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Debate Series

Applying the codependency concept to concerned significant others of problem gamblers: Words of caution

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Abstract

Two competing models of understanding concerned significant others (CSOs) of people with addictions have emerged: codependency (CD) and stress-coping. In the context of CSOs of problem gamblers, some research has begun to examine the effectiveness of the stress-coping model, but no research to date has examined the utility of incorporating the CD concept into treatment planning. The purpose of this paper is to: critique the CD concept while highlighting possible differences between problem gambling and substance abuse (i.e., financial issues, the ability to hide the problem, cognitive distortions, and societal attitudes); identify important considerations when working with CSOs of problem gamblers; make recommendations for program managers regarding hiring and training practices; and recommend directions for research and in-depth program evaluations to assess what is actually occurring in existing practice.

Two models for conceptualizing the experience of concerned significant others (CSOs) of substance abusers that have emerged over the past few decades are a) codependency (CD) and b) stress-coping (Hurcom, Copello, & Orford, 2000). Both models continue to be popular today. Details of how the CD concept was first established remain unknown (Miller, 1994), but consensus in the literature indicates that the concept was developed in the 1970's within the substance abuse field (Knudson & Terrell, 2012; Wright & Wright, 1995).

CD is considered to be influenced by family systems theory (Krestan & Bepko, 1992; Miller, 1994) and disturbed personality theory (Kalashian, 1959). Although definitions vary, CD generally includes: "external focusing, self-sacrificing, attempting to control other people, and suppressing one's emotions" (Dear, Roberts, & Lange, 2005, p. 189). CD primarily evolved through the Al-Anon

self-help movement, which ''advocates loving detachment, acceptance of the CSO's helplessness to control the alcoholic, and group support for the CSO'' (Miller, Meyers, & Tonigan, 1999, p. 688). CD can be applicable to men and women but, typically, women are the target of the label (Collins, 1993) to the point where some historical treatment program and Al-Anon materials exclusively refer to ''wives'' (Harper & Capdevilla, 1990).

Soon after the development of the CD approach, the stress-coping model emerged as part of a shift away from pathologizing, victimizing, and stigmatizing partners of substance abusers (Watts, Bush, & Wilson, 1994). With the stress-coping model, CSOs are considered ''normal people placed in an abnormal situation and having to cope with the stress arising from this'' (Hurcom, Copello, & Orford, 2000, p. 496). Unlike a CD approach that was supported only by the speculations and anecdotes of spouses of substance abusers (Miller, 1994), the stress-coping model has been, and continues to be, supported by empirical evidence for CSOs of substance abusers (O'Farrell & Clements, 2012; Orford, Copello, Velleman, & Templeton, 2010; Rychtarik & McGillicuddy, 2005) and CSOs of problem gamblers (Makarchuk, Hodgins, & Peden, 2002; Rychtarik & McGillicuddy, 2006).

The motivation for writing this article stemmed from one of the authors' experiences observing a hospital-sponsored psycho-educational group (not a twelve-step group) for gamblers and family members of problem gamblers. On four separate occasions with four different family members, the lead facilitator's first question to the CSO was ''What is *your* problem?'' At least three times across a span of six weekly meetings, the facilitator told the group that family members rarely come to more than one session because they will not admit that they have a problem. While the word *codependent* was never used, the facilitator's questions to the CSOs repeatedly focused on what Dear, Roberts, and Lange (2005) describe as characteristics of CD: ''external focusing, self-sacrificing, attempting to control other people, and suppressing one's emotions'' (p. 189).

The psycho-educational group facilitator's approach was also reflective of the family systems theory considered to have influenced the conception of CD. In the much-cited and classic work on structural family therapy by Minuchin (1974), the first words uttered by Minuchin in his first example of a therapeutic intervention were ''What is the problem?'' (p. 1). Aligned with Minuchin and Fishman's (1981) technical approach, the facilitator of the problem gambling group described above presented as ''expert'' and was confrontational and accusatory, with no acknowledgement of the more recent therapeutic trends such as a strengths perspective, solution-focused therapy, and a stress-coping model of understanding CSOs. This facilitator repeatedly indicated knowing about the process because of personal experience as ''a recovered addict'' and being ''a family member of an addict.'' Not surprisingly, three of the four CSOs (all women) did not complete the program. The fourth CSO was already divorced from the gambler, having little contact and concern about him, and voiced disagreement about the facilitator's accusation that

she needed to discover "her problem" – she attended the group to get ideas for explaining to her young children her ex-husband's lack of availability and financial support.

