JOURNAL
OF
ADDICTIVE DISORDERS

Codependency among health care professionals:

Is an understanding of codependency issues important to the therapeutic counseling process?[1]

H. Spencer O'Neal, Dr.AD, LEP, M-RAS, CATC

> "MANTECA, Calif. — The woman desperately gripped a windshield wiper blade, her body splayed across the hood of the minivan as it raced down a Northern California freeway in the middle of the night, reaching 100 mph… [The woman's husband]… got into the family's minivan around 12:30 a.m. Saturday after he and his wife had an argument at their Manteca home, said police spokesman ... "She kind of goes with the van to try to stop him, gets up on the hood and is hanging on to the wiper blade," he said. "She obviously didn't think he would keep driving." [The woman's husband]… sped through Manteca, got on the freeway and didn't pull over until he reached Pleasanton… One witness followed [the van] most of the way and told police his speed reached 100 mph. The wild ride happened several days after [the woman's husband]… was arrested for being under the influence of a controlled substance…" (Huffpost Staff Writer, 2011)

The above March 2, 2011 news article illustrates a classic example of some of the dramatic types of behaviors that can often occur in the alcoholic / chemical dependent household. The interpersonal relationships between the husband and wife in this article will appear sad and obviously dysfunctional to the outside observer. Typically however, to most couples in similar situations, the relationship they share is one of seeming normalcy to them. He is enraged by her focus on his addictive indulgences, and she becomes his self-appointed protector. Climbing onto the hood of a car is obviously a very dangerous thing to do. If she were asked why she got onto the hood of the car, her most likely response would be "Because I love him! He was drinking (using) again and I didn't want him to wreck the car or hurt himself."

In an attempt to try to understand such a dramatic emotional response and such extreme potentially self-harmful behavior, and in response to the question "How do alcoholics affect families and friends?" the Al-Anon Family Groups comprised of the families and friends of alcoholics states:

---

[1] This copyrighted material may be copied in whole or in part, provided that the material used is properly referenced, and that the following citation is used in full: O'Neal, H.S. (2011). Codependency among health care professionals: Is an understanding of codependency issues important to the therapeutic counseling process? ***Journal of Addictive Disorders.*** Retrieved [date retrieved] from Breining Institute at http://www.breining.edu.

> "Alcoholism is a family disease. The disease affects all those who have a relationship with a problem drinker. Those of us closest to the alcoholic suffer the most, and those who care the most can easily get caught up in the behavior of another person. We react to the alcoholic's behavior. We focus on them, what they do, where they are, how much they drink. We try to control their drinking for them. We take on the blame, guilt, and shame that really belong to the drinker. We can become as addicted to the alcoholic, as the alcoholic is to alcohol. We, too, can become ill." (Al-Anon Family Groups, 2006)

Another support group for codependency is Codependence Anonymous or (CoDA). CoDA does not specifically define Codependency, but rather describes "Patterns and Characteristics of Codependence". These patterns and characteristics are provided for the individual sufferer to explore for self-review. The category headings for these Patterns and Characteristics are: Denial Patterns; Low Self Esteem Patterns; Compliance Patterns; Control Patterns; and Avoidance Patterns. (CoCA, 2011). These Patterns and Characteristics are a good source of information for use in self-evaluation for anyone who is exposed to chemically dependent individuals and are recommended for review by new and prospective Addiction Professionals as well.

Codependency is defined in Wikipedia as:

> "Codependency (or codependence, co-narcissism or inverted narcissism) is a tendency to behave in overly passive or excessively caretaking ways that negatively impact one's relationships and quality of life. It also often involves putting one's needs at a lower priority than others while being excessively preoccupied with the needs of others. Codependency can occur in any type of relationship, including in families, at work, in friendships, and also in romantic, peer or community relationships. Codependency may also be characterized by denial, low self-esteem, excessive compliance, and/or control patterns." (Wikipedia, 2011)

The pattern of codependency of the wife who climbed on the hood of the car in the example cited earlier is fairly easy to see. Such a pattern of codependent behavior is also fairly easily definable as noted in this definition. What is not so easy to see is how codependency can seep into almost any caring relationship, including the counseling relationship. Codependency often comes in shades and tones that are much more subtle than those seen in the initial example. Codependency can also be situational. In other words, an individual may exhibit normal emotions and behaviors in most interpersonal relationships, but in certain situations, or in relationships with certain people, this same individual may experience varying degrees of codependency.

Addictive Behaviors breed Codependent Responses

Codependency essentially is a state of mental and emotional being that often occurs when a caring individual is in a close relationship with, or is in relatively close contact with, someone who is progressing through the various stages of alcoholism, chemical dependency, or other addiction. The book Alcoholics Anonymous (Anonymous, 2001, p. 21) defines the "Real Alcoholic" as someone who:

> "… may start off as a moderate drinker." "… at some stage of his drinking career he begins to lose all control… once he starts to drink." He puzzles you… "in his lack of control." "He does absurd, incredible, tragic things while drinking. He is a real Dr. Jekyll and Mr. Hyde."… "His disposition resembles his normal nature but little. He may be one of the finest fellows in the world. Yet let him drink for a day, and he frequently becomes disgustingly, and even dangerously anti-social."… "He is…. Well balanced concerning everything except liquor, but in that respect he is incredibly dishonest and selfish. He often possesses special abilities, skills, and aptitudes, and has a promising career ahead of him. He uses his gifts to build up a bright outlook for his family and himself, and then pulls the structure down on his head by a senseless series of sprees."

