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The Relationship Between Codependency, Alcoholism,

and the Family of Origin

(TITLE)

BY

WILLIAM ANSARA

Thesis

SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
FOR THE DEGREE OF

MASTER OF ARTS

IN THE GRADUATE SCHOOL, EASTERN ILLINOIS UNIVERSITY
CHARLESTON, ILLINOIS

1995

(YEAR)

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Abstract

This study examined the relationship between the construct of codependency, family alcohol consumption patterns, degree of family dysfunction, and gender. It was proposed that codependent behaviors, feelings, and attitudes would be present in persons regardless of the reported degree of family alcohol abuse if dysfunctional patterns of relating exsisted in the family of origin. It was further hypothesised that women would evidence higher codependency scores than males in all groups. The Spann-Fischer codependency assessment instrument was use to measure subjects feelings and attitudes. Subjects were divided into four groups based on their report of family dysfunction and family alcohol consumption patterns. Results indicated codependent characteristics were more prevalent in subjects from the maximum dysfunction group compaired to those in the minimum dysfunction group regardless of reported degree of family alcohol consumption. Females did not score significantly higher than males. The additional questions assessing the concept of Hypervigilence did not show significant intercorrelations and only correlated moderately with the Spann-Fisher assessment instrument. The concept of codependency is reviewed and implications for future research are discussed.

Acknowledgements

Many thanks to Dr. Russel Gruber for his guidence, patience and direction in preparation of this thesis. Thanks to Dr. William Bailey for his tireless proof reading and his keen awareness of style and flow, which help greatly in preparation of this work. Thanks to Dr. Michael Havey for his helpful comments and suggestions through all phases of preparation of this document.

Lastly, great thanks to my relatives, friends and associates who distributed questionnaires throughout the country. Without them this research project could not have been undertaken.

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The Relationship Between Codependency, Alcoholism, and the Family of Origin

William Ansara

Eastern Illinois University

The term co-dependency has become part of the American vernacular in the last decade and a half. Once used exclusively to describe those persons living with an alcoholic or alcohol abusing family member, the term is now used to describe any person living in, coming from, or displaying characteristics of persons growing up in a dysfunctional family (Bradshaw, 1988; Fischer, Spann & Crawford, 1991; Forward, 1989; Kriestan & Bepko, 1991; Lasater, 1988; Lyon & Greenberg, 1991; Melody & Miller, 1989; Morgan, 1991; O'Brien & Gaborit, 1992; Potter-Efron & Potter-Efron, 1989; Schaef, 1986).

The concept of codependency finds its roots in the study of the alcoholic family (Beattie, 1987) and Potter-Efron (Potter-Efron & Potter-Efron, 1989) consider it the "paradigm for which to gather information about co-dependency" (pg. 38). It is believed that the behaviors of those close to an alcoholic are maladaptive responses and coping strategies meant to deal with the unpredictability and stress brought on by the alcoholic (Beattie, 1987; Black, 1981; Cermak, 1987; Schaef, 1986; Smalley, 1982; Woititz, 1983). The behaviors are thought to have been developed and internalized by the individual as a result of a dysfunctional family environment in which alcohol abuse and more recently, mental illness or extremely repressive or vicissitudinous rules operated to influence, distort, suppress, and change normal healthy familial interactions (Black, 1981; Cermak, 1987; Forward, 1989; Schaef, 1986; Smalley, 1982; Wright & Wright, 1991). The term, first "para-alcoholic", "co-alcoholic" and then "codependent",

was originally designated to label the spouse of an alcoholic (Harper & Capdevilla, 1990). Many of the characteristics now labeled as codependent were first noted by counselors advising the spouses of alcoholics (Lyon & Greenberg, 1991; O'Brien & Gaborit, 1992). As more was learned about them, it was found that many spouses had been raised in a household with at least one alcohol abuser (Beattie, 1987; Woititz, 1983).

The Adult Children of Alcoholics movement, ACOA, started as a grassroots support group whose self identified members were composed of persons who grew up in an alcoholic family. As the ACOA movement grew, an emerging set of feelings, beliefs and thinking patterns were recognized as being the product of a substance abusing home.

The alcoholic home environment is typified by inconsistency, fear, guilt, blame, anger, resentment, and secrecy (Deutsch, 1983). Members function in an unhealthy manner, developing and sustaining poor strategies for communicating, problem solving, and anxiety and stress reduction. These stratagies are thought to impede the many aspects of emotional and psychological growth of all family members (Beattie, 1987; Bradshaw, 1988; Cermak, 1987). Family systems theorists contend that if there is a internal threat to the family system, such as the alcoholic family member becoming intoxicated and uncontrollable, a delicate balance is upset and all of the other family members adapt in ways such as withdrawal, acting out, placation, manipulation, over-achievement, and other

maladaptive stress reduction strategies (Black, 1981; Bradshaw, 1988; Haaken, 1990). Writers in the area of ACOA have even defined several roles, principally the "Hero", " Mascot", "Scapegoat" and the "Enabler", that are assumed by family members to adapt to the alcoholic member (Black, 1981). The Hero role is one in which the child of an alcoholic family resolves his or her emotional pain by acting out, over achievement and hyper-responsibility (Black, 1981; Woititz, 1983). Over-achievement can be in school and extra-curricular activities. Hyper-responsibility refers to a child who has taken on many of the responsibilities of the family such as domestic chores and the care of siblings. The Enabler, according to Friel (Friel & Friel, 1988), "Keeps everyone together, preserving the family unit at any cost (including physical violence or even death) and trying [sic] to smooth out ruffled feathers and avoid conflict is the ultimate goal" (pg.55). The Mascot role is one in which the player acts as a kind of class clown. He or she is usually the youngest member of the family and provides the comic relief or a sense of playfulness and pseudo happiness that is meant to combat the anxiety and stress of the family. The cost, according to Friel (Friel & Friel, 1988), is that "the true feelings of pain and isolation never get expressed..." (pg.56). Lastly, the Scapegoat acts out all the dysfunction of the family, usually in the form of delinquency and truancy (Friel & Friel, 1988). It is on this member that the blame for the family's problems is placed (Black, 1981). Family members can assume more than one role and play each, according to the needs of the family at any given

point in time (Black, 1981).

