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NOVEMBER 1992 VOL.5, NO.4

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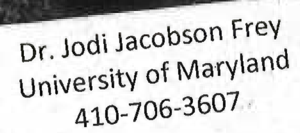

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EmployeeAssistance

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NOV. 1992 VOL. 5, NO. 4

Page 18

Page 24

Page 31

FEATURES

Recovering Healthy Sexuality 13

Addressing sexual addiction can enable the EAP to play a part in mending broken people and broken relationships and help clients take crucial steps toward freedom from other dependencies.
by Mohan S. Nair

Trauma and the Adult Child 18

Many carry the baggage of devastating early experiences into workplaces still in the process of understanding the severe, destructive consequences of that pain. But the hurting can stop when understanding and treatment take over.
by Cardwell C. Nuckols and Kathleen McFarlane

A Family Business Fairy Tale 21

An alcoholic's son tries to run away from his past, only to visit it upon his own family and bring the firm he built out of love to the brink of ruin—until a wise EA professional helps break the cycle of denial and secret strife.
by Ted Larrison

Codependency at Work 24

Some employees try to be all things to all people in a bid to control others and retain control of themselves. The good they often do complicates discerning the harmful forces at work and intervening effectively.
by Seth Allcorn

Adult Men: Happy Children, Miserable Mates 30

Gender differences in coping with alcoholism may lead to coping behaviors in childhood that throw up communication roadblocks in marriage.
by Barry Fraser

Marketing: Removing the Mystery 31

A strategy adaptive to the changing needs of the '90s can make the process of publicizing what your EAP can do sharp, colorful and effective.
by Michael B. Garfield and Sewell F. Gelberd

16 Ways to Keep Your Services Thriving 37

If you can understand the needs of a given situation and how to apply your EAP's resources to it, you're on your way to effective health promotion.
by Ronald W. Greenfield

COLUMNS

Insight ■ **By Paul M. Roman, PhD** 6

Perspective ■ **By Bradley K. Googins, PhD** 8

Changes ■ **By Jim Francek** 10

Cover illustration by Ariel Orr Jordan in affiliation with Adult Survivors of Child Abuse treatment centers of Bellflower, Calif., an organization whose range of services includes an acclaimed art therapy program.

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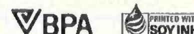

Robust Marketing Can Lead Way Back

I keep material I want to write about in a Manila folder in my desk. This morning I opened a file and headlines dropped out: "Hospital Chairs Accused of Much Cheating on Insurance," "Fair Oaks Sister Hospital Targeted in Probe," "The Humana Flap Could Make All Hospitals Feel Sick," "HCA Hospital Plans to Sell 22 Facilities," and others. It's not bad enough that managed-care companies are decreasing admissions, but now the news media also have been reporting on psychiatric improprieties. In addition to that, Michael Ford, President of the National Association of Alcoholism Treatment Providers (NAATP), reported at the recent Behavioral Healthcare Conference that 300 to 400 treatment centers have closed their doors during the past three years.

Just what are the chemical dependency and mental health facilities doing to fight back? They are advertising. They are attending EA trade shows. They are marketing like never before. They are continuing to do quality, cost-effective treatment.

Now, what are the EAPs doing to stave off the onslaught of managed care, private insurers and utilization-review companies? Some EAPs are merging with insurance carriers or other providers; others are joining with managed-care companies and others are marketing, marketing, marketing.

What is your EA program doing to keep its name and services before your market niche? EA magazine wondered about that this month, so we asked marketers from the treatment side to share what they do successfully and to make suggestions on how treatment centers and EA programs could benefit. Ron Greenfield and Richard Burnett stepped in to tell us. We also asked EAPs what they were doing. Sewell Gelberd and Michael Garfield told us in their article.

EA also looks this month at codependency (CODEP) and adult children of alcoholics (ACOA). Among the nation's more than 250 self-help groups, these two issues are burgeoning. American Demographics (M92) pegs membership in self-help groups between 12 million and 15 million members. Ted Larrison and Seth Allcorn explain codependency in the workplace this month. Attendance at CODEP and ACOA meetings at work have offered a cost-effective adjunct to treatment when problems in these areas spill over onto the job.

We focus our clinical section this month on sexual abuse and addiction and its relation to chemical dependency. Mohan Nair wrote this article.

By the time you read this our 1993 editorial calendar will be out. Although meant to point the direction *EA* will take next year, it is not cast in stone. If you are seeing a trend in the field, please let us know so we can follow up on it. Clear trends are, frankly, difficult to identify this year. No single direction or focus has emerged. As always, however, we can assure you that we will provide increasing editorial emphasis on how to get the job done. Our advisers and readers have pointed out that they want more articles on doing the job well; more on how to assess, diagnose and refer; more on training and more on human behavior problems.

We will be taking this issue to the Southeastern Conference on Alcohol and Drug Abuse (SECAD). Please say hello and give us your thoughts on trends and editorial directions in the coming year.

Chip Drotos

J.Chip Drotos, CEAP
Associate Publisher

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The Legacies of Jack Erfurt

By Paul M. Roman, PhD

One hardly treasures the opportunity to write about one who has been taken from us by death. Such reflection may give us insight into our own lives through appreciating what another's life had added to humankind. This month I am using this column to write about a gentle giant of a man who was suddenly lost to the EA field on September 9, 1992: John C "Jack" Erfurt.

Jack was co-director (with Andrea Foote) of the Worker Health Program in the Institute for Labor and Industrial Relations at the University of Michigan. He was near and dear to all of the tiny band who have made up the "EAP researchers" over these past decades. He had many projects about which he was enthusiastic, and this magazine was one of them.

He always read this column, and with that in mind, I often tried to needle him in print. But I have been indecisive about whether it was right to use the column to write about Jack's legacies. My pondering ended when I heard what sounded a lot like his voice, "Go for it!"

Jack Erfurt had come to be the "energy center" of the EA research group. It was he who always brought the enthusiasm and interest to conferences or any kind of specialized meeting. He energized the rest of us in so many ways. This enthusiasm spread to others because Jack was a very kind person. He took an interest in new people who were gingerly approaching EA research and always worked to make them feel welcome.

While others might have a different vision of the contours of Jack's special contributions, I see them in five categories:

First, from my point of view, his strongest concern in recent times has been the issue of standards for EA work, particularly focusing on programs, but also with concern about the standards for individuals performing EA work, as well as those performing worksite wellness functions. He knew that EA work could not progress until it took seriously the business of understanding and internally managing what it meant by "quality."

Unlike many of the rest of us, he used his concern about standards to energize action, drafting materials and working hard in committee settings. Most importantly, he crossed the researcher-practitioner boundary to ensure that implementation was only a short way down the road.

Second, my own obsessive interest in EA follow-up and relapse-prevention comes directly from the work of Jack and Andrea. There is absolutely no doubt that the failure to systematically follow up with EA clients is the Achilles' heel of EA work.

Jack coined the phrase, "Our No. 1 Enemy, Relapse," which indeed could and should be a central motto for EA work. His research on follow-up and aftercare demonstrated, however, that the effectiveness of such strategies depends on more than good intentions.