This description of the alcoholic, which also roughly describes characteristic patterns of behavior present with other addictions, is presented here in order to illustrate the *personality change* that occurs when the addicted person is engaged in his or her addictive behavior (drunk, loaded, gambling, eating, etc.). An article on alcoholic behavior noted that most people who drink, and even those who sometimes get drunk "will keep their same personality" (Alcoholic Behavior, 2009). The obvious implication then is that those who, as noted above, are *real alcoholics*, and/or those otherwise addicted, will *change* into someone or something they are not. The non-addicted individuals who love, care for, and/or have a close relationship with the addicted individual, generally will stay with and assist the addicted individual, and unknowingly commence to go through the process of becoming *codependent*. Even though they may be shocked and often hurt by the behavior of the addicted individual, they generally stay with, forgive, and rationalize the addicted individual's behavior. They have great affection for their dear friend Dr. Jekyll, and are stunned when faced with Mr. Hyde. They only desire for the return of Dr. Jekyll, and will not leave one stone unturned until they have helped the good Doctor rid himself of his unwelcomed intruder, Mr. Hyde. They feel this behavior change was so out of the ordinary that it is most likely an anomalous behavior that is probably a one-time occurrence. The addicted individual helps them in this belief by sincerely *promising* such behavior "will never happen again". The fledgling *codependent* internalizes this promise and continues the relationship. If the offending individual is truly *addicted*, the same or similar behaviors will occur again and again and again. With each new occurrence, the *codependent* again rationalizes, assists, and excuses the behavior. Now, the codependent individual may begin to shield and protect the addicted person from having to take responsibility for his or her actions. The definition of insanity that is typically applied to both *dependent* and *codependent* individuals now becomes apropos: "Insanity is doing the same thing, over and over again, but expecting different results." (Franklin). Thus, the "Merry-Go-Round of Denial" starts to spin (Kellermann, 1969).

Codependency in the Therapeutic Process

Nature instills in most humans an innate desire to help others who are in need of assistance. In particular, this innate helping instinct is peaked when a friend, family member, or loved one is afflicted with significant difficulties. Most humans react with a compassionate desire to help when someone close to them is in desperate need. Such needs could include disease, physical or emotional pain, financial difficulties, legal complications, mental health concerns, family or relationship problems, etc. As a caring individual begins to provide assistance to the addicted individual in order to *help* them out of their difficulty, "*just this once,*" then the

groundwork for a pattern of codependency begins forming. As the addicted individual is *rescued* from his or her immediate dilemma, the *inner voice* of their addiction *speaks* and, although they may say they are grateful for being helped out of their problem, instead of *learning their lesson* and staying away from the addictive behavior(s) that others can see as the cause of their initial problem, they react by engaging in the destructive addictive behavior yet again. Why do they do this? Because their addiction says to them "See, there is nothing wrong with you. Did you see how easy it was to get out of that situation? It wasn't so bad after-all. Your can have another [drink]. One won't hurt you."

As the addicted individual succumbs again to his or her addiction, the cycle begins to repeat itself (Kellermann, 1969). As the cycle repeats itself, the original non-addicted, caring individual who only intended and desired to help a friend, or loved one, becomes increasingly enmeshed in the addict's downward spiral. As the dependency (disease) of the addicted individual increases so too does the dependency (disease) of the *helping individual*. Thus, both the addicted individual and the *helping individual* are both dependent on the same dependency producing substance or behavior. As such, the *helping individual* is *codependent*. The *helping individual* then becomes addicted in the addiction of the addict. This addiction is therefore called "codependency". The addict begins to form a pattern of behaviors that elicits codependent responsiveness in those with whom they establish relationships. Various types of counselors and addiction professionals will come in contact with addicted individuals who are involved in situations where they are in need of significant help. In these cases, it is essential that the addiction professional / counselor understand the dependency – codependency process and not permit the cycle to begin. In essence, *the addiction* is controlling the emotions and behavior of both the dependent addict and the codependent. Acknowledgement of the *existence* of this cycle, and consciously (counter- intuitively) breaking or interrupting this cycle, is often the only way out the addiction process for either or both participants.

The Importance of Understanding Codependency in the Therapeutic Process

Why do counselors and other mental health practitioners need to understand codependency and its relationship to the therapeutic process? The answer to this question is the basis of why the question needs to be asked. The answer is the counselor's predilection to the traits of *love and caring*. Prior to the 1935 advent of Alcoholic Anonymous there is no historical record of any lasting, successful treatment for alcoholism or other addictions. All prior attempts at facilitating such rehabilitation ultimately failed (Breining, et al., 2008, pp. 21-22). This failure was due in large part due to the addictive properties of codependency. Counselors may initially be drawn to the mental health field for a variety of reasons, but typically decide to enter the profession to "fulfill a need to help others…" (Breining, et al., 2008, pp. 359-366). Those helping individuals who enter the Counseling profession typically possess particular attitudes and characteristics, the most important of which is caring. "The counselor is a knowing person, but … is also a caring person. Most people can know all that a counselor knows, but unless a person cares, he is not a counselor… *Counseling is caring*." (Wrenn, 1973).

