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Donald Nelsen
Major professor

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FAMILY, CULTURE, AND CODEPENDENCE: A DEVELOPMENTAL PERSPECTIVE

By

Nancy Jane Lorris

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ABSTRACT

FAMILY, CULTURE, AND CODEPENDENCE:
A DEVELOPMENTAL PERSPECTIVE

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Although there has been much debate among mental health professionals about the construct of codependence, little empirical work has been done to support or refute differing theoretical stances. The purpose of this study was to examine the etiology of codependence from a developmental perspective. In particular, family of origin and other childhood socio-cultural influences were assessed as contributors to codependence in adulthood.

A sample of 41 adults (90% female; 85% White) responded to a five-part questionnaire. The Friel Co-Dependency Assessment Inventory (FCAI)(Friel, 1985) measured codependence; the Trust Scale (Rempel et al., 1985) assessed trust in a current adult partner. Retrospective measures of childhood relationships included the Adult form of the Parental Acceptance/Rejection Questionnaire (PARQ)(Rohner, 1980) and the Family-of-Origin Scale (FOS)(Hovestadt et al., 1985). These assessed primary caregiver rejection and family of origin mental health. The fifth part of the questionnaire contained a demographic survey designed by the researcher.

This correlational study employed a variety of statistical techniques in order to establish relationships between variables and predict the development of

codependence. Specific research questions were: (a) What are the primary childhood factors which contribute to the development of codependence? (b) Does an adult's relationship with a partner affect his/her present degree of codependence? (c) What combination of childhood and adult factors is most predictive of codependence?

Childhood factors which were found to contribute uniquely to codependence, using the FCAI, were poor family of origin mental health, caregiver rejection, and being the oldest or youngest child in one's family of origin. A revised form of the FCAI, one in which family of origin items had been removed, demonstrated different results. In this analysis only caregiver rejection and birth order were found to be significant predictors of codependence. A subject's level of trust in a current adult partner was found to be negatively related to her degree of codependence. The most powerful combination of childhood and adult predictors of codependence was found to include caregiver rejection, birth order and lack of trust in a current adult partner. This was true for both versions of the FCAI.

To the memory of my paternal grandparents,

Mark and Anna Lorris,

who began their lives as Macarius Lawriwsky and Anna Wowchyuk

in another part of the world.

Their boundless love and belief in my worth have made all

things possible. Every child should be so lucky.

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Friends, inside the university and out, came bearing gifts. Validation, empathy, humor and lots of chocolate reminded me that there was an end in sight and that my friends would be waiting to celebrate with me.

Specific thanks go to each member of my doctoral committee. Don Melcer consistently expressed confidence in

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A host of other players enabled me to complete the dissertation. Dolores Borland-Hunt modeled goal-oriented tenacity and encouraged me whenever the opportunity arose. The Department of Family and Child Ecology provided me with teaching assistantships and fellowship monies. Department secretaries and support staff were patient, kind and helpful beyond their job descriptions. Contact persons at data collection sites committed precious time and energy to helping me find subjects. And, of course, a huge thank you goes to the subjects of the study, who volunteered to answer very personal questions about themselves and their relationships. Their responses generated the force which energized this project and guaranteed its completion.

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INTRODUCTION

More than two million copies of Codependent No More have been sold since the book was first published in 1987. The phenomenonal sale of Beattie's book, and others on the same subject, support the probability that issues connected with codependence resonate through the lives of many adults. In addition to those who read about codependence, there are those who decide to seek professional advice. They often enter counseling with symptoms of depression, anxiety, and feelings of worthlessness. Sometimes they are very angry with others in their lives. In many cases, what causes these people to seek help is a need for relief from a painful pattern of living. Troubled by unsatisfying relationships with others, they are looking for answers. Why do they always seem to be involved in difficult relationships? And what can they do about them?

Background of the Study

History

In the mental health field, particularly in the area of chemical addictions, the problems connected with codependence have been identified for many years. What is now called codependence was once called co-alcoholism. The label "co-alcoholic" was originally given to spouses of alcoholics (Cermak, 1986). Just as the drinker's life centered on the availability of alcohol, the co-alcoholic's life revolved around the drinker. Treatment providers noticed a surprising pattern; the alcoholic might seek and receive help, but family dysfunction often continued after the drinking had ceased. Spouses and children of alcoholics continued to exhibit behaviors and beliefs which reinforced the familiar homeostatic system. Even after the central chemical organizer of the family was removed, the dysfunctional characteristics of the co-alcoholic remained.

The other perplexing outcome was that co-alcholic behaviors sometimes manifested themselves in families in which no one was chemically dependent. This caught the attention of mental health professionals outside the chemical addictions field, who recognized these symptoms in some of their clients. This led to a new name for co-alcoholism--co-dependency, also known as co-dependence, codependency, or codependence. This lack of clarity around naming has also

been reflected in the quest for a workable definition and classification for the problem. Although many professionals agree that the phenomenon exists (their clients provide consistent data), uncertainty remains around the issues of definition, categorization, etiology and treatment.

Theoretical Definitions of Codependence

While there is general agreement that defining codependence is a first step toward conceptualization, different authors offer a variety of definitions, many of which share common characteristics. A concern shared by all is that the definition of codependence be used in such a way that it does not become diluted, and therefore, meaningless. Some emergent definitions of codependence include:

1. Co-dependency is a pattern of painful dependence on compulsive behaviors and on approval from others in an attempt to find safety, self-worth and identity. (U.S. Journal Training Inc.'s First National Conference on Co-dependency, 1989)

2. A co-dependent person is one who has let another person's behavior affect him or her, and who is obsessed with controlling that person's behavior. (Beattie, 1987)

3. Co-dependency is an emotional, psychological, and behavioral condition that develops as a result of an individual's prolonged exposure to, and practice of, a set of oppressive rules--rules which prevent the open expression of

feeling as well as the direct discussion of personal and interpersonal problems. (Subby, 1984)

4. Co-dependency is a dysfunctional pattern of living which emerges from our family of origin as well as our culture, producing arrested identity development, and resulting in an over-reaction to things outside of us and an under-reaction to things inside of us. Left untreated, it can deteriorate into an addiction. (Friel & Friel, 1988)

5. Co-dependence is a recognizable pattern of fixed personality traits, rooted in the internalized shame resulting from the abandonment that naturally happens to everyone in a dysfunctional family system. (Bradshaw, 1988)

6. Codependence describes individuals who organize their lives--decision-making, perceptions, beliefs, values--around someone or something else. (Brown, 1988)

7. Many clinicians and researchers simply define codependence as being the spouse or child of a chemically dependent person, which is simultaneously a broad and a narrow definition. (Whitfield, 1990; Wright & Wright, 1984)

Disease, Disorder, Syndrome, Social Norm?

One of the many arguments which has engaged professionals interested in codependence is how to classify the phenomenon. Some mental health specialists say that codependence has been described in such general terms, and could therefore apply to so many people, that it no longer explains deviance. This

criticism has been offered by Edith Gomberg (1989), a professor of psychology and social work at the University of Michigan: She notes that the term has been expanded "without any consideration of its meaningfulness or its contribution to theory and practice, so that it encompasses virtually the entire population of the United States" (p. 8). Dilution is indeed a risk. But the enormous circulation of books and articles related to codependence suggests that, for many people, these "common" traits are a very real concern.

There are those who believe that codependence should remain aligned with its origins in family substance abuse. Brown (1991) suggests confining codependence to "the interactional systems dynamics of alcoholism and chemical dependence" (p.9), in the belief that a restricted population will increase understanding. She is concerned that there is a danger of turning systems dynamics into individual pathology, and employs a multi-track approach to the study of codependence solely in alcoholic families.

Critics of codependence have appeared in feminist circles. There are concerns that the literature pathologizes a female identity based on caretaking (Asher & Brissett, 1988; Krestan & Bepko, 1990), and that women who are labeled codependent are seen as complicitors in family alcoholism and/or physical abuse (Frank & Golden, 1992; Haaken, 1990; VanWormer, 1989). Such authors worry that the tendency to perceive codependence as a "sickness" is another version of blaming the victim. But there are mental health advocates

for women who see the codependence movement as having created a positive social environment to deal with women's problems (Webster, 1990). Writers of this school suggest that codependence be defined for women as learned helplessness, not as a sickness (O'Gorman, 1991). The hot arguments among professionals in the field, combined with sustained and widespread interest from the public, support the probability that codependence touches many people, even if it is sometimes confused with broader life issues and concerns.

Of course, not everyone who identifies with some of the characteristics of codependence is clinically diagnosable. Timmen Cermak (1986), a psychiatrist who has made a case for creating a new diagnostic category for codependence, says:

> The critical point for our purposes is that while co-dependent traits may be widespread, the diagnosis of Co-Dependent Personality Disorder can only be made in the face of identifiable dysfunction resulting from excessive rigidity or intensity associated with these traits. (p. 10)

He continues to explain that other traits--such as narcissism--are virtually universal in the population, but that these traits are only diagnosable when they portray dysfunction. (Virtually the same argument can be made for for depression; most people are "depressed" at some point in their lives, but they are judged to be clinically depressed when they become dysfunctional.) Cermak suggests that codependence,as a diagnostic category, could be included within the framework of Mixed Personality Disorder in the Diagnostic and Statistical Manual of Mental Disorders.

Diagnostic Criteria for Codependence

The diagnostic criteria for codependence most often used by clinicians were formulated by Cermak (1986) and reflect his belief that codependence is a personality disorder. They are included here in order to provide a brief description of symptoms which identify codependence:

A. Continued investment of self-esteem in the ability to control both oneself and others in the face of serious adverse consequences.

B. Assumption of responsibility for meeting others' needs to the exclusion of acknowledging one's own.

C. Anxiety and boundary distortions around intimacy and separation.

D. Enmeshment in relationships with personality disordered, chemically dependent, other co-dependent, and/or impulse disordered individuals.

E.Three or more of the following:

1. Excessive reliance on denial

2. Constriction of emotions (with or without dramatic outbursts)

3. Depression

4. Hypervigilance

5. Compulsions

6. Anxiety

7. Substance abuse

8. Has been (or is) the victim of recurrent physical or sexual abuse

9. Stress-related medical illnesses

10. Has remained in a primary relationship with an active substance abuser for at least two years without seeking outside help.

Competing Theoretical Models of Codependence

As might be expected, if there is no single definition of codependence with which everyone agrees, there is also no generally accepted explanation for how people become codependent. Much of the controversy surrounding the diagnosis of codependence is that it seems to include both intrapsychic and interpersonal dynamics. This powerful combination of self and others, while recognized as synergistically potent, is not recognized equally in the conceptual models created by authors in the field. Some of the proposed models include:

Family Systems--Rules.

Black's (1981) three rules, "Don't talk. Don't trust. Don't feel.", explain the ways in which dysfunctional families discount their members' rights to talk about problems and/or feelings. If one is to be accepted as a member of this kind of family, one cannot honestly "own" feelings or acknowledge problems openly. Successful accommodation to these rules eventually leads to mistrust of self and others, inability to distinguish among feelings (if one can claim them at all), and distortion of objective reality.

Family Systems--Roles.

Wegscheider-Cruse (1981) writes about rigid roles occupied by children growing up in dysfunctional families: Hero, Scapegoat, Lost Child, and Mascot. Larsen (1985) also describes adult roles which unhealthy families allow: Caretaker, People-Pleaser, Workaholic, Martyr, Perfectionist and Tap Dancer. Neither author claims that these are found only in unhealthy families. What they suggest is that functional families do not lock members into a role, but allow them to move back and forth between them as needs and circumstances change. It is the flexibility of roles which distinguishes functional families from dysfunctional ones.

Ego Psychology.

The Friels and Subby (1984) contend that identity disturbances lie at the core of codependence. Once a person has invested more psychological energy in maintaining an undeveloped "self" than in developing a mature "self", codependence is firmly in place. At this point, a person is codependent, whether or not they are presently living in a dysfunctional family system.

Behavioral and Intrapsychic.

Wegscheider-Cruse (1985) describes codependence as a condition that is primarily characterized by extremes of preoccupation and dependency (emotional, social, and sometimes physical) on a person. Eventually, this becomes a pathological condition that affects the codependent person in all other relationships.

Medical.

Whitfield (1984), describes codependence as "a primary illness with a recognizable, diagnosable, and treatable range of symptoms and a chronic and progressive prognosis--just like chemical dependence" (p. 17). He writes about symptoms, course, etiology and treatment, using a medical model. He links codependence directly to living with an alcoholic, and is careful to explain that a person becomes codependent in response to the problems created by the drinking.

Social System.

Schaef (1986) suggests the most global perspective for explaining codependence. She describes codependence as "a disease that has many forms and expressions and that grows out of a disease process that is inherent in the system in which we live" (p. 21). She writes about an "addictive

process", which embraces chemical dependence, eating disorders, codependence, character disorders, and sexism. All of these serve as symptoms for sociological inequities and ills.

The Role of Shame

Shame is a unifying theme in all of the theoretical models proposed for codependence, including this research. Codependence and shame are linked in that both are a consequence of relating to significant others. Codependence is a manifestation of "breaking the interpersonal bridge" (Kaufman, 1980, p. 11) between the self and another. The result is shame, a feeling that one has been diminished in some fundamental sense.

Kaufman (1980; 1989) suggests that the seeds of shame, of feeling deficient, are sown in childhood. As a child matures within her family and larger culture, she internalizes beliefs and attitudes about herself. These messages have been sent by significant others in her interpersonal environments, and they form the core of her emerging identity. They are the blueprint of what it is to be a "Good Girl" in her family and the larger society. The unspoken agreement is that as long as she conforms to these expectations, she will be accepted and loved. As an adult, she will confront shaming situations whenever she feels she has been deficient in following her prescribed role.

For those who grapple with codependence, opportunities for shame abound. Intense needs for the control of self and others, denial of one's own needs while assuming responsibility for others', anxiety, and boundary distortions are common symptoms of codependence. A person who must always be in control, who is compelled to be selfless, and who anxiously vacillates between over-involvement and distancing in her relationships is shame-bound. If she cannot control herself and her relationships she feels deficient. If she cannot live up to her internalized image of what she believes is a "Good Girl", she feels shame.

Need for the Study

Creating a More Complete Model

All of the models cited show an appreciation for the dynamics of codependence. But none of them explain how codependence occurs, when it occurs, or the range of contributors to the disorder. None of them have demonstrated predictive validity. And no writer has stated decisively whether one comes already codependent to adult relationships or whether pathology in an adult relationship causes codependence.

A key question is whether a psychologically healthy person could be considered at risk for codependence. Some clinicians have sugested the possibility of employing a

vulnerability model. They have speculated that the roots of codependence develop in childhood and adolescence, but that the tree bears bitter fruit only in a pathological adult relationship. Clearly, such a model raises more questions than answers, and little can be claimed for it in the absence of systematic exploration of the phenomenon of codependence.

