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Commentary on Calderwood and Rajesparam (2014)

Response to the commentaries by Lee, Harkness, and Orford

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We would like to begin by thanking the reviewers, editors, and authors of the commentaries, for their enthusiasm for this topic and their support for our agenda to re-open the debate about the codependency (CD) concept. Our primary goal is to initiate sufficient critical discussion for service providers to be more cautious about using the CD tenets while at the same time reflecting on its origins, strengths, and limitations. While we recognize that the concept has had some utility for a large number of people around the globe, we are concerned about the societal messages that the concept conveys, such as women being responsible for others' addictive behaviour, and the devaluing of caregiver roles. Our motivation in the original opinion paper came from the experience of witnessing a service provider's first words to concerned significant others (CSOs) of problem gamblers be ''What is your problem?'' Orford's indication that this example is very widespread confirms for us the importance of initiating this debate.

We thank Lee for providing the family theory perspective. We are both too young to have been directly involved with, or knowledgeable about, the emergence of the CD concept. So our statement that the conceptualization of CD was influenced by family systems theory was solely based on what we found in the literature (e.g., Krestan & Bepko, 1992; Miller, 1994). We welcome Lee's clarifications pertaining to family systems therapists like White, Haley, and Satir, and their call to ''raise sensitivity to how language is used'', and her clarifications pertaining to the fact that ''in the second wave of family therapy, the therapist is seen as a co-constructor rather than an expert in the therapeutic process.'' These points from Lee contribute further to our argument that the CD concept has failed to evolve in a way that is aligned with the direction of other supportive interventions. As Lee indicates, ''the negative assignment of blame and neediness to the partners in 'codependency' is a bastardization of family therapy's way of conceptualization and problem formulation.''

Neither of us is a family therapist, hence our individualistic bias. We agree that the CD literature focuses too much on the individual, and we support Lee's argument for the

importance of providing, and researching, couple therapy in the addiction context. Further, the CD literature does not include the possible impacts that subscribing to CD tenets may have on the children of the family. In the past several decades, in areas of family interventions such as custody and access, Western society has shifted to decision-making in the *best interests of the child(ren)* (BIC). To date, the CD literature has not addressed the BIC (Calderwood & Rajesparam, in press). Considering the children, as well as the adults in the family system, might serve as an effective preventive approach to address the intergenerational patterns referred to by Lee.

We also thank Lee for introducing the following two points: ''The disclosure and discovery of a partner's problem gambling and its aftermath may in itself be traumatic for the CSO''; and ''CSOs likely need more in-depth healing than learning stress coping skills.'' Upon further reflection, we agree. From what we know of the stress-strain-coping-support model presented by Orford, Copello, Velleman, and Templeton (2010), its focus is very practical: addressing ''stress,'' ''strain,'' ''coping,'' and ''support.'' The focus is on the here-and-now, and on the ''addiction problem'' (Copello, Templeton, Orford, & Velleman, 2010, p. 91). Advantages of this model, as indicated by the authors, include the relative ease with which service providers can be trained on its use, and the fact that it does not use oppressive labelling, which could lead to the stigma seen with the CD approach. However, we wonder if its simplicity risks failing to validate, explore, and address the trauma and loss experienced by the CSO. We do not yet know whether the trauma and loss experienced by CSOs of problem gamblers differs from that of the CSOs of substance abusers. Orford appropriately challenges us about whether there are meaningful differences between the substance use and the problem gambling experience. We acknowledge that Orford may be correct, but we were unable to locate research that has explored this question specifically for the experiences of CSOs. For example, a trauma from unexpectedly and suddenly learning about the gambling behaviour, and the major loss of the spouse you thought you had (or home, or finances) may be more likely for CSOs of problem gamblers.

