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Co-dependence: A disease inherent to dysfunctional family systems

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Co-dependence: A disease inherent to dysfunctional family systems

Abstract

Co-dependence is an idea that has emerged recently in the chemical dependency field especially relating to alcoholism. The term co-dependence was originally used to describe those persons whose lives were affected by involvement with a chemically dependent person (Subby and Friel, 1984). Most research prior to 1982 was centered on individual personality traits and characteristics of the alcoholic or the alcoholic's spouse rather than looking at the relationship process or family system (Jacob and Seilhamer, 1982; Steinglass, 1982). Attention was focused on understanding and helping the alcoholic while the non-drinkers in the family, if considered at all, were thought to be passive victims of the alcoholic (Wilson, 1982).

CO-DEPENDENCE:
A DISEASE INHERENT TO DYSFUNCTIONAL FAMILY SYSTEMS

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Co-dependence is an idea that has emerged recently in the chemical dependency field especially relating to alcoholism. The term co-dependence was originally used to describe those persons whose lives were affected by involvement with a chemically dependent person (Subby and Friel, 1984). Most research prior to 1982 was centered on individual personality traits and characteristics of the alcoholic or the alcoholic's spouse rather than looking at the relationship process or family system (Jacob and Seilhamer, 1982; Steinglass, 1982). Attention was focused on understanding and helping the alcoholic while the non-drinkers in the family, if considered at all, were thought to be passive victims of the alcoholic (Wilson, 1982).

The theory has been that if the alcoholic stops drinking, the family will recover, but Woititz (1979) challenged this theory as being too simplistic. This dooms the family whose alcoholic does not recover, assumes that family recovery must start after the alcoholic begins to recover, and doesn't take into account that the family may be as sick, or sicker, than the alcoholic.

Whitfield (1984) defined co-alcoholism or co-dependence as "ill health or maladaptive, problematic, or dysfunctional behavior that is associated with living, working with, or otherwise being close to a person with alcoholism" (page 16). The idea is becoming prevalent that almost everyone who has any relationship with an alcoholic is at sometime co-dependent (Wegscheiger, 1981; Schaef, 1986). It is estimated that from three to six or more people are affected

by association with each alcoholic (Whitfield, 1984; Woititz, 1979). Since there are about ten million alcoholics in the United States, this means that there could be 30 to 60 million co-alcoholics (Whitfield, 1984). The focus, however, has been on the alcoholic and on helping the enabler learn not to help perpetuate the addiction in the alcoholic while the co-dependency goes untreated (Schaef, 1986; Greenleaf, 1984).

Co-dependence and alcoholism are often present in the same individual (Whitfield, 1984). Many people who have become chemically dependent were first co-dependent and turned to alcohol or other substances in an attempt to alleviate or medicate the pain already existing from co-dependence (Subby, 1984; Subby and Friel, 1984). Treating the alcoholism without treating the co-dependence may create a "dry drunk" who is an individual exhibiting the behavior, attitudes, and thinking associated with the active disease but is no longer drinking (Wegscheider-Cruse, 1984; Schaef, 1986).

Co-dependence as a Disease

Co-dependence, like alcoholism, is considered to be a primary disease (Wegscheider-Cruse, 1984, Whitfield, 1984, Schaef, 1986). Schaef (1986) explained that co-dependence fits the disease concept in that it "has an onset (a point at which the person's life is just not working, usually as a result of an addiction), a definite course (the person continues to deteriorate mentally, physically, psychologically, and spiritually), and, untreated, has a predictable outcome (death)" (pg. 6). The disease of co-dependence is chronic

(Whitfield, 1984), progressive (Whitfield, 1984; Capell-Sowder, 1984), and treatable (Whitfield, 1984; Wegscheider-Cruse, 1984; Schaef, 1986; Schlesinger and Horberg, 1988). The disease may progress if untreated in spite of the alcoholic's recovery, but the focus may shift with another member of the family displaying the addictive or other dysfunctional behavior (Woititz, 1984; Whitfield, 1984). In some cases, as the alcoholic's situation improved, the spouse's adjustment deteriorated (Edwards, Harvey and Whitehead, 1973). These symptoms in other family members dissipated if the addict relapsed into the addiction (Textor, 1987). If the untreated and unrecovered co-dependent gets out of one destructive relationship, they tend to fall into the same kind of relationship with children, friends, or a new spouse (Schaef, 1986).

