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Family with an alcohol problem. Functioning of a co-addicted person

1. Characteristics of families with alcohol problems

In recent years, a family has been increasingly recognized as a system. A system approach treats the family as a whole, a community, as one body. In this recognized family, its structure is analyzed as an entity made up of its members and relationships that occur between them, and this analysis seeks to describe the borders, which are methods of exchange between persons in the family system, as well as between the family and the environment[1].

A properly functioning family has flexible boundaries to protect the autonomy of the individuals that form the family unit; these boundaries differentiate this coherent family circle from those who surround the family. Thus, there are limits governing the number and type of contacts of family members with others.

When the family does not properly fulfill its functions, it becomes a dysfunctional family.

M. Ziemska (1975, p. 35-40) defines a family as dysfunctional if it does not fulfill its tasks properly, both to society (and therefore the procreative function, service and care function, socialization, and psycho-hygienic function) and to its members (economic function, meeting the domestic and child care needs or emotional). A dysfunctional family is a family of irregular relationships that prevent the proper functioning of the family system. Adopted rules and performed roles are not clearly outlined and accepted. Also, contact with the environment are often not correct (discussed e.g. by Ryś, 2001; Woronowicz, 2001).

[1] Treating the family as a system, and thus a whole, is derived from general theory of systems of Ludwig von Bertalanffy. The basis of the issues concerning family theory of systems was developed by Salvator Minuchin (1974; after Grzesiuk, 1987). The analysis of the system conception of the family in included in Polish psychological literature undertook by, inter alia: de Barbaro (1994), M. Braun-Gałkowska (1992), P. Budzyna-Dawidowski (1994), Cz. Czabała (1988), L. Grzesiuk (1987), B. Józefik (1994, 2003), K. Ostoja-Zawadzka (1994); A Pohorecka (1997), R. Praszkier (1992, 1994), M. Radochoński (1984, 1986), M. Ryś (2001); B. Tryjarska (1994).

Bradshaw (1988) believes that the dysfunctional family is one that does not fulfill tasks, which include:

- securing the survival and development of its members,
- meeting the emotional needs of its members: finding a balance between autonomy and dependence, learning social and sexual behaviour
- ensuring the development and growth of all its members,
- developing a sense of self,
- functions of socialization.

Other terms used to dysfunctional families are: a defective family, educationally inefficient, problematic (Mościcka, 1991, p. 3n).

Dysfunctional families are not able to provide its members the right conditions of daily living and care. Lack of functional compliance in the sphere of socialization leads to deviant behaviour in children and young people, and to their lack of socialization. A malfunction of the psycho-hygienic function takes place when the family introduces emotionally immature persons to society, with a low threshold of sensitivity to frustration and a shaken sense of security, demonstrating their behaviour deviations from the accepted standards of social functioning (Ziemska, 1975, p. 35-40).

Dysfunctional families do not perform their responsibilities to children adequately. These include broken families, in which there are very serious conflicts influencing the mental development of children, families with alcohol abuse, or even families in which members commit crimes, practice prostitution, or are severely physically or mentally ill. The consequences of functional disruption in a family can be measured by the level of mala-djustment of children from these families (Jarosz, 1982, p. 153).

A family with alcohol problem is a family, in which someone drinks in an excessive, destructive or uncontrolled way. Such a family is be recognized as a dysfunctional inside-family system, a distorted scheme in which the drinking of one member is an integral part of this system. Alcoholism of the addicted person becomes a reference point for the experiences, attitudes, behaviours, and processes occurring in this family. The drinking person in the family creates life, financial, and emotional problems for other family members in a devastating manner, so that the whole family suffers from a wider „alcohol problem”[2].

Abstinent family members often take actions to maintain the balance of the family system. Their activities may maintain drinking and affect the internal formation of coping strategies to deal with this difficult situation. The family system may develop different types of adaptations to the current situation (Kłodecki, 1990, p. 84).

Alcoholism affects the entire family system shaping interactions that can enhance the „alcoholic lifestyle”. So a family with alcohol problems is a family in which the basic parental

[2] Ackerman (1983, 1987, 1989, 2000); Kowaluk (1998); Margasiński (1995); Marynowicz-Hetka (1989); Niebrzydowski (1999); Ochmański (1985, 2001); Pawłowska (1996); Pielka (1986); Pohorecka (1997); Ryś (2007); Śledzianowski (1998); Sztander (1995); Żak (2006).

and marital functions are affected, socialization and emotional processes are impaired, and instead of imparting socially desirable behaviour patterns, a family with alcohol problems provides antisocial – or even criminal - behaviour patterns (Pacewicz, 1994, p. 15).

Analyzing the structural properties of family systems, M. Plopa (2004, p. 14-17) emphasizes the importance of distinguishing a systematic approach to family items such as: overall approach, organizational complexity, and interdependence.

In a family with alcohol problems, the drinking of one of family member becomes an integral part of the system. The alcoholism of one parent becomes a point of reference for gained experiences, attitudes, and behaviours of the entire family system. This type of family tries to block the problem with alcohol abuse so that they can function with it. Hence, „family with an alcoholic" changes to „alcoholic family". Pathological drinking is involved in the homeostatic[3] mechanism of family functioning.

In this family, at work are mechanisms of merging family and integration of the family system. Very often, it is a process of pseudointegration (discussed by e.g. Ryś, 1998b, 2003, 2007).

Pseudointegration is primarily caused by the denial of existing problems, which prevents the search for solutions. Observations, thoughts, aspirations and fantasies, and feelings - particularly negative feelings, such as anxiety, loneliness, sadness, hurt, and rejection are denied here. People living in such families tend to control all interactions, feelings, and behaviour of others. This control is an important defense strategy against the shame a dysfunctional family deals with. It provides, to some degree, of sense of security, gives a sense of power, and imparts a capacity to anticipate events. However, the effect of this type of control is the rigidity of roles and loss of spontaneity (Bradshaw, 1988).