Third, I will always associate Jack with innovative technology in the delivery of wellness programs in the workplace. Perhaps because of the health problems he had personally experienced, he had a special empathy with those whose health practices put them at risk of premature death.

He was in favor of practically any form of pressure or persuasion ("short of coercion") that could be used to convince people to maintain positive health-related behaviors, once they had decided to change in a healthy direction, such as losing weight or quitting smoking. And he knew that the workplace had the unique structures in

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place to maximize likelihood of change. Managers and union reps only had to use them.

Fourth, Jack only recently completed a major work on the potentials for integrating EA and wellness work, published as the lead article in the first issue of the *Journal of Employee Assistance Research.* I argued with Jack endlessly over the futility of this "marriage from hell," but finally I was persuaded. Indeed, the evidence is mounting that wellness and EA work can be synergistic. Jack's carefully derived argument on this integration is typical of his interest in looking into the future rather than attempting to be a Don Quixote of the present.

Finally, Jack was a real pioneer in describing what EA work did and how it did it. I recall an ALMACA meeting in New York in the late 1970s when the "brown book" was first coming into circulation. It laid out in crystal-clear detail (including Jack's ever-present diagrams) the nature of structure and process within employee assistance work. It was followed shortly by the "green book." In this second monograph, he and Andrea were among the first to use data to demonstrate the efficacy of EA work. They generated across several companies outcome data, health-care utilization and other cost data, and most post-treatment behavioral data. These two books, both long out of print, are relatively unheralded classics of EA research.

I have tried my best to find a way to express Jack's personal legacies. One of the fascinations about human life is the vast range of beliefs that we hold about what "happens" after death. As many already know, Jack was an intense supporter of cryonics, and his body has been carefully frozen and stored by experts. The goal is that the body can be revived at some later date when science has developed some form of effective cure for the cardiac problems that led to Jack's death.

Cryonics is, of course, based upon scientific knowledge and scientific expectations, precisely consistent with much of Jack's approach to life. I personally believe that cryonics indeed offers the possibility of a return to life. It simply makes logical, scientific sense.

The beauty of this belief system is the intense love of life reflected in a desire to return and to stretch the living experience to its utmost limits. Such a love of life was made clear in many of Jack's poems. Reflecting upon what is meant by a love of life shows us that it means loving others, being with others, loving nature and animals and the sky and the stars. The tremendous evidence of Jack's love of life is a warm reflection for all of us who were able to be with him.

In a remarkable circular way, Jack's enthusiasm for cryonic procedures is clearly and directly linked to what EA work is about. It would not be difficult in any EA setting to find employees whose route back to their lives began with their EA contact.

In a seamless and special way, some of those EA and wellness clients came back to life because of the application of scientific data that Jack had a hand in developing. Helping to revive others through EA and other workplace programs was Jack's lifework over the past two decades. While we can no longer hear his voice or his laugh (at least for a time), his legacy is very much alive in the ways he helped develop for restoring the lives of others. EA

Roman is a research professor of sociology and director of the Center for Research on Deviance and Behavioral Health at the University of Georgia.

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PERSPECTIVE

The Challenge of EAPs in the New Corporation

By Bradley K. Googins, PhD

If anything is clear in this all-too-murky and ever-changing world, it is that we continue to be buffeted by the forces of change at home, at work and in just about every aspect of our life. From an EA perspective, the change is as dramatic as it is universal. I know of no workplace that is not dealing with either the direct or residual effects of dramatic change.

Because the EA program has come to define and treat the workplace as its client, these changes are presenting themselves to the EAP in ways never imaginable just a few short years ago. The challenge for the EAP is to understand what these changes are, how they influence employees and the corporation, and how EA has to reposition itself to serve the new corporation beginning to emerge.

In examining the work environment, a number of profound changes have taken place, affecting some groups more than others. For some, the changes are as direct as a move from lifetime tenure to sudden, extensive layoffs. The downsizing movement has been felt in just about every sector of the economy and within most corporations. It has proven to be a particular jolt to many corporations that had either lifetime tenure or some implicit understanding of lifetime employment.

The massive layoffs, accompanied by a virtual certainty of permanent unemployment, have broken the long-standing employment contract, explicit or implicit, that stood at the heart of employee-employer relationships. For those whose ties have been severed with the corporation, shock and bitterness have begun to set in as the trauma of the situation sinks into their everyday world.

THE OTHER SHOE. For another group of employees, the survivors, an equally disturbing and confused world has emerged from these changes. For them, an even more uncertain world has unfolded, a world of change, new rules, increased ambiguity and unpredictability. Will they be next? How can they ever be sure that their job is secure? What will be the next development in this corporate shakeup? The breaking of the contract has left many waiting for the other shoe to fall, and reassessing their careers and the context of their work life and contract.

For the survivors, and even for those who do not assume a survival role, an additional set of traumas and stresses has emerged relative to the quest for productivity. Through downsizing, work speed-up and working smarter (talk about euphemisms, that one really smarts) the world of achieving more with less has brought with it a less healthy work environment.

Of course, any system can get along on less than all cylinders, but at what cost? Since most of these events are relatively recent, there has not been sufficient time to assess the damage or to determine the limits of shrinking resources within the workforce. However, sufficient anecdotal evidence reveals symptoms of trouble.

For another group of employees, supervisors or managers, the new corporation has brought with it not only all of the dynamics discussed above, but the added challenge of managing within an environment where many of the rules have been thrown out and existing guidelines for managing are less than helpful.

As Humpty Dumpty is put back together, managers have to adjust to managing within new structures and new sets of organizational behaviors. The total-quality movement has turned things on their heads. Furthermore, the end demands of flexible manufacturing, on-time inventory and newly configured employee-relations and human-resource functions have created, and will create, a new environment for most corporations. While this has particular impacts on all employees, it falls most directly on the shoulders of managers to adjust to these changes and to guide the new corporation.

Much of what is occurring within most of our work organizations is taking place within such a hurried-up framework that it is next to impossible to absorb the changes and to adjust to the new realities.

In some ways, it reminds me of the devastating impact of Hurricane Andrew as it ripped across Florida and in an instant rearranged the landscape and the lives of hundreds of thousands of families. In the midst of this destruction, no one was spared—individuals and their families, businesses, infrastructure (both social and physical) all were traumatized beyond belief. As the storm moved on, the shock of the devastation took hold, and the next several days were a test of individual grieving, and a struggle over what supports from the private (insurance, Red Cross, etc.) and public (government) sectors would come to their aid. As the days turned to weeks, the growing realization took hold that life would not be the same ever again, and their communities would rebuild around new realities.

Hurricane Andrew can be seen as a symbol for EAPs and the new corporation. The hurricane of change that has swept through corporations of America, with its winds of downsizing and restructuring, has also left in its wake undeniable signs of human suffering and organizational destruction.

Not only have the lives of individuals been uprooted and changed forever, but in many ways the organization itself is struggling to hold some semblance of normality in the midst of the trauma. For some in the corporation, there are great questions about the future: Will there be one, and what will it look like if I am a part of it? For others, there is the responsibility for creating the future. This requires moving into uncertain, uncharted waters—fully understanding that the next storm may threaten the very nature of organization existence.

