

Codependence with hypersexual and gambling disorder

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Background: The risks of behavioral addictions are well documented. There are biological, medical, social, spiritual, psychological, and safety risks to the individual as well as risks, like ripple effects, to the family and friends with whom the individual with behavioral addictions lives. The phenomenon of collateral damage from addictions, especially alcoholism and substance dependence, is well documented. **Aims and methods:** A selected review of the literature reveals little regarding the risks of collateral damage, in particular codependence, from behavioral addictions on non-addicted family and friends. **Results:** This article theoretically posits the existence of codependence to those with two well documented and researched behavioral addictions, hypersexual and gambling disorder, using the biopsychosocial lens. **Conclusions:** Addictions professionals are encouraged to revisit the literature on codependence and consider its influence on family and friends of those with behavioral addictions when providing services.

Keywords: addiction, behavioral addictions, biopsychosocial model, codependence, hypersexual disorder, gambling disorder

Rooted in the alcohol treatment literature, codependence (COD) was once called co-alcoholism (Cermak, 1986a, p. 4), coaddiction (Milrad, 1999), and “para-alcoholism” (Wilson Schaef, 1986). Whitfield (1991) suggested that COD could be a social contagion, an “acquired illness” (p. 5), and a survival strategy. Codependence can also be a learned adaptation from dysfunctional families if the parents are workaholics, psychotic, or have sexual disorders (Kitchen, 1991). The key factor is that the co-dependent person is over-responsible when at least one other family member is under-responsible (Krestan & Bepko, 1991). Still others view COD as an attempt to pathologize women (Anderson, 1994) and as a learned socio-cultural phenomenon (Miller, 1999). A lack of consensus on COD caused research efforts to wane although the self-help community continued to address it.

Despite its multiple interpretations, attempts are made to objectively define and measure COD. Seen as a dysfunctional condition that effects all dimensions of life, as per the biopsychosocial lens, COD is a preoccupation with others to the extent that the self is lost or abandoned (Whitfield, 1991). The criteria for COD include unsuccessful yet continued attempts to control others, assumptions of responsibility for others to the exclusion of oneself, enmeshment and blurred boundaries, anxiety, depression, denial, emotional restrictions, and involvement in a primary relationship with a substance dependent individual for at least two years (Cermak, 1986b). Attempts to control others may manifest in areas like working, eating, cleaning, or perfectionism (Koffinke, 1991). Other typical symptoms of COD include preoccupation with others, lack of identity, repression of feelings, rescuing behaviors (Koffinke, 1991), and enabling. Enabling includes an array of conscious and unconscious behaviors that can simultaneously perpetuate or even support addictions in others while reducing stress in the co-dependent person(s) (Rotunda & Doman, 2001; Shain &

Suurvali, 2003). Examples of enabling behaviors include covering up deviance, not expressing concern for unhealthy choices, dishonesty, minimizing risks, not enforcing policies at work, or not confronting disrespect.

The authors suggest that COD can be a valuable construct to better understand family and friends of those with behavioral addictions. Addictions service providers, researchers, and educators need to be prepared for the latest iteration of COD: COD to individuals with behavioral addictions. This paper is not intended to present an exhaustive review of behavioral addictions nor is it prosing that COD be considered a behavioral addiction similar to relationship or love addiction; instead, it will build on the literature by using the biopsychosocial lens to holistically describe COD. It will highlight the parallels between the COD experienced by family and friends of those who are substance dependent and COD experienced by family and friends of those with behavioral addictions, specifically hypersexual and gambling disorder – the two most researched of the behavioral addictions.