The concept of co-dependency has been tremendously popular in the field of addictions counseling and its jargon is frequently used in contemporary psychology. It has given rise to numerous workshops, public lectures, public television programming and a several popular self-help books. To illustrate this popularity, in July of 1990 Co-dependents Anonymous meetings numbered 2,088 weekly throughout the US. Sixty-four international meetings were registered with the CoDA International Service Office (Rice, 1992). Melody Beattie's Codependent No More (1987) remained on the Publishers Weekly best seller list for 154 consecutive weeks and was the tenth best-selling trade paperback (Rice, 1992). Further, John Bradshaw's Bradshaw On: The Family (1988) and Healing the Shame that Binds You (1989) were selling a combined total of 40,000 copies per month. His most recent book, Homecoming: Reclaiming and Championing Your Inner Child was the ninth best selling non-fiction hard cover (Rice, 1992).

Despite this popularity, the concept of codependency has been the brunt of many jokes (Miller, 1987; Weinberg, 1987), and other more serious review. Moreover, its attempted explication has been based almost exclusively on clinical observation and casework (Kriestan & Bepko, 1991). The term codependency has been used, expanded and irresponsibly applied to many groups with little regard to empirical research or refinement and clarification of the construct (Gierymski & Williams, 1986; Lyon & Greenberg, 1991; Potter-Efron & Potter-

Efron, 1989). Codependency's less than auspicious beginnings and continued liberal use of the term has led to a serious loss of credibility and has produced skepticism in the mainstream psychological community (Potter-Efron & Potter-Efron, 1989). This skepticism and loss of credibility has created difficulty in building a credible theoretical framework on which to understand, communicate, and investigate the phenomenon (Gierymski & Williams, 1986; Lyon & Greenberg, 1991). However, the imprecise and numerous variations in the definition of codependency and lack of empirical validation have not curtailed many mental health care providers from designing and implementing entire treatment regimens aimed at this putative population.

No two writers exploring the codependent construct use the same definition (Harper & Capdevilla, 1990; Wright & Wright, 1990). Several authors have contributed their own definitions. They include:

a.) "A pattern of beliefs about life, learned behaviors, and habitual feelings that make life painful" (Smalley, 1982).

b.) "One who has let another person's behavior affect him or her, and who is obsessed with controlling that person's behavior" (Beattie, 1987).

c.) "A pattern of painful dependency on compulsive behavior and approval seeking in order to gain safety, identity and self-worth" (Laing, 1989).

d.) "An emotional, psychological, and behavioral condition that develops as a result of an individual's prolonged exposure to, and practice of, a set of oppressive

rules" (Subby &Friel, 1984).

e.) "It is a toxic relationship to a substance, a person, or a behavior that leads to self-delusion, emotional repression and compulsive behaviors that results in increased shame, low self worth, relationship problems and medical complications" (Wegscheider-Cruse, 1988).

f.) "A codependent is an individual who has been significantly affected in specific ways by current or past involvement in an alcoholic, chemically dependent, or other long term stressful environments" (Potter-Efron & Potter-Efron, 1989).

g.) "Any suffering and dysfunction that is associated with or results from focusing on the needs and behaviors of others" (Whitfield, 1989).

h.) "A codependent is anyone who lives in close association over a prolonged period of time with anyone who has a neurotic personality" (Larsen, 1983).

i.) "A psychosocial condition that is manifested through a dysfunctional pattern of relating to others. This pattern is characterized by: Extreme focus outside of self, lack of open expression of feelings, and attempts to derive a sense of purpose through relationships" (Spann & Fischer, 1990).

j.) "A preoccupation with the lives, feelings, and problems of other people" (Roosa, Sandler, Gehring, Beals, & Cappo, 1987).

Family and chemical dependency (CD) therapists have asserted that a constellation of common behaviors, behavior patterns, distorted thinking, and feelings exist in persons with codependence. Beatty (1987) cites a lengthy list of

characteristics including an overdeveloped sense of responsibility, low self-esteem, a self depreciatory and overly self-punitive style, the need to control others, the lack of appropriate boundaries in relationships, difficulty in recognizing normal behavior in others, and extreme fear of abandonment as significant traits of codependants. Similarly, "fusion" or the loss of one's own identity in intimate relationships is considered in another description (Hogg & Frank, 1992). Cermak (1987) and Cermak and Brown (1982) list several factors they consider common to the codependence construct including anxiety and boundary distortions around intimacy, excessive reliance on denial, hypervigilance (a sensitivity to detect change before it gets out of control) and the ability to maintain a controlled facade despite whatever turmoil might exist within themselves or the relationship, as key components of codependency. Smalley (1984) notes "a drive toward constant external validation" (pg.13) that is fundamental to the codependency construct. Woititz (1983) distinguishes a difficulty in establishing intimate relationships and "guess[ing] at what normal is" (pg.24). These behaviors, feelings and perceptions comprise the core constituents of codependence. Not only are these behaviors carried into adult romantic relationships from the family of origin , but many writers assert they are evident in all relationships (Beattie, 1987; Bradshaw, 1987; Shaef, 1986; Smalley, 1984).

