A Critical Analysis of the Co-dependence Construct

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CO-DEPENDENCE is a diagnostic term that has gained increasing usage in clinical and self-help settings. While it is used to encompass a broad range of clinical phenomena, it generally refers to an identity, particularly common among women, based on caretaking and excessive responsibility for others. This paper explores the clinical implications of the co-dependence construct from both social-psychological and psychodynamic perspectives.

Co-dependence is a mental health idiom that has achieved tremendous currency in the popular clinical literature in recent years. Books on co-dependence now fill self-help sections of bookstores, and therapeutic gurus promote workshops offering relief for this newly identified population of sufferers. The prototypical co-dependent is also described in the burgeoning literature on adult children of alcoholics (ACOA). ACOA has become part of this new psychotherapeutic lexicon as well, indicating, particularly among women, a socially recognized emotional disability as ell as a prescribed course of recovery. Counselors and therapists draw increasingly on ACOA language in their therapeutic practices and marketing tactics, e.g., offering specialty counseling for "ACOA's" or "co-dependents."

In clinical situations, the term *co-dependence* carries the same pitfalls as diagnostic labeling generally: the potential for reifying the patient or applying labels as a substitute for careful analysis. Diagnostic categories can also be used defensively by therapists in responding to pressures and anxieties felt in therapeutic situations, e.g., a readiness to label demanding patients as "borderline." But the term co-dependence also raises broader social questions in that it is being used increasingly by groups and individuals as a basis for self-definition and group identity.

Constituting a unique social and clinical phenomenon, the co-dependence literature and the many recovery groups it has spawned are of interest because they apply the Alcoholics Anonymous Twelve step philosophy (see appendix) and the disease model of addiction to interpersonal problems, extending these ideas far beyond the primary addictions," i.e., drug and alcohol. With the growing public anxiety over alcoholism and drug dependence, the concept of addiction, as both metaphor and reality, has come to occupy a larger and larger terrain in American popular psychology, encompassing a broad range of social and emotional ills. The analysis presented here criticizes the co-dependence literature from psychodynamic and social-psychological perspectives.

Psychodynamically, the co-dependence literature is conceptualized in the critique presented here as containing insights consistent with current psychoanalytic theory and as paralleling the current psychoanalytic emphasis on interper-

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sonal phenomena and character pathology. This paper describes these parallels as well as the problematic limitations and over-incorporative quality of the co-dependence literature. The co-dependence literature popularizes diagnostic conceptions of interpersonal conflicts by pointing to constellations of behavior, which are conceived of as symptomatic of an underlying mental disease with an associated set of antecedent or causal deficits and a subsequent set of functional impairments. It is argued here that the extension of the disease concept of addiction, popularized by Alcoholics Anonymous, to more pervasive personality and character phenomena represents a troubling trend in the popular psychology literature.

I will be exploring implicit assumptions about gender in the co-dependence literature from a feminist psychodynamic perspective as well as a social-psychological perspective. I will also discuss the tendency in the co-dependence literature to pathologize a feminine identity based on caretaking and to oversimplify dependency conflicts.

CO-DEPENDENCE AND THE CLINICAL CONSTRUCTION OF FEMINITY

Co-dependence historically describes a feminine malady, but perhaps more, basically, it describes the emotional condition of the oppressed. While some clinicians use the term co-dependence to encompass a broad range of psychopathological conditions (see Beattie 1987; Schaef 1986), it more commonly refers to an identity based on caretaking and responsibility for: others. The co-dependent's caretaking I identity is formed out of the experience of I powerlessness; it is an identity forged out of the adaptive necessity of compromise, appeasement and covert manipulation.

Co-dependence originates in a tendency, particulary common among daughters in “dysfunctional" families, to overcompensate for parental inadequacies by becoming parentified and by developing an excessive sensitivity to the needs of others.

The concept of the dysfunctional family, which originally referred to patterns of interaction associated with alcoholism, has gradually expanded to incorporate all family systems based on "denial" (Middleton-Moz 1989; Richketson 1989; Wegscheider-Cruse 1985) or "shame-based rules" (Bradshaw 1988). This broader conception of the dysfunctional family includes a wide range of pathogenic dynamics and impoverished emotional interactions within the family, particularly where avoidance of confrontation or the inability to develop healthy means of resolving conflict predominate. Co-dependence refers to a set of counter-identifications with parental deficiencies.