Scientists analyzing the organizational functioning of a dysfunctional family with alcohol problems usually indicate activity in several areas:

1) This family is closed, its members live in isolation from the outside world, without a close social contacts, friendships, or contacts are superficial, conventional, dominated by false appearances, lacking in true feelings, dishonest, and possess the inability to seek help.

2) Families with alcohol problems live in hypocrisy, lacking honesty and speaking the truth about the problems facing family members, and falsifying and distorting reality.

3) In such families, reciprocity is missing and no one helps anyone else, there is a focus on the self, and the problems of other members are ignored, or conversely relationships are based on overbearing care of one another.

[3] The concept of „family homeostasis" assumes that the family as a whole tends to maintain a sense of balance.

For this purpose it develops a variety of mechanisms to reject any change that could threaten the maintenance of stability. In the case of the alcoholic family these will be repetitive, stereotyped pathological behaviour patterns (Gaś, 1993).

Areas of family life, which are particularly vulnerable to alcohol problems are the following:

- Emotional life. Alcohol destroys the emotional life of the family. Members of the family experience continuous fear and insecurity, accompanied by anger, shame, and a sense of injustice and guilt.
- Support and mutual assistance. In a family with alcohol problems, there is lack of support systems and mutual help. The family life is the major source of problems, including in the external social environment, and creating great burdens for the particular individuals.
- Contact and understanding. In an alcoholic family, a continuous simulation is observed with many lies and manipulations, which lead to impoverishment and a lack of contact and mutual understanding between family members.
- Contact with the outside world. A family with alcohol problems closes off its tragedy and suffering, isolating it from the outside world and other people. This is due to feelings of shame, guilt, and social stereotypes concerning attitudes toward an alcoholic and his family.
- Material resources. Financial difficulties of varying dimensions often occur in alcoholic families (Mellibruda, 1999).

A dysfunctional family is characterized by the rigid division of roles and inadequate vision of the world and of behaviour, which are valid even then if there is no longer a need to be guided by defensive reactions (Woydyłło, 1990, p. 77-80).

A characteristic feature of a poorly functioning family system is incorrect borders between its members. In contrast to a normal family, where the boundaries are flexible and each family member has the right to privacy and space, in a dysfunctional system, the boundaries between individuals are excessive, overlapping, or rigid and impermeable. In these cases, intimacy and the creation of normal ties are not possible. Family members are strangers to each other, they feel lonely and abandoned, and no one is in touch with their true feelings (Mellody, 1993, p. 27-36).

In dysfunctional families, there is no proper communication between members. People ignore problems with silence, although they are obvious. „The elephant in the room" associated with family problems that everyone knows but no one speaks about prevents the open and honest exchange of ideas, isolating family members (Sztander, 1993).

According to J. Conway (1997), dysfunctional families are characterized by an inability to express emotion, a tendency towards emotional abuse, rigidity of rules, and perfectionism. These families do not discuss the topics related to significant problems in their lives with anyone outside their circle, and they lack the ability to resolve painful interpersonal conflicts.

Dysfunctional families seek more security than satisfaction with their own activities. Their members suppress emotions, deny them or express them in a milder form, assuming that emotional confrontation or expressing unpleasant feelings may lead to chaos in the

family. Authentic feelings are never well recognized, nor are they expressed. Members of such families also cannot truly connect with their own internal experiences. Hence, they tend to have many inconsistencies in verbal messages (spoken words) with nonverbal expressions (gestures face) when communicating. The rules by which disrupted families are guided are too rigid or undisclosed (Tryjarska, 1994).

In disrupted families, dysfunctional communication can facilitates a mutual reduction of personal self-esteem, and means of communication are often based on conjecture. Desires and accusations are not delivered directly, but may appear as paradoxical injunctions (e.g. to be more dominant or spontaneous, you should be more confident) (Budzyna-Dawidowski, 1994).

A. Dodziuk and W. Kamecki (1994, p. 106) identify the following as characteristic features of families with alcohol problems:

- chaos, constant stress, disorganization of family life, and thus - a lack of security;
- concentration of all family members on the addict and the alcoholism while hiding alcoholism from the surroundings, and as a result, isolation from it;
- Neglection of self-needs by non-drinking family members, overtaking of the addict's duties, changing the original, natural roles within the family;
- Numerous and violent conflicts;
- „Freezing" of their own feelings

V. Satir (1983) draws attention to the fact that inappropriate relationships between spouses in a dysfunctional marriage lead to dysfunctional parenting.

In families with alcohol problems, parents often do not properly exercise parental authority (they are too despotic or too docile to the children), they do not define the rules of behaviour of children, or they do not enforce them. In such families, we observe a lack of feelings of security, a lack of clear definition of norms and values, and there is no clear division of roles (e.g. in families with alcohol problems, children often have to take over the „parental" responsibility from their own mother or father). Such a family copes very poorly with normal developmental crises through which every family goes (discussed e.g. by Ryś, 2001).

A dysfunctional family with alcohol problems is characterised interactions among its members, leading to frustration over the basic needs of their members, exploitation, violations of major personal rights, loss of accountability from certain family members, and hyper accountability of others (see e.g.: Rys, 1998b, p. 66).

J. Bradshaw (1988) treats the family with alcohol problems as a compulsive family repeating an ineffective behaviour causing each of its members to live in chronic stress. A dysfunctional family system requires its members to take overly rigid roles. Roles are assigned to individuals, which takes away from them their own identity, a loss they are forced to endure in order to maintain balance in the system. In such a system, the family does not serve the members, but rather members serve the family (ibid. p. 101n).

In a family with alcohol problems, high loyalty and a rigid consistency are expected at the cost of sense of compliance with the individual experience of reality. There is an atmosphere of an emotional distance and emotional coldness.

Family members are with each other more out a sense of obligation or habit rather than from emotional needs, although from the outside it may seem that they are strongly connected with each other (Tryjarska, 1994).