SHELTER IN THE STORM. EAPs sit in the middle of all this, not too unlike the disaster-relief workers who swarmed all over Florida after the storm. While they have to deal with their own shock and trauma, they are expected to rise above much of this and provide assistance to those individuals and to the organizations as they begin their rebuilding process.

On one level, they provide concrete services, tending to the immediate needs and suffering that have occurred as a result of the storm. On another level, EAPs can be expected to provide the less tangible, but more important, psychological and moral support to those who will be finding it difficult to rebuild. Disaster assistance is no easy task for those directly affected by the storm or those working with its impact and refugees.

A number of EAPs have taken (or been asked to take) leadership in finding ways by which those survivors not only survive, but reorganize and mobilize into effective action. In a number of corporations, for example, EAPs have developed and led seminars on coping with change. These have been well-received by employees who often have few resources by which they can adjust to the new demands and realities of the new corporation.

A seminar focused on managing change can provide basic information to employees about the dynamics of change, help them understand the nature of the change within their organization, and explore individual and organizational strategies by which they can cope and even thrive in the midst of change.

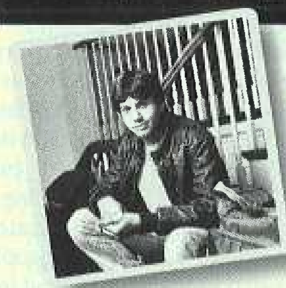
The very nature of groups of employees struggling with these difficult times is a major tool in normalizing their experiences, assisting them in realizing that they are not alone in their feelings or experiences, and that others struggle in much the same manner they do. To the extent EAPs can assist in this process, they play an invaluable role in helping develop a transition from the old order to the new.

THE EAP'S NEW ROLE. As the economy begins to turn, as it inevitably must, it is time for the EAP to plan how best to serve the emerging needs of its clients, both individual and organizational. From many accounts, the challenge will be enormous. Given the events of the past several years, much of the existing social and psychological contract has been broken. Where lifetime tenure existed, no such certainties continue. Where relatively predictable markets created somewhat stable planning forecasts, the constantly changing environments of today leave in their wake uncertainty and an inability to ensure a future.

For most employees, the net results of these changes have left them demoralized, mistrustful and less able to cope with the present. For corporations, the challenge will be primarily how to rebuild the trust, loyalty and commitment—in short, a new

continued on page 12

SOMETIMES THE PICTURE OF A HAPPY TEEN IS A LITTLE HARDER TO DEVELOP.



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CHANGES

The Power of Myths

By Jim Francek

Every culture and every time produces myths that direct a flow of events. A number of myths operate today that have a direct or indirect bearing on EA activities. Here are four. I'm sure you have more.

MYTH #1. *The government has no role in business.* Over the last 12 years, this public policy myth has been put into full practice. As a result, we have experienced a rash of savings-and-loan failures and insurance companies foundering. We have seen an unprecedented period of the pillaging of our corporate and manufacturing base.

A few individuals have bought low, leveraged high debt and sold off the assets and muscle of our manufacturing companies. Company after company has been caught in a spiral of decline. A whole new vocabulary evolved in the '80s to describe the impact of these actions: leveraged buyout, merger, takeover, downsizing, right sizing, relocation.

As a result of this myth, the government has failed completely to serve as a *referee* in this one-sided game. This lack of an overriding policy on work, and the subsequent failure of the last two administrations to lead by developing a national workforce policy, has created an unprecedented number of people who are stressed to the limit. Actual job loss or fear of job loss has created an abundance of clients for EA professionals. As people are faced with the terrifying reality of no way to make a living, family stress, alcohol and drug misuse, and workaholic behavior are all on the increase.

MYTH #2. *Everything that is an asset (including people) can be moved and removed with little negative impact.* The categorization of people as if they were equal to material and financial resources and assets has made many organizations highly impersonal. Unfortunately, in some organizations, "human resources" has become a function solely administering company policy. In others, HR has developed creative ways to cut employee benefits and keep the company "in compliance."

Today the role of employee advocacy is totally lost in many HR functions. Managers of the "people assets" of the company have now become singularly focused on maintaining the organization's direction. In their haste to reshape a company in transition, many practices have focused on ways to cut head counts and related costs.

Many who work in large organizations today feel totally isolated from their organization's mission, strategy and future. They have suffered the trauma of "emotional dismissal" while staying in place within an organization. From an EA perspective, this means we now have to think in terms of organizational depression and the subsequent impact it has on performance, safety, worker's compensation and health-care costs.

EA professionals today need to think beyond the individual clinical interventions and begin to chart a new course in developing organizational interventions.

MYTH #3. *The way to better services is to cut costs.* Everywhere we turn we hear we must do it for less. The

 Circle 5 on card.

evolution of managed care has radically influenced the practice of employee assistance. Many forms of managed care are developing. In the last few years, more than 400 chemical-dependency programs have closed because of the impact of managed care. The justification? Research indicating that the outcomes of inpatient or outpatient treatment are no different.

As a result, those in managing care have concluded that outpatient treatment is a preferred mode because it is less costly. But cost is not the most important variable for selecting treatment.

From 1988 to 1990, I participated on a committee of the National Academy of Sciences—Institute of Medicine. We worked at developing a report to Congress that would summarize the status of alcohol treatment in our country. After reviewing an exhaustive number of studies and taking testimony from addiction-treatment professionals around the country, it was clear to us "that there was no one uniformly effective treatment approach for all persons with alcohol problems." Providing appropriate specific treatments could, however, substantially improve the outcome.

The key is not the wholesale elimination of treatment centers, but rather a systematic use of all modes of treatment. When those who limit or deny access to treatment decide based only on costs, they deny appropriate treatment to many. The challenge for both EA and managed-care professionals is to match specific forms of treatment to specific client needs. When the differential assessment of addiction and the matching to appropriate treatment becomes the norm rather than the exception, we will have tackled the right part of the question.

Unfortunately, with the present state of our economy, those who would cut our costs without reference to need may still rule the day for some time. This will further separate the "haves" from the "have nots." Those with the resources will pay for their treatment. Others will simply be excluded.