The co-dependence literature expresses the pain, anguish and helplessness, combined with an overwhelming, wearisome responsibility for others that dominates the lives of many women. While there are stories of men in the co-dependence literature, for the most part they are women's stories. They are stories of women who are trying desperately to hold families together and to keep things going under seemingly impossible conditions. This literature speaks of the emotional deprivations of women, particularly in their relationship with men, and of the experience of finding gratification/ and a sense of strength through what Hochschild (1983) refers to as "emotional work" i.e., managing the feelings of others.

Beattie (1987), one of the leading writers of co-dependence literature, understands that the appeal of her book is not only to those in the helping professions but to women who exhaustively take care of others and feel emotionally deprived and depleted by these efforts. She poses the following question: "Does endlessly taking care of other people . . . mean, Marlys is a good wife and mother? Or could it mean Marlys is co-dependent?" (p. 22). Beattie describes clients who present with an array of life difficulties and a sense of confusion and feeling crazy. In responding to an illustrative client. Beattie offers the explanation that "maybe your husband is an alcoholic, and your

problems are caused by the family disease of alcoholism" (p. 20). She goes on to explain summarily that "now, if you ask Patty what her problem is or was, she will answer: “I'm co-dependent.”

Beattie defines a co-dependent as "one who has let another person's behavior affect him or her and who is obsessed with controlling that person's behavior" (p. 31). She goes on to describe this condition as one that results from victimization but that requires "each of us to decide what part we played in our victimization" (p. 32).

The theme of victimization is pronounced in the co-dependence literature. The assumption is that victims internalize a set of rules that were adaptive in the family of origin but cause them to recreate their victimization as adults. Subby and Friel (1984) define co-dependence as "an emotional, psychological, and behavioral condition that develops as a result of an individual's prolonged exposure to, and practice of, a set of oppressive rules" (p. 31). Schaef 1987) links racism, sexism and homophobia to the "addictive thinking" that creates codependence. The implicit idea here is that institutionalized oppression cultivates pathological forms of dependency whereby both victim and perpetrator, master and slave, share a common, impoverished emotional world.

While the co-dependence literature focuses on victimization, the typology is general enough to include anyone who is often upset or who has emotional difficulties that are manifested interpersonally. Schaef (1986) concludes that *"everyone* who works with, lives with, or is around an alcoholic (or a person actively in an addictive process) is by *definition* a co-dependent and a practicing co-dependent" (p. 29). Beattie lists dozens of problems and psychopathological conditions — from neurosis to personality disorder and psychotic conditions-that are all subsumed under the umbrella of co-dependence. Cermak (1986) views co-dependence as a mixed personality disorder that can be manifested symptomatically as depression, anxiety disorder, hysterical personality disorder, dependent personality disorder or borderline condition.

While the co-dependence construct does not have real diagnostic discriminative validity, the popular literature that has emerged under this idiom clearly suggests that it articulates important themes in the lives of many—again, particularly of women. Its appeal lies in giving a name — i.e., a conceptual container-to a broadly defined set of emotional ills, interpersonal pressures, and conflictual dependencies, and in providing a message of hope, that is, a path to recovery.

Co-dependence converges with another so-called feminine malady, "relationship addiction" or "love addiction," popularized by Robin Norwood (1986), who is also a proponent of Twelve-step recovery groups. The co-dependence literature provides more clinical elaboration of this malady, introducing a broad constellation of pathological behaviors and etiological explanations associated with an identity based on caretaking and over-involvement in relationships. While some use the terms love addiction and co-dependence interchangeably, the latter term refers to a more general pattern of behavior, i.e., a personality disorder based upon excessive responsibility for others. Put still another way, the love addict is assumed to be co-dependent, but the co-dependent is not necessarily a love addict. Whereas the love addict becomes over-involved in dyadic relationships, the co-dependent may manifest her/his "disease" through a tendency to take responsibility for the feelings and well-being of others in myriad interpersonal contexts. Nonetheless, both constructs are based on an extension of the disease model of addiction advanced by Alcoholics Anonymous to conflictual interpersonal dependencies.

