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The relationship of codependence to career choice

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THE RELATIONSHIP OF CODEPENDENCE TO CAREER CHOICE

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by:

Karen H. Barnett

May, 1991

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by

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TABLE OF CONTENTS

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Abstract

The Relationship of Codependence to Career Choice

The purpose of this study was to investigate the possible correlation between codependency and career choice. A review of the literature seems to indicate that the helping professions attract people who are "prone" to codependency. For this reason, this study focused on four groups of undergraduate students: nursing students, psychology students, and social work majors, as the "helping profession" students, and students majoring in business-related fields. The study was also designed to provide empirical evidence to conplement the descriptive studies which have been the main source of information available up to the present time.

Subjects were drawn from students attending Christopher Newport College and Riverside Regional Medical Center's School of Professional Nursing. Each group consisted of 40 students.

Subjects were asked to complete three self-report inventories: The Moos Family Environment Scale (FES), The Adjective Check List (ACL),(Real and Ideal), and The Behavioral Assessment Inventory, which was actually the Friel Codependency Assessment Inventory (FCDI) combined with the L asnd K scales of the MMPI.

It was hypothesized that: Students in helping professions will score higher on the Behavioral Assessment

Inventory than business students; Students in helping professions will show a larger discrepancy between Real and Ideal Self on the ACL and will also score higher on the Nurturance and Abasement scales of the ACL than business students; and students in the helping professions will score higher on the Conflict and Control scales of the FES than business students.

None of the results were significant at the 0.05 level. However, an artifact of the research indicates there is a significant difference on the K scale (incorporated in the FCDI) ($t=2.79, p<.05$) between helping profession and business students.

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THE RELATIONSHIP OF CODEPENDENCE TO CAREER CHOICE

Chapter 1

Introduction

Definition

Co-dependency is a dysfunctional pattern of living and problem solving nurtured by a set of rules within the family system (Friel and Subbby, 1984).

Justification for the Study

The concept of "co-dependency" is rapidly becoming accepted in the mental health professions, and it is recognized that co-dependency is a problem that is not restricted to families with chemical dependency issues. Codependent patterns of living and problem solving can develop in many types of dysfunctional family systems; and it is quite possible that they emerge in any culture that fosters exaggerated dependencies or that interferes with ones own feelings identification process (Friel, 1985).

According to Mulry (1987) codependency is a common problem that underlies much of the psychosomatic pathology and emotional stress that physicians encounter in their practice. Assuming that four family members are affected for each of the 10 million alcoholics in the United States, there are potentially 40 million American codependents, which translates to 20 percent of the patients in a family physician's

practice. They are rarely diagnosed, often because the physician is also a codependent. In many instances, a physician has been a "codependent family hero", a person whose drive for success has developed in reaction to growing up in a codependent family.

Several researchers in the chemical dependency field have been noted by Fausel (1988) as agreeing with the statement that "most mental health professionals are untreated codependents who are actively practicing their disease in their work in a way that helps neither them nor their clients". Fausel (1988) states that the incidence of alcoholism in the general population is between twelve and fifteen million people. He further states that there is "reasonable evidence" that codependency in all its forms is more prevalent among professionals than primary addiction to alcohol or other chemicals. Even though empirical data directly dealing with professional social workers are lacking, Fausel says that if professionals are at the same risk as other Americans of being affected by chemical dependency in their family of origin, or other close relationships, the major sources of codependency, then approximately one in three members (at a minimum) have been affected by the disease. According to Fausel (1986) from 30,000 to 170,000 people involved in the helping professions are at high risk of becoming codependent.

Beattie (1987) estimated that there are about 80 million people who are chemically dependent or involved with a chemically dependent person. She states that many experts have shown that codependents tend to choose careers in the helping professions such as nursing, social work, and other related disciplines.

Erickson (1988) states that the incidence of nurse codependents is 50 percent higher than in the general population; one in seven nurses is at risk and no area of practice is immune.

Approximately 25 percent of adult children of alcoholics choose a career in the helping professions, according to Erickson (1988). Codependents are drawn to those who are in some way "needy". Nurses are expected to suppress their personal needs and feelings while they work. The whole focus of the therapeutic relationship is directed to the patient's well-being.

Erickson (1988) states that nurses and nursing students need information that will help them cope with uncertainty, change, conflict, stress, and burnout. She believes they need to know and understand the role of co-dependency in nursing and where to draw the line between caring/helping and that of co-dependency behaviors. I believe this is an excellent strategy for <u>all</u> helping professionals.

Statement of the Problem

Trying to determine the prevalence, incidence, and base rates for codependency is extremely difficult. Cermak (1985) estimates that one of every eight Americans is a child of an alcoholic. By many researchers' criteria, these people are all codependent. But, codependence can arise from sources other than alcoholism. Wegscheider-Cruse (1988) reports that according to the National Association for Children of Alcoholics (NACoA), there are 28 million codependents in the United States. Whitfield (1984) puts that figure at 30 to 50 million.

Fausel (1988) emphasizes that social workers and other helping professionals are not immune to the primary disease of alcoholism or other addictions, or from assuming the role of professional codependents. A helping professional does not have to be working with alcoholic or other dependent clients to be hooked by his/her own codependency.

We cannot assume that intelligence and professional education alone can protect a helping professional against codependency nor can we assume that the problem is uncommon (Fausel, 1988).

Whitfield (1980) believes most caregivers are enablers or co-alcoholics. Because of this, he feels there is a great deal of denial and ignorance which perpetuates a vicious cycle of nonrecognition of the problem and inappropriate treatment

by most caregivers, by denying, covering up, and perpetuating the disease of codependency.

If these assumptions are accurate any helping professional who is also an untreated codependent is not helping his/her clients nor him/herself.

According to Whitfield (1984), 30 to 50 million people may develop symptoms of co-alcoholism that are severe enough to seek treatment. But Whitfield believes many helping professionals are not trained to recognize, manage, or refer these clients appropriately. The helping professional is unknowingly acting as an enabler of continued co-alcoholism.

Whitfield (1984) believes that nearly all untreated or untrained people in the general population are to some degree co-alcoholic, even though they are not now, nor have they ever been, closely related to or associated with an alcoholic. Whitfield also states that approximately 80% of all helping professionals remain untrained in this area. He feels that a major reason for this is that the faculty and administrators of professional schools are themselves untrained and/or untreated codependent professionals.

A review of the literature seems to indicate that the helping professions attract people who are "prone" to co-dependency. However, most of the studies look only at the helping professionals; there is no comparison of people who are in any of the business oriented professions. There are also few if any empirical studies dealing with this topic.

This study focused on college students who are majoring in helping professions: nursing, social work, and psychology; in addition it focused on students majoring in business oriented professions. The main purpose was to determine whether students planning on entering helping professions will exhibit more "codependent traits" than those students in business professions. The Friel Co-Dependency Assessment Inventory provides an objective estimate of severity or degree of co-dependency. While Friel (1985) cautions that care should be taken in interpreting these test scores, he does feel it helps focus on areas in a person's life which may be troublesome.

Since there appears to be more descriptive rather than empirical evidence dealing with codependence, tests were used that were currently available in an attempt to correlate codependence with certain relevant scales of these tests.