Years of heartache, health and social problems, and even premature death may result from the undifferentiated exclusion of people from certain treat-

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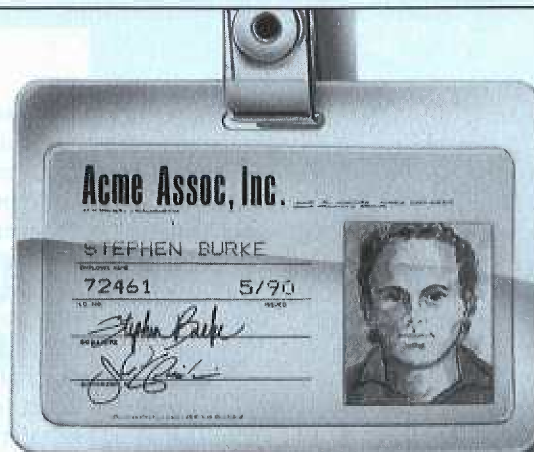
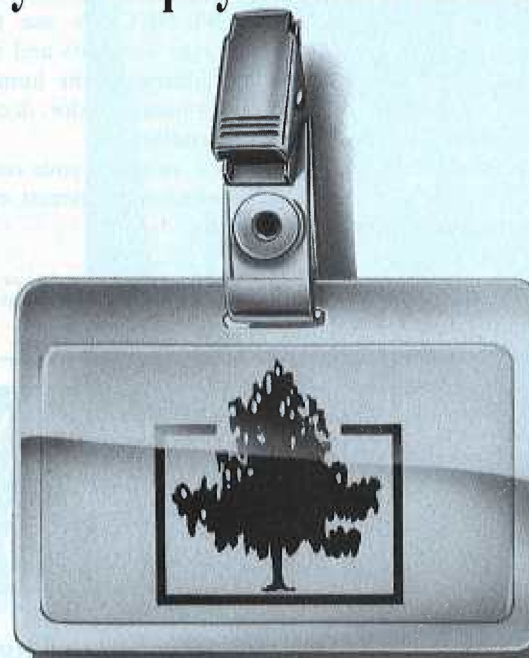


When your employee comes back to work,



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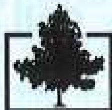

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continued from page 11

ment modalities.

MYTH #4. *A culture of fear in an organization will maintain a practice of safety over time.* In many safety-sensitive organizations, a culture of fear is the bed on which safety programs are built and maintained. Compliance with the law is the focus. Punishment may be the response if people are caught out of compliance.

We live in a time when fear already serves as a major backdrop to our lives. Fear can be generated by job insecurity and financial instability. When the leadership of a company sets out to increase the fear factor, it creates a "search and punish" mode of operation. Most behavioral approaches are founded on reward and punishment consistently given when certain behavior surfaces. In the short run, behavior-modification programs work. But then, program effectiveness falls off as the consistency of response falls off.

If an organization is really concerned about its safety, it will attempt to create a culture of openness, trust, connectedness and mutual responsibility. When members of a work team reach the level of functioning that lets them give and receive corrective feedback to one another, they will have moved well beyond the culture of fear. Highly connected and responsive work teams make a much better context for an effective culture of safety.

When EA professionals sense their organization tilts more toward the fear side, they might consider introducing SAFE-NET. We use this method to prevent accidents and improve quality by addressing the human factors with team-based candor, decisive action and responsibility.

I'd welcome your comments. If I've sparked some interest, call or drop me a note. EA

Franceck is president of Jim Franceck & Associates. He can be reached in care of EmployeeAssistance, *P.O. Box 2573, Waco, Texas 76702-2573.*

continued from page 9

social contract with employees.

If the economic struggles with Japan have taught us anything, it is that employee loyalty is an essential ingredient in ensuring high levels of performance and productivity. For the workforce emerging from the devastation of downsizing and restructuring, previous qualities of loyalty and commitment have been virtually wiped out in the process.

Consequently, the new corporation has to find a way to restructure and reinvigorate the workforce, effectively writing a new contract.

The question and challenge for the EAP remains: What role are you going to play in this process? Given the centrality of the EAP to the organization, I believe this is a good example of the EAP seizing on an opportunity to build a value-added dimension to its operations, and to play a vital part in assisting the old corporation's transition. EA

Googins is an associate professor in the Boston University School of Social Work.

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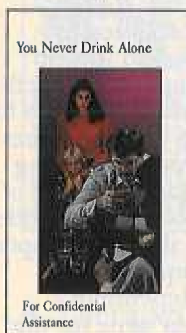

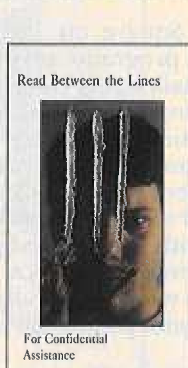

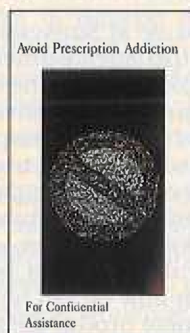

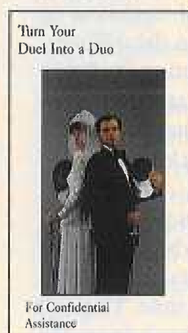

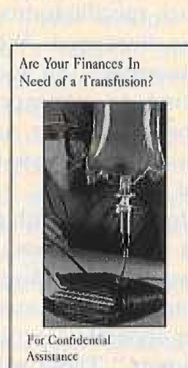

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Recovering Healthy Sexuality

Ariel Orr Jordan

EAPs can play a crucial role in mending broken workers

By Mohan S. Nair, MD

Roger is a 54-year-old blue-collar worker, a recovering alcoholic and cocaine abuser who, after one year of sobriety, went into a nine-day binge that caused him to be re-hospitalized under my care. A Vietnam veteran, he had become suicidal, was having flashbacks, and became increasingly incoherent and agitated until his wife left him and then called the paramedics.

Roger's decompensation took place nine days previously. His wife, who rarely drank, became slightly tipsy after drinking a glass of champagne at a social event that the two attended. Subsequently, she attempted to make love to him. The couple had not been sexually active for more than a year.

Roger became anxious, could not perform. He became angry at his wife, stormed out, got into his car, obtained cocaine, used it, then sought out a male prostitute for sex. A Marine Corps veteran with exaggerated machismo, Roger followed such behavior, as in previous years, by self-hate and drinking to the point of passing out.

Roger's dual addiction to sex and drugs had been pointed out previously. Though he attended Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) meetings, he did not attend sexual addiction 12-Step meetings. He did not do any therapy work directed

continued on page 14

continued from page 13

toward sexual recovery. He continued to live in a sexless relationship with his wife until her sexual approach broke out his addiction.

Later it was uncovered that the early genesis of his sexual addiction may have been rooted in the anal rape molestation to which his uncle had subjected him. His own parents were depressed individuals and gave him no joy or praise. In an empty life in childhood, his uncle, who molested him, was also the only person who gave him attention.

Later on he would compulsively seek such sexual contact during periods of depression—using alcohol and cocaine to act out, and then alcohol alone to drown his shame and self-hate.

He had also been started in 12-Step Sexaholics Anonymous meetings—with the firm warning that his chemical sobriety depended upon his sexual recovery. Roger is a sex and substance abuse addict.

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Unfortunately, it was not until he was 54 and had been through more than seven chemical-dependency programs that his sexual addiction was addressed.

What is sexual addiction? Sexual addiction is preoccupation—or acting out—sexually in a compulsive or impulsive manner.

Mood, behavior and thoughts are affected. Sexual addiction also affects the capacity for achieving healthy intimacy (sexual or otherwise), work, play, creativity and healthy parenting.

Sex haters—the sexually aversive and individuals involved with sexual addicts—may be carrying the seeds of sexual addiction themselves and may seek numbing in chemicals and food.

CHILDHOOD TRAUMAS. Both chemical dependency and sexual addiction are noted in individuals who come from dysfunctional, traumatic backgrounds in childhood and infancy. Parents are often out of control sexually, or so impoverished sexually that the child has no sense of healthy sexuality—feelings, behavior and self-image.

Often there is incest and overt sexual abuse.

