Relationship Addiction in Women:
A Proposed Conceptual Framework

LuAngela Cervone

A Scholarly Project: Submitted to Michigan State University in partial fulfillment of the requirements for the degree of Master of Science in Nursing

Running Head: RELATIONSHIP ADDICTION

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Acknowledgements

A warm and special thank you to Barbara Given, Committee Chairperson, who saw the promise in me and encouraged its gradual unfolding. Her persistance and perfectionism facilitated me to maximize my potential. Thank you to Clare Collins, who selectively self-disclosed ideas that helped to validate my own experience and challenged me to be thorough and concrete in my presentation and articulation of ideas. In fond appreciation, thank you to Linda French who listened, loved, corrected and cared. You know me well, and our trips back and forth to Lansing will be forever memorable. I appreciated your insistance upon clarity throughout the manuscript.

I wish to thank Jackie Wylie, my supervisor at Bronson School of Nursing for her continued support and encouragement. Thank you to Julie McEvers, my colleague and partner and to all faculty at Bronson for their continued interest and support. Special thanks to Judy Buss, my typist who endured many revisions and much printer aggravation.

Most of all, thank you to my loving, supportive family: My lover and best friend, Terry, for his understanding and tolerance of my strong will and determination at two in the morning. My daughters Autumn and Angeline, for their endurance of "early bed times so mommy can work on her paper". Never again will we skip a bedtime story! My mother, for her careful editing. My father, for his faith in me. My sister Mickie, for her listening ear and soul support. My sister Lynnette, for her understanding of

Co-Dependence. And my brother Antonio, for a sincere appreciation of graduate work and scholarly endeavors. I love you all.

Finally, for those who sat with me at meetings daily listening to my obsession with this work, thank you. You, too, are my family.

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ABSTRACT

In this scholarly project, the concept of relationship addiction in women is fully discussed. Etiological factors are proposed and resulting descriptive characteristics are postulated. Gilligan's theory of women's psychosocial development is considered as a possible predisposing factor. These concepts are then applied within Martha Rogers' nursing theoretical framework. The significance of the topic within the field of nursing is addressed. Concepts are all integrated and applied to the role of the clinical nurse specialist in the primary care setting. The necessity of public and health provider education is addressed. The importance of research to validate the presence of the problem and substantiate evidence for effectiveness of treatment measures is proposed. Finally, concerns regarding the popularity of the topic are addressed and recommendations for research proposed.

CHAPTER I

INTRODUCTION TO THE PROBLEM

The concept of addiction is, at its best, a misunderstood catch-phrase used indiscriminately in social circles today. For some working in the area of chemical dependency, addiction is that final physiologically involved stage in which all body systems biologically depend upon the substance to maintain life. For the drug or alcohol addict himself, addiction becomes an experience; a way of life involving loss of self replaced by a substance defining self. For the bulemic, addiction involves relationship between the self and that needed but never satisfying substance called food. For the compulsive gambler, compulsive worker, or the compulsive spender, the addictive experience is, once again, a relationship between an owned emptiness and an experience which never satisfies the insatiable hunger within. For the public,addiction becomes a word used in passing to emphasize a habitual engagement in a pleasant pastime. ("I'm <u>addicted</u> to those Goo Goo Clusters." "I'm just <u>addicted</u> to this TV show.")

It becomes easy to understand then how the concept of addiction can become so misconstrued based on the varied contextual definitions. It is important, to clarify this concept — addicition—in a generic sense and to outline those characteristics which validate its presence regardless of context. One

purpose of this scholarly writing, then, will be to clarify the concept of addiction and to outline characteristics consistent within any contextual framework.

Once a basic understanding of addiction has been established the concept will then be applied more specifically to relationships. Relationship addiction is an even more obscure area of study than any of the aforementioned addictions. Little has been written in the area of relationship addiction with the exception of self-help literature and some case study presentation in the psychology literature. Covert representation of the characteristics of relationship addiction lie within Horner's work on Object Relations, (Horner, 1978 and Horner, 1979) but no specific reference is made to the concept "addiction".

Pathogenesis will then be proposed for the addictive process and multiple variables explored in their relationship to the developing pathology of addiction, more specifically, relationship addiction. One major variable predisposing one to this difficulty may be gender. An in-depth discussion of women and patterns or relating will be discussed.

After integration of concepts and a thorough review of the literature, these concepts will be applied within Martha Roger's nursing theoretical framework.

The overall goal of this scholarly writing is to develop a conceptual framework of relationship addiction as it applies specifically to women. This will be done in an attempt to 1) more clearly define concepts upon which to base valid and reliable quantative and qualitative methods of research and 2) to provide a base for delineating valid credible means by which the CNS may facilitate wellness in women experiencing relationship addiction.

Background

An interest in the concept of relationship addiction begins as one becomes aware of the distinct difference conversationally between men and women. Content, for the most part of many women, professional or non-professional seems to be centered around relationships with others: Friends, lovers, children, parents, men. Men they are in love with, dating, sleeping with, caring for, married to, getting to know, wanting to meet, wanting to avoid: Men. This author began to wonder how much self esteem of a woman is the result of, or the reason for, how she relates to a man. When one attends social functions, it becomes apparent that women cluster in the kitchen or on the porch chatting about and watching "their" men interact with other men. One senses a feeling of satisfaction among them, a contentedness and a nurturing tone as they comment on the behavior of the men. The

men, on the other hand, interacted much more actively with content matter centering around sports, news, and work.

The author elicited an informal poll and asked various people at various times and settings what they hungered for in a relationship. Men responded generally with "I want someone to be mine. I want someone to belong to me." Women, on the other hand, responded with "I want to belong to him. I want to be somebody's." The first, seemed to connote security in owning, in enveloping; a fairly powerful and active role. The latter seemed to connote security in being owned, being enveloped; a much more passive role. At what price, the author began to inquire. And what do women learn to assist them in getting these needs met? Since increased passivity and powerlessness affords a better chance for belonging to, how far are women willing to go to ensure the outcome?

The hunger for intimacy and human closeness seems to be tied strongly to the female gender. Gilligan (1982) proposes that women's development distinctly differs from men's in that connection becomes primary in defining self for women, whereas separation becomes primary in defining self for man. Mitchell (1975) speculates that this emotional attachment of the female gender is innate rather than learned behavior. Regardless of the origin for the behavior, most authors agree that in most cultures, women become emotionally attached in relationships more so than

men. "Women (often) define themselves in terms of their relationships with others" (Washborn, 1971, p. 53).

One's concern for women in relationships grows in watching many women sacrifice their integrity, self-esteem, and self-respect for crumbs of pseudo-intimate moments which later often ended in disaster and despair. Men seem to walk away from relationships, although hurt, with a network of support and varied interests, whereas women seem to have lost their soul. Men's loss seems to be exterior and life goes on. Women's loss seems to permeate their being and a general rebuilding of the self is often necessary.

From personal experience and careful observation the author's assumptions are these:

1. More women than men experience a loss of self in relationships.
2. Women endure trials and tribulations within the relationship more so than men in an attempt to ensure getting emotional needs met.
3. Most women experience dependence upon men due to socio-culturally learned behaviors (perhaps some inate behaviors). Some authors postulate men's dependency needs are greater but more easily met and/or hidden than women's. (Dowling, 1981)

4. Some people experience the dependency at such great lengths so as to limit appropriate judgment, produce inappropriate behavior, and interfere with health (the symphonic interaction between human and environment). Usually these people are those whose dependency needs were not met at an early age. Halpern (1982) addresses this through the concept of Attachment Hunger: That process which occurs between mother and child by which the child learns to trust that needs will be met in infancy. If this process is not completed and successful, attachment hunger persists throughout life and becomes the basis of addiction. The roots of such a theory lie in object relations theory.

Because women are socialized as dependent and passive, they may be at a higher risk than men in entering into an addictive relationship with another person. Since nurturing, social support, and emotional intimacy are all interactional events important to the substance of most women's self-esteem, it seems apparent that the "drug of choice" for most women prone to an addictive nature might be one that involves another person -- either the relationship (defining herself in terms of the relationship), the person (defining herself in terms of the other person), or elements of the relationship (romance, sex, competition).

For these reasons, in this scholarly writing "relationship addiction" will be discussed as an occurrence among women.

Statement of the problem.

What is relationship addiction? Very little concept development has been done in this area. In most literature, addiction is immediately associated with drug/alcohol use. Peele has begun to address the topic from a sociological perspective (1975,1985); Tennov (1980) and Norwood (1985) from a psychosocial perspective; and Halpern (1982) and Salzman (1981) from a psychodynamic point of view.

Does dependence differ from addiction? How so? There seems to be a dividing line between the two. A distinction needs to be made and a concrete formula proposed to be able to distinguish where the pathology of addiction begins. No such clear distinction has yet been addressed in the literature. Pathology must be defined to appropriately direct research and practice.

Finally, how does being a woman affect one's propensity to such a disorder? Does the need for connection (Gilligan, 1982) affect the predisposition of a woman to the addiction process? Or does it merely provide a channel for the addictive disorder to manifest itself in, provided other etiological factors are in place. (attachment hunger, Halpern, 1982; unreasonable parental achievement expectations, Woodman, 1987)

It is imperative to clearly define the concept and to delineate those characteristics (both descriptive and etiological) associated with the concept to provide a framework from which to work in establishing credible research in the area of relationship addiction.

What is relationship addiction? One must first address the concept of addiction prior to specifying type. A broad definition of the term "addiction" is found in Tabers (1977) which states "Enslavement to some habit..." (p.A33). Peele (1975) defines addiction as:

> A pathological habit...a malignant outgrowth...an extreme unhealthy manifestation of normal human inclinations...An experience...one which grows out of an individual's routinized subjective response to something that has special meaning for him... something, anything, that he finds so safe and reassuring that he cannot be without it. (pp 15-16)

Peele clarifies in a later text (Peele & Brodskey, 1985), "The difference between not being addicted and being addicted is the difference between seeing the world as your arena and seeing the world as your prison." (p.64) A very important classification is made in the latter experiential definition. The concept of choice and lack thereof is implied. Thus, perceived lack of choice becomes an important criteria in definition. The element of

escapism is also inherant in addiction. Salzman (1981) states, "The techniques of defense, denial, rationalization and many others...reflect the human desire for easy, magical solutions and man's inability and unwillingness to endure discomfort or tolerate anxiety." (p.340) He goes on to say that "Although dependence, orality, masochism, and passivity play a large role, obsessional devices to control and manipulate oneself and the environment are even more important in behaviors of excess." (p. 341)

Woodman (1987) adds another refreshing dimension to the concept of addiction. She addresses the concept with a Jungian approach proposing the insatiable hunger to be of a spiritual origin with surrender as its salvation. The human soul of the addict seeks the higher self and gets lost in elusive and unsubstantial endeavors along the way. Relief and recovery come only through "death and resurrection" (p.61)...death to old ideas, old gods (substances, objects), old habits, old fears (inability to tolerate life's discomforts). Surrender to its principle (usually occurring at one's "bottom"—lowest point in addiction) brings about resurrection: The new self---realistic, humble, capable, in essence the higher self.

Addiction, therefore, is a pathological state which can be identified by the presence of the following characteristics:

1. An insatiable emotional hunger
2. An emptiness within

3. A perceived lack of choice in anything associated with the object of addiction use.
4. A perceived lack of power and/or satisfaction without the object of addiction.
5. A periodic sense of power and/or satisfaction with the object of addiction.
6. A sense of remorse following indulgence in the object of addiction.
7. An inability to tolerate emotional discomfort
8. An overwhelming desire to control the circumstances involving the object of addiction.
9. A sense of safety when engaged in interaction with the object of addiction.
10. Obsessional thoughts about and cravings for the object of addiction.
11. Spiritual starvation.
12. Habitual involvement with the object of addiction.
13. Compulsive, self-defeating behavior associated with the object of addiction.
14. Defense mechanisms of denial and rationalization utilized in association with use or abuse of object of addiction.
15. Constant attempt to protect self from environment.

"Object of addiction" indicates any substance, situation, activity, person, or thing which becomes the addicted person's vice.

Relationship addiction, then, can be perceived as habitual involvement in a relationship which interferes with symphonic interaction between human and environment manifested by persistant craving and obsessional thoughts about a person, relationship, or elements thereof whereby choices seem to be lacking and powerlessness and enslavement to the situation prevail.

The objects of relationship addiction may include:

1) The relationship itself: The woman may find her identity enmeshed in the relationship. Her elements of identity are dependent on the interaction that occurs in the relationship.
2) The partner himself: The woman may find that suddenly her preferences have changed. She enjoys the interests of her partner and begins to use likes, beliefs, of the partner to define her self.
3) Components of the relationship: Romance, sex, abuse (emotional and physical) and competition. The thrill of these occurrences within the relationship are often enticing in that they

> usually produce strong feelings. It has been suggested that addiction to strong feeling itself is viable with some biochemical changes proposed.

Bennett (1976) suggests that "addiction to strong feelings can occur as a result of a surge of Norepinephrine (NE) in the brain at the time. The effect of the NE is a state of arousal which can later be sought for by the individual and obtained when expressing strong feelings." Women addicted to these experiences do so in an habitual effort to escape painful reality, or in attempts to succeed at mastering the task (abuse). Habit rather than definition of self is more often the issue in this group.