Definition

There have been many attempts to define codependency using a variety of different criteria. Some take a clinical approach (i.e. DSM III criteria), others a family systems approach, and still others, a medical model approach. Wegscheider-Cruse (1985) offers one of the more encompassing definitions: Codependency is a specific condition that is characterized by preoccupation and extreme dependence (emotionally, socially, and sometimes physically), on a person or object. Eventually, this dependence on another person

becomes a pathological condition that affects the codependent in all other relationships.

Cermak (1985) stresses that above all, codependence is an internal feeling. As in alcoholism, it doesn't matter if someone else is putting the label on you. What matters is whether you feel that the label fits yourself.

Theoretical Rational

Chemical dependency is an illness of dependence on intoxicating substances. Codependency is a companion illness classically occurring in persons who are (or have been) in close relationships with chemically dependent persons. The codependent, in effect, is addicted to a person who is addicted to an intoxicating drug (Mulry, 1987).

Subby (1987) does not link codependency solely with chemical dependency. His focus is on growing up in a family where the rules are oppressive.

Wegscheider-Cruse (1985) believes codependency is a lifestyle, a patterned way of relating to others. It's a way of interpreting experience. And, it's a lifestyle based on low self-esteem.

Zerwekh and Michaels (1989) tell us that while there are many definitions of codependency, most experts in the field agree that it is a disease entity with definable onset, a set of physical and psychological symptoms, and a predictable medical course. As pointed out by Fausel (1988), Many of the definitions are more descriptive than operational, and some

are so broad that they could include the entire population. Many of the definitions stem from different theoretical frameworks, including family systems approaches, ego psychology, and behavioral and interpersonal models (Zerwekh and Michaels, 1989).

In applying family systems theory to the study of the alcoholic within a marital subsystem, the drinking symptoms may be seen as an indication of a family dysfunction. Both spouses are seen as contributors to the alcoholic-problem and are affected by it (Rothberg, 1986).

Haley (1977) agrees that alcoholism is a symptom of marital dysfunction. It gives the partners permission to avoid dealing with the dysfunctional elements in their relationship.

Within a chronic alcoholic family, there is frequently a decline in the effort to communicate within the family unit. There seems to be little willingness to promote a level of constructive exchange of feelings. The style of communication here becomes a manipulative tool to try and control the other person through blaming and berating remarks. The emphasis is on destructive expression of negative, highly judgmental feelings. This poor level of communication erodes the chances of family goals being addressed (Rothberg, 1986).

It would seem that the lack of communication may serve as a homeostatic mechanism for maintaining the family's existence. Even though a low level of functioning would

continue, the family would still be together. Rothberg (1986) believes this reduction in communication could stave off a family breakup.

Bowen's (1978) theory involves two main variables. One is the degree of anxiety, and the other is the degree of integration of self. There are several variables having to do with anxiety or emotional tension. There are many more variables that have to do with the level of integration of the differentiation of self.

According to Bowen (1978) systems theory assumes that all important people in the family unit play a part in the way family members function in relation to each other and in the way the symptom finally erupts. The part that each person plays comes about by each "being himself". The symptom of excessive drinking occurs when family anxiety is high. The appearance of the symptom stirs even higher anxiety in those dependent on the one who drinks. The higher the anxiety, the more the other family members react by anxiously doing more of what they are already doing. The process of drinking to relieve anxiety, and increased family anxiety in response to drinking, can spiral into a functional collapse or the process can become a chronic pattern.

Differentiation of self is the cornerstone of Bowen's theory. Bowen (1978) says this concept defines people according to the degree of fusion between emotional and intellectual functioning.

The way this is handled is by a no-self, adaptive spouse and dominant spouse configuration. Over time, when this adaptive pattern loses its flexibility, the adaptive one is vulnerable to chronic dysfunction which is combined with emotional distancing. Bowen theorizes that people marry at similar levels of self-differentiation. When two pseudoselves fuse into a "we-ness", there is a high potential for impaired functioning in one spouse. Differentiation of self is the degree to which the person has a "solid self" or solidly held principles by which he lives his life. This is in contrast to a "pseudoself" made up of inconsistent life principles that can be corrupted by coercion for the gain of the moment. The differentiation of self is roughly equivalent to the concept of emotional maturity. Bowen (1978) also stresses that the family is a system in that a change in the functioning of one family member is automatically followed by a compensatory change in another family member.

Family systems theory was developed during the course of family research for emotional problems. Bowen (1978) says that part of the effort was directed at extracting facts from the "morass of subjectivity, discrepant explanations, and verbal dialogue that is common in psychiatric research."

Systems theory attempts to focus on the functional facts of relationships. It focuses on what happened, how it happened, and when and where it happened, insofar as these observations are based on fact (Bowen, 1978).

Part of the family structure is also the boundaries and relationships among and between family members (Friel and Friel, 1988). Each individual being should have a clearly-defined boundary around himself/herself, which is like a psychological fence around us, defined by us. This individual boundary lets certain things into our lives and keeps certain things out of our lives (Friel and Friel, 1988).

According to Friel and Friel (1988) if your individual boundaries are too weak, you will always let anyone do to, or with you, what they wish. You can never say no . If you do this long enough, you will develop serious emotional problems. Eventually you will swing to the opposite extreme and set up completely rigid boundaries, in which nothing gets in to you and nothing gets out to other people.

In dysfunctional families, individuals swing back and forth, hoping to find some kind of balance. However, the only true balance happens when you have flexible boundaries (Friel and Friel, 1988).

Besides individual boundaries, Friel and Friel (1988) tell us there are also intergenerational boundaries and family boundaries. Intergenerational boundaries are those invisible lines between the parents and other adults in the family, and the children in the family.

If parents have rigid individual boundaries, the intergenerational boundary will also be rigid. These children always feel alone; their parents are never "there" for them,

either physically or emotionally or both. With weak intergenerational boundaries, the line between adults and children is very unclear. This is very common in dysfunctional families (Friel and Friel, 1988).

Family boundaries are those which surround the family as a whole unit. With a closed family system where the "No Talk" rule is in full force, rigid family boundaries are found. With diffuse family boundaries, the family has no sense of unity at all. People flow in and out. No one seems to be "in charge". There are no clear limits or rules. It doesn't feel like a family at all. Friel and Friel (1988) tell us that "chaotic" describes this system best.

In the past thirty years, since the American Medical Association formally recognized alcoholism as a disease, the knowledge and treatment of alcoholism has expanded significantly. According to Fausel (1988), the concepts of co-alcoholics, para-alcoholics, and most recently co-dependents, have enlarged the circle of those who are affected by the disease. Social workers and other helping professionals are not immune to the primary disease of alcoholism or other addictions, or from assuming the role of professional codependents. Fausel (1988) believes that people who have grown up in alcoholic families, or other dysfunctional families, are particularly susceptible to working out their codependency needs on clients.

Definition of Terms

The following definition of terms should be of benefit in clarifying some of the major constructs of this study:

Co-Alcoholic: Ill health, or maladaptive or problematic behavior that is associated with living, working with, or otherwise being close to a person with alcoholism. It has also been called "para", or "near alcoholism" and "Co-dependence".

Codependence: A pattern of living, coping, and problem-solving created and maintained by a set of dysfunctional rules within the family or social system. These rules interfere with healthy growth and make constructive change very difficult, if not impossible (Subby, 1987).

