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CHAPTER 6

CODEPENDENCY: AN EMPIRICAL STUDY FROM A SYSTEMIC PERSPECTIVE

Jim Cullen & Alan Carr

INTRODUCTION

The term codependency was initially used to denote the psychological, emotional and behavioural difficulties exhibited by the spouses, and subsequently the children, of alcoholics who inadvertently enabled maintenance of the drinking problem. It replaced the less inclusive term's co-alcoholic, para-alcoholic and enabler (Cermak, 1991; Hands & Dear, 1994; Harper & Capdevilla, 1990; Miller, 1994; Whitfield, 1984; Wormer, 1989). The concept was subsequently expanded to include individuals significantly affected by drug addiction, gambling, sexual addiction and any other stressful family of origin experience which rendered them prone in later life to forming dysfunctional care-taking relationships with addictive, compulsive, or exploitative individuals (Potter-Efron, & Potter-Efron, 1989; Prest & Protinsky, 1993; Schaef, 1986).

Definitions of codependency tend to be diverse, lacking in rigor and none are universally accepted (Gomberg, 1989; Irwin, 1995; Krestan & Bepko, 1990). Spann and Fischer (1990) operationally defined codependency as a pattern of relating to others characterised by an extreme belief in personal powerlessness and the powerfulness of others; a lack of open expression of feelings; and excessive attempts to derive a sense of purpose through engaging in personally distressing caretaking relationships which involve high levels of denial, rigidity

and attempts to control the relationship. This definition acknowledges both the intrapsychic and interpersonal aspects of the construct of codependency (Cermak, 1986a, 1986b, 1991).

The lack of empirical validation for any of the definitions of codependency is a major source of scepticism (Gierymski & Williams, 1986; Gomberg, 1989; Morgan, 1991; Wright & Wright, 1990). Furthermore, many authors have rejected the concept on the grounds that it is denigrates women and blames innocent victims of substance abuse (Asher & Brissett, 1988; Frank & Golden, 1992; Haaken, 1990; Harper & Capdevila, 1990, Krestan & Bepko, 1990; van Wormer, 1989; Webster, 1990). However the phenomenon to which the concept refers remains an all too common clinical reality. Consequently there is a need to conceptualise and explore codependency in a way that enhances our understanding of it while avoiding the pitfalls highlighted by critics.

This study aimed to empirically investigate the relationship between codependency and family of origin experiences, intimate relationship functioning, personal adjustment and gender. Relevant literature concerning these four areas is reviewed below.

Codependency and family of origin experiences

Empirical support for the linkage of codependency with parental substance abuse is equivocal. Indeed no researcher has clearly demonstrated that codependence is more prevalent among the family members of substance abusers. While Carson and Baker (1994) and Lyon and Greenberg (1991) found codependent behaviour in adults to be associated with parental alcoholism, the majority of studies conducted to date have not (Crothers & Warren, 1996; Fischer et al., 1992; Irwin, 1995; Meyer, 1997; O'Brien and Gaborit, 1992; Zuboff-Rosenzweig, 1996). Interestingly, Roehling, Kobel and Rutgers (1996) found the correlation between codependency and parental alcohol abuse to be mediated by emotional and physical abuse. Thus the professed association between codependency and

parental substance abuse may be the product of dysfunctional aspects of family life which are related to, but conceptually distinct from, the presence of a chemically dependent parent. These findings, on the whole, challenge the universal application of the codependency label to the family members of substance abusers.