Schaef (1986, 1987) proposed a theory that the addictive process is a basic disease and co-dependence, alcoholism, drug abuse, eating disorders, obsessive-compulsive personalities, and certain psychoses are all sub-syndromes of the basic addictive disease. The addiction can be to an ingested substance, such as a chemical or food, or to processes, such as work, gambling, accumulating money, sex, and relationships (Schaef, 1987). Co-dependence is an addiction to a person and/or to a relationship. The person involved in a primary love relationship with someone addicted frequently displays symptoms of addiction in the way they relate to the relationship (Capell-Sowder, 1984). Those characteristics are preoccupation with that person and extreme emotional, social, and often physical dependence

(Wegscheider-Cruse, 1985). The co-dependent person seems dependent on or addicted to the alcoholic with a need for emotional and physical attachment and a desire to control the alcoholic's behavior (Wegscheider-Cruse, 1985; Whitfield, 1984).

Origins

Larsen (1987) stated that "co-dependency is caused by those self-defeating, learned behaviors that diminish our capacity to initiate or participate in a loving relationship" (pg. 14). Co-dependency can result from living in a dysfunctional family where there is denial, compulsive behavior, emotional repression, bizarre rules, and distorted communication even if alcoholism or chemical dependency is not present in the family (Wegscheider-Cruse, 1985). According to Subby (1984), co-dependence results from an individual being exposed to and living under a set of oppressive rules that restrict the expression of feelings and discussion of personal and interpersonal problems. It seems that co-dependent patterns of coping can result from living in a dysfunctional family even if there is no chemically dependent member of the family.

Many co-dependents come from families where alcohol has been a problem (Whitfield, 1984). The child, growing up in a family, is affected by the co-alcoholic parent as well as the alcoholic parent (Greenleaf, 1984; Black, 1981). They learn by imitation the only behaviors that they have ever witnessed. They do not learn behaviors that they have not experienced (Greenleaf, 1984). Alcoholics and co-dependents have been their role-models. Rules in

their families were "don't talk, don't trust, and don't feel" (Whitfield, 1984, pg. 18; Black, 1981, pgs. 33-49). Subby (1984) expanded these rules to "we don't talk about how we feel, we don't talk about our problems, and we do not rock the boat" (pg. 26).

"Co-" means "with or necessary for functioning" (pg. 6), so the co-alcoholic is the person who helps to maintain the social and economic equilibrium of the alcoholic (Greenleaf, 1984). They maintain both the homeostasis of the family and the alcoholism. The co-alcoholic shields the potential alcoholic from experiencing the harmful consequences of his/her drinking. Facing those consequences might have prevented the individual from becoming dependent on a substance or a process (Whitfield, 1984).

Family systems theory tells us that when one family member is stressed, others shift to achieve emotional balance and stability or just for survival (Whitfield, 1984). Co-dependency then is an adaptive behavior (Greenleaf, 1984; Whitfield, 1984). It is initially a normal response to an abnormal situation (Whitfield, 1984). For the family to turn their backs on the alcoholic would mean disrupting their lives as well as deserting someone they love, so they stay and adapt to the illness. There is no healthy way to adapt to alcoholism (Wegscheider, 1981). The adapting only creates a sick family system that seeks to protect and enable the alcoholic either overtly or covertly (Textor, 1987).

Co-dependency for the adult is voluntary only it doesn't seem that way to the person involved (Schlesinger and Horberg, 1988;

Greenleaf, 1984). The child is trapped and has no choice but to stay in the dysfunctional family (Greenleaf, 1984). The adult loses his/her awareness that there is a choice because of the pressure of daily life with the addict. Because co-dependents struggle to control the uncontrollable and reason with the unreasonable, they are destined to fail. This failure creates the illusion that nothing is under control in their lives as they see the family's emotional and material resources being consumed (Maxwell, 1986; Schlesinger and Horberg, 1988).