A Proposed Model for Codependence

Concerns with the limitations of prior models of codependence led the researcher to construct a model which was more inclusive. A more thorough discussion of the ecological and developmental bases of its construction appear in Chapter II. This model was based on the definition of codependence suggested by Friel (1988): that codependence is arrested identity development stemming from one's family of origin and culture. It is arrested identity development in that the developmental task of constructing an authentic, autonomous identity has not been undertaken. In this model, codependent adults remain prisoners of childhood rules, roles, and relational experiences from their families of origin and culture.

The model of codependence proposed here contains some general propositions which overarch its components and organization:

1. Codependence is a product of both intrapsychic and interpersonal dynamics.

2. A person may be influenced to be codependent by interactions at the individual, familial, cultural, and institutional level(s).

3. Codependence is a developmental process which begins in infancy and continues through the lifespan, mediated by potentiating and protective factors.

Rationale for an Etiological Perspective

This study was important because so little empirical work had been done in the area of codependence. The popular press had written extensively about it, and there was no dearth of self-help literature in bookstores, but very little empirical research had been conducted. A topic which had claimed the imagination and examination of so many interested parties deserved the attention of research. It was hoped that some of the controversy which surrounds the topic of codependence might be resolved as a consequence of careful study.

Etiology, the study of causes of problems, was chosen as a focus because of its primacy as a source of information. In particular, etiological models are useful in that they identify characteristics which are crucial for assessment, classification, treatment, and epidemiology. Clinicians tend to be responsive to information in all of these areas because it improves the quality of service to clients. Constructing an empirical base for the etiology of codependence would add to the clinical impressions which presently guide the

therapeutic community. Ultimately, the benefits of this research were directed toward clients who are codependent.

Purpose of the Study

Based on the model which the researcher constructed, this study attempted to recognize the contributions of psychodynamics, family systems, and sociological factors to the development of codependence. In particular, the childhood influences of attachment, family of origin mental health, gender, and religious and academic training were of interest. In an effort to recognize the possible contributions to codependence made by current circumstances, the study was also designed to include the degree of trust felt by a subject toward an intimate adult partner.

Assumptions

1. It was assumed that there is a psychological construct called codependence based on the attention given to the term by mental health professionals and the popular press.

2. It was assumed that there would be a reliable outcome, although there are few national norms on the Friel Co-Dependency Assessment Inventory due to the lack of empirical research on the instrument.

3. It was assumed that subjects would respond truthfully to the items in the questionnaire. There was a risk that

subjects might tend to respond in a socially desirable manner in order to present themselves and their relationships in a favorable light.

4. It was assumed that retrospective information gathered from subjects is considered valuable for research.

CHAPTER II

REVIEW OF LITERATURE AND CONCEPTUAL FRAMEWORKS

This chapter offers a review of the current research literature related to codependence. Following the review, a two-part section elucidates the conceptual frameworks which guided this study. The first part addresses the application of ecological theory to the research. In the second part, developmental psychopathology is defined, and the childhood predictor variables are discussed from that perspective.

Review of Literature

Wright and Wright (1990) studied the characteristics of a clinical sample of men and women whom they classified as codependent. As a definition for codependence, the Wrights used "involvement in a serious heterosexual relationship with an alcohol or drug-abusing partner." Characteristics studied included:

1. Level of stress in the relationship due to alcohol or drug use;

2. Level of stress in the relationship not directly related to alcohol or drug use, e.g., economic difficulties,

long separations, chronic or severe illness or disability, outside interference in the relationship;

3. Scores on the Friel Co-Dependency Assessment Inventory;

4. Relationship variables measured by the Acquaintance Description Form (ADFF); and

5. Variables hypothesized to be characteristic of codependents' personal relationships, e.g. control, worth dependency, and an exaggerated sense of responsibility.

The Wrights' results have implications for the present study in supporting the use of the FCAI and in finding gender differences. First, both codependent men and women had high scores on the FCAI, compared with subjects not classified as codependent. High scores were related in a negative way to solid, rewarding, and personally involving relationships. For codependent men, only two of the hypothesized characteristics, Control and Responsibility, were associated with being in a codependent relationship. For codependent women, Control, Responsibility, Worth Dependency, Rescue Orientation and Change Orientation were found to be significant.

A doctoral dissertation completed in 1990 by West-Willette was designed to assess the internal consistency of the FCAI. West-Willette chose to define the codependent females in her study as "subjects with a history of chemical dependency in either their spouse, significant others, or their parents." Using a sample of 596 Caucasian women, 274

of whom met her criteria for codependence and 322 of whom did not, West-Willette used a factor analysis of the FCAI to test her research hypotheses. She found that the dimensionality of the FCAI was very similar within the two samples, and that there were only subtle differences in the factor structure of the FCAI. Her conclusions were that there were more similarities than differences in the two samples in terms of the number of factors, the make-up of the factors, the strong test-retest reliability (assessed at the outset of the study using samples of 25 women and 5 men), and the high codependence scores of both groups of women. This supports the probability that codependence is a common problem for many women in this culture, regardless of their family's history of chemical dependency.

Scher's (1991) sample included 62 subjects, 93% of whom were female. Subjects were family members of persons attending a drug and alcohol treatment program, and county employees who were attending a workshop on the subject of codependence. Scher's purposes were: (a) to investigate the reliability of the FCAI, (b) to examine the relationship between family substance abuse and codependence, and (c) to compare codependence with depression and traditional sex-role identity. She tested for internal consistency using "a similar reliability check as that originally done by the test designer, Friel," and found that the FCAI is reliable. She also found that while family substance abuse was significantly related to codependence, a subject's personal

use or extended family abuse were unrelated to codependence. Subjects with high scores on the measure of codependence also tended to have high scores on the depression measure.

In Scher's study codependence was inversely correlated with masculine sex role stereotype, but bore no relationship with a feminine sex role stereotype. She suggests that the last set of findings could be explained in that sex role identity is on a continuum and codependence (nonaggressive stance) is at the opposite end from traditional masculinity (aggressive stance) but different from traditional femininity. It is also possible that the FCAI's apparent inverse relation to a traditional masculine sex role identity is an influence of the construction of the Personal Attributes Questionnaire (PAQ) (Spence & Helmreich, 1978), which was used to measure sex role identity in this research.

Scher's findings suggest that unhealthy family interactions, characterized in her study as substance abusing families, contribute to the development of codependence. She points out that Beck's (1979) tripod of depression (negative attitudes toward self, environment and future) speaks to intrapersonal and interpersonal concerns, and that these issues also figure in the construct of codependence.

Neary and Susarla completed three studies on codependence in the fall of 1991. Their first study questioned whether inpatient treatment for codependence was legitimate and justified. Based on data gathered from the medical records of 70 consecutive persons admitted to an inpatient

codependence treatment program, they found that the type and severity of symptoms (e.g. suicidal ideation, severe depression) offered solid substantiation of the need for hospitalization. That the admitted patients were indeed codependent was shown by high FCAI scores, high incidence of substance abuse, and fulfillment (by 88% of admitted patients) of at least four out of five of Cermak's criteria for Codependent Personality Disorder. In addition, identified pre-admission stressors typified problem areas for codependents. Pre-admission stressors included: (a) conflict or rejection within a continuing romantic relationship (51% of admissions); (b) unwanted termination of a romantic relationship (40%); (c) job trouble, stress, or termination (39%); and (d) victimization by sexual or physical abuse (31%).

In their second study (1991), Neary and Susarla compared the levels of codependence in 51 mental health professionals with those of 53 inpatient codependents using the FCAI. The mean score of the mental health professionals ($\underline{M}$ = 21.94) was considerably lower than the mean score of the inpatient codependents ($\underline{M}$ = 43.83). In addition, the mental health professionals obtained a mean score less than those (28.3; 29.35; and 22.37) obtained from three "normal" groups appearing elsewhere in the literature. This result contradicts the common belief that mental health workers are high in codependence.

In their third study (1991), Neary and Susarla offered further validation of the FCAI. First, they found concurrence between extremely high scores on the FCAI and: (a) the a priori identification of these persons by their psychiatrists as codependents, (b) Friel's classification of scores in this range as "moderate to severe", and (c) fulfillment (by 88% of the patients) of at least four out of five of Cermak's diagnostic criteria for Codependent Personality Disorder. Second, they found the FCAI was able to discriminate among "normals", outpatients, and inpatients, in that the FCAI scores of these groups differed in the expected direction. Third, they cross-validated the instrument by showing that separate samples of inpatient codependents from different hospitals yielded similarly high average scores.

The research of Neary and Susarla indicates the severity and scope of codependent concerns. High scores on the FCAI reflect significant dissatisfaction and disruption in the lives of their subjects. Their research also indicates that, for codependent persons, relationship conflict, relationship termination, and rejection from a partner can all be sufficiently traumatic to contribute to a host of self-destructive feelings and behaviors. Issues around identity, autonomy and boundaries tend to surface as an immature self deals with relationship loss. Such strong reactions in an adult relationship indicate the likelihood of antecedents in a person's developmental history, particularly with regard to

early experiences with primary caregivers.

O'Brien and Gaborit (1992) examined the relationships between codependence, chemical dependence of a significant other, and depression in a sample of 115 undergraduates. The Significant Others' Drug Use Survey determined whether a subject was in a relationship with someone at risk for chemical dependency. The researchers found codependence and chemical dependency to be independent. A significant correlation was observed between depression and having a chemically dependent significant other. The findings support the probability that codependence occurs not only in families in which substance abuse is a problem.

Fisher and Beer (1990) examined the relation between codependence and self-esteem with 21 female and 25 male high school students. They discovered that the girls tended to have higher codependence scores than boys, but there was no difference between the sexes on self-esteem. Self-esteem and codependence scores were negatively correlated. The data demonstrate the influence of gender, and the connections between codependence and feelings of self-worth.

Conceptual Models

An Ecological Perspective

Bubolz and Sontag (in press) suggest the need to consider the interaction of the natural physical-biological, social-

cultural and human-built environments as they influence individuals and family systems. In this study, the natural physical-biological environment was represented by the variable of gender. The social-cultural environment consisted of the perceived family health in a subject's family of origin, as well as the perceived degree of attachment between the subject and his/her primary childhood caregiver. Religious training was also considered a product of the social-cultural environment.

It is also significant to note the ways in which this study follows the guidelines established by Bronfenbrenner's process-person-context model, which assesses developmental processes and outcomes as a joint function of the person and the environment:

> 1) The design permits assessment not only of developmental outcomes but also of the effectiveness of the processes producing these outcomes. 2) The design reveals how both developmental outcomes and processes vary as a joint function of the characteristics of the person and of the environment, thus permitting the detection of synergistic effects. Stated more succinctly, the model identifies any differences in developmental processes and outcomes associated with different ecological niches. Ecological niches are particular regions in the environment that are especially favorable or unfavorable to the development of individuals with particular personal characteristics." (Bronfenbrenner, 1989, p. 199f.)

Consonant with Bronfenbrenner's suggestion that any study of human development include this triumvirate, the variables of gender, age and race are considered in this research.

Developmental Psychopathology

This research takes a developmental approach to the formation of codependence. Under the conceptual umbrella of developmental psychopathology, the influences of psychodynamic, family systems and sociological theories provide a framework for understanding this identity disturbance. Zigler (1986) states that developmental psychopathology provides a perspective of "the whole person" throughout development, including interrelationships of intrinsic and extrinsic factors over time. He refers to adaptive mechanisms by which individuals survive in their environments, and suggests that persons move back and forth between pathological and non-pathological behaviors as situations change. Sroufe and Rutter (1984) define developmental psychopathology as:

> the study of the origins and course of individual patterns of behavioral maladaptation, whatever the age of onset, whatever the causes, whatever the transformations in behavioral manifestation, and however complex the course of the developmental pattern may be. (p.18)

Within this "macroparadigm" of developmental psychopathology (Achenbach, 1990), theories of identity development, attachment, family systems, gender, and socio-cultural influences are interrelated in this study with respect to codependence.

Identity Development.

The construct of psychosocial identity is recognized as central to personality development as one constructs a mature self through childhood, adolescence and young adulthood. In this study, codependence is defined as arrested identity development. Erikson (1968) identified eight stages of psychosocial development, suggesting that identity consolidation should occur in adolescence or early adulthood. During consolidation, an individual experiences the final steps of what Erikson called an "identity crisis" (1956; 1959; 1963). Throughout adolescence, an individual experiments with new ideas and behaviors, rejecting those which don't match a developing sense of self. The resolution of this quest for identity is an acceptance of one's individuality. Erikson felt that the next stage, intimacy, was not possible unless a person had come to both self-knowledge and self-acceptance. He believed that in order to risk intimacy with another person, one had to have a strong sense of self.

Building on Erikson's work, Marcia (1980) provided an Eriksonian definition of identity:

> I would like to propose another way of construing identity: as a self-structure--an internal self-constructed, dynamic organization of drives, abilities, beliefs, and individual history. The better developed this structure is, the more aware individuals appear to be of their own uniqueness and similarity to others and of their own strengths and weaknesses in making their way in the world. The less developed this structure is, the more confused

> individuals seem to be about their own distinctiveness from others and the more they have to rely on external sources to evaluate themselves. (p.159)

Marcia (1966) had developed a classification for different levels of progress toward consolidation. These levels included:

Foreclosure: Individuals who have never experienced an identity crisis, and have not struggled with ideological or occupational choices. This is a "pseudo-identity" which is based more on the choices made by one's parents, rather than through autonomous self-assessment.

Identity Diffusion: Individuals who have not made ideological commitments or decided on an occupation. If they experienced an identity crisis, they were not able to resolve it.

Moratorium: Individuals who are experimenting with life choices, but have made no definite commitments. They are in the middle of an identity crisis.

Identity Achievement: Individuals who have made their own conscious decisions concerning ideology and occupation. They feel these choices were made autonomously, and that they reflect their true self.

An individual who has not had an opportunity to develop a true self has instead constructed a "false self" throughout childhood and adolescence (Winnicott, 1953; 1960). This is a kind of role reversal in which the child's task is to reconfirm the parent's values or point of view, becoming an extension of the parent rather than a differentiated self.

Functioning as the predominant structure of the parent-child bond, this defensive adaptation to parental needs on the part of the child results in a split self, a "collection of reactions" (Winnicott, 1975, p. 296). As a person matures, it becomes impossible for them to identify what constitutes the "person who is me, who is only me" (1975, p. xxix).

Many of the symptoms of codependence reflect a lack of identity consolidation. Problems with autonomy and intimacy, difficulty establishing functional boundaries, and poor differentiation from one's family of origin are common diagnostic criteria for codependence. These concerns reinforce the likelihood that codependent individuals have not successfully negotiated the task of identity formation and are stuck in foreclosure (Friel, 1985). Friel's view supports the position that codependence can be explained as arrested identity development.

Attachment.

Human infants depend for survival upon their adult caregivers. In these early dyadic relationships bonds are formed and attachment systems (Bowlby, 1980;1985;1988) develop. Attachment behaviors, which are maintained throughout life, are described as "any form of behavior that results in a person obtaining or maintaining proximity to some other clearly identified individual who is conceived as better able to cope with the world." (1988, p.27).