How does addiction differ from dependence? A distinction must be made between dependence and addiction. To "depend" is described by Webster (1961) as "to be contingent; to require something as a necessary condition" (p.604). Dependence is defined as "the quality or state of depending upon something else" (Webster, 1961, p. 604). Dependence, therefore, becomes a part of everyday life. One depends upon his automobile to function properly to drive himself to work. One depends upon food for replenishing the body's nutritional stores. People depend upon one another for needs to be met — physically and emotionally.

Dependence is a part of the human condition often tempered with independence to ensure balance.

Salzman (1981), in attempts to distinguish between dependence and addiction, states:

> Dependency on drugs or devises may arise for many reasons and serve many purposes which can be classed under two headings: analgesia or stimulation. In either case, drugs are taken to alleviate painful feelings or to stimulate and enhance pleasurable effects. The individual does not suffer from the behavior, but enjoys it. The development of drug addiction is related to the pleasant effects of the drug combined with the individual's capacity to deny the deleterious effects. (p.342).

The same is true in situational addiction where one becomes addicted to a person or event. Hence, dependence is for the most part a pleasant event, where healthy interaction still occurs between person and environment. Addiction begins to occur when the person experiencing pleasure from the situation begins to experience deleterious effects, denies them, and continues the habit. Healthy interaction between person and environment is impaired. Choices seem limited. The individual experiences powerlessness.

Therefore, for purposes of clarification in this paper "dependence" will be described as a non-pathological human phenomenon evidenced by the following characteristics:

1. A sense of needing combined with an ability to get needs met.
2. A perceived ability to choose.
3. A sense of self power remains.
4. Minimal indulgence, no remorse.
5. A dislike for but tolerance of discomfort.
6. Feels in control of self; no need to control outside matters.
7. Experiences some vulnerability, but generally experiences the world as a safe place in which to exist.
8. Minimal obsessional thinking.
9. Spiritually content.
10. A lack of habitual or compulsive behavior
11. Inability to make decisions readily
12. Passivity
13. Some healthy interaction with environment.

Dependency, if placed on a continuum, preceeds addiction and may be a precusor to addiction. All dependent people, however, are not at risk for developing addictive behavior. Dependence is

not the pathogenesis for addiction. Another etiological factor must be present (attachment hunger, unreasonable parental achievement expectations).

Being a Woman: Evidence has been presented earlier in this paper supporting the notion that women may be more vulnerable to relationship addiction. The three primary ideas that support this, stated briefly are that:

1) Women's development may differ from men's in that connection seems to be an integral part of being and defining self whereas separation seems necessary in male development. (Gilligan, 1982)
2) Women are socialized to be nurturing and to value interpersonal contacts and relationships more so than men. (Washburn, 1977)
3) Women are socialized to be dependent on men hence creating a climate conducive to a progression from dependence to addiction and a need to find self-identity in reference to a man. (Norwood, 1985, Washburn, 1977)

For the above stated reasons, these concepts and constructs surrounding relationship addiction will be applied to women. The author does not deny the possibility of the occurrence of relationship addiction in men. However, informal observation by the author and others (Halpern, 1981, Tennov, 1980, Norwood, 1985) has provided data which supports the occurrence of the problem

more frequently and more intensely in women. Since men experience separation as a normal part of their development, and since men are ascribed roles promoting the separation sociologically, the major predisposing factors central to the etiological construct appear to be absent in men. Being "woman" then, is central to the phenomenon under study in this scholarly writing.

For purposes of clarification in this paper, the concept "women addicted to relationships" will be defined as follows: Woman experiencing obsessive thoughts about a person, relationship or elements thereof, whereby the experience interferes with daily functioning of the unitary being. The woman's experience includes a perceived lack of choice regarding actions or thoughts, with persistant cravings for the person, relationship, or elements thereof and an enslavement to the habits that perpetuate deleterious effects of the relationship. Denial of deleterious effects is often present. The experience leads to increasing interference in harmony between the environment and the person thereby limiting health and wellness until the situation resolves or replays itself.

Rationale for selection of topic:

It is obvious from popular non-fictional literature sales (Norwood, 1985; Cowan, 1985; Dowling, 1981) that women in problematic relationships with men is a significant societal problem. Informal observation of personal interations, media, and

literature further validate the presence and extent of the problem. Treatment centers, which traditionally facilitated recovery of only the substance addict, are now acknowledging and treating people for situational addictions. Further societal significance of relationship addiction will be addressed in the review of the literature.

Limitations

The literature is scarce in reference to relationship addiction. Therefore information will be drawn from the areas of substance abuse, including addiction and co-dependence literature, women's studies, including developmental theories, and popular psychology and self-help literature. A very real limitation is that little has been done theoretically in reference to relationship addiction, with the exception of Peele (1975), Halpern (1982) and Horner (1978). No valid and reliable quantitative research has been done in the area. No tools have been developed. Although case studies are cited in each book, no real qualitative research has been described. It therefore seems appropriate to begin to clarify the concept to facilitate utilization for research.

Significance of topic to nursing practice and theory

Since nursing has been defined as, "the diagnosis and treatment of human responses to actual or potential health problems" (ANA Publication, 1982), it seems appropriate to study a

problem which actively impacts upon symphonic interaction between the unitary being and the environment. A goal in nursing is to maximize health and wellness (symphonic interaction between person and environment). To do so, one must develop a framework within which to place a concept. This scholarly writing will attempt to develop that framework from which to work in doing research to validate the experiences of relationship addiction and later, to substantiate treatment effects.

Summary

In summary, in chapter one the author has provided an introduction to the concept of relationship addiction. An overview of the broad concept (addiction) and the specific concept (relationship addiction) has been discussed. Possible intervening variables (woman's development, pathogenesis) have been proposed. An in-depth review of the literature will follow and the development of a conceptual framework with a Rogerian base will be proposed. Finally possibilities for research will be reviewed with an application to advanced nursing practice.

CHAPTER II: REVIEW OF THE LITERATURE

In this chapter, the author will review and critique the literature associated with relationship addiction. The topic of healthy relationships will be addressed briefly to provide a base from which to work. A discussion of how women relate will follow. The concepts of addiction and relationship addiction will then be discussed in depth including definition, characteristics, and proposed etiological factors.

A. Healthy Relationships

Shaeffer (1986), a psychotherapist whose interest lies in the area of relationship addiction defines working, functional relationships in terms of "healthy belonging". The goal "in loving is not dependency on another, but healthy belonging". (Shaeffer, 1986, p. 1). She goes on to describe the experience of healthy belonging. The experience of healthy belonging is one in which the individual in a relationship:

1) Allows for individuality.
2) Experiences both oneness and seperateness from a lover.
3) Brings out the best qualities in both partners.
4) Accepts endings.
5) Experiences openness to change and exploration.
6) Invites growth in the other.
7) Experiences true intimacy.
8) Feels the freedom to ask honestly for what is wanted.
9) Experiences giving and receiving in the same way.

10) Does not attempt to change or control the other.

11) Encourages self-sufficiency of partners

12) Accepts limitations of self and partner

13) Does not crave unconditional love

14) Finds commitment acceptable

15) Has a high self-esteem

16) Trusts the memory of the beloved; enjoys solitude

17) Expresses feelings spontaneously

18) Welcomes closeness; risks vulnerability

19) Cares with detachment

20) Affirms quality of self and partner

(Shaeffer, 1986, p. 3-4)

Overall, the experience includes maintaining of self while risking vulnerability and closeness to other. A healthy sense of self-respect, combined with a desire and need for connection, occurs.

Fromm (1956) addresses the concept of healthy relationships in a more theoretical sense by discussing love as an art: a learned experience which most people have not yet learned. He passes this on three premises. "Most people see the problem of love primarily as that of being loved, rather than that of loving, one's capacity to love." (Fromm, 1956, p. 1) The first premise, then, is that energy is consumed in attempting to be loved rather than in learning to love. The second premise is that societal

perception is such that it believes the difficulty lies not in the inability to love, but in finding "the right object to love or be loved by." (p. 2) The third premise is that "falling in love" is often confused with love and true intimacy. Short-lived intimate moments do not create the ground work for the experience of loving over time. Fromm proposes that love is an art that must be learned by mastering first the theory and then the practice. The practice of any art, including love, "requires discipline, concentration, and patience." (Fromm, 1957, p. 91-92). This is followed by "a supreme concern with the mastery of the art" (p. 92) — that is, the art must be "of supreme importance" to the apprentice in order to achieve mastery (p. 92).

So, whereas Shaeffer provides a somewhat simplified framework of the makings of a healthy relationship, Fromm proposes a much more theoretical approach in defining the makings of love. Fromm discusses content (theory) as well as process (practice). Fromm's work seems much more substantial as a theoretical base from which to work in studying the process of love.

B. How Women Relate

Gilligan (1982) proposes that women relate differently than men. The roots in this difference lie in early childhood development as proposed by Chodorow (1974). Gilligan gives a summary of childhood development that proposes, cross culturally, women's early childhood care promotes female identity formation through

connection and attachment with others, whereas male identity formation is the result of separation to establish firm ego boundaries. Chodorow (1974) further proposes that "women (do not) have weaker ego boundaries than men" (p. 167). Instead she states "Girls emerge from this period with a basis for 'empathy' built into their primary definition of self in a way that boys do not" (p. 167). She goes on to say, "Girls emerge with a stronger basis for experiencing another's needs or feelings as one's own (or thinking that one is so experiencing another's needs and feelings)" (p. 167).

Gilligan (1982), commenting on Chodorow's reflection, states:

> Consequently, relationships, and particularly issues of dependency, are experienced differently by women and men. For boys and men, separation and individuation are critically tied to gender identity since separation from the mother is essential for the development of masculinity. For girls and women, issues of femininity or feminine identity do not depend on the achievement of separation from the mother or on the progress of individuation. Since masculinity is defined through separation while femininity is defined through attachment, male gender identity is threatened by intimacy while female gender

> identity is threatened by separation. Thus males tend to have difficulty with relationships, while females tend to have problems with individuation. (p.8)

In a recent study, Pollak and Gilligan (1982) found that men perceive danger in situations of affiliation whereas women perceive danger in situations of achievement. In this study, Pollak and Gilligan utilized Thematic Apperception Test cards to elicit a response in male and female college students. Stories were written by the students correlating with the picture on the TAT. Four pictures were chosen for the study: two implying affiliation between a man and a woman and two implying "impersonal achievement situations" (p.41) The study reports "statistically significant sex differences in the places where violence is seen and in the substance of violent fantasies as well" (Gilligan, 1982, p.34.) The stories written by the students were analyzed. Men perceived affiliative (connective) situations with fear. Women, on the other hand, perceived achievement situations with fear and interpreted them as potentially harmful — a threat to connection with others.

Women's need to connect and affiliate is central to her experience as an individual. Furthermore, Gilligan proposes, her committment to care for, help, and not hurt is central to her decision making process in moral dilemmas.

Gilligan goes on to test this premise in clinical testing situations utilizing a moral dilemma from a series of moral dilemmas developed by Kohlberg. Her results found in this dilemma, and in other moral descriptions, that males tend to arrive at a moral conclusion mathmatically and logically in a very separate sense, claiming clearly what is right and just, whereas females tend to arrive at a moral conclusion by restructuring the dilemma to allow for responsiveness and connectedness. Gilligan proposes that presentation of the Kohlberg dilemma testing may be biased in that the idea presented by the test subject is never heard or recognized as a reconstrued dilemma, but is judged "less than" on the male moral development scale.

Gilligan (1982) also studied women undergoing an abortion decision and found the statements of the women centered around connection with self and that the process entailed conflicts of caring for herself and/or others more so than "right" or "wrong" decisions. Again, connection and care are the main concerns to women.

Male interpretation of responsibility, she concludes is "a limitation of action, a restraint of aggression...He seeks rules to limit interference and thus to minimize hurt." (p. 37) Female interpretation of responsibility "proceeds from a premise of connection" (p. 58) and connotes action taken to ensure connection. Considering this proposed primacy of connection in

relationships for women, it is easy to understand their vulnerability to relationship addiction.

In summary, Gilligan proposes a unique means of experiencing self and relating to others as a woman. She sees definition of self and moral decision making as a unique process encompassing such factors as connection and caring. A pathological element present (attachment hunger, unreasonable parental achievement expectations) in combination with women's developmental characteristic of needed connection makes relationship a prime object of addiction.

C. Concept of Addiction

It seems only appropriate to begin discussion with the origin of the addiction process concept. The concept of addiction has been studied since the time of Freud in the early 20th century.

Classic work on addiction came to the forefront in the literature via alcohol addiction in the 1950's and 1960's. It becomes important, then, to review this literature for an appropriate base from which to work.

