

Commentary on Calderwood and Rajesparam (2014)

Commentary on “Applying the codependency concept to concerned significant others of problem gamblers: Words of caution”

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I was asked for comments on this opinion paper only because I have conducted and published research on codependency. I know virtually nothing about those who treat gambling disorder, and I am probably not alone (Gallon, Gabriel, & Knudsen, 2003; Kaplan, 2003; Mulvey, Hubbard, & Hayashi, 2003).

The focus of Calderwood and Rajesparam’s “Words of Caution” is the treatment and mistreatment of concerned significant others (CSOs) affiliated with problem gamblers. A cautionary tale, it was prompted by the negative experience of one of Calderwood or Rajesparam, who observed an “expert” facilitator, self-described as a recovering addict, browbeat the participants of a hospital-sponsored psycho-educational group for problem gamblers and CSOs. On four separate occasions with four different family members, the lead facilitator’s first question to the CSO asked: “What is your problem?” Then, like a broken record, the expert proceeded to badger group participants about the putative characteristics of codependency for six weeks, albeit without actually ever uttering the offensive c-word. Noting that three of the four CSOs enrolled in the group became drop-outs, the authors became worried that other CSOs might also be at risk, because “workers in the gambling field have adopted or adapted treatment strategies used in the substance abuse field,” by which they mean problem-focused family systems theory, a codependency disease model of human behavior, and in-your-face confrontation. As an antidote, Calderwood and Rajesparam prescribe “more recent therapeutic trends such as a strengths perspective, solution-focused therapy, and a stress-coping model of understanding CSOs.”

I have to agree that badgering and browbeating clients doesn’t sound very helpful, but I would like to tell a tale of my own. I received my clinical training in the early 1970s, and the National Institute on Drug Abuse funded the first of the fellowships that put me through school. My second fellowship was funded by the National Institute on Mental Health, with a service obligation to provide mental health care in an era when the treatment of substance use and mental disorders were in two

different worlds. Ten years later, I returned to school for additional training in evidence-based practice and research. As it happened, three of the people who trained me were the pioneers of the *strengths perspective* movement, an alternative to the prevailing medical model of clinical practice (i.e., the diagnosis and treatment of what's wrong).

When I was asked to develop a graduate course on the evaluation and treatment of substance use disorders in the early 1990s, my practice experience in mental health clinics and training in research shaped the assumptions and content of my teaching. I viewed addiction counsellors as paraprofessionals, and I was privately dismissive of their models of human behavior, confrontational methods of treatment, and practice traditions. My assumptions and attitudes became a point of contention when a certified addiction counsellor enrolled in our graduate program used the term codependency in class, and apparently I responded by smirking, rolling my eyes, and looking to the walls and the ceiling.

After class, the student came to my office with a challenge to extend him the courtesy of the strengths perspective I championed in the classroom, to partner with him in a systematic study of codependency, and help him acquire some hands-on experience with evidence-based methods and standards. Although he was a talented student, I had other pressing interests – but I had to agree because I'd boxed myself in.

Our study began with a systematic review of the literature. Our reading list included the extant works cited in Calderwood and Rajesparam's "Words of Caution" – and many others as well, although some (Dear, Roberts, and Lange [2005], for example) had yet to be published. But unlike Dear, Roberts, and Lange (2005), whose goal was "to define the core-defining features of codependency that are contained within the most influential published definitions of codependency" (p. 192) in "the major books on the self-help best-seller lists ... cited by researchers and reviewers" (p. 193), our review emphasized scientific disputes, as illustrated in the following example:

On one hand, Fischer, Spann, and Crawford (1991) [sic]; Fischer and Crawford (1992); and Fischer, Wampler, Lyness, and Thomas (1992) have defined codependency as a dysfunctional pattern of relating to others with "an extreme focus outside oneself, lack of open expression of feelings, and attempts to derive a sense of purpose [exclusively] through relationships" with others. The investigators developed a self-rating scale to operationalize that definition and used it to examine the association among co-dependency, family substance abuse, family functioning, risk taking, parent-child relationships, and offspring alcoholism in samples drawn from self-help groups and university students. Thus defined, the phenomenon of co-dependency was gender-free, and associated with neither chemical dependency nor dysfunctional family patterns.

On the other hand, Lyon and Greenberg (1991) have operationalized co-dependency as women finding exploitive men attractive and offering them help. Their experiment drew daughters of persons with alcoholism or sober parents from a sample of university students and exposed them to requests for help by a male confederate under exploitive and neutral conditions. Daughters of parents with alcoholism found the exploitive man significantly more attractive, and offered him help at twice the rate of their counterparts from sober families. Thus defined, co-dependency has gender and signals family dysfunction. (Harkness & Cotrell, 1997, p. 474)

Our review of the multiple meanings of co-dependency in the literature led us to suspect that codependency was largely a social construction, as much perceiver as perceived, a conclusion with which Lee might well agree. Noting how little seemed to be known about the counsellors who treat substance use disorders, we began planning, conducting, and reporting a series of studies designed to unravel their social construction of codependency in clinical practice – where constructed meaning shapes the treatment that consumers receive. Although our work was not cited in Lee’s rebuttal, what we sought to observe was what actually occurred in practice, as its authors recommend.

I was asked to provide a comment on Lee’s piece titled “Words of Caution”, and not to provide a lengthy description of our own research (e.g., Harkness, 2001; Harkness, 2003; Harkness & Cotrell, 1997; Harkness, Hale, Swenson, & Madsen-Hampton, 2001; Harkness, Manhire, Blanchard, & Darling, 2007; Harkness & Piela, 2009), so I’ve summarized our findings here only briefly. Although we remain decidedly non-partisan on the question of what codependency is, 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. Faced with the evidence, to finish my story, I had no choice but to swallow my pride, and eat my own words.

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