On Terms Used and Abused: The Concept of "Codependency"

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As with any biopsychosocial disorder, the language used by researchers and clinicians presents problems. There are other manifestations of disordered behavior (neurosis, anxiety, etc.) in which problems of definition are critical, but is there any like alcohol and drug abuse which produces both dictionaries of "the alcohol language" (Keller & Seeley, 1958; Keller & McCormick, 1968; Keller, McCormick & Efron, 1982) and a compendium of slang or "street" terms for the reinforcers and the processes (Johnson et al., 1988)? The unending squabble over whether alcoholism is to be defined as a disease or not defined as a *disease* (Jellinek, 1960; DeLint, 1971; Finn & Clancy, 1972; Keller, 1976; Room, 1981; Keller, 1982; National Council on Alcoholism, 1988; Fingarette, 1988) is not resolved. The World Health Organization has struggled with and changed its definition of drug dependence and alcohol dependence over the years (World Health Organization, 1954; Eddy et al., 1965; World Health Organization, 1980).

Definition of the terms used by practitioners, diagnosticians and researchers are so fluid that the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM-III, 1980) required revision within a few years of publication (DSM-IIIR, 1987); the re-

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moval of a distinction between "substance abuse" and "substance dependence" is one among many revisions. And the definition and diagnostic criteria are under review again.

In the 1970s and 1980s, both research and clinical facilities for alcohol and drug abusing persons expanded very rapidly. The expansion of research created a need for more journals so that research results could be communicated. The number of journals increased. The expansion of detoxification, treatment and rehabilitation facilities for substance abusers created a demand for training in relevant skills. A surfeit of trainers, institutes, visiting "experts" and consultants developed to meet this demand. As a byproduct, a number of rather simple-minded conceptualizations developed. These were, for the most part, insider terms like "enabler" "ACOA" (adult children of alcoholics), "coalcoholic," "chemical dependency," "codependent," etc. Some would argue that "chemical dependency" makes no sense as a description of drug abuse because we are dependent on oxygen, water, food and other chemicals for survival. Perhaps "chemical dependency" grew out of the trend toward integration of services for problem drinkers and persons involved with other drugs, which began in the 1960s. Perhaps "chemical dependency" was a term which originated in the recognition of multiple drug abuse; while drug dependent people may have a favorite substance, most appear to use more than a single drug (Gomberg, 1982a; Gomberg, 1982b; Gomberg, forthcoming; Johnston, 1973; Stimmel et al., 1972).

Another interesting term which has surfaced is "coalcoholic." To me, the term suggests the alcoholic's drinking companions but as used by insiders, it means someone who, in a sense, conspires with the alcoholic to maintain his/her drinking, presumably a family member or spouse who is therefore also an "enabler."

We will examine the origins and development of one of these invented terms, "codependency," the popularization of which has proceeded apace, totally out of touch with rich research developments in family processes, the impact of alcoholism on the family, and systems theory. Our discussion of "codependency" will present three theses:

1. The impact of a deviant member of a family, whether that member is alcoholic, depressed, schizophrenic, phobic, brain damaged, mentally retarded, delinquent or symptomatic in any way, has *long* been recognized as a major source of stress and distress within the family.
2. There are *no* data at all which justify diagnosing family members in any family in which substance abuse occurs, as manifesting personality disorder, solely on the basis of their family membership.
3. The term, "codependency," has been expanded without any consideration of its meaningfulness or its contribution to theory and practice, so that it encompasses virtually the entire population of the United States.

WHAT IS "CODEPENDENCY"?