Jellenick, (1960) known to many therapists and authors in the area of substance abuse as the father of the disease model of alcoholism, defines alcoholism as, "any use of alcoholic beverage that causes any damage to the individual, society, or both." (p. 33). Jellenick breaks down the concept of alcoholism into five catagories (p. 33-35) as follows:

1) Alpha alcoholism - a purely psychological addiction where there is continued dependence and reliance upon the effect of alcohol to relieve bodily or emotional pain. The person experiences "undisciplined" drinking and a "loss of control" at times when drinking. There is an inability and sometimes an unwillingness to abstain. Low productivity ensues and financial distress appears. Damage lies in disturbance of interpersonal relations. Often there are no signs of the progressive process. One may go 30-40 years without progression.
2) Beta alcoholism - Clinical signs include polyneuropathy, gastritis, cirrhosis. Often these occur without physical or psychological dependence. Instead, there seems to be an extreme sensitivity to alcohol and its detrimental effects on the body.
3) Gamma alcoholism - an increased tissue tolerance to alcohol occurs with adaptive cell metabolism. One experiences withdrawal without the drug and a loss of control with the drug. There is progression from psychological to physical dependence. Health problems arise with physical dependence.
4) Delta alcoholism - same as gamma plus inability to abstain.
5) Epsilon - periodic inability to abstain.

One might question the relevence of such staging data for alcoholism within the context of this scholarly writing. The importance of this data lies in society's misperception of a dysfunction occurring only when one is diagnosed with gamma, delta or epsilon alcoholism. The truth lies in that many in society function "normally" as an alpha or beta alcoholic with no perception of the effects of the substance on the mind, body, or relationships. It is proposed by others (Norwood, 1985, Schaeffer, 1987) that many women experiencing relationship addiction come from such functional alcoholic homes.

The literature is quite consensual on defining addiction whether in reference to drugs or alcohol. Swinson and Eaves (1978) explore drug addiction and habituation and describe them as follows:

Drug addiction includes:

1. An overpowering desire or need to continue taking the drug and to obtain it by any means.
2. A tendency to increase the dose.
3. Psychological and physical dependence on the effects of the drug.
4. Withdrawal symptoms when drug is removed.
5. The effect is detrimental to individual and society.

(p. 56)

Drug habituation includes:

1. A desire to continue taking the drug for a sense of improved well-being.
2. Little or no tendency to increase the dose.
3. Psychological dependence, no physical dependence or withdrawal.
4. Detrimental effects on the individual himself only. (p.56)

Swinson and Eaves (1978) descriptors can be applied within the framework of relationship addiction. Usually the person experiencing relationship addiction is consumed by the experience and will give up important healthy functioning events in order to obtain more and more time, energy,and presence of the other person. Bennett's (1976) proposed "addiction to strong feeling" could support physical dependence upon the situation and may suggest a physiological withdrawal when Norepinepherine is no longer available in large quantities at the synapse sights. Finally, any obsession disorder to this degree affects society by one's dysfunctional interaction with the environmental field. It could be speculated, then, that relationship addiction is a valid and credible addiction that possibly meets even drug addiction criteria.

The process of addiction was proposed in 1960 when Jellenick delineated a progression. The process consists of a general pro-

gression of symptoms from the early stages of denial, through remorse over drinking, through attempts to control drinking into the middle stages where physical changes begin to occur (liver enzymes elevated, blood pressure elevated) into the late stages of the disease, where all attempts to control drinking are exhausted and tolerance is very low. Death, insanity or recovery are imminent. (Refer to Figure 1 page 36)

The process of addiction in codependents (those closely associated with the chemically dependent person) follows a similar progression with the major focus as the alcoholic, rather than the alcohol itself. The partner denies the reality of the drinking and experiences remorse over discord with the alcoholic. The co-dependent then develops medical problems and may begin to utilize prescription drugs to remedy the situation. Finally in the last stages, suicidal threats and attempts are made. Again, death, insanity or recovery are imminent. (Refer to Figure 2 page 37)

Norwood (1985) takes the progression process one step further and applies it to relationships (Refer to Figure 3 page 38). The progression and outcomes are virtually the same, but the obsession is not focused on a drinker, necessarily, but on a man and/or the relationship.

The idea of addiction in relationships is not all new. Peele (1975) discusses this possibility as early as 1975. He embraces the idea that addiction to love is a far more serious problem

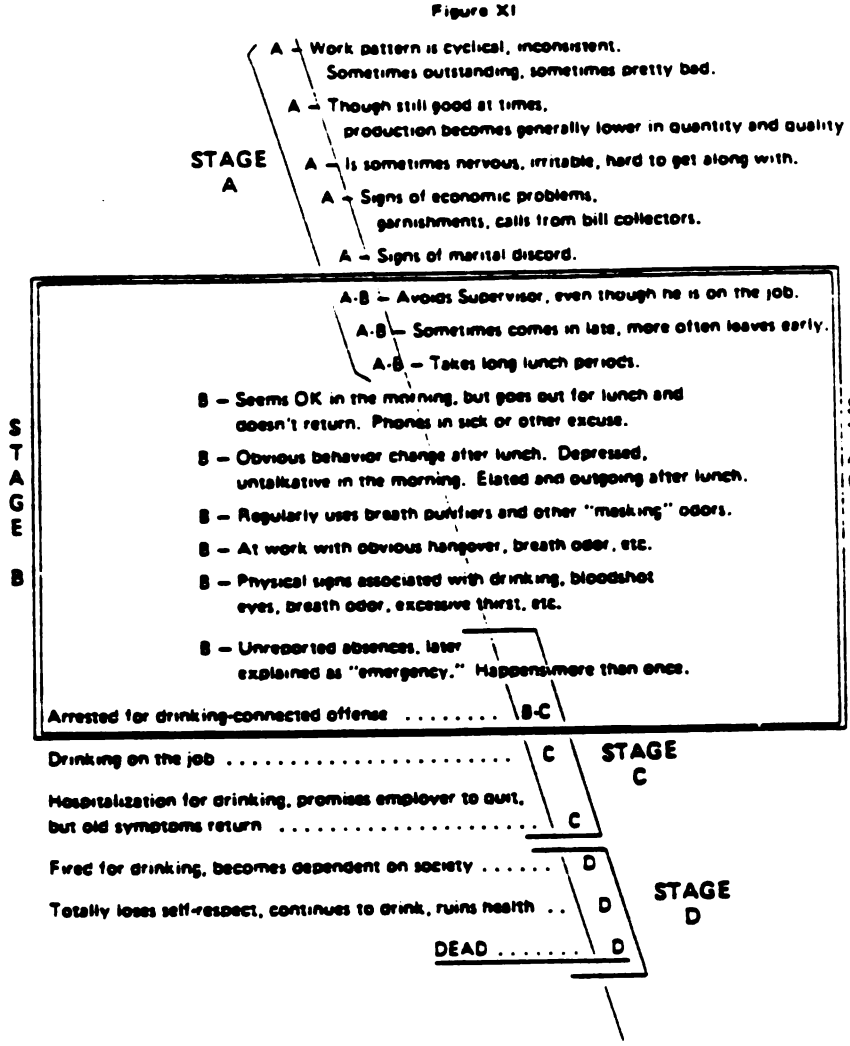
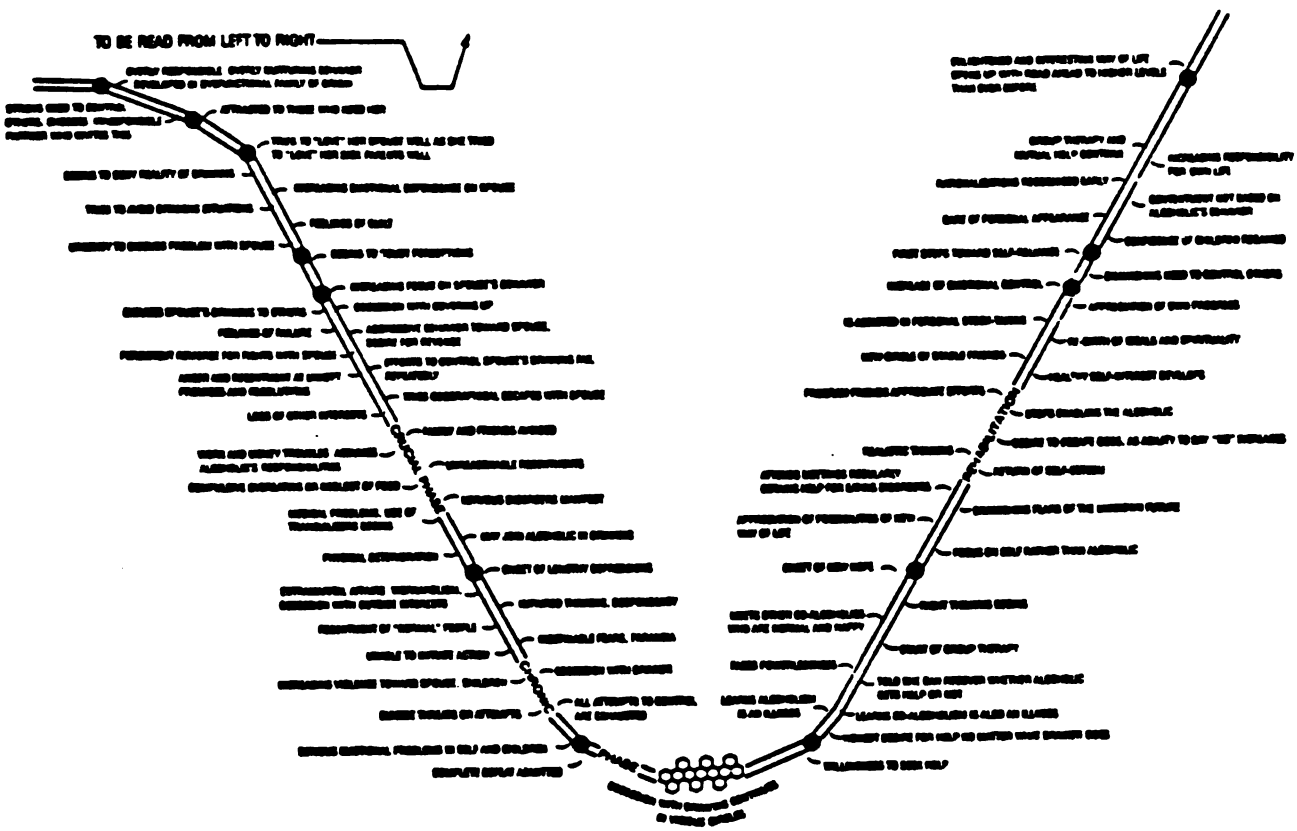


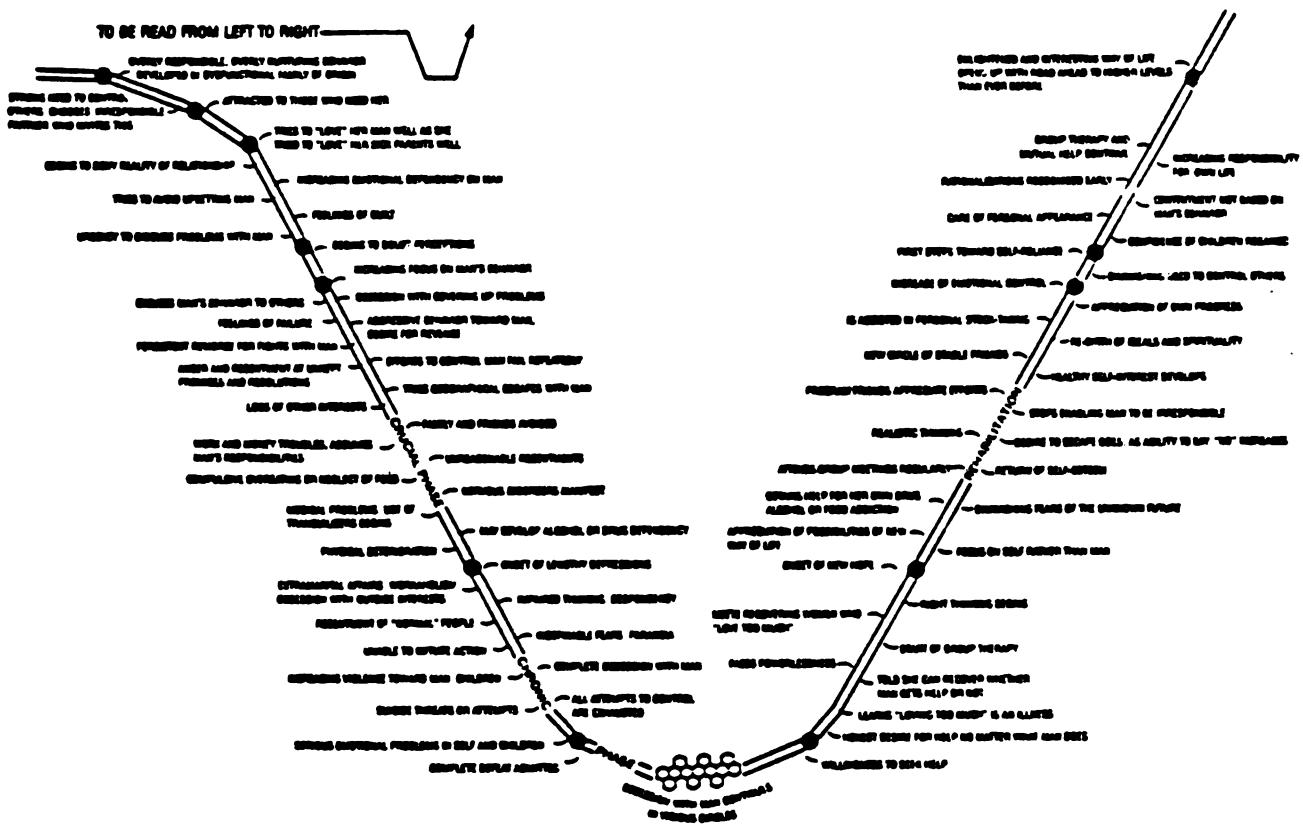
Figure 1: Process of Progression of Alcoholism as proposed by Jellenick. (1960). Taken from Johnson, V. (1980). I'll quit tomorrow. N.Y.: Harper and Row Publishers