Codependent professional: Any person engaged in the mental health field (ex: nursing, social work, medicine, counseling, etc) who is a co-alcoholic, and who has not had treatment specifically for the co-alcoholism (Whitfield, 1984).

Helping professions: Those occupations in the health/mental health field, such as nurses, social workers, psychologists, etc.

Research Hypotheses

Hypothesis #1

Students majoring in nursing, psychology, and social work will display more codependent characteristics as measured by

the Friel Co-Dependency Assessment Inventory than students majoring in business-oriented fields.

Hypothesis #2

Students majoring in nursing, psychology, and social work will show a larger discrepancy between Real and Ideal Self on the Ideal Self Scale of the Adjective Check List than students majoring in business-oriented fields.

Hypothesis #3

Students majoring in nursing, psychology, and social work will score higher on the Nurturance scale of the Adjective Check List than students majoring in business-oriented fields.

Hypothesis #4

Students majoring in nursing, psychology, and social work will score higher on the Abasement scale of the Adjective Check List than students majoring in business-oriented fields.

Hypothesis #5

Students majoring in nursing, psychology, and social work will score higher on the Conflict scale on the Moos Family Environment Scale than students majoring in business-related fields.

Hypothesis #6

Students majoring in nursing, psychology, and social work will score higher on the control scale of the Moos Family Environment Scale than students majoring in business-related fields.

Sample Description and Data Gathering Procedures

The target population for this study was college students enrolled at Christopher Newport College and student nurses at Riverside Regional Medical Center's School of Professional Nursing. The sample consisted of 40 student nurses, 40 students majoring in psychology, 40 students majoring in social work, and 40 students enrolled in various business majors.

As this was a descriptive study, no "treatment" per se was given. Each student was asked to :

1) Supply biographical information
2) Complete the Adjective Check List, Real and Ideal forms
3) Complete the Moos Family Environment Scale, Real form
4) Complete the Friel Codependency Assessment Inventory

Limitations of the Study

Since instruments used in this study are largely self-report, there is a question as to the subject's objectivity and/or ability to answer questions relating to themselves.

All participants in this study were volunteers. This raises the possibility of a biased sample since volunteers have been found to be different than non-volunteers in several characteristics.

No special considerations or adjustments were made for demographic variables of age, sex, or race. My sample was predominately female, caucasian, and young (18-40 years old).

This is certainly not a random sample and may limit generalization of results.

Chapter 2

Review of the Literature

Historical and Theoretical Development--Family Systems Theory

Systems theory is a unifying theory. This perspective allows us to see each member of a family in relation to other family members, as each affects and is affected by the other persons. According to systems theory, it makes no sense to analyze any person independently. Becvar and Becvar (1982) believe the systems perspective has wide generality and applicability to a wide variety of phenomena. There seems to be abundant empirical evidence to suggest that the family system exerts the greatest influence on an individual, followed by other systems such as school, church, and work, which impact upon the family.

The components of the family system are its members and the relationships which exist between and among family members. Family members have perceptions, cognitions, affections, and acts of which each is aware as belonging to "family". The family system refers to interpersonal processes, and these processes are assumed to be somewhat predictable, and as such fall within the domain of scientific inquiry (Becvar and Becvar (1982).

The family systems perspective is derived from General Systems Theory as it has evolved vis-a-vis an attempt to understand the dynamics of families. Becvar and Becvar (1982) feel that the systems perspective has demonstrated its efficacy in the physical, biological, and social sciences; its application to the study of human beings has been equally fruitful.

The emergence of a systems perspective for families and its acceptance by a significant number of practitioners suggests that a change has occurred which represents a shift in paradigms. A paradigm is a coherent tradition or framework shared by a given scientific community. It refers to a whole realm of experience, including beliefs, values, and methodology, subscribed to by members of that community (Becvar and Becvar, 1982).

Bowen (1978) states that theoretical interest in the family goes back to the beginning of psychoanalysis when Freud made his original formulations about the part played by parents in "causing" emotional illness. This was followed by a period of more than fifty years with only minor changes in theory and with treatment focused almost entirely on the "patient". The only exceptions were in child psychiatry and some social casework and counseling efforts. In the early 1950's efforts were begun to involve the family in treatment. There was a sudden increase in family research in order to further understanding of family dynamics. Some of the

research resulted in new theories or modifications in existing theory. This was followed by innumerable variations in psychotherapeutic techniques designed to involve multiple family members in the treatment process. In the 1970's and 1980's the number of people working with families had multiplied greatly. Terms such as family psychotherapy and family therapy have come into common usage to refer to a wide variety of methods and techniques.

From a systems viewpoint, Bowen (1978) believes alcoholism is one of the common human dysfunctions. As a dysfunction, it exists in the context of an imbalance in functioning in the total family system. From a theoretical viewpoint, every important family member plays a part in the dysfunction of the dysfunctional member. From a systems therapy viewpoint, the therapy is directed as helping the family to modify its patterns of functioning. The therapy is directed at the family member, or members, with the most resourcefulness, who have the most potential for modifying his or her own functioning.

Prior to the 1950's, alcoholism research and treatment focused primarily on the problem within an individual context. But Rothberg (1986) tells us that there has been a shift on how to treat alcoholism, from working with the individual, to working with the "dry spouse", to working with the whole context of maintenance people, including the would-be rescuers who only "spur the alcoholic on to more heroic boozing".

Alcoholism fits well into family systems concepts based on the fact that it is a common human dysfunction. Both spouses are seen as an indication of a family dysfunction. Both spouses are seen as contributors to the alcoholic problem and are affected by it. "The dry is as sick as the drunk, except that the bodily damage is not there".

Friel and Friel (1988) state that each family has a structure and function. They use an analogy of a mobile formulated by Virginia Satir to describe chemically dependent family systems.

According to Friel and Friel (1988), whatever happens to one part of a mobile effects the other parts of the mobile. Therefore the mobile analogy can explain a great deal about principles of systems, such as: 1. Systems have a definite structure to them. Each piece of the mobile has its place. It would not be the "same" mobile if we were to rearrange the pieces. 2. The whole is greater than the sum of its parts. 3. Changes in one piece in the system affect all of the other pieces in the system (but not necessarily in the same way). 4. Systems always try to return to their original state. It would not be the "same" mobile unless after it was bumped, it returned to the same place that it was before I bumped into it.

Enlightened therapists and as enlightened general public are helping families see that problems affecting one person are really symptoms of problems in the entire family system.

When one member of the system is displaying a serious problem in adjustment, it means, in most cases, that all of the other members are experiencing problems too. It's just that these other members' defenses and roles are more socially acceptable and less troublesome on the surface (Friel and Friel, 1988).

Kritsberg (1985) believes that the adult child of alcoholics syndrome can only be understood by having knowledge of the alcoholic family. It is the alcoholic family system that causes the adult child syndrome. When children are born into this system, they are delivered into a unit that, from the beginning, inhibits their development as healthy human beings. Kritsberg states emphatically that the symptoms and behaviors of adult children of alcoholics are directly related to the experience of being raised in an unsafe, dysfunctional, alcoholic family system.