The popular appeal of these constructs for many contemporary women seems to be related to the apparent contradiction between objective conditions approaching greater parity with men and a subjective lag in feelings of autonomy and independence. Old feminine ideals, including women's identification with mothering

and relational concerns, now feel ego dystonic for many women. In a society that prizes competition and narcissistic self-sufficiency, the legacy of the feminine past feels "dysfunctional" (see Herman and Lewis 1986). The women's movement of the 1960s and 70s involved, psychodynamically, the recovery of the powerful pre-oedipal mother of our collective, archaic past-a sense of goodness and strength that extended beyond familial concerns to a larger social ethos. With the decline of the women's movement, and a concomitant assimilation of women into the paid work force, maternal identifications for women are less apt to be experienced as an adequate internal bridge to external reality.

ORIGINS IN THE ALCOHOL AND CHEMICAL DEPENDENCE FIELD

Much of the literature on co-dependence comes out of the alcohol and chemical dependence field (see Schaef 1986; Wegscheider-Cruse 1985; Whitfield 1985). The term began to appear in mental health literature in the late 1970s as drug and alcohol treatment programs began to focus more extensively on "family systems." These programs have focused increasingly over the past decade on the role of family members, particularly parents and spouses, in maintaining the addict's self-destructive behavior. The movement to adopt a family systems perspective in the treatment of alcohol and drug abuse did open up new areas of insight into the complex social and psychological aspects of these problems.

The essential insight behind the co-dependence construct emerged out of the treatment of alcoholics. Family members, typically the spouse of the alcoholic, inadvertently supported the very behavior that they were ostensibly trying to control. By intervening and protecting the alcoholic—e.g., lying to the alcoholic's boss, cleaning up messes, and paying unpaid bills-the spouse was compensating for the alcoholic's irresponsibility and loss of control. However, these very attempts at restoring control had the effect of preventing the alcoholic from experiencing the uncomfortable consequences of his/her own behavior. As the spouse increasingly took over areas of the alcoholic's life and functioning, the alcoholic's tendency to deny the destructiveness of his/her behavior intensified. In Al-Anon, the organization formed in 1951 by wives of alcoholics recovering in AA, this pattern of behavior is called enabling," and historically it has been the wife who has played this role in relation to the alcoholic husband.

The enabling dynamic presupposes gender dynamics within the family in which women, in the role of wives and mothers, are in the ambivalent position of being both emotionally protecting and potentially "castrating" or overpowering. As Chodorow (1989) has argued, women's near-exclusive involvement in the care of young children creates a psychological legacy, for both men and women, of both the "good," all-powerful pre-oedipal mother and the "bad," devouring one. Women as mothers are associated with the regressive pleasures and fears of early childhood, whereas men as fathers come to represent the "reality principle" of the larger social order. In patriarchal societies, males come to repress their early identification with the mother and its associated dependency longings, but they are compensated for this loss by identifying with the rights and privileges of the father, i.e., in developing a masculine sense of entitlement. The girl is required to give up her infantile claims to the mother without the compensating right to patriarchal power and privilege that is offered the boy in his relinquishment of the same infantile claims (Janeway 1974; Mitchell 1974).

Family systems approaches to "enabling" in the alcoholic family generally fail to address either the infantile components of family members' fury toward the mother or the different social bases of power within the family. In the prototypical alcoholic family, the father/husband may be consciously or unconsciously perceived as

being "castrated" by his alcoholism. Paradoxically, the alcoholic state can represent both an assertion of the man's masculine sense of entitlement and, ultimately, a condition that imparts a sense of impotence, both sexually and socially. Unconsciously, the intoxicated state also permits a regressive recovery of infantile pleasures — a rebellion against a masculine identity based on the renunciation of dependency longings (see Chodorow 1978). For the mother/wife, the husband's alcoholism evokes twin fears of having become the "devouring, castrating" mother in relation to her husband and of having failed to be the good, protective mother in relation to her children.