The impact of problem gambling on CSOs has only begun to receive attention in the literature (e.g., Calderwood & Wellington, 2014; Copello, Templeton, & Powell, 2010; Darbyshire, Oster, & Carrig, 2001; Grant Kalischuk, Nowatzki, Cardwell, Klein, & Solowoniuk, 2006; Mathews & Volberg, 2013; Tepperman & Korn, 2003). Only a few researchers have studied CSO's coping strategies and interventions for addressing their coping in the context of problem gambling (Krishnan & Orford, 2002; Makarchuk, Hodgins, & Peden, 2002; Rychtarik & McGillicuddy, 2006). When evidence is lacking in the context of problem gambling, typically, workers in the gambling field have adopted or adapted treatment strategies used in the substance abuse field (e.g., Petry, 2005). However, given that we know so little about how the experience of a CSO of a problem gambler differs from the experience of a CSO of a substance abuser, these adoptions or adaptations of substance abuse programs risk making assumptions that do not suit the gambling experience. We applaud Makarchuk, Hodgins, and Peden (2002) for holding focus groups with CSOs of problem gamblers before developing their adapted version of the Community Reinforcement and Family Training (CRAFT) program, but even more research is needed to explore the differences and to improve programming that addresses the unique needs of CSOs of problem gamblers.

In this article, we critique the use of the CD concept as it relates to CSOs of problem gamblers, and highlight important considerations in clinical practice. We encourage administrators to be cautious in their hiring and training practices to ensure that best practices are being utilized. We also advocate for researchers and program managers to develop evidence-based programs, and to conduct in-depth program evaluations that assess what actually occurs in treatment programs, rather than rely on what programs claim to do.

Critique of Codependency as it Relates to Problem Gambling

There are many criticisms of the CD concept, mostly from a feminist perspective (e.g., Babcock & McKay, 1995; Calderwood & Rajesparam, in press). A complete review of the criticisms is beyond the scope of this paper, but we highlight the major ones most relevant to the context of problem gambling and the scenario presented above. First and foremost, the CD concept lacks an empirical basis and lacks consensus about a definition (Dear, Roberts, & Lange, 2005; Peled & Sacks, 2008; Rotunda, West, & O'Farrell, 2004; Stafford, 2001; Wright & Wright, 1995). The criteria for CD are so extensive and inclusive (e.g., Beattie's [1992] bestseller provides 200 characteristics of the concept) that almost everyone in any relationship might be considered to be codependent (Miller, 1994). While some measures to assess CD have been attempted (e.g., Dear & Roberts, 2005), to date there has been limited scientific research focused on examining measures to assess CD (Marks,

Blore, Hine, & Dear, 2012) and no consensus or evidence of reliable and valid measures (Dear, Roberts, & Lange, 2005). CD has never been included in any version of the *Diagnostic and Statistical Manual of Mental Disorders*.

Another criticism of CD is that it is yet another ''label''. Often, without intent, the terms within the medical model (e.g., ''disease'' and ''illness'') hold negative connotations and can affect the manner in which people, including educated professionals, treat people with an addiction (White & Kelly, 2011). The term *addict*, for example, has been found to elicit negative, often stigmatizing and shameful feelings within clients (Gray, 2010). Miller (1994) notes that even though framing an addiction within the medical model has helped remove some of the stigma associated with alcohol abuse, the CD terminology victimizes, blames, and internalizes the ''problem'' faced by CSOs. Labeling people, mostly women, as ''codependent'' increases their grief and guilt (Collins, 1993; Harper & Capdevila, 1990), particularly since codependents are often ''accused'' of having chosen their spouse because they ''needed to be needed''. Unless frontline workers familiarize themselves with the literature, they would not know that the belief that CSOs of problem gamblers need to be needed is a myth: Lorenz and Shuttlesworth (1983) found that only 10% of respondents ''were aware that their spouse was a compulsive gambler at the time they were married (p. 71), and 25% ''did not recognize that a problem existed until nine or more years after the start of the marriage'' (p. 69). This lack of awareness that a problem exists may be a fundamental difference between spouses of problem gamblers and spouses of substance abusers.