The alcoholic family and the healthy family are at opposite ends of the spectrum. The alcoholic family operates in a way that contains and controls the members of the system. This control stifles the mental, emotional, and sometimes physical growth of its members. The healthy family, on the other hand, assists its members in their development. The controls that the healthy family places on its members are appropriate to the age group and the abilities of the individual members (Kritsberg, 1985).

The Family System Continuum formulated by Kritsberg (1985) illustrates many of the points we have already

addressed very well. This chart is scaled from -10 to +10, with -10 being the low end or most dysfunctional, and +10 being the high or most functional end. The alcoholic family will always fall in the 0 to -10 range, depending on the degree of dysfunction.

Kritsberg (1985) says he has never met a totally healthy (+10) nor a totally unhealthy (-10) family. He believes most alcoholic families fall in the -2 to -6 range, depending on the inflexibility of the family; healthy families fall in the 0 to +5 range, depending on family flexibility. The healthy family can, for a short period of time, act in a very dysfunctional way, depending on the nature of the family crisis. The healthy family does not remain in a dysfunctional mode of operation for an extended period of time. It will reassert its health and return to a normal state. This is not true for the alcoholic family; crisis increases the amount and intensity of dysfunction, and the family does not recover. It gets worse.

It seems obvious that the person who grows up in an alcoholic family will view life in a different way from the person who comes from a healthy one. The adult children of alcoholics' basic approach to life is different. Adult children of alcoholics view the world as an unsafe place and cope with an unsafe world by using the rules that they learned as children (Kritsberg, 1985)

A family systems approach is necessary in therapy for Haley (1976) also. He believes therapy should focus on solving a client's presenting problems within the framework of the family. Haley believes that a therapist needs to design an intervention in the client's social situation to change that presenting symptom.

Caldwell (1986) also agrees with Haley's premise that preparing a family for effective intervention requires a high degree of therapeutic skill as well as an understanding of drug dependency and family systems. Caldwell tells us that the dependent individual has a distorted perception of his/her drug-effected behavior and is unable to reliably define the consequences of his/her drug dependence. By means of successful work with family members, a more accurate picture of the dependence may be seen and this can be utilized in developing viable treatment options.

Merely by being present in the office of the helping professional, the family is admitting its intense pain and systemic distress. They have exhausted the means contained within their system to deal with the drug dependent member. As a result, the other family members have developed role-specific behaviors and defenses, which may distort or prevent objective assessment of their life situation. Having exhausted their own means for dealing with the problem, they have decided--probably reluctantly--to come for professional help (Caldwell, 1986).

Families are our first social group, and this group has a profound and long-lasting effect on every member. Long after one leaves their family of origin, they continue to interact with others around them according to "roles" or patterns learned in their families. In "healthy" families one learns to behave in a socially (and personally) appropriate manner. In dysfunctional families one learns to interact in an unhealthy manner in order to survive. These inappropriate behaviors have harmful consequences as the individual attempts to function in the larger social context.

Families of alcoholics have multiple problems; it seems that no member of the family escapes the alcoholic's influence. Alcoholism is considered to be the greatest drug problem in this country. When one considers the number of people who are intimately involved with alcoholics, it becomes apparent that there is a large number of people who are also dysfunctional, or who fall into the "high risk" category.

Therapy focusing only on the identified client (i.e.: the alcoholic) has been proven to be less effective than a family systems approach because the problem needs to be resolved in context rather than in isolation. Most experts in the field of alcoholism believe that a family systems approach is best suited to the study and treatment of alcoholics and codependents.

The purpose of this study was to determine if there is a higher incidence of codependent characteristics in those

individuals who enter the helping professions as opposed to those who enter business-oriented professions.

In attempting to understand how these characteristics were instilled, this study utilized family systems theory as it is elaborated by Jay Haley and Murray Bowen, two of the foremost family systems theorists in this country. The family systems approach is most valuable in explaining how dysfunctional families foster these characteristics and influence their children's personalities, long after they leave their family of origin.

If helping professionals become aware of these problems and their origin, they will not only gain self awareness but become better at their chosen professions. Perhaps in the future, people desiring to enter the mental health professions will undergo additional screening so that they can become more fully aware of the possibility and pitfalls of codependence.

Research on Intervention Strategies or Descriptive Topics

Research on The Codependent Professional

As stated previously, Fausel (1988) believes many health professionals are codependent. Fausel (1988) notes the worker who: needs to "fix" every client; finds it difficult to confront a client because of his/her own need to be liked and be the "good guy"; can't say no to over demanding administrators; needs to control expression of feeling because

it triggers unresolved issues in his/her life; his or her personal life is unmanageable because of the time devoted to work; is quick to accept excuses and minimizes problems; resists getting into material because it reactivates unresolved issues from the past. These are just some of the manifestations of codependency that a professional can exhibit.

Whitfield (1984) adds the concept in the field of chemical dependency of the untreated professional. Whitfield defines the untreated professionals as a helping professional, supervisor, or administrator who is also a co-alcoholic (codependent), and who has not had treatment specifically for the co-alcoholism. The dynamics are the same as those for all codependents. A major difference between the laymen codependents and the untreated codependent professional is that the latter can spread the illness of co-alcoholism to many more people and can, under the guise of "helping" actually harm them (Whitfield 1984).

Whitfield (1984) believes codependency is more prevalent in our society than the number of primary addictions. It is estimated that there are about 10 to 15 million alcoholics in the United States, and that for every alcoholic, there are from three to five people seriously affected by being around the alcoholic, or in other words, there are between 30 and 50 million co-alcoholics! Focusing on this segment, which includes, in addition to family members, most helping

professionals, law enforcement workers, politicians, employers, and others, could result in a cultural change that would force the chemically dependent person into treatment much sooner.

In a recent study cited by Erickson (1988) of 50 practicing nurses and 35 student nurses, it was confirmed that a large percentage of nurses have perceptions consistent with codependent behavior.

Erickson (1988) says that although this survey was small, greatly limited in scope, and needs replication, it is possible that codependency may be a major factor leading to chemical dependency and abuse among nurses. Other studies (Haack, 1984) show that nurses tend to view themselves as helpers, not as recipients of help, and that nurses believe their knowledge protects them from illness. Other factors contribute to the codependency problem, such as drug accessibility, burnout, stress, etc., but codependence seems to provide an umbrella under which many of them fall.

Nurses and nursing students need information that will help them cope with uncertainty, change, conflict, stress, and burnout. They need to know and understand the role of codependency in nursing and where to draw the line between caring/helping and that of codependency behaviors (Erickson, 1988).

Kijek (1989) also reports that many codependents tend to choose careers in the helping professions such as nursing, social work, and other related disciplines.

The children of dysfunctional families rarely develop healthy senses of self. They constantly look for ways to feel good and to verify their existence. The family dynamics have led "many into adulthoods of addiction, depression, compulsion, unhealthy dependency, stress disorders, unsatisfactory relationships, and lives of quiet desperation". Codependents may become so involved in other peoples' lives that they have no time for themselves (possibly as helping professionals). Consequently, they become angry and resentful or depressed. They do not know how to get their needs met because they never learned. They may not even know what their needs are. They may only feel, or not feel, the consequences of isolation, abandonment, neglect, abuse, indifference, or deprivation (Kijeck, 1989).