Alcohol Addiction and Recovery

Figure 2: Process of Progression of Codependence

As proposed by Glatt



The Progression of "Loving Too Much" and Recovery

Figure 3: Proposed Progression of Relationship Addiction

(Norwood, 1985)

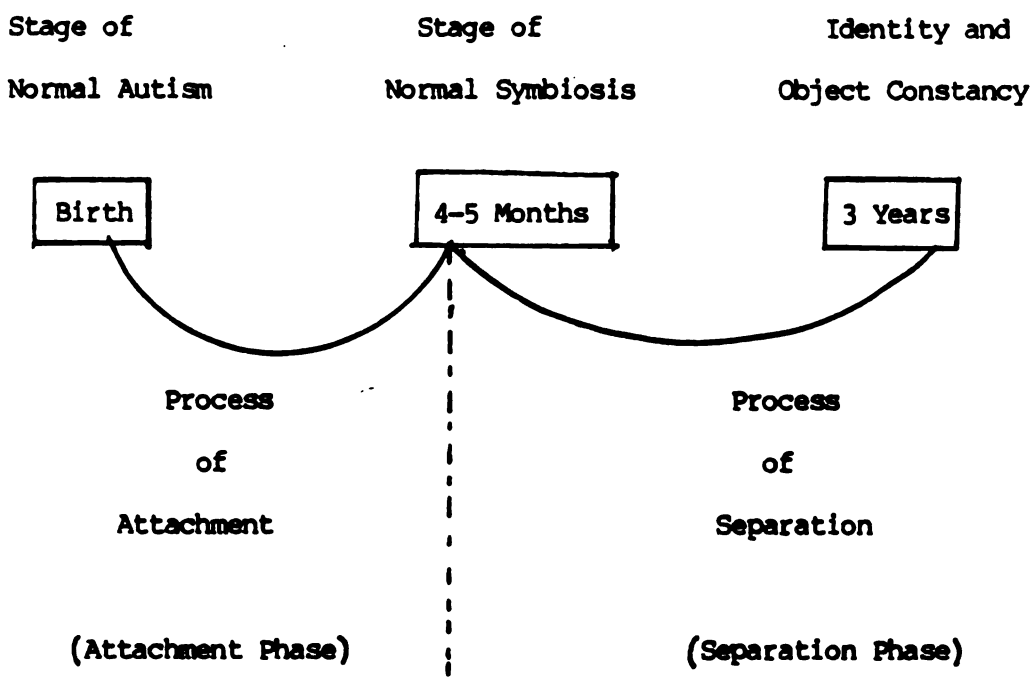
merely because of its prominence and secrecy (it is not openly discussed). Tennov (1980) masterfully addresses the problem of romantic love. She coins the word "limerence" to describe "being in love" and discusses obsession in her limerent subjects ranging from 20% to 100%, at which time complete immobilization of the subject occurs. Subjects have left positions, dropped classes, stopped eating, and become socially recluse for a period of months to years depending on the severity of the obsession and limerence. Tennov asserts that the problem is not gender specific (pp. 220-221). It seems women discuss the issue more openly, but many men, particularly middle-aged professionals, responded to Tennov in confidence following publication of a newspaper and magazine article.

Norwood (1985) studies specifically women and their responses. A common characteristic of the women described by both Tennov and Norwood was their "together" appearance. Most women going through such experiences appear to be very astute, alert, intelligent and capable. They appear to be very independent. Norwood postulates that the independent nature of the women may be a survival mechanism learned growing up in dysfunctional, often alcoholic, homes. The children in such families generally grow up quickly to learn to care for and protect themselves and their siblings. Dependency needs were not met in childhood and were surpressed or repressed in adulthood. When a dependence begins,

it is not so easily tempered with independence and a balance achieved. The addiction process often sets in as an attempt to "consume" the affection and attention denied for so many years.

Proposed pathogenesis, possible etiologies and descriptive characteristics: How the trouble began is often necessary to discover, if one is interested in proposing treatment possibilities. Substance abuse and codependent literature are proposing that relationship addiction often occurs in a group receiving increasing attention today: Adult Children of Alcoholics. These children grow up learning to function independently at a very young age and exhibit many addictive behaviors related to substances, food, gambling, relationships, and/or work. (Black, 1982, Norwood, 1985, Shaeffer, 1987).

Some psychologists see alcoholism and chemical dependency as an oversimplified answer to describing addictive behavior in relationships and instead propose that roots for relationship addiction lie within dysfunctional development in the attachment phase within object relations theory. (Halpern, 1982). Horner (1979) (Refer to Figure 4 page 41) describes the stages of development to include Stage I: Normal Autism, Stage II Normal Symbiosis, and Stage III, Identity, Object Constancy and Healthy Self Esteem. (p. 26). The process which occurs between State I and Stage II is the Attachment process: that process where the infant attaches and experiences the world as a part of himself.



Appendix 4: Object Relations Development Theory.

(Horner, 1984)

The above model displays the process of identity formation as discussed by Horner. A proposed etiological factor is that of attachment hunger which occurs as the result of an uncompleted attachment phase. Note here, also, that Gilligan's model proposes a possible gender distinction in the separation phase.

Trust is the core issue in the attachment phase. The process proposed to occur between Stage II and Stage III is separation and individuation. Through a series of steps, the child progresses or "hatches" (p. 30) from the normal symbiotic relationship to become more autonomous through a series of steps. Impedement in this process at the attachment phase, where dependability is not available to the infant, leaves the individual with an insatiable yearning or "attachment hunger" (Halpern, 1982, p. 14). The separation phase is then hampered and a reactive separation and individuation occurs, but the insatiable hunger and neediness continue throughout life if untreated. Because the individuation and separation is reactionary, the person may at times appear highly productive and independent. The neediness, however, remains though well-masked by the independence.

Caution must be taken here to note that Gilligan's proposed developmental gender differences may be in conflict with the latter stages of object relations theory. Separation process may differ between male and female. The important aspect to consider is that a dysfunctional attachment phase (same for male and female) may be the pathogenesis involved.

Integrating the ACA and attachment hunger issue, then, it becomes obvious that many children growing up in alcoholic homes, were probably victims of an attachment disorder. The parent may have been ill enough to not be present physically, certainly pro-

moting dysfunctional attachment, or the parent may have been emotionally unavailable in the early stages of their disease, thereby also promoting an attachment disorder for the child.

Another etiological perspective to examine is one addressed by Woodman (1982) where she proposes that unrealistic parental expectations of a child (hyper-responsibility and hyperproductivity at an early age) help to create an emptiness in the child. The child begins in search of the "answer" to the emptiness and begins to follow an addictive path utilizing many objects or situations in the process.

All etiological perspectives conclude in the hunger or emptiness within as the primary characteristic of the addictive experience.

The Addictive Experience. Peele (1983) sets criteria by which to identify the addictive experience. (p.65) He states the experience:

1. Eradicates Awareness.

This primary standard involves absorption of one's consciousness "...so as to eradicate awareness of pain, tension, anxiety, and problems which bring these on." (p.65)

2. Destroys Other Involvements and Gratifications.

The addictive experience dominates one's life to the exclusion of other relationships and satisfying events.

3. Provides Artificial Sense of Power and Self-Esteem.

One uses the addictive experience to gain a temporary sense of control that dissipates quickly, following the event, when powerlessness and diminished self worth set in. This then in turn leads the addicted person to reproduce the experience in attempts to regain a temporary sense of control.

4) Not Pleasurable.

"A person turns to an addiction to obliterate other experience, not to enhance it." (Peele, 1983, p. 65). The addiction results from an unpleasant experience of reality.

5) Predictable.

The experience, drug or other wise induced, results in a predictable outcome, usually temporary relief. (p.65)

Halpern (1982) proposes five signs of addiction in a relationship:

1. Even though your objective judgment (and perhaps the judgment of others) tells you that the relationship is bad for you and you cannot expect any improvement, you take no effective steps to break with it.
2. You give yourself reasons for staying in it that do not hold water or that are not really strong enough to balance the negatives in the relationship.
3. When you think about ending the relationship, you feel dread, even terror, and you cling to it even harder.

4. When you take steps to end it, you suffer acute withdrawal symptoms, including physical distress, that can only be relieved by reestablishing contact.
5. When the relationship is really over (or you fantasize that it has ended), you feel the lostness, aloneness, and emptiness of a person eternally exiled—often followed or even accompanied by a feeling of liberation. (p. 10)

Hence, again, a comparison with the process of alcoholism is made. Halpern not only addresses the attachment hunger etiology basis for relationship addiction; he integrates the etiology into the experience and links it to the similar experience of alcoholism.

Shaeffer (1987) lists indicators for the experience of addictive love:

> People in addictive relationships experience the following:
>
> 1. They feel consumed.
> 2. They cannot define ego boundaries.
> 3. They exhibit sadomasochism.
> 4. They fear letting go.
> 5. They fear risk, change, and the unknown.
> 6. They experience little individual growth.
> 7. They do not experience true intimacy.
> 8. They play psychological games.

9. They give to get something back.
10. They attempt to change the other.
11. They need the other to feel complete.
12. They seek solutions outside the self.
13. They demand and expect unconditional love.
14. They refuse to commit themselves.
15. They look to others for affirmation and worth.
16. They fear abandonment when routinely separated.
17. They recreate old, negative feelings.
18. They desire, yet fear, closeness.
19. They attempt to take care of others' feelings.
20. They play power games. (p. 38-39)

She goes on to clarify each of the statements with a brief description. Again, although a somewhat simplified structure, it provides guidelines for classifying a relationship as addictive or non-addictive. Most assuredly, research needs to be done to validate the presence of these characteristics in addictive relationships.

A Sociological Perspective. It is important to note here that the addictive substance or event itself is not the problem. Peele (1983) states:

> ...Addiction is based on the experience the person derives from a drug. The person's need for that experience, and the way in which this experience fits in with the rest

> of the person's life...Addiction does not come from the drug: it begins with the person, his or her sitution, and that person's search for a given experience. (p.59-60).

Many sociologists are becoming increasingly concerned with the rise in the occurrence of addiction in society. In some advertisements, "An addictive appeal (may be) created". (Peele, 1983, p.71) Most advertisements display a product (alcohol or medicinal drugs primarily) to help one cope with the dissatisfaction in their lives. Some government-sanctioned betting is advertised in such a way. So although it is not the activity or substance that is harmful, a person addictive in nature may be particularly vulnerable in such a culture that promotes "quick fixes" for discomfort, maximized in a fast-paced western world.

Covert social approval for Love or Relationship addiction is displayed in films, popular music and television. It is certainly apparent in popular films that the woman is the subject of such pathology. A film depicting the addiction in relationships well was "Splendor in the Grass" where the young woman is so obsessed with her high school boyfriend that his disinterest leaves her immobilized and somewhat insane.

Tennov (1980) addresses primarily the addiction to romance. She coins the experience "limerance"...that occurrence of being in love with and walking on air. Limerance alone is not the problem. Many people in relationships experience limerance in an

unobtrusive manner. The literature clearly indicates however, that in some instances limerance is accompanied by obsessive thoughts about the relationship to the point of interference with daily living. (Halpern, 1982, Peele, 1975, Norwood, 1985, Washbourn, 1977, Peele, 1978, Tennov, 1980). Halpern (1982) states, "Most addictive relationships start with limerances." (p.27) He goes on to clarify that when the limerance is accompanied by Attachment Hunger, the addiction process is in place. Peck (1978) sees limerance as an "act of regression" (p.88) representing the union early in life in the womb of a mother. He sees it as unfounded in reality. The hunger for such an experience is clearly understandable with the addicted person searching for a safe place, a refuge from discomfort, and self identity.

The public expresses addiction unknowingly. Popular music reeks of limerence and lament. One popular rock song is presently entiled "Addicted to Love". Some films portray relationship addiction accurately. And certainly, any daytime television viewer will observe obsession and compulsive behavior in sex and romance on familiar afternoon sagas. Most American people are exposed to relationship addiction regularly. Many experience it themselves.

Further validation of relationship addiction being a general concern to the public might stand in acknowledging the difficulty

obtaining the popular literature in this area. This author attempted for several months to obtain library copies of Peele and Brodsky (1975), Tennov (1980), and Peele (1985). All three were being utilized most of the term and when obtained, were found in very used condition. Norwood's (1985) book is a very popular item in bookstores. The public is interested. Popular literature and magazines address the topic. Magazine articles promote self help affirmation rituals, and self help groups such as Love Addicts Anonymous are becoming accessible.

