (1991). History of Narcotics Anonymous. Transcript of tape recorded June 8, 1991 at the 7th San Diego/Imperial Regional Convention of Narcotics Anonymous (SDIRCNA VII). Retrieved December 15, 2003 from <http://www.bosewell.com/Scott%20A%20and%20Phil%20-%20History%20and%20Jimmy%20K.htm>
- Beattie, M (1987). Codependent no more: How to stop controlling others and start caring for yourself. Center City, MN: Hazelden Foundation.
- Beattie, M (1989). Beyond codependency and getting better all the time. Center City, MN: Hazelden Foundation.
- Bradshaw, J (1989). Healing the shame that binds you. Deerfield Beach, FL: Health Communications, Inc.
- Co-Dependents Anonymous (1998a). Co-Dependents Anonymous. Retrieved November 22, 2003 from <http://www.codependents.org>
- Co-Dependents Anonymous (1998b). Welcome to newcomers! Retrieved November 22, 2003 from <http://www.codependents.org/newcom.html>
- Co-Dependents Anonymous (1998c). Patterns and characteristics of codependence. Retrieved November 22, 2003 from <http://www.codependents.org/codapatt.html>
- Cohen, R & Swerdlik, M (1999). Psychological testing and assessment: An introduction to tests and measurement (4th ed.) Mountain View, CA: Mayfield Publishing Co.
- Earll, B (1989). I got tired of pretending. Tucson, AZ: STEM Publications.

- Franken, A & Smalley, S, pseud. (1992). I'm good enough, I'm smart enough, and doggone it, people like me! Daily affirmations by Stewart Smalley. New York: Dell Publishing.
- Haaken, J (1993). From Al-Anon to ACOA: codependence and the reconstruction of caregiving. Signs, 18, (2), 321-345.
- Harris, T (1969). I'm OK, you're OK: A practical guide to transactional analysis. New York: Harper & Row.
- Loughead, T; Spurlock, V; & Yuan-Yu Ting (1998). Diagnostic indicators of codependence: An investigation using the MCMI-II. Journal of Mental Health Counseling, 20, (1), 64-76.
- Mellody, P (1989). Facing codependence: What it is, where it comes from, how it sabotages our lives. San Francisco: Perennial Library.
- Millon, T (1992). Tests and assessment: Millon Clinical Multiaxial Inventory: I & II. Journal of Counseling & Development, 70, 421-426.
- Peele, S (1989). The diseasing of America: Addiction treatment out of control. Lexington, MA: Lexington Books.
- Springer, C; Britt, Thomas; & Schlenker, B (1998). Codependency: clarifying the concept. Journal of Mental Health Counseling, 20, (2), 141-158.
- Wilson, B (1939). Alcoholics Anonymous. New York: Alcoholics Anonymous World Services.
- Zetterlind, U & Berglund, M (1999). The rate of co-dependence in spouses and relatives of alcoholics on the basis of the Cermak co-dependence scale. Nordic Journal of Psychiatry, 53, (2), 147-151.