Attachment theory suggests that the origins of the self, including identity, affective experience, and patterns of relationship, begin with the earliest child-caregiver relationships. In these relationships, children develop core beliefs about themselves and about relationship patterns which persist as templates for future relationships.

Several writers (Bowlby 1973; Bretherton 1980, 1985; Main et al. 1985) refer to these templates of relational expectations as internal "working models." Bowlby states that these models, once developed, operate at an unconscious level and resist dramatic changes (1980). Changes which do occur are tied to cognitive development, with changing concrete experiences altering models for children, and formal operations serving as the vehicle for change in adolescence and adulthood. Sophisticated thought processes and psychotherapy have been cited as ways in which adults alter their internal working models (Bowlby 1988a; Egeland et al. 1988; Guidano & Liotti 1983; Hunter & Kilstrom 1979; Main & Goldwyn 1984; Main et al. 1985).

Attachment theory has its origins with the neo-Freudians (Fromm 1947; Horney 1937; and Sullivan 1953), and later with the British School of Object Theorists (Fairbairn 1981; Guntrip 1969; Winnicott 1953, 1960). Most recently, Kohut (1971) and other self-psychologists have also emphasized the importance of core relationships to individual development. These theorists describe the belief systems a person develops about self and others in response to early interactions with

care-giving figures. These beliefs are persistent, often unconscious, and serve to organize one's perceptions about relationships. Through the processes of introjection and identification, the fundamental structure of the self is formed. If early relationships are unhealthy, the "bad" parts split off from the psychic core and the self is fragmented. This "splitting" prevents further growth and individuation, leaving an individual stuck in pathological patterns of interactional behavior.

Sroufe and Fleeson (1986) concur that early relationships strongly influence personality formation. They suggest that this "organization of attitudes, feelings, expectations, and behaviors of the individual across contexts" (p.51) is rooted in an individual's earliest dyadic relationships. They also posit that persons select relationships beyond childhood which confirm their expectations and feel familiar, even when those relationships are painful (Sroufe & Fleeson,1988). Epstein and Erskine (1983) agree that social, emotional and personality development are a consequence of early social relations.

Hazan and Shaver (1987) expanded Bowlby's working models to examine how adult love is related to attachment styles by converting the typology of Ainsworth et al. (1978) into adult forms. They found that the frequencies of attachment styles in adulthood parallel those of infancy and that a person's adult style of love is related to their attachment style. Collins and Read (1990) found similar results when examining

the relationship between adult attachment style and the quality of adult relationships. Additionally, they discovered three dimensions which underlie attachment styles: comfort with closeness, seeing other people as available, and anxiety about being unloved.

Within the context of attachment theory, it is easy to understand why adults finds themselves attracted to some people, but not to others. At an unconscious level, the person is attempting to create what is familiar, what is known, by choosing someone who will replicate early dyadic relationships. The person's working model provides a constellation of characteristics with which to select a partner and construct a relationship. Consequently, persons whose early relationships with caregivers were unhealthy may tend to choose partners who cooperate in creating unhealthy adult relationships. This would explain the codependent pattern of choosing one dysfunctional partner after another.

Another common codependent issue is ambivalence concerning intimacy, or even rejecting it altogether out of a fear of object loss. Those who are codependent may be anxious and/or depressed if they feel unable to control their partner and the relationship. Control becomes a promise of psychological safety, for in the infant-caregiver dyad it meant physical survival. As an adult, that translates into psychological survival, often at great cost to the self.

Family Systems.

Every system has both structural and functional characteristics. In a family, the individual members make up the structure of the system. Other structural characteristics include boundaries and relationships among members. Another characteristic of families is the tension between morphostasis (structure maintenance) and morphogenesis (structure change). Boundaries must be flexible enough to allow for some interactions while preventing others. Rigid boundaries tend to produce emotional distance and detachment in families; weak boundaries often produce a blurring of adult/child roles (Minuchin, 1974).

Families also serve several functions. Maintenance functions meet basic needs for food, clothing and shelter. In healthy families maintenance functions also provide safety, warmth and nurturance to all members. Optimal functioning in families allows for flexibility around family roles and rules (Satir, 1964). In constrast, rigid role assignment (Wegscheider, 1981) and proscribed, restrictive rules about affective expression, communication, and trust characterize dysfunctional families (Black, 1981). Additionally, well-functioning families provide opportunities for autonomy and differentiation, so that individuals can explore their own ways of constructing their lives. If separation is disallowed, individual needs for growth are

smothered and development is hindered (Bowen, 1978).

Systems theory suggests that ongoing circular feedback processes continually shape family functioning. Subtle feedback loops reinforce the expression of certain behaviors and decrease the expression of others within a family (Dell, 1982). These interactional patterns of relationship and behavior encourage movement toward homeostasis, which is a form of internal stability (Watzlawick et al., 1974). In an unhealthy family, homeostasis results in a tightly controlled and narrow system which disallows a range of feeling and behavior.

It seems reasonable that people who suffer from codependence grew up in families with a variety of problems. All of the problems mentioned in the paragraphs above contribute to the development of an unhealthy sense of what families are and how their members interact. When children from dysfunctional families grow up and attempt to create families of their own, they find that behavior that was once adaptive for them no longer works. They begin to exhibit the symptoms of codependence in response to their confusion and pain. Locked into old, dysfunctional patterns from their families of origin, they are unable to choose a new life for themselves.

Gender

The influences of gender in relationships are discussed by several theorists. Miller (1976, 1984) raised the "self-in-relation" to others theme and suggested that women express more envy, vulnerability, self-directed hostility, weakness and helplessness than do men. The differential, in her theory, occurs because women occupy a subordinate position which requires them to please and accommodate men and to serve as conduits for emotions which men find ego-alien.

The idea of connectedness with others is also a theme for Gilligan (1982), who explains moral development in women as based on responsibility to others, as contrasted with a male emphasis on rights. If these authors are correct, women in our culture are socialized to be the emotional carriers of relationships, based on caretaking, from a "one-down" position.

According to Lewis (1983) and Chodorow (1978, 1989), attachment differs for men and women, producing different emotional experiences. Lewis argues that attachment is critical, and that the threat of loss of attachment in women results in the emotions of shame and/or guilt, in an effort to restore the attachment. According to Chodorow's argument, the sex of the primary caregiver determines the future emotional orientation of the children. Because the caregiver is usually female, girls identify with her and feel a strong sense of connection with others. On the other hand, boys

must clearly separate from the female caregiver in order to form a masculine sexual identity, producing repression of affective and relational issues. As adults, women tend to report discomfort with separation and individuation, while men often acknowledge feeling smothered by intense personal relationships.

Observational data collected on child and parent behavior within the realm of approval-seeking was published by Allaman et al. in 1972. This longitudinal study examined the relationship between maternal warmth, control, and encouragement in the early years of a child's life and the child's need-for-approval in later years. For males, deficits in maternal warmth show up in a higher need for approval by age six. From ages six to twelve, males in this group demonstrated approval dependence; after age 12 the effect disappeared. For females, there is a "sleeper effect" in that approval dependence tends to appear not at school age, but somewhere between age 12 and early adulthood. At a developmental stage when individuation is supposed to be occurring, females whose mothers have been cold are most vulnerable to the approval of others. One wonders how this need for validation must effect the developing self within the context of social relations.

A codependent female is a "Good Girl" grown up. According to Symonds, "'Good Girl' behavior is socially approved behavior. A good girl is conforming, compliant, deliberately avoids confrontations and focuses on pleasing

other people" (Interviewed in Gornick, 1989) If one is constantly reinforced to be a Good Girl, there is little room for identity development outside the parameters of taking care of others' needs. Genuine feelings, especially if they are not "nice", e.g. anger or disappointment, are suppressed in an attempt to maintain a smooth facade in personal relationships. The codependent Good Girl is constantly vigilant for signs of approval or disapproval, and has a strong need to control her own behavior and that of others in order to feel psychologically safe.

Religion as a Social-Cultural Influence.

Schaef (1986) is critical of religious institutions which encourage compliance, self-sacrifice, and the suppression of honest feelings. Those who preach that the self is evil, and that one should not think about the self or one's needs hinder development. The "good Christian" who is always "sweet, caring, even-tempered, never angry, and always long-suffering" (p.72) does not represent an ideal of mental health, according to Schaef. She suggests that the churches promote affective and relational dishonesty and shame those who do not conform to their rules.

This study questions whether childhood religious training is related to codependence, which is defined as arrested identity development. The focus on childhood is intentional, in the belief that religious training in the early years

contributes to a developing sense of self. Whether those contributions are carried intact into adulthood, or whether they are modified through experience and increasing cognitive sophistication, there is little question that they influence personality development. The following studies focus specifically on the relationship between religion, identity construction, and mental health.

Research conducted by McClain (1979) demonstrated a connection between autonomy and an intrinsic religious orientation in a sample of 174 female fourth and fifth year university students. Those who scored significantly higher on seven autonomy scales also had lower scores on the Religious Orientation Inventory (ROI) (Allport & Ross, 1967). The study concludes that women who report being less influenced by religion are more inclined to think and act independently, and to pursue private goals.

In 1980, Wiebe and Fleck published a study in which personality profiles of 158 male and female university freshmen were compared across religious orientation and religious affiliation. In the terms of their study, an intrinsic religious orientation reflects "a more committed religious stance" than an extrinsic orientation. Using the ROI (Allport, 1967) and the Sixteen Personality Factor Questionnaire (Cattell, 1970), the investigators found that nonreligious subjects "indicated the least trend towards neurosis ($r = -.77$)" (p. 185). Intrinsically religious Protestants tended to be moderately neurotic (.50), and

intrinsically religious Catholics tended to be strongly neurotic (.93). Extrinsically oriented Protestants demonstrated low neurotic tendencies (-.34), and extrinsically oriented Catholics demonstrated somewhat higher levels of neurosis (.23). These correlations suggest that a religious orientation contributes to neurotic tendencies, and that one's religious affiliation affects the level of neurosis.

In 1991, Richards conducted research with 268 undergraduate student subjects. His objective was to examine the relation between religious orientation and mental health. Richards found no significant differences between intrinsically oriented subjects, extrinsically oriented subjects, and a group he called "nontraditionally religious" subjects (those uncommitted to traditional religion) with regard to depression, shame and existential well-being. However, intrinsic subjects did tend to score higher on guilt proneness and lower on functional, attitudinal, and emotional separation from parents. If guilt proneness becomes too extreme, it could contribute to depression and other emotional problems (Lewis, 1971; Prosen, Clark, Harrow & Fawcett, 1983). Dependency and a lack of differentiation could also lead to emotional disturbances as a person attempts to construct an autonomous identity (Hoffman, 1984).

Steketee et al. (1991) examined the relationships among the type and severity of obsessive-compulsive symptoms, types of religious practice and upbringing, degree of religiosity,

and guilt. Subjects were 33 outpatients with obsessive-compulsive disorder (OCD) and 24 patients with other anxiety disorders. The investigators found that the severity of OCD pathology was positively correlated with both religiosity and guilt, but not religious denomination or type. Greater religious devotion was also positively correlated with guilt in OCD subjects but not in subjects with other anxiety disorders.

The research summarized in the preceding paragraphs supports the possibility that religion is linked with codependence. Women who described themselves as more religious were less autonomous in their behaviors and goal orientation. Young adults of both sexes were found to be more neurotic if they described themselves as intrinsically religious, compared with those who were nonreligious. This was especially true if they were raised in the Catholic faith. A religious orientation was linked with guilt and difficulty with differentiation from one's family of origin, and religiosity positively correlated with guilt in people with compulsive disorders. Since codependence is defined in this study as arrested identity development, evidence that religion hinders differentiation and the development of an autonomous stance seems noteworthy. The association between religiosity, denomination and neuroticism further supports the exploration of religion, especially Catholicism, as a contributor to codependence. Guilt, religion, and compulsivity are also potentially linked with codependence.

Those who suffer from codependence frequently engage in compulsive behaviors and are prone to feelings of guilt and shame.

Summary

The research conducted prior to this study suggests that codependence is related to gender (Fisher & Beer, 1991; West-Willette, 1990; Wright & Wright, 1989;). There is also support for the influences of family of origin experiences (Scher, 1991). Attachment, as it was manifested in adult intimate relationships, is seen as important by Neary and Susarla (1991). Religion, although not directly related to codependence in previous studies, has demonstrated significance as an influence on mental health and identity formation (McClain, 1979; Richards, 1991; Steketee, 1991; Wiebe & Fleck, 1980).

This study is unique in that it attempts to measure family of origin relationships and processes retrospectively and link them to codependence. It also differs from previous studies in that it includes the variable of religion as a possible predictor of codependence. The use of adults over the age of 25 as subjects distinguishes this study of codependence from those which relied on adolescents or undergraduates. And the inclusion of normal subjects separates this study from those which used only clinical samples without comparison groups.

Identity formation, attachment, family systems, gender, and religious training have been examined by scholars from different disciplines and perspectives. In this study, elements from each of these areas are woven into a possible explanation for the development of codependence. In doing so, the hope was that the data would create a model for clinicians to consider when treating codependent clients.

CHAPTER III

METHODOLOGY

This chapter describes the methods used to address the questions posed by the study. The chapter is divided into the following sections: subjects; research questions; hypotheses; design; instrumentation; data collection; and data analysis.

Subjects

The subjects of this study included 41 residents of Michigan and Illinois who were at least 25 years of age. Women made up 90% of the total sample. Approximately half of the sample (54%) was drawn from employees of a public utility company. The company was chosen as a data collection site for two reasons. First, the employees seemed to represent a broad cross-section of the adult population in terms of demographic characteristics. Second, many of the employees were male, creating the possibility that males might be well-represented in the sample.

The other half (46%) were patients who were being treated for codependence in hospital-based programs or by private

clinicians. One hospital provided subjects from its inpatient and outpatient programs; three private therapists provided clients who were willing to be subjects. The primary diagnosis for all of the clinical subjects was codependence, although comorbidity with other disorders was also a possibility for some subjects.

Table 1 summarizes some of the demographic and background characteristics of the total sample, as well as the clinical and normal subsamples. The next section is devoted to a discussion of the general characteristics of the overall sample.

The mean age of the 41 subjects sampled was 38.7 years. The range spanned 38 years, with the youngest subject at 25 years and the oldest at 63 years. The racial/ethnic distribution was 85% White, 10% African-American and 5% Hispanic. Approximately half of the subjects (51%) reported Protestant childhood religious training. Of the remaining half, 34% were Catholic, 2% were Jewish, 2% were Fundamentalist Christian, 2% were Other (Greek Orthodox was specified by a subject), and 9% reported no childhood religious training.

In terms of education, 5% indicated that they had completed less than 12 years of school, 20% had completed high school, 41% had some college or trade school experience, 24% had an undergraduate degree, 2% had done graduate work at the college level, and 8% had earned Master's or other graduate degrees. Public schools were a source of education

for 63% of subjects; parochial schools were attended by 37% of subjects.