Another risk of the CD label, indicating that the CSO has a disease, is that it provides the addicted person with ''a partner in crime'': normalizing ''sickness'' and giving the addict a vehicle for shirking responsibility for the behaviour and its consequences (Krestan & Bepko, 1992). This shirking of responsibility is an important consideration, perhaps more so with gambling than with substance abuse, since cognitive distortions are considered to play a greater role in gambling disorders: In the *DSM-5*, a gambling disorder is the only disorder listed in the ''Substance-related and addictive disorders'' chapter that indicates ''distortions in thinking'' as an associated feature (American Psychiatric Association [APA], 2013, p. 587). No one has researched the impact that cognitive distortions have on family members who may attempt to ''rationalize'' with the gambler, and who are in a position to attempt to manage family dynamics, a home, and the upbringing of the children, in the context of a family member who may be irrational and unrealistic about finances and other family issues. Efforts to cope with the problem gambler's irrational behaviour(s) may even occur while the CSO is still unaware that there is a gambling problem.

One example of a cognitive distortion relates to the cultural norm in any given community, particularly in some communities where the media ''glamorizes'' and ''normalizes'' gambling (Tepperman & Wanner, 2012). As indicated in the *DSM-5* (APA, 2013), a ''gambling disorder must be distinguished from professional and

social gambling'' (p. 589). It can be difficult for a layperson, not educated in the symptoms of a gambling disorder (e.g., a CSO) to discern when the gambler has crossed the line from acceptable ''professional'' and ''social'' gambling, to behaviour that is unacceptable and considered to be a ''disorder''. This lack of clarity about ''acceptable'' levels of gambling facilitates gamblers' normalization of their behaviour, and may be confusing for CSOs, leading to additional stress, struggles about how to best cope, and reducing the amount of understanding and support received at a societal level.

Also related to culture, few authors highlight that the CD concept stems from male, Anglo-centric values of individuality and autonomy, often overlooking cultural and collectivistic perspectives, including interdependence and a commitment to the family unit (Granello & Beamish, 1998; Inclan & Hernandez, 1992; Kwon, 2001). Across the globe, many of the symptoms of CD are simply a description of the expectations of women within that society. For example, Noriega, Ramos, Medina-Mora, and Villa (2008) found that in Mexico, ''women with a submissive cultural script were nearly eight times more likely to develop codependence than those without this programming'' (p. 199). Many of the Eastern and South Asian communities continue to value the collectivistic and ''traditional'' family values of caring for one another; where a woman may be considered ''overly'' responsible in a Western community, this same woman may be viewed as quite ''normal'' in an Asian community.

Except for Calderwood and Rajesparam (in press), the CD concept has not been critiqued in the context of changing gender roles in Western society. When CD was first conceptualized, women were assumed to be submissive, dependent, and if employed at all, only employed in caregiving roles; today, women in Western societies are more independent, both financially and emotionally (Calderwood & Rajesparam, in press). Contrary to the focus of family systems theory, women also are a part of other systems outside of the immediate family system, such as employment, volunteer work, hobbies, friendships, and new marriages; women gain self-esteem and strengths from their involvement in these other systems (Calderwood & Rajesparam, in press). Typically, the wives in early studies in the gambling field were housewives (e.g., Boyd & Bolen, 1970). As Ferentzy, Skinner, and Antze (2007) indicate, more research on the impact that changes in women's roles in society has on recovery for problem gamblers is necessary, particularly since it seems that spouses' support for problem gamblers has diminished due to women's increased levels of independence.

Also related to societal influences, few authors highlight the role that community or society plays in enabling addictive behaviour. For example, gambling venues entice patrons to attend their facility through free transportation, free accommodation, free meals, and gambling coupons. Gambling venues also encourage patrons to stay longer by providing bank machines on-site and only offering free transportation home after a certain hour. If we must lay blame on someone for facilitating the

gambling behaviour, as the CD concept suggests, we should expand the blame to include a much broader system than the immediate family unit. More advocacy efforts need to occur, to raise awareness about how little the broader societal system does to prevent the development of, and to arrest, problem gambling.