A Spiritual Quest

One refreshing perspective of the addictive experience is a paradoxical one proposed by Woodman (1987). "The positive side of addiction is that many addicts are profoundly religious people. They have immense energy and are not satisfied with the world as it is...they want meaning in their lives." (p. 59-60) She fathoms that an empty hole exists and the soul feels empty. "They go through death and (then) resurrection" as they quiet the soul and surrender to "the feminine principle...that slow rhythm of the earth." The awareness comes that "you are not God and cannot control your life" (p. 61) in the moment of truth when the addict lets go of his power (which has not helped, obviously, at this point) and begins to trust.

The paradox of death and resurrection is an old, familiar one. Any recovering addict or alcoholic will tell you he has

experienced this. It is a message of hope for those still in distress.

Critique of the Literature. Difficulty lies in the fact that most of the literature available on relationship addiction is speculative at best. Primiarily, the topic is being addressed in popular literature and self help books. A sound sociological perspective is presented by Peele (1975, 1983, 1985). A speculative case method presentation is offered by Norwood (1985), Tennov (1980), and Halpern (1982). Although case method presentation was offered by the above stated authors, no systematic approach was described in terms of data collection or analysis. Schaeffer proposes a number of descriptors for the experience of relationship addiction, but provides no rationale for her arrival at such descriptors and proposes no means of validating the experience or the recommended solutions. A philosophical approach is provided by Fromm (1974), Washbourn (1977) and Peck (1978) speculating differences between love and limerance. No substantial qualitative or quantitative research has been done in this area. This author found no quantitative research for substance abuse applied to situational addiction. The concept is in the early stages of development, although romantic obsession has been expressed through literature since the earliest of time.

There needs to be at this time, sound concept development to provide a framework for exploration and description, thereby

promoting detection, prediction and prescription for nurses and other appropriate professionals treating the individual with an addictive problem.

Summary

In this chapter, the author has summarized literature relating to the concept of addiction to conclude specific characteristics of the concept "relationship addiction". Women's development was discussed as a possible predisposing factor, and possible etiological theories proposed. A sociological and a spiritual context was reviewed. Overall, literature from differing disciplines re: varying perspectives was found to be consistent in describing the experience of addiction.

Chapter III will apply the concepts discussed within a nursing conceptual framework. The remainder of the scholarly writing will then address potentials for research and practice.

CHAPTER III: CONCEPTUAL FRAMEWORK

Conceptual Framework

Having reviewed this concept of relationship addiction, it now becomes important to place this concept within a theoretical structure of nursing. The context in which one perceives the concept will give further direction in describing, exploring, predicting and prescribing for relationship addiction. The purpose of applying the concept within a nursing theory is to provide a structure, a consistent framework from which to study and practice.

Roger's Life Process Theory. In 1970, Martha E. Rogers published her first in-depth work proposing a nursing theory focusing on man as a unitary being. She proposes that "man" or the "human field" is an irreducible, four dimensional energy field identified by patterning and manifesting characteristics that are specific to the whole and cannot be predicted from knowledge of the parts (Rogers, 1970). Man as an energy field greater than the sum of his parts is the theme central to Rogers' theory. Environment is described as an "irreducible four dimensional energy field identified by patterning and integral with the human field". (Malinski, 1986, p. 193). Man and environment are in constant interaction with one another. Health is seen as an expression of the life process. Rogers' believes it to be part of a dichotomous notion "arbitrarily defined, culturally infused, and value laden." (Rogers,1970, p. 85). Nursing is described as both

an art and a science: An art in that the practice of nursing is used in service to man; a science in that it is a body of abstract knowledge arrived at by scientific research and logical analysis (Rogers, 1970, Malinski, 1986), Rogers (1970) states:

> Professional nursing practice seeks to promote symphonic interaction between man and the environment, to strengthen the coherence and integrity of the human field and to direct and redirect patterning of the human and environmental fields for realization of maximum health potential. (p.122).

Health then, for clarity's sake within this paper, will be synonymous with symphonic interaction between man and environment.

In order to make Rogers' Theory come alive, one must be committed to understanding the concepts and principles therein. If the Life Process theory is perceived as an alternative language or perspective, one can more easily conceptualize life in the context of her theoretical framework. Four concepts are basic to this framework: energy fields, openness, pattern, and four dimensionality. Energy fields are described by Rogers in the following exerpt from Malinski's book "Exploration on Martha Roger's Science of Unitary Human Beings."

> Energy fields are postulated to constitute the fundamental unit of both the living and the nonliving. Field is a unifying concept. Energy signifies the dynamic nature of the field. Energy fields are infinite.

> Two energy fields are identified: the human field and the environmental field. Specifically, human beings and environment are energy fields. They do not have them. Moreover, human and environmental fields are not biological fields or physical fields, or social or psychological fields. Neither are human and environmental fields a summation of biological physical, social, and psychological fields. This is not a denial of other fields. Rather, it is to make clear that human and environmental fields have their own identity and are not to be confused with parts. (Rogers, 1986, p. 4).

"Openness" is that concept describing the integrality of the human and environmental fields. Energy fields are always open, therefore "change is continuously innovative." (Rogers, 1986, p. 5). This openness indicates simultaneity therefore invalidates causality. Hence, in application to the relationship addiction model proposed, one must perceive all characteristics proposed, both etiologic and descriptive in simultaneous occurrence.

Rogers (1986) describes "pattern" as:

> ...the distinguishing characteristic of an energy field perceived as a single wave. Pattern is an abstraction. It gives identity to the field. The nature of the pattern changes continuously. Each human field pattern

> is unique and is integral with its own unique environmental field pattern. The term "pattern" is used only to refer to an energy field. Manifestations of field pattern emerge out of the human and environmental field mutual process. (Rogers, 1986, p. 5).

Manifestations of field patterns emerging out of the human and environmental field mutual process are a part of the principle of helicy.

"Four dimensionality" refers to the non-linear domain of human and environmental fields. Both field are witout spatial or temporal attributes.

Principles of Homeodynamics are building blocks for this proposed framework. Principles of Homeodynamics describe the nature and direction of change manifested by unitary beings (man) in mutual process with the environment. (Rogers, 1970). There are three principles currently proposed by Rogers. They are:

1) Resonancy - Continuous change from lower to higher frequency wave patterns in human and environmental fields.
2. Helicy - Continuous innovative, probabilistic increasing diversity of human and environmental field patterns patterns characterized by non-repeating rhythmicities.

3. Integrality - continuous mutual human field and environmental field process. (Malinski, 1986, p.194)

An important aspect of Rogers' theory is that change is unidirectional in nature, irreversible and nonrepeatable. "Change proceeds by the continuous repatterning of both man and environment by resonating waves." (Rogers, 1970, p.102).

Relationship Addiction within the Context of Life Process Model Primarily, it becomes important to take note of addiction in context with other associated behaviors. Figure 1 shows linear continuums describing such contextual placement. It is important to note the similarities among the three continuums. At either end of the spectrum social isolation occurs. Whether addicted to substances or relationships, one narrows outside stimuli to the object of obsession. Man's interaction with environment is non-symphonic at the two extremes. Note, also, the prepositions. "With" is most indicative of symphonic interaction.

Figure 1 on next page.

Substances: Drugs & ETOH

Aversion to	Independence from	Social interaction with	Dependence on	Addiction to

Situations: Events, People, Relationships

Aversion to	Independent from	Interdependence	Dependent on	Addicted to

Relationships

Avoidance of	Independent from	Interdependent with	Dependent on	Addicted to

Figure 1

Since the context of behavior is the same or similar among all three types of addiction, for the purposes of placement within the Life Process model, one definition is proposed:

> Environmental Addiction: Whereby the human field becomes pathologically dependent on the environmental field for his substance, diminishing his coherence and integrity so that he experiences being indistinguishable from the environment.

Further elaboration of the five levels of interaction with the environment can be seen in Figure 2. "Aversion to" or Avoidance of" usually involves fear. The fear pushes the energy field far out into the environment to protect man from that which he fears. The quantity of the interaction is minimal. The

quality is that of low level interaction whereby man is aggressive and directs and imposes himself upon the environment. Addiction to, on the other hand, visually describes the above stated definition. Environmental field protrudes far into the unitary being field due to the decreased integrity and coherence of man. Quantity of the interaction again is minimal. Quality is low level whereby man is passively impinged upon by the environment. A main premise, then, in environmental addiction is that man becomes enslaved by and defined through elements of his environment thereby minimizing quality interaction.

Figure 2 follows on next page.

In terms of Principles of Homeodynamics, reasonancy continues to occur during the addiction process, as it does in any process. As the person approaches and moves into recovery, it is proposed that higher frequency patterns would be occurring at a more rapid pace than during the onset and peak of the addiction process.

Helicy would also continue to occur, but it proposed that patterns repeat themselves in closer proximity to one another, showing a slowed unidirectional progression (Figure 3) as the addiction process interferes with symphonic interaction between man and environment. It is important to note at this time that the events occur simultaneously and not as a result of. Cause and effect are not applicable in Rogers' theory. Addiction and decreased symphonic interactions occur simultaneously and in relationship to one another.

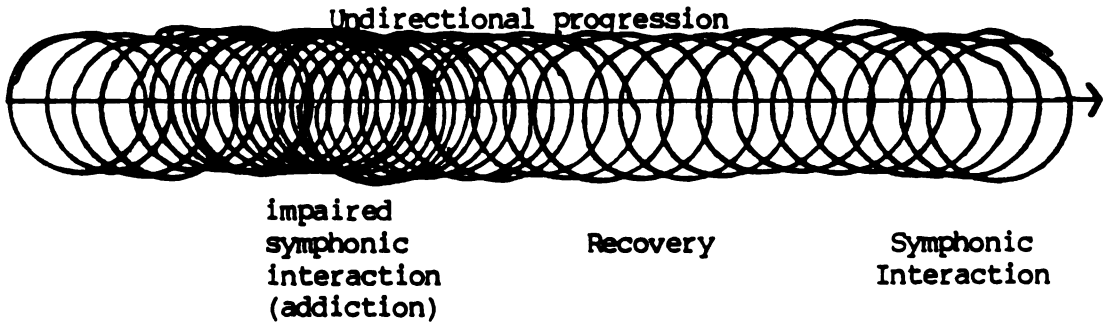


Figure 3

A diagram showing the etiological characteristics of environmental addiction can be seen in Figure 4. Etiological possibilities are shown impinging upon unitary being and environment. (Women's development is seen as predisposing primarily in unitary being, but also in environment.)

Etiological factors impinge upon either the unitary being or the environment (see Figure 4) and can be separated into three sources. (See Figures 4 a, b, c). The internal frequency source (4a) and the internal/external frequency source (4b) directly interact with the unitary being. The external frequency source (4c) directly interacts with the environment. Frequency refers to wavelength resonancy originating within the identified source.

The quantity of arrows impinging upon unitary being show the loss of coherence and integrity of unitary being's field. He struggles to control the environment which he feels invades his field and predicts behaviors for him. Perceived powerlessness and perceived lack of choices occur. Power and control become major themes. He experiences emptiness and an insatiable hunger along with a despair and purposelessness in living (spiritual starvation). Safety and satisfaction occur only in the moments of indulgence followed by and entangled with moments of bitterness and remorse. Ego boundaries get lost, hence the constant attempt to protect self from the environment. (See Figure 5 for Resulting Characteristics Describing the Addictive Experience.)

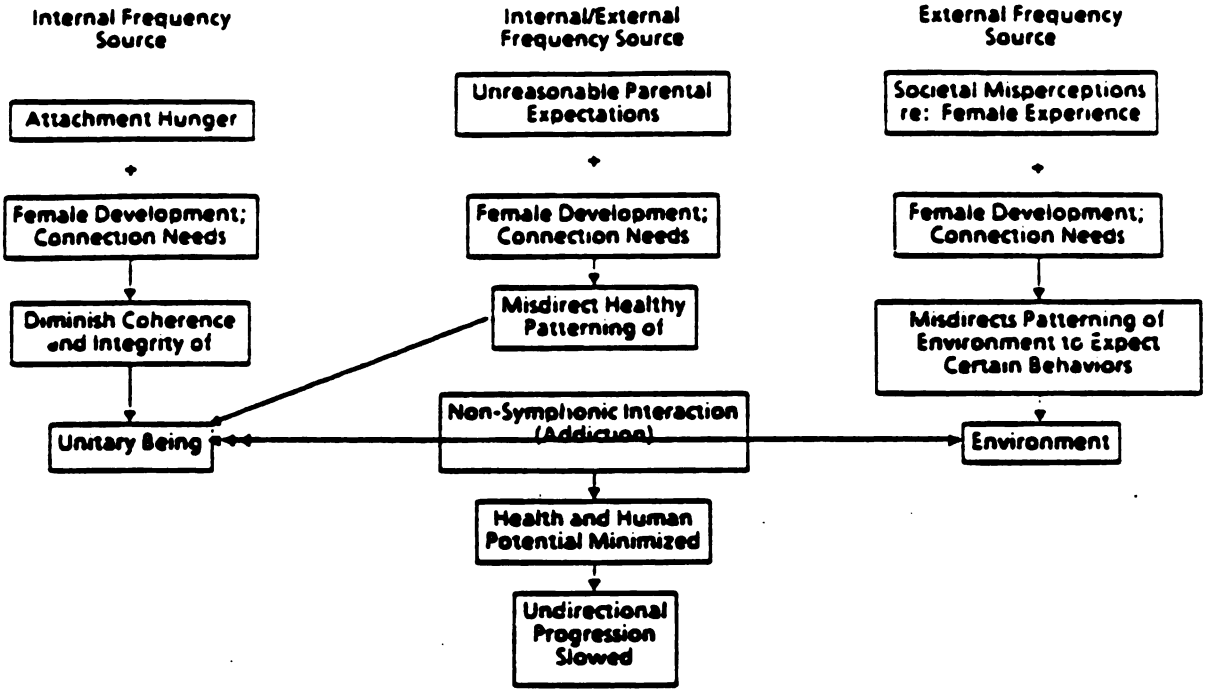


Figure 4 - Etiological Characteristics

A proposed diagram for possible etiological factors involved in depicting dysfunctional attributes of environmental addiction. Adapted from B. Givens' "Dominant Themes in Rogers' Concepts of Nursing Focused on Professional Nursing Practice and Nursing's Aim and Goals."