Almost half of the sample was married (44%). Of the remaining subjects, 22% were single, 27% had divorced, and 7% said they were cohabiting. None had been widowed. Subjects reported being moderately satisfied with their current partner (3.6), friendships (3.8), and work situation (3.5) using a 5-point Likert scale.

In their families of origin, a significant number of subjects had been either the oldest or youngest child (73%), or the oldest or only of child of their sex (66%). Many had experienced family substance abuse (49% immediate family; 58% extended family) as a child.

The notable differences between subsamples were in the areas of childhood religion, educational source, marital status, and family history of substance abuse. Most subjects from the normal subsample were raised as Protestants (73%), while most from the clinical subsample reported a Catholic rearing (63%). As might be expected, 86% of normal subjects attended public schools as children and adolescents; 63% of clinical subjects attended parochial schools for at least part of their education. A majority of normal subjects were married (68%), and a total of 27% were either single or divorced. This contrasted with clinical subjects, only 16% of whom were married, and 73% of whom were single or divorced. In the area of family substance abuse, a moderate number of normal subjects reported immediate (32%) or

Table 1

Sample Characteristics

Demographic Variables		Overall Sample (n = 41)	Normal Subsample (n = 22)	Clinical Subsample (n = 19)
Age	Mean	38.7	39.4	37.8
	SD	8.7	8.4	9.3
Racial/Ethnic:				
% African-American		10	18	0
% Hispanic		5	5	5
% White		85	77	95
Childhood religion				
% Protestant		51	73	26
% Fundamentalist		2	5	0
% Catholic		34	9	63
% Jewish		2	0	5
% Other/None		11	13	6
Educational level				
% Less than 12 yrs		5	0	11
% High school grad		20	32	5
% Some higher		41	37	41
% Received B.A.		24	14	37
% Some grad study		2	5	0
% Advanced degree		8	12	6
Educational source				
% Public schools		63	86	37
% Some parochial		37	14	63
Marital Status				
% Married		44	68	16
% Single		22	9	37
% Cohabiting		7	5	11
% Divorced		27	18	36
Satisfied (1-5 scale)				
with partner		3.6	3.9	3.3
with friendships		3.8	4.0	3.5
with work		3.5	3.9	3.2
%Oldest/Youngest Child		73	64	84
%Oldest Girl or Boy		66	64	68
%Positive history of alcoholism in				
immediate family		49	32	68
extended family		58	43	74

extended (43%) family substance abuse. Clinical subjects indicated that 68% had experienced immediate family substance abuse, and 74% had experienced extended family substance abuse. Smaller differences between the subsamples existed in other background characteristics.

Research Questions

Because of the developmental approach taken toward codependence in this study, two research questions were asked:

1. What are the primary childhood factors which contribute to the development of codependence in a person?

2. Does an adult's relationship with a partner affect his or her present degree of codependence?

Hypotheses

From the stated research questions eight related hypotheses were generated:

H1. There is a positive relationship between the degree of codependence and perceived caregiver rejection in the family of origin.

H2. There is a negative relationship between the degree of codependence and perceived family of origin mental health.

H3. There is a positive relationship between the degree of codependence and childhood religious training as a

Catholic or Fundamentalist Christian.

H4. There is a positive relationship between the degree of codependence and being female.

H5. There is a positive relationship between the degree of codependence and family of origin birth order (first or last born child in a family).

H6. There is a positive relationship between the degree of codependence and an immediate family history of substance abuse.

H7. There is a positive relationship between the degree of codependence and an extended family history of substance abuse.

H8. There is a negative relationship between the degree of codependence and the degree of trust in an adult partner.

Conceptual and Operational Definitions of Variables

The following section provides definitions of the major variables used in this study. Operational definitions follow the conceptual definitions.

CODEPENDENCE: Conceptually this was defined as arrested identity development. It results in an over-focus on others and an under-focus on the self. Operationally, a subject's level of codependence was measured by their score on the Friel Co-Dependency Assessment Inventory (Friel, 1985). Certain post hoc analyses used an abbreviated version of the FCAI, referred to as the FCAI-REV. (See Appendix B; FCAI is

listed as "Part 1: Current Life" of the questionnaire given to subjects.)

ATTACHMENT: This was defined as the relationship, beginning in infancy, between a child and its care-giving or parental figures. The purposes of the attachment system are to provide protection and a sense of "felt security" for the child. In this study, attachment and caregiver acceptance or rejection were conceptually linked. Operationally, the level of rejection between a subject and her childhood primary attachment figure was measured retrospectively using the Adult form of the Parental Acceptance-Rejection Questionnaire (Rohner, 1980). The composite score was used. (See Appendix B; PARQ is listed as "Part 4: Mother/Caregiver" of the questionnaire.)

PERCEIVED FAMILY HEALTH: Conceptually, this was defined as perceived levels of autonomy and intimacy within the subject's family of origin. Operationally, the level of perceived family health was measured retrospectively using the Family of Origin Scale (Hovestadt et al., 1985). In this study, Gavin and Wamboldt's (1992) condensed version of the FOS was given to subjects. (See Appendix B; FOS is listed as "Part 3: Family of Origin" of the questionnaire.)

GENDER: Whether the subject was male or female was coded from the demographic data gathered on the survey. (See Appendix B.)

RELIGIOUS TRAINING: Conceptually, this was defined as formal, organized religious instruction which begins in

childhood before age 10. Operationally, this information was gathered from the demographic survey. Subjects were asked to identify childhood religious affiliation and attendance at parochial schools using discrete categories. (See Appendix B.)

TRUST: Conceptually, this was defined as a subject's feelings of trust toward her current, or most recent, intimate partner. Operationally, this variable was represented by a Trust Scale (Rempel et al. 1985, listed as "Part 2: Feelings About Partner" of the questionnaire given to subjects. (See Appendix B.)

BIRTH ORDER: Conceptually, this was defined as whether a subject was the first or last born child in her family of origin. Operationally, this variable was represented by a question contained within the demographic survey. (See Appendix B.)

FAMILY HISTORY OF SUBSTANCE ABUSE: Conceptually, this was explained as being related to immediate or extended family members who have had problems with alcohol/chemical dependency or abuse. Operationally, these variables were represented by two questions in the demographic survey. (See Appendix B.)

Research Design

This exploratory study employed a non-experimental survey research design. It was cross-sectional and identified the

individual adult as the unit of analysis. Self-administered questionnaires were completed by volunteer subjects who returned them by mail to the researcher. Questionnaires were received during a two month period from November, 1992 to January, 1993.

Instrumentation

A five-part questionnaire was given to the subjects in this study. The first four parts included the Friel Co-Dependency Assessment Inventory, the Trust Scale, the brief form of the Family-of-Origin Scale, and the Adult form of the Parental Acceptance-Rejection Questionnaire. In addition, to elicit background information about participants, a demographic survey was designed by the researcher. (See Appendix B for the full questionnaire.)

The dependent variable, a subject's degree of codependence, was measured using the Friel Co-Dependency Assessment Inventory (Friel, 1985). The FCAI is a 60-item True-False inventory which covers several areas of codependent concerns: 1) self-care, 2) self-criticism, 3) secrets, 4) "stuckness", 5) boundary issues, 6) family of origin, 7) feelings identification, 8) intimacy, 9) physical health, 10) autonomy, 11) over-responsibility/burnout, and 12) identity. Sample items include: "When someone I love is bothering me, I have no problem telling them so," and "I am very comfortable letting others into my life and revealing

'the real me' to them."

According to Friel,"the inventory was designed as a research tool and clinical instrument for measuring co-dependency as we have conceptualized it. Initial reliability figures for the total scale using KR-20 were in the range of 0.83 to 0.85 on fairly homogeneous samples with somewhat restricted range." The average scores found for "significant others who are in family programs in chemical dependency treatment are in the neighborhood of 30-35." Higher scores indicate greater problems with codependent concerns. (Direct quotations are from a personal communication, September, 1992.)

Support for the reliability of the FCAI comes from West-Willette (1990) and Scher (1991), both of whom have conducted research on codependence using the FCAI. Wright and Wright's (1989) research demonstrated that the FCAI clearly distinguishes between control and experimental samples in their clinical study. Further validation of the FCAI was presented by Neary (1991). Neary found that the FCAI differentiated levels of codependence, distinguishing among "normals", outpatient codependents and inpatient codependents. Studying inpatient admissions (1991), Neary also found evidence of concurrent validity for the FCAI. This was indicated by the concurrence between the extremely high scores on this assessment instrument ($\underline{M}$ = 43.22) and: (a) the a priori identification of these persons by their psychiatrists as codependents needing intense, inpatient

treatment; (b) Friel's representation of these patients' average score as "moderate to severe;" (c) fulfillment by 88% of the patients of at least four out of five of Cermak's (1986) criteria for Codependent Personality Disorder. (The percentage of 88 is used from an overall sample of 70 patients because the 36 patients who took the FCAI were dispersed throughout the overall sample of 70.) Cross-validation of the instrument was obtained through comparison of samples of inpatient codependents taken from two different hospitals. The two samples yielded similarly high average scores ($\underline{M}_1$ = 43.22 and $\underline{M}_2$ = 45.12).

The FCAI was selected for two reasons. First, of the two instruments available to measure codependence, it has been more widely used by researchers and clinicians. Its psychometric characteristics have been more carefully examined and compared with the other instrument. Second, the FCAI is conceptually closer to the definition of codependence used in this study.

The independent variable of attachment was measured with the Adult form of the Parental Acceptance-Rejection Questionnaire (Rohner, 1980). The PARQ is a 60-item self-report instrument constructed to measure individuals' perceptions of parental acceptance and rejection (i.e., the warmth dimension). The instrument assesses adult subjects perceptions of how their primary caregiver treated them between the ages of seven through twelve years of age. Most of the items refer to caregiver behavior, rather than

attitudes, since attitudes are more difficult to measure accurately. The PARQ is comprised of four scales which measure parental acceptance/rejection: (a) Warmth/Affection (20 items), (b) Aggression/Hostility (15 items), (c) Neglect or Indifference (15 items), and (d) Rejection (Undifferentiated) (10 items). Questionnaire items include statements such as "talked to me in a warm and affectionate way," "got angry at me easily," and "made me feel wanted and needed." A 4-point Likert format is employed with possible scores ranging from 60-240 for the composite total. Higher scores on the total scale indicate more rejection from the caregiver.

Reliability data were gathered from a sample of 147 male and female undergraduates. Cronbach's alpha for the four scales ranged from .86 to .95. A second sample of students demonstrated a range from .83 to .96. Interscale correlations are high and statistically significant (range is from -.43 to .89), which indicates that the scales are assessing the same construct of parental acceptance-rejection. The Warmth/Affection scale is negatively correlated with the Rejection (-.43), Neglect/Indifference (-.71), and Aggression/Hostility (-.45) scales, as one would expect.

A significant amount of validity data is available. Some of the studies will be cited here.

Concurrent and convergent: Significant correlations are reported between the PARQ-Adult Warmth/Affection scale,

Neglect/Indifference scale, and Rejection scale and the Child Report of Parent Behavior Inventory (CRPBI) (Schaefer, 1964) scales of Acceptance (r=.90), Hostile Detachment (r=.86), and Rejection (r=.81). The PARQ Aggression/Hostility scale was positively correlated (r=.81) with the Physical Punishment Scale of the Bronfenbrenner Parent Behavior Questionnaire (Siegelman, 1965).

Discriminant: The Neglect/Indifference and Warmth/ Affection scales correlate more significantly with the scales cited above than with other PARQ scales. Correlations between the Aggression/Hostility and Rejection scales and their validation scales are the same as the interscale correlations and noncriterion scales. Factor analysis of PARQ items showed two factors which relate to parental-acceptance. The first factor consisted of items from the Aggression/ Hostility, Neglect/Indifference, and Rejection scales, and denoted rejection. The second factor consisted of items from the Warmth/Affection scale and demonstrated acceptance.

The instrument was selected because of its sound research record, and because it offers a retrospective look at a subject's child-rearing. Although the PARQ was not created as a measure of attachment, it does provide information about a person's developmental history. Considering the conceptual framework employed by the current study, it seemed useful to examine subjects' earliest, significant, dyadic relationships.

Belsky and Isabella (1988) used the PARQ-Adult as a

measure of maternal characteristics, and addressed the concern of perceptions versus objective reality with regard to memories of one's childhood. They suggest that "it is also worth noting that from a functional standpoint, the absolute accuracy of these retrospective reports may be less important than their perceived accuracy because a mother's sense of how she was treated while growing up may be developmentally more influential than how she actually was reared by her parents" (p. 61). Since the approach of this study is developmental, the internalized perceptions captured by the PARQ seem to be particularly valuable.

A second independent variable, a subject's perception of her family of origin mental health, was measured by the Family-of-Origin Scale. The FOS is a 40-item self-report questionnaire developed by Hovestadt, Anderson, Piercy, Cochran, and Fine (1985). The FOS measures perceived family health, defined as perceived levels of autonomy and intimacy (combined), within one's family of origin. Twenty items provide a measure of autonomy (four items addressing each of five constructs). The other twenty items provide a measure of intimacy (four items addressing each of five constructs). A 5-point Likert format is employed with possible scores ranging from 40-200. According to the authors, scores are broken down as follows: scores of 40-134, 135-159, 160-200 indicate low, medium, and high levels of family health, respectively.

The perceived level of autonomy has five constructs:

(a) clear expression of thoughts and feelings, (b) individual members' acceptance of responsibility for their own behavior, (c) respect for family members' right to self-expression, (d) openness and receptivity among family members, and (e) acceptance of separation and loss issues. The perceived level of intimacy also has five constructs: (a) open expression of a wide range of feelings, (b) maintenance of a warm, positive atmosphere, (c) resolution of conflict with minimal accompanying stress, (d) sensitivity to others' needs and feelings, and (e) seeing the essential goodness in human nature.

In a study of 63 premarital couples conducted by Gavin and Wamboldt (1992), an abbreviated 12-item form of the FOS was used as an overall measure of family of origin health. A sample of items from the scale included "the atmosphere in my family usually was unpleasant,""in my family, I felt that I could talk things out and settle conflicts," and "the members of my family were not very receptive to one another's views." The abbreviated FOS is derived from factor analytic and correlational analyses which showed that "the FOS contains one robust construct that can be measured easily with a subset of items from the larger questionnaire" (pg. 183). Hovestadt (personal communication, September 10, 1992) concurs with Gavin and Wamboldt's conclusion that the short form of the FOS is as useful as the original, longer version. He also recommends using only the combined score as a measure of family health, ignoring the individual measures and

constructs.

Use of the brief form would create a range of scores from 12-60, with higher scores indicating better family of origin mental health. Per Gavin and Wamboldt the brief scale possesses acceptable demonstrated internal consistency (Cronbach's alpha =.94). This short form of the FOS also demonstrated good validity, according to their research.

Convergent validity: Comparisons of the brief FOS with the Family Relationships Index from the Family Environment Scale (Holahan and Moos, 1983) showed a correlation of .72, $p<.001$. When correlated with Bengston and Schrader's (1982) multiple measures of Affectional and Associational Solidarity between parents and their adult children, the results ranged from .41 to .68, $p<.001$.