The primary traits of the quality counselor are *helping and caring*. The dilemma of the counselor who is engaged in therapeutic relationships with those addicted to alcohol and other chemicals or behaviors, is that addicted individuals are not helped by being helped (Al-Anon Family Group B-6, 1978, pp. 35, 196). In fact, the more helping the counselor attempts to be, the more comfortable clients becomes in their addiction, and the less likely are their chances of

recovery. The natural inclination for the counselor then, when the helping therapeutic approach hasn't produced the desired movement toward recovery, is for the counselor to feel that he or she isn't being helpful and caring enough. In this frame of reference, the counselor redoubles his or her efforts to *care harder*. As a result, the addicted individual consciously or unconsciously begins to gain emotional control over the counselor/counselee relationship and thus subverts the therapeutic process. In this incremental progression, the counselor begins the gradual slide into a codependent role in the counseling relationship.

So far, the discussion of "counselors" has centered on the traits usually found in typical individuals who enter the mental health field and are professionally trained as counselors or therapists. However, somewhat of a distinction must be drawn in the area of addiction counseling. The success behind the program of Alcoholics Anonymous, and discussed in their book from which the organization gleaned its name, was the premise that "one alcoholic talking to another alcoholic" was the key ingredient to helping a problem drinker to achieve sobriety (Anonymous, 2001, pp. 15-16, 18, 89-103). As centers for the treatment of alcoholism and other addictions began to emerge in the late 1960's, 70's, and early 80's, counselors in these facilities often required no formal training in counseling techniques or certification, but were often required to be a sober alcoholic with a specified period of sobriety (Miller, 1980, pp. 3-7). The field of Addictions Counseling has become more formalized and certification is now required for both current and new counselors (California Department of Alcohol and Drug Programs, 2011). However, it is no longer a prerequisite that an addictions counselor be an individual who has recovered from a substance abuse or other addiction. The removal of this prerequisite makes it imperative that an understanding of codependency issues be instilled in new counselors as they will be more susceptible to be lured into the codependent role than those who are in a recovery program themselves.

At a conference of the Philadelphia Psychiatric Society in April, 1946, some interesting comments were made by members in attendance. Their comments were preserved in Society Transactions of the Archives of Neurology & Psychiatry (Hadden, 1946). Research into the field of chemical dependency has made significant strides since 1946 and many of the statements made in this article are not accurate by today's standards, however, it is interesting to note the progression of medical thought. Medical thought in the absence of research, often displays logical, well-reasoned, and common sense solutions. Codependency was not a recognized disorder when this article was written, never-the-less, when Dr. Keyes' statements are viewed in light of today's knowledge of codependency, the progression of thought for mental health providers begins to take shape. Dr. Keyes stated he was pleased that the legal profession was coming to see that Alcoholism was a "disease" that required "care and prevention rather than punishment and incarceration." He noted that alcohol provides "quick relief" from anxieties for the alcoholic and that "most investigators of the causes of alcoholism are agreed" that "weaknesses and deviations of personality" in combination with a compelling desire for the relief of "acute stress" eventually cause alcoholism. Dr. Keyes continues that the *primary* necessity for treatment is "…the patient must himself wish to recover from his alcoholism, for unless he holds to this decision firmly he is certain to fail any measure outlined to help." "In many cases, however, the patient cannot reach this conclusion without a great deal of patience, tolerance and understanding on the part of those trying to guide him" (Keyes, 1947). Certainly current research demonstrates Dr. Keyes conclusion that the alcoholic patient "must wish to recover," but his conclusion that the counselor must provide a "great deal of patience, tolerance and

understanding" for the perspective he was alluding to, may only tend to breed codependency in the counselor and thus can inhibit recovery.

Speaking at the same conference, as recorded in the same journal article, Dr. C. Nelson Davis presented his experience with the program of Alcoholics Anonymous. He painted a positive picture of Alcoholics Anonymous but presented his findings as related to his role as a therapist who works with alcoholics, and those addicted to other substances, outside of that program and usually prior to an individual commencing attendance in the Alcoholics Anonymous program. As to those individuals Dr. Davis states: "The alcoholic addict hurts many people – his father, his mother, his sister, his brother, his employer. He even hurts his physician, for of all the patients the doctor treats the alcoholic is probably the most contemptible, and the one who will not follow advice. Frequently, the alcoholic patient comes to the doctor because he is literally dragged to him, and of course that places the physician at a disadvantage (Davis, 1947).

Why is it important to understand codependency in the therapeutic process? The simple answer is that the client will not recover if the counselor displays significant symptoms of codependency. Additionally, when they continually fail to see their patients make progress toward recovery, good counselors, despite *caring* with all their might, may experience loss of confidence in their abilities and may encounter professional *burn-out*. This burn-out also breeds resentment of addicted clients, particularly those who go on to recover seemingly without the loving therapeutic support of the counselor. This phenomenon of resentment is described in the book Alcoholics Anonymous. Although contained in a chapter directed "To Wives" of alcoholics, the codependent emotional resentment discussed here can be applied to any individual who is in a helping relationship with the addict. The passage states that resentment may be felt in that "…love and loyalty could not cure our husbands of alcoholism. We do not like the thought that the contents of a book or the work of another alcoholic has accomplished in a few weeks that for which we struggled for years" (Anonymous, 2001, p. 118). This *resentment* in combination with *love/caring* then became two key elements in what was later to become the concept of *codependency.* As mentioned earlier, prior to the advent of the program of Alcoholics Anonymous there was no effective treatment for alcoholism or other addictions. Following Alcoholic Anonymous' appearance on the scene, mental health professionals began to reluctantly admit that the Alcoholics Anonymous program was producing results where their scientific knowledge had all but failed. These therapeutic professionals were reluctant to discuss the *spiritual* element contained in the program of Alcoholics Anonymous, but in some instances admitted that they could not disprove such an element played a significant role in the recovery of alcoholics. Examples include: Dr. Davis: "The previous speakers have mentioned the spiritual side. There is no doubt that it does play an important part. Alcoholics Anonymous has helped a great many men. There are since the first year or two 41 members who have remained dry; that is a much better record than I have attained…." (Davis, 1947); Dr. Silkworth, in a paper discussing a successful approach to treatment for alcoholics stated "Here is a movement that puts its arm around medicine on one side, and religion on the other." "The physician while an earnest seeker after truth is in no position to recommend all the fads presented to him. Here is a plan emanating from no "authority," no leaders, nothing to sell, strictly ethical, and asking for and receiving the cooperation of physicians." (Silkworth, A Highly Successful Approach To The Alcoholic Problem Confirmed in Medical and Sociological Results, 1941); Dr. Silkworth, as the prominent physician who's expertise on alcoholism was noted in the book Alcoholics Anonymous in which he is described as the "chief physician at a nationally prominent hospital specializing in alcoholic and drug addiction…" made comments relevant to this discussion of