Authors have posited several fundamentally different ways of viewing, treating and measuring the co-dependency construct. Wright and Wright (1991)

see codependency as being both a personality disorder and a mode of interacting, using the terms "chronic" or "endogenous" and "reactive" or "exogenous" respectively. They note important differences in the two. Endogenous codependents "are more likely to be involved in repeated dysfunctional relationships"... [and] "have a more difficult time changing behavior and relationship patterns in response to therapy" (pg.443) and in treatment, spend a large amount of time on past problems focusing of family of origin issues. In contrast to endogenous codependents, exogenous codependents spend less time with family issues, respond more quickly in therapy, and "become involved with an addicted or similarly dysfunctional person whose problems were not obvious at the onset of the relationship" (pg.443). Cermak (1984) also sees codependency as encompassing both patterns of relating and an intrapsychic state. He sees codependency as a set of rules countermanding honest expression and at the same time representing a distorted way of viewing relationships and oneself.

Codependency is conceptualized most often as a personality disorder. Among the many problems faced by codependent persons, a marked distrust of ones own feelings, the inability to recognize normalcy in interactions with others, and difficulty building and sustaining fulfilling emotional relationships are cited as major components (Cermak, 1986; Friel & Friel, 1988; Wegsheider-Cruse, 1988; Woititz, 1983). Most writers look to the family of origin for answers, however, they offer little empirical evidence that implicate causal factors for codependent

traits.

Woititz (1983) contends that questioning one's perceptions and distrust of feelings in adulthood are likely a result of questioning one's perceptions and feelings as children. Several authors assert that in the alcoholic (i.e. dysfunctional) family, children were constantly told to essentially disregard their feelings and perceptions regardless of the turmoil around them (Beattie, 1987; Smalley, 1984; Woititz, 1983). Consequently, these children grew up trying to disregard their feelings thinking this was normal, no matter how uncomfortable any situation became. When they reached adulthood and encountered similar situations that provoked the same feelings, they react with the same strategies that helped them endure their home environment (Beattie, 1987; Subby & Friel, 1984; Woititz, 1983). The inability to recognize normalcy and a difficulty in establishing fulfilling emotional relationships again is made problematic because of the codependent's home environment. Woititz (1983) succinctly states; "... the most obvious reason is that they have no frame of reference for a healthy, intimate relationship, because they have never seen one". "... Not knowing what it is like to have a consistent, day-to-day, healthy, intimate relationship with another person makes building one very painful and complicated." (pg.39).

Codependency also represents a way of communicating and behaving toward one's mate and others which is characterized by an obsession with controlling another's behavior (Beattie, 1987). Beattie (1987) cites a recurrent

theme of the alcoholic's spouse who tries to manipulate the drinkers environment to control consumption. The attempts at control are actually efforts that inadvertently enable the alcoholic to continue his/her drinking (Beattie, 1987). Cermak writes; "For the codependent, loss of control is phobically avoided...". "Control of self and others, feelings, and things is blindly pursued as an antidote to free-floating anxiety" (pg.39).

Other authors hypothesize codependent characteristics to be dysfunctional attempts to gain intimacy through over-control and are thought to evolve from an intimacy dysfunction in the alcoholic family (Smalley 1984; Woititz 1983). Schaef (1989) also sees codependency as an intimacy dysfunction taking the form of addictions. She constructs an intimacy avoidance model in which persons form addictions to sex, romance and relationships. She believes that all three are attempts to gain intimacy that fail because of the paradoxical deep fear of intimacy. She believes intimacy has its foundations in a strong sense of self. She further asserts that "any form of dependency is destructive. Any relationship that is defined in terms of dependency of any sort cannot be intimate" (Schaef, 1989; p.106).

Some writers assert codependence is primarily a personality disorder of women (Frank & Golden, 1992; Haaken, 1990; Hagan, 1989; Kriestan & Bepko, 1991). Hagan (1989) asserts that codependence is simply a euphemism for the practice of dominance and subordination of women. This view is considered the

genesis of most arguments posited by feminist writers addressing the codependence construct. Haaken's characterization of codependence is one based on a caretaking role which develops from powerlessness in which compromise, appeasement and covert manipulation are developed to a greater extent by females coming from an alcoholic family environment than in those coming from families with more healthy interactions (Haaken, 1990). She believes that women coming from dysfunctional families were, as children, trying to overcome parental inadequacies by assuming more of the role of the parents and by developing an excessive sensitivity to the needs of others. Black (1981) echoes this sentiment and argues that a sense of over-responsibility felt by adults - which is a key feature of this disorder, is thought to be derived from a childhood in which the child has been forced to assume many of the responsibilities of adulthood and thus become what Haaken (1990) calls "parentified" (pg. 39). In the absence of consistency and structure during childhood, Black (1981) asserts that some children, usually the oldest or only child, welcomes this role of responsibility which brings them a sense of control in a family where stability and consistency are rare. This role is then reinforced by the parents through praise and adulation (Schaef, 1989). As a result, the child learns to become prematurely self-reliant (Black 1981).

Still others regard codependency as a renamed version of Bowen's undifferentiated self (Fagan-Pryor & Haber 1992) or Horney's morbid dependency (Lyon & Greenberg, 1991). In Bowens theory, the greater the degree of

undifferentiation of self from others, the more likely a person will derive their self definition through interaction with others (Fagan-Pryor & Haber 1992). Morbid dependency is the necessity of obtaining and preserving affection at the expense of engaging in a dependent, exploitive relationship (Lyon & Greenberg, 1991). These authors believe understanding codependency through the use of concepts delineated by Bowen and Horney will help to ground codependency in a solid theoretical foundation (Fagan-Pryor & Haber 1992).