At other times, the child may use compulsive sexual fantasizing and masturbation to block out the reality of an environment that is fearful, empty or chaotic—an effort to self-soothe and feel alive in a crazy, empty world.

Later on, sex addicts may welcome drugs, which will help them both to numb their shameful sexual fantasies or—as is often seen with cocaine abusers—use drugs to act out repressed sexual behaviors and fantasies. The actual acting out of the two addictions may happen simultaneously, or one may be used to replace the other.

In one group of adolescents treated for chemical dependency, 50 percent remembered sexual trauma (many may not have) and showed a high degree of sexual acting out behaviors.

What should cause an employee-assistance professional to suspect sexual addiction in a chemically dependent individual? What are some of the signs and symptoms?

Sexualized behaviors—provocative dressing as a pattern in women, men who have a pattern of sexually harassing co-workers, constantly making sexual jokes and comments—may be

indications.

Tardiness, unexplained absences, poor money management, distractedness and poor work performance may all be indications that individuals may be too busy concentrating on their next "sexscapades" instead of concentrating on work. They may not be getting enough sleep in their quest to seek or please sexual partners. They may be staying up late watching pornographic films or riveted into 976-type telephone sex—a growing industry in large metropolitan areas.

Sexual addicts may also present with overt depression, suicidal feelings, anxiety, and stress-related physical problems as they struggle to juggle the addiction with jobs and family. Drugs and alcohol may be used to cope in this juggling.

As one addict put it, "I found myself taking longer breaks and leaving early so I could do the sex stuff."

In his case, that meant going to topless bars. He would self-medicate with alcohol to calm his nerves before going back home to his family. He had great difficulty having sex with his wife. He would masturbate in his car thinking about the topless waitresses.

SIGNS OF STRAIN. Marital relationships are severely strained by sexual addiction. A lack of sexual intimacy, sexual violence in marriage and relationships, or the ongoing use of drugs to sustain a caricature of sexual intimacy may be indications of sexual addiction.

Other more overt indications are legal problems related to pedophilia, exhibitionism, sexual solicitation and rape. Chemical use goes on concurrently, or may follow closely, and the dual treatment is critical for maintaining sobriety in both areas. Spiritual healing, with strict 12-Step attendance and sponsor-connected participation, is essential to break the cycle.

Moving toward healthy sexual intimacy is a necessary step, and individuals who may "run" from sex may be living a white-knuckled recovery that often ends up in chemical or sexual acting out, relapse, or both.

Some have tried to treat rape, pedophilia and exhibitionist addictions and compulsions with drugs such as Depo-provera or, more recently, Prozac and Anafranil. But the overwhelming evidence indicates that these have little impact on long-term recovery and show poor compliance because of serious side effects.

Chemical-dependency programs usually put a lid on patients talking about sexual abuse and sexual addiction and perpetuate the denial of the often coexisting conditions.

Unfortunately, even many sexual-addiction programs discourage individuals from talking about specific sexual addictions—especially those involving exhibitionism, obscene phone calls, playing with feces, pedophilia, and cross dressing. The emphasis too often is on "generic" sexual addiction (i.e. hypersexuality), and individuals who struggle with the other sexual addictions fall through the cracks, go untreated and relapse.

A program that treats sexual addiction needs to be 12-Step-based and facilitate the sharing of any and all

continued on page 16

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SPECIAL SECTION

Trauma and the Adult Child

Pinpointing the pain of growing up with devastating experiences

Listen to the stories, the questions, the memories that adult children of alcoholics share when they converse among themselves and you begin to get a vivid understanding of trauma.

• "I never had birthday parties as a kid—I just always knew my dad would use it as an excuse to get drunk. My mom always let me know in the most subtle, and sometimes not subtle, ways that if I had a birthday party (which would be tough 'cause I didn't have many friends) my dad would get drunk and crash it. I only had a couple of friends. Both their dads were dead—and I pretended/wished that mine was too....Was 7-10 years old. I remember other things from those years, but this and other memories I block out."

• "If anyone out there is still dealing with a dysfunctional family outside the home and past painful events, HOW DID YOU GET THROUGH IT? It is affecting my sobriety. Any tips at all? Right now, I am seeing a psychiatrist."

• "I am an adult child of an alcoholic who is a recovering addict. I know a lot about wanting things I can't have. I have gone through a divorce and have been through more bad relationships than I care to remember. I have found that I spend too much time trying to understand people and control their lives."

Consider some of the trauma-indicative questions that Al-Anon asks of those who grew up with problem drinkers: Do you overextend yourself? Have you had problems with your own compulsive behavior? Are you uneasy when your life is going smoothly, continually anticipating problems? Do you feel more alive in the midst of a crisis?

Trauma is an all-too-common reality among adult children, although often traumatized people, like the man in our first example, cannot relate the details of their abuse. These details are just too horrifying to remember. Fortunately, the brain has mechanisms to shield from such pain.

Trauma is an affliction perpetrated upon the defenseless and powerless. Traumatic events overwhelm the senses and sensibilities.

Society views trauma based upon the political movement and theme of the era. Three times during the past 100 years the issue of trauma has come to the surface of the public consciousness.

The first emergence resulted from the study of hysteria when Janet in France and Freud in Vienna arrived at a similar conclusion: Hysteria was caused by earlier life trauma. Politically, theirs was an era of republican government. This government wished to promote the scientific explanation of symptoms of hysteria, as opposed to designating hysteria as demonic possession. Freud and Janet converted the mystical to the scientific and received the applause of the prevailing political regime.

The second emergence of trauma into public awareness came in the form of combat neurosis. Traditionally, society viewed combat neurosis or "shell shock" as caused by cowardice and considered those afflicted by it as malingerers. Soldiers should revel in the glory of war. But the anti-war movement of the Vietnam era, accentuated by graphic television images of war entering homes daily for the first time, made many U.S. citizens more acutely aware than ever of the horrible atrocities and consequences of war. Gradually, society decided that "shell shock" (now called post-traumatic stress disorder) could occur in the strong and the brave.

The most recent trauma to come into public awareness has been sexual and domestic violence. Three of every five reported incest cases occur in the alcoholic home. The feminist movement documented domestic violence as a common occurrence in a woman's domestic and sexual life. Further research has established the incidence of domestic violence as a problem for men as well.

Given our discomfort at listening to victims and our ambivalence about perpetration, traumatic events were once considered rare. As late as 1980, the American Psychiatric Association's bible, the *Diagnostic and Statistical Manual* (DSM III) described such occurrences as "outside the range of usual human experience."

COMMON EXPERIENCE. But trauma, as adult children will tell you, is so much a part of life that it must be viewed as a common human experience.

Surprise, feelings of being trapped, or exposure to the point of exhaustion, all exaggerate the harm of trauma. So does physical injury or violation, such as incest, or exposure to extreme violence. These experiences tend to fill their victims with terror and a sense of inevitable helplessness. Intense feelings of anger and fear also pervade the senses. Neither resistance nor escape is possible.