Larsen (1983) described as a codependent, ". . . anyone affected . . . " by a substance abuser, and Wegscheider-Cruse (1984) elaborated the concept so that it included not only spouse, lover or children of alcoholics, but anyone who "..grew up in an emotionally repressive family." Cermak (1984, 1986a, 1986b) defined the diagnosis of "codependence" so that substance abuse professionals might find, diagnose and treat these "codependents":

> . . . Co-dependence is a recognizable pattern of personality traits, predictably found within most members of chemically dependent families, which are capable of creating sufficient dysfunction to warrant the diagnosis of Mixed Personality Disorder as outlined in DSM III . . . (Cermak, 1986a)

The diagnosis having been made, the next step is treatment:

> . . . In response to a rapidly growing need as more and more people identify themselves as codependents or adult children from dysfunctional families, an increasing number of treatment centers and individual therapists are offering codependency treatment . . . (Cruse & Johnson, 1988)

The concept probably reaches its full flowering in a recent book by Schaef (1986) which describes "codependency" as an addiction and a disease. With the belief that "codependency," addiction and other "diseases" are fostered by the lack of moral and spiritual values in American society, it emerges finally that *the whole society* is in the grip of "the addictive process." So we have moved with this concept from the impact of a substance abusing member on other family members to anyone who grew up in an "emotionally repressive family," to psychiatric diagnosis and treatment of the family member, to a sick society!!

THESIS 1

The impact of a deviant member of a family, whether that member is alcoholic, depressed, schizophrenic, phobic, brain damaged, mentally retarded, delinquent or deviant in any way, has *long* been recognized as a major source of stress and distress within the family.

In midcentury urban America, the state of theory and practices relating to causes and treatment of mental disorders, was heavily influenced by psychoanalysis. In retrospect, it is interesting to note the extent to which the therapist's full attention was focussed on the patient. Among most practicing psychoanalysts, for example, the idea of contact—even a single interview with a family member of a patient—was looked upon as questionable. The assumption was that such contact would disturb the delicate balance of transference effects and should, therefore be avoided. The psychoanalytic theory viewed the disorder as a product of the patient's interaction with others, primarily parents, and the history obtained by the therapist was self-report, i.e., the family history as perceived and reported by the patient. Preoccupied with the unconscious, the effect of the patient on people around him was given short shrift.

During the same time period, the redefinition of alcoholism as a psychosocial problem, rather than a moral issue, was taking hold. It is of interest that in the volume of lectures delivered in the 1944 Yale Summer School of Alcohol Studies, one sociological lecture was given on "excessive drinking and the institution of the family" (Bacon, 1945), and another, more clinically-oriented lecture was

delivered on "social case work with inebriates" (Baker, 1945). Baker noted that,

> . . . the social case worker seldom sees the alcoholic as an isolated person but rather as an integral part of the world he lives in. Others in that world must gain insight into his problem and their reaction to it in order to help him become a well-adjusted person like themselves . . .

A long way from the view of those who are, ". . . an integral part of the world (the alcoholic) lives in," as personality disordered and pathological!

Early studies reported the wife of the alcoholic to be a frustrated, dependent woman whose hostility often generated the husband's drinking bouts (Price, 1945). It was argued that the wives had married alcoholics to deal with needs of their own, and such wives were described as, ". . . Suffering Susan . . . Controlling Catherine . . . Wavering Winifred . . . Punitive Polly . . . " (Whalen, 1953). Furthermore, as the alcoholic recovered, the wife "decompensated" (Futterman, 1953; Kalashian, 1969). These early works may be seen as the ancestors of "codependency": the nonalcoholic wife is indeed described as "dysfunctional."

A classic paper appeared in 1954 which dealt not only with the *reactions of family members to an alcoholic in the family*, but went much further in recognizing that such reactions were dynamic and *changed with the duration of the problem* (Jackson, 1954). Jackson, using participant-observer methods, described the stages in family adjustment to alcoholism. Families began with attempts to minimize and deny during the early incidents of intoxication, and ended with reorganization after the husband/father achieved sobriety.

At about the same time, family treatment approaches in alcoholism began to develop. Gliedman and co-workers (1956) used concurrent group meetings of male alcoholics and their wives. Ewing and his collaborators (1961) evaluated concurrent group therapy, and found that the likelihood of engaging and keeping an alcoholic in treatment was greatly increased by the group therapy approach. There are several early reviews of the literature on alcoholism and marriage (e.g., Bailey, 1961). By 1975, twelve distinct family ther-

apeutic approaches were being used (Bowen, 1975) which included working with alcoholics in conjoint family therapy (Meeks & Kelly, 1970), multiple couples therapy (Cadogan, 1973) and others. A recent review of work on marital and family therapy (O'Farrell, 1987) distinguishes among approaches to motivate into treatment, to produce "short-term changes," and to prevent relapse, i.e., maintain the changes.