Nurses are asked to give more and more of themselves because the patients are sicker and there are fewer nurses. Many of these nurses are superb caretakers of everyone but themselves. Hall and Wray believe the concept of codependency fits such nurses "to a T", (Hall and Wray, 1989).

Hall and Wray (1989) list and discuss the characteristics of codependent nurses:

Caretaking. When a nurse attempts to meet other's needs to the point of neglecting her own, she becomes a caretaker.

As such, she feels responsible for all aspects of another's life--even those that lie beyond her professional consideration. She's attracted to people who need her and feels most secure when giving to them, but feels guilty when others attempt to give to her. She also feels sad because she gives so much yet receives so little in return.

Perfectionism. The codependent nurse's perfectionism stems from her need to keep every aspect of her life under control, even at times when life is unhappy and uncontrollable. Constant criticism of herself and others becomes her stock-in-trade. This creates a low self-esteem.

Denial. Refusing to acknowledge anything painful in her life, she ignores or represses all problems and difficulties. To avoid thinking about them, she keeps busy. Many codependent nurses become workaholics or develop other addictions.

Poor Communication. She talks freely about others while holding back information about herself. Her interactive style is manipulative, blaming, threatening, and geared toward what she thinks others want or need to hear.

Cermak (1986) says that if you have spent your life practicing staying sane in the midst of insanity, going into the mental health field makes a lot of sense. Unfortunately, becoming a mental health worker puts them at a great risk of having any unresolved codependent tendencies activated since they come into daily contact with clients who exhibit the

denial, projection, and rationalization that were typical in the homes they grew up in.

Another factor leading to active codependence among helping professionals is the very nature of their job. Therapists are expected to keep their personal needs on the back burner while they work to be present for their clients. The whole focus of the therapeutic relationship is the growth of the client, and therapists are expected to have that as their guiding principle. Cermak (1986) believes the job is a set-up for activating (and rewarding) codependent tendencies.

Whitfield (1980) believes most caregivers are enablers or coalcoholics. Because of this, he states that there is nearly universal denial and ignorance feeding the "vicious cycle" of non-recognition of the problem and inappropriate treatment by most caregivers.

The caregivers to the children of alcoholics come from many backgrounds and specialties, according to Whitfield (1980). First there are those caregivers who work in family planning. Then, there are several kinds of medical specialists, including obstetrician-gynecologists, pediatricians, family practitioners, psychiatrists, nurses, and nurse midwives.

Whitfield (1980) says the child may also encounter clergy, child psychologists, family therapists, social workers, as well as eventually dentists and lawyers. In

school, as adolescents, and throughout their adult life, they will be supervised by school teachers and professors, as well as trainers, supervisors, and bosses of all sorts.

Whitfield (1980) continues by saying that the words "caregiver", "helper", "teacher", "physician", and "therapist" all imply that help will be rendered. But he feels that help is not rendered or if it is, it is often directed at the symptoms and not the codependence. If caregivers are enablers or codependents themselves, they are denying, covering up, and perpetuating the disease of alcoholism. If this is true, then it is a basic and serious treatment issue for children of alcoholics.

A review of the literature certainly seems to indicate that the helping professions (ex.:nursing, social work, counseling) attract people who are prone to codependency. However, most of the studies look only at the helping professionals; there are no comparative data on people who are in any of the business oriented professions. I felt a comparison of these two groups would be beneficial.

This study focused on students who are majoring in helping professions: nursing, social work, and psychology and business-oriented students. The main thrust was to determine whether students planning on entering helping professions would exhibit more "codependent traits" versus those students entering business oriented professions.

This study attempted to measure these codependent traits using the following tools: 1) Adjective Check List (Real and Ideal) 2) The Friel Adult Child/Codependency Assessment Inventory

3) Moos Family Environment Scale

It is well known that the incidence of drug dependence is quite high in such professions as medicine and nursing. Chemical dependence is also one of the characteristics of people who are codependent. Further research could be called for to determine the interrelations involved in this manifestation. Perhaps it is possible that codependents set themselves up for personally stressful situations by entering helping professions, thereby giving them an "excuse" for drug dependence.

Most of the studies (excluding a few who used student nurses as subjects) look at people already established in helping professions. I used college students as my subjects. I think it opens an avenue for additional research in the area; for example, it might be feasible to do a longitudinal study wherein you administered ACL and codependent trait lists to students and re-interviewed them several years later when they have become somewhat established in their professions.

Research on Dysfunctional Roles

On the surface, codependent families may differ from each other, but Cermak (1985) believes they have a great deal in

common beneath that surface. When a codependent becomes chemically dependent as well, the family system takes on a more rigid structure, with all the other members limiting themselves by the specific roles they play to support the system. For example, codependent spouses may resort to the use of chemicals as well, or perhaps deny that any problems exist, remaining unaware that their partner is as alcoholic. Alternatively, they may play a martyr role and devote their lives to an effort to rescue the alcoholic. Another role that is often assumed by the spouse is that of a prosecutor devoted to punishing or shaming the alcoholic into sobriety. The truth is, most spouses fall into one or the other of these categories. Spouses who are not codependent do not allow their own self-destruction to proceed in step with the alcoholic's decline. The alcoholic either gets into treatment, or the marriage tends to unravel.

Cermak (1985) asserts children in an alcoholic/codependent family also find that they have a limited number of roles available to them. The advantage of playing one or another of these roles is simply that it buys them "a place at the family table".

Some of the primary family roles for children are: the Hero, the Scapegoat, the Lost Child, and the Mascot. The Hero attempts to hold the family together and make up for their parents' deficiencies. He/she provides self-esteem for the family. He/she makes the family proud; but at a terrible

price in terms of his own well-being (Wegschieder-Cruse , 1981 and Friel and Friel, 1988).

The Scapegoat misbehaves and gives people something to focus on besides alcoholism. The Scapegoat gets to act out all of the family's dysfunction and therefore takes the blame and "the heat" for the family. Wegscheider-Cruse (1981) and Friel and Friel (1981) say the Scapegoat gets drug addicted or steals, is the "black sheep", gets in a lot of fights, acts out sexually, etc. The family then gets to say if he/she weren't such a delinquent, we'd be a healthy family.

The Lost Child, as identified by Wegscheider-Cruse and Friel and Friel deals with the family dysfunction by means of escape. But, in a sense, this is the person taking care of the family's needs for separateness and autonomy. This is the child who stays in his/her room a lot. He/she is alone, but it is not a healthy aloneness. It is a deep loneliness that pervades those who have that role.

The Mascot is often one of the younger children. According to Wegscheider-Cruse and Friel and Friel, the Mascot provides the humor and comic relief for the family. He/she gives the family a sense of fun, of silliness, and a distorted type of "joy". The cost to the Mascot is that his/her true feelings of pain and isolation never get expressed, and he/she remains an emotional cripple until he gets into a recovery program of his/her own.

Cermak (1985) stresses the point that roles are determined more by a family's needs than by a person's own inherent personality. The roles themselves are not the problem. People in healthy families also tend to adopt roles. But, in healthy families, people develop their role from their own individual talents and needs. These roles also remain more flexible. In alcoholic families, the roles are usually rigidly imposed on you. Your role is assigned to you; you are expected to play that role, whether it fits your personality or not, whenever the family is in trouble.