codependency. He implied that there is a class of alcoholic that is “hopeless”; and “as for two of you men, whose stories I have heard, there is no doubt in my mind that you were 100% hopeless, apart from divine help”; He discussed too how the medical profession struggled with spiritual concepts vs. science. He stated, “We doctors have realized for a long time that some form of *moral psychology* was of urgent importance to alcoholics, but its application presented difficulties beyond our conception. What with our ultra-modern standards, our scientific approach to everything, we are perhaps not well equipped to apply *the powers of good* that lie outside our synthetic knowledge.” The *emphasis* in this statement were added in order to clarify that Dr. Silkworth used the phrases, “moral psychology” and “the powers of good”, to denote spiritual concepts in secular terms (Anonymous, 2001, pp. xxv-xxxii & 43). Based on the premise then, that Alcoholics Anonymous was effective in treatment of alcohol addiction, its general principles and 12 steps eventually became a model and guide for the treatment of virtually all other addictions.

Counselor safeguards against codependency

To summarize briefly, for those individuals with a chemical dependency or other addiction, being provided with *help* often has the opposite effect. More often than not, *helping* doesn’t help. In fact, *helping* the addicted individual is often counterproductive to his or her recovery. Logically, and in most other types of therapy, the greatest asset of a mental health professional is his or her ability to *care* for the client’s issues and the desire to *help* the client. However, for those clients suffering from addictions, this *quality* typically found in *helping professionals,* if it leads to the development of codependency, can be very detrimental.

Herein lies the dilemma for the addiction specialist or substance abuse counselor. These addiction professionals *do care* and *do desire* to *help* their clients. The counselor’s dilemma is solved by a shift in mindset and a realization that the therapeutic strategy that *must* be employed to actually help the client is *counterintuitive* to their initial logical and emotional reaction to the client’s presenting issues. Under normal circumstances, if we witness a person starting to fall, our immediate instinct would be to reach out catch them. By catching them, preventing them from falling, we would prevent them from injuring themselves – and, they would be grateful. Such an action is considered to be *intuitive*. Letting them fall would be *counterintuitive*. Letting them fall goes against the natural human reactive instinct to help. This reactive instinct is subconscious and comes immediately and without conscious thought. In virtually all other circumstances, this intuitive-reactive saving process is the correct action to take.

The problem faced with addicted individuals, is that if someone is there to catch them as they fall, they will assume and *expect* that someone will always be there to break their fall and catch them, thus preventing them from being injured. Based on their expectation that someone will always be there to catch them, they will continue to place themselves in situations where they are likely to fall again. What they learn from being *caught* is that someone will rescue them from the consequences of their actions. Therefore, they will continue placing themselves in situations that are potentially harmful to them or others. Additionally, even though they know that their actions are problematic and harmful, if rescued, they will not take the serious steps necessary to prevent future occurrences. If they don’t *fall*, they won’t *hit bottom.* If they don’t hit bottom, they won’t find it necessary to begin the process of recovering from their addiction. It is reasonable to state then that therapists often don’t help by helping. By continuously interceding

on behalf of the client, and not permitting them to experience the consequences of their actions, the counselor can literally *intuitively* love the client to death. Recognizing and overcoming the naturally intuitive desire to *help* the client minimize the effects of his or her behavior, will then permit the client to fully experience the natural consequences of their behavior and will assist the client in taking *ownership* in their behaviors and provide motivation to alter the patterns of their behavior.

Purpose of this Study

The purpose of this study is to explore the therapeutic process between the addictions counselor and the addicted client. This relationship is often unique in the helping professions in that the client–counselor interaction involves the risk of codependency on the part of the counselor. The very characteristics necessary to produce quality counselors are typically the same ones that make them vulnerable to codependency. General characteristics of the dependent addict and the codependent have been presented, along with some of the resulting difficulties that proceed from the interpersonal relationship between these types of individuals.