The impact of the alcoholic member of a family on family life has been recognized, studied, reported from the beginning of recognition and treatment of alcoholism. The first thesis, that the impact of a deviant member of the family on others in the family, has *long* been recognized, is demonstrated. Q.E.D. What is needed at this time is recognition of the impact of *all* deviant, disordered or stressful behavior on family life. A parent, child or sibling who is depressed or who is handicapped or who is chronically ill, produces marked effects and a need for adjustment within the family system. While alcoholism or other drug dependence may have *unique* effects on family members, this remains to be demonstrated.

THESIS 2

There are *no* data at all which justify diagnosing family members in any family in which substance abuse occurs, as manifesting personality disorder solely on the basis of their family membership.

Most of the work in family therapy in alcoholism has been focused on the male alcoholic *and the wife*. In a comprehensive critical review of the literature, Edwards et al. (1973) organized the foci into three categories: the disturbed personality theory, the stress theory, and the psychosocial theory. Wives who had separated from the alcoholic husband and wives living with the husband were compared in several studies, and the question of the uniqueness of personality disturbance among alcoholics' wives was raised. There were many methods of coping, e.g., safeguarding the family's interests, withdrawal, attacking, acting out, protecting the alcoholic husband (Orford & Guthrie, 1968). *The evidence did not support the view of the alcoholic's wife* as pathological, but rather suggested that there was a wide range of personalities and a wide range of adjustments. Where problems occur, they appear to be related to the

stresses, and Edwards et al. concluded that, " . . . the only tenable hypothesis is that these wives are not unique."

While the believers in "codependency" do not limit themselves to wives of alcoholics, problem behavior and pathology in the nonalcoholic family members is the resurfacing of an old viewpoint. Such conceptualization ignores the recency and duration of the drinking problem (e.g., Jackson, 1962), the different family effects of daily versus binge drinkers (Jacob, 1987), differing family patterns of response (e.g., Kaufman & Pattison, 1981; Stanton & Landau, 1985; Steinglass, 1981; Vannicelli, Gingerich & Ryback, 1983; Wolin et al,, 1980; Fichter & Postpischil, 1988). There is a wide range of behaviors, adaptive and maladaptive, which is manifested by individual members and by families in which there is an alcohol or drug abusing person. Labeling family members pathological, i.e., mixed personality disorder, ignores the individual differences and myriad coping mechanisms with which people and families continue to function.

If it is true that in "chemically dependent families," there is a recognizable pattern of personality traits found among most family members which creates sufficient dysfunction to warrant a psychiatric diagnosis, the burden of proof rests on those who posit this state of affairs. Indeed there are some family members who show serious disturbance when confronted with the problem of an alcoholic family member and this will vary with the age of the family member, the relationship, presence or absence from the home, and other variables. That some family members will be disturbed is a long way from the assumption that, ". . . most members" of the family show dysfunction. Where are the data? There are no surveys, no clinical research, no evaluations only descriptive, impressionistic statements. There are lists of "codependency" characteristics, like adult-children-of-alcoholic traits, and there are "dysfunctional family rules." One need not be a relative:

> . . . Any relationship in which one of the partners is chemically dependent is likely to manifest at least some degree of dysfunction . . . Parents, children, marital partners and even co-workers can be affected. (Jenkins, 1988)

All the hypotheses about "chemically dependent families" and the dysfunctional nature of relationships with a "chemically dependent" person may be true, but where is the evidence? Our second thesis, then, that there are *no* data to justify the descriptions of "codependency" with added stigma of psychopathology and personality disorder, is demonstrated. Q.E.D. Quod erat demonstrandum.