All energy and family activities are aimed at trying to change the destructive behaviours of the alcoholic. Therefore, according to the B.T. Woronowicz (2001, p. 120), other spheres of family life, especially matters concerning children, are neglected and ignored.

In a dysfunctional family with alcohol problems, children experience shame associated mainly with parental neglect. This neglect may occur in the form of actual physical abandonment or mental distance, and a lack of meeting the child's needs. Parents may commit physical, sexual, emotional, and spiritual abuse against their children (discussed e.g. by Bradshaw, 1988).

Families with alcohol problems are often families with low socioeconomic status and low-cultural needs and the possibility of satisfying them, and at the same disturbed educational environment.

2. The rules and principles of life in a family system with alcohol problems

Parental alcohol abuse results in the deprivation of constructive role models for children. Parental alcoholism creates a belief system in the child that breaking the rules of moral conduct is permissible. As J. Bradshaw defines (1988) in alcoholic families, discipline is modeled by *„undisciplined discipline makers",* so parents are modeling inconsistency.

Dysfunctional families often unconsciously adopt certain rules. These include:

- Control. Control manifests itself with the compulsion to verify all interactions, feelings and behaviours. It is an important defence strategy against shame, it gives family members a sense of a peculiar kind of power and predictability of events to somehow meet safety needs;
- Perfectionism. Members of the system try to maintain the accuracy of what they feel, they think and do. This type of attitude leads to feelings of hopelessness, because the ideal of perfection in a family with alcohol problems cannot be achieved;
- Accusation. Accusing other members of the family is a defensive attitude hiding shame, it is used especially when control fails;
- Denial of feelings, thoughts, experiences, observations and expectations. This denial relates primarily to negative feelings such as anxiety, loneliness, sadness, hurt, and rejection;

- Creation myths. This process leads to a reformulation of injuries in such a way that they divert attention from what is really happening in the family;
- Not finishing matters – not closing cases happening between family members. For many years, the same conflicts and disagreements are supported, which may take the form of chronic war and conflicts without a real solution;
- Lack of confidence (ibid. p. 97-107).

Wegscheider, based on clinical observations, found families employ certain general rules to maintain the balance. These rules, which family members run more or less unconsciously, determine specific patterns of relationships and communication within the family. Wegscheider includes here:

- Treating of drinking of addicted person as the most important issues in the family. The lives of family members centre around the activities of the alcoholic, and their attitudes are aimed at making the person stop drinking;
- Recognition that it is not the alcoholic who is responsible for the use of alcohol, but someone else or even the external situation. The most common situation is where the alcoholic's spouse is charged with the fault for drinking. Members of the family with alcohol problems often deny that addiction is the main cause of family problems, or, it is considered as only a factor in some way complicating family life;
- Maintenance of balance of the system at the expense of all family members. The departure of any person from the family or the attempt to change the status quo are perceived as a threat;
- Recognition of the need to protect the addicted person and the drinking problem.

All behaviours, in the minds of family members, are a sign of mutual love and loyalty, but their unintended purpose and effect is to maintain the status quo in the family (after Cierpiałkowska, 1997, p. 47n).

In the alcoholic family, three basic principles are assumed: *do not talk, do not feel* and *do not trust* (discussed by Bradshaw, 1988; Gaś, 1994; Sztajner, 1994; Sztander, 2003; Woronowicz, 2001).

The principle: *„do not talk"* is a strong message often not expressed verbally. Members of a dysfunctional family avoid talking about their problems. This is an attempt to circumvent unpleasant feelings, guilt, sadness, irritation, and touching unhealed wounds. With time, any conversation concerning a painful family situation becomes impossible. Conspiracy of silence also applies to conversations with people outside the family. Children are silent in order to keep the secrets of the family in the hope that things will get better, that something will change, and they do this also because of shame (Sztander, 2003, p. 13N). The principle of *„do not talk"* commands the hiding of alcohol problems in the family and a ban on talking about what happens in it. This also applies to concealing feelings and experiences. This ban covers both members of their own family (*„in order not to increase worries and not*

exacerbate the crisis of the family") and environment (*„no one cares, it's just our matter").* This principle entails adverse consequences for the family: family members do not communicate with each other, cannot help each other, and do not know what they feel and think. Also the environment does not provide the possibility to provide assistance, particularly in the initial phase, when the problem is not yet advanced (Sztajner, 1994, p. 5).

Persons applying the principle of *„do not feel"* seek to eliminate emotions.

The message of this principle is not to go too deep into emotions and not to be subjected to emotions and guided by them (in accordance with the statement, *„you have to be tough"* or *„do not think about what you feel and why, and what are the consequences"*). Family members tend to stifle true feelings, which are the essence of personal human identity. Suppression of emotion leads to a loss of truth about ones' emotional life (Bradshaw, 1988). It turns into a distortion of internal reality and a weakening of the *„emotional sensors"* necessary in life. Defence and moving away from others fills people with rigid and schematic modes of action (Sztander, 2003, p. 14n). Adherence to the principle *„do not feel, be tough,"* and growing up in a disorganized environment can make a child a psychopath (Sztajner, 1994, p. 5).

The principle of *„do not trust"* includes both family members and people outside of the family unit. The main consequence of living with this principle is a lack of a sense of security (Gaś, 1994, p. 37, see also: Woronowicz, 2001, p. 123). This principle denotes coming to the conclusion that life is chaos, and it is a reaction to the trauma that life in a dys-functional family provides. Lack of adult support deprives children of confidence and discernment. Broken promises, breach of promises, inconsistency of actions, and inconsistency of education are not conducive to the formation of orientation and confidence (Conway, 1997, p. 92, see also: Sztander, 2003, p. 12).

Families with alcohol problems differ depending on, inter alia, the development of dependence, personality of family members, or material status of the family, though these families show enough similarities that it is possible to identify phases of adaptation of members of the alcoholic family.

The literature usually distinguishes two models of adaptive behaviour of family members with alcohol problems.