USING THE BIOPSYCHOSOCIAL MODEL TO UNDERSTAND CODEPENDENCE

COD is thought to have multiple origins and manifestations and thus there are many models or paradigms through which COD can be viewed and understood. If viewed from the psychoanalytic model, COD would be seen as an unconscious

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attempt to maintain family dysfunction, while reacting to collateral damage (Abbott, 2000) and trauma. The psychoanalytic model also suggests that co-dependent individuals exhibit traits of dependent personality disorder (American Psychiatric Association, [APA], 2000). If viewed through the disease model, co-dependent individuals would be seen as suffering from the same chronic, relapsing, primary disease of addiction as the substance abuser. It describes COD as a primary family condition (Zetterlind & Berglund, 1999) or “a relationship disease” (Wilson Schaef, 1989, p. 106), which can be transmitted through genetics (Inaba & Cohen, 2011) or “dysfunctional families” (Weinhold & Weinhold, 2008a, p. xiii). A more comprehensive, holistic approach to COD is the biopsychosocial model. It encompasses all aspects of an “addicted person’s life – on the conscious, unconscious, intellectual, emotional, behavioral, social, and spiritual” level (Alexander, 2008, p. 35). The biopsychosocial model reflects the “multivariate nature of addiction” (Fisher & Harrison, 2000, p. 51) and can be useful in describing the many complexities and risks of COD.

Biological factors

Addiction and COD are the “quintessential biobehavioral disorder[s]” (Leshner, 2001, para. 4) in which the brain is high jacked by exogenous drugs and endogenous neurotransmitters. An inherited genetic vulnerability to substance dependence is documented in the children and grandchildren of alcoholics (Doweiko, 2006; Robinson & Rhoden, 1998). Research identifies inherited nutritional, enzyme, hormonal, and neurochemical deficiencies in these children and grandchildren (Robinson & Rhoden, 1998) making them more vulnerable to injuries and illness (Lawson & Lawson, 1998). Given this research and the fact that biology can influence and be influenced by psychological and social factors, it is suspected that biological factors impact COD.

Psychological factors

The psychological etiology of COD stems from conditioned, developmental, and/or emotional contributors. COD is termed a “psychosocial condition” (Spann & Fischer, 1990, p. 27), as well as an investment in the false self to the detriment of the true self (Friel, Subby & Friel, 1984). Beattie (2009) contends that the causes of COD are more important than the behaviors characterizing COD. These causes include character flaws or deficits, personality traits (Cermak, 1986a), and a developmental failure to establish autonomy (Weinhold & Weinhold, 2008b). Co-dependents are described as inauthentic; becoming who they have to be in order to get needs met (Beattie, 2009). Psychologically, co-dependent persons are lost (Zetterlind & Berglund, 1999) since they define themselves in terms of others (Wilson Schaef, 1989). The co-dependent individual feels “imprisoned” (Doweiko, 2006, p. 323) and thus repeats non-productive behaviors in a “downward spiral” of neediness (Beattie, 2009, p. 106). Most co-dependent individuals make well intentioned, loving, albeit ineffective attempts to care for their substance abusing family member or friend (Abbott, 2000) and inadvertently they become a problem separate from and in addition to the substance abuser (Rotunda, West & Farrell, 2004). Thus, the common denominator of COD is the caretaking of another to the exclusion of the self.

Sociological factors

The social ramifications of COD are seen in families and friends. COD is typically thought to be triggered by substance abuse which has a social ripple effect, whereby each substance abuser may negatively and sometimes significantly influence four to six others (Abbott, 2000). Research by O’Brien and Gaborit (1992) suggests that COD can also be triggered by living and associating with other co-dependents, those with compulsive disorders like eating disorders, and chronically mentally ill people. Wilson Schaef (1986) was the first to describe COD as a cultural phenomenon and a new “norm for society” (p. 71). Family members deal with the addiction by adopting coping or “survival” (Robinson & Rhoden, 1998, p. 36) roles such as the super overachiever, the super underachiever, hero, mascot, scapegoat, and lost child. Roles are determined by age, gender, innate traits, cultural expectations, the functional level of adult caregivers, and the extent of community supports. A plethora of 12-step support groups serve family and friends of those with substance addiction, including Al-Anon and Alateen, for spouses and children of alcoholics; Co-Anon, for family and friends of those addicted to cocaine; and Nar-Anon, for family and friends of those addicted to narcotics.