THESIS 3

The term "codependency" has been expanded without any consideration of its meaningfulness or its contribution to theory and practice, so that it encompasses virtually the entire population of the United States.

In the increasing recognition of alcoholism as a distressing personal and social problem, and with increasing third-party payments for treatment available, inevitably, facilities to treat alcoholics and other kinds of drug abusers have increased. These include detoxification units, hospital wards, outpatient clinics, residential facilities. With this growth of services, the demand for useful ideas and for skill training has also increased. Unfortunately, this has *not* led to a notable increase in knowledge base training. This is true not only for "two hatters" and nonprofessional people with interest in substance abuse, it is also true in medical education, social work and nursing training, and the education of psychologists.

Is a knowledge base useful or essential for those who would help the individual alcoholic and the family, or—for that matter—those who seek to influence policy? It is of historical interest to note Jellinek's discussion, in 1945, of the curriculum of the first Yale Summer School of Alcohol Studies:

> . . . I know that the lecture program may disappoint many of you. The disappointment of the different members of this group may lie in different directions. Those who are interested primarily in the question of what to do with the alcoholic may find it a bore to have to listen to such lectures as, let us say, the philosophy of the temperance movement or the economic aspect of alcohol in modern society . . . those who are interested in alcoholism primarily as a national manifestation may be impatient with the lectures which are devoted to the individual problems of the alcoholic and to the treatment of the alcoholic. But I can assure you that unless those interested in the public care and therapy of the alcoholic learn about the economic and social involvements which have led their patients to the need for treatment, efforts at rehabilitation will be frustrated. And those who are interested in alcoholism as a national phenomenon will never be successful until they have realized the importance of those individual problems whose aggregate forms the national manifestation. (Jellinek, 1945, pp. 6-7)

Whether it was the Keep-It-Simple-Stupid attitude of some members of Alcoholics Anonymous, the influx of many recovering alcoholics into the treatment field, the anti-intellectualism and anti-science of the last decades, or simply the wish for quick, easy solutions to problems of need for training, Jellinek's view has gone by the board. Most summer schools, institutes, workshops emphasize skill training and there is very little communication between the researchers who hold their own meetings, and the practitioners.

In the demand for skill training, the concept of "codependency" expanded. Starting from its original application to members of the alcoholic's or drug abuser's family, it has gone far afield. The family, of course, may include one's parents, grandparents, aunts and uncles, children, cousins, spouses, siblings, nieces, nephews, etc. (Miller W.R., 1987), but these are all familially related to the alcoholic. One expansion of the term "codependent" is the application to *co-workers* and *friends* of the alcoholic or drug abusing person. The term is, in fact, applied to ". . . any relationship" (Jenkins, 1988). *Any* relationship! Still another expansion moves the term to include not only human beings; "codependency" then becomes ". . . an unhealthy preoccupation or dependence" on:

> . . . someone or something. The dependency may be on *work* such as with one who is labeled a workaholic. It might be dependence on *food* as in the compulsive overeater, the bulimic or anorexic. The dependence might be on *religion* . . . (Williams, 1988) [italics added]

Ms. Williams adds that ". . . codependency, like alcoholism, is a progressive and sometimes fatal disease."

Expansion of the concept of "codependency" has gone as far as ". . . codependence among helping professionals" (Murck, 1988), described as a major cause of on-the-job professional problems among helping professionals. A historical note: among practitioners in the earlier days of alcoholism treatment (the 1940s to the 1970s), there was a good deal of concern about "burnout," usually attributed to the difficulties of working with the alcoholic client who was resistive, denying, and tended to relapse. There is a sharp contrast between contemporary behavioral treatment strategies sometimes described as "relapse prevention" and the "codependency" view which attributes professional problems and difficulties in treating the drug dependent client to the professional therapist's own shortcomings and disturbances. Commenting on the apparently disproportionately large number of therapists with family histories of alcohol or other substance abuse, it is argued that for persons with such a history, entering the help profession increases "..the risk of activating codependence tendencies" (Murck, 1988). Instead of blaming the victim, this becomes an exercise in blaming the therapist.