The spouse of a gambler often is unaware of the debt being accrued, the house being re-mortgaged, and bills not being paid until the consequences are so severe that bankruptcy is inevitable. More so than substance abusers, gamblers can keep their compulsive behaviour hidden from those close to them for quite some period of time (Borch, 2012; Lorenz & Yaffee, 1989; McComb, Lee, & Sprenkle, 2009), typically, going unnoticed until a significant amount of money is lost. Unlike substance abusers, gamblers will not be caught gambling and driving (although that time may arrive once Internet gambling is increasingly available on cell phones), they do not smell like gambling, and their behaviour and physical appearance can be consistent, despite great financial losses. In fact, economic consequences of gambling is one area that has been identified as being different from substance abuse to the point where Gambler's Anonymous places more emphasis on finances, and does so earlier in the recovery process than substance-related anonymous groups (Ferentzy, Skinner, & Antze, 2009). Relevant to family members is that the consequences of bankruptcy often are long-lasting and may lead to CSOs being legally responsible for the financial debts of their partner. As supported by many who subscribe to the CD concept, a quick solution for a spouse of a substance abuser may be to leave the relationship. However, for the spouse of a problem gambler who has exhausted all monetary savings, leaving will not resolve the financial burden caused by the gambling behaviour. In fact, leaving might even put the spouse in a deeper economic crisis.

Recommendations for Working with CSOs

Given that there is evidence to support a stress-coping model for CSOs, our first recommendation is that service providers (regardless of their past personal or training experiences) align their philosophy with evidence-based approaches. We also recommend that all service providers be knowledgeable about the CD concept and its limitations, as we know that clients often present to treatment already having adopted the CD identity (Frank & Bland, 1992), and possibly finding this identity to be helpful. In terms of definition, since there is no consensus in the literature, we recommend that if a client presents having already adopted the CD identity, the service provider inquire about the client's definition and support the client in what works for him or her. In addition, it is important to recognize that the literature has identified two types of CD: those whose symptoms are a reaction to a stressful circumstance (Whitfield, 1984) and those who seem to have a personality where they seek partners who ''need'' them (Wright & Wright, 1991). We suggest that this distinction be considered along a continuum rather than two opposing options.

We recommend that for instances when a client has already adopted the CD identity, frontline workers (such as the lead facilitator described above) take the time to learn about where the client sees him or herself along this continuum. It is important not to assume that a spouse who has had a healthy upbringing, healthy relationships, strong self-esteem, and many life successes, has a ''needy personality'', is ''codependent'', and intentionally chose to marry ''a bad boy''. Similarly, we cannot assume that a spouse knew about the gambling problem and intentionally contributed to the problem by giving money and lying for their spouse. As discussed above, problem gamblers often are successful at hiding the problem for extended periods of time. Thus, the spouse may not have been aware of the problem until recently.

We recommend that service providers be aware of the power and influence of self-help materials, support groups, and online information. During the time of writing this manuscript, one of the authors was in a very remote small town gift shop carrying Beattie's (1992) bestseller: *Codependent no more: How to stop controlling others and start caring for yourself*. Without any prompting, a local woman who noticed the book commented ''Oh isn't that a great book? It is so true that we women in our society give too much of ourselves. I can't tell you how helpful that book has been for me''. As she spoke, it was clear that she had uncritically adopted everything in the book with no knowledge of competing approaches, such as a stress-coping model of understanding. We believe it is incumbent on service providers to be knowledgeable about the range of perspectives available and be able to educate clients, using sound clinical judgement.

We recommend that counsellors explore the reasons as to why a CSO has sought treatment. For example, given that financial devastation has long-term and possibly life-long consequences, a spouse may seek help for a number of reasons, including: how to deal with bailiffs and creditors, explaining to the children why there is no money, and explaining to the children why the other parent may not be spending time with them. These are valid reasons for seeking treatment that are not necessarily related to CD. Further, the financial devastation, accompanied by lying and deceit, often leads to a lack of trust and betrayal (Dickson-Swift, James, & Kippen, 2005). Spouses or ex-spouses of problem gamblers may attend treatment to find ways to trust their spouse, a future partner, or others. Again, this may not be attributable to CD.