The biopsychosocial model broadens our understanding of COD, highlighting the ways individuals are impacted by the addictions of another. Similarities in some of the effects of substance dependence on the addicted person and the effects of COD on family or friends are summarized in Table 1.

CODEPENDENCE WITH AN INDIVIDUAL WITH BEHAVIORAL ADDICTIONS

Addiction is commonly associated with alcohol, tobacco, or other drugs. Current literature also cites addictions to the internet, sex, debting, relationships, exercise, gambling, eating, and technology to name a few (Crozier & Rokutani, 2008; Demetrovics & Griffiths, 2012; Grant, Potenza, Weinstein & Gorelick, 2010). Also called toxicomania and habit formation (Elster, 1999), addiction is defined as excessiveness, immoderation, lack of self-control, obsession, and gluttony (Orford, 2001). The criteria for addictions builds upon the criteria for substance dependence; tolerance, withdrawal, increased dose, unsuccessful efforts to cut down or control use, preoccupation, compromise of values, and continued use despite negative consequences (APA, 2000). Addiction is a compulsive engagement with rather than an impulsive reaction from an activity that results in physical, psychological, or social harm to the user. Chamberlain (2004) compresses the meaning of addiction into three C’s; loss of control, compulsive behavior, and continued use regardless of negative side effects.

Addictions result from substance and non-substance behaviors. All addictions have similar neural circuits and chemicals (Maté, 2009) as well as neurohormonal processes (McCowan & Chamberlain, 2000). Addictions can also influence neural plasticity which ultimately influences behaviors (Chaudhri & Karim, 2012). Shaffer et al. (2004) identify addiction to either repeated substance or behavior use as a syndrome comprising similar expressions to biopsychosocial and environmental triggers, similar neurological pathways, and resulting in similar consequences over time. Hol-

Table 1. Similarities between the effects of substance dependence on the addicted person and co-dependent family or friends

Effects on addicted person (APA, 2000)	Possible effects on the co-dependent family or friends
Increased tolerance	Adaptation to increasing amounts of abuse, neglect, discomfort, or pain over time; loss of perspective about the addicted person's dysfunction; emotional numbness; increased rationalization and denial
Presence of withdrawal symptoms	Adjustment to the addicted person's non-use due to abstinence/treatment; increased psychological and somatic stress because of uncertainty of relapse (Seilhamer, 1991); social withdrawal and avoidant behavior
Substance often taken in larger amounts or over a longer period than intended	Coping with increasing amounts of stress, disorganization, and chaos; possible post-traumatic stress disorder, battle fatigue, and despair
Persistent desire or unsuccessful efforts to cut down or control	Attempts to control the addicted person, family, or the work environment (Seilhamer, 1991); rigidity and inflexibility; adoption of coping roles in an attempt to help the family, or control one's own feelings; efforts to dilute or pour out the alcohol or dispose of the drug
Time spent in activities necessary to obtain, use or recover	Time spent covering up for the addicted person, for example doing his/her chores at home; overcompensating; intentionally avoiding outsiders due to guilt, shame, or reluctance to discuss the addicted person's condition
Reduced social, occupational, or recreational activities	Disengagement through rationalization, intellectualization or isolation, from the addicted person and outsiders; lower expectations of the addicted person
Continued substance use despite knowledge of negative consequences	Denial and minimization of risks/problems; erratic behavior, hypervigilance, and self-doubt due to unpredictability of the addict caused by blackouts, cognitive impairment, or accidents; coping roles continued and used outside the family, becoming permanent regardless of their usefulness; self-esteem and self-efficacy damaged; inadvertently coping in problematic ways such as substance use, engaging in other addictive behaviors, or school underachievement; medical problems such as ulcers, emotional problems, insomnia, migraines (Koffinke, 1991); poor parenting and family management