The family's belief that the mother is the "real" villain—the one who "enabled" the husband's alcoholism — can be over determined by archaic fantasies of the omnipotent mother. The family's confrontation of the "enabler" can be based on both its recognition of the mother's *actual* ambivalent motivations (nurturant and unconsciously hostile) and its infantile rage toward her. In addition, there may be disappointment in her for failing to protect the family from the father's abusive behavior, e.g., "If she had responded differently to him, he would not have been so sick"

The problem of enabling also points to moral dilemmas within the family associated with women's caretaking position. In her study of gender and moral development, Gilligan (1982) concludes that females, who identify more closely with the mother, are more likely than males to experience moral conflict in situations where they fail to provide nurturance or to maintain relational ties. In female development, the pre-oedipal tie to the mother is not as fully relinquished as it is in male development, creating a tendency in women toward more flexible ego boundaries (Chodorow 1978). In the context of moral choice, females are more apt to require moral justification for failing to respond to the needs of others, whereas males are more apt to construct moral arguments in relation to preserving social distance, i.e., not "intruding" and managing competitive strivings (Chodorow 1978; Gilligan 1982).

In the enabling situation, it is noteworthy that the woman's failure to respond to the problems of her alcoholic husband requires justification in terms of *his* need for a different response. It is understandable that many women embrace the enabling construct and experience some relief in being told that to *not* respond to the demands of the alcoholic spouse is actually more loving than to do so. The underlying feminine ideal of maternal sensitivity to others is preserved by a reframing of the moral issues.

The tendency for family systems therapists to ignore or downplay these gender dynamics may be related to a conservative tendency of the theory itself-a tendency that has informed conceptions of "The Alcoholic Family." Family systems theorists view the family as a system in much the same sense that an individual is a system - an organism constituted of interdependent parts and a set of self regulating mechanisms. The family is conceptualized as having a distinctive personality and identity based on a personal past, and as having self-regulating mechanisms that mediate its relation to internal and external reality, i.e., that function like an ego (Steinglass 1987). The assumption here is that the family, as an organism, equally benefits from or is compromised by dysfunctional" patterns of interaction.

There is much that is useful in this conception of the family as an interdependent system, particularly when it allows family members to recognize their own unconscious contribution to the disturbing behavior of another family member. From this perspective, the alcoholic or addict is no worse (or better) than the person who vicariously supports the self-destructive habit. The notion of alcoholism as a "family disease" introduces a taboo against self-righteous condemnation of the alcoholic and points to the social context of individual pathology. Consistent with this systems approach, Subby (1987) focuses on

the importance of family dynamics in potentiating alcoholism:

> I have no doubt that there are real genetic factors behind alcoholism and other forms of chemical dependency. But I don't believe that even someone who was born with all that genetic loading and as a result becomes alcoholic, would have to practice their alcoholism or addiction long before they would also have to find or create a new co-dependent system to support their alcoholism, [p. 12]

The family systems model, however, obscures differences in ego strength and power and minimizes the conflictual aims of family members. The family is a socially constructed institution, with economic and affinitive bases for both interdependence and conflict. It is quite unlike an individual organism in that the family has no superoridinate ego or self that organizes its conduct. Many family systems theory models draw extensively on organismic metaphors that can blind theorists to the conflictual and socially constructed dimensions of family life and family dynamics.

Steinglass (1987) provides an analysis of the alcoholic family that draws on systems theory while challenging the tendency in systems theory to oversimplify family phenomena. He concludes that the alcoholic family is one where alcohol-related behavior becomes central to both the family's identity and its self-regulating capacities. A central finding of his study is consistent with the shift in the alcoholism literature from understanding alcoholism as a discrete behavioral syndrome to an emphasis on interactive and personality dynamics. Steinglass found that the level of alcohol consumption per se was not associated with disturbing family dynamics or with individual pathology within the family. It was in association with social/behavioral aspects of alcoholism—i.e., when alcohol use became associated with unpredictable and destructive behavior-that the family identity became "alcoholic." In contradistinction to the co-dependence literature, however, Steinglass stresses the heterogeneity of alcoholic families, pointing to the tendency in the literature to provide too narrow a typology of alcoholic family dynamics. In finding that alcohol consumption is not a simple causal variable of family distress, he concludes that what is common to alcoholic families is the focus on alcohol as the family's *explanation* for irrational behavior.