Researchers have identified the following family of origin experiences as fostering and maintaining codependency: childhood abuse (Carson & Baker, 1994); parental coercion, non-nurturance and maternal compulsivity (Crothers & Warren, 1996); authoritarian paternal parenting style (Fischer & Crawford, 1992); dysfunctional parenting (Kottke, et al.,1993); repressive family atmosphere and physical and verbal abuse (Zuboff-Rosenzweig, 1996); lack of acceptance (Fischer and Crawford, 1992; Kottke et al., 1993), communication, satisfaction and support (Fischer and Crawford, 1992; Fischer et al., 1991; Spann & Fischer, 1990); and high levels of control and enmeshment (Fischer and Crawford, 1992; Fischer, et al., 1991). Alternatively, a number of researchers have found no significant relationship between codependence and traumatic childhood events (Irwin, 1995) or the severity of dysfunctional patterns in the family of origin (Irwin, 1995; Fischer, et al., 1992). From this brief review it may be concluded that questions remain about the link between codependency and parental substance abuse; parental mental health; childhood abuse; and family of origin dysfunction.

Codependency and intimate relationships

A number of empirical studies have addressed the hypothesis that codependent individuals tend to become involved in problematic relationships, often with chemically dependent partners, and remain committed to the care and support of their partners in the face of severe social and emotional difficulties (Wright & Wright, 1991). O'Brien & Gaborit, (1992) found no significant statistical correlation between codependency and a relationship with a chemically

dependent significant other. Similarly, Gierymski and Williams (1986) summarised a number of studies that investigated personality characteristics of the wives of alcoholics and concluded that a proximal relationship to an alcoholic may not always be a factor in codependency. However, Prest & Storm (1988), in a sample of compulsive eaters and drinkers, found the spouses of compulsive persons to be codependent. These studies confirm that there is still a lack of clarity about the relationship between co-dependency and the nature and quality of intimate relationships.

Codependency and psychological adjustment

Empirical evidence of a relationship between codependency and depression (Carson & Baker, 1994; Fischer et al., 1991; Lyon & Greenberg, 1991); anxiety (Fischer et al., 1991; Roehling, et al., 1992); interpersonal sensitivity (Gotham & Sher, 1996); somatisation, (Gotham & Sher, 1996); low self esteem (Fischer & Beer, 1990; Fischer et al., 1991); compulsivity (Gotham & Sher, 1996; Prest & Storm, 1988); and drug use (Teichman & Basha, 1996) have been documented. Although empirical research has shown that individuals with codependent profiles deviate from controls on measures of psychopathology these effects are often only of small to moderate size and tend not to fall within the clinical range. In addition, other studies have found no association between codependency and depression (O'Brien and Gaborit,1992); self-esteem (Lyon & Greenberg, 1991); or alcoholism (Fischer, et al., 1992). Unfortunately no empirical research has been conducted into the purported relationship between codependency and help seeking orientation despite the proposed link between the avoidance of help-seeking and codependency (Cermak,1988). Taken together, the results of these studies suggest that there continues to be a lack of clarity about the relationship between codependency and personal psychological adjustment.

Codependency and gender

Feminists have criticised the codependency construct on the basis of gender bias (Asher & Brissett, 1988; Cowan & Warren, 1994; Frank & Golden, 1992; Haaken, 1990; Harper & Capdevila, 1990, Hogg & Frank, 1992; Krestan & Bepko, 1990; Van Wormer, 1989; Webster, 1990). They argue that women have traditionally been conditioned via societal norms to be nurturing, caring, loyal, resilient, helpful and sensitive to the needs of others. Much of what is identified as codependent behaviour therefore overlaps with stereotypically feminine gender roles (Siegal, 1988; Krestan & Bepko, 1990). Consequently, many women but few men would be expected to display characteristics of codependency (Tavris, 1992; Wright & Wright, 1995). Cowan and Warren (1994), Fischer et al., (1991), and Fisher and Beer (1990) provided empirical support for this view. Codependence has also been found to be positively associated with negatively valued feminine characteristics, and inversely related to positively valued masculine characteristics (Cowan & Warren, 1994; Roehling, Kobel, & Rutgers, 1996). However Gotham & Sher (1996), in a study involving 467 participants, and Irwin (1995), in a study involving 190 participants, found no significant gender effect. The relationship between gender and codependency is currently unclear and deserves further investigation.