lander and Wong (1995) suggest addictions lie along a continuum characterized by compulsive, risk avoidant behaviors like eating disorders to impulsive, risk seeking behaviors like gambling disorders. Seen as "syndromes analogous to substance addiction but with a behavioral focus other than ingestion of a psychoactive substance" (Grant et al., 2010, p. 233), behavioral addictions resemble substance addiction "in terms of compulsion, loss of control, and continued activity in spite of adverse consequences" (Smith & Seymour, 2004, p. 28). Behavioral addictions have "common face validity" (Koob & Le Moal, 2008, p. 46) with the dynamics of substance addiction and may be growing at a faster rate than substance addictions (Alexander, 2008).

Behavioral addictions, such as hypersexual disorder and gambling disorder, are also termed process addictions (Crozier & Rokutani, 2008), psychological addictions (Naegle & D'Avanzo, 2001), non-ingestive addictions (Thombs, 1999), nonpharmacological addictions (McCowan & Chamberlain, 2000), impulse-compulsive behaviors (Chaudhri & Karim, 2012), and nondrug addictions (Thombs, 1999). Although ample research points to the existence of behavioral addictions (Shaffer et al., 2004; Inaba & Cohen, 2011), they are not a distinct classification in the Diagnostic and Statistical Manual TR-IV ([DSM]; APA, 2000) or the International Classification of Diseases-10 (World Health Organization, 2012). Behavioral addictions will presumably align with two sections in the forthcoming edition of the DSM under obsessive-compulsive and related disorders and disruptive, impulse control and conduct disorders (APA, 2012a, 2012b; Demetrovics & Griffiths, 2012).

Although substance dependence is historically viewed as a family condition (Lewis, Dana & Blevins, 2011), thus far behavioral addictions are generally described as an individual condition. Eventually, however, all addictions cause collateral damage to the family and friends of the addicted person in addition to negative health, psychological, interpersonal, spiritual, and financial consequences to the addicted

person (Kingery-McCabe & Campbell, 1991). Addictions create a feedback loop whereby the addicted person affects his/her family and friends and is affected by those same family and friends. The risks to family and friends of those with behavioral addictions include COD, enabling, collusion (Schneider, 2004), and other problems such as marital discord, financial ruin, or occupational loss. Codependence with hypersexual and gambling disorder will be further described. These two prevalent and well researched disorders have self-help groups for those with the specific behavioral addiction, such as Sex Addicts Anonymous and Gamblers Anonymous, as well as self-help groups for their respective family and friends, such as S-Anon and GamAnon.

Codependence to an individual with a hypersexual disorder

Hypersexual disorder is characterized by "unmanageability" (Schneider, 2004, p. 199) and loss of control such that repeated attempts at controlling problematic behaviors end in failure (APA, 2012b; Reid, Garos & Fong, 2012; Zitzman & Butler, 2005). Individuals who engage in sexual fantasies, urges, or behaviors may experience an intense, preoccupying, altered state of consciousness from a rush of innate neurotransmitters such as epinephrine (Carnes, Murray & Charpentier, 2004) which is often accompanied by depression, guilt, anxiety, regret, irritability, and shame (APA, 2012b; Goodman, 2001). These psychological expressions can trigger repetition of the cycle and an increase in the number and frequency of sexual acts, much like the increase in tolerance experienced by substance abusers. Thus, these individuals and their partners experience unharmonious relationships, mistrust, infidelity, detachment, trauma, and post-traumatic stress disorder (Schneider, 2004; Zitzman & Butler, 2005). They feel a range of conflicting emotions from sexual inadequacy to betrayal, and from fear to anger (Schneider, 2000). Couples develop maladaptive ways of in-

teracting in an effort to deal with the hypersexual disorder (Zitzman & Butler, 2005). Families of individuals engaged in hypersexual disorder can experience low self-esteem, self-doubt, shame, hurt, antagonism, withdrawal (Laaser, 2006; Milrad, 1999; Zitzman & Butler, 2005) and poor family management (Schneider, 2000). The similarities between some of the effects of hypersexual disorder on the addicted person and possible effects of COD on family or friends are summarized in Table 2.