To this point, information has been examined that describes the necessary characteristics typically prevalent in counselors and inherent in those individuals who are attracted to the helping professions as prospective counselors. Some of these elements include: empathy, compassion, understanding, knowledge, a desire to learn helping techniques (counseling philosophies), a desire to be of service, a desire to help, a desire to engage in productive and meaningful interactions with clients, a striving to gain fulfillment through assisting in the facilitation of the client's positive, successful growth, and in helping others achieve a new and better quality of life. These elements have been summed in this study under the labels of *loving/caring* and *helping* (Shertzer & Stone, 1980). Counselors, addiction professionals, psychologists, therapists, etc. who possess these *helping* characteristics are then confronted with their clients. The addicted client generally exhibits traits such as: "excessive dependency; an inability to express emotions; low frustration tolerance; emotional immaturity; a high level of anxiety in interpersonal relationships; low self-esteem; grandiosity; feelings of isolation; perfectionism; ambivalence to authority; and guilt" (Woititz, 1983), and additional traits that include: "justification; sensitivity; impulsiveness; and defiance" (Renascent, 2009). Addicted clients also tend to exhibit explosive outbursts and a dual personality (Anonymous, 2001, p. 73) (Al-Anon Family Groups B-4, 1989, p. 8).

As noted previously, counselors who interact with addicted clients in an effort to *help* them overcome their myriad of difficulties may be prone to the same emotional forces that afflict other *caring* individuals who have attempted to assist the addicted individual. As such, counselors, particularly those new to the profession or those who work with addicted clients sporadically, may wish to consider a *counterintuitive* approach to therapy.

Counseling Concerns and Considerations

Following are two areas of concern to be considered by Addiction Counseling Professionals. The first are general treatment issues that may be reflected on in preparation for entering into addiction counseling. The second area is primarily concerned with suggestions related to safeguarding the counselor from negative consequences that may arise from characteristics typical of counselors that make them susceptible to codependency issues.

General Treatment Issues

- New client characteristics or thought processes may include: fear of the unknown; evasiveness; manipulation; responding in ways he/she feels the counselor wants to hear; a desire to 'get the heat off'; protection of the future ability to drink or use; the feeling that the counseling process and related programs of recovery are stupid and irrelevant to them; the feeling 'my case is different'; feeling that the counselor doesn't know what he/she is talking about; trying to use the counselor to help them regain loses such as: family, job, home, spouse, esteem, finances, legal problems, cars, etc. The client will often be contemplating ways to 'pretend' that they are making progress in counseling and that treatment is 'working' for them, however, they are not actually following the therapeutic process or internalizing the information presented.
- The nature of the disease of addiction is that the sufferer does not believe he or she is ill. As such, if recovery is to occur, the alcoholic/addict must come to recognize their need of help, and be willing to take the steps necessary to facilitate recovery (Al-Anon Family Groups B-1, 1984, p. xvii).
- A subtle but distinct difference exists between the nature of alcoholism and drug addiction. Alcoholics are genetically predisposed to alcoholism, i.e., They suffer from an inherent abnormal physical affliction or allergy which instills an emotional attachment of which they must come to terms. The drug addict is addicted to an addictive substance. They may have no emotional or "psychological attachment" to the substance other than a "physical addiction" (Moyes, 2011). In other words, the addict may believe that there is nothing wrong with them. Implications for treatment and recovery between these addictions are distinctive as their origins differ substantially (O'Neal, 2011).
- Despite the successes of Alcoholics Anonymous, the American Psychiatric Association maintained substance abuse disorders as "untreatable personality disorders" and clients with addictive behaviors were "labeled as recalcitrant and resistive recidivists." These were regarded as hopeless and terminal conditions." With greater research and treatment knowledge, the then new Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM-III) included alcohol abuse and dependence in a category titled "substance use disorders" rather than as a personality disorder (Miller, 1980, p. 6).
- The initial purpose of treatment is to bring the client to a tipping point where the preponderance of information, experience, and reality of their disease brings on an epiphany concerning the nature of their condition and rendering them amenable to accept and internalize treatment. The prelude to successful treatment requires that the client be brought to an understanding that a problem exists and formulating an actual desire to quit. "Primarily, the patient must himself wish to recover…." (Keyes, 1947). "The only requirement for membership is a desire to stop drinking" (Anonymous, 2001, p. 562) or, "The only requirement for membership is an honest desire to stop drinking" (Anonymous, 2001, p. xiv). In the Book Alcoholics Anonymous this tipping point is described as "We learned that we had to fully concede to our innermost selves that we were alcoholics. This is the first step in recovery" (Anonymous, 2001, p. 30).