Figure 4

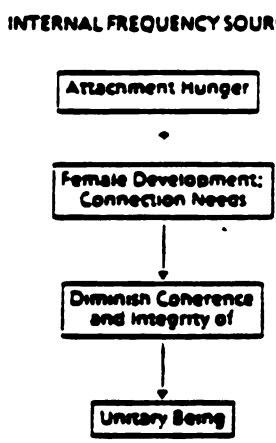


Figure 4a: Internal Frequency Source of Etiological Characteristics

Etiological factors predisposing the unitary being to environmental addiction: Internal Frequency Source. These existing predispositions arise from within the unitary being and comprise etiological characteristics of the internal frequency source. Attachment hunger diminishes coherence ↔ integrity of the person; coupled with connection needs, the attachment hunger may potentiate diminished integrity ↔ coherence of the unitary being, thereby resulting in undefined ego boundaries (see Figure 5).

Figure 4a

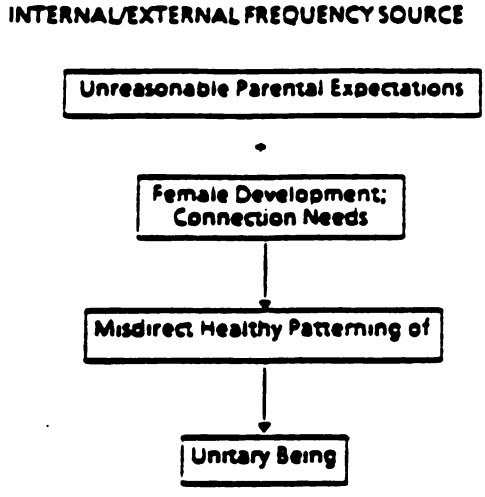


Figure 4b: Internal/External Frequency Source of Etiological Characteristics

Etiological factors predisposing the unitary being to environmental addiction: Internal/External Frequency Source.

These existing predispositions arise from both internal sources (connection needs) and from external sources (unreasonable parental expectations). Both, however, directly deal with the unitary being and therefore comprise etiological characteristics of the internal/external frequency source. Unreasonable parental expectations directly influences the patterning of the unitary being. In conjunction with connection needs + the need to appease to facilitate that connection, unreasonable parental expectations may result in compulsive behavior that never satisfies the emptiness within due to unmet self expectations (see Figure 5).

Figure 4b

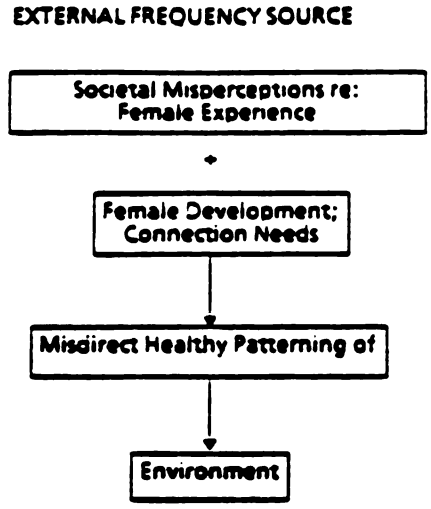


Figure 4c: External Frequency Source of Etiological Characteristics

Etiological factors predisposing the environment to facilitate environmental addiction in the unitary being: External Frequency Source.

These existing predispositions arise primarily from external sources (environment) although female development + connection needs is an internal function. Coupled, they deal with the environment and therefore comprise the external frequency source. Societal misperceptions of the female experience (lower level of decision making ability in moral dilemmas, less autonomy and ego development, inferiority) in conjunction with women's connection needs, results in the vulnerability of women in an aggressive society. These societal misperceptions misdirect the patterning of the environment to expect certain behaviors from women (dependent roles). This coupled with the connection needs of women may result in unhealthy societal behaviors: emotional or physical abuse, sexual abuse, sadomasochism.

Figure 4c

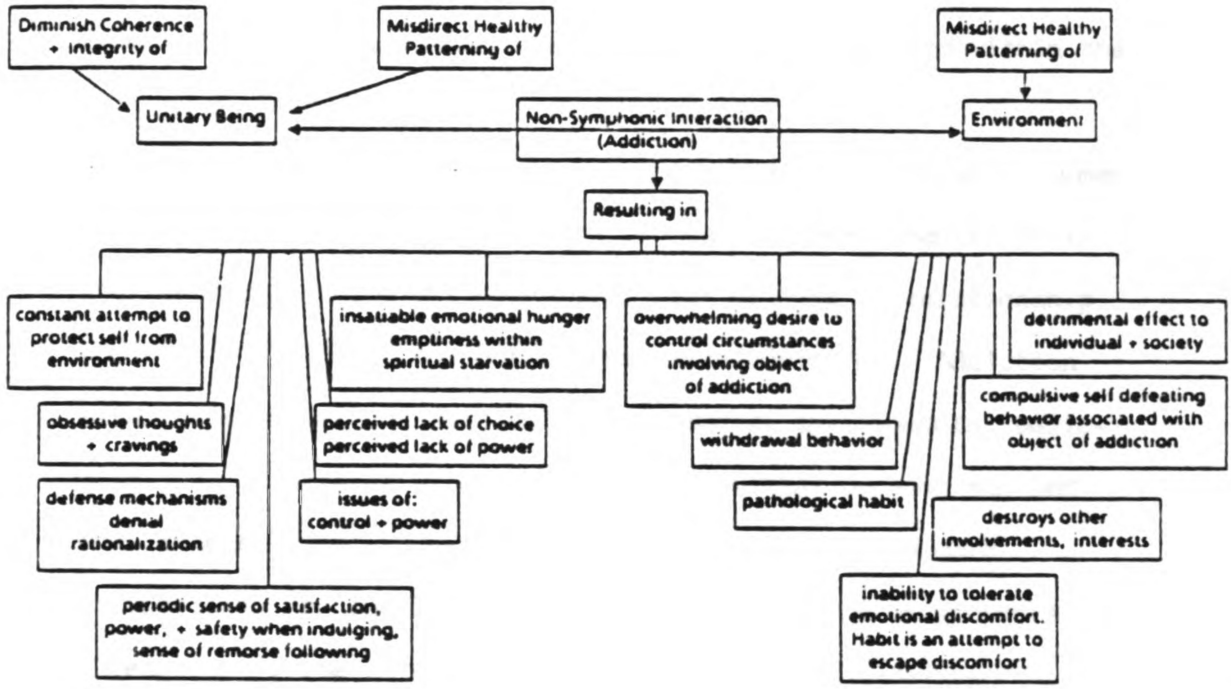


Figure 5: Descriptive Characteristics of the Addictive Experience Integrates and identifies all characteristics describing the addictive experience. All characteristics occur simultaneously and in conjunction with the aforementioned etiological factors.

Summary

In this chapter, the author has applied the concept of addiction and characteristics thereof within the theoretical framework of Roger's Life Process Model. A definition for "environmental addiction" was formulated. Etiological factors and descriptive characteristics were described and depicted within the context of Roger's Model.

Relationship addiction is a fairly recent concept which women may be particularly vulnerable to because of developmental tasks and learned sociological behaviors. The process of relationship addiction is similar to that of substance addiction. Addiction within the context of nursing can be seen as environmental addiction. It interferes with symphonic interaction between man and environment. Since nursing's role is to promote symphonic interaction, her involvement in the addiction process includes strengthening the integrity of the human field and redirecting patterning of both the environment and the human field. Further research needs to be done to begin to direct nursing practice, education, and research in the area of relationship addiction.

In the following chapter, nursing's role in Advanced Practice will be discussed concerning environmental addiction. Public Education will be proposed. The author will address the importance of qualitative and quantitative research in the area of environmental addiction.

CHAPTER IV:

IMPLICATIONS FOR PRACTICE, EDUCATION, AND RESEARCH

In prior chapters of this scholarly writing, the concept of relationship addiction was described and defined and etiological factors proposed. The concept was then placed within a nursing framework to substantiate evidence for its relevence within the field of nursing. Impaired symphonic interaction which occurs simultaneously with the addictive process limits the health and well-being of the individual. This interference with health becomes of primary importance to the advanced nurse clinician as she attempts to promote the coherence and integrity of the individual and to direct and redirect healthy patterning of the individual and the environment. In the 4th and final chapter, previously discussed concepts and frameworks will be applied to the appropriate roles of the CNS within the context of the primary care setting. Discussion of appropriate means of practice, education, and research will be addressed. A brief conclusion including the author's recommendations and concerns will follow.

The Primary Care Setting

The primary care setting is the port of entry to the health care system. It is typically an office or a clinic setting in which health screening is done to detect for lack of symphonic interaction between the client and the environment. (Illness or dysfunction). Clients utilize the primary care setting to maintain and promote health, prevent illness and restore wellness.

The health care provider within the primary care setting serves as a coordinator of health care, treating appropriate conditions and referring those conditions inappropriate for treatment in the primary care setting. The primary care setting is then, the most frequently used means of accessing the health care system. It then becomes apparent that this setting would be important in the detection of this often neglected, health interfering problem called relationship addiction. It is important to note here that detection of such a disorder is a difficult task since most clients experiencing any environmental addiction may present with somatic manifestations of psychological distress and often the patterning of these symptoms is overlooked.

How would one present to the primary care system with such a disorder? The aforementioned descriptive characteristics are the predominant cues indicating the problem exists. In a blatent case, a complete health history including a thorough health pattern assessment (Gordon's tool, revised, see page 71), may help to identify the presence of etiological factors and descriptive characteristics. To evaluate the Internal/External Frequency Source an in-depth family history and Role-Relationship assessment must be completed. Such an assessment may expose a history of unreasonable parental expectations. The unreasonable expectations may be evident initially as the client exposes her own unreasonable expectations of self, unaware of the significance or

Gordon's Health Pattern Assessment

Self-perception-self concept pattern

a. How would you describe yourself? Most of the time, feel good (not so good) about yourself?
b. Changes in your body or the things you can do? Problem to you?
c. Changes in way you feel about yourself or your body (since illness started)?
d. Find things frequently make you angry? Annoyed? Fearful? Anxious? Depressed? What helps?
e. Ever feel you lose hope? Not able to control things in life? What helps?

Role-relationship pattern

a. Live alone/ Family? Family structure (diagram)?
b. Any family problems you have difficulty handling? (nuclear/extended)
c. How does family usually handle problems?
d. Family depend on you for things? How managing?
e. If appropriate: How family/others feel about your illness/ hospitalization?
f. If appropriate: Problems with children? Difficulty handling?
g. Belong to social groups? Close friends? Feel lonely (frequency)?
h. Things generally go well for you at work? (School?) If appropriate: Income sufficient for needs?
i. Feel part of (or isolated in) neighborhood where living?
(j. How do you normally relate to women? to men?
k. What happens when you and your significant other disagree?
l. How much time do you spend thinking about the important people in your life? Does this ever intervere with your ability to function normally? Does it ever cause you emotional discomfort? How so? What is that like for you?
m. What was your relationship with your parents like?)

Coping stress tolerance pattern

a. Any big changes in your life in the last year or two? Crisis?
b. Who's most helpful in talking things over? Available to you now?
c. Tense a lot of the time? What helps? Use any medicines, drugs, alcohol?
d. When (if) have big problems (any problems) in your life,how do you handle them?

e. Most of the time, is this (are these) way(s) successful?
(f. Any obsessive thoughts or ideas? About what? What do you do about them?)

Value belief pattern

a. Generally get things you want out of life? Important plans for the future?
b. Religion important in your life? If appropriate: Does this help when difficulties arise?
c. If appropriate: will being here intervere with any religious practices?
(d. Describe your idea of being spiritually content.)

Taken from: Gordon, M. (1987). Manual of nursing diagnosis. St. Louis: McGraw Hill. Additions in parenthesis.

implications of such behavior. Careful assessment of previous roles and relationships may provide evidence of unreasonable parental expectations in the woman's childhood. The client's investment in the connection needs identified as normal to female development by Gilligan may be confirmed by careful assessment of the Role-Relationship, Self-Perception/Self-Concept and Coping-Stress health patterns. The Clinical Nurse specialist would find this apparent in how the woman describes herself in relationship to others. A general theme of "need for connection" will normally be apparent in any woman. It is the combination of this need with other etiological factors, (attachment hunger, unreasonable parental expectations, societal misperceptions) that may produce the environmental addictive experience.