The author of the first model is Joan Jackson, who, on the basis of years of research and observation of fifty alcoholic families, identified seven phases of adaptation to the problem of addiction:

Phase l. Emerging sporadic incidents of excessive drinking by one of the spouses create increasing tension. The spouse then tries to influence the cessation of the partner's drinking of the partner, but she faces resistance. In this phase, increasingly frequent excuses and justification occur. A drinking person makes promises that are not kept. The dominant attitude in this phase is a denial of the existence of the problem.

Phase 2. Incidents of alcohol drinking begin to increase, and therefore tensions and mutual claims of family members increase. Relations between spouses deteriorate; thoughts and behaviour of the family begin to focus on the drinking. Attempts are made to maintain

the structure of family life as it stands, therefore the negative consequences of drinking are hidden, and the family becomes very isolated from the outside world.

Phase 3. Family members begin to resign from behaviours controlling the drinking of an alcoholic, and focus on actions that reduce short-term problems and difficulties. Disorganization of family life becomes apparent. Emotional disorders in children start to occur. The family gets rid of the illusion that the alcoholic will stop drinking.

Phase 4. In this phase, the non-drinking parent takes control over the family life, and as a result, the family becomes more stable and organized. This reduces the negative effects of the alcoholic's behaviour. Grievances and hostility towards the alcoholic occurring previously are replaced by compassion and caring feelings.

Phase 5. Actions of the non-drinking parent (usually wife) focus on solving existential and emotional problems. This is connected with the beginning of the separation process from the addicted person and a determined struggle to save this person and their children. The end of this phase usually results in parting from the alcoholic.

Phase 6. The family, now without an addicted person, attempts to reorganize life. Family members learn independence and begin the process of coping with grief, unfulfilled expectations, and pretensions to the addicted parent.

Phase 7. This phase occurs if an alcoholic reaches a stable abstinence. Then the family includes him in the course of family matters and tries to cope with the new problems that are associated with the process of becoming sober by an alcoholic (after Szczepańska, 1992, p. 36-38, see also: Sztander, 1993, p. 17-19; Gaś , 1994, p. 38-41).

Each of these seven phases may last for many years, and not every family goes through all phases. Sometimes a family comes only to the sixth phase and decides that an alcoholic cannot return to the family. Often adapting to life in a family with alcohol problems stops in the fourth phase, and in this phase the family stays (after Sztander, 1993, p. 19).

Another interesting model that describes the adaptation of the family to life with an addiction problem is the model proposed by P. Steinglass. It grows out of the developmental approach to family (after: Gaś, 1994, p. 28). According to this theory, becoming an alcoholic family is a process, during which the family is introduced into alcohol (in different periods of its life and for various reasons), and its use becomes a basic principle organizing and shaping family life (see also: Gaś, 1993, p. 31).

Steinglass distinguished major periods in family life: premarital, early marriage, mid-life, and late marriage. He characterizes each of these periods in terms of stability / instability and the use / non-use of alcohol. According to Steinglass, main characteristics of this model concern the majority of alcoholic families.

In the premarital period, the life partner is chosen. This choice takes into account various psychological and cultural-social factors. From a standpoint of addiction, there are three possible combinations of the selection of brides: two non-drinking people or two drinking people, or one non-drinking person and one drinking person. None of these

combinations guarantees protection against the introduction of alcohol to the family, but the likelihood of becoming a family with alcohol problem increases the more partners that are involved in alcohol abuse (after: ibid. p. 31-33, see also: Gaś 1994, p. 31).

The period of early marriage is a rather unstable time. During this period, spouses work out specific rules of mutual coexistence, and marital and family behaviour patterns. During this period, spouses allocate roles and functions carried out in the family and determine the rules governing the internal and external life of the family. If, during this period, one of the spouses uses alcohol to discharge tension and stress associated with this period, two kinds of consequences may arise.

In the first scenario, alcohol use clearly increases the difficulty of implementing roles associated with family, profession, and society, and it becomes the cause of conflicts and more and more frequent quarrels in the family, which eventually leads to divorce. (Divorce at this stage appears frequently in the case where the alcohol addiction occurred after the wedding and concerned one of the parties). Alternately - the use of alcohol becomes embedded in family life, and so a family with an alcoholic is transformed into family with alcohol problem. Alcoholism becomes involved in the homeostasis of family life and cannot be removed from the family without interfering with its balance (after: ibid. p. 33n; see also: Gaś, 1994, p. 31).

In cases where the family includes alcohol in the principles of it's functioning, the abuse of alcohol and behaviours of the drinker become the main principles organising family life. A new period of family stability begins. During this period, we can distinguish alternating, successive times spans of the following phases: sobriety and intoxication. This period has usually a very dramatic course, as interior and exterior family stresses occur during this time (e.g. events from birth of children, to their growth, and ultimate leaving). Here, in a family with alcohol problems, one of two behaviours appears: either the severity of alcohol abuse increases, or the addict discontinues its use. Severe alcohol use further increases even more emerging stress reactions, and leads to vulnerability to alcoholism and emerging new problems. As a result, the family becomes unstable. The elimination of alcohol also leads to some entirely new difficulties, often so strong that they may end in divorce. Most often, however, intermittent, alternating periods of the drinking phase to sobriety phase and vice versa are observed (after: ibid. p. 34-36).

In the late marriage period, further decisions are taken regarding the future of the family. There are different possibilities leading to the formation of different types of family stability, such as:

- Stable, drinking alcoholic family, whose lifestyle revolves around systematic abuse of alcohol and compliance with it. Stressful external factors do not work here anymore, and the family focuses on concrete issues of everyday life, yet still repeats previously developed, inefficient methods of operation.

- Stable, non-drinking alcoholic family, in other words, a family that has successfully managed to give up drinking. Family life is still focused on alcohol, but now in terms

of recovery from alcoholism and striving to keep the reformed addict from returning to alcohol. Patterns of family function change here.