The therapeutic interventions described by Steinglass focus on initially distinguishing between the family with an alcoholic member and an alcoholic family. This distinction suggests that an underlying set of personality variables mediates alcohol use in the family. "Family alcoholism" suggests interactive and personality dynamics potentiated by and organized around alcohol intoxication.

While the family systems approach to alcoholism has opened up new avenues of insight and clinical intervention, it limits understanding of the emotional and interpersonal complexity of alcoholism and other addictive processes. As Scharff and Scharff (1987) have argued, systems approaches to family therapy provide means of quickly organizing the problem and actively intervening. But in doing so, they often sacrifice important clinical material of diagnostic and prognostic significance (Friedman 1980). When a hypothesized disease process with unitary symptoms and progressive stages is combined with a family typology of alcoholism, the differing and specific ego strengths, object relational capacities, and psychopathology of individual family members become obscured. For example, some alcoholics are able to sustain empathic ties with their children, and some cannot. Some are abusive when drunk, and some are not. These are important clinical distinctions that are lost in the joining of the disease model of alcoholism with family systems perspectives.

PSYCHODYNAMIC IMPLICATIONS OF CO-DEPENDENCY

There are problematic implications, both etiologically and therapeutically, in

the notion of an underlying congruence among addictive processes-whether those processes refer to substances or to interpersonal relationships. While a review of the debates on addiction falls outside the scope of this paper, the psychiatric literature does suggest that there are no clearly identifiable dynamics nor consistent etiological factors underlying drug or alcohol dependency (Meyer 1986; Mirin 1984; Rounsaville et al. 1987). Further, regardless of how one conceives of the regressive component of chemical or alcohol addiction, there are myriad problems in extending these formulations to the interactive pressures and dependencies of relationships. In some formulations addiction implies a regressive retreat from the object relational world, with the drug becoming the substitute object. But the women who are described in the co-dependence literature do not achieve the euphoria that might be expected in a logical extension of addiction theory. Whatever the pathology that underlies these conflicted attachments, it exists in a world of real objects that make demands requiring some capacity for sublimation, ego functioning and normal dependency despite the pathology.

However, it can be granted that there is a certain phenomenological congruity to compulsive forms of desire, whether the object is alcohol, drugs, or people (Peele and Brodsky 1975; Simon 1982). To describe something or someone as addictive is to express the power of infantile longings and the emergence of an archaic split between exciting and persecutory objects. Falling in love has been described as an intoxicating state, and alcohol has been described as a faithful lover. In both experiences the euphoria of union contains the memory of an idealized, gratifying, comforting object, along with the heightened narcissism derived from it. It also awakens the experience of infantile ambivalence and the sense of terror and loss when the exciting, "bad" object is withdrawn.

There is a notable congruence between the ideas voiced by the co-dependence literature and the interpersonal approach to psychopathology that has gained currency with the ascendance of object relations theory and) self psychology within psychoanalysis (see Greenberg and Mitchell 1983). Both the psychoanalytic literature and the co-dependence literature stress the interactive manifestations of psychopathology and primitive mechanisms of defense, e.g., splitting and projective identification. The co-dependence literature describes a compulsive tendency to attempt to maintain emotional stability and a sense of well-being by maintaining contact with someone who is out of control.

Inherent to this dynamic conception of co-dependence is the psychoanalytic notion of projective identification. Projective identification refers to interpersonal dependencies and interactive processes based on the primitive defense of splitting (for discussion, see Meissner 1980). The good self preserves a sense of goodness and wards off knowledge of disturbing, bad-object representations by maintaining contact with an externalized bad object. For the co-dependent, this external object is the alcoholic, drug addict, or abusive partner, who is identified with and conforms to the disturbing projections. The split-off ego functions that underlie these anguished interpersonal dependencies can be manifested by shifting valences in the dependency ties as well. The abused partner, who is initially emotionally dominated by and dependent up on the abuser, begins to assume control by taking over the ego functions of the abuser.