Hypotheses

In the present study we set out to profile the attributes of groups characterised by high, medium and low levels of codependency, and to test a series of hypotheses suggested by the work reviewed above.

Specifically, we expected the high codependency group to

1. include more females,
2. report more difficulties in the functioning of their family of origin, more parental mental health problems and more parental alcohol and drug abuse problems,

3. report more difficulties in the functioning of current or recent relationships, more compulsivity in their partners and more relationships with chemically dependent partners, and
4. report more psychological adjustment problems including more psychological symptoms, lower self-esteem, greater compulsivity, more drug abuse and less frequent help-seeking behaviour.

METHOD

Participants

Seventy-two male and 212 female psychology students participated in this study. They ranged in age from 17 to 50 years (mean = 20.5; SD = 5.14). Most were single (48%), 47% were currently dating, 5% were engaged or married, and less than 1% were divorced or separated.

Instruments

Spann-Fisher Codependency Scale (Fischer, Spann, & Crawford, 1991). This 16 item rating scale was used to assesses codependency. Its items cover three core features of the construct: (1) the maintenance of an extreme external locus of control; (2) the lack of an open expression of feelings; and (3) the use of control, denial, and rigidity in order to create a sense of purpose through relationships. Six point Likert-type response formats are used for all items and scores on these are summed to yield a single codependency score which ranges from 16 to 96, with high scores indicating greater codependency. In the present study the internal consistency reliability as measured by Cronbach's alpha for the codependency scale was .76. The scale has been shown to discriminate between

self-identified codependents and recovered codependents, thereby demonstrating construct validity.

The Family Assessment Measure General Scale (FAM-50, Skinner et al, 1993) This fifty item multidimensional rating scale was used to assess participants' perceptions of the functioning of their families of origin across the following seven specific domains: task accomplishment, role performance, communication, affective expression, involvement, control, and values and norms. Four point Likert-type response formats are used for all items. Raw scores are converted to T scores and higher scores indicate higher levels of dysfunction. Internal consistency reliability for the scale as a whole as measured by Cronbach's alpha is above .9. The FAM-50 has been shown to differentiate between distressed and non-distressed families and so has external validity.

The Family Assessment Measure Dyadic Relationship Scale (FAM-42, Skinner et al., 1993). This forty two item version of the FAM-50 assesses the same domains as the FAM-50 but with respect to a specific dyadic relationship. In the present study it was used to assess participants' perceptions of their current or recent intimate relationships. The reliability of the FAM-42 is above .9 and the scale has been shown to distinguish between distressed and non-distressed relationships.

General Health Questionnaire (GHQ-28; Goldberg & Williams, 1988). Psychological adjustment was evaluated using the 28 item version of the GHQ which yields an overall score and subscale scores for somatic symptoms, anxiety, social dysfunction and depression. For each item, four-point response formats were used and the 0,0,1,1 scoring method was employed to obtain total and subscale scores. Cases receiving scores of 5 or more following psychiatric interview typically receive a psychiatric diagnosis (Goldberg & Williams, 1988).

Internal consistency reliability coefficients range from .79 to .90 for the subscales and from .91 to .94 for the GHQ-28 total scale (Krol, et al., 1994).

Rosenberg Self-esteem Scale (Rosenberg, 1965)**.** On this ten item rating scale a 4-point Likert-type response format is used for each item. The scale yields a single self-esteem score which ranges from 10 to 40 with higher scores indicating higher self-esteem. The scale's reliability and validity have been established.

Compulsivity Rating Scales. Two six item rating scales were adapted from Crothers and Warren's (1996) Parental Compulsivity Measure to assess compulsivity in both the participants and their partners. Compulsive behaviours in the following six areas were assessed: over-eating, gambling, spending, use of pornography, smoking and cleaning. For both scales five point Likert-type response formats were used for all items and each scale yielded a single compulsivity score which ranged from 6 to 30 with higher scores indicating greater compulsivity. Cronbach's alphas of .44 for the participants' and .53 for the partners' versions provided evidence of only a moderate degree of internal consistency. However, because of the theoretical significance of the construct of compulsivity as a correlate of co-dependency it was thought important to include the compulsivity scale in the study despite its limitations. Caution is advised when interpreting compulsivity scores.