Discriminant validity: The FOS was related to instruments that measure related but conceptually distinct constructs in order to establish discriminant validity. The brief FOS was compared with the Organizational and Control subscales of the Family Environment Scale (Moos and Moos, 1986) and the Dyadic Adjustment Scale (Spanier, 1976), which reports each subject's satisfaction with his/her current premarital relationship. The Organizational subscale was found to be unrelated to the FOS (.15), as was the Control subscale (-.18). There was also no significant relationship between scores on the Dyadic Adjustment Scale and the FOS (.19). This means that subjects' perceptions of their families of origin were not significantly related to their level of

satisfaction with their current premarital partners.

Criticism of the complete FOS, and rebuttals, have surfaced in the Journal of Marital and Family Therapy. Lee, Gordon, and O'Dell (1989) state that the FOS is not useful because it has only one good subscale and "delivers little information." They concluded that the FOS "has little value as a research instrument" (pg. 19). Mazer et al. (1990) responded with the critique that Lee et al. had worked from an inadequate sample, and conducted their own factor analysis with much larger samples. Their conclusion was that the FOS is a useful scale. They claim that "since the FOS has been shown to differentiate among clinical populations such as addicts, children of alcoholics, the mentally ill, and the incarcerated, implications for the utility of the FOS in applied research are apparent" (pg.426). Their opinion is shared by Gavin and Wamboldt, although they suggest that the FOS be used to measure "an intrapsychic construct . . . rather than a systemic construct" (pg.187).

As in the case of the PARQ-Adult Scale, the Family-of-Origin Scale was chosen because of its retrospective look at one's family of origin. There are those who would argue that observational data collected by a disinterested third party would be more likely to represent actual family process. While acknowledging that an "outsider's" view of a family may be different than an "insider's" (Olson, 1977), one can be argue that both perspectives are valid. Whether subjects' perceptions of their families of origin reflect an objective

reality is not the issue in this study. What matters are the intrapsychic constructs which subjects have formulated about relationships as a consequence of their family of origin experiences. These constructs are the subjects' reference points for future interactions with others.

As a measure of the independent variable, a subject's level of trust in a current partner, the Trust Scale was used in this research. This refined version of the Trust Scale is a 17-item self-report questionnaire developed by Rempel, Holmes, and Zanna (1985). It was designed to measure levels of trust within close interpersonal relationships. Items are divided into three components of trust: predictability, dependability, and faith. Predictability is one's perceived ability to predict a partner's behavior. Dependability is the extent to which one feels a partner can be relied on when needed. Faith measures the belief that a partner will continue to be responsive to one's needs and caring, overall. Questionnaire statements include "though times may change and the future is uncertain, I know my partner will always be ready and willing to offer me strength and support," and "when I share my problems with a partner, I know he/she will respond in a loving way even before I say anything." A 5-point Likert format is used with possible scores ranging from 17-85. Scores have been found to correlate significantly with the Rubin Love Scale (Rubin, 1973), which is a measure of love and happiness in a romantic relationship. Faith, as a subscale, was most strongly

correlated with love ($r = .46$, $p < .001$) in the Rempel et al. study.

The overall Cronbach alpha for the trust scale was .81, with subscale reliabilities of .80, .72, and .70 for the faith, dependability, and predictability subscales, respectively. The three subscales were moderately correlated, with "r's" ranging from .27 to .46.

Collins and Read (1990) used the Trust Scale to examine the relationships between adult attachment working models and relationship quality, and found a relation between trust and current satisfaction in relationships. Women who were rated as Anxious trusted their partners less; they had much less faith in their partner ($-.50$, $p < .001$) and thought he was less dependable ($-.31$, $p < .01$). Men rated as Anxious also had less faith in their partner ($-.19$, $p < .10$) and thought she was less dependable ($-.22$, $p < .10$). The responses of anxious individuals were very different from those given by women and men who were categorized as being comfortable with closeness (Close) and those who felt that it was safe to depend on others (Depend).

A subject's level of codependence might be a response to a combination of childhood experiences and contemporary relationships. The role of trust could be viewed from two perspectives with respect to codependence. There is the possibility that those who experienced problems with relationships in childhood come to adulthood already at risk for problematic relationships. In this case, trust would

serve as a mediating variable, one that displays isomorphism between childhood and adult relational experiences. Codependence would be an anticipated outcome of poor childhood and adult relationships.

The competing hypothesis for the role of trust as it relates to codependence focuses on the significance of current adult relationships. If a person with a poor childhood relational history entered a healthy, trusting relationship as an adult, she might be less inclined to manifest codependence. In this case, trust would be a moderating variable, since it moderated the effects of her childhood experiences. Moderating variables tend to alter projected developmental trajectories.

Data Collection

The data were collected through self-administered questionnaires. They were completed by the participants and returned by mail to the researcher, along with a consent form. A cover letter was enclosed explaining the study. (See Appendix C.) Pre-addressed, postage paid envelopes were used for the return of the questionnaires and consent form. Also, a pre-addressed postage paid postcard was enclosed if the respondent wanted a copy of the results of the study. It was to be returned separately from the instruments to assure confidentiality.

Subjects were solicited from the public utility by

posting signs advertising the study on bulletin boards in all departments. In addition, department heads agreed to publicize the study at departmental meetings. An administrator in the human resources department acted as a liaison during the process of soliciting volunteers. Copies of the research packets were available through department heads and the administrator. Potential participants were also encouraged to call the researcher if they had questions or wanted packets. After six weeks time, reminders were posted urging those who had picked up packets to complete and return the questionnaire. Of the 60 packets which were requested by employees, 22 were completed and returned to the researcher.

Requests to gather data from patients were made to the clinical directors of hospital-based programs for codependence and private therapists through telephone calls from the researcher. In the case of the hospitals, a thorough review process was required before permission was granted to solicit subjects. Current patients who were being treated for codependence were asked by their therapists whether they would like to participate in the study. If their answer was affirmative, they were given a research packet and asked to complete and return the questionnaire according to the written instructions. Of the 21 patients who requested packets, 19 completed and returned them to the researcher.

Before data collection could begin at any site, permission for the present study was granted by the Michigan

State University Human Subjects Review Committee (UCRIHS). (See Appendix A.)

Data Analyses

Data analyses were conducted separately for childhood predictor variables, the adult predictor variable, and the combination of childhood and adult variables. Descriptive statistics were computed for each of the dependent and independent variables in order to examine distributions. Independent t-tests and chi-square analyses were conducted to examine the differences in means between subsamples. Zero-order correlations were calculated to establish the extent of associations among the predictor variables. Correlations were also computed to examine the relation between the degree of codependence and measures of the predictor variables.

Simple and multiple regression analyses were performed in order to identify the best fitted model in the following categories: childhood predictor variables; adult predictor variable; and a combination of childhood and adult variables. A chance probability level of less than .05 was set to reject the null hypotheses. All tests were two-tailed.

CHAPTER IV

RESULTS AND DISCUSSION

This chapter presents the results of the data analyses. First, the means and standard deviations for the measures used in the study are reported. This is followed by a subsample analysis, with a table listing the results of t-tests and chi-square analyses for each of the variables in the two subsamples.

The next two sections discuss the relations among groups of variables. Again, there are tables. The first shows the relations among all of the predictor variables. The second table demonstrates the relations between all of the predictor variables and the dependent variable, codependence.

Discussions of these tables are followed by a presentation of simple and multiple regression analyses in tabular form. Models which include childhood predictor variables, the adult predictor variable, and a combination of the two are shown. The fit of the data in the various models is discussed. Post hoc analyses and their results follow. Implications for the hypotheses are presented. Finally, the contributions made by childhood and adult variables to the development of codependence, based on the data collected, are

discussed in relation to the conceptual model proposed by the researcher.

Discussion of Measures for the Overall Sample

Means and standard deviations were computed for each of the measures used in the study. For the overall sample, the Family of Origin Scale, which measured family of origin mental health, had a mean of 32.6 and a standard deviation of 11.9. As a retrospective measure of caregiver rejection, the Parental Acceptance-Rejection Questionnaire mean was 128.5, and it had a standard deviation of 39.6. The Trust Scale, which measured subjects' current levels of trust in their adult partner, had a mean of 58.4 and a standard deviation of 17.2. The mean of the original measure of codependence, the Friel Co-Dependency Assessment Inventory, was 33.0, and its standard deviation was 12.6. A revised form of the FCAI, the FCAI-REV, was used in post hoc analyses and had a mean of 29.8 and a standard deviation of 11.6.

In relation to the median scores published by the developers for each of the predictor measures, the overall sample was characterized by poorer than average family of origin mental health, less than average caregiver rejection, and greater trust in their current partner. The mean scores of both the FCAI and FCAI-REV were within the range of scores that Friel calls "moderate concerns" (1985, p. 21) about codependence.

Differences Between Subsamples for Predictor and Outcome Variables

Examination of the differences between subsamples using independent t-tests and chi-square analyses yielded information about the measures used in the study (see Tables 2 and 3). As anticipated, subjects from the clinical subsample tended to come from families with relatively poor mental health, had caregivers who were more rejecting, and had higher scores for codependence. Subjects from the normal subsample had family mental health backgrounds which were better, suffered less rejection from their caregivers, and had lower scores for codependence. However, both groups had similar means for trust.

The differences between subsamples on the independent variables support the likelihood that these childhood variables are useful predictors of codependence. Family of origin mental health, in particular, was highly significant in discriminating between the subsample subjects. Caregiver rejection, although not as significant, still separated normal subjects from clinical subjects. Higher average scores for codependence could be predicted from lower average scores for family of origin mental health and higher average scores for caregiver rejection.

The validity of the measures of codependence was also supported by the difference in means between the subsamples. Whether using the FCAI or the FCAI-REV, clinical subjects'

Table 2

T-Tests for Differences Between Normal and Clinical Subsamples Predictor and Outcome Variables

Variable	Mean (SD) Normal Subsample (n = 22)	Clinical Subsample (n = 19)	t-value	df	Prob.
FOS	38.8 (10.7)	25.5 (9.1)	4.24	39	.00***
PARQ	115.8 36.5	143.1 38.7	-2.32	39	.03*
TRUST	57.8 (16.9)	59.1 (17.9)	-0.22	38	.82
FCAI	29.4 (12.3)	37.6 (11.8)	-2.06	39	.05*
FCAI-REV	26.4 (10.9)	33.7 (11.4)	-2.19	39	.04*

Note. One Trust Instrument was incomplete and dropped from the study.
* $p < .05$ *** $p < .001$

Table 3

Chi-square Analyses for Differences Between Normal and Clinical Subsamples Predictor and Outcome Variables

Variable	Normal Subsample (n = 22)	Clinical Subsample (n = 19)	χ^2	Prob.
CATH	34.6%	65.9%	64.289	.00***
PAROSCH	36.6%	63.4%	44.637	.00***
OLD/YNG	63.6%	84.2%	25.612	.00***
FHA	31.6%	68.2%	34.198	.00***
EFHA	42.9%	73.7%	17.017	.00***

*** $p < .001$

scores, on average, were higher than normal subjects' scores. This was an expected result since clinical subjects were being treated for codependence.

Chi-square analyses of the remaining predictor variables demonstrated similar results. The subsamples differed in the areas of religion, parochial school attendance, birth order, and family history of substance abuse. Clinical subjects were more likely to be Catholic, and had attended parochial schools in greater numbers. They were also more likely to be first or last born children in their families of origin. Clinical subjects were also more likely to have come from families in which substance abuse was an issue.

Relations Among Predictor Variables

When constructing the table of predictor variables, gender was eliminated because there were not enough male subjects to conclude anything meaningful about the influence of gender on codependence. Since only one subject reported religious training as a Fundamentalist Christian, the variable of religion was represented by Catholicism and parochial school attendance. The hypothesized childhood variables of caregiver acceptance/rejection (PARQ), family of origin mental health (FOS), childhood religious training (CATH and PAROSCH), birth order (OLD/YNG), immediate family of origin history of substance abuse (FHA), and extended family of origin history of substance abuse (EFHA) were

included. The adult predictor variable of trust (TRUST) was also featured in the correlation table. Family substance abuse histories were included because they were found to be significant in other research on codependence (Friel, 1985; Scher, 1991; West-Willette, 1990). Birth order was included because of the researcher's clinical experience with codependent clients, most of whom were first or last born children in their families of origin. Correlational analyses were performed to determine the extent of associations among the predictor variables. Table 4 presents the zero-order correlations for all of the predictor variables.

Table 4

Relations Among the Predictor Variables

	FOS	PARQ	CATH	PAROSCH	OLD/YNG	FHA	EFHA	TRUST
FOS	1.00							
PARQ	-0.72***	1.00						
CATH	-0.43**	0.17	1.00					
PAROSCH	-0.40**	0.17	0.74***	1.00				
OLD/YNG	-0.17	-0.05	0.20	0.23	1.00			
FHA	-0.65***	0.40**	0.33*	0.17	0.40	1.00		
EFHA	-0.56***	0.45**	0.17	0.14	-0.08	0.62***	1.00	
TRUST	0.39*	-0.39**	0.10	0.17	0.09	-0.23	-0.33*	1.00

Note. CATH was coded 1 if childhood religion was Roman Catholic, 0 if other. PAROSCH was coded 1 if any parochial school attendance was reported and coded 0 if none was reported. OLD/YNG was coded 1 if subject reorted being an oldest or youngest child. FHA and EFHA were coded 1 if subject reported either an immediate or extended family history of alcoholism and/or chemical dependency.
* $p < .05$ ** $p < .01$ *** $p < .001$

Relations Among Childhood Predictor Variables

A number of significant correlations were found among among the childhood variables. All of the correlations were in the expected directions, and were moderate to large in magnitude. Subjects who reported relatively poor family of origin mental health also tended to have rejecting childhood caregivers, were raised as Catholics and had attended parochial schools, and came from substance-abusing families, both immediate and extended. Caregiver rejection was also significantly related to immediate and extended family substance abuse. Immediate family of origin substance abuse was associated with being raised as a Catholic. Not surprisingly, immediate and extended family substance abuse were highly correlated.

It is noteworthy that these data support the literature on family substance abuse which indicates that dysfunction at the dyadic and systemic levels is common (Brown, 1988). If the abuse of alcohol or other drugs, and the resulting consequences of abuse, command most of the attention of adults in a family, their children's physical and emotional needs will not be fully met. A mother who spends her time and energy trying to cope with her husband's alcoholism is probably not accessible to her children in ways that would benefit them. If she is alcoholic, even more powerful deficits are likely in the caregiver-child relatioship. In terms of systemic family interactions, alcoholic families are

typified as being rigid around family rules and roles (Black, 1981; Wegscheider, 1981) . These characteristics do not support family mental health, and tend to promote coping strategies in children which do not serve them well as adults. As a consequence, children from alcoholic families often have trouble constructing and maintaining healthy relationships and families of their own in adulthood.