Cermak (1987) distinguishes codependency from Dependent Personality Disorder by indicating control issues are central in the codependent construct, while dependency/autonomy are at the core of Dependent Personality Disorder. Morgan (1991) includes other differences between the two disorders. He asserts that an essential feature of the codependent person is their reliance on will power to control another's behavior and notes that, "codependent individuals actually believe that they can control the feelings and behaviors of others by sheer force of will" (p.725). Second, codependent persons feel their self worth and esteem is based on their partner's success or failure (Morgan, 1991). Cermak (1987) believes the problems in achieving a clear definition of codependence lie more in our inability to define a conceptual model rather than the question of it's true existence as a concrete entity. He acknowledges that the concept of codependence encompasses constituents of other established personality disorders such as dependency needs, narcissism, control issues, and depression, but argues it

represents a specific diagnostic entity that can be of considerable value in the design of treatment methods (Cermak, 1987).

Among the codependency construct's detractors, Gomberg (1989), in speaking of codependency in substance abusing families, contends; "there is no data [sic] which justifies diagnosing family members in any family in which substance abuse occurs, as manifesting a personality disorder solely on the basis of their family membership" (p.118). She sees the need for recognition of the impact of all disordered or stressful behavior on family life but, does not consider codependency a separate disorder (Gomberg, 1989). Haakken (1990) believes that the codependence construct does not have real diagnostic discriminatory validity but concedes that "the popular literature clearly articulates important themes in the lives of many people" (pg. 398). Kriestan & Bepko (1991) consider the codependence phenomenon a socially constructed artifact that "speaks to the power of our descriptions of reality to invent reality and to invent disease for economic and political gain..." (p.230). Harper and Capdevila (1990) challenge the existence of codependency and state, "[The] methods of treatment and the validity of treatment for what remains an unverified diagnostic entity are challenged on the grounds of professional ethics and therapeutic efficacy" (pg.285).

Logue, Sher, and Frensch (1992) report that the purported characteristics of Adult Children of Alcoholics (i.e. codependents) may be the product of a

"Barnum Effect" (i.e. vague, double-headed, high baserate descriptors). They asked two groups of subjects, ACOA's and non-ACOA's to rate bogus personality profiles on how accurately they described Self, People in General, or Children of Alcoholics. Both groups found all profiles, regardless of content, to be highly descriptive of Self, more so than of people in general or children of alcoholics (Logue, Sher & Frensch, 1992). This may be a plausible explanation for the popularity of codependence descriptors.

The strongest evidence to date for the support of codependence as a diagnosable entity separate from chemical dependency comes from two studies. O'Brien and Gaborit (1992) administered a codependence measure (CDI), the Significant Others' Drug Use Survey (SODS) and the Beck Depression Inventory to a sample of 115 undergraduate students. (O'Brien & Gaborit, 1992). The authors found scores for the CDI and the SODS to be independent of one another, concluding that these results support the hypothesis that codependency exists independently of chemical dependency. These researchers did not find a significant correlation between codependence and depression, however, they found that those persons involved with a chemically dependent or problem drinker were more depressed than those who were not involved with such a person. The authors concluded that depression may have existed in their sample, but, because codependents "typically have a dull awareness of their feelings " (pg.134) depression was not detected. In a second study, Fischer, Spann and Crawford

(1991) assessed five groups (three student samples, one Al-anon recovery group, and one group of self-identified codependents seeking treatment) using the Spann-Fischer Scale. They found that codependency scores were negatively correlated with self-esteem and masculinity, but found no correlation between codependency scores and traditional feminine roles. Additionally, they found that family interactions as measured by parent/child communication, child satisfaction with their upbringing, and the child's perception of parental support were negatively correlated with codependency and that control was positively correlated.

Lyon and Greenberg (1991) hypothesized that women from families with an alcoholic parent (designated codependent) would be more helpful than women from a family with no alcoholic parent (designated controls) when exposed to an experimenter portrayed as exploitive than to one portrayed as nurturant. The dependent variable was the amount of time volunteered to the confederate experimenter by the subjects. As predicted, there was a significant main effect and significant interaction. Overall, the codependents were generally more helpful than were controls. Codependents volunteered much more time when the experimenter was portrayed as exploitive than when portrayed as nurturant. The researchers also found a significant main effect for depression such that codependents were more depressed than controls. Subjects were also asked to rate each of their parents using the Michigan Alcohol Screening Test, MAST, as a supplementary measure. All codependent subjects had one or more alcoholic parents and none of

the control group subjects rated either parent as being alcoholic. The Lyon and Greenberg study is in accord with another study examining Adult Children of Alcoholics, Tweed and Ryff, (1991) who concluded that ACOA's are similar to other adults, although their sample evidenced more depression and anxiety. Prest & Storm (1988) examined codependent relationships of compulsive overeaters and drinkers and found no difference in codependent characteristics between the two types of relationships.

Codependency is a disorder still considered by some in the chemical dependency field to be the result of being raised in an alcoholic family. Most authors now consider other dysfunctional family environments to be contributory to codependence. However, there is a paucity of empirical evidence to support either conclusion (O'Brien & Gaborit, 1992; Potter-Efron & Potter-Efron, 1989). The purpose of the current study was to help determine if codependent characteristics are prevalent in persons from families without substance abuse. This investigation may help confirm or refute the supposition that codependence is prevalent in any family, regardless of alcohol involvement, if dysfunctional patterns of relating exist.