In important respects, however, the codependence literature differs from psychoanalytic formulations of these processes and the means of resolving conflict between good and bad self and object representations. Whereas projective identification refers to a primitive mechanism of defense central to particular character pathologies, the co-dependence construct is used as a label for a broad range of conditions and as a basis for individual and group identity. A key difference here is that the co-dependence literature fails to

differentiate between extreme pathologies and those neurotic conditions which afflict people with some real object relational capacity and ego strength. There is little attention in the co-dependence literature to specific developmental factors associated with greater or lesser degrees of ego integration and object relational capacity.

By focusing exclusively on pathology-e.g., assuming that co-dependents are unable to develop emotional "boundaries" (Schaef 1986, p. 48) - the co-dependence literature fails to identify positive identifications and developmental experiences that often co-exist with the pathology. Just as psychotherapists who focus exclusively on pathology can make the patient feel "sicker" than he/she is, the co-dependence literature tends to cast the reader into a chaotic world of bad object and self representations without adequate recognition of the problems attendant to emotionally assimilating these warded-off aspects of the self.

PSYCHODYNAMICSOFTHE TWELVE-STEP PATH TO RECOVERY

With few exceptions, the co-dependence literature promotes Twelve-step programs or recovery groups and argues that such groups are essential to "breaking through the denial" associated with the "disease" of co-dependence. Whereas the early Alcoholics Anonymous and Al-Anon literatures focused on a shared but circumscribed set of problems associated with alcoholism, the unifying basis of contemporary recovery groups such as Adult Children of Alcoholics (ACOA) is much broader and more defining of the self. The groups are organized around a self-diagnosed, shared personality disorder originating in a dysfunctional family understood in a particular way. A central basis for the appeal of Twelve-step programs for those who identify with the co-dependence literature is their provision of a means of emotionally containing and conceptualizing the experience of being out of control or the experience of being with someone who is out of control.

The transformation of alcoholism and other addictions into disease categories did have its progressive aspects, permitting the moral neutralization of chemical dependence so that it could be understood psychologically and therapeutically. As long as these problems were understood to be the result of moral weakness or lack of self-discipline, the distance between the alcoholic and the rest of humanity seemed mysteriously vast and beyond human capacities to bridge.

And yet, Twelve-step programs do offer a moral interpretation of addiction alongside the disease model. Even though the alcoholic is not seen as morally responsible for the disease, alcoholism, like Original Sin, requires spiritual redemption and divine intervention. Just as the concept of Original Sin liberates the believer from personal responsibility for his/her "fallen state" while at the same time making the "sinner" responsible for seeking salvation, so too the AA disease model shifts the moral ground from the alcoholism (a disease for which the alcoholic is not responsible) to the alcoholic's responsibility to seek recovery through a Twelve-step program.

The first step in recovery groups is to acknowledge that one has lost control—that the destructive compulsion has taken over and is beyond personal attempts to regain mastery. Whatever the object of the compulsion—alcohol, food, drugs, or relationships with people—the message is that the individual feels out of control because he/she is suffering from a progressive disease, a pernicious condition that can only be arrested by following the Twelve-step path to recovery. This requires a conversion experience in which the sufferer turns his or her life and will over to a "Higher Power," whose guidance is sought in the moral awakening that follows from the conversion experience.

In Twelve-step programs, the disease concept of alcoholism operates psychodynamically much as the concept of the "devil" does in fundamentalism. (For relat-

ed discussion, see Antze 1987.) What characterizes fundamentalism is not only particular ways of thinking about God and Scripture but the extent of one's belief in the devil, the devil and hell are full rivals with God in the religious cosmology. The appeal of both fundamentalism and Twelve-step programs is similar: the hope of connecting with a source of goodness and benevolent control amidst a world dominated by chaotic, destructive forces. Both belief systems permit a mystical transformation of bad feelings and experiences into good feelings of peace and well-being. God comes to represent the longed-for object of comfort and hope — the object that has failed the believer in reality but that he/she hopes to recover through faith and relinquishment of personal will. The complexity of experience is reduced to some basic unifying ideas, and anxiety is warded off by following a set of prescribed steps.