The association between being Catholic and attending parochial schools is an obvious one. That Catholicism and immediate family substance abuse are linked may be a function of the composition of this sample, since a disproportionate share of Catholic subjects reported family substance abuse. Of the 20 subjects, overall, who reported family substance abuse, 10 were Catholic, although Catholic subjects made up only 34% of the sample. It is unlikely that half of the family substance abuse in the Midwest is found in Catholic families. This was an unexpected finding, and the reasons for the association are unclear.

Relations Between Childhood and Adult Variables

In addition to the significant correlations already discovered among the childhood variables, interesting and significant correlations were found between trust and several of the childhood variables. The signs of the coefficients were in the anticipated directions. Subjects whose family of origin mental health was not very good were less trusting of

their adult partner. The subjects who perceived their mothers as rejecting in childhood were less likely to trust their adult partners. They were also likely to be less trusting if they grew up in an extended family where substance abuse was a problem.

These correlations demonstrate the connections between childhood relational experiences and adult relationships. If a person spends her formative years with a primary caregiver whom she remember as rejecting, and/or her family was significantly dysfunctional, she will be less inclined to find her adult partner trustworthy. Learning as a child that others are not to be trusted discounts one's inclination to trust others as an adult. This is true, irrespective of the actual trustworthiness of others. The other side of the argument is that a person may select adult partners who will allow the duplication of childhood relationships in an attempt to find familiarity, even when the results are painful. Non-trustworthy partners close the circle of a relationship whose parameters are known.

The association between trust and extended family of origin substance abuse can be explained as an intergenerational problem. Feelings about trust and safety are woven into the family patterns which pass from one generation to the next. Even when the chemical catalyst for dysfunction is removed between generations, there is no guarantee that family members will learn new ways of relating to each other. One generation teaches the next what it has

learned about the fundamentals of relationships, even when some of the context may have changed.

Relations Between Childhood and Adult Predictor Variables and Codependence

This section discusses the associations between all of the predictor variables and codependence, assessed with the FCAI. Table 5 presents zero-order correlations, listing childhood variables first. Most of the childhood variables, and the adult variable of trust, were significantly related to FCAI scores. The signs of the correlation coefficients were in the expected directions.

Table 5

Zero-order Correlations Between the Predictor Variables and the Friel Co-dependency Assessment Inventory (FCAI)

Predictor Variable	FCAI	Predictor Variable	FCAI
FOS	-0.62***	OLD/YNG	0.30
PARQ	0.64**	FHA	0.43**
CATH	0.05	EFHA	0.39**
PAROSCH	0.04	TRUST	-0.53***

** $p < .01$ *** $p < .001$

As was anticipated, poor family of origin mental health and caregiver rejection were related to the development of codependence. Higher scores for codependence were linked with immediate and extended family of origin substance abuse. Subjects who reported higher FCAI scores were also less trusting of their adult partner.

Based on the relative strength of the correlations, it is clear that a person's family of origin has a profound influence on their predisposition toward codependence. In particular, poor family of origin mental health and caregiver rejection seem to set the stage for later relational difficulties. The data suggest that a troubled childhood relational history eventually leads to a problem with codependence. It also appears from the data that trust and codependence are interrelated; those who find it difficult to trust their current adult partner are also more likely to be troubled by codependence.

Multiple Regression Analyses

Childhood Predictors of Codependence.

Multiple regression analysis of all the childhood predictor variables was used in order to discover which variables contribute uniquely to codependence. Simultaneous entry was the form of regression used to test the postulated model. The variables included were: family of origin mental

health (FOS); attachment (PARQ); religious training (CATH and PAROSCH); birth order (OLD/YNG); immediate family substance abuse (FHA); and extended family substance abuse (EFHA). Separate analyses using CATH and PAROSCH, and FHA and EFHA, were computed in order to avoid collinearity. The best fitted model of all childhood variables and codependence is found in Table 6. Family of origin mental health, attachment, parochial school attendance and birth order explained 58% of the variance in the scores for codependence.

Table 6

Multiple Regression Analysis: Childhood Predictors of FCAI Scores

Predictor Variable	β	t-Statistic	Prob. > t
Constant	0.00	0.01	.99
FOS	-0.34	-1.99	.05
PARQ	0.49	2.79	.00
PAROSCH	-0.24	-2.02	.05
OLD/YNG	0.32	2.76	.00
R^2	0.58		
F-Ratio	12.57		.000

Note. Betas presented are standardized betas.

The addition of other childhood variables provided a more complete explanation of the ways in which childhood experiences contribute to the development of codependence.

Parochial school attendance and birth order emerged as important influences, as well as family of origin mental health and attachment. This may seem surprising since neither variable demonstrated statistical significance when correlated with codependence. The presence of birth order in this regression model might be explained by the fact that its "p" value when correlated with codependence was .059.

Parochial school attendance, on the other hand, might be explained as a suppressor variable. Attending parochial school was viewed as a protective factor in this model, one that made it less likely that a subject would report high scores for codependence. According to Glass and Hopkins (1984), a suppressor variable is a predictor that does "not correlate with the criterion . . . (and) can increase the multiple correlation by 'suppressing' irrelevant variance in other independent variables." If this is the case, parochial school attendance increased the explanatory power of this regression model by suppressing irrelevant variance in FOS scores, PARQ scores and birth order. It served in this capacity, even though its correlation with codependence was low (.04).

It is interesting to note that this model does not contain either of the variables connected with family substance abuse. The zero order correlations suggest that the effect of substance abuse may be indirect and mediated by family of origin mental health and caregiver rejection, which are more proximal processes.

Adult Predictor of Codependence.

A simple regression analysis of the adult predictor variable of trust was performed in order to assess the contribution of a subject's current level of trust in a partner to their degree of codependence. The model is shown in Table 7. Trust was found to predict codependence, explaining 25% of the variance in the scores for codependence. This demonstrates the importance of trust, a variable with childhood antecedents, as a predictor of codependence.

Table 7

Regression Analysis: Adult Predictor of FCAI Scores

Predictor Variable	β	t-Statistic	Prob. > t
Constant	-0.03	-0.25	.81
TRUST	-0.50	-3.59	.00
R^2	0.25		
F-Ratio	12.81		.000

Note. Betas presented are standardized betas.

Multiple Childhood and Adult Predictors of Codependence.

Multiple regression analysis using a combination of childhood and adult predictor variables was computed as a way of assessing the best overall model for predicting codependence. Although this was not part of the original study, its inclusion seemed a natural outgrowth of the preceding analyses. To construct this hierarchical model, trust was added to the relevant childhood predictors from the previous regression analysis. The model is shown in Table 8.

Table 8

Multiple Regression Analysis: Childhood and Adult Predictors of FCAI Scores

Predictor Variable	β	t-Statistic	Prob. > t
Constant	0.02	0.01	.81
PARQ	0.52	-1.99	.00***
OLD/YNG	0.35	2.78	.00**
TRUST	-0.39	-2.02	.00**
R^2	0.61	2.76	
F-Ratio	18.81		.00***

Note. Betas presented are standardized betas.
** p < .01 *** p < .001

This model is interesting for several reasons. The first is that this distillation of all predictor variables portrays

the profound importance of early dyadic relationships. Attachment, trust and birth order, inextricably linked throughout a person's developmental history, provide the best explanation for the manifestation of codependence in adulthood. This triadic set of childhood relational experiences is so powerful that variables like family of origin mental health, religious training and substance abuse become less relevant as predictors.

The second reason this model invites interest is because of its explanatory power relative to the childhood model. This model, using all childhood and adult predictor variables, explains 61% of the variance in scores for codependence as compared with 58% for the childhood model. Remembering that trust might be described as an adult extension of one's family of origin experiences, one might view the two models as being remarkably similar. The elimination of parochial school attendance in this inclusive model accentuates the predominant influence of family over other institutional factors. It could be argued that one could predict with some accuracy the formation of codependence in a person before they reach adulthood, based on their childhood family experiences.

Post Hoc Analyses

Revision of the Codependence Measure

Post hoc analyses involving a revised form of the FCAI were also conducted by the researcher. In order to construct the revised FCAI (FCAI-REV), five items from the original instrument which pertained to childhood (Numbers 7, 11, 17, 30, and 59) were removed. This was done in order to assess whether different results might be obtained from the analyses when there was no possibility of overlapping items from the childhood instruments and the FCAI.

Predictor Variables Relations to the Revised Measure.

The relations among the predictor variables reported earlier in this chapter remained the same. Table 9 shows the new set of correlations obtained between the predictor variables and the FCAI-REV. There were many similarities between this set of correlations and the ones computed with the original FCAI. The coefficients ranged from small to moderate in size and were in the expected directions. Most of the coefficients were slightly weaker when compared with those computed with the original FCAI. The exceptions were parochial school attendance,which remained the same, and

family history of substance abuse, which became slightly stronger. Of the childhood variables, caregiver rejection and immediate and extended family histories of substance abuse were significantly related to codependence. Family of origin mental health was highly significant in its relationship to codependence. The adult predictor variable of trust was also highly significant in its relationship to codependence.

This set of correlations also suggested that childhood family of origin experiences continue to be influential into adulthood when codependence is manifested. Of particular interest are the ways in which early dyadic relationships and family rules and roles seem to set the stage for adult experiences with others. Trust, whether cast as a mediating or moderating variable, also continues to be important when examining codependence.

Table 9

Zero-order Correlations Between the Predictor Variables and the Revised Codependence Measure (FCAI-REV)

Predictor Variable	FCAI-REV	Predictor Variable	FCAI-REV
FOS	-0.54***	OLD/YNG	0.27
PARQ	0.61**	FHA	0.44**
CATH	0.02	EFHA	0.37**
PAROSCH	0.04	TRUST	-0.50***

** $p < .01$ *** $p < .001$

Single and Multiple Regression Analyses Against the Revised Codependence Measure.

Simultaneous entry of the childhood predictor variables which comprised the best fitted model for the original regression analysis revealed somewhat different results with the FCAI-REV. (See Table 10.) Like the model tested with the FCAI, this model also contained caregiver rejection and birth order. But family of origin mental health and parochial school attendance dropped out of the model. The two remaining variables predicted 46% of the variance in scores for codependence.

Table 10

Multiple Regression Analysis: Childhood Predictors of FCAI-REV Scores

Predictor Variable	β	t-Statistic	Prob. > t
Constant	0.00	0.00	.98
PARQ	0.62	5.17	.00***
OLD/YNG	0.32	2.27	.01
R^2	0.46		
F-Ratio	16.29		.00***

Note. Betas presented are standardized betas.
*** p < .001

With the elimination of family of origin items from the original FCAI, scores on the PARQ became more powerful. Thus the role of family of origin mental health was overshadowed by caregiver rejection. Parochial school attendance, which had served to suppress irrelevant variance in the FOS, was eliminated from the model with family of origin mental health.

A simple regression using the adult variable of trust and the FCAI-REV revealed that trust remained significant as a predictor of codependence (see Table 11). In this model it explained 25% of the variance in scores for codependence.

Table 11

Regression Analysis: Adult Predictor of FCAI-REV Scores

Predictor Variable	β	t-Statistic	Prob. > t
Constant	-0.03	-0.25	.80
TRUST	-0.49	-3.55	.00**
R^2	0.25		
F-Ratio	12.59		.00***

Note. Betas presented are standardized betas.
** p < .01 *** p < .001

Using hierarchical entry, the adult variable of trust was added to the childhood variables of caregiver rejection and birth order in a multiple regression analysis. These variables constituted the best fitted model (Table 12) for

predicting codependence using the FCAI-REV, and they explained 56% of the variance in scores.

Table 12

Multiple Regression Analysis: Childhood and Adult Predictors of FCAI-REV Scores

Predictor Variable	β	t-Statistic	Prob. > t
Constant	0.03	-0.23	.82
PARQ	0.47	4.04	.00***
OLD/YNG	0.34	3.13	.00**
TRUST	-0.35	-2.94	.00**
R^2	0.56		
F-Ratio	15.31		.00***

Note. Betas presented are standardized betas.
** p < .01 *** p < .001

Trust as a Moderating Variable

In order to assess whether trust served as a moderating variable in this study, the following analysis was conducted. Trust scores for the overall sample were divided at the median into High Trust and Low Trust groups. For each group, the correlations between childhood measures and the measure for codependence were then transformed into z-scores. The resulting, standardized correlations were compared for the

two groups. Table 13 shows the comparison between the High and Low Trust groups. Due to the small size of the samples, achieving statistical significance was not possible at the .05 level. However, the trend was that trust served as a moderating variable between caregiver rejection and codependence, since the correlation of the High Trust group is lower than that of the Low Trust Group.

Table 13

Z-Tests for Differences Between Correlations of High-Trust Subjects and Low-Trust Subjects

Correlation	High TRUST (n = 20)	Low TRUST (n = 20)	z-ratio	Prob.
FCAI-FOS	-0.55*	-0.73***	0.49	.30
FCAI-PARQ	0.52*	0.95***	-1.26	.10

Note. Correlations presented are standardized correlations.
* $p < .05$ *** $p < .001$

Implications for Hypotheses

H1. There is a positive relationship between degrees of codependence and degrees of perceived caregiver rejection.

The hypothesis was supported by the results from both sets of analyses, those computed with the original FCAI and the FCAI-REV. Caregiver rejection was found to be a predictor of codependence in the regressions using only

childhood variables and in the regressions using a combination of childhood and adult variables.

> H2. There is a negative relationship between degrees of codependence and degrees of perceived family of origin mental health.

The hypothesis was supported by the results of one of the analyses using the FCAI. The model which included the childhood predictors of codependence found that family of origin mental health contributed uniquely. This was not true of the model which included the childhood and adult predictors, together. When similar analyses were computed using the FCAI-REV, family of origin mental health was no longer a predictor of codependence in either model.

> H3. There is a positive relationship between degrees of codependence and childhood religious training as a Catholic or Fundamentalist Christian.

When using the original version of the FCAI, the hypothesis (for Catholic only) was not supported by the childhood model of predictor variables, using attendance at parochial schools as the variable. Parochial school attendance was shown to protect against the development of codependence. The model which included childhood and adult predictor variables did not include parochial school attendance. In the models which were tested using the FCAI-REV, different results were found. Parochial school attendance was not part of either the model of childhood predictors or the combination model of childhood and adult predictors.

H4. There is a positive relationship between degrees of codependence and being female.

There were not enough male subjects to test this hypothesis.

H5. There is a positive relationship between family of origin birth order (first or last born child in a family) and degrees of codependence.

When using the original FCAI, the hypothesis was supported by the model of childhood predictor variables and by the model which included childhood and adult predictors. Use of the FCAI-REV revealed similar results. Birth order emerged as a predictor of codependence in both the childhood model and the combination model of childhood and adult predictors.

H6. There is a positive relationship between an immediate family history of substance abuse and codependence.

The hypothesis was not supported by the analyses in any of the models. Whether using the original FCAI or the FCAI-REV, immediate family history of substance abuse was not found to be a predictor of codependence.

H7. There is a positive relationship between an extended family history of substance abuse and codependence.