Sexual and Physical Abuse Scale. The occurrence of sexual and/or physical abuse during childhood was assessed with a modified version of Stout and Mintz's (1996) Physical and Sexual Abuse Scale. The scale included four questions related to sexual abuse (e.g., "During childhood, did anyone ask you to show them your breasts or genitals, or watch you in a sexual manner?"); three questions related to physical abuse (e.g., "During childhood, did anyone ever punish you physically in such a way that you had marks, bruises, or cuts on your body?"); and one question related to threats of abuse ("During childhood, did

anyone ever threaten you with physical harm either verbally or through threatening behaviour?"). To each of these questions respondents indicate whether or not a specific abusive event occurred by responding *yes* or *no* and if an abusive event occurred, the participant specifies how the experience affected them using a five point rating scale ranging from *not at all* (1) to *extremely* (5). Higher scores indicate higher levels of distress. Internal consistency reliabilities as measured by Cronbach's alpha in this study were .82 for the sexual abuse scale and .84 for the physical abuse scale.

Drug Use Questionnaire. The frequency of use of cannabis, alcohol, nicotine, solvents, heroin, stimulants, barbiturates, hallucinogens, cocaine and ecstasy was assessed with this 10 item questionnaire. The frequency of use of all 10 drugs was rated for the previous month on 5-point anchored rating scales that ranged from *none* (1) to *more than once a day* (5). An item analysis showed that usage of only 3 of the drugs were endorsed by participants. These were cannabis, alcohol and nicotine. Internal consistency reliability as measured by Cronbach's alpha was .59 for the these three items suggesting that the items formed a scale with a moderate degree of internal consistency. This 3 item scale was used in further analyses as an index of drug use. Scores range from 3 to 15, with higher scores indicating higher levels of drug use.

Paternal and Maternal Alcohol, Drug Abuse and Mental Health Questionnaires. In order to assess the presence of parental alcohol problems, drug abuse and psychological problems participants were asked whether their fathers or mothers had problems in these areas. Berkowitz & Perkins (1988) and Baker & Stephenson (1995) found that asking whether or not parents had an alcohol abuse problem as accurate at assessing parental abusive drinking as the 30 item Children of Alcoholics Screening Test.

Procedure

Volunteers were solicited directly from undergraduate and postgraduate psychology classes at University College Dublin. Completion of the questionnaires, which took approximately 15-20 minutes, was voluntary and anonymous. Participants were given a debriefing statement and telephone number to ring if they had any concerns arising from participating in the study. Each questionnaire was checked, scored and the results recorded in an SPSS data file (Norusis, 1990). Participants were assigned to the low medium and high codependency groups on the basis of their scores on the Spann Fischer Codependency Scale. Cases falling below the 33rd percentile were assigned to the low codependency group. Those scoring above the 66th percentile were assigned to the high codependency group. The remaining participants were assigned to the medium codependency group.

RESULTS

Data management

For categorical variables Chi square tests on 2 (variable values) X 3 (groups) crosstabualtion tables with df=2 were conducted. Where Chi Square values were significant at $p<.05$, the standardised residual (Hinkle, Wiersma, & Jurs, 1994) was computed for each category to determine which of the categories were major contributors to the statistical significance. Results analysed in this way are given in Tables 6.1 and 6.3. Significant intergroup differences occurred on 5 of the 10 categorical variables.

