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Commentary on Calderwood and Rajesparam (2014)

A response to Calderwood and Rajesparam's ideas on codependence

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I welcome this opinion paper by Calderwood and Rajesparam in this issue and largely agree with what they say. However, I believe they could have gone yet further in their criticisms of the codependency idea in two ways: By recognising that the concept is part of a more general and insidious view of the causes of human adversity, and by recognising that such a model is a very inadequate basis for developing a more effective and comprehensive service for family members harmed by others' substance misuse.

The two models that the authors refer to go back a long way, at least to the early 1950s when Joan Jackson (1954) wrote of wives coping with the stress of their husbands' excessive drinking. She was reacting to the assumptions contained in the dominant models of the time which pictured women married to alcoholic husbands as motivated to choose and remain with them, and even to undermine the husbands' attempts at sobriety, on account of their own pathological needs. Although such overtly prejudiced views are now clearly seen as outdated, more subtle prejudice and more ambiguously pathological models remain. Codependency theory is an obvious example; as the authors say, there is some ambiguity as to whether it refers to a reaction or a personality type, but the very term codependency implies that what is being described is more than a reaction to an imposed set of stressful circumstances.

But codependency is not the only perspective which is ambiguous in this respect. Any approach which implies that the fault lies at least partly with a partner, parent or other close family member (and it is more often women who are implicated) runs the risks which the authors allude to – of labelling, stigmatising and blaming the victim. The example given of witnessing a family member being asked "What's your problem?" is very telling because in my experience this assumption that a family member affected by addiction must have a problem beyond simply being the victim of someone else's addiction is very widespread. At worst, the family member may have been abusive (an assumption more likely if the family member is a parent or is male) or pathologically vulnerable or over-controlling (an assumption more likely in the case of women partners), but at the very least the assumption is that the family

member has been drawn into some kind of complementary transaction or maladaptive way of coping; she should therefore be prepared to talk about herself and not just about her husband's behaviour and the impact that it has had on her. In fact, this contrast between ways of explaining adversity runs through the health and social sciences and relevant policy debates, extending far beyond the topic of addiction and the family. One thinks, for example, of assumptions about rape which implicate victims, or of poverty which implicate the personal shortcomings of the poor, or of the communities in which they live.

As well as being a pathological, or at best ambiguous, model, codependency also shares with other perspectives favoured by the psychological and health sciences a focus on individuals or at most the interiority of families. In the process it neglects, as the authors point out, all that goes on externally to the family which helps to promote and maintain addiction, whether that be the concentration of gambling venues in relatively deprived areas, the development and marketing of technologically more advanced and more dangerous products, intense advertising and lobbying by the industry, or the co-option of scientists in diverse ways (Adams, 2008; Babor, 2009). This can be conceptualised as the exercise of power in its various, more or less hidden, ways (Orford, 2013). Seen in those terms, family members affected by their relatives' gambling or other kinds of addiction, are comparatively powerless and progressively disempowered by addiction.

Whilst Calderwood and Rajesparam recognise the limitations and dangers of codependency theory, they seem to say that it should not be dismissed if family members find it useful. This reminds me of once debating on the BBC radio program *Women's Hour* with a woman who was convinced that the most helpful thing for her had been to recognise the contribution that her codependency had made to her husband's alcohol dependence. Who was I, I thought afterwards, to have argued with her experience? On further reflection, however, I am convinced that I was right to argue that codependency is no basis for the development of a public service that would be sensitive to the position of the large numbers of family members who are affected by addictions, including gambling, and which would be able to offer them what they need. The authors make an appropriate analogy with Alzheimer's disease, to which one could add any number of disabling conditions or sets of adverse circumstances: If we were to design an ideal health and social care system which included family members in as effective and respectful a way as possible, we would surely not base it on codependency or other family pathology model. Meanwhile, sadly, providers of health and social services, who come across many family members affected by their relatives' addictions, albeit often unknowingly, have often heard little in their training other than some variety of codependency theory or similar.

I very much agree with the authors that family members and service providers should be much more aware of stress-coping alternatives. Our group has focused on the development and testing of a 5-Step Method (Copello, Templeton, Orford, &

Velleman, 2010a,b) which is based on the stress-strain-coping-support model (Orford, Copello, Velleman, & Templeton, 2010), and which is designed specifically to meet the needs of affected family members in their own right. It aims to be sufficiently flexible to be delivered in a variety of different formats (including group, self-help handbook and web-based). Those who deliver the intervention need not be specialists in addiction or mental health but they do require a brief period of induction/training (6 to 12 hours ideally). The method has been used with promising results in a variety of countries and sociocultural groups and has been adapted for work with family members affected by gambling (see the Addiction and the Family International Network, AFINet, website at www.afinetwork.info).

Finally, I would like to comment on some of the interesting things that Calderwood and Rajesparam say about the possible differences between the family experience when a relative has a gambling problem compared to the experience when the problem is that of alcohol or drug misuse. I agree with much but not all of what they say here. My own and my colleagues' conclusions are that these experiences are on the whole the same, with some differences of emphasis (Velleman, Cousins, & Orford, in press). I do agree that the centrality of money means that family financial harms are particularly prominent in the case of gambling. I also agree that it is more possible to keep excessive gambling hidden from members of the family for a long time. But of course these features figure in the case of alcohol and drug problems also, and I am doubtful whether the lack of clarity about when a line is crossed from acceptable to problematic gambling, or the importance of helping a family member understand excessive gambling and the gambler, which the authors refer to, are any different from their parallels for substance problems.

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