- A stable, sober non-alcoholic family, where alcohol has been definitively eliminated, also in the physical dimension, because the addicted person does not drink. Thus, mental, behavioural and emotional activity of family members is no longer involved in the problem with alcohol.

The stable, controlling drinking non-alcoholic family is, in the opinion of many therapists, only a theoretical possibility, because the person once dependent on alcohol is ever not able to fully recover and drink in a controlled manner (after: Gaś, 1994, p. 36-38).

3. Co-addicted spouse

3.1. The concept of co-addiction

It is often assumed that co-addiction it is a multidimensional (physical, mental and spiritual) condition, which manifests itself by the disturbance of normal functioning caused by concentration on the needs and behaviours of others. It develops from the abandonment of responsibility for managing one's own life and happiness to focusing instead on someone else's (Sagadyn, 1996, p. 17).

In the broadest sense, co-addiction can be defined as dependence on people, things, or behaviours. It is characterized by a false belief that inner feelings can be controlled by controlling other people, things and events (Hemfelt, Minirth, Meier, 2004, p. 12).

Co-addiction to an addict is treated as a specific form of dependence on both this person and on the problem of alcohol abuse[4]. This condition is characterized by a concentration of thoughts, feelings, and behaviours focused on the addict, feeling a sense of necessity to monitor his or her behaviour, holding hope of maintaining safe quantities of drinking, as well as the development of more inflexible behaviours and reactions in regard to the drinking (Mellibruda, Szczepańska, 1998b).

> Co-addiction refers to people who, being in a relationship with an addict, exhibit similar features and behaviours to those characteristic of their addicted partners. This term is now commonly used among psychologists and therapists, however a clear and universal definition has yet to be accepted. Though there is a high level of consistency from researchers in the description of manifestations of co-addiction in various spheres of operation (Cierpiałkowska, 1997, p. 18N).

Co-addiction is an obsessive focus on the alcoholism of a loved one, which leads to the neglection of one's own needs, emotional loosening and suffering. „Many of the tensions and burdens of a wife in a situation of her husband's increasing drinking are a direct

[4] Gordon, Barrett (1993); Kurza (2000a-e, 2001, 2002, 2003ab, 2004); Libera (2003); Ray (1994).

consequence of strategies that she employs to cope with the situation" (Szczepańska, 1996, p. 6).

> According to M. Kisiel (2001, p. 16) co-addiction is a way to respond to the highly stressful situation of living with an alcoholic, which causes progressive involvement in the situation. The co-dependant person (usually the wife) begins to make changes, which, in her opinion, will lead to improvement of the situation, when in reality, her actions actually worsen and perpetuate the situation. When looking for a solution, she subconsciously focuses on the problem of the alcoholic: „What can I do to make him stop drinking?", rather than on her own problems. Therefore, the changes that she introduces usually become ways of adapting to the destructive relationship, which in turn reinforces destructive behaviour, and consequently prevents finding a solution to the problem.

Analyses of the literature on co-addiction identify three basic concepts which the attempt to shed light on the issue[5].

The first concept advocates treating a co-addiction as a disease. The second approach assumes that it is more of a personality disorder than a disease. This disorder originates from early experiences in family relations and dysfunctional rules of operation, and further develops in marriage with an alcoholic. The third approach treats co-addiction as a result of adaptation to the chronic presence of a stressful situation.

3.1.1. Co-addiction as a disease

The first approach in explaining the phenomenon of co-addiction accepts the assertion that it is a disease that arises and develops from the need of a person to live with dependent partner (Schaef, 1986, p. 21)[6].

Janet G. Woititz (1989) also points to the dimension of co-addiction as a disease. She claims that the co-addiction is a disease of alcoholics' wives, and is just as harmful as alcoholism itself. The degree to which the disease advances depends on the level of close contact with the alcoholic. According to Woititz, co-addiction is the mirror image of alcoholism, with the difference being that the alcoholic is dependent on alcohol, whereas the co-addict is dependent on the alcoholic[7]. The author mentions symptoms of co-addiction

[5] Fuller and Warner (2000) have made an interesting attempt to measure symptoms of co-addiction in different groups, combined with a review and comparison of research tools. The authors came from the assumption that the symptoms of co-addiction are perhaps not specific only to families with alcohol problems, that perhaps more critical to the issue may be the level of family stress. O'Brien and Gaborit (1992) are of the view that co-dependency may be present in the relationships in which neither spouse is chemically dependent.

[6] According to the author's approach, treatment of co-addiction as a disease (like alcoholism) is only a matter of time.

[7] According to Kapler (1999, p. 13) diagnosis of co-addiction should distinguish it from emotional dependence, or addiction to a person, which is based on the fixed coercive behaviour towards

including: a compassionate focus on the alcoholic, protectiveness, guilt, obsessions, constant worry, anxiety, hopelessness, a sense of injustice, despair, lies, false hopes, disappointment, confusion, anger, and the avoidance of situations in which the addict person would have the opportunity to drink. The main mechanism influencing the development and persistence of the illness is denial – denial of her husband's illness, of her own difficulties, and of the failure to see the real situation in the family.

American therapist Melody Beattie (1987, 1994) also treats the phenomenon of co-addiction with a broad understanding not limited to alcoholism. She views the phenomenon of co-addiction through the prism of a disease, but believes that symptoms of co-addiction may occur in any destructive relationship in which any dependence of any of its members is observed. It may, therefore, also occur in families with problems such as gambling, sex addiction, gluttony, or workaholism.

The common element in these family systems is their devastating influence and ways, in which co-addicted people try to affect their partners. Melody Beattie defines the co-addict as someone who, „has let another's behaviour affect him or her, and who is obsessed with controlling that person's behaviour" (ibid.).