The significance of intergroup differences on continuous (rather than categorical) variables was evaluated with a series of one-way ANOVAs, with df = 2, 281, followed by Tukey-B post-hoc comparisons in instances where F tests from ANOVAs were statistically significant at $p<.05$. To limit the probability of

Type 1 error (mistakenly concluding intergroup differences are statistically significant), subscale scores from multiscale instruments were only analysed if ANOVAs for the total scores from the scales were significant at $p<.05$. For the FAM-50, the FAM-42 and the GHQ-28, ANOVAs on total scores were significant so ANOVAs on all subscales were conducted. From Table 6.2 it may be seen that significant intergroup differences occurred for 18 of 27 continuous variables.

Demographic characteristics

From Table 6.1 it may be seen that the high medium and low codependency group were demographically similar and did not differ significantly with respect to age, gender or marital status.

Table 6.1. Demographic characteristics

	Variable		Group 1 Low CD (N=100)	Group 2 Medium CD (N=88)	Group 3 High CD (N=96)	Chi Square
Gender	Male	%	26	28	21	1.07
		f	26	25	21	
	Female	%	74	72	78	
		f	74	63	75	
Age	17-19y	%	55	66	67	7.49
		f	55	57	64	
	20-24y	%	32	25	34	
		f	32	22	28	
	25-30y	%	6	6	1	
		f	6	5	1	
	31-50y	%	7	3	3	
		f	7	3	3	
Marital Status	Single	%	42	51	51	8.67
		f	42	45	49	
	Dating	%	48	47	46	
		f	48	41	44	
	Engaged/Married	%	9	2	2	
		f	9	2	2	
	Separated	%	1	0	1	
		f	1	0	1	

Note: All Chi squares are non-significant. CD = Codependency.

Family of origin experiences and parental adjustment

From Table 6.2 it may be seen that with respect to family of origin experiences, the high codependency group obtained higher mean scores than the low codependency group on the FAM-50 total scale and the role performance and affective expression subscales of this instrument.

Table 6.2. Family of origin experiences, intimate relationship functioning and psychological adjustment in 3 groups with differing levels of codependency

Variable		Group 1 Low CD (N=100)	Group 2 Medium CD (N=88)	Group 3 High CD (N=96)	F	Group Differences
Family of origin experiences						
FAM-50 Total	M	51.91	54.16	55.49	3.32*	1<3, 1=2
	SD	9.84	9.69	10.10		
FAM-50 Task accomplish.	M	52.92	55.66	55.90	1.49	
	SD	13.70	13.35	13.01		
FAM-50 Role performance	M	52.62	54.70	56.88	4.23*	1<3, 1=2
	SD	9.97	10.23	10.52		
FAM-50 Communication	M	51.76	55.00	55.58	2.85	
	SD	11.85	11.73	12.57		
FAM-50 Affective express.	M	51.00	55.64	57.33	6.98**	1<2=3
	SD	12.02	12.18	12.67		
FAM-50 Involvement	M	49.48	51.00	52.31	1.25	
	SD	11.42	11.80	10.96		
FAM-50 Control	M	53.09	54.35	53.02	1.21	
	SD	11.68	12.01	12.03		
FAM-50 Values and norms	M	53.92	54.00	56.10	1.31	
	SD	10.95	9.91	10.93		
Physical abuse	M	2.18	2.67	2.83	0.82	
	SD	3.80	3.57	3.78		
Sexual abuse	M	0.87	1.32	1.77	2.55	
	SD	2.13	2.72	3.39		
Intimate relationships						
FAM-42 Total score	M	48.12	52.22	54.23	12.60***	1<2=3
	SD	8.89	8.47	8.67		
FAM-42 Task accompliish.	M	58.38	56.25	56.44	1.67	
	SD	13.50	13.06	12.68		
FAM-42 Role performance	M	46.78	50.89	54.73	12.28***	1<2<3
	SD	11.42	10.90	12.00		
FAM-42 Communication	M	46.02	51.27	53.77	12.91***	1<2=3
	SD	10.88	10.48	11.32		
FAM-42 Affective express.	M	46.60	52.05	52.21	7.90**	1<2=3
	SD	11.78	11.53	10.24		
FAM-42 Involvement	M	48.84	51.91	53.54	4.62*	1<3, 1=2
	SD	11.65	11.57	9.69		
FAM-42 Control	M	47.18	50.75	52.69	7.56**	1<2=3
	SD	9.73	9.83	10.60		
FAM-42 Values and norms	M	48.06	52.43	56.25	10.80***	1<2=3
	SD	11.67	12.50	12.87		
Partner's compulsivity	M	7.30	7.75	8.39	3.96*	1<3, 1=2
	SD	1.87	2.37	8.49		
Psychological adjustment						
GHQ Total score	M	3.68	5.13	9.54	34.30***	1=2<3
	SD	4.11	6.79	6.28		
GHQ Somatic complaints	M	1.52	1.68	2.62	8.11**	1=2<3
	SD	1.87	1.97	2.25		
GHQ Anxiety	M	1.18	1.67	3.36	27.62***	1=2<3
	SD	1.67	1.94	2.43		
GHQ Social dysfunction	M	0.78	1.38	2.45	22.09**	1<2<3
	SD	1.34	1.85	2.08		
GHQ Depression	M	0.19	0.38	1.22	20.65***	1=2<3
	SD	0.58	1.01	1.68		
Self-esteem	M	32.04	29.98	27.43	30.38***	1>2>3
	SD	4.08	2.16	4.21		
Personal compulsivity	M	7.58	8.13	9.19	12.71***	1=2<3
	SD	2.02	2.19	2.56		
Drug use	M	6.88	6.69	7.47	2.26	
	SD	2.51	2.47	2.81		