It is important to disentangle codepencence from alcoholism for several reasons. First, some authors assert that codependent persons become involved in a multitude of unhealthy relationships, compulsive behaviors. These relationships may involve people, sex, food, work, gambling or any behavior that becomes

problematic in a persons life (Beattie, 1987; Schaef, 1986; Smalley, 1984; Woititz, 1983). By identifying codependent patterns, it may be possible to identify those at high rise to be involved in unhealthy relationships. It is well documented in the case study literature that those coming from dysfunctional families tend to involve themselves in similarly dysfunctional romatic relationships (Beattie, 1987; Black, 1981; Cermak, 1987; Friel & Friel, 1988; Schaef, 1986; Smalley, 1982; Wegsheider-Cruse, 1988; Woititz, 1983). Second, very little treatment is available for codependency outside of substance abuse treatment facilities. Those who grew up in dysfunctional families without alcohol or drug abuse would likely benifit from treatment that addresses the specific symptoms of codependence without the inclusion of substance abuse education. That is to say, resources can be utilized more effectively if time and effort are not misdirected at a population who could be better served with treatment aimed specifically at codependency. Third, clinical research will benifit by further examination of extremely stressful or dysfunctional family environments. This work, although directed at separating codependency and alcoholism, may help define the most prominent types of dysfunction that lead to codependent characteristics. Lastly, people abuse alcohol for many reasons, and it is possible that alcohol is used to escape the distress of life that codependents reportedly feel. Labeling a person an alcoholic or alcohol dependent may inadvertently place them in a group membership which they do not belong. This could prove problematic in treatment

and may be psychologically injurious.

Three hypotheses are advanced:

1. Scores on the Spann-Fischer Codependency Scale will be significantly greater in the maximum dysfunction group versus the minimum dysfunction group regardless of alcohol involvement (Alcohol positive/maximal dysfunction [Apmx] group versus Alcohol negative/maximal dysfunction [Anmx] group).
2. Women will exhibit higher scores than males on the Spann-Fischer Codependency Scale regardless of degree of reported familial dysfunction or familial alcohol consumption patterns.
3. The three questions assessing hypervigilence will correlate positively with one another and with the Spann-Fischer codependency assessment instrument.

Method

Subjects

Subjects were fortuitously recruited from diverse populations to maximize sampling heterogeneity. Questionnaires were distributed to college students, white collar professionals, factory workers, women's groups, and other demographically dissimilar populations. Sampling procedure was based on convenience. Volunteers who assisted in the distribution of the questionnaire were friends, associates and relatives of the author. They were instructed to distribute the questionnaire evenly between sexes.

To minimize the sampling bias inherent in mail-in type sampling procedure, additional questionnaires were administered in person by the author to several individuals and small groups (n=75). Three hundred seventy five mail in type surveys were distributed. The final number of questionnaires analyzed was 262. This produced a return rate of 49.86 percent. The minimum necessary N for each cell was 25.

Materials

The questionnaire consisted of a cover letter containing directions for completing the form and assurances of confidentiality (see Appendix 1).

The Spann-Fischer Codependency Scale was used to assess the degree of codependent characteristics of respondents. This is a brief, 16 question, Likert-type inventory. It has shown reasonable internal consistency (Cronbach's alpha .86) and test-retest reliability of .87 (Fischer, Spann, & Crawford, 1991). Four significant factors were extracted from this scale. The first and second factors were identified as placing locus of control outside oneself and engaging in caretaking behaviors. The third was labeled lack of open expression and the last factor was identified as achieving a sense of purpose through relationships. These factors are consistent with traits associated with the codependent construct. Three additional questions were added to assess hypervigilance, another dimension of the codependency construct not addressed in the Spann-Fischer scale. Hypervigilance refers to a hypersensitivity to ones interpersonal relationships in an attempt to

anticipate and detect any change in the other person. The choice of question used to address this component of codependency was determined by attempting to assess the need of the respondent to anticipate another's feelings (see appendix 2).

Twenty statements were used to assess respondents perceptions of their family life while growing up. Consistency of discipline and rules, parental accord and harmony, verbal, sexual and physical abuse, nurturing by parents, stress, patterns of communication, primary care such as food and shelter and other indicators of family functioning were addressed in this assessment (see appendix 1). Since no suitable scale exists to assess family dysfunction, these statements have been created by the author after examinations of descriptions of dysfunctional family characteristics in the literature (Brown & Christensen, 1986; Forward, 1989; Roosa, Sandler, Gehring, Beals, & Cappo, 1987; Schaef, 1986).

Finally, the CAGE (*C*ut down on drinking; *A*nnoyed by complaints about their drinking; felt *G*uilty about their drinking; had an *E*ye-opener first thing in the morning) alcohol screening questionnaire was used to assess familial drinking patterns (Frank, Graham, Zyzanski, & White, 1992). It is a brief, four question screening instrument that has shown excellent internal consistency (Cronbach's alpha = .89). Using a cut-off score of two, the CAGE has a reported sensitivity (the ability to distinguish a person with alcohol problems) of 90.3% and a negative predictive value of 96.1% (Frank, Graham, Zyzanski, & White, 1992). Negative predictive value refers to the ability of the instrument to detect a true negative. It

is determined by a post questionnaire examination of a respondents drinking patterns. Of these examinations, 3.9% of the respondents who tested negative for alcohol problems with the CAGE were determined to have a drinking problem.

Scoring

On the Spann-Fischer Codependency Scale and the family dysfunction statements, subjects were asked to rate the extent to which they agree with each statement by indicating responses ranging from "strongly disagree" to "strongly agree" and scored one to six in the direction of agreement. Statements phrased in the negative were reverse scored.