Regarding the conceptualization of CD, we agree with Harkness that it is a social construction. We want to clarify that when we recommended that researchers ''assess what is 'actually' occurring in existing practice,'' our intent was to indicate that a program (such as the one referred to in the original ''Words of Caution'' article) may present itself as evidence-based, and then behind closed doors with clients, counsellors may actually be using techniques that are not evidence-based. We recommend even more scrutiny than what Harkness and colleagues have done to date, although their work is a good start. In his commentary, Harkness states that ''the substance use counsellors we have studied were able to describe, operationalize and assess it with impressive reliability in clinical practice, and with promising evidence of concurrent, convergent, discriminant, and predictive validity.'' It is noteworthy, however, that the Harkness and Cortell (1997) study that demonstrated these findings was limited to a 22% response rate for substance abuse counsellors, and likely limited to counsellors who subscribed to the CD concept (otherwise they

would not have been able to appropriately complete the survey). The study did not reflect the views of counsellors who do not subscribe to the CD concept, nor did it articulate what criteria the respondents used to determine the degree of CD among case scenarios. While the findings showed reliable rankings for the degree to which sample cases were codependent, we argue that CD may not have been a unique construct that respondents were measuring; we suggest that if respondents had been asked to rank order the exact same cases based on the degree of ''stress'' or ''coping skills'' or ''problem-severity'', the rankings would have been the same.

Surveying substance abuse counsellors and clients who do not buy into the CD concept would provide additional insight into the flaws of the concept. For example, as counsellors who do not subscribe to the concept, we find it disturbing to see what the counsellors in Harkness and Cotrell's (1997) study considered to be ''Low Co-dependency.'' The example in that article to us is not CD at all, but a mother trying to be the best parent she can be. This ''Low-Codependency'' case is similar to the presentation of the four CSOs described in our original ''Words of Caution'' article who were asked ''What is your problem?'' Based on the information available to us, we assert that none of the four believed they had a problem or considered themselves to be codependent. We too did not consider them to be codependent. However, we have no doubt that most counsellors who subscribe to the CD concept, including the respondents in Harkness and Cotrell's study, would have considered the four CSOs to be codependent simply for the reason that they were, or had been, in a relationship with someone with an addiction. Similarly, the bottom three scenarios in the Idaho Codependency Scale (Harkness, Swenson, Madwen-Hamptom, & Hale, 2001), to us, are not examples of CD but of individuals trying to do the best they can with their current high-stress environment. We suggest that the remaining scenarios in the Idaho Codependency Scale all seem to fit one or more diagnoses in the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2013), such as dependent personality disorder and depression. As such, we argue that having a separate category called CD does nothing to contribute to the criteria, and diagnoses, that already are widely supported, and evidence-based.

We thank Orford for questioning our recommendation to not dismiss the CD concept if a client finds it useful. This recommendation was made in the context of treatment, not in the context of raising public awareness. Aligned with Orford's concern about promoting CD on a BBC program, we argue that in the interests of advocating for more empowering approaches to treatment, the CD concept should never be promoted, or glamorized, in prevention and other awareness raising initiatives. At the same time, we appreciate Harkness' account of a student who challenged him on his dismissal of CD. The first author of the ''Words of Caution'' article has had several similar experiences, finding that the CD principles are so entrenched for some people that to critique the concept in their presence risks insulting and alienating them. In the treatment context, a negative attitude toward the CD concept risks an increase in attrition rates for clients who do take on the CD identity, and find it to be useful.

Having said all this, we feel that we are preaching to the converted, as it seems that our views are generally supported by the views of others who read and publish scholarly literature. The challenge lies in how to inform and open the debate among those who do not use an evidence-based approach and who religiously subscribe to the CD tenets. It would have been useful to have a commentary by a strong supporter of the CD concept, to reflect on their perspective. As Lee indicates: ''Once a concept such as codependency has gained traction through wide circulation in popular and addiction recovery culture, it acquires a taken-for-granted meaning that seldom gets scrutinized.'' Also, Lee questions, ''if the codependency narrative is inadequate and potentially damaging, then what are the alternatives?'' We recommend that future research examine both the utility and risks of employing the concept. From this research, we hope that an alternative is developed that addresses the needs of CSOs, while eliminating the oppression that currently occurs with the CD concept. The next step will be to find ways to educate those who advocate for the use of the CD concept so that they recognize its oppressive nature, and consider the alternatives.

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