The hypothesis was not supported by the analyses in any of the models. Whether using the original FCAI or the FCAI-

REV, extended family history of substance abuse was not found to be a predictor of codependence.

H8. There is a negative relationship between degrees of codependence and degrees of trust in an adult partner.

When using the original FCAI, the hypothesis was supported by the model which included trust only, and by the model which included all childhood and adult predictors, together. Similar results were found when using the FCAI-REV. Trust was found to be a predictor of codependence in both the adult predictor model and in the combination model of childhood and adult predictors.

Research Findings and the Conceptual Model

In Chapter I a model for codependence was proposed by the researcher. It was derived from the assumptions of developmental psychopathology. An ecological perspective was also employed in an attempt to recognize the influences of multiple environments on a person's development. The data from this study speak to the researcher's model for codependence in the following ways:

1. Codependence is a product of both intrapsychic and interpersonal dynamics.

Internalized perceptions regarding one's family of origin interactions, and one's perceptions about childhood

caregiver acceptance or rejection, influence the development of codependence. What was said and done in childhood become memories, beliefs and feelings which form a template for behaviors in adult relationships.

2. A person may be influenced to be codependent by interactions at the individual, familial, cultural, and institutional levels.

Responses to the PARQ, FOS, and Trust Scale indicate the significance of interactions between individuals and within families. At the cultural and institutional level, religious training appears to be associated with family of origin mental health. Although not significantly related to codependence directly, parochial school attendance seems to influence other variables which are predictors of codependence.

3. Codependence is a developmental process which begins in infancy and continues through the lifespan, mediated by potentiating and protective factors.

The links between attachment, family of origin mental health, birth order and trust suggest a developmental approach to the study of codependence. There were also significant associations between childhood variables and trust, which appeared to moderate the effects of childhood experiences in some cases. Further, trust was found to predict codependence by itself and appeared as a predictor in both combination models. It is also possible that trust is

an outcome variable, that codependence predicts trust. In this case, a person's degree of codependence might influence how trusting they are of a current partner.

It seems that healthy families and accepting caregivers innoculate their children against the formation of codependence. Children who are fortunate enough to have been given a solid foundation for identity and relationship construction appear to be less at risk for manifesting codependence as adults. But the data also show that childhood experiences can be moderated by current adult relationships. This injects a note of hope for those who suffered from unhappy childhoods at home. Those whose family of origin experiences were less than good may find that experiencing a trusting relationship with an adult partner places them less at risk for codependence. These data indicate that unfortunate developmental trajectories may be altered by positive choices in adulthood.

CHAPTER V

SUMMARY, CONCLUSIONS, LIMITATIONS, DIRECTIONS FOR FUTURE RESEARCH, AND IMPLICATIONS FOR CLINICAL PRACTICE

This chapter summarizes the findings of the study, offers conclusions and limitations of the research, and concludes with suggestions for future research as well as implications for clinical practice.

Summary of the Study

The original purposes of this study were twofold: to discover the primary childhood factors which influence the development of codependence; and to identify the effects of current partner relationships on degrees of codependence. During the course of the research, additional analyses were conducted in order to offer a more complete explanation of the etiology of codependence. These lead to a third purpose: to identify the most important contributors to codependence, whether their origins were in childhood or adulthood. Additional post hoc analyses using a revised form of the

Friel Co-Dependency Assessment Inventory (FCAI-REV) were included as further tests of the hypotheses. This summary includes all of the variables which were used in the analyses of data, and offers a comparison of models which include the three purposes of the study.

Table 14 shows the two best fitted regression models for codependence using the original FCAI. The first model was computed from a combination of all the childhood predictor variables including: family of origin mental health; attachment; childhood religious training as a Catholic; parochial school attendance; birth order; immediate family of origin substance abuse; and extended family of origin substance abuse. After regression, family of origin mental health, attachment, parochial school attendance and birth order remained as predictors of codependence. The second model includes all of the childhood and adult predictor variables as part of the regression. After analysis, the variables which emerged as most predictive of codependence were trust, attachment, and birth order.

Table 14 also displays the best fitted regression models for codependence using the FCAI-REV, which are nearly parallel to the FCAI models. The first was derived from a combination of childhood predictor variables; the second includes a combination of childhood and adult predictor variables. The similarities and differences between the two childhood models and the two combination models are of particular interest.

Table 14

Comparison of Best-fitted Childhood and Childhood/Adult Models Predicting FCAI and FCAI-REV

Model	β	F-ratio	R^2
	I: FCAI		
Childhood Model			
Constant	0.00	12.57***	.58
FOS	-0.34*		
PARQ	0.49**		
PAROSCH	-0.24*		
OLD/YNG	0.32**		
Childhood/Adult Model			
Constant	0.02	18.81***	.61
PARQ	0.52***		
OLD/YNG	0.35**		
TRUST	-0.39**		
	II: FCAI-REV		
Childhood Model			
Constant	0.00	16.29***	.46
PARQ	0.62***		
OLD/YNG	0.32*		
Childhood/Adult Model			
Constant	0.03	15.31***	.56
PARQ	0.47***		
OLD/YNG	0.34**		
TRUST	-0.35**		

Note. Betas presented are standardized betas.
* $p < .05$ ** $p < .01$ *** $p < .001$

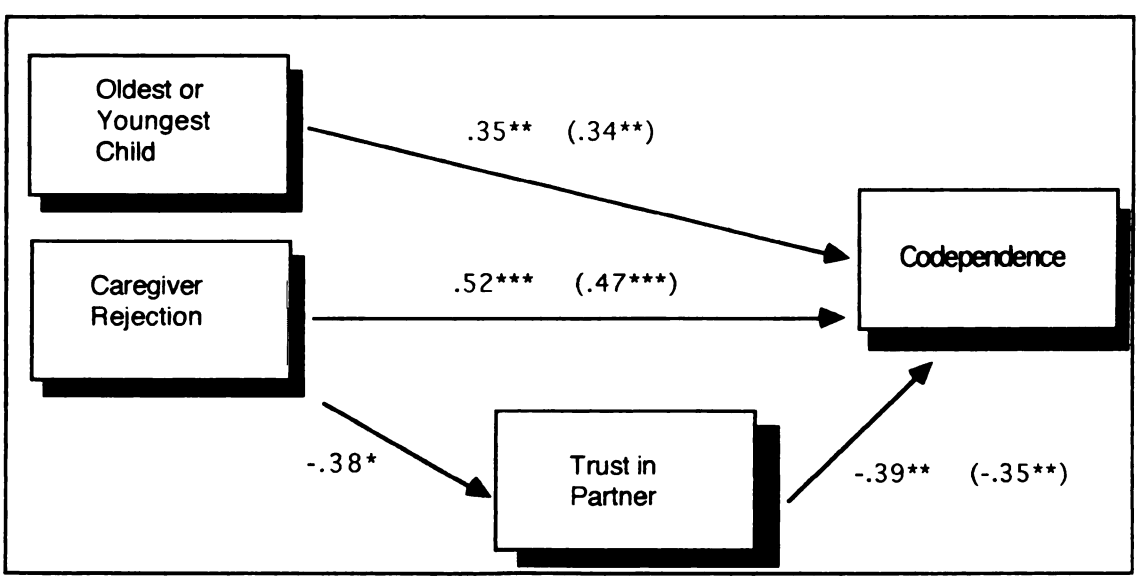
In both versions of the first model, birth order and caregiver rejection were present. Family of origin mental health and parochial school attendance appeared in the model computed using the original FCAI, but they were absent from the model which used the FCAI-REV. It appears that the elimination of family of origin items from the original FCAI

served to increase the relative strength of caregiver rejection, compared to other measures. When this occurred, family of origin mental health and parochial school attendance became less important as predictors of codependence and disappeared from the model. In the same way, caregiver rejection overshadowed family of origin mental health and parochial school attendance as predictors when comparing the combined childhood/adult models.

A graphic display of the relationship of the best fitted models for predicting codependence is found in Figure 1. Since the predictor variables are the same whether the original FCAI or the FCAI-REV is used, both sets of standardized betas are included in one figure.

Figure 1

Path Diagram Illustrating the Best-Fitted Regression Models



Note. Numbers in diagram are standardized betas. Numbers in parentheses refer to the FCAI-REV.

Conclusions

Childhood matters. One of the subjects wrote on the back of her consent form: "When a child is hurt, adults said, 'They are children and will get over it.' THIS IS NOT SO. We lock ourself up and there is no key to let us out." With painful eloquence, she explained that a person's childhood experiences carry weight, not only at the time but for all of her life. This study makes the same point as it provides in aggregate form the lives of the persons who volunteered to be subjects. What happened to a person in childhood as a family member matters. What is learned about relationships as a child is carried into adult life. If one was fortunate enough to come from a loving, healthy family where children were valued and nurtured, what was learned was that it is safe and good to reach out to others. If one was given permission to be imperfect, to express a range of feelings, and to differentiate when it was time for that task, it was easier to construct an identity that was authentic. But if childhood family experiences were not as positive, a consequence might be the symptoms of codependence as an adult.

The results of this study suggested that the model which included a combination of childhood and adult variables was best for predicting codependence. This was true whether one relied on the results of analyses using the original FCAI or the FCAI-REV. The two versions of the combination model produced higher r^2 and equivalent or higher F-ratios compared

with the childhood models. What emerged as a model for predicting codependence was a related set of factors from past and current experiences. Dyadic and family systems dynamics were related to trust in current adult relationships, as well as to the outcome of codependence. It appeared that trusting adult relationships could moderate the effects of childhood family of origin experiences. Trust and codependence were also mutually influential, although the direction of their relationship was less clear. Based on the data collected for this study, it seems reasonable to conclude that childhood relational experiences are predictive of the development of codependence.

Limitations

Some limitations are inherent in any research design. Sampling posed several difficulties in this research. One limitation of this study is that generalizability to other populations will be difficult because of nonprobability sampling. Also, the size of the sample, while adequate, is small enough to raise the possibility of Type 2 errors. Because a social desirability scale was not included as part of the study, there is the possibility that subjects might have responded to the questionnaire in ways that would cast them and their relationships in the most favorable light.

The sample, virtually all-female and all-White, does not accurately represent a cross-section of adults, and the

scarcity of male subjects made it impossible to say anything about hypothesized gender effects. Of interest, however, is a comment by a male public utility employeee who called this researcher about becoming a subject for the study. When he learned that he would be answering questions about current and past personal relationships, he emphatically explained that he and his male colleagues would be unlikely to participate because, "Guys don't care about relationships!" Although the public utility company was chosen, in part, because of the large number of male employees, it appears that not all males are equally interested in research about relationships. It is also the case that women are overrepresented in therapy, which explains the small number of men in the clinical subsample.

Another concern is that the FCAI is a relatively new instrument and has not been thoroughly validated. There is also the problem that questionnaires do not yield as good data as a structured interview, in part because of an inability to clarify points of confusion or ask follow-up questions. There is a concern that because so little empirical work has been done in the area of codependence, it is difficult to know whether significant variables were neglected.

Directions for Future Research

Replication of this research with a large, representative sample would serve to confirm or disconfirm the results of this study. It would be especially interesting to include, as part of the sample, males who scored in the upper ranges of the FCAI. Other researchers (Wright & Wright, 1990) have pointed out that codependent males are difficult to locate, so their presence in a replication of this research would be very helpful.

Future research on the etiology of codependence might look at variables other than the ones selected for this study. A different set of childhood and adult predictor variables could either support this study's results or offer a different perspective on the origins of codependence. Another variation would be to select the same variables used in this research, but to choose different instruments with which to measure them. Of course, the FCAI would benefit from further validation, but beyond the question of the usefulness of specific instruments, research is needed on the general issue of the assessment of codependence, since co-morbidity with other disorders may be a problem.

While the topic of codependence does not suffer from a surfeit of qualitative or quantitative research, it is important to remember that the subject is not just of academic interest. Specifying codependence and determining its causes are important tasks for future researchers.

Finding effective therapeutic approaches is perhaps even more important. Codependence needs to be studied in the clinic. Studies of both treatment methods and treatment outcomes would be very useful.

Implications for Clinical Practice

Based on the results of this study, it is clear that the etiologies of codependence are found in a person's childhood. This is both good news and bad news for clinicians. The good news is that etiology and treatment are linked in the process of effective therapy, and these data provide clinicians with some guidance for choosing therapeutic interventions. The bad news is that the origins of codependence reach so far back into a client's developmental history, and are so persistent and pervasive, that they will resist easy undoing. To communicate to a client that she is currently suffering the sequelae of unfortunate birth order and maternal (usually) rejection which began when she was a young child is, in effect, to tell her that the work ahead is not going to be easy or proceed quickly. This is not the stuff of brief therapy.

Still, a client may benefit from the awareness that her tendency to choose bad partners, or her inability to risk intimacy with potentially good partners, originated in the crucible of early childhood relationships. With the help of a therapist, she can reconstruct the childhood influences

which have troubled her adult relationships. With guided exploration and education come awareness, and with awareness comes the possibility of change. But both the client and her therapist must remember the primitive origins of her feelings about safety, trust, and intimacy. These feelings are extraordinarily powerful because they were learned when she was young and vulnerable. Stressful experiences in adult relationships are likely to activate old defenses. Fear-driven responses to perceived assaults on the ego will be hard to overcome.

APPENDICES

MICHIGAN STATE UNIVERSITY

OFFICE OF VICE PRESIDENT FOR RESEARCH
AND DEAN OF THE GRADUATE SCHOOL

EAST LANSING • MICHIGAN • 48824-1046

November 5, 1992

TO: Nancy J. Lorris
951 Sunset Lane
East Lansing, MI 48823

RE: **IRB #:** 92-533
TITLE: FAMILY, CULTURE AND CODEPENDENCE: A DEVELOPMENTAL PERSPECTIVE
CATEGORY: 1-C
REVISION REQUESTED: N/A
APPROVAL DATE: November 3, 1992

The University Committee on Research Involving Human Subjects' (UCRIHS) review of this project is complete. I am pleased to advise that the rights and welfare of the human subjects appear to be adequately protected and methods to obtain informed consent are appropriate. Therefore, the UCRIHS approved this project including any revision listed above.

UCRIHS approval is valid for one calendar year, beginning with the approval date shown above. Investigators planning to continue a project beyond one year must seek updated certification. Request for renewed approval must be accompanied by all four of the following mandatory assurances.

1. The human subjects protocol is the same as in previous studies.
2. There have been no ill effects suffered by the subjects due to their participation in the study.
3. There have been no complaints by the subjects or their representatives related to their participation in the study.
4. There has not been a change in the research environment nor new information which would indicate greater risk to human subjects than that assumed when the protocol was initially reviewed and approved.

There is a maximum of four such expedited renewals possible. Investigators wishing to continue a project beyond that time need to submit it again for complete review.

UCRIHS must review any changes in procedures involving human subjects, prior to initiation of the change. Investigators must notify UCRIHS promptly of any problems (unexpected side effects, complaints, etc.) involving human subjects during the course of the work.

If we can be of any future help, please do not hesitate to contact us at (517) 355-2180 or FAX (517) 336-1171.