The degree of family dysfunction was established by the aggregate score for each respondent on those statements dealing with family dysfunction. The median was used to determine group membership (O'Brien & Gaborit, 1992). Respondents who scored above the fiftieth percentile were placed in the maximum dysfunction groups (either alcohol positive or alcohol negative) and those who score below the fiftieth percentile were placed in the minimum dysfunction group (either alcohol positive or alcohol negative). The family dysfunction questions were scored in the same way as the Spann-Fisher scale items. Respondents who score two or greater on the CAGE were categorized as Alcohol positive; all others as alcohol negative.

Procedure

Questionnaires, along with a cover letter, were assembled and enclosed in

addressed, postage paid envelopes to facilitate ease of return. Several hundred were sent to various areas for distribution including Boston, Chicago, Dallas, Detroit, Grand Rapids, Miami, San Jose, and Vermont. Additionally, questionnaires were distributed personally by the author to several persons in southwestern Michigan.

Design and Analysis

Respondents were grouped according to the scoring criteria stated above: Alcohol positive/minimal dysfunction (Apmn), Alcohol positive/maximal dysfunction (Apmx), Alcohol negative/minimal dysfunction (Anmn), Alcohol negative/maximal dysfunction (Anmx). The dependent measure was the scores achieved on the Spann-Fischer Scale. Analysis of variance was used to determine if significant differences exist between groups. Lastly, because several authors assert codependency exists in females to a greater degree than males (Beattie, 1987; Gomberg, 1989; Hagan, 1989; Kriestan & Bepko, 1991), sex was a factor in the analysis.

Results

Two hundred sixty-two responds were used in the analysis, 141 females and 121 males (see table 1).

Table 1

MEAN SCORES ON THE SPANN-FISHER SCALE
BY CATEGORY AND GENDER

		Dysfunction Catagory			
Alcohol Catagory		Maximum	(n)	Minimum	(n)
Positive	Females	3.30	38	3.11	28
	Males	3.36	34	2.93	30
Negative	Females	3.33	39	3.04	36
	Males	2.97	25	2.84	32

A 2x2x2 analysis of variance revealed significant main effects between groups. The first hypothesis was supported. The Maximum Dysfunction Group showed higher codependency scores than did the Minimum Dysfunction Group, $F(1,259) = 6.242$, $p = .013$. There was no difference in codependency scores of the alcohol positive versus the alcohol negative groups $F(1,261) = 2.90$, $p = .090$. Contrary to the second hypothesis, females did not exhibit higher codependency scores than males $F(1,261) = 3.35$, $p = .068$, though a trend towards significance was seen.

The three additional questions addressing hypervigilence showed low intercorrelations and the mean of these three questions showed only a moderate relationship with the mean of the Spann- Fischer Codependency measure (see table 2).

Table 2

CORRELATION MATRIX - HYPERVIGILANCE QUESTIONS

(N=262)

	HM	H1	H2	H3	SM	DM
HM						
H1	0.7502					
H2	0.6535	0.1820				
H3	0.7872	0.4188	0.3017			
SM	0.5143	0.4253	0.2472	0.4466		
DM	0.2079	0.0457	0.1749	0.2433	0.2026	

Note: HM= Hypervigilance mean, SM = Spann-Fisher mean, DM = Family Dysfunction mean

When correlations were run seperately by sex and by group (Apmn, Apmx, Anmn, Anmx) significant correlations were noted but no trends were apparent (see table 3). There were no significant interactions between groups.

Table 3

CORRELATION BETWEEN MEAN OF SPANN-FISCHER SCORES AND MEAN OF QUESTIONS ASSESSING HYPERVIGILENCE (N=262)

	Condition			
	APMN	APMX	ANMN	ANMX
Male	0.519	0.512	0.237	0.717
Female	0.273	0.498	0.669	0.656

APMN - Alcohol positive minimum dysfunction
APMX - Alcohol positive maximum dysfunction
ANMN - Alcohol negative minimum dysfunction
ANMX - Alcohol negative maximum dysfunction

Discussion

This study was undertaken to assess the extent to which codependencexists separately from alcohol abuse and addiction. Family dysfunction is evidenced by collective family behaviors such as maladaptive patterns of communication , negative or problematic parental attitudes, poor strategies for conflict resolution (e.g. triangulation, fighting or parental flight), verbal abuse and physical violence, excessively weak, rigid or fluxuating boundaries involving the demarcation of parental roles and responsibilities and failing to meet the emotional needs of other family members. It was hypothesised that these factors would be the prime contributory elements leading to codependent dysfunctional characteristics. This

hypothesis was supported in this study. Though codependency is still frequently associated with alcoholism and alcohol abuse, this study did not support the contention that only those who are exposed to alcohol abusers will manifest the symptoms of codependency.

Several female authors also assert that codependent characteristics are simply an exacerbation, to a pathological level, of normal female role characteristics prominent in this society such as caretaking and a greater investment in a relationship than males (Frank & Golden, 1992; Haaken, 1990; Hagan, 1989; Kriestan & Bepko, 1991). Evidence from this study does not support this contention, nor was this thinking supported in the previous study in which Fisher et.al. (1991) found no significant correlation between codependency scores and traditional feminine roles. Men's responses on the Spann-Fisher codependency assessment instrument were not significantly difference compared to women. It is possible that men may indeed feel, to the same extent, like women, but because of cultural stereotypes do not display or verbalize such feelings to others. It is also quite possible that this codependency instrument was not sensitive enough to detect more subtle differences between the sexes. Further, a larger sample size may have differentiated scores since alpha was approaching .05 but did not achieve significance. The present study cooborates the Fisher, Spann, and Crawford study (1991) in that both point to a strong relationship to family dysfunction. Fisher et. al. (1991) found that high subject satisfaction with family

interactions while growing up were negatively correlated with codependency scores.