Numerous stresses contribute to co-dependency in addition to alcoholism. Wegscheider-Cruse (1985) mentioned the family secret which evokes the "don't talk" rule. Family trauma is another situation where the issue is not discussed with family or outsiders and feelings are suppressed. Rigid family rules and dogmas encourage and teach learned helplessness as well as manipulation and control of others through reward systems and emotional repression. Whitfield (1984) listed increased inconsistencies, chronic distresses, and the double binds that result from having to live with an actively drinking alcoholic in a co-alcoholic and enabling society as other stressors. Additional stresses facing the potential co-dependent in an alcoholic family, according to Jacob and Seilhamer (1982), are social isolation, problems with children, economic problems, sexual problems, violence, and cultural attitudes and stereotypes.

Characteristics

As with alcoholism, a basic characteristic of co-dependence is denial (Woititz, 1979; Wegscheider-Cruse, 1985; Whitfield, 1984; Greenleaf, 1984; Capell-Sowder, 1984). Wegscheider-Cruse (1985) stated that for the co-dependent to recognize that the relationship is dysfunctional would mean that they would also have to recognize their own role in enabling the undesirable behavior, their own dependency, and their own dysfunctional behavior. Rationalizing and minimizing are forms of denial as is selective blindness.

Schaef (1986) listed external referenting as the most central characteristic of a co-dependent. Co-dependents use relationships as an alcoholic uses alcohol. They will do anything to be in a relationship regardless of how awful it is. Each of the people in the relationship feels they cannot survive without the other. The reward is to feel secure, but the price is that the relationship is static with no growth. The co-dependents lack boundaries and don't know where they end and the other person begins. They personalize and feel responsible for everything that happens around them. They also attempt to manage how others perceive them. They need others to see them as they want to be seen. Insecurity and low self-esteem requires them to depend on others to prove their worth. They are people-pleasers and try to live up to the expectations of others. Unable to trust their own perceptions, they dismiss their perceptions until verified externally. Subby and

Friel (1984) agreed that co-dependents have difficulty in trusting and identifying their feelings and are in constant need of approval from others.

Another characteristic of the co-dependent is being a care-taker. They feel protectiveness, pity, and concern for the alcoholic (Woititz, 1979) in addition to feeling overly responsible for others' behavior or feelings (Subby and Friel, 1984). By doing things for others that the other person really can and needs to do for themselves, the co-dependents attempt to make themselves indispensable. Often they keep chaotic situations going when the really caring thing to do would be to blow the whistle and force the other person to take responsibility (Schaefer, 1986).

Lying and dishonesty are common characteristics of the co-dependent (Greenleaf, 1984; Schaefer, 1986; Woititz, 1979). There is lying to protect and cover up for the alcoholic (Woititz, 1979) and lying to get out of an uncomfortable situation (Schaefer, 1986). It is also dishonest not to understand one's feelings or to be able to express them. Basing thoughts, feelings, and perceptions on perceived expectations of others denies the true personality of the individual.

Tied in with lying and dishonesty is a loss of morality or a compromising on one's value system (Schaefer, 1986; Capell-Sowder, 1984). Subjecting one's self and body to unnecessary stress and neglecting the people we are responsible for or care significantly about are examples of a compromised value system (Schaefer, 1986;

Subby and Friel, 1984). The co-dependent may have an affair, abuse or neglect the children, or abandon their spiritual beliefs (Capell-Sowder, 1984). Often their values are narrowed to one thing... survival (Wegscheider-Cruse, 1985).

Repression of feelings is another characteristic usually seen in the co-dependent (Schaef, 1986; Wegscheider-Cruse, 1985; Greenleaf, 1984; Whitfield, 1984; Subby and Friel, 1984). Having become progressively out of touch with their feelings, the co-dependents have difficulty in identifying and expressing their emotions and feelings (Subby and Friel, 1984; Schaef, 1986). Family rules in the dysfunctional family teach that only "acceptable" feelings can be felt, so co-dependents distort their feelings to maintain the impression that they want to have of themselves. When feelings are distorted or repressed, resentment, anger, and depression build up, eventually finding expression in physical illness or such devious ways as jealousy, possessiveness, procrastination, helplessness, and hypochondria (Schaef, 1986; Wegscheider-Cruse, 1985).