Note: CD = Codependency. FAM-50 = Family Assessment Measure General Scale. FAM-42 = Family Assessment Measure Dyadic Relationship Scale. GHQ = General Health Questionnaire-28. For all ANOVAs, df=2, 281. *p<.05. **p<.01. ***p<.0001.

Thus, compared to the low-codependent group the high codependent group perceived their families of origin to be more dysfunctional overall, but particularly in term of the clarity of roles and level of affective or emotional expressiveness. The medium codependency group did not differ from the low codependency group on the FAM-50 total scale or the role performance subscale. Also they did not differ from the high codependency group on the affective expression subscale. Thus the main area in which they perceived their families of origin to have difficulties was with affective or emotional expressiveness.

From Table 6.3 it may be seen that more members of the high codependency group reported that their mothers and fathers had mental health problems compared with the other two groups. However, there were no intergroup differences in the frequency with which the three groups reported parental alcohol and drug abuse problems.

Current or recent intimate relationships

From Table 6.2 it maybe seen that with respect to current or recent intimate relationships, the high codependency group obtained higher mean scores than the low codependency group on the FAM-50 total scale and all subscales of this instrument with the exception of task accomplishment. Thus, compared to the low codependent group, the high codependent group perceived their families of origin to be more dysfunctional overall, but particularly in terms of the clarity of roles, the quality of communication, the level of affective or emotional expressiveness, the level of emotional involvement, the level of behavioural control and the quality of values and norms. The medium codependency group did not differ from the low codependency group on the involvement subscale of the FAM-42 or on the partner compulsivity scale. In contrast, they did not differ from the high codependency group on the total scale of the FAM-42, and on the communication, affective expression, control and norms and values subscales of

this instrument and on all of these dimensions scored higher than the low codependency group. With respect to the role performance subscale of the FAM-42, the medium codependency group scored lower than the high codependency group but higher than the low codependency group.