It may be true that there is a disproportionately large number of substance abuse therapists with positive family histories. That is a testable hypothesis, although one of the research issues might be to question what is the optimal proportion of therapists with positive family history working in *any* mental health area. It may also be true that the reported "..codependence among helping professionals," is attributable to the large number of therapists and counselors who are themselves recovered alcoholics or drug abusers. Once again, the question is: what is a *large* number? Again, this is a researchable, testable hypothesis: are there significantly more recovered alcoholics and/or drug abusers among counselors and therapists working in substance abuse than there are recovered individuals in other areas of mental health work? Are recovery rates for patients the same, better, or worse for counselors and therapists who come from alcoholic or drug abusing families as for those who do not? From these research questions, one may proceed to others: are there differences in first choice of treatment modality, in interactional style, in patient rapport, between therapists with positive personal or family history of substance abuse and therapists with no personal or family history of substance abuse?

Perhaps the conceptualization and expansion of "codependency" is most understandable in historical perspective. Public interest and governmental interest in alcohol and drug problems have been intensifying for two decades, and in the 1988 election, drug abuse and the call for more treatment resources was a campaign issue. A decade earlier, the competition between ". . . degreed and nondegreed counselors" (Ottenberg, 1974; Valle, 1977) intensified, and while the rivalry and negative feelings of professionally trained and the recovered alcoholic therapists became less with time (or at least less overt), the acceptable standards for a counselor or therapist in substance abuse have been defined only recently and in response to a chaotic situation. Both professionally trained and "nondegreed counselors" required additional training. Inevitably, the demand was met by entrepreneurs who supplied such training and many of them established training businesses, consultantships, and traveling presentations. Jellinek's idea that a knowledge base about alcohol was useful, even necessary, for the development of treatment skills, went by the board, and the chasm between researchers and scholars on the one hand, and the treatment community on the other, grew larger. Services directed by physicians, usually within hospitals, went their own way. Perhaps inevitably, simplistic concepts like "codependency" expanded to include not only family members but co-workers, friends, any relationships, "workaholics," dependence on food or religion, "helping professionals," and so on.

The third thesis, that the concept of "codependency" has been expanded and extended without consideration of its meaningfulness or of its contribution to theory and practice, is demonstrated. Q.E.D. Quod erat demonstrandum.

RECENT CRITICISM OF "CODEPENDENCY"

In the same journal issue in which Cermak outlined his diagnostic criteria (1986), there appeared a critical review of the concept of "codependency" (Gierymski & Williams, 1986). The authors de-

scribed "codependency" as being used to diagnose ". . . a primary disease (and) a treatable diagnostic entity," in spite of the fact that it was a concept not based on data but rather on intuition, assertion and anecdotes. Gierymski and Williams, affiliated with the Hazelden Foundation in Minnesota, commented on the heterogeneity of response of those who live with an alcoholic person and the remarkable variety of inner resources and personal strategies for coping such people display. The conclusion: while family members in alcoholic families, as a group, manifest more emotional problems than comparable family members in nonalcoholic families, the degree and kinds of emotional problems vary but, " . . . no clear-cut clinical entity, corresponding uniquely to the concept of codependency has emerged."

This was followed by an announcement by the Hazelden Foundation (Professional Update, 1987) that it would no longer use the diagnosis of "codependency." Challenging the validity of the concept elicited a response which may say a great deal about reasons for the popularity of "codependency" (Miller, M.E., 1987):

> . . . But what's wrong with calling a co-dependent just that? For many, the term has become a guiding light in the dark despair that has shrouded their lives for years. It is a word that connotes a sense of belonging so often lacking in their lives.