Trauma produces lasting changes in emotion, cognition and physiology. The traumatic event appears to be "hot wired" into the older, emotional part of the brain. The newer, computer portion of the brain can make no sense out of the previous events. Physiological changes occur:

• *Increased autonomic nervous system arousal.* The body stays in a state of hyper-alertness called "fight or flight" syndrome. The individual appears anxious.

• *Reduction in functions of the hypothalamus-pituitary adrenal axis.* This hypo-functioning often takes the form of depressive symptoms.

• *Alteration in the endomorphin system.* The individual has low resting endomorphin levels that leave him ill-equipped to manage pain and anxiety. When a stressful event does occur, the endomorphin system over-fires. Trauma survivors often handle a crisis but fall apart a few hours or days later.

• *Sleep abnormalities.* A trauma survivor may endure night terrors with content that replays the traumatic event.

An adult with a history of trauma may not be able to relate to the details of the abuse. A child tends to re-enact the abuse repeatedly in play behavior. The adult re-enacts the abuse in relationships with other people. Unfortunately, the same brain mechanisms that protect the child may now conceal realization of destructive behavior from the adult.

CYCLE OF DEVASTATION. If not treated, trauma survivors may continue to self-destructively "play-out" their past history. This "acting out" takes on an addictive quality that can actually give immediate relief. For example, sexual promiscuity may reduce feelings of depression, anxiety or pain. The use of food, alcohol and drugs keep the pain away while bringing slight, short-lasting relief. Trauma survivors will have an enhanced incidence of food

continued on page 20

By Cardwell C. Nuckols, PhD, and Kathleen McFarlane, BA

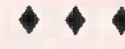
Joe Griffin Photography

continued from page 21

other. The conflict got so out of control that one day Buffo and Betty ignored a customer while they shouted at each other.

Business declined. New markets went unexplored, and old customers were lost. Ira Hickenlusher, his sons Buffo and Willie, and his daughters Betty and Faye, did not live happily ever after.

How does this modern fairy tale end? Are the conflicts resolved? Does Ira Jr. take an early retirement? Does he sell out to Leathers International Inc.? Or does Ira, in a moment of panic and in a flash of insight, grab his phone and call for help for himself, his family and the business?



Hickenlusher Leathers illustrates how the family-owned business is unique among business enterprises. It combines both the difficulties of the marketplace and the complicated dynamics of the family. The unresolved conflict from their families of origin entangles their lives and the climate of the business.

The spouses of these driven men, like Mr. Ira Hickenlusher Jr., often find themselves functioning as a single parent while their husband struggles to get the business established. The sacrifices husband and wife make for the future success of the business take their toll. Then the children inherit both the business and the elements of dysfunction that make it possible.

Employee assistance programs are asked to work with the owners of the business. For the external EA provider, learning to market our family therapy and consultation skills gives several opportunities:

First, it provides a way of expanding product line and income base. Adding consulting services for the family business gives a wider portfolio of skills to offer.

Second, it provides another contact point from which we can sell EA benefits. Our organization has more than one EA agreement that has grown out of conducting family therapy with the owners of businesses.

It is a natural transition to move from the resolution of their own family crisis to help them look at how their employees resolve personal problems.

Third, marketing provides a way to strengthen our service to the company by showing our expertise in dealing with the problems of the "management class."

Consulting with the family business requires an understanding of how to help effect change within a family and an organization. It is not enough to make the claim, then hang out our shingle. Rather, it requires that we develop our assessment and intervention skills and arrange for good clinical supervision. It would be a serious mistake to misrepresent ourselves and make a mess of an already complicated situation.

Turn instead to the excellent resources available to the EA professional. For example, Joseph Mancuso, director of the Center for Entrepreneurial Management, has developed a *Family Business Resource Guide* to help both the consultant and the family.[1] The guide lists organizations, books, periodicals and training resources for the consultant and for the family business. Another resource is the American Association of Marriage and Family Therapy.[2]

Hickenlusher Leathers was a business in trouble, and all the family knew it. But none knew what to do. Willie went to his

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mother complaining about his brother Buffo: "His drinking has gotten so bad that he comes to work hung-over."

"Now Willie," she said, "you know how hard your father can be on Buffo. I'm sure he just had a few drinks to relax."

Buffo went to his mother saying, "Mom, I just can't talk with Dad. Anytime I tell him about a production problem we're having, I get attacked and blamed."

"Now Buffo," she said soothingly, "your father is tired, and I think he must be worried about Betty and Faye. Remember the fight they had in the office this week?"

Faye went to Willie saying, "I don't know what to do, Will. You know how Betty's always been Dad's favorite. I can't put up with it anymore. I'm doing her work and mine too, and I get blamed for all of her mistakes."

Willie said, "Don't worry about it, Faye. I'll talk to Betty. By the way, have you noticed that Buffo's drinking seems a lot worse lately?"

"Well, of course it has," Faye said. "I told you a long time ago that if he doesn't get his alcoholism treated, his drinking is going to destroy the business."

"What do you mean alcoholism? He may have a drinking problem, but he's not that bad," said Willie.

Mrs. Hickenlusher called the consultant. The consultant met with each of the family members in the business—as well as some of the other employees—to assess the situation. He met with the family as a group and observed their interaction.

With the consultant's help, the Hickenlushers learned about alcoholism. The consultant helped the family confront Buffo, and he got into treatment.

Ira Hickenlusher was referred to a local ACOA (Adult Children of Alcoholics) meeting. He learned that his behavior as a father and business owner came from trying to cope with the chaos of his own childhood. Ira began learning to control his temper and became more relaxed and attentive to his family.

The family also learned about triangles. They learned how they had been indirect with each other and avoided conflict by talking to a third person rather than dealing with their father or their brothers or sisters.

They learned how Mrs. Hickenlusher, by trying to soothe the conflicts, kept conflicts alive. She learned to redirect the person and to insist that they deal with the other family member directly.

They learned about boundaries between individuals as persons, as family members, and as employees in the company. They developed a new sense of appreciation for the gifts that each family member had. Slowly, the family stepped back from the brink of chaos—though not without some continuing pain. Buffo, realizing that he needed more space, left the business.

Ira decided, on the advice of the consultant, to set up an outside board of directors to help the company with it its transition from his leadership to the next generation of leadership. He and his wife, Ada, took their first vacation and left the business with Willie as the new manager.

Ira and Ada saw a rainbow, and there were even some bright sunbeams of joy. And they all lived more happily.... EA

REFERENCES

1. Center for Entrepreneurial Management Inc., 180 Varick Street, New York, NY 10014-4606.
2. AAMFT, 1100 17th Street NW, 10th floor, Washington, DC 20036.

Larrison is Manager of Business/Industrial Services for Southern Hills Counseling Center of Jasper, Ind., an organization that provides EAP services to several family-owned businesses.

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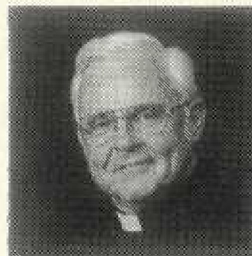

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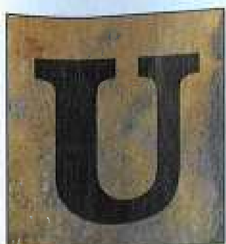
SPECIAL SECTION

Codependency At Work

The employee trying to be all things to all people may need the EAP's help to find a true self with healthy interactions

By Seth Allcorn, PhD



Understanding people at work is a challenging proposition. Human nature, in all of its diversity, makes it difficult to predict what employees will do and, more importantly, why. In particular, everyone in the workplace is unconsciously motivated. One way of understanding unconscious life at work is through the lens of personality. A newly described personality disorder that promotes better understanding of one facet of unconscious motivations at work is codependency.