To assess for attachment hunger in the Internal Frequency Source the CNS must extensively collect data in the Role-Relationship, Self-Perception/Self-Concept, Coping Stress, and Value-Belief Health Patterns. It is important to discover what it is that the woman values as a source of strength. What are her needs? What satisfies these needs? How does she get these needs met? How does she deal with a dependence-independence conflict? Do any such conflicts exist in her life?

To evaluate the External Frequency Source, the CNS must assess the clients environment and if at all possible, interview family members or significant others to establish whether or not

misperceptions exist re: the female experience. How do those members of her environment perceive women? What are their expectations of them? What roles do they assume in the relationship?

Assessment of the above mentioned three frequency sources must be coupled with an in depth interview consisting of exploratory and non-exploratory response modes directing the content of the health interview to expose the presence of any of the descriptive characteristics. A thorough assessment of health patterns and medical history will provide enough data to ascertain whether a number of descriptive characteristics seem to be present or not. Once a descriptive characteristic is identified, it is strongly urged that the CNS be very specific in attempting to illicit information pertaining to other characteristics. If the client is somewhat protective or defensive during the interview, if eye contact is limited, verbals/non-verbals inconsistent, distancing present, and partial information extrated, protection may be an issue. Further barriers may include the defense mechanisms of denial and rationalization. Withdrawal or isolating behavior may be noted. Mood swings may also be evident resulting from a periodic sense of satisfaction and power alternating with a sense of discouragement and remorse. Self-defeating behaviors will become apparent throughout the interview. Careful assessment of the Role-Relationship pattern will reveal limited social and

community involvement and diminished outside interests. A persistant theme throughout the interview will be the client's perceived inability to control events. Careful assessment of Self-Perception/Self-Concept will reveal the clients belief that she has no power and that choices are limited. The woman may make brief mention of experiencing a sense of being imprisoned by some force or nature. Anger may be evident while discussing a certain topic. The CNS must be astute enough to isolate this topic area and gather further information about the clients response to the possible object of addiction. The anger may be indicative of power and control issues surrounding the object of addiction. Client verbalizations may project an over whelming desire to control circumstances surrounding the object of addiction. A thorough assessment of the coping/stress health pattern may reveal an inability to tolerate emotional discomfort. Occasionally the client will acknowledge that a habit exists either directly (verbalization of) or indirectly (recurring theme of habitually returning to substances or situations that may be harmful). An astute CNS may be able to identify a covert expression of obsessive thoughts and cravings.

Finally, an emotional insatiability becomes apparent to the CNS as each suggestion made by the CNS is minimized, by the client. Careful assessment of the Value/Belief health pattern reveals a hunger for spiritual meaning in life. Generally, the

client may present as one seeking truth and meaning in the experience of life.

The sum of such characteristics results in a detrimental effect to the individual and society. The experience is simultaneous in occurrance (ethiological factors, descriptive characteristics, non-symphonic interaction between the unitary being and environment). The overall result is the minimization of health and human potential and a slowing of unidirectional progression in the helicy process (as seen in Figure 3, pg. 60).

On most occasions, however, the above stated characteristics are not apparent upon presentation. Even upon interview, the client may deny some of the subjective symptomology referred to above. Often this is due to the clients own lack of awareness regarding the problem. Frequently the defense mechanism of denial is firmly in place in an attempt to protect the individual from the painful experience. The client most frequently presents with a number of ill-defined complaints: Headaches, backaches, general malaise, gastric distress, persistent abdominal cramping and diarrhea, sleeplessness, nutritional changes, menstrual irregularities, depression, anxiety. All are common concerns of the unaware individual experiencing situational addiction.

Such concerns are often unattended to in the primary care setting. "Patients with somatization disorders are frequently unrecognized and misdiagnosed." (JAMA, 1985, p. 3075) Each

somatic complaint is addressed seperately, thereby overlooking the pattern of symptomotology. "Highly skilled physicians repeatedly fail to recognize patients with somatization disorders." (Quill, 1985, p. 3075).

"Somatization disorder (Briquet's Syndrome) is a polysymptomatic disorder that begins early in life, chiefly affects women, and is characterized by recurrent, multiple somatic complaints..." (Zoccolillo and Cloninger, 1986, p. 532) Quill (1985) also describes the disorder:

> For the patient with a somatization disorder, symptoms and illness become a way of life. They become a form of communication, a means of expressing emotion, and a way of controlling the environment. The patient presented herein shows the typical outcome of the disorder when unrecognized over time -- numerous operations and procedures, drug allergies, drug dependence, and a life dominated by medical experiences. The potential for iatrogenic disease is enormous, for these patients have great faith in the powers of aggressive medical intervention to alleviate their problems. Physicians often share this faith, and unless the pattern of multiple diverse symptoms, work-ups, and medical interventions without lasting improvement is recognized the patient and physician together may do more harm

than good in their search for elusive organic diagnoses. (p. 3076)

Quill continues:

> Despite the chaotic, often violent personal life experiences that these patients endure, they do not present to their physicians with anxiety, depression, or trouble coping, but rather with numerous physical symptoms. Their symptoms tend to be atypical, and they have a history filled with multiple, varied medical experiences. They believe their problems to be entirely physical, so they seek out internists and surgeons rather than psychiatrists. (p. 3076)

Since somatization disorders are "seen predominantly in women," (Smith, Monson, Ray, 1986, p. 69) significance becomes important in that women manifesting such a disorder may be experiencing an environmental addiction.

Careful review of the above stated literature reveals a covert manifestation of some of the descriptive characteristics previously mentioned. There is an obvious inability to tolerate emotional discomfort, hence the somatization of such discomfort. There seems to be an insatiable hunger for answers, although proposed psychological interventions would probably be offensive to the client resulting from an in tact denial defense mechanism.

Since affective responses are not always obvious in the somatizing client, one must also address the issue of the client presenting with depressive or anxiety disorders that are often overlooked. Katon, Kleinman, and Rosen (1982A) propose that many depressive, anxiety, and obsessive-compulsive disorders are overlooked in the primary care setting. They cite studies indicating that "the primary care physician failed to diagnose depression in 50% of the cases." (p. 128) Their contention is that the clients present with somatic manifestations of depression, are misdiagnosed, and the treated symptomatically. The result is "potential iatrogenic harm to the patient" (p. 127) and unnecessary health care costs. Proper diagnosis is essential to appropriate treatment of the patient.

It is imperative to note that affective disorders may be responses to manifestations resulting from the experience of environmental addiction. Careful detection of depression or anxiety will provide direction for further data collection related to the area of the addictive experience. The clinical nurse specialist must, then, be astute in the detection of somatic or affective disorders and pursue further appropriate assessment to detect for the possibility of relationship addiction in association with these disorders.

Somatic and affective disorders must be distinguished from relationship addiction. Although characteristics of relationship

addiction may be present in the individual presenting with vague and ill defined complaints, all affective and/or somatic disorders are not necessarily indicative of the presence of a relationship addiction problem. Somatization disorder is defined as, "a chronic, fluctuating disorder beginning before the age of 30 years and presenting as multiple physical complaints without adequate explanation, seen predominantly in women." (Smith, Monson and Ray, 1986, p. 69). Affective disorders include "depression, mixed anxiety and depression, anxiety state, and affective psychosis." (Katon, Kleinman, and Rosen, 1982, p. 128). Although manifestations of either or both these disorders may be present in the relationship addicted individual, one would need to question further to identify whether or not the indicated characteristics of relationship addiction (Figure 5, page 66) were also present. Therefore, one must carefully assess and analyze data to determine whether the somatic or affective complaints are associated with relationship addiction or are simply their own seperate manifestations.

Care also must be taken to acknowledge that not all relationship addicted individuals will present with somatic or affective disorders. Therefore, the lack of symptomotology associated with somatic and affective disorders does not indicate the ruling out of relationship addiction. Again, the clear indicator is the presence of the descriptive characteristics

(Figure 5, page 66.)

As stated previously, the health care provider detects a sense of general dissatisfaction with life on the part of the client. Although the provider poses many options and solutions to the above ill-defined complaints, the client finds reasons to discount all proposed solutions. "Well, I've tried that before and it just doesn't work," is often a standard reply. Often this help-rejecting behavior is an indicator that the true problem has not been identified or addressed. The provider may find herself irritated with this behavior. It is important to recognize it as a manifestation of the addiction problem and to address it as such. This help-rejecting behavior gives direction for problem identification and therefore, subsequent appropriate intervention. Another important prominent behavior seen in this client is "doctor shopping" whereby the client searches for answers to an unknown problem by visiting a number of health care providers. To each she divulges parts of the problem, but rarely discloses the entire picture. Again, this may be due to her lack of awareness of her own experience.

Occasionally, if the addiction problem has progressed over an extensive period of time, the client may present with signs of physical abuse or a blatent alcohol or drug addiction problem along with multiple ill-defined complaints. This is not to imply

that substance addiction is consistantly related to situational addiction, although Boyd and Mast postulate a possible causal relationship between women's drug use and their relationships with man:

> Our observations suggest that an important causal factor for women may be an inability to cope constructively with feelings of anger and depression related to their dealings with men. The patterns we observed of female drug use fluctuating in response to a partner's actions might be anticipated in light of the low self-esteem of these women and is compounded by women's dependence on men in general for validation for their actions and themselves. (1983, p. 12)

In summary, this relationship addicted individual often has direct contact with a health care provider at a primary care facility. It is therefore imperative to the health care provider at such a facility to be knowledgeable in the detection of such a disorder. Presentation may not always include the descriptive characteristics mentioned in previous chapters. Instead, the unaware individual may present with a number of ill defined complaints, help rejecting behavior, a history of "doctor shopping" and dysfunctional relationships with health care providers. The individual may have a propensity for eliciting

irritation in the health care provider due to the help rejecting comments and behavior. Finally, a blatent manifestation of physical abuse or substance abuse may be apparent.

The Health Care Provider in the primary care setting must be astutely aware of how one may present with an environmental addiction disorder. The clinical nurse specialist in primary care must be able to carefully extract and analyze data that may be indicative of patterns implying somatic or affective disorders and further assess to distinguish the presence of, or ruling out of, relationship addiction in these cases. She must carefully assess the Role-Relationship, Self-Perception/Self-Concept, Coping-Stress, and Value-Belief health patterns to detect the presence of etiological factors and/or defining characteristics. The prominent implication within the primary care setting in reference to relationship addiction is that of the necessity of detection. Once detected, referral is usually made for appropriate treatment with continued coordination of care provided by the CNS in the primary care setting.

When is it appropriate for referral or intervention? At what point does one intervene in the primary care setting for the relationship addicted individual? Some criteria or guides need to be established to facilitate the appropriate timing in intervention. This is particularly necessary since many women may experience this problem to some degree. Critical points need to

be specified to assist the care giver in appropriately analyzing the women's position on the addiction-isolation continuum. (Figure 1, pg 58) Criteria should be established for points between "dependent on" and "addicted to" on this continuum. The key compenent indicating the need for intervention might be the women's expressed dissatisfaction with herself, her relationships, or her ability to function purposefully and comfortably (emotionally), within her environment. Upon further assessment, if obsessive thoughts are impairing her judgment and abilities, the care provider must consider intervention. If somatic disorders resulting from repressed relationship addiction are interfering with normal routines (sleep, eat, work) one must consider therapeutic intervention. If an affective disorder results from the characteristics described, particularly withdrawl (depression) or obsessional thoughts (anxiety), intervention must be considered.

Appropriate CNS intervention also depends on the readiness of the individual. A woman may present with concern about her relating abilities, or about a poor self image. Awareness of the presence of a problem, named or unnamed, often indicates readiness for learning on the part of the client. Although this individual may not be so impaired by the problem as another in acute crises, readiness to learn/often indicates an openness to intervention.

More difficult will be dealing with the client presenting with an obvious addictive problem with denial firmly in place. Often the presentation of such an individual is a loquacious female, with a controlling verbal and non-verbal message insisting that "everything is great!" This individual will probably need to enter into some crises before the problem becomes apparent. It has been said that pain is the alcoholic's best friend, for it brings him into taking action on dealing with the problem. Likewise it is true with the relationship addicted woman.

The CNS, therefore must be astute in not only recognizing the presence of such a problem, but also in discerning its interference in the quality of the woman's life and in assessing her openness and readiness for intervention. If interference in the quality of life is present and the woman is open to treatment, further information on the problem can be disseminated and a referral made. If, however, the woman fervently denies the existance of the problem upon confrontation, one must wait for client readiness.

