Codependency And The Dharma

The term “codependency” has evolved since it was first proposed in the 1980’s to understand how alcoholism affected others in a family system. An early rendering of the term was “co-alcoholic”, focusing on the vulnerability of people close to alcoholics to problematic drinking as well. Literally, the term “co-dependence” represents the co-occurrence of particular behaviors and relationship patterns that can be found in those people who are closely involved with alcoholics.

As treatment facilities became more prevalent during the late 1980’s and early 1990’s, the term codependent became more generally associated with other substance dependencies, such as cocaine and heroin addictions. At the same time, family systems researchers began to identify particular roles that family members took on, such as *enabler, dependent, scapegoat, hero, lost child* and *mascot*. The *enabler* was the person who’s attitudes and behaviors enabled the addicted person to continue to access their primary addictive substance (this is the codependent). The *dependent* was the person who was addicted or most vulnerable to addiction. The *scapegoat* was the person who was systemically designated the problem that caused the addictive behavior, i.e. “If it wasn’t for you I wouldn’t drink!”. The *hero* was the person whose behavior “rescued” the system, that is, someone who was athletically or academically outstanding. The *lost child* was the person who withdrew into silent compliance with the dysfunctional systems dynamics. The *mascot* was the person whose role was to be cute or amusing—a distraction from the stress of the system’s dysfunction. It is not uncommon for folks to move from one role to another as the system’s dynamics changed over time.

Regarding the roles described above, the *enabler* sacrifices her or his best interests (and perhaps of other family members or co-workers) in order to maintain the status quo in the relationship with the addicted person. The *dependent* role involves blending values and behavioral patterns with the addicted person (If not the identified addictive process, than a substitute—my father was an alcoholic, and I abused marijuana). The *scapegoat* role conditions a person to act out in ways that divert attention to her or his behavioral problems (these folks are sometimes labelled “the *identified patient*”, who might be clinically anxious or depressed, which any of the members are vulnerable to). The *hero* role forces a person to see her- or himself as required to excel, to not fail at any time in their role. The *lost child* role disables the person’s ability to speak up, to have authority in the system. The *mascot*’s role is to entertain the other members of the system, as a distraction away from conflict. In all these roles, a person’s ability to negotiate effectively in relationships is compromised.

Anne Wilson Schaef is an important author who developed the concepts of codependence. In 1986 she wrote *Co-dependence Misunderstood-Mistreated*. In this book she expanded the range of the circumstances that could foster and sustain codependency, including any family system disrupted by a chronic condition that minimizes effective communications and emotional authenticity. These conditions might include physical/sexual/emotional abuse, or even a chronic, debilitating health condition suffered by a family member. Later she wrote *When Society Becomes An Addict*, in 1987, that associated the general dysfunction of contemporary culture, and in 1990 she coauthored *The Addictive Organization* with Diane Fassel. In the last two books, she proposes that the broad cultural conditioning of emotional repression and misogynistic leadership has significantly increased the frequency of codependency. Her analysis stretches the frequency and impact of codependent behaviors perhaps beyond useful bounds. At one point, there is a suggestion that, if everyone who worked with or otherwise had significantly negatively affected relationships with an addictive disorder, nearly 95% of our culture is codependent!

More recently, the concept of codependency has extended to anyone who is adversely affected by a family system significantly impacted by a chronic disability in one or more family members. For example, if someone in the family has a serious, debilitating disorder requiring ongoing monitoring and care, then the whole system adjusts to this condition. Unfortunately, because the opportunities to become addicted are so prevalent in this culture, the codependent interpersonal dynamics can foster a member’s vulnerability to becoming dependent on addictive behaviors in a maladaptive attempt to cope with the stress.

How can codependency be functionally understood? It may be useful to say that *codependency is a distortion of self-image, such that the codependent person lacks the internal awareness and interpersonal skills to successfully negotiate interpersonal boundaries.* One of the characteristics attributed to codependent family systems is “*Don’t think, don’t feel, don’t talk* (about the dysfunction) and *don’t rock the boat* (that is, don’t violate the dysfunctional relationship rules of the family system)”.The *don’t think* conditioning requires thoughts that are congruent with the denial aspects of the system. The *don’t feel* conditioning represents the disallowing of emotional awareness or expression (except, perhaps, for rage). The *don’t talk* pattern creates isolating the family members from openly talking about the dysfunctional behaviors, either in- or outside of the family. The *don’t rock the boat* rule is to maintain the dysfunctional patterns, at the cost of personal integrity.

These injunctions become embedded in the members of the family system, and frequently reappear in relationships outside of the family system. These dysfunctional “rules of engagement” are not specifically described or explained to the individuals affected by them—they emerge through unspoken adaptive functions that the dynamics of the family system impose. The codependent conditioning is often accompanied by feelings of shame, which can be a mystery to the affected person as to the pervasiveness of the shame.

How is this related to what Buddhist principles and practices may offer? The key concept to understand is that of craving and clinging. The craving is a strong pull to continue to reenact the dysfunctional patterns, including emotional blunting or anxiously brittle self-state processes. The clinging is the embedded identification with the dysfunctional family rules to the extent that it is hard to conceive of thinking or behaving differently from the family rules. The practice of mindfulness meditation enhances insight into how prior conditioning may bias our behaviors into any of the above described roles. The practice of redirecting attention away from impulsive reactions to what the mind creates, and to develop the skill of “not scratching the itch”, supports increased ability to effectively negotiate interpersonal needs, even when there’s some emotional potency involved, as is often the case among people who have long-term relationships.

In all the 12 step organizations, such as Alcoholics Anonymous, or, particularly Alanon or Adult Children Of Alcoholics, there is an imperative for increased self-awareness and accountability for the distorted thoughts and behaviors exemplified in the addictive family system. In particular, the 11th step involves “daily meditation and prayer”. I have always regarded mindfulness based concepts and practices as being primary training in the 11th step. Next week’s talk will involve discussion about the similar benefits derived from committed Buddhist principles and practices and what is offered through a committed working through of the 12 step system.