Counseling Practices to Safeguard Against Codependency

- A starting point for the Addiction Professional, particularly for those who are new to the profession, and especially those who do not come from a recovery background, in dealing with the issue of codependency, is self-examination. A prepared counselor will know their own issues with regard to addictions: Am I an alcoholic? Drug addict? Am I prone to other addictions? Did I come from an alcoholic/drug addicted home? Do I already struggle with codependency issues? Am I emotionally prepared? Are my motives appropriate and ethical? A prepared counselor will know their limitations. Prepared does not mean perfect. However, when the counselor knows where his or her limits are, they can step back when those limits are being approached and thus avoid being drawn into difficulty. If the counselor begins to feel uncomfortable or perhaps their own weaknesses/issues are surfacing, then it may be time to take a break, consult with another counselor, ask for the assistance of another counselor, or restate the issue in a manner that redirects the session to safer emotional ground, etc.
- Set Boundaries. Establish clear ground rules for conduct of the counseling interaction. Do not deviate from the boundaries. Even minor deviations will be viewed as a chink in the armor from which more procedural concessions can be manipulated.
- Accept *action only* as a basis for compliance with counseling progress. Addicts are often masterful at creating excuses/reasons for non-compliance with therapeutic assignments, etc. Their words are only valid if backed by action.
- Stay Emotionally Detached. Counselors are by nature caring and nurturing. They find themselves easily drawn to emotional attachment to their clients. Addiction counselors can and should have regard and concern for their clients, but need to remain emotionally detached as a safeguard to drifting into codependency, but to avoid manipulation by the client. Certainly as the counselor observes major therapeutic progress in the client, a closer, more encouraging relationship may be apropos.
- Personal Attraction, Awareness of. Along the same lines as Emotional Detachment, the counselor needs to be aware of certain personality types, physical appearance, and gender issues that they may be attracted to. There are certain individuals whose personality types 'gel.' With these types of individuals, conversation is easy, counseling sessions are a joy, rapport is easily built, and trust rapidly established. The counselor may tend to back off of boundary issues, may not require the same stringent 'action' requirements, etc., and leave themselves open for codependency issues to encroach into the relationship. This same ease of attachment too is often likely to occur with opposite sex clients with which the counselor may be physically attracted to. Physical attraction may not be immediate, but may grow over the course of treatment. In 12 step programs there is an unwritten rule-of-thumb that "Men work with men and women work with women". Experience shows that this rule has merit in avoiding situations that may compromise the sobriety of both parties. This procedure is obviously not a luxury that is available to the addiction counselor. However, the concept and principle involved needs to be consciously guarded against by the counselor. Significant boundaries and emotional detachment by the counselor are issues that should remain front and center in the therapeutic relationship to avoid compromise. In each case it should be noted by the counselor that newly sober clients don't emotionally know who they are. They are not accustomed to the emotions they are about to connect with and 'feel' in sobriety. An emotional attachment to such individuals will leave the counselor vulnerable to the full range of emotion and transference-countertransference issues that may come as

'feelings' and 'reality' hit the newly sober client full force. Additionally, such close attachment may leave the counselor with feeling of guilt, remorse, and responsibility should the client relapse.

- Along with Detachment is the concept of Expectations. The counselor and the client are aware of the nature of treatment and what is expected of the client. In order to help guard against the emotions that may lead the counselor into codependency the counselor should remain not only detached emotionally, but have no expectation that the client will follow his or her recovery plan or act upon the suggestions of the counselor. An Al-Anon principle is that "Expectations are premeditated resentments" (Al-Anon Family Groups B-16, 1992, p. 153). For the counselor, this rule-of-thumb implies that if one does not have an expectation then one has nothing to be upset about. Conversely, if/when good things begin to occur, then actual progress is being made. In either case, detachment is maintained. Resentments in the counseling relationship can be very detrimental. One definition of resentment heard in 12 step programs is that having a "resentment is like taking poison and waiting for the other person to die" (McCourt, (n.d.)). As such then, if counselors do not remain relatively detached, begin to have 'expectations' of their clients, begin to prod, excuse, or accept unmet expectations – which will lead to more unmet expectations – attempt to do for the client what the client should be doing for themselves in order to 'help' the client meet counselor expectations. Then when those expectations are not met, anger and resentment sets in, codependency is firmly established and hopes of an effective counseling relationship are virtually non-existent.
- With Emotional Detachment and having no Expectations of the client, the counselor is in good stead with self. Counselors often expect much of themselves. They should of course continually strive to improve their skills and abilities. However, they should not entirely base their success and personal esteem on the progress/success of their clients. Naturally, a higher than average failure rate would require examination, but codependency thrives on basing one's esteem on the lives of others.
- Communicate with, and gain/provide support from/to other addiction professionals. As noted above, a counselor should not totally base their personal esteem on the successes or failures of their clients. However, the healthy counselor will build a support network with which to vent, consult, console, commiserate, inquire from, learn from, share experiences with, seek support/recommendations from, and realistically compare self to. Such a professional support network will assist the counselor in staying firmly grounded. If the counselor is not firmly and professionally grounded codependent feelings of being isolated, alone, and/or seeking of support and reassurance from the client may subconsciously commence, thus thwarting the therapeutic processes. Additionally, if the counselor is a person in recovery, then staying firmly grounded in and to their individual program also is paramount. Counselors should remain active participants in their own programs and accountable to their own sponsors, etc. Furthermore, it may be advantageous to all area addiction professionals, therapists, counselors, etc. to form a private/closed Al-Anon meeting. Such a meeting could help address, and thus help to prevent isolation and other codependency issues from developing in the individual counselors involved.
- Spirituality is the solution denoted in the founding principles of all 12 step based recovery programs. Regardless of what Power the counselor views as important in their lives, the important principle in the counseling for recovery process is to comprehend that the counselor is there to guide, but the solution is outside their control. Ego and

believing that they, the counselor, are the primary element in the recovery of the client will also lead to codependency in that the counselor will again base their pride and ego on their own abilities (hence on the success of the client) and will doom themselves to eventual failure. Counselors should find their spiritual center; define their personal 'right and wrong' based on that center, and stay there. Grow spiritually, but don't deviate to accommodate the needs or desires of the client – or the counselor's need or desire for the client. The counselor and the client will be well served if the counselor views themselves as an instrument of their spiritual center and as being of service of others.