In the co-dependence literature, the anguish of conflicted dependency is transformed through a form of reaction formation, i.e., defensive transformation of the feared or hated object into its opposite. Many co-dependence authors argue that conflicted attachment must yield to a state of detachment, and that "when confronted by a foe, praise him bless him, let him go" (Norwood 1988, p. 264). There is an emphasis on the transformative power of emotional surrender as "we allow life to happen instead of forcing and trying to control it" (Beattie 1987, p. 66). The disturbing sense that something important is missing—either within oneself or within one's life experience—is warded off by renouncing conflict and doubt. "Detachment means accepting reality-the facts . . . the natural order and destiny of things in this world. . . . We believe in the rightness and appropriateness of each moment" (Beattie, p. 66).

CONCLUSION

Co-dependence is presented in the popular clinical literature as a condition that has varying symptoms but is based on underlying personality disease shared by all sufferers. According to the literature, it originates in all sufferers in an equivalently understood, repressive, addictive family system, it progresses in an equivalent way toward ultimate self-destruction, and it requires the same redemptive solution. The person who attempts to hold the family together is the same as the alcoholic who abandons it; the person who depends upon drugs for a sense of well-being is the same as the one who depends upon people for the same feelings. There are no victims and therefore no perpetrators in this no-blaming world of moral equivalents. While the co-dependence literature does reject the repressive moral categories of the past, it provides a morally and psychologically impoverished substitute world devoid of the tensions inherent in differentiated consciousness.

The self-help groups that draw so extensively on the co-dependence literature do offer comfort and hope to individuals who share a common experience of feeling overwhelmed and out of control. The groups provide a place and language for talking about emotional pain in society that provides little space for such release. Recovery groups reduce the sense of isolation and aloneness so common in American society and convey hope and a commonality of purpose through which members can transcend the limits of individual experience (Cutter and Cutter 1987).

On the other hand, the contemporary co-dependence literature and the recovery groups that draw on this literature pathologize caretaker dilemmas and vastly oversimplify problems of human dependency and interdependency. The message that "co-dependents" must disinvest in unrewarding relationships is particularly compelling for women today, who continue to carry the traditional burdens of care-taking responsibilities and whose entry into the paid work force has, to some degree, intensified these burdens. While women have gained some measure of autonomy and freedom from enforced dependencies upon men and family life, condi-

tions of daily life have not permitted a real emancipation from the old division of domestic and emotional labor. The old social contract between the sexes has unraveled, and as yet new forms of reciprocity and healthy interdependence between men and women haye not been sufficiently realized. The co-dependence literature vastly oversimplifies these problems of dependency and interdependency, on both the social and individual levels.

The construct of co-dependence embraces much of humanity in a common psychopathological net. While this clinical concept articulates concerns that are common to many in our society and points to the need for sociological and cultural explanations for psychopathology, it assimilates far too much in attempting to offer one simple construct to explain the multifarious existential, social and psychopathological bases of human emotional suffering.

We do need theories and ideas that speak to core human dilemmas and to the commonalities in human emotional suffering. But as clinical work has become increasingly guided by narrowly defined specialties on the one hand, and by ad hoc eclecticism, such as co-dependency models, on the other, the potential for broad-based theorizing has diminished. Clinicians who are not anchored in broad-based traditions backed by well-developed theories are tremendously vulnerable to clinical trends and popular literature that "pull it all together" conceptually. The co-dependence label becomes a broad conceptual container into which myriad life difficulties and internal and external pressures are placed. The message is compelling because it seems to provide both the therapists who draw on the co-dependence literature and the individuals who identify with the "disease" deliverance from the difficult task of separating out what is internal from what is external, and what is healthy and emotionally useful from what is pathological and emotionally destructive in worrisome, conflictual, interpersonal relationships.

Appendix

THE TWELVE STEPS OF ALCOHOLICS ANONYMOUS

1. We admitted we were powerless over alcohol [in groups for co-dependents, "relationships" or "people" is substituted for alcohol].
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being, the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry it out.
12. Having had a spiritual awakening as a result of these steps, we tried to carry this message to alcoholics [or, to "other co-dependents"], and to practice these principles in all our affairs.

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