When members of the family have fixed roles, their behavior is predictable. The roles reduce the possibility of spontaneous behavior on the part of the family members. The alcoholic family is a very chaotic system, and the roles provide some stability. They also divert attention from the often bizarre behavior of the family to the behavior of the member who is playing a role (Kritsberg, 1985).

Each role serves the purpose of trying to maintain the status quo, and each person cast in a particular role is playing that role in order to survive a fearful and dangerous situation. Kritsberg (1985) adds that as the disease of alcoholism progresses the roles become more and more fixed and rigid.

In addition to the roles detailed by Wegscheider-Cruse (1981) of Hero, Scapegoat, Lost Child, and Mascot, Kritsberg (1985) adds two more roles, that of the Placater and the

Enabler. The Placater tries to reduce the conflict in the family by smoothing things over. The Enabler prevents the alcoholic from experiencing the consequences of his or her alcoholic behavior. The Enabler also provides all of the nurturance and sense of belongingness in the family. For the Enabler keeping everyone together, preserving the family unit at any cost (including physical violence or death) is the ultimate goal. Fear of abandonment and fear that other family members cannot stand on their own two feet are what motivates this role.

Kritsberg (1985) also adds that in the family, roles often become blended. It is not uncommon to have a Clown-Placater type, or a Hero-Scapegoat type. Although these six roles are the most common and well known, the alcoholic family is not limited to using just those; roles will be created based on the needs of the family.

Friel and Friel (1988) add three additional roles they believe operate in dysfunctional families: the Do-er, Dad's Little Princess/Mom's Little Man, and the Priest/Nun/Rabbi/Saint. The Do-er makes sure kids are taken care of, pays the bills, irons the clothes, and cooks dinner. Because the Do-er is operating in a dysfunctional family, that's about all the Do-er has the time or energy to do. So the Do-er feels tired, lonely, taken advantage of, neglected, and empty. But the Do-er gets a lot of satisfaction out of being so accomplished at his or her tasks, and the family

encourages the Do-er either directly or indirectly. And, the Do-er's own unhealthy guilt and overdeveloped sense of responsibility keeps him/her going.

Dad's Little Princess/Mom's Little Man is a severe form of emotional abuse which many professionals call "emotional or covert incest". Friel and Friel (1988) say this role feels good to a child, who gets to be "a little spouse" to one of the parents in the system. This child does not get to be a child, though, and is actually seduced into the role by a parent who is too afraid and too dysfunctional to get his/her needs met by another adult.

The Saint/Priest/Nun/Rabbi is the child who expresses the family's spirituality and is expected to become a priest, a nun, a rabbi, or a monk, and not to be sexual. Often the expectation is never a spoken one. It is implied and subtly reinforced and encouraged. This child is unconsciously molded into believing that he or she will only have worth if they act out the spirituality for the family. And if they don't, they will have little or no worth (Friel and Friel, 1988).

Children raised in homes where open communication is practiced and consistency of life styles is the norm usually have the ability to adopt a variety of roles dependent on the situation. These children learn how to be responsible, how to organize, to develop realistic goals, to play, laugh, and enjoy themselves. They learn a sense of flexibility and spontaneity. They are usually taught how to be sensitive to

the feelings of others, and are willing to be helpful to others. These children learn a sense of autonomy and also how to belong to a group. Black (1981) reminds us that children growing up in alcoholic families seldom learn the combinations of roles which mold healthy personalities. Instead, they become locked into roles based on their perception of what they need to do to "survive" and to bring some stability to their lives.

Mulry (1987) stresses that the roles that develop in the codependent family are exaggerations of normal family roles; they are assumed to a pathologically rigid degree and are compulsively retained when they are no longer functional. These roles are then recreated in the next generation's nuclear family. Although roles often develop by birth order, a drug-abusing adolescent will induce them, in modified form, in both parents and siblings.

As this study focuses on the dysfunctional behavior evidenced by those who are codependent, the use of family roles (prevalent in family systems theory) sheds much light on the origin of those dysfunctional behaviors. Since alcoholism is such a wide-spread disease which touches many more people than just those who are dependent on alcohol, most researchers believe there are a great number of people who are codependent as a result of growing up in a dysfunctional home. While it may be somewhat risky to make sweeping generalizations, when one looks at codependent professionals

it certainly seems apparent that they fit the model of certain family roles, such as the Hero, the Doer, and even the Enabler.

If, as many experts believe, these roles are determined by the family of origin's needs, for codependent professionals, these roles may be maintained and encouraged by the very nature of the helping professions themselves. Since these family roles provide stability in the family, the codependent person may become so involved in the role he plays in his family that he may naturally extend this role into his professional life. These roles are rigidly maintained and one is expected to act in ways that are very comforting and comfortable for the codependent professional; he/she cannot "hide" behind his/her role in all aspects of life. Unfortunately an Enabler may actually be harming clients instead of helping them by allowing them to continue in a dysfunctional fashion and "assisting" them along the way. The Enabler may end up taking over responsibility for a client's life without providing the impetus, knowledge, or insight needed for change and growth. This is not productive for either party.

In this study it was expected to find that students who are planning to enter selected helping professions will exhibit certain kinds of roles (ex: Caretaker, Enabler, etc.) more than those entering the business professions.

Research on Family Rules/Dynamics in Dysfunctional Families

According to Jorgensen and Jorgensen (1990), the first rule of thumb adopted by family members is the "no talk" rule. The denial systems shared by the alcoholic and every member of the household prevent each child and adult from ever questioning either the drinking or the insane behaviors that go on around them. As the disease progresses, no one in the family talks about the consequences of those behaviors either: the embarrassing incidents, the fighting, and the money problems.

Black (1981) also cites the "Don't Talk about the Real Issues" rule operating in alcoholic families. Many adult children report being instructed not to talk about things which would upset mom or dad; or they simply learned by themselves that things went much easier when they did not "rock the boat".

Black (1981) believes that helplessness, despair, and hopelessness cause family members to believe that if you just ignore it, maybe it will not hurt; if you just ignore it, it may just go away.

Well adjusted children who experience daily childhood problems would, most likely, talk about family problems with other family members. Because of the denial of the alcoholism in an alcoholic family, the children's problems are rarely

recognized, and the family problem is never discussed (Black, 1981).

Many children fear that they won't be believed, according to Black (1981). In addition to this, they may feel a sense of guilt and/or betrayal in talking about their parents' problems. Children often feel very loyal to their parents, and usually end up defending their parents. They may rationalize that it isn't really all that bad and continue in the denial process.

Subby (1987) explains that individuals learn the "no talk rule" in two ways. First, the parents may come right out and say, "what happens in this house is no one else's business, so keep your mouth shut".

But according to Subby (1987), it is more common to learn this rule by watching the parents. Mom and dad don't talk about problems, even though there is a great deal of tension in the air. The "no talk" rule eventually causes them to avoid their problems or deny that there are any problems. This fosters a feeling of impending doom, typified by knots in the stomach, free-floating anxiety, headaches, and sleeplessness.

Friel and Friel (1988) add that in dysfunctional families the "no talk" rule means, "don't yell for help when you are about to drown". It means children must go to school every day, smiles on their faces and knots in their stomachs, because they have been up half the night listening to their

parents battle over money or alcohol. It means those children don't share their pain with anyone because if they do, they will be emotionally or physically beaten or shamed for sharing "family secrets" outside the family. And above all, it means those children will grow up to believe that they must handle all their problems by themselves, alone, and in isolation.