- Counselors are often presented with personal problems, questions, outside concerns, etc. with clients. Various temptations to act, well meaning, innocent, or otherwise may arise. Before acting, of course, check for ethical implications, but in all cases the counselor should ask themselves three questions: "What's my motive? Is it any of my business? And will my taking this action measure up to my spiritual principles?"
- Remember that addiction involves a *personality change* in the client. Consequently, recovery will bring to light 'someone' who may be totally different than the person who entered into treatment. Counselors need to anticipate that *change* will occur. A counselor who has started down the path of codependency with the client will often attempt to prevent this personality change from occurring in the client and thus impede the recovery process.
- Don't help. Remember that the counselor does not help by helping. The client is responsible for his or her own recovery process. They will do it or they won't. Protecting the client from the consequences of their own actions or inactions will prolong or prevent recovery and build codependency in the counselor.

Counselors are by nature helping, caring, and loving individuals. These very traits make them susceptible to codependency. Is an understanding of codependency issues important in the therapeutic counseling process? It is the view of this researcher that the answer is in fact, yes. Codependency issues in the therapeutic process, if not understood and well managed, can have a devastatingly adverse effect on both the client and the counselor. Counselors must countermand the urge to *help* their clients. Clients learn from experience. Counselors may know an easier way that would help the client *not* experience the consequences of their actions, but it is often those consequences and resulting pain that will be the touch-stone of their growth and recovery. As with most of us, clients learn from experience, and from the experiences of everyone they encounter. In some of these experiences they learn what *to do*; in others they learn things to *avoid* doing. They learn by listening and observing the reactions and behaviors of others. They may test the limits and boundaries of their counselors and attempt to manipulate therapy to avoid the work involved in the process. They may not view their counselor(s) as having the therapeutic knowledge and skills necessary to handle the client's self-perceived unique needs – and may bluntly express these feelings to the counselor. However, in spite of his or her manipulative tactics, the client will learn significant recovery lessons by observing their counselor's calm resolve to set and observe boundaries, require therapeutic *action,* observe the importance the counselor places on his or her own spiritual (moral and ethical principles) center, and 'feel' the goal for the client that the counselor continually points to. That goal is for the client to reach the tipping point or self-admission or surrender to their difficulties and gaining the personal desire for recovery. By observing these things in the counselor the client will *know* they are *loved, cared for,* and have been *helped* by an Addiction Professional Counselor. A counselor who *cared* enough to overcome the emotional tug of codependency,

stay true to the principled approach, and become the steadfast *rock* the client may now wish to emulate in recovery. “I remember when I was in treatment my counselor said…”

REFERENCES

Al-Anon Family Group B-6. (1978). *One Day at a Time in Al-Anon B-6.* New York: Al-Anon Family Group Headquarters, Inc.

Al-Anon Family Groups B-1. (1984). *Al-Anon Faces Alcoholism.* New York: Al-Anon Family Groups Headquarters Inc.

Al-Anon Family Groups B-16. (1992). *Courage to Change (One Day at a Time in Al-Anon II).* Virginia Beach: Al-Anon Family Group Headquarters Inc.

Al-Anon Family Groups B-4. (1989). *The Dilemma of the Alcoholic Marriage.* New York: Al-Anon Family Group Headquarters, Inc.

Al-Anon Family Groups. (2006). *How do Alcoholics affect familites and friends?* Retrieved March 5, 2011, from Al-Anon / Alateen : http://www.al-anon.alateen.org/new_8question.html

Alcoholic Behavior. (2009, June 27). Retrieved March 8, 2011, from Alcoholic Behavior, Diagnosing and Addressing Alcoholism: http://alcoholicbehavior.net/Alcoholic-Behavior.html

Anonymous. (2001). *Alcoholics Anonymous* (Fourth Edition ed.). New York City, New York, USA: Alcoholics Anonymous World Services, INC.

Anonymous. (2001). *Alcoholics Anonymous* (4th ed.). New York City: Alcoholics Anonymous World Services, Inc.

Bankole A. Johnson, N. A.-D.-Q. ((Published online January 19, 2011). Pharmocogenetic Approach at the Serotonin Transporter Gene as a Method of Reducing the Severity of Alcohol Drinking. *Am J Psychiatry* , doi:10.1176/appi.ajp.2010.10050755).

Breining, B. G., Anderson, S. T., Breining, M. J., Brown-Lidsey, V., Dakai, S. H., Ganaway, J., et al. (2008). *Addiction Professional; Manual for Counselor Competency* (Second ed.). Orangevale, California, United States of America: Breining Institute.

California Department of Alcohol and Drug Programs. (2011, March 7). *Counselor Certification.* Retrieved April 5, 2011, from State of California: http://www.adp.cahwnet.gov/Licensing/LCBhome.shtml

CoCA. (2011, March). *Patterns and Characteristics of Codependence.* Retrieved March 5, 2011, from CoDA: http://www.coda.org/tools4recovery/patterns-new.htm

Davis, C. N. (1947). Alcoholics Anonymous. *Archives of Neurology and Psychiatry , 57* (4), 516-518.

Diane Duke. (1998, January 15). *Scientists identify strong genetic link to allergies.* Retrieved February 4, 2011, from Washingston State University in St. Louis: http://wupa.wustl.edu/record_archive/1998/01-15-98/4477.html

Farlex. (2011). *Medical Dictionary; Inflamatory Diseses; Inflamation.* Retrieved February 3, 2011, from The Free Dictionary : http://medical-dictionary.thefreedictionary.com/Inflammatory+diseases

Franklin, B. (n.d.). Retrieved April 8, 2011, from Great-Quotes.com: http://www.great-quotes.com/quote/332975

Genetic Allergies and Research. (2010, July 21). Retrieved January 2, 2011, from Healthtree.com: http://www.healthtree.com/articles/allergies/genetics/

Gizer, I. R., Ehlers, C. L., Vieten, C., Seaton-Smith, K. L., Feiler, H. S., Lee, J. V., et al. (2011). Linkage scan of alcohol dependence in the UCSF Family Alcoholism Study. *Drug & Alcohol Dependence , 113* (2/3), pp. 125-132.