Provided that problem gamblers are known for their cognitive distortions (APA, 2013), a spouse may be seeking guidance about how to manage a household and raise children in the context of a family member who may often be irrational. This could be considered comparable to a spouse who attends counselling after their significant other has been diagnosed with Alzheimer's disease. Would a spouse of someone with Alzheimer's automatically be deemed codependent? In some instances, the spouse may have already separated from, or be divorced from, the problem gambler and legally may be required to have continued contact with the

problem gambler, due to child custody and access agreements. As such, strategies to cope with irrational thinking and behaviour are crucial, and would be more related to practical necessity than to symptoms of CD.

When spouses repeatedly talk about their partner with a gambling problem, it is important not to assume that this is ''external focusing'' or ''attempting to control other people'', indicators of CD as defined above. Instead, the CSO may be striving to simply understand the gambler, or his or her choices to be with the gambler prior to knowing there was a gambling problem. If the CSO was unaware of the problem for an extended period of time, he or she may question how the signs may have been missed and question the choices he or she made. Seeking to make sense of it all is typical in any kind of loss. Lorenz and Shuttlesworth (1983) found that 99% of 250 spouses indicated an increased ''understanding of the compulsive gambler'' (p. 70) contributed most in their coping.

We also recommend that frontline workers pay particular attention to recruitment and retention. Although we do not know the percentage of CSOs that seek treatment, we do know that in general, only 1% to 2% of problem gamblers seek treatment in any given year (Rush, Shaw Moxam, & Urbanoski, 2002), and only 7% to 12% of people with a lifetime history of problem gambling have ever sought treatment or attended a self-help group for their gambling (Slutske, 2006). There are also some indications that admission rates for gambling issues are declining in treatment programs (Abbott, 2007; Calderwood & Wellington, 2014) and in GamAnon (Ferentzy, Skinner, & Antze, 2010). This may be because more spouses are separating from the gambler as Ferentzy, Skinner, and Antze (2010) suggest, or it may be for other reasons such as our ineffective treatment strategies and failure to appropriately engage clients. Clearly, in the case scenario described above, the facilitator failed to engage the CSOs. Given that loss theories have repeatedly shown that a first reaction to receiving a diagnosis is denial (e.g., Kubler-Ross, 1969), informing CSOs in the first few sessions of treatment that they are codependent and/or ''have a problem'' is likely to lead to denial and increase the risk of the CSO not completing the program, as was the case in the scenario described above.

Recommendations for Program Managers and Researchers

Krishnan and Orford (2002) are among the few authors who have written specifically about coping strategies for family members of problem gamblers. Using an adapted version of the Coping Questionnaire (Orford et al., 1975), Krishnan and Orford found that family members of gamblers were more likely than family members of substance abusers to use ''engaging'' ways to cope: ''controlling, assertive, emotional and supportive'' [p.67]). Participants in this study were not as likely to use strategies such as tolerance (''inactive, tolerant and supportive'' [p. 67]) or withdrawal (''inactive, independent and avoidance'' [p. 67]). These findings suggest that spouses of problem gamblers exhibit fewer CD traits than spouses of substance abusers, as the tolerance form of coping is the one most aligned with CD.

These findings highlight the importance of continuing research on the differences in needs and coping strategies between CSOs of substance abusers and those of problem gamblers. The findings also reinforce our position that those working in the problem gambling field should not blindly adopt what is thought to be effective in the substance abuse system.

We recommend that research in this area not be limited to the stress-coping model. Several authors who critique the CD concept suggest alternative ways to focus the treatment of family members including: communication and problem-solving (Miller, 1994); the issue of being over- and under-responsible (Krestan & Bepko, 1992); the CSO's sense of entitlement in preparation for reducing their level of responsibility (Lederer & Brown, 1991); how CSOs relate to others (Wright & Wright, 1991); immaturity presented not as a disease but as "a stage that we must all pass through" (Larsen & Goodstein, p. 50); growth (Malloy & Berkery, 1993); empowerment (Collins, 1982; Frank & Bland, 1992); and larger societal issues such as "fair and equal relationships, devoid of power games, where real intimacy can develop through a loving and respectful partnership" (Noriega, Ramos, Medina-Mora, & Villa, 2008, p. 200). We suggest that each of these be considered in the development of interventions appropriate for CSOs of problem gamblers.