There are at this moment, at least two constructive, parallel, independent lines of inquiry which involve alcoholism and the family. One is current research on family interactions, the role of family rituals and the disruption of such rituals as an important factor in the intergenerational transmission of alcoholism (e.g., Wolin et al., 1980). Another fruitful line of inquiry is the family interaction study of Jacob and his colleagues (1987) which reports significant differences in marital satisfaction measures when binge drinkers and steady drinkers are compared. It is anticipated that such research, using the methods of the experimental laboratory and the ethnography of the family, will yield results which could be utilized by practitioners. A second line of constructive development is practitioner-oriented and consists of a beginning revolt against the narrow definition of a family member in an alcoholic family as "codependent." This revolt comes from practitioners who are sensitive to the heterogeneity of human response to stress and will not fit their client into neat, predetermined pigeonholes.

A NOTE ON THE TERM "ADDICTION"

There are so many definitions of addiction, it has become a word which, " . . . eludes precise definition" (Ray & Ksir, 1987). In fact, most definitions of addiction include: tolerance, physiological and psychological dependence, the abstinence syndrome, and addiction-related human problems.

In 1957, the World Health Organization Expert Committee on Addiction-Producing Drugs tried to distinguish between definitions of "addiction" and "habituation." The definition of "addiction" included tolerance, psychological and physiological dependence, individual and societal problems, and compulsion or craving. Unfortunately, what this produced was uncertainty and,

> . . . confusion in the use of the terms addiction and habituation, and particularly misuse of the former. (Eddy et al., 1965)

A commonsense, dictionary definition of addiction says nothing about tolerance, drug dependence or addiction-related problems but it forthrightly sets down a concept of craving. The word *addiction* is defined as,

> . . . the compulsive uncontrolled use of habit-forming drugs beyond the period of medical need or under conditions harmful to society. (Webster's, 1964)

The concept of craving or compulsion has been a touchy point in discussions of addiction. In the ill-fated 1957 attempt to differentiate between addiction and habituation (World Health Organization 1957), *habituation* was defined as including, ". . . a desire (but no a compulsion) to continue taking the drug." Addiction, then was defined as involving *compulsion* or *craving*, whereas habituation was defined as involving *desire* but not compulsion. In the subsequent confusion, it is small wonder that drug experts argued for decades about whether cocaine was an addicting substance!

In the 1980s, there have been a number of works looking for definitions and models of addiction (e.g., Miller, 1980; Orford, 1985; Peele, 1988). Some behaviorists omit the concept. Marlatt and Baer (1988), summarizing recent experimental work on addictive behaviors, define addiction behavior as,

> . . . a repetitive habit pattern that increases the risk of disease and/or associated personal and social problems. (Marlatt et al., 1988)

Other behaviors, however, do struggle with theoretical processes and treatment issues involved in the concept of craving (Baker et al., 1987).

In spite of the generally agreed upon core of addiction as including tolerance, dependence and personal/social consequences, the whole problem of defining addiction is neatly set aside by the American Psychiatric Association. In both the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition (1980), and the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition-Revised (1987), the word does not appear. Perhaps the committees which assembled the Manuals agree with Ray and Ksir (1987) that addiction is ". . . a muddy term."

There has been one use of the term, *addicted*, which should be noted. That is the popular description of infants born to alcohol or drug abusing mothers with evidence of the drug's presence in the infant, as "addicted babies." Obviously the effects of drug use by a pregnant woman will have both short-term and long-term effects on the developing fetus, but the infant, born with clinical signs of the presence of the drug, is described both by the media and, often by professional personnel, as "addicted." Is the infant "addicted"? An interesting legal question has arisen recently in the case of a cocaine-abusing mother; she is charged with violation of the drug laws because of her baby's "cocaine addiction" (*New York Times*, 1988).

FROM ALCOHOLIC TO LOTTOHOLIC

It is the term *alcoholic* which has inspired an astonishing proliferation. One early extension was a description of driving, hard-working people as "workaholics." People fond of chocolate became

"chocaholics," and there are, ". . . confessions of a lottoholic" (Firestein, 1989).

In these popular extensions, one may become addicted to almost anything. There are "religious addicts," complete with a support group called Fundamentalists Anonymous. There is a ". . . hidden addiction" to sugar (Phelps & Nourse, 1986). There is "exercise addiction," (Health in the Workplace, 1988), "romantic and sexual addictions" (Diamond, 1988) and, ultimately, addictions to relationships or "women who love too much" (Norwood, 1986). One may become addicted to shopping, addicted to video games, addicted to playing lotto games.