Hadden, S. B. (1946, April 12). *Society Transactions, Philadelphia Psychiatric Society.* Retrieved March 19, 2011, from Journal of the American Medical Association Archieves of Neurology & Psychiatry: http://archneurpsyc.ama-assn.org/cgi/reprint/57/4/513

Huffpost Staff Writer. (2011, March 2). California Woman Survives 35-Mile Car Ride on Minivan Hood. *Huffington Post*. Retrieved from http://www.huffingtonpost.com.

Kellermann, R. J. (1969). *Alcoholism, A Merry-Go-Round Named Denial.* Virginia Beach: Al-Anon Family Groups Headquarters, Inc.

Keyes, B. L. (1947). The Problem of Alcoholism. *Archives of Neurology and Psychiatry , 57* (4), 513.

Li, N. D.-K. (2004, December). Drug addiction: the neurobiology of behaviour gone awry. *Nature Reviews Neuroscience* , pp. 963-970.

McCourt, M. ((n.d.)). *Great-Quotes.com*. Retrieved April 8, 2011, from http://www.great-quotes.com/quote/521946

Miller, W. R. (1980). The Addictive Behaviors. In W. R. Miller (Ed.), *The Addictive Behaviors: Treatment of Alcoholism, Drug Abuse, Smoking, and Obesity* (1st ed.). New York: Pergamon Press.

Moyes, M. H. (2011). Opioids: Use, Abuse and Treatment. *Journal of Addictive Disorders* . Available on-line at Breining Institute, http://www.breining.edu.

NA World Services. (2010). *Information about NA.* Retrieved February 6, 2011, from Narcotics Anonymous Web site: www.na.org

NIH News. (2011, January 19). *Gene variants predict treatment success for alcoholism medication:.* Retrieved January 28, 2011, from National Institute on Alcohol Abuse and Alcoholism (NIAAA): http://www.niaaa.nih.gov/NewsEvents/NewsReleases/Pages/Genevariantspredicttreatm

O'Neal, H. (2011). Genetic Predisposition: A Review of Primary Chemical Addictions, their Etilolgy and Possible Implications for Treatment and Recovery. *Journal of Addictive Disorders* . Available on-line at Breining Institute, http://www.breining.edu.

Renascent. (2009). *Personality Traits of an Alcoholic or Drug Addict*. Retrieved April 6, 2011, from Renascent: http://www.renascent.ca/treatment-family-addict-traits.asp

Shertzer, B., & Stone, S. C. (1980). *Fundamentals of Counseling* (3rd ed.). Boston: Houghton Mifflin Company.

Silkworth, W. D. (1941). A Highly Successful Approach To The Alcoholic Problem Confirmed in Medical and Sociological Results. *Medical Record , 154*.

Silkworth, W. D. (2001). The Doctor's Opinion. In Anonymous, *Alcoholics Anonymous* (Fourth Edition ed., pp. xxv-xxxii). New York City, New York, USA: Alcoholics Anonymous World Services Inc.

U.S. National Library of Medicine. (2011, January 21). *MedlinePlus.* Retrieved February 2, 2011, from U.S. National Library of Medicine, National Institutes of Health: http://www.nlm.nih.gov/medlineplus/allergy.html

V A Ramchandani, J. U.-V. (2010, May 18). A genetic determinant of the striatal dopamine response to alcohol in men. *Molecular Psychiatry* , p. Original Article.

Wikipedia. (2011, February 24). *Codependency.* Retrieved March 5, 2011, from Wikipedia: http://en.wikipedia.org/wiki/Codependency

Wilson, B. (1958). *Problems Other Than Alcohol (excerts).* New York City, New York, USA: Alcoholics Anonymous World Services, INC.

Woititz, J. G. (1983). *Adult Children of Alcholics.* Pompano Beach, FL: Health Communications, Inc. .

Wrenn, C. G. (1973). *The World af the Contemporary Counselor.* Boston: Houghton Mifflin Company.

Wyman, J. R. (1997, July/August). Promising Advances Toward Understanding the Genetic Roots of Addiction. *National Institute on Drug Abuse - NIDA NOTES Volume 12, Number 4* .

ACKNOWLEDGEMENTS AND NOTICES

This article may contain opinions that do not reflect the opinion of Breining Institute, and Breining Institute does not warrant the information and/or opinions contained herein.

This copyrighted material may be copied in whole or in part, provided that the material used is properly referenced, and that the following citation is used in full: O'Neal, H.S. (2011). Codependency among health care professionals: Is an understanding of codependency issues important to the therapeutic counseling process? ***Journal of Addictive Disorders.*** Retrieved [date retrieved] from Breining Institute at http://www.breining.edu.

This article was prepared in 2011 by H. Spencer O'Neal, who earned the Doctor of Addictive Disorders (Dr.AD) Degree from Breining Institute in 2012, is a Licensed Educational Psychologist (Lic. No. 2480) in California, has earned the internationally-awarded Masters Level – Registered Addiction Specialist (M-RAS) credential from Breining Institute, and holds the CATC Credential from the California Association for Alcohol / Drug Educators (CAADE).