Table 6.3. Personal and parental adjustment and intimate relationship problems of 3 groups with different levels of co-dependency

			Group 1 Low CD (N=100)	Group 2 Medium CD (N=88)	Group 3 High CD (N=96)	Chi Square	Group Diffs
Parental adjustment	Parental mental health probs	%	11	7	21	8.03*	1=2<3
		f	11	6	19		
	Maternal mental health probs	%	9	6	17	6.75*	1=2<3
		f	9	5	16		
	Paternal mental health probs	%	2	2	9	2.85*	1=2<3
		f	2	2	10		
	Parental alcohol abuse	%	13	18	22	2.59	
		f	13	16	20		
	Parental drug abuse	%	1	0	2	1.99	
		f	1	0	2		
Personal adjustment	Does not seek help for probs	%	65	80	78	5.86*	1<2=3
		f	65	70	75		
Intimate relationships	Relationship with CDP	%	13	9	25	8.74*	1=2<3
		f	13	7	22		

Note: CD = Codependency. GHQ = General Health Questionnaire-28. CDP=Chemically dependent partner. In all analyses df= 2. *p<.05. ***p<.0001

From Table 6.3 it may be seen that more members of the high codependency group reported having relationships with chemically dependent partners.

Psychological adjustment

From Table 6.2 it may be seen that the high codependency group obtained higher scores than the other two groups on the GHQ-28 total scale and the somatic complaints, anxiety and depression subscales of this instrument. They also obtained higher scores than the other two groups on the personal compulsivity

scale. For the social dysfunction GHQ-28 subscale and the self esteem scale the high codependency group obtained more abnormal scores than the medium codependency group who in turn returned more abnormal scores than the low codependency group.

From Table 6.3 it may be seen that more members of the high and medium codependency groups reported not seeking help for problems compared with the low codependency group.

DISCUSSION

The first hypothesis, that the high codependent group would contain more females was not supported by the results of this study. However, the generalizability of this finding is limited by the use of a college sample which, traditionally, is not as strongly gender typed as samples of older adults (e.g., Gotham & Sher, 1996).

The second hypothesis, concerning greater family of origin difficulties in the high co-dependency group was partially supported by our results. The high codependency group reported more difficulties with family functioning particularly in the area of task accomplishment and affective expression and there was a higher incidence of parental mental health problems in this group. However, contrary to expectations the high codependency group did not report a greater incidence of parental drug and alcohol abuse problems and childhood physical and sexual abuse,

The third hypothesis concerning greater difficulties in the functioning of current or recent relationship, found considerable support in this study. The high codependency group reported greater difficulties with their relationships particularly in the areas of roles, communication, affective expression, emotional involvement, control and values and norms. In addition, more members of the

high co-dependency group had chemically dependent partners and they reported higher levels of compulsivity in their partners.

Table 6.4. Summary of status of 3 groups with differing levels of codependency on all variables on which they differed significantly

Variable Category	Variable	Group 1 Low CD (N=100)	Group 2 Medium CD (N=88)	Group 3 High CD (N=96)
Family of origin	FAM-50 Total score	-	-	+
	FAM-50 Role performance	-	-	+
	FAM-50 Affective expression	-	+	+
	Parental mental health problems	-	-	+
	Paternal mental health problems	-	-	+
	Maternal mental health problems	-	-	+
Intimate relationships	FAM-42 Total score	-	+	+
	FAM-42 Role performance	-	o	+
	FAM-42 Communication	-	+	+
	FAM-42 Affective expression	-	+	+
	FAM-42 Involvement	-	-	+
	FAM-42 Control	-	+	+
	FAM-42 Values and norms	-	+	+
	Partner's compulsivity	-	-	+
	Relationship with CDP's	-	-	+
Psychological adjustment	GHQ Total score	-	-	+
	GHQ Somatic complaints	-	-	+
	GHQ Anxiety	-	-	+
	GHQ Social dysfunction	-	o	+
	GHQ Depression	-	-	+
	Low self-esteem	-	o	+
	Compulsivity	-	-	+
	Does not seek help for problems	-	+	+

Note: CD = Codependency. GHQ = General Health Questionnaire-28. - = few problems in this area. O = intermediate level of problems in this area. + = Many problems in this area.