A second rule adopted by many addicted and dysfunctional families is "don't trust". Children growing up in the tense, unpredictable environment found in these dysfunctional families begin receiving a succession of disappointments early in life: broken promises, inconsistent or absent affection, and failed sobriety. In reaction to this pattern of discouragement, children of alcoholics gradually learn to develop a thick emotional shell to protect themselves from further pain and disappointment (Jorgensen and Jorgensen, 1990).

The "don't trust" rule is also cited by Black (1981). Children raised in alcoholic family structures have learned that it is best not to trust that others will be there for them, emotionally, psychologically, and possibly even physically. To trust another means investing confidence, reliance, and faith in that person. Confidence, reliance, and faithfulness are virtues often missing in the alcoholic home. Children need to be able to depend on parents to meet their physical and emotional needs in order to develop trust. In alcoholic environments, parents simply are not consistently

available to their children either by being drunk, physically absent, or mentally and emotionally preoccupied with alcohol, or with the alcoholic. Black stresses that children are responding to both the drinking and enabling parent. She believes these children respond to the alcoholic family on the whole.

A third family rule according to Black (1981) is "don't feel". Black believes that children raised in alcoholic homes do whatever they can to bring stability and consistency into their lives. They behave in a manner which makes it easier for them to cope and easier for them to survive.

The "don't talk" and "don't trust" rules teach children that it isn't safe to share feelings either. Children learn not to share their feelings and inevitably learn to deny feelings because they don't trust that these feelings will be validated by family members, other relatives, or friends (Black, 1981).

However, Jorgensen and Jorgensen (1990) say that the "don't feel" description is unfortunate and inaccurate. They believe these children do "feel". Jorgensen and Jorgensen (1990) say they experience incredibly strong emotions. Usually, they choose to keep their feelings within rather than face disbelief, ignorance, or negative family emotions.

Kritsberg (1985) takes a slightly different approach to the rules operating in dysfunctional families. He states that there are four rules operating in these families: 1. The Rule

of Rigidity 2. The Rule of Silence 3. The Rule of Denial 4. The Rule of Isolation.

Research on Rule of Rigidity

Kritsberg (1985) believes the rigidity of the alcoholic family system is easily observed in the way the family influences its children. Children need a safe place where they can try different ways of behaving, and where they can change and grow. The alcoholic family does not provide the kind of flexible environment that children need in order to experiment with life.

Because of its rigid structure, the children in an alcoholic family are not allowed to grow emotionally. The parents try to keep the children, children. This does not mean that children get no responsibility--they usually do. They get the responsibility to take care of parents and siblings and to do household duties, but they never get the opportunity to develop emotionally into adults. The system is rigid and fixes the children as children. When these children become adults, they are in most cases still children emotionally. This is particularly obvious when ACoAs are relating to their parents (Kritsberg, 1985).

Growing up with "The Rule of Rigidity" translates as an adult, into a need to control. This control means no spontaneity, and therefore no playfulness. Kritsberg (1985) reminds us that ACoAs are generally very serious people.

Research on Rule of Silence

This rule is the same as the "don't talk" rule previously discussed. Kritsberg (1985) believes that the only way ACoAs can get free of the "Rule of Silence" is by talking about what happened to them and expressing their repressed feelings. The "Rule of Silence" works at the expense of both the ACoA's emotional well-being and ability to function honestly and openly in the world.

Research on Rule of Denial

This rule is similar to the "don't feel" rule already discussed. Much has also been written about both alcoholism and codependence as diseases of denial. Kritsberg (1985) reminds us that children model the behaviors of the adults in their lives. This is one of the ways they learn to become healthy human beings. In the alcoholic family the denial of feelings is so prevalent that children never learn how to honestly express emotions.

Research on Rule of Isolation

The alcoholic family is a closed system. It resists the movement of its members in and out of the system and resists adding outsiders as members. The members cling to each other emotionally, but never become intimate. The alcoholic system tries to be self-sufficient. It creates the myth that no one outside of the system is to be trusted (Kritsberg, 1985).

The system cannot afford to have people outside of the family know what is happening in the system. Kritsberg (1985)

believes this is the reason some alcoholic families have a tendency to move from place to place. The family moves because it cannot bear the scrutiny of its neighbors. As the alcoholic behaviors become more extreme, the family becomes more isolated.

But, Kritsberg (1985) also says that the family that does not move a lot is often as isolated from its neighbors as the family that does move.

It would seem that the isolation of the alcoholic family would serve to draw the family together. However, while many alcoholic families have a them-against-us attitude, the individual members are as isolated from each other as the family is isolated from the community (Kritsberg, 1985).

It is Kritsberg's (1985) belief that every ACoA is codependent because he/she was raised to follow this set of rules which insures the development of codependency. Kritsberg defines codependency as the condition of a person who is emotionally dependent on an outside force to get feelings of self-esteem and who focuses on external stimuli in order not to feel his/her own pain. He believes all ACoAs fall within this broad definition of codependence. But Kritsberg (1985) also states that while all ACoAs are codependent, not all codependent people are ACoAs. Many codependents are raised in nonalcoholic dysfunctional family systems or learn codependent behavior when they become involved in unhealthy relationships.

Most researchers seem to agree that all families, functional or dysfunctional, operate according to certain rules. These rules are well conceptualized but there is no empirical validation. The rules stated seem to "make sense" from a family systems perspective but validation from a statistical viewpoint is needed.

Some researchers say that the adults in a dysfunctional family establish quite clearly the rules for expected behavior, such as, "Don't talk about our family to anybody". These rules are certainly easy to discover and validate simply from a first person account or case history in some people; however, it is the rule that operates on an agreed-upon, unspoken basis that this study hopes to verify.

This study used the Adjective Check List (ACL) and the Moos Family Environment Scale (FES-form R) in an attempt to isolate or validate the existence of these rules. It was expected that the most information related to family rules would be obtained from the FES and supportive evidence from the ACL. The R form of the FES was used to determine how subjects realistically viewed their families of origin rather than how they would want their ideal family to be.

Research on the Characteristics of ACoAs

Kritsberg (1988) states that A person who is raised in a dysfunctional family develops a set of characteristics that are similar to those of others raised in the same kind of

system. Kritsberg groups these characteristics of ACoAs into four main categories: 1. emotional characteristics 2. mental characteristics 3. physical characteristics 4. behavioral characteristics.

According to Kritsberg (1988), even though ACoAs do not share the same mental, physical, or behavioral characteristics, they do share the same underlying emotional states. (see Following chart).

ACoA's Characteristics Grouping Chart

Emotional Characteristics	Mental Characteristics	Physical Characteristics	Behavioral Characteristics
Fear	Thinking in absolutes	Tense shoulders	Crisis-oriented living
Anger	Lack of information	Lower back pain	Manipulative behavior
Hurt	Compulsive Thinking	Sexual dysfunction	Intimacy problems
Resentment	Indecision	Gastro-intestinal disorders	Unable to have fun
Distrust	Learning disabilities	Stress-related behaviors	Tries to fit in
Loneliness	Confusion	Allergies	Compulsive-addictive disorders
Sadness	Hypervigilance		
Shame			
Guilt			
Numbness			

Friel and Friel (1988) break ACoA characteristics into two main categories: Emotional/Psychological and Physical.