A. Wobiz (2001, p. 20) believes that co-addiction is a disease (syndrome of psychiatric disorders), which results in the degradation of human life, the loss of ability to maintain a healthy relationship with another person (i.e. a relationship based on partnership and respect), and the loss of ability to correctly recognize shared responsibility for the quality of a relationship and for the responsibility for one's own thoughts, feelings and behaviours. The co-addicted person (usually the woman) sheds responsibility for her own emotional states on the partner, and instead takes responsibility for the addict's thoughts, feelings and behaviour. According to Wobiz, co-addiction is manifested through the progressive abandonment of oneself and one's own needs in favour of the needs other person, combined with a sense of increasing entanglement that ultimately prevents a positive change in the situation and breaking free from the destructive relationship. The author expresses the view that co-addiction, like alcoholism, is a continuous and progressive process leading to the physical and psychological destruction of the body.

3.1.2. Co-addiction as a personality disorder

This is the approach presented by Cermak (1986). In his opinion, the following are present in this disorder: subordinating self-reliance on the ability to control oneself and others in an emergency situation; taking responsibility for meeting the needs of others, even at the expense of not meeting one's own needs; fear and problems associated with defining the border between approaching and maintaining distance; the tendency to seek out complicated close relationships with people with personality disorders, chemical

a partner, aimed at triggering and maintenance of the intense emotional bond, rather than adaptation to a destructive behaviour of a partner, what happens in the case of co-addiction.

dependence, co-addicts and / or with disturbed drives or impulses. Co-addicted people can also be characterized by: an extensive system of denial; suppression of feelings; depression; excessive vigilance; compulsiveness; states of anxiety; psychoactive substance abuse; psychosomatic disorders associated with stress; repeated episodes of experienced violence from physical or sexual abuse; being in close relationships with an addicted person without attempting to seek help from outside.

The concept of co-addiction as a personality disorder assumes that wives of alcoholics have certain features formed in childhood in a dysfunctional family, primarily in relation to dysfunctions associated with alcoholism of a spouse. These features deepen and further develop as a result of a relationship with an alcoholic, leading to co-addiction.

Some scientists in the analysis of co-addiction as personality disorders go back to the concept of Millon, who distinguished a dependent personality, the same type that characterises a co-addicted person. Such persons are characterized by, for example, submissiveness, passivity, subordination, a conciliatory attitude, avoidance of competition and conflict, willingness to sacrifice, lack of confidence, lack of autonomy, and a lack of coping skills in interpersonal relations (after Millon, Davis, 2005).

Bradshaw (1988) treats co-addiction as a set of rigid personality traits developed in childhood as a result of being brought up in a dysfunctional family, rooted in internalized shame that is the result of negligence. He claims that the main feature of co-addicted persons is an external control and lack of their own autonomy. Co-addiction is „an excessive rigidity of thinking and action resulting from difficult life experiences (formed at a much earlier stage than the marriage to an alcoholic), and further restrained in the life with the addict; stiffness prevents the beneficial and effective addressing of one's own problems and the problems of one's family" (Sztander, 1997).

Norwood presents a similar position (2004, p. 12). On the basis of her own therapeutic work with the wives of alcoholics, she found that most co-addicted people come from dysfunctional families, where they experienced trauma.

P. Mellody (1993, p. 21-63) also stresses the special relationship between the occurrence of co-addiction and being raised in a dysfunctional family. The conditions in a dysfunctional family influence the emergence of abnormal personality traits and disorders of the system of borders, leading to the possible emergence of co-addiction in later relationships. Mellody thus defines co-addiction as a disability of maturity caused by childhood trauma. She has distinguished characteristics of people brought up in dysfunctional families, which lead to co-addiction in subsequent relationships:

- difficulties in the development of high self-esteem, which is the proper love of self;
- difficulties in establishing boundaries between yourself and other people, thereby protecting your own personality;
- difficulties in the proper recognition of objective truths about oneself, or in defining oneself and deciding how to share oneself with others;

- difficulties in correctly defining and addressing one's needs and desires, or taking care of oneself;
- difficulties in experiencing and expressing an objective truth about yourself, or in other words, thriving in normal life conditions and being able to handle external circumstances.

W. Sztander (1997, p. 28) emphasizes both aspects of adaptation and personality co-addictions. According to the author, co-addiction is not a disease, but rather an excessive rigidity of thinking and action arising from adverse life experiences, which occur much earlier than marriage with an alcoholic. This rigidity of thinking and action is restrained, and further stiffened in life with an addicted person. It prevents beneficially and effectively solving one's own and one's family problems.

A. Margasiński (2000, p. 34) examines the symptoms of co-addiction as neurotic personality traits. By co-addicted personality, he refers to a type of neurotic personality characterized by excessive emotional entanglement arising from life „in the orbit of the other person." This excessive emotional entanglement brings emotional, health, family, and social damages to this person.

3.1.3. Co-addiction as an adjustment disorder; an adaptation to a long-term stressful situation

Co-addiction is also defined as a way to respond to highly stressful situations in life with an alcoholic or other person acting destructively, causing progressive entanglement (Kiehne, OGorman, Spann, Fischer, after: Cierpiałkowska, 2000, p. 90)[8].

Sobolewska (1996) emphasizes that co-addiction may occur as a result of participation in a permanent, destructive relationship, in which a co-addicted person not only enters, but also co-creates. Symptoms of co-addiction are due to specific adaptive responses to a situation in life. But, she also points that not all wives of alcoholics have symptoms of co-addiction. In her view, there are three groups of determinants: stress - what is happening in the relationship; past life experiences and the psychological mindset with which the person entered into the relationship; psychological changes occurring as a result of the former two types of circumstances (ibid.).

[8] It seems that the vast majority of authors dealing with co-addiction are in favour of restricting this concept to the description of the adaptation difficulties experienced by the individual in situations of high stress in the family life. At this level of the diagnosis, co-dependency understood as a term used to describe the individual's response to the problems of adaptation may become a clinically useful term, provided clarification of diagnostic indicators. (see: Millon and Davis, 2005; Szczukiewicz, 2008). However, any changes in the classification of diseases are introduced after a broad range of environmental consulting, and each change requires an international consensus of the majority of the representatives of the psychiatric and psychological circles, hence the road to such a consensus still seems very distant (Magrasinski, 2009).