As stated above, self-help materials, including online resources, influence frontline workers. Although family systems theory seems to have influenced the conception of CD (Krestan & Bepko, 1992; Miller, 1994), it is important to note that, typically, service providers in the addictions field are not family therapists (Harper & Capdevila, 1990). In fact, self-help groups have been the ones to address the issues of CSOs much more so than government supported/funded services (Barber & Gilbertson, 1996; O'Farrell & Fals-Stewart, 2001; Rychtarik & McGillicuddy, 2006). Recent years have seen a bridging of traditional twelve-step approaches and evidence-based approaches, particularly since budget constraints make no-fee self-help groups a more viable option for individuals and for treatment system planning. We acknowledge the value of peer support and peer-led treatment programs but caution against counsellors being hired solely for their twelve-step and personal experience without any formal academic training that might introduce them to evidence-based approaches. This seems to have been the case in the scenario described above.

As stated above, recruitment and retention is another important issue for problem gambling services, with some concern about admission numbers declining. Only a few studies have been conducted to determine what leads CSOs to seek, and not seek, help from formal treatment. Pulford et al. (2009a; 2009b) for example, investigated reasons for seeking help and barriers to seeking help for a gambling problem, primarily focusing on pre-determined "person-centred" categories about problems that may have arisen for the gambler because of the gambling. We applaud the authors for including open-ended questions but encourage others to specifically ask about "service-centred" factors such as the reputation of the

program, quality of service received, and alignment between program approach/techniques with CSO's learning and life styles. We recommend more research, particularly qualitative research, with CSOs of problem gamblers who have dropped out of programs, to determine what they found and did not find useful in the treatment approach, so that we may develop more appropriate program approaches to better meet their needs.

Conclusion

CD was a term developed in the substance abuse field, with no empirical basis and no reliable or valid identified criteria. There are many critiques of the CD concept, mostly from a feminist perspective. This paper highlights some of those critiques relevant to the context of CSOs of problem gamblers. In addition, this paper emphasizes the importance of identifying where the experience of CSOs of substance abusers may differ from that of CSOs of problem gamblers, particularly as the differences are relevant for clinical practice. More research is required to further identify the differences and to determine best practices for providing services to CSOs of problem gamblers. We agree with Krishnan and Orford (2008) that a stress-coping-support perspective "offers an appropriate framework for understanding problem gambling and the family" (p. 62), and encourage others to further study how CSOs of problem gamblers cope, the effectiveness of the coping strategies, and the impact those strategies have on all involved. However, we also present suggestions for other topics to include in treatment with CSOs and encourage researchers, program managers, and frontline workers to not limit their interest to one perspective.

Some authors believe that since no causality between CD and the presence of an addiction has been identified, professionals who continue to automatically assume a CSO is codependent are doing more harm than good (Cox Jr., Ketner, & Blow, 2013; Granello & Beamish, 1998). We do not critique CD to this extreme, recognizing that many clients may present to treatment already subscribing to the CD identity (Frank & Bland, 1992) and recognizing that many people find CD to be useful. Instead, we advocate that service providers strive to use evidence-based approaches and be knowledgeable and respectful of other approaches, educating clients as clinically appropriate.

Ferentzy, Skinner, and Antze (2009) found that GA members "would not have achieved and maintained abstinence if not for the presence of their wives in GamAnon, … others even held the (startling) view that recovery from pathological gambling is impossible without a spouse in that fellowship" (p. 44). This finding supports other authors' views (including ourselves), who emphasize the important role of family support in treatment (e.g., Han, Kim, Lee, & Renshaw, 2012). As such, we advocate for service providers, program managers, and researchers to be cognizant of and study issues relating to recruitment and retention of CSOs of problem gamblers. We also recommend that program managers and researchers

recognize the factors that affect attrition, and be cautious about whom they hire, what training is provided, and how program evaluations are conducted (examining fidelity to agency philosophy and treatment approaches).

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