Sincerely,

David E. Wright, Ph.D.
UCRIHS Chair

DEW:pjm

cc: Dr. Donald Melcer

APPENDIX B

SUBJECT QUESTIONNAIRE

Note. The text of the subject questionnaire follows. The material has been reduced to 9 point type so it could appear essentially as it did to subjects, yet stay within the margin specification of dissertation manuscripts. All apparatus for indicating responses (e.g., Likert foils) has been removed.

Part 1: Current Life

Below are a number of questions dealing with how you feel about yourself, your life, and those around you. As you answer each question, be sure to answer honestly, but do not spend too much time dwelling on any one question. There are no right or wrong answers. Take each question as it comes, and answer as you usually feel. Circle "True" if that is how you feel most of the time; circle "False" if that is how you feel most of the time.

1. I make enough time to do things just for myself each week.

2. I spend lots of time criticizing myself after an interaction with someone.

3. I would not be embarrassed if people knew certain things about me.

4. Sometimes I feel like I just waste a lot of time and don't get anywhere.

5. I take good enough care of myself.

6. It is usually best not to tell someone they bother you; it only causes fights and gets everyone upset.

7. I am happy about the way my family communicated when I was growing up.

8. Sometimes I don't know how I really feel.

9. I am very satisfied with my intimate love life.

10. I've been feeling tired lately.

11. When I was growing up, my family liked to talk openly about problems.

12. I often look happy when I am sad or angry.

13. I am satisfied with the number and kind of relationships I have in my life.

14. Even if I had the time and money to do it, I would feel uncomfortable taking a vacation by myself.

15. I have enough help with everything that I must do each day.

16. I wish that I could accomplish a lot more than I do now.

17. My family taught me to express feelings and affection openly when I was growing up.

18. It is hard for me to talk to someone in authority (boss, teachers, etc.).

19. When I am in a relationship that becomes too confusing and complicated, I have no trouble getting out of it.

20. I sometimes feel pretty confused about who I am and where I want to go with my life.

21. I am satisfied with the way that I take care of my own needs.

22. I am not satisfied with my career.

23. I usually handle my problems calmly and directly.

24. I hold back my feelings much of the time because I don't want to hurt other people or have them think less of me.

25. I don't feel like I'm "in a rut" very often.

26. I am not satisfied with my friendships.

27. When someone hurts my feelings or does something that I don't like, I have little difficulty telling them about it.

28. When a close friend or relative asks for my help more than I'd like, I usually say "yes" anyway.

29. I love to face new problems and am good at finding solutions to them.

30. I do not feel good about my childhood.

31. I am not concerned about my health a lot.

32. I often feel like no one really knows me.

33. I feel calm and peaceful most of the time.

34. I find it difficult to ask for what I want.

35. I don't let people take advantage of me more than I'd like.

36. I am dissatisfied with at least one of my close relationships.

37. I make major decisions quite easily.

38. I don't trust myself in new situations as much as I'd like.

39. I am very good at knowing when to speak up, and when to go along with others' wishes.

40. I wish I had more time away from my work.

41. I am as spontaneous as I'd like to be.

42. Being alone is a problem for me.

43. When someone I love is bothering me, I have no problem telling them so.

44. I often have so many things going on at once that I'm really not doing justice to any one of them.

45. I am very comfortable letting others into my life and revealing "the real me" to them.

46. I apologize to others too much for what I do or say.

47. I have no problem telling people when I am angry with them.

48. There's so much to do and not enough time. Sometimes I'd like to leave it all behind me.

49. I have few regrets about what I have done with my life.

50. I tend to think of others more than I do of myself.

51. More often than not, my life has gone the way that I wanted it to.

52. People admire me because I'm so understanding of others, even when they do something that annoys me.

53. I am comfortable with my own sexuality.

54. I sometimes feel embarrassed by behaviors of those close to me.

55. The important people in my life know "the real me," and I am okay with them knowing.

56. I do my share of work, and often do quite a bit more.

57. I do not feel that everything would fall apart without my efforts and attention.

58. I do too much for other people and then later wonder why I did so.

59. I am happy about the way my family coped with problems when I was growing up.

60. I wish that I had more people to do things with.

Part 2: Feelings about Partner

This part of the questionnaire is concerned with your current relationship with a partner. Partner is defined as a spouse or other adult with whom you have a committed relationship. If you are not currently involved with someone, please think about your most recent important relationship and answer the questions from the perspective of that relationship. Using the following scale, circle the appropriate number. Please respond to each statement.

Key : 5 = Strongly agree that it describes my feelings about my partner.
4 = Agree that it describes my feelings about my partner.
3 = Neutral.
2 = Disagree that it describes my feelings about my partner.
1 = Strongly disagree that it describes my feelings about my partner.

1. My partner has proven to be trustworthy and I am willing to let him/her engage in activities which other partners find too threatening.

2. Even when I don't know how my partner will react, I feel comfortable telling him/her anything about myself; even those things of which I am ashamed.

3. Though times may change and the future is uncertain, I know my partner will always be ready and willing to offer me strength and support.

4. I am never certain that my partner won't do something that I dislike or will embarrass me.

5. My partner is very unpredictable. I never know how he/she is going to act from one day to the next.

6. I feel very uncomfortable when my partner has to make decisions which will affect me personally.

7. I have found that my partner is unusually dependable, especially when it comes to things which are important to me.

8. My partner behaves in a very consistent manner.

9. Whenever we have to make an important decision in a situation we have never encountered before, I know my partner will be concerned about my welfare.

10. Even if I have no reason to expect my partner to share things with me, I still feel certain that he/she will.

11. I can rely on my partner to react in a positive way when I expose my weaknesses to him/her.

12. When I share my problems with my partner, I know he/she will respond in a loving way even before I say anything.

13. I am certain that my partner would not cheat on me, even if the opportunity arose and there was no chance that he/she would get caught.

14. I sometimes avoid my partner because he/she is unpredictable and I fear saying or doing something which might create conflict.

15. I can rely on my partner to keep the promises he/she makes to me.

16. When I am with my partner I feel secure in facing unknown new situations.

17. Even when my partner makes excuses which sound rather unlikely, I am confident that he/she is telling the truth.

Part 3: Family of Origin

The family of origin is the family with which you spent most or all of your childhood years. This scale is designed to help you recall how your family of origin functioned. Each family is unique and has its own ways of doing things. Thus, there are no right or wrong choices in this scale. What is important is that you respond as honestly as you can. In reading the following statements, apply them to your family of origin, as you remember it. Using the following scale, circle the appropriate number. Please respond to each statement.

Key:5 (SA) = Strongly agree that it describes my family of origin
4 (A) = Agree that it describes my family of origin
3 (N) = Neutral
2 (D) = Disagree that it describes my family of origin
1 (SD) = Strongly disagree that it describes my family of origin

1. Mealtimes in my home usually were friendly and pleasant.

2. The atmosphere in my home was cold and negative.

3. The atmosphere in my family usually was unpleasant.

4. I remember my family as being warm and supportive.

5. We usually were able to work out conflicts in my family.

6. In my family, I felt that I could talk things out and settle conflicts.

7. Sometimes in my family, I did not have to say anything, but I felt understood.

8. In my family, no one cared about the feelings of other family members.

9. The members of my family were not very receptive to one another's views.

10. Conflicts in my family never got resolved.

11. My family members usually were sensitive to one another's feelings.

12. My parents encouraged family members to listen to one another.

Part 4: Mother/Caregiver

The following pages contain a number of statements describing the way different mothers act toward their children. Read each statement carefully and think how well it describes the way your mother treated you while you were growing up. Especially think about the time when you were about 7-12 years old. Work quickly; give your first impression and move on to the next item. Do not dwell on any item. Using the following scale, circle the appropriate number. Remember, there is no right or wrong answer to any statement so be as frank as you can. Respond to each statement the way you feel your mother really was rather than the way you might have liked her to be. If a person other than your mother took care of you most of the time when you were a child (infancy to age 12), please think of that person as your mother for the purposes of these statements.

Key : 4 = Almost always true of my mother
3 = Sometimes true of my mother
2 = Rarely true of my mother
1 = Almost never true of my mother

1. Said nice things about me

2. Nagged or scolded me when I was bad

3. Totally ignored me

4. Did not really love me

5. Talked to me about our plans and listened to what I had to say

6. Complained about me to others when I did not listen to her

7. Took an active interest in me

8. Encouraged me to bring my friends home, and tried to make things pleasant for them

9. Ridiculed and made fun of me

10. Ignored me as long as I did not do anything to bother her

11. Yelled at me when she was angry

12. Made it easy for me to tell her things that were important

13. Treated me harshly

14. Enjoyed having me around her

15. Made me feel proud when I did well

16. Hit me, even when I did not deserve it

17. Forgot things she was supposed to do for me

18. Saw me as a bother
19. Praised me to others
20. Punished me severely when she was angry
21. Made sure I had the right kind of food to eat
22. Talked to me in a warm and loving way
23. Got angry at me easily
24. Was too busy to answer my questions
25. Seemed to dislike me
26. Said nice things to me when I deserved them
27. Got mad quickly and picked on me
28. Was concerned who my friends were
29. Was really interested in what I did
30. Said many unkind things to me
31. Ignored me when I asked for help
32. Thought it was my own fault when I was having trouble
33. Made me feel wanted and needed
34. Told me that I got on her nerves
35. Paid a lot of attention to me
36. Told me how proud she was of me when I was good
37. Went out of her way to hurt my feelings
38. Forgot important things I thought she should remember
39. Made me feel I was not loved anymore if I misbehaved
40. Made me feel what I did was important
41. Frightened or threatened me when I did something wrong
42. Liked to spend time with me
43. Tried to help me when I was scared or upset
44. Shamed me in front of my playmates when I misbehaved
45. Tried to stay away from me
46. Complained about me

47. Cared about what I thought and liked me to talk about it

48. Felt other children were better than I was no matter what I did

49. Cared about what I would like when she made plans

50. Let me do things I thought were important, even if it was inconvenient for her

51. Thought other children behaved better than I did

52. Made other people take care of me (for example a neighbor or relative)

53. Let me know I was not wanted

54. Was interested in the things I did

55. Tried to make me feel better when I was hurt or sick

56. Told me how ashamed she was when I misbehaved

57. Let me know she loved me

58. Treated me gently and with kindness

59. Made me feel ashamed or guilty when I misbehaved

60. Tried to make me happy

DEMOGRAPHIC SURVEY

Please do not put your name on this sheet. All information is for research purposes only and will be kept strictly confidential.

Date of birth _____ Sex: ___ Male ___ Female

Race/Ethnicity:___ African American/Black ___ Asian ___ Hispanic
___ White/Caucasian ___ Native American ___ Other(Specify)

CHILDHOOD religious background: ___ Protestant ___ Catholic ___ Jewish
___ Fundamentalist Christian ___ Muslim___
___ Buddhist _____ Other (Specify) ___ None

Educational Level: ___ Less than 12 yrs. ___ High School Graduate
___ Some college or trade school
___ Bachelor's degree ___ Graduate work
___ Master's/other Graduate degree

Source(s) of education before 12th grade: ___ Public schools
___ Parochial schools
___ Both

IF you attended parochial schools, indicate number of years in:

___ Elementary___ Junior High___ High School

Marital Status: ___ Married ___ No. of previous marriages
___ Single ___ Cohabiting
___ Widowed ___ Divorced

Have you experienced a divorce, death of a partner, or termination of a romantic relationship within the last year?

___ Yes___ No

Number of Children: _____

Have you ever been in counseling/therapy? ___ Yes ___ No

If "Yes", how many months of counseling/therapy have you experienced?

_____

Are you currently in a relationship with someone who has problems with alcohol/chemical dependency or abuse?

___ Yes___ No

How satisfied are you with your relationship with your mate, partner or spouse (5=very much to 1=not at all)?

5 4 3 2 1

How satisfied are you with the number and quality of your friendships (5=very much to 1= not at all)?

5 4 3 2 1

How satisfied are you with your work and career life (5=very much to 1=not at all)?

5 4 3 2 1

The remaining questions concern the family in which you were raised :

How many brothers and sisters did you have? _____

Were you an oldest or youngest child? ____ Yes ____ No

Were you an oldest (or only) of your sex (oldest, or only, girl or boy)?

____ Yes ____ No

Has anyone in your immediate family ever had problems with alcohol/chemical dependency or abuse (father, mother, brother, sister)?

____ Yes ____ No

Has anyone in your extended family ever had problems with alcohol/chemical dependency or abuse (aunt, uncle, cousin, grandparent)?

____ Yes ____ No

APPENDIX C

LETTER TO SUBJECTS

November 10, 1992

Dear Participant,

Thank you for your interest in participating in this study about human relationships. When adults find themselves in satisfying or unsatisfying relationships, they often wonder why and how this happened. Some of the answers may lie in the ways they grew up as children. This research looks at the way a person currently feels about their life and their relationships, as well as memories about their childhood. Perhaps connections will be found between past and present experiences.

This packet contains a four-part questionnaire, a factual survey, and a consent form for you to complete and return. Parts 1 and 2 of the questionnaire deal with current circumstances; Parts 3 and 4 pertain to childhood. Although all of your responses are valuable, you have the right to refuse to answer certain questions if you choose. Once you have completed the forms, please mail them back to me in the self-addressed, stamped envelope. Once I receive your packet, your consent form will be separated from your responses and will be stored in a safe deposit box. Your responses will be given an identification number. Only identification numbers will be used to collect information. Your name will not appear on any of the forms. In order to protect your privacy and guarantee confidentiality, your name will never be used in any report of research findings. You indicate your voluntary agreement to participate by completing and returning this questionnaire.

The questionnaire and survey will probably take less than half an hour of your time to complete, but are vital to this research. Please return them as quickly as possible. Once the study is completed, a summary of the results will be mailed to you if you would like. If you would like a summary, please print your name and address on the enclosed postcard, and return it separately from the questionnaire and survey.

By agreeing to share some of your life experiences, you are providing family life educators and counselors with information which will enable them to help people in their communities. Since a limited number of people are being asked to participate in this research, your responses are especially important. If you have any questions or concerns, please write to me at the address below, or call (517) 337-7371. Thank you for taking the time to help others by completing these forms. I look forward to hearing from you as soon as possible!

Sincerely,

Nancy J. Lorris, M.A.
Department of Family & Child Ecology - Michigan State University
951 Sunset Lane
East Lansing, Michigan 48823

APPENDIX D

CONSENT FORM

December 15, 1992

Dear Participant:

You have been invited to participate in a study of human relationships. A letter which explains the research, its purposes and its procedures has been given to you. This explanatory letter also outlines how your privacy will be protected under all circumstances. You have been informed that your participation is voluntary, and that you may choose not to answer certain questions contained within the questionnaire and survey. You know whom to contact if you have questions or concerns about your participation in the study. You understand that only the researcher will have access to this consent form.

Thank you for your participation in this study.

I have read and understood the conditions of this study.

_____
please print name

_____
signed (respondent)

_____
address

_____
date

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