According to Mellibruda and Sobolewska (1997, p. 426n), the fundamental principle of co-addiction is increasing entanglement in a destructive relationship with an alcoholic. Both a person with personal problems or emotional disorders or a healthy person can enter into such a relationship. But the determining factor for whether someone will become co-addicted depends on whether she has the ability to either change or leave the system, or if she will instead adapt to it.

So this concept, highlighting the current situation of co-addicted people, draws attention to certain personality traits of the person creating the destructive scheme.

3.2. Symptoms of co-addiction

Many professionals involved in the treatment of alcohol problems agree that although co-addiction not has been included yet by the World Health Organization in the International Classification of Diseases, it is possible to highlight specific symptoms of co-addiction. T. Cermak (1986) includes among them:

- Overdeveloped need to control oneself and others in an emergency situation[9];
- Overdeveloped sense of responsibility for meeting the needs of others, even at the expense of not meeting your own needs;
- Problems setting boundaries between approaching and maintaining a distance, and associated anxiety[10];
- The tendency to seek out relationships with people with disturbed personalities, chemical dependence, co-addicts and / or disturbed drives[11];
- Presence of at least three of the following problems:

highly developed mechanism of denial; repression of feelings; depression; expressing over-vigilance; compulsiveness[12]; anxiety; abuse of con-sciousness-altering drugs; current or

[9] Self-esteem in an alcoholic's wife is dependent on the perceived ability to control and exert influence by her on her feelings and behaviour and other people, often in spite of repeated failures. This attitude manifests itself in four spheres of operation: distorted relation to the power of will and exercising control (difficulties in distinguishing a situation, which we can influence, from those that are beyond the possibilities of our influence), impaired stability of self-esteem and borders of our „I" (the primary criterion for assessing of self is the mood and behaviour of other people), the system of denial (delusions of control and positive impact on the behaviour of others), and low self-esteem. These four areas of operation are in a mutual relationship with each other (after Cierpialkowska, 1997, p. 20-23).

[10] The wife of an alcoholic experiences anxiety and identity disorder in interpersonal contacts. Psychological boundaries of self become blurred, co-addicted people do not have clear sense of who they are, and what desires and needs they have. Lack of self-boundaries raises fear of losing one's own identity and each change creates a fear of loss and rejection of already formed self-image (Szczepańska, 1992, p. 56-60).

[11] Co-addicted people tend to maintain close relationships with persons of a disturbed personality, with people addicted to various behaviours or drugs and with co-addicted people (ibid.).

[12] Compulsive tendencies are a defence mechanism that allows cutting off from threatening feelings, distress and anxiety that may escalate into panic and existential anxiety (ibid. p. 56-60).

past experience of physical or sexual violence; serious somatic illnesses associated with stress; being at least two years in a close relationship with an addicted person without trying to seek help.

H. Szczepańska (1996, p. 60n) distinguishes criteria of co-addiction parallel to the phenomena characterizing dependence on alcohol.

- Thoughts, feelings and behaviour of the co-addicted person are centered on the alcoholic's drinking. The co-addicted person has a subjective feeling of necessity to hinder an alcoholic from drinking;
- Behaviour and reactions of co-addicted person associated with the drinking of an alcoholic are stiffened and limited;
- A co-addicted person makes numerous failed attempts to refrain from the typical reaction to her partner's drinking. With the passage of time, changes in the intensity of the response to the alcoholic's drinking are visible;
- A co-addicted person experiences an unpleasant emotional state, anxiety, and irritability during periods of sobriety of the alcoholic, while during periods of drinking , the intensity of her experienced emotional states is reduced.
- A co-addicted person has a sense of inability to part with the alcoholic forever, even though she often wants to leave him.

Other therapists define co-addiction rather in terms of defective adaptation syndrome.

They distinguish here the following criteria:

- Suffering and emotional chaos;
- Psychosomatic disorders in inclusive neurosis;
- Use of hypnotics and sedative drugs, including alcohol, to relieve pain, tension and anxiety;
- Presence of an illusion and denial system, which interferes with true assessment of alcohol-related problems;
- Stiffening of marriage and family, which maintains the drinking of an alcoholic (after Sobolewska, 1996).

Z. Sobolewska draws attention to three groups of determining factors for whether a person will become co-addictive or not. These include:

1) A stressful marital and family situation, which is dependent on the family structure, the way roles are performed[13], responsibilities of various family members, financial and material dependencies, and emotional ties between family members.

[13] A spouse in an alcoholic family usually takes on the role of the proxy, which gives her a sense of super responsibility, and for the family is causing the postponement of the family crisis. A proxy takes over the duties of an addict and established protection around him, and thus initiates the process of isolating the family from social gatherings, which leads to feelings of rejection and misunderstanding of co-addicted person (Cierpiałkowska, 1992, p. 58n).

Particularly important here is the behaviour of the alcoholic in his professional and social position, as well as the position of his spouse (especially concerning the existence of a group of persons to whom she can turn to for support). Conducive to the emergence of co-addiction are: a strong emotional and material dependency, poor occupational status, social isolation family, and all forms of pressure not to disclose the problem.

2) Personal psychological equipment, which the person enters into the relationship. Of particular significance in this instance are: the existence of childhood trauma, family relationships, and one's personal vision of the world.

Previous relationship experience and ingrained beliefs about family roles and relationships between persons of different sexes are also of great importance. In this regard, certain personality features, emotional functioning, self-image, and stress coping mechanisms are emphasized. Occurrence of co-addiction is more likely in people from dysfunctional families, who are emotionally immature, have reduced self-esteem, have a strong need to belong to other people or groups, and who have poor psychological boundaries, as well as a deficit of skills to cope with difficult situations.