The fourth hypothesis concerning psychological adjustment problems and codependency was also largely supported by the results of this study. The high codependency group reported more psychological symptoms overall and these spanned a wide spectrum of areas including anxiety, depression, somatic complaints and social dysfunction. In addition they reported greater compulsivity and lower-self esteem. They did not differ from the other groups on level of drug abuse but more people in the high codependency group reported that they did not seek help for their problems.

Profiles of the three groups, summarising the significant results of the study are given in Table 6.4. From the table it may be seen that the high and low codependency groups differed on a wide range of variables in the domains of family of origin experiences; current intimate relationships; and psychological adjustment. The profile of the medium codependency group shared some characteristics with each of the extreme groups.

The reliability and validity of the measures used and the confidentiality entailed by the experimental procedures and the consistent patterning of the results all permit us to place considerable confidence in some aspects of our results. We believe that our findings cast considerable doubt on the validity of the linkage between codependency and parental substance abuse (e.g., Cermak, 1991; Schaef, 1986) and the link between codependency and physically or sexually abusive experiences in childhood (e.g., Carson & Baker, 1994). Where such linkages have been observed in the past, the results of our study suggest that they may have been mediated by more general parental mental health difficulties and problems in family functioning, specifically those associated with role clarity and affective expression. Our results suggest that youngsters who grow up in families where there is a lack of clarity about roles and a lack of warm, supportive and appropriate affective expression and where parents have mental health problems find themselved in a family context which promotes the development of codependency. Problematic family roles may engender a belief in personal powerlessness and the powerfulness of others. Difficulties with affective expression in the family of origin may engender difficulties in the open expression of feelings. Experiences with parents who have mental health problems may socialize children into care-taking roles early in their lives and so lead in adulthood to their excessive attempts to derive a sense of purpose through engaging in personally distressing caretaking relationships which involve high levels of denial, rigidity and attempts to control relationships.

Our findings should alert professionals to the dangers of perpetuating the myth that all family members of parents with alcohol abuse problems or those

who have been abused will develop codependence and therefore require codependency treatment. Future research on codependency should be targeted at families on the basis of the presence of problematic interactional patterns in their family of origin rather than parental substance abuse or child abuse per se (Carr, 1995, 1997, 1999). Future preventive therapeutic or educational systemic interventions should focus on enhancing affective expression and role performance in at risk families.

The wide ranging difficulties in current intimate relationships of highly co-dependent individuals and the wide-ranging nature of their personal psychological symptoms also suggest that a narrow individually-based focus on co-dependency may be unwarranted. At a systemic level, interactional patterns which maintain personal psychological symptoms should be a central focus for treatment. Future research should aim to map patterns of interaction in which codependent individuals and their intimate partners become entrenched.

There are several limitations to this study. First, strictly speaking, the results are generalizable only to college students, who may not be fully representative of the wider population in terms of co-dependency. Second, no independent measures of interpersonal and intrapsychic functioning were sought from participants' parents or partners. Third, there were many mediating factors that were not included in this study, such as divorce and remarriage in the family of origin and level of support in the extended family and community. Future research with samples drawn from community and clinical populations are needed to extend the generalizability of this study's findings. Such research should include observational and self-report data from families of origin and partners and should be extended to include lifecycle issues such as divorce and wider-system variables such as the availability of extrafamilial social-support.

SUMMARY

To empirically investigate the construct validity of codependency, differences between young adults who scored in the high, medium and low ranges on a measure of codependency on theoretically relevant variables were examined. Compared with individuals who scored low on codependency, those who obtained high scores reported significantly more family of origin difficulties and parental mental health problems; problematic intimate relationships including relationships with chemically dependent partners; and personal psychological problems including compulsivity. However, contrary to prevailing theoretical predictions the high codependency group did not contain more females or individuals whose parents had alcohol or drug abuse problems, nor was there a higher level of childhood physical or sexual abuse in the high codependency group. These results suggest that co-dependency is one aspect of wider multigenerational family systems problems which are not unique to families where drug and alcohol abuse or physical and sexual abuse are major concerns.

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