Co-dependency is very destructive to the physical well-being of the individual, so medical problems are characteristic of the co-dependent. The strain of keeping volatile feelings inside (Wegscheider-Cruse, 1985) plus the frustration of trying to control the uncontroallable (Schaef, 1986) lead to hypochondria, insomnia, depression, anorexia nervosa, bulimia, suicide attempts, colitis, bowel problems, bronchial asthma, hypertension, and many other physical illnesses. The co-dependent is also very susceptible to

acquiring other addictions (Schaefer, 1986). Schaefer (1986) also stated that the co-dependent will often die sooner than the alcoholic. Chronic hypochondria is common because illness allows the co-dependent to receive a little nurturing (Wegscheider-Cruse, 1985). These physical illnesses are all secondary to the primary disease of co-dependence.

In the progression of the co-dependence, the individual may respond aggressively, passively, or sometimes in both ways. Possible aggressive responses are repulsion, hatred, fantasies and dreams of the alcoholic's death, attempts to hurt the alcoholic, disliking or refusing to have sex, avoidance of communication, verbal and/or physical abuse, and temporary separation or desertion. Passive responses would include hiding feelings, withdrawal, depression and extended crying, obsession with cleanliness or work, bargaining prayers, giving all one's love and attention to the children, phobias, anxiety disorders, and hypochondria to get attention of the alcoholic or others. Male co-dependents are apt to respond more aggressively while female co-dependents exhibit more passive responses (Whitfield, 1984).

The Helping Professional as a Co-dependent

A common theme in much of the literature about co-dependence is that an overwhelmingly large number of helping professionals, such as psychologists, social workers, physicians, nurses, and clergy, are co-dependents actually enabling the continuance of alcoholism or co-dependence in their clients. They fail to recog-

nize symptoms, minimize the importance of treatment, or deny that recovery is possible, thereby becoming accomplices as would-be helpers whose actions enable the continuation of addiction by undermining and thwarting the therapeutic progress (Whitfield, 1984; Wegscheider-Cruse, 1985; Schaef, 1986; Dean, 1982). Costly, long-range, and ineffective treatment perpetuates both the client's dependence and the helper's co-dependence (Schaef, 1986).

Society as a Co-dependent

Society does much to condone and perpetuate alcoholism and co-dependence. The drinking of alcoholic beverages is encouraged and even expected. It is socially "in" to drink but socially "out" to become addicted (Woititz, 1979). Institutional co-dependence occurs when the group attitudes and customs promote excessive drinking while discouraging education and treatment for alcoholism. Examples are hospital staffs refusing to treat alcoholics for their alcoholism while treating them for medical and psychological consequences of their alcoholism, and states collecting millions of dollars in liquor taxes and allocating only 10% to alcoholism treatment (Whitfield, 1984).

Schaef (1986) proposed the idea that the family, the schools, and the church are organizations that promote co-dependence by encouraging co-dependent behavior.

Conclusion

Co-dependence was discovered in the chemical dependence field when family systems were applied to the treatment of alcoholism. As the various pioneers in the field investigate co-dependence, new insights and awarenesses are emerging. Definitions are being integrated and refined as knowledge is acquired, and the scope of co-dependence is expanding into other fields.

Co-dependence is an addictive disease that is encouraged and enabled by the society in which we live. It is a disease independent of substance abuse yet closely related. It often results from close association with a substance abuser, yet also may be a factor in the development of substance abuse. Zweben (1986) stated that the factors associated with higher levels of alcohol use such as the failure of the alcoholic spouses to participate in everyday family events, the maintenance of adequate standards of personal hygiene, and the relating to the family in a cordial or non-belligerent manner seem to impact the marriage adversely. Conversely, the preexisting quality of the marriage relationship affects the possibility of alcoholism developing.

In a chemical dependent marriage both partners are affected by the chemical; one directly, the other indirectly. One is addicted to the chemical, the other is addicted to the chemically dependent partner (Woititz, 1984).

Beyond the chemical dependency field, co-dependence can become a generalized way of relating to others; a lifestyle that is not

only condoned but encouraged by society. More is known about having this disease than about being free of it. It is so common and ordinary that few, if any of us, are not affected by the disease.

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