3) Changes in the way a person functions result from stressful situations in a marriage, from the personal equipment of the person, and also from prolonged exposure to a pathological relationship. These changes may go into the intellectual sphere, in the direction of magical thinking, denial and belief in the ability to control everything, in the emotional sphere in the direction of generalized anxiety, anger suppression and mood changes, while the structure of „I" in the direction of guilt and a sense of injustice and the dissipation of limits of self" (ibid., p. 6-9, see also: Mellibruda, Sobolewska, 1997, p. 424-426).

1.2.4. Functioning mechanisms of co-addicted people

The most significant manifestation of co-addiction is a focus on the partner's addition problem. Actions and feelings of the co-addict are entirely absorbed by one thought: how to stop the spouse from drinking alcohol.

Controlling the behaviour of on alcoholic and limiting the amount of alcohol consumed by him becomes the primary objective of the daily life of this person (usually the woman). She tries various methods of persuasion and factual argumentation, enforces promises not to drink, and points out facts incontestably proving the existence of dependence.

This type of behaviour, however, does not bring the desired results; rather it drags this person into a trap of dependence on a partner, because all areas of her life revolve around alcohol. Therefore, the situation of a co-addicted person becomes an endless circle of co-addiction (Sztander, 1997, p. 42).

The risk of the psychological trap, according to Rubin and Brockner, occurs when a person considers that she has invested too much to give up a relationship (after Pospiszyl, 1998).

The classic symptom of falling into a trap is the continuation, or even intensification, of actions that do not generate any positive effects, in particular bearing all responsibility for the drinking of the spouse.

The decision to remain in the destructive relationship may arise in this case from a sense of guilt for what happens to the alcoholic and taking the responsibility on oneself for any failures (discussed e.g. Grudziak-Sobczyk, Morawski, 1988).

A problem of co-addicted people is not only the taking over of responsibility for the alcoholic, his drinking, his behaviour, and the consequences of his actions. The person also gradually begins to take over all duties and responsibilities of the addict out of fear that they will not be properly executed, or even executed at all. The more responsibility the co-addict takes on, the less responsible the alcoholic becomes (Ryś, 2002, p. 53).

Attempts to control the conduct of a dependent person or quantities of substances consumed by this person often are of an obsessive-compulsive nature. The co-addicted person is obsessed with „helping" the alcoholic, which is unachievable, so since her efforts to stop alcoholic from drinking are not fulfilled, there is no reliable method of control of the other person. The interdependent person begins to look for new ways of controlling the partner which may prove to be more effective. When her efforts again prove futile, she begins to be obsessed with punishing the addicted person (Twerski, 2001, p. 19).

Long-term support of an alcoholic's illness and the attempt to adapt to this situation exert a strong influence on the partner's self-esteem. The primary focus on others permits spouses of alcoholics to escape from painful feelings arising from a lack of self-esteem and lack of love. A sense of pride from living for others and ignoring one's own needs becomes a defence against the anxiety and fear associated with the situation in which they live. This attitude is an evolution of the lack of meeting own needs in order to be good and worthy of a man's respect. The main way of coping with such situations becomes overly responsible behaviour, based on granting help and advice to others, and on strengthening the conviction that someone is a necessary and useful person (Szczepańska, 1996).

The co-addicted person (usually the woman) tries to make changes that, in her view, are designed to improve the situation. However, her actions often perpetuate and aggravate the situation (Sztander, 1997).

The experiences of co-addicted person are associated with life in long-term mental stress. The effects of stress are largely centered on the love life of this person. The co-addicted spouse is constantly exposed to difficult and unpleasant emotions, such as helplessness, shame, guilt, anxiety, anger, sorrow, and a sense of injustice (Sztander, 1997, p. 32-37).

These feelings occupy the bulk of the space in the psyche, much more than happiness or love. In addition, a co-addicted person cannot deal with these feelings constructively. As a result of her suffering, relationships with her loved ones change and become far from satisfactory (Sztander, 1993).

Prolonged emotional stress often leaves traces in the form of psycho-physical ailments. Interdependent people often suffer from neurotic disorders, or psychosomatic symptoms such as, for example: headaches, stomach problems, and alarming heart symptoms. Such a mental or physical condition may push these people to reach for sleeping pills, sedatives, or analgesic drugs. Attempts to suppress unpleasant psychophysical states may lead to dependence on drugs, cigarettes, and even gluttony disorder and alcohol (Sztander, 1997, p. 38).

M. Beattie (1996), among the attitudes that characterise co-addiction, first of all points to: obsessive control of others, continuous help, overprotection, obsessive caring for others, low self-esteem bordering on self-hatred, intensive anger and guilt, a strong dependence on particular people, a high tolerance for relationship irregularities with others, and a focus on others leading to self-neglect.

In these studies, two different patterns of functioning alcoholics' wives were isolated: submissive and dominant. These models can alternate in a single person creating a so-called intermediate pattern of functioning. „Submissive" wives are characterized by a tendency to be influenced by interpersonal situations, and „dominant" wives have a tendency to influence others (Sobolewska, 1996, p. 8). A „submissive" wife perceives her husband as a strong and responsible man who is responsible for the well-being of the whole family. Therefore, they do everything so that his drinking does not reflect negatively on his career and opinions among friends and family. They quickly accept and sustain the husband's denial and believe in all his promises to improve. Their behaviour seeks to rescue the current situation at home rather than find ways to change the situation. The husband's drinking inspires feeling of anger and a sense of powerlessness, however, the wife tries to ignore and suppress these feelings.

A „dominant" wife, in turn, sees her husband as weak and concentrates mainly on the struggle to reduce his drinking. The negative effects of husband's drinking, themselves, are not a problem, but rather a tool in the fight with to limit the husband's drinking. She believes that she has an great impact on all things in her husband's life, that she is responsible for diverting her husband from alcohol, and that without her, her spouse would not be able to cope with his life (ibid. p. 10n).

Despite so many negative effects of living with the addicted person, spouses often endure in this relationship for many years, and even for life.

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