Overall, the questions used in this study to assess hypervigilence did not correlate significantly with each other. The mean of these three questions showed only a moderate correlation with the Spann-Fischer mean (r.= .5143, see table 3). If these three questions had addressed hypervigilence as currently defined in the literature, then one would expect to see a significant intercorrelation as well as correlation with both the Spann-Fisher questions and the questions assessing family dysfunction. Further, a pattern of higher correlations would be expected when analyized by group. That is to say, higher correlations would be expected to be found in both dysfunction groups regardless of alcohol involvement. This was not the case.

The concept of hypervigilence is not new and is not solely the province of codependency. It is a condition in which an organism is exposed to traumatic assault which is perceived as, or is genuinely life threatening. The person is effected physically, mentally, and emotionally and begins to be constantly on guard. It is seen in persons with Post Traumatic Stress Syndrome (especially combat veterans), sexual assault victims, and in the children of families where punishment was administered disproportionately for deserved acts, or at the whim of an often out of control caretaker. It is even seen in studies in which rats received electrical shocks regardless of their behavior (Gleitman, 1990). A parallel

can be drawn in all cases: Each represents an external agent that threatens the well being of the organism. The combat veteran may become extremely tense and scan the environment in situations that resemble the combat experience, the sexual assault victim may not be able to tolerate sexual relations, the rat begins to pace, fidget, and dart around the cage looking for some indication of when the next shock will occur, and the codependent person may constantly analyze the words, voice intonation, body language and facial expressions of another that may signal a loss of control of the individual or the situation. It is possible that hypervigilence noted in persons identified as codependent occurs when a situation is perceived by that person as one in which others may loose control or when the individual perceives that he or she cannot control the situation. This may account for codependents reporting a difficulty in dealing with angry people (Lincoln & Janze, 1983) or inability to relax or have fun (Beattie, 1987; Cermak, 1987; Schaef, 1986; Woititz, 1983).

There are several methods one might use to assess the hypervigilance component. Another method may be to appraise a persons level of reactivity to others in specific situations that are theorized to cause anxiety in the codependent. For example, a survey question may read, "I seem to be overly sensitive in sensing tension between others". Hypervigilance might also be assessed by asking the respondent how others see him or her. A survey question might read, "I've been told I'm overly sensitive to others", and may help identify this codependency

component. Further, hypervigilance may be assessed in a more direct manner such as, "I seem to have a 'sixth sense' about other peoples moods and feelings", or, "I am extremely sensitive to peoples nonverbal communication". Finally, the issue of control, so central to the concept of codependency, is thought to be best represented as a fear of loss of control over a person or situation. Hypervigilence might better be measured in those terms by directly assessing an individual's fear of loss of control.

One cannot explore any new construct without addressing the topic of baserates. Several authors have asserted that no differentiation between a clinical population and others can be made when descriptors for a disorder actually encompass a significant majority of the population (Logue, Sher & Frensch, 1992) and, as Morgan (1991) states; "there is still little agreement about whether codependency is a disorder at all" (pg. 723). Cermak (1987), in refuting the proposition that the issues delineated in the codependency construct are simply problems faced by everyone through the normal course of life, argues that most people have experienced depression at one point in their lives and then asks, " Do we then say that depression does not exists as a pathogenic entity because it appears so frequently in the population?" (pg.39).

The specific issues addressed in the codependent construct are, in most cases, issues faced by everyone. We all have the need to be loved and valued, experience times of self-doubt and indecision, and have periods of anxiety over

relationships and other interpersonal stressors. What separates "codependents" from others is the degree to which they manifest those concerns and needs and the lengths and specific ways in which they address each issue. Codependency traits may exist in everyone on a continuum from low to high and may only be label as codependent when the person involved reacts in ways which the vast majority of others would not. For example, Beattie (1987) cites a recurrent theme in the codependent's life in which they try to control another in an attempt to gain emotional security and to influence their partner to share in the responsibilities of a relationship. She notes that the codependent person is likely to stay in a relationship and exert pressure despite overwhelming emotional pain and continued evidence that the other person will not change. Another characteristic of persons who are codependent is a self critical style rooted in low self-esteem. Most writers list this trait as an integral part of the codependent construct. Again, most persons will at times struggle with moments of apprehension and self doubt, but they are not likely to "judges themselves without mercy" (Beattie, 1987, pg. 34) as codependents persons do. The defining factor for differentiation between codependent and non-codependent seems to be the manner and degree in which individuals react to specific life events. As Beattie (1987) states, "Codependents are reactionaries. They overreact. They underreact. But rarely do the *act*" (pg.33).

It is not a theoretical leap to understand how specific parental actions or omissions in the dysfunctional family in childhood can lead to codependent

characteristics and relating in adulthood. Additional focus could be directed towards determining exactly what type of parental behaviors lead to exactly what of codependent characteristics. We may speculate that physical abuse, especially abuse that is not preceded by some causal factor, may lead to hypervigilance. Verbal abuse or an overly critical parenting style may lead to the codependent traits of excessive feelings of responsibility or feeling that one must "portray" a role rather than be genuine. An inability to recognize normalcy in interpersonal relations may indeed stem from a lack of parental modeling in childhood as some authors assert (Beattie, 1987; Smalley, 1984; Woititz, 1983), but it may also be due, in part, to low self-esteem and a lack of assertiveness.