Codependence to an individual with a gambling disorder

Gambling behavior lies along a continuum, from non-problematic and social to professional and pathological (APA, 2000). It is characterized by preoccupation, irritability, using gambling to deal with emotional issues, compulsion to chase the next win despite negative consequences to self and relationships, hiding debt, and committing illegal acts to fund gambling (APA, 2012a). Following a gambling episode, an individual may feel remorse, anger, depression, or suicidal (McCowan & Chamberlain, 2000). Individuals with gambling disorder may use defense mechanisms or a return to gambling to cope. The pathological gambler learns to tolerate increased risk, anxiety, and changes to lifestyle. Gambling disorder behaviors affect not only the gambler but his/her family, friends, and entire social system (McCowan & Chamberlain, 2000).

Families of individuals who are engaged in gambling disorder may experience increased stress, pending legal actions, deception, financial losses, and absent parents (Lesieur & Rothschild, 1989). Children of pathological gamblers are reported to feel depressed, angry, hurt, lonely, guilty, abandoned, and rejected, which they may express by running away from home, using substances, gambling, or through psychosomatic illnesses (Lesieur & Rothschild, 1989). A study of Gamblers Anonymous attendees found that 8% of male pathological gamblers and 37% of their wives were physically abusive to their children (Lesieur & Rothschild, 1989).

The similarities between some of the effects of gambling disorder on the addicted person and possible effects of COD on family or friends are summarized in Table 3.

RECOMMENDATIONS

There are many steps that addictions service providers, researchers, and educators can take to address COD to an individual with behavioral addictions. They can initially work to increase awareness of COD with behavioral addictions. Then, they can develop evidence-based strategies for prevention, treatment, and recovery for co-dependent family and friends of individuals with behavioral addictions (Zitzman & Butler, 2005) while addressing “the physical, mental, emotional, and spiritual” needs of the COD individual (Whitfield, 1991, p. 210).

Addictions service providers can expand their knowledge of and screenings for behavioral addictions (Crozier & Sligar, 2010). They can apply theories on the addiction interaction disorder (Carnes et al., 2004) and the “interchangeable” (Maté, 2009, p. 221) nature of addictions to clients. Thus, providers can treat addiction as a syndrome without a hierarchy (Wilson Schaef, 1989) regardless of how the addiction manifests. Addictions service providers can refer clients with behavioral addictions such as hypersexual disorder or gambling disorder to 12-step support groups and refer their family and friends to complimentary 12-step support groups such as S-Anon and Gam-Anon. All addictions service providers should be trained to treat dual addictions as per research on individuals with food, debt, and online sex addictions (Cooper, Griffin-Shelley, Delmonico & Mathy, 2001) and substance and gambling addictions (Brewer, Grant & Potenza, 2008).

With increased awareness of behavioral addictions, addictions service providers can better attend to the family and friends of clients with behavioral addictions. Prevention services can be offered to children living with family members who have behavioral addictions. Addressing COD through marital, group, and family therapy helps family and friends detach from individuals with behavioral addictions, identify enabling behaviors (Rotunda & Doman, 2001), avoid feeling as if they are the problem, set healthy boundaries, rebuild positive relationships, utilize support systems, and learn new skills. It is critical that addiction service providers receive pre and post service training in behavioral addictions and related COD in family and friends.