Along with the new categories of addiction, has come a new term, a new kind of practitioners: an "addictionologist," one who can presumably treat addiction to anything. Modeled on the assumptions of Alcoholics Anonymous, it appears that the prevailing viewpoint posits any addiction, whatever it involves, as "a disease." Staying with the Alcoholics Anonymous model, the addiction is a "disease" which cannot be cured although it can be arrested (this is the rationale by which members of Alcoholics Anonymous may argue that they are not to be called "recovered" alcoholics but only "recovering" alcoholics). Treatment is modeled on Alcoholics Anonymous too, and there are self-help groups called variously Sexual Compulsives Anonymous, Workaholics Anonymous, Gamblers Anonymous, Co-Dependents Anonymous, etc. Members of such groups, interviewed by journalists, often assert that membership in the group has helped them. It probably has, and it is a commentary on the lonely crowd.

One may wonder if this phenomenon has run its course or if it will expand further. A few recent media articles have asked questions like, "Is America becoming hooked on addictions?" (Hall, 1988). Amusingly, *Utne Reader*, an "alternative press" magazine, featured a recent article, "Are you addicted to addictions?" (1988). The magazine cover has a picture of Opus, speaking at a meeting of "Herringholics Anonymous,"

> . . . Hi. My name is Opus, and I am a herringholic. I admit I am powerless over fish innards and that my life has become unmanageable.

DISCUSSION

We have discussed the concept of "codependency," and the extension of the term *addiction* to cover a very wide range of behaviors. Both phenomena have similar origins: popularizers write books and give workshops and lectures about the invented terms, and the response of the book-buying public and the training-skills-seeking practitioner is positive and supportive. In both instances, there is a neglected parallel development, a rich body of research literature and clinical reports. There is a burgeoning development of research on family processes and family therapy, and there is also an increasing, challenging professional literature on conceptions of addiction.

Perhaps these popularizations and the support they receive is not a controversial issue at all, but a kind of Gresham's law in which there is need, on the one hand, and an offer of easy, simple answers. Easy, simple answers apparently tend to drive out of the marketplace more complex ideas which take more energy and time to master.

What are the needs these simplistic concepts speak to? In the case of "codependency," we have suggested that the need is related to substance abuse treatment as a growth industry, an expanding number of facilities, and the need for education and training in substance abuse treatment. In the case of the expansion of the conception of addiction, it is more difficult to say. Perhaps a kind of trendy fashion, keeping in style: a "shrink" or a psychoanalyst for one generation, an Addiction Anonymous group for another? Perhaps a need for belonging and a substitution for religious belief? Perhaps a true *cri de coeur*?

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Adult Children of Alcoholics: Is It Really a Separate Field for Study?

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During the past few years adult children of alcoholics has emerged as a field of study. As such, this field has produced a large body of literature, which generally attempts to define difficulties in adult human functioning and/or adjustment as rooted in having had an alcoholic parent.

Indeed, this is a new field of study, and much of the work remains primarily anecdotal (e.g., Ackerman, 1983; Wegscheider, 1981; Woititz, 1983). However, a small body of recent empirical studies does exist (e.g., Black et al., 1986; Clair and Genest, 1987). In addition to work which is focused directly on the adult child of the alcoholic, there is relevant empirical work on the effects of alcoholism on the family (e.g., Moos and Billings, 1982) and more general grounded theory on adult adjustment and coping (e.g., Lazarus and Folkman, 1984; Seltzer, 1982; Vaillant, 1977) which cannot be ignored in the discussion of adult children of alcoholics.

The focus of this article will be to delineate a number of the core issues involved in understanding the process of adjustment of adult children of alcoholics. In doing so it will draw upon representative work in the field as well as relevant work in related fields. No attempt will be made to provide a complete critical review of the literature. The focus will be on identifying a number of core issues. Thus, this article deals with knowledge development and theory and

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