Codependency arises from personality rigidities that create compulsive behavior. Such behavior has a major impact upon organizations, groups and others at work.

Codependency does not have an agreed upon definition. For this article, we define it as a system of unconscious personality traits that leads to the compulsive development and maintenance of painful, dysfunctional, self-defeating and self-destructive interpersonal relationships at work.

This definition emphasizes that codependency is an interlocking, mutually reinforcing system of beliefs, thought processes and feeling distortions. These elements of codependency have meaning only in relation to each other and the past.

The definition allows for rigid and maladaptive thoughts, feelings and actions that produce the undesirable interpersonal behavior. The interpersonal world includes parents, siblings, spouses, lovers, children—anyone upon whom the codependent depends for affection, meaning and approval.

At work, the definition includes attachments from relative superiors, employees, colleagues and clients. To the extent that attachment needs are not met at home—which may frequently be the case for codependents—they are acted out at work. Interpersonal and positional boundaries between superiors, subordinates and others become blurred, which produces a range of outcomes such as close friendships, dating and sexually intimate relationships.

A last interpersonal consideration is that codependency contributes to the dysfunctional behavior of others. To the extent that codependents take care of others and tolerate behavior, they enable that behavior. Others do not need to change or improve.

Understanding codependency means achieving some degree of empathy for the self-impoverishment, loss of self, pain and denial, dread of abandonment, and domination and compulsiveness that pervade the codependent's interpersonal world.

Codependency's thinking and feeling distortions, fueled by low self-esteem and minimal personal integrity, create a self-sealing system of existence. In it the self-destructiveness is denied in favor of believing that the sacrifices are made for the good of others.

Codependency is something everyone experiences to some extent some of the time. It is also important to appreciate that everyone faces a degree of codependency that will vary from hour to hour and from one situation to the next.

The discussion below speaks of diagnostic criteria and the codependent. This paper relies upon diagnostic criteria as a convenient necessity. The reader is cautioned not to use the diagnostic criteria to classify people with a personality disorder. The use of "codependent" to discuss codependency is also a matter of writing convenience. It helps keep in mind that most people around us suffer to some extent from symptoms of codependency. When the actions of others at work become compulsive and rigid, these individuals can be thought of as codependent.

Codependency is an interpersonal, as well as intrapersonal, disorder that has been described by many (Allcorn, 1992; Beattie, 1989; Cermak, 1986; Hayes, 1989; Norwood, 1985; Schaef, 1986 and Wegscheider-Cruse, 1985). It introduces an element of irrationality into the workplace.

CODEPENDENT CRITERIA. The following section explains the relationship between the diagnostic criteria proposed by Cermak (1986) and the workplace.

1. The codependent's self-esteem is invested in controlling self and others—despite considerable evidence that the control does not work. Codependents seek this control to curb anxiety. They will act in ways that others desire. The codependent's true sense of self is abandoned, and a false self emerges that aims to control what others think, feel and do relative to the codependent. The intent of the control is to secure approval that will shore up low self-esteem.

The codependent can be counted on to defend others and groups, regulate conflicting interactions, and maintain high, if not nearly perfect, work standards. Feeling that mastery of work is essential, he may work many extra hours.

The codependent can also be expected to have tension-filled and polarized interactions with superiors. "Bad" relationships may develop and continue because the codependent does not want to deal with the pain of transfer or changing jobs, especially given his low self-esteem, assertiveness and autonomy.

The codependent will be keenly aware of uses of power and authority that represent a loss of control. If used inappropriately

continued on page 26

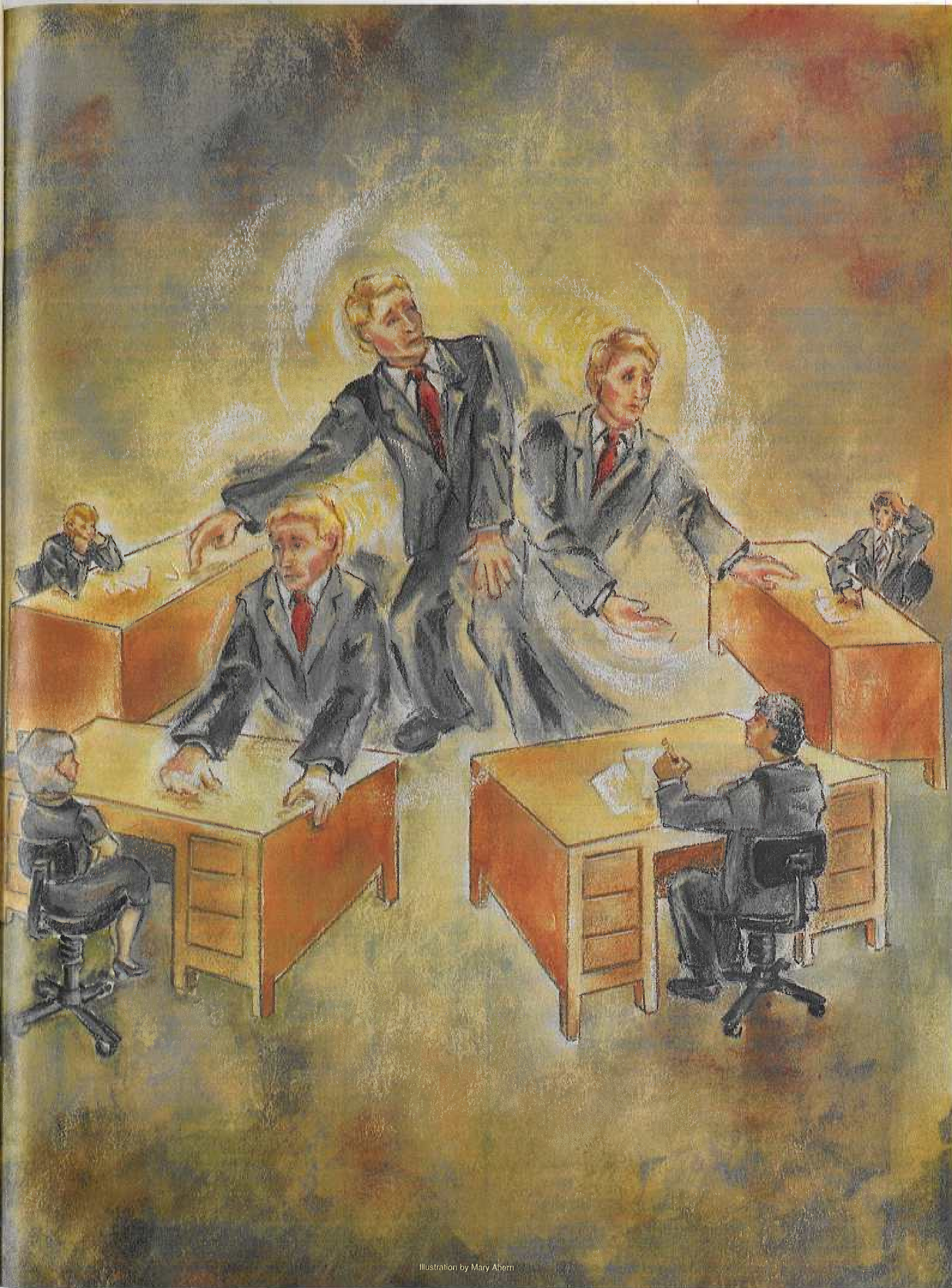


Illustration by Mary Ahern

continued from page 24

(bureaucratically or autocratically), this power and authority confronts the codependent with infantalizing alienation from the organization, self, others and the products of his work.