Table 2. Similar effects of hypersexual disorder on the addicted person and co-dependent family or friends

Effects of hypersexual disorder on the addicted person (APA, 2012b)	Possible effects on family or friends
Excessive time is consumed by sexual fantasies and urges, and by planning for and engaging in sexual behavior	Disproportionate amount of time is spent reacting to, covering up for, and engaging with the addicted individual thus reducing the amount of time for other endeavors
Repetitively engaging in these sexual fantasies, urges, and behaviors in response to dysphoric mood states (e.g. anxiety, depression, boredom, irritability)	Potential attempts to self-medicate to relieve increasing levels of anxiety, depression, boredom, and irritability
Repetitively engaging in sexual fantasies, urges, and behaviors in response to stressful life events	Increasing stress and family dysfunction, often leading to separation/divorce; decreasing attention paid to children; relieves family stress via coping role such as mascot or scapegoat (Schneider, 2004)
Repetitive but unsuccessful efforts to control or significantly reduce these sexual fantasies, urges, and behaviors	Unable to control the individual with hypersexual disorder thus feels like a failure personally and socially; children may be exposed to sexual material such as books, magazines, websites, and TV shows
Repetitively engaging in sexual behavior while disregarding the risk for physical or emotional harm to self or others	May experience increasing risk from rape, violence, asphyxiation, and abuse; attempts to regain affection of the addicted partner by engaging in new sexual practices, possibly against his/her values

Table 3. Similar effects of Gambling Disorder on the addicted person and co-dependent family or friends

Effects of gambling disorder on the addicted person (APA, 2012a)	Possible effects on family or friends of COD
Gambles with increasing amounts of money in order to achieve the desired excitement	Increasing desire for control of the family finances; builds a tolerance to adrenalin due to living in a state of anxiety
Restless or irritable when attempting to cut down or stop gambling	Feels anxious, stressed, and confused but may have nonetheless set unrealistic standards for him/her self
Repeated unsuccessful efforts to control, cut back, or stop gambling	Tries to control the pathological gambler by scolding or yelling at him/her; bails the pathological gambler out or intentionally leaves him/her in jail
Preoccupied with gambling (e.g. persistent thoughts of reliving past gambling experiences, handicapping or planning the next venture, or thinking of ways to get money with which to gamble)	Increasing preoccupation with the pathological gamblers losses or gains that he/she loses a sense of self and neglects other responsibilities
Gambles often when feeling distressed (e.g. helpless, guilty, anxious, depressed)	Depression, low self-esteem; feels shame and guilt; believes she/he caused the gambling disorder and can thus control it; acts as if walking on eggshells to avoid disturbing the pathological gambler
After losing money gambling, often returns another day to get even ("chasing" one's losses)	Becomes self-centered like the pathological gambler; may start to gamble in order to chase the losses
Lies to conceal the extent of involvement with gambling	Lies to self, family members and others outside family; may steal to recoup losses
Jeopardizes or loses significant relationships, jobs, or educational or career opportunities because of gambling	Feels anger or rage due to marital, job, or income losses; children are at increased risk for medical, school, behavioral, and emotional risks (McCowan & Chamberlain, 2000)
Relies on others to provide money to relieve a desperate financial situation caused by gambling	Pursues relatives to cover financial losses; may steal from friends or workplace; children work to supplement family income

Addictions researchers can play a key role in expanding knowledge about COD and how COD develops in reaction to individuals with behavioral addictions. Researchers can also improve screening and assessment tools for co-dependents who are impacted by behavioral addictions. The Beck Codependency Assessment Scale (Fischer & Corcoran, 2000), for example, can be revisited for usefulness, reliability, and applicability to the effects of behavioral addictions.

Addictions counseling educators play a major role in preparing the next generation of providers. They can present emerging literature on addictions, not only on substance specific information but on potentially addictive behaviors such as hypersexual disorder and gambling disorder, dual-addictions, and the addictive interaction disorder (Carnes et al., 2004). They can also present information on how family and friends are affected by behavioral addictions. Students in counselor education programs need to learn about 12-step support groups for family and friends of individuals with behavioral addictions because these groups play a vital role in the recovery process.

The authors suggest a broadening of the addictions paradigm such that professionals embrace the potential of COD as it relates to behavioral addictions. The steps taken by addictions service providers, researchers, and counseling educators have the potential to impact a multitude of co-dependent family and friends of clients with behavioral addictions.

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