Several methodological points must be considered as detracting from this study. First, taking the range of scores representing the alcohol group and the family disfunction group and collapsing them , we decreased the sensitivity of the Spann-Fisher instrument and it's ability to detect differences. For example, in using only two categories for both assessing alcohol abuse characteristics and family dysfunction, we may have failed to detect differences in populations had we created three levels of family dysfunction or three levels of alcohol use. Secondly, the majority of responses were via return mail. These respondents were essentially volunteers and therefore are not representative of the population. To offset this sampling bias, this author distributed several questionnaires in person to individuals and small groups. However, the total number of respondents was

approximately one quarter of the total sample. Third, some questions in the Spann-Fischer codependency scale were somewhat ambiguous or created conditions in which a respondent may answer in a way that he/she perceives as socially desirable. For example, "I often put the needs of others ahead of my own" may provoke a response that is commensurate with our culture and value system. Responses to these questions may be artificially inflated given that being unselfish is virtuous in our society.

The development of a highly sensitive codependency assessment instrument is essential in investigating the construct. Factor analysis from several studies using different codependency assessment instruments, yielded similar themes. Although the Spann-Fischer instrument was adequate in this study, development of future instruments could include a validity scale to assess test taking attitudes such as defensiveness. The assessment of other components of the codependency construct not included in the Spann-Fischer scale such as hypervigilence, the inability to recognize normalcy in interpersonal relations, and a self-depreciatory response style, would help further delineate the construct. It may be necessary to add further specificity to the questions. In the Spann-Fisher scale for example, under what circumstances would one "put the needs of others ahead of ones own"? All of the time? Only for close family members? Since so much of the codependency construct encompasses feeling states, questions might better be phrased to tap into how subjects feel in a given situation. For example, " I usually

feel guilty if I don't comply with others' requests", would assess a persons ability to say "no" and the internal state of the subject.

It has been shown that there is a cluster of indicators that point to an identifiable constellation of behaviors and feelings that exists in persons coming from families with problematic patterns of relating and existing. Those indicators are the types and levels of dysfunction in the family of origin. It appears that, although alcohol abuse is prevalent in many dysfunctional homes, it is not a necessary component of codependency.

Very little research has been performed to clarify the codependency construct yet it's popularity is apparent. It has not been investigated for several reasons, primarily, because it's evolution occurred not in mainstream psychology, but in the field of alcohol and chemical addictions. The addictions field as a whole has not waited for psychologists and sociologists to investigate the construct. Instead, counselors chose to use the seminal writings of Beattie, Black, Woititz and others to form their own conceptual framework from which treatments were developed. If the concept of codependency is to gain acceptance as a real disorder, more research will be needed. Further definition and delineation through empirical research will eventually lead to a refinement of the codependent construct and with that, a more streamlined direction for intervention and efficacious treatment.

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Appendix 1

Please express the extent to which you agree with the statements in this next section as they pertain to your current lifestyle and attitudes. There are no right or wrong answers, only how you feel. Write in the appropriate number according to the following format:

1 = Strongly Disagree

2 = Disagree

3 = Slightly Disagree

4 = Slightly Agree

5 = Agree

6 = Strongly Agree

____When I'm involved in a conversation with someone, I'm usually wondering what they think of me.

____I often anticipate others' wants and needs before they make them clear to me.

____My behavior is often influenced by the possibility of rejection or anger of another.

Note: If you were raised by someone other than your parents (for example an aunt and uncle) then just substitute where the word parent appears. If you were raised by a single parent, answer these questions in reference to that parent.

____When I was growing up, my family life was just as pleasant as anyone elses.

____While I was growing up, I couldn't tell my parents how I really felt.

____When I was growing up, I was afraid to bring friends home because I never knew what my parents would say or do.

____While I was growing up, it seemed like one of my parents was very involved with the kids while the other parent did almost nothing.

____When a request was denied by one parent, I could always go to the opposite parent to help me get my way.

____As an adult, I often become (became) anxious or uneasy when I anticipate(d) spending time with my parents.

____While arguing, one of my parents would often try to get myself or a sibling allied with them against the other parent.

____One or both of my parents physically abused myself or my siblings.

____When I was growing up, there was always one of my siblings (or myself) who could

1=Strongly Disagree

2=Disagree

3=Slightly Disagree

4=Slightly Agree

5=Agree

6=Strongly Agree

"get away with murder".

____When I was growing up, one of my parents would sometimes secretly confide in me or a sibling about their personal problems.

____When I was growing up, my parents fights often included name calling, screaming and sometimes violence.

____While growing up, there were always clear rules and consistent consequences for bad behavior.

____When I was young, I was often frightened of one or both of my parents - even while having done nothing wrong.

____One or both of my parents often put-down, teased or mocked myself or a sibling.

____I don't feel like I got much love and support when I was growing up.

____While I was growing up, I felt like my parent(s) often minimized my feelings, thoughts and opinions.

____One or both of my parents moods were often very unpredictable.

____As I now reflect on it, my parent(s) were alway sure to meet my basic needs (food, clothing etc.) but did not meet my emotional needs while I was growing up.

Appendix 2

Dear respondent,

Thank-you for taking the time to participate in this study. Be assured, all questionnaires are completely anonymous.

The survey consists of a portion requesting personal information such as your age, marital status and years of education. The last portion contains questions concerning the family in which you were raised, and questions asking you to characterize your thoughts, feelings and attitudes about various aspects of your current lifestyle. There are *no* right or wrong answers, only how you feel. Please answer all questions as openly and honestly as possible.

Enclose the completed questionnaire in the postage paid envelope provided, seal it and mail.

Thank-you for your time. With your effort, you are contributing to the body of knowledge in the field of psychology.

Sincerely,

William Ansara