The codependent's compulsive tendencies to take charge at almost any personal cost are, paradoxically, admirable and adaptive to the workplace.

2. The codependent assumes responsibility for meeting the needs of others to the virtual exclusion of acknowledging or meeting her own needs.

The codependent assumes inordinate amounts of responsibility for the well-being of others and the performance of work—to the exclusion of self-advocacy, self-assertion and personal well-being. Extraordinary self-sacrifice, it is believed, makes the "worthless" codependent of value to others.

Ironically, codependents' compulsive tendencies to take care of everyone and everything make them an important contributor in the workplace and an effective, sensitive supervisor.

3. Boundary distortions exist that affect achieving intimacy, and threats of separation or abandonment lead to the existential fear of loss of self.

Poor boundary-management skills give the codependent a difficult time regulating work-related and interpersonal stress. As a result, codependents are chronically mobilized. The codependent readily owns the feelings of others and personally experiences their distress because he suffers from so much pain. The codependent is particularly intent upon regulating interpersonal distance to avoid feelings of being abandoned (rejected) and engulfed (dominated).

Codependents' compulsive tendencies to make sacrifices when confronted with powerful and authoritative others can make them excellent followers. Their compulsive tendencies to own all feelings also make them good crisis managers. They are good fight-or-flight leaders and highly motivated to act on behalf of others, even if it is self-defeating.

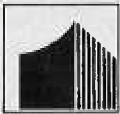
4. The codependent searches for relationships with others who suffer from personality or impulse disorders, chemical dependency or self-centeredness. These relationships tend to exclude other, more healthy individuals.

To feel needed, the codependent is attracted to caring for others who have personal and work-related problems. These relationships become personal in nature and the basis for friendships and sexualized friendships. The codependent is unduly dependent upon meeting others at work for social relationships.

PARADOXICAL PERSON. To the extent that developing social relationships at work is construed as negative by superiors and others, the codependent's career may be adversely affected.

5. The codependent will deny or rationalize self-defeating actions at work and select friends and membership in support groups that will enable such behavior.

The codependent may also locate as friends other codependents who will fur-



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ther enable the codependency. Oddly enough, he may find some codependents to be despicable. Their pain-filled, self-defeating lives will remind the codependent of his own compulsive and self-defeating behavior.

6. Constriction of emotions (with or without dramatic outbursts) offers yet another diagnostic benchmark.

The codependent readily suppresses feelings and can be expected to be relatively unaffected by many events at work. The codependent may be seen as someone to come to with problems and may frequently be singled out to deal with major problems and conflict. Ironically, while being a fearless leader, the codependent further drains herself of vital, life-giving energy. This exposes her to more criticism—further increasing rage, escalating anxiety and lowering self-esteem.

7. The codependent may be depressive and moody and often act out feelings relating to painful work and non-work relationships.

The codependent's self-defeating actions create a continuing life of bitter sacrifice, self-victimization, and pain that will negatively influence moods and feeling states at work. As a result, the codependent's work effectiveness and career progression may be inhibited.

8. The codependent is hypervigilant and finds fault and threat everywhere.

The codependent may occasionally seem paranoid and filled with an anxious sense of persecution. As a result she, as mentioned, may become an effective fight-or-flight leader. These tendencies may also make the codependent effective at one time and ineffective or dysfunctional at others.

CRY FOR ACCEPTANCE. When excessive vigilance results in something productive, the codependent will be accepted. However, close work friends and superiors may find the codependent's chronic state of vigilance distressing and distance themselves from the codependent's fear of abandonment.

9. The codependent will compulsively pursue personal agendas and work goals aimed at sublimating or binding painful anxiety and repressed rage. The codependent may be a prodigious producer, exhibit boundless energy and demonstrate a willingness to perform painstaking, undesirable work. This may reflect having been made to feel worthless or may demonstrate that the codependent is worthy.

10. The codependent possesses a high baseline of anxiety and can be expected to be anxious about performance, appearances and interpersonal relationships.

Since the codependent feels worthless and undesirable, the threat of being criticized, affronted, rejected, abandoned or dominated is omnipresent. If the status quo is challenged, the codependent may lose familiar ways of coping with anxiety.

11. The codependent may rely upon alcohol and illegal or prescription drugs to fight off the pain of childhood victimization and self-victimization.

Such childhood pain may have come from trying to love parents who were abusive, insensitive, unpredictable, emo-

continued on page 28

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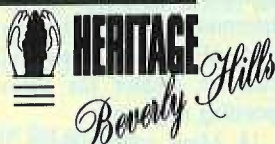

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continued from page 27

tionally cold or unavailable, detached, unfair, uncaring and incessantly critical.

The development of mood-altering substance abuse to bolster the fragile, difficult-to-maintain levels of denial, suppression, and selective inattention can be expected.

12. Codependents tend to be past or present victims of conflict-laden, abusive relationships with parents, spouses, lovers, children and others.

The codependent locates others who will use him to meet their own needs. These pathetic bonds can become extraordinarily strong since the codependent eventually invests his false self in meeting the needs of the other self-centered person who, at work, may be a superior, subordinate, colleague or friend. The codependent sacrifices work time for this caring, creating stress over lost performance and the need to work late or at home to make up for the lost time.

ENABLING ABUSE. Others may also be encouraged (enabled) by the codependent to be abusive. For example, a male subordinate goads his codependent female supervisor by frequently challenging her decisions and demeaning her work. She responds by feeling anxious and suppresses her anger in favor of being friendly, receptive, nondefensive and supportive. In this example, the male employee is rewarded (enabled) for his aggressive behavior and thereby encouraged to continue it.

13. The codependent will suffer from stress-related, psychosomatic illness, such as tension and migraine headaches, asthma, hypertension, stroke, gastritis, spastic colon, peptic ulcers and sexual dysfunction (Cermak, 1986).

Some of this may result because at work the codependent is willing to suffer through excessive work demands, punitive and insensitive management styles, lack of personal development or promotion, discrimination, harassment and lack of recognition because he does not feel deserving of better and cannot do anything about it, anyway.

Clearly, the codependent's life is stressful, filled with threats and the need to control self, others and events. He is determined to do this at virtually any personal cost. The more difficult the control, the greater the threat and corresponding response.

14. Many codependents sustain a relationship with an active substance abuser for

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