Role of the CNS in Advanced Practice

Many roles would be appropriate for the Clinical Nurse Specialist in the primary care setting. Probably the most obvious and important role of the CNS would be that of the Assessor. Detection of the addiction problem is imperative and, as stated previously, the primary care setting presents an ideal opportunity

for such detection. As assessor, the CNS must be knowledgeable regarding the problem and typical presentation of client. This knowledge would assist her in synthesizing the data to formulate the appropriate impression. Astuteness in this role would lead her to efficiency in her role as a clinician, where she would formulate nursing diagnoses and interventions appropriate to the primary care setting. Nursing diagnoses most frequently utilized may be: Ineffective Individual Coping, Reactional Depression, Anxiety: (Severe, Moderate, Mild), and Independence/Dependence Conflict. Initially she will serve as a counselor, providing stabilizing human support, but primary intervention for this problem will probably be most effective through referral to the appropriate resource. Such resources dealing with this problem may be scarce. Some investigative work may need to be done to uncover the appropriate resource ensuring an agency's (or therapist's) clear understanding of the addictive process, women's connection needs, and possible underlying etiological pathologies. The CNS would continue to follow the client as a coordinator of her care by closely collaborating with the referral agency or therapist. Throughout the detection, referral, and follow-up process, the clinical nurse specialist would advocate the clients involvement in her own care. She would promote self responsibility for recognition of described behaviors and for follow through regarding recommendations made by the referral

agency or therapist. As she provided follow-up care, she would evaluate the effectiveness of treatment. However, since there has not yet been a tool developed to measure and assess the level of situational addiction, evaluation would be a somewhat subjective account. The following may be included in attempts to evaluate progress of the problem: Are verbals/non verbals now consistent? Is use of denial and rationalization diminished? Is client discussing and owning the problem? Does client recognizes apparent choices? Has self defeating behavior diminished? Can client verbalize feelings experience discomfort? Is mood somewhat trusting and less defensive? Does client recognize the usefulness of talking about the problem? Can client acknowledge that she does not have control over object of addiction. Can client see her own progress? Again, collaboration with the referral agency or therapist and the client would provide a clearer perspective on progress made.

Throughout her interaction with the relationship addicted client, the CNS in the primary care setting will function primarily in a supportive capacity, coordinating efforts to identify and label the problem and to facilitate recovery. Advanced nursing practice in primary care allows opportunities for developing a "helping relationship". The "psychotherapeutic relationship" will be developed between the client and the therapist more adequately prepared to intervene in this area.

Appropriate interventionists may be psychiatrists, psychologists, social workers, counselors, or clinical nurse specialists concerned with the addictive process and its possible etiological components. (This author proposes that the appropriately educated CNS may be the best qualified interventionist due to her Rogerian conceptual approach.) It is also preferred that the interventionist be female and/or fully cognizant of Gilligan's proposed theory to facilitate intervention consistent with this theory. If appropriate and indicated, the family may also be referred for therapy.

Role of the CNS in Education

Clearly, a knowledge deficit about relationship addiction exists at the public level. As previously mentioned, reviewing media, literature, music and the performing arts makes this perfectly clear. Furthermore, health professionals have limited awareness of the existance of such a problem and a lack of understanding regarding the implications of such a problem. The CNS would function as a leader and change agent in the community by publicly speaking to target populations. She would discuss the concepts with prominent women's groups in the community and offer her expertise to create public awareness through the media (radio and television interviews). Women's Health Centers are becoming a popular channel for lay education. The CNS could provide information to lay women through such a center. Education impacts

greatly at the college level. Speaking to groups of students would be an effective means of disseminating information. Community education programs could be provided through the school system to provide information to parents of adolescents that may be prime candidates for relationship addiction. Education to parents may also provide insight as to the results of unreasonable parental expectations.

Since the public has become increasingly aware of this topic through popular literature, education in the community would need to consist of not only the components of the experience of relationship addiction, but viable options for dealing with it. Care must be taken to inform potential victims that with the trendy status of the topic, quick-fix solutions are often proposed in some self-help literature and by some therapists. The topic is popular, but superficially addressed. There are no studies to validate the effects of such proposed quick-fix solutions. The woman interested in recovery must be made aware of the importance of finding appropriate and qualified professional assistance. The woman must be informed that, if committed to recovery, the journey will be long and difficult, but with appropriate assistance, she will be supported and recovery will be possible. It is important to note here that many women may not be interested in recovery. Since the process of changing behavior patterns is often tedious, energy consuming, and long-term, such an intense process may not

be of interest to many clients. Motivation and committment must be present on the part of the client.

Health care providers particularly those in the primary cre setting, need to be educated also. Education should be centered around the significance of such a problem and the importance of its detection. Since many clients present as "Vague and ill-defined complaints", detection of such a problem may help to alter this behavior in some clients. A clients perception of interaction with the health care system may change. Certainly, this behavior change would be beneficial to the health care provider by reducing the amount of irritation elicited by such energy consuming interactions.

Nursing schools need to address the issue to provide nursing students with the skills necessary to detect such a problem. Nursing schools particularly with conceptual frameworks built upon Rogerian theory, need to incorporate such concepts into the curriculum.

At the undergraduate level, an integration of the concept of environmental addiction, proposed etiological factors, and descriptive characteristics must occur in an upper division Psych/Mental Health course. Practicum experiences in this course might include a clinical component in a chemical dependency 28 day (or long term) treatment program. Many women experiencing chemical dependency have other environmental addiction problems

occurring, particularly in relationships. Another option for practicum experience might be working within a mental health clinic that treats women for such problems. Some students may be interested in observing or co-leading groups in these areas.

At the graduate level, primary focus should be on detection. Knowledge of detection in any graduate tract (Family, Gerontological, Adult Med-Surg, Women and Children, Community, Psych/Mental Health) would be important since screening skills are so in depth at the graduate level. Graduate Psych/Mental Health Nursing content may include more on treatment of such disorders. Practicum experiences would be tract specific with an emphasis on screening for and detection of such a disorder within the context of each clinical site chosen.

Presently practicing RN's need to be educated in detection of the addictive problem also. Inservices provided for staff nurses on etiological factors and descriptive characteristics may facilitate early recognition of such a problem and appropriate referral. Life long education for nurses could incorporate detection of such a problem into a workshop or course specifically in addiction. Another possible course or workshop would be one on dealing with difficult clients since the environmentally addicted woman often presents with vague and ill-defined complaints. Since the problem is conceptully constructed of nursing theory, it is appropriate that <u>all</u> nurses be educated regarding the concept

of environmental addiction which applies to any type of addiction and manifests itself in the descriptive characteristics constructed in Figure 5, Chapter 3.

Finally, clients need to be educated and informed. The uninformed client needs to be informed regarding the prominence of the problem in women. The CNS may carefully explore areas with the client that may be potentially hazardous. It is the clients acknowledgement of such a problem that opens the doors to further education and recovery. Client education would include simplified components of Gilligan's theory of female development, thoughts, feelings and behaviors indicative of and perpetuating the problem, and appropriate avenues for recovery. If appropriate, family education may also be indicated.

Major responsibility for public and professional eduction lies with the CNS in this proposed model. The unique perception of the unitary being as an entity itself now in non-symphonic interaction with the environment in the addictive experience allows the CNS the vantage point from which to address the addiction problem.

Role of the CNS in Research

This author found no research in the literature addressing situational or relationship addiction. The only method utilized was case presentation in Norwood, (1985) Tennov, (1980) and Halpern, (1982). In all three books there was no consistency or

method described in interpreting or analyzing each case.

Nursing research on Relationship Addiction needs to be done to 1) validate the existance of such a problem (survey research), 2) explore the meaning of such an experience to a number of individuals (phenomenological qualitative research), 3) describe the experience (descriptive qualitative research), 4) predict outcomes of the experience (quantitative, post-test only control group design) and 5) prescribe reliable treatments for the problem (pretest, post-test, control group design).

Phenomenological and descriptive research need to be instituted initially to provide and validate a theory base. "A primary goal of qualitative research is the generation of theory." (Parse, 1985, p. 4). Survey and quantitative research then follow to explore and predict specific constructs within the theory.

The author cautions the reader against biasing the aforementioned qualitative studies as minimally important in comparison with quantitative research. Although quantitative research is well reputed and respected, it is only qualitative research that can offer the simultanaeity paradigm which more closely aligns with Roger's theory of unitary being, the whole being greater than the sum of its parts. Parse (1985) states, "The qualitative approach offers the researcher the opportunity to study the emergence of patterns in the whole configuration of Man's lived experiences. It is an approach in which the researcher explicitly

participates in uncovering the meaning of these experiences as humanly lived." (p.3). Parse also addresses the commonly noted misclaimer of qualitative research...that referred to as "bias" in quantitative research. She states, "Qualitative research takes into account the researcher's frame of reference (paradigm) and makes this frame of reference explicitly part of the research report." (p.3) One must take into account all threats to reliability and validity in each tool and experimental design.

Therefore both qualitative and quantitative research must be done to effectively address the discovery of meaning associated with the experience of relationship addiction in women. Both methods are valuable, each providing a distinct purpose.

Phenomenological research seems most appropriate to begin with and would be the most favored method of qualitative research. The addictee's perspective of the experience and ascribed meaning to the experience seem most relevent in reviewing this unexplored area of environmental addiction. Since the phenomenological method is directed toward uncovering the meaning of a phenomenon as humanly experienced (Parse, Coyne, Smith, 1985, p. 5) it seems appropriate to apply this method. The descriptive method would also be instituted in order to describe data gathered in relationship to the conceptual framework. This method is more structured and allows for description of the experience within the context of the proposed conceptual framework.

Quantitative methods would follow specifically addressing, as stated previously, prediction of the experience, and effectiveness of prescriptive measures. Retrospective studies would provide data for the question: What is the incidence of childhood experiences of lack of attachment and/or unreasonable parental expectations in those clients experiencing relationship addiction? Other questions might include: What role does female development play in the development of relationship addiction? What is the incidence of relationship addiction among women and among men? What is the occurence of each descriptive characteristic in the relationship addicted woman? What is the most frequent object of addiction---the partner, the relationship, or components of the relationship? Quantitative studies would need to be done to validate the effects of such an experience. Are health and human potential minimized? Howso? Is unidirectional progression slowed? A correlational study between the human field motion (helicy) and environmental addiction must be done to validate this proposed theory. Finally quantitative methods would be indicated in validating effectiveness of prescriptive measures: Does redirecting healthy patterning of the unitary being and the environment affect health and human potential? What are effective means for repatterning? What are effective methods of strengthening the coherence and integrity of the unitary being?

Many questions are unanswered in the area of environmental addiction. The proposed conceptual framework will offer direction for beginning research and further study.

Conclusion

In conclusion, Relationship Addiction in women is a popular social issue often neglected and undetected in Health Care Facilities. Though major amounts of attention have been afforded to this area through recent popular literature, little substantiative work has been done in the area. No clear theoretical constructs have been developed and no research has been done. This scholarly writing proposes a framework for theoretical development and research in the area of relationship addiction in women. The author proposes beginning with qualitative research to provide a baseline of data and to validate theoretical constructs presented within this writing. Further writing, critiquing (none of which has been done presently), and conceptualizing are recommended.

The author has some concerns regarding the topic. One, as stated earlier, is the neglect in the health care system to identify the problem's existance or to acknowledge the validity of such a problem. Education, research and role modeling in the area may stimulate a change in the attitudes of individual providers. Certainly, more clinical nurse specialists in primary care settings emulating the assessor role and addressing the problem

would facilitate an overall awareness of the validity of such a problem.

The second concern is that of the popularity of the concept. With the enormous amounts of attention given to the topic in popular literature, everyone claims to be an expert on the topic. Literature is a money maker as are therapists claiming to be experts in the area. The consumer is vulnerable and uninformed as to the implications of such a problem and the difficult and lengthy recovery process. The self help literature often proposes simplified solutions to complicated problems. Furthermore, since no research has been done, it is difficult to evaluate the success of proposed interventions. Once again, the author proposes the institution of research in the area to begin to move out of the popular arena and into credible territory. Clients deserve effective treatment. Education must be done in an attempt to direct the consumer to credible resources.

In summary, the concept of relationship addiction has been explored and placed within a nursing theoretical framework. Significance of the topic within the field of nursing has been established. The importance of detection in the primary care setting has been discussed and roles appropriate for clinical nurse specialist in this setting have been proposed. The concept has been addressed in terms of roles appropriate to advanced nursing practice, education, and research. Finally, the author

has recommended that research be done to validate theoretical constructs and has voiced concerns regarding neglect of detection, topic popularity, and lack of substantiated treatment base possibly interfering with appropriate therapy in vulnerable clients.

The purpose of this scholarly project was to clarify the concept of addiction by outlining specific characteristics and to propose pathogenesis resulting in these specific characteristics. The model proposed in Chapter III clearly identifies these specific descriptive characteristics (Figure 5) and pathogenetic etiological factors (Figures 4, 4a, b, c). A definition of relationship addiction has been proposed (page 16.) and a clear distinction has been made in differentiating dependence from addiction. Evidence has been provided to support the assumptions proposed earlier (page 10,11). The idea of women being more vulnerable to predisposition of this problem (relationship addiction) has been supported throughout the paper. A conceptual framework has been developed and presented specifically applying the concept of relationship addiction to women within a Rogerian nursing theoretical framework. Concepts have been defined within this framework to allow for the beginnings of qualitative and quantitative research. A base has been provided for detection of relationship addiction within the primary care center. Roles for

facilitating wellness in women experiencing relationship addiction have been proposed for the CNS.

The concept of relationship addiction in women is an infant in development. It is the hope of this author that the conceptual framework proposed will offer a base from which to work at further theory construction. Hopefully each study will provide nourishment in the growth of the concept to a substantiated and credible theory.

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