Emotional/Psychological characteristics include:

- Depression
- Anxiety/panic attacks
- Suicide or suicidal thoughts
- Obsessions and Compulsions
- Chemical addictions
- Low self-esteem
- Personality disorders
- Phobias
- Suspiciousness
- Intimacy problems
- Dissociation
- Flat affect
- Difficulty concentrating
- Excessive anger
- Low frustration tolerance
- Passive/Aggressive personality
- Extreme dependency
- Inability to have fun
- Inability to be assertive
- People-pleasing
- Approval seeking
- Identity confusion
- Hysteria
- Sexual dysfunction
- Inability to be interdependent

Physical characteristics include:

- Chemical dependency
- Eating disorders
- Accident proneness/ chronic pain syndrome
- Tension and Migraine Headaches
- Respiratory problems
- Ulcers, colitis, digestive problems
- Constipation/Diarrhea
- Sleep disorders
- Muscle tension
- TMJ (temporomandibular joint disorder)

Friel and Friel (1988) say that addictions, compulsions, unhealthy dependencies, depression, stress symptoms, phobias, and anxiety are the most common group characteristics of ACoA's.

Ann Wilson Schaef's (1986) listing of codependent characteristics is very helpful, since she has categorized a number of sub-diseases under major headings:

1. External referenting. Including: relationship addiction; Cling-cling relationships, lack of

boundaries, impression management (what will others think?); not trusting your own perceptions.

2. Caretaking. Including: needing to be needed; being a martyr.
3. Physical Illness. Resulting from working hard at taking care of others.
4. Self-Centeredness. Believing that everything that happens to a significant other is the result of something the codependent does.
5. Control issues. Attempting to control the uncontrollable.
6. Feelings. Including: being out of touch with feelings; distorted feelings.
7. Dishonesty. Making up elaborate stories to fulfill others' expectations or to protect others.
8. Being central. Compensates for fear of abandonment.
9. Gullibility.
10. Loss of morality. Including: lying to oneself, neglect of self and the body, spiritual deterioration.
11. Fear, Rigidity, Judgmentalism.

Weddle and Wishon (1986) list the following characteristics of ACoA's...They may:

1. become isolated and afraid of people, particularly authority figures.
2. become approval seekers, losing their identities in the process.

3. be frightened by angry people and/or personal criticism.
4. live life from the viewpoint of helping others and seeking "victims" for this purpose.
5. have an overdeveloped sense of responsibility.
6. experience guilt feelings when standing up for themselves.
7. confuse love with pity.
8. bury feelings.
9. judge themselves harshly due to poor self-esteem.
10. be terrified at the thought of abandonment.
11. be reactors rather than actors.
12. eventually become alcoholics, marry them, or both--or find another compulsive personality with whom to share their lives.

Hall and Wray (1989) list many of the same characteristics of ACoA's as mentioned already. They also state that members of a dysfunctional family feel smothered and angry by unconfronted problems, and their need for autonomy and self-esteem go unmet. Members of dysfunctional families spend all their energy taking care of other family members instead of caring for themselves. Family dynamics center around denying each member's dysfunctional patterns of living.

As children from dysfunctional families become codependent adults, many suppress their dependent, fearful

inner selves by turning to strong helper roles (Hall and Wray, 1989).

Whitfield (1988) says that codependence affects not only individuals, but whole families, communities, businesses, and other institutions and states and countries. His examples of its manifestations include:

In Patients and Clients (Children and Adults)--

Behavioral or psychological symptoms such as anxiety, depression, insomnia, hyperactivity, or aggression.

Functional or psychosomatic illness.

Family violence or neglect.

Alcoholism or another chemical dependence of "drug problem".

In the Helping Professional--

Failure to make the diagnosis of alcoholism.

Failure to treat alcoholism as a primary illness.

Treating the alcoholic with long-term sedatives or minor tranquilizers.

Treating the co-alcoholic with sedatives or minor tranquilizers.

In Society-at-Large--

Not confronting relatives, friends and colleagues who are inappropriately intoxicated.

Placing a positive social value upon those who drink.

Stigmatizing those who are alcoholic or who do not drink.

"Codependents" can be viewed as exhibiting many similar symptoms and characteristics because their families of origin were dysfunctional. It seems that due to the dysfunctional nature of the families there are some fairly predictable outcomes or consequences, both of a physical and/or psychological nature. The physical symptoms are quite similar to many stress-related disorders. Many of the psychological characteristics center around low self-esteem, fear of intimate relationships, depression, and chemical dependency.

In this study it was expected that many of these "typical" characteristics would be found in subjects who are majoring in nursing, social work, and psychology, but not in those majoring in business-oriented fields. It was hypothesized that these traits will be evident even though subjects are still students in the field rather than established professionals. This would support the hypothesis that codependents are drawn to the helping professions, rather than becoming codependent after working in the field. Weddle and Wishon (1986) believe codependents seek out "victims" so that they can be their caretakers.

A great deal of information has been written concerning the codependent's "need" to be a responsible caretaker. The problem is that they take care of everybody but themselves; they try to meet everybody's needs while their own needs go unexpressed and unmet. Then they assume a martyr's role which complements the caretaker role.

Whitfield (1988) estimates that about 80% of all helping professionals lack any training in the area of codependence. He believes this is due to the fact that the majority of faculty and administrators of their professional schools are untrained and/or untreated codependents.

This suggests another avenue which may warrant further research to assess the faculty of the students used as subjects as well as the students. If students were assessed at the beginning of a training or educational program and then when they were close to the completion of that program, one might expect to see more characteristics of codependence near the end of their training. One factor could be their own predisposition to codependence; but another factor could possibly be that their instructors "taught" or reinforced codependent behaviors.

It is well known that college students make up 80% of all experimental subjects. Therefore the author felt comfortable in using this population for this study, although many researchers have questioned the validity of making generalizations based on a group of subjects that may very well <u>not</u> be representative of society at large. However, since the interest was in looking at students just entering their chosen field of study, this sample was thought to be appropriate. Furthermore, college students seem both able and ready to take part in tests and studies.

Chapter 3

Collection of Data

Sample Population

The sample for this study was drawn from a nursing school and a community college. The sample consisted of 40 nursing students, 40 social work majors, 40 psychology majors, and 40 students majoring in business oriented professions. Students came from all levels (i.e. Freshman through seniors) of undergraduate study at these two schools. Subjects were recruited on a voluntary basis and received no monetary remuneration or academic credit.

Description of Interventions

The subjects were tested in groups or individually, depending on convienence and availability. Each subject was asked to complete The Adjective Check List (Real and Ideal forms), the Moos Family Environment Scale (form R), and the Friel Codependency Assessment Inventory. Tha ACL and the FES were administered first, followed by the Friel Codependency Assessment Inventory.

See Instrumentation section for further detail on ACL and FES.

Instrumentation

The Adjective Check List (ACL)

The ACL is a self-report inventory consisting of 300 items arranged in 37 scales. The subject checks the adjectives he feels are appropriate (ex. self description). It can be administered either individually or as a group procedure (Gough and Heilbrun, 1983).

The 1980 edition of the ACL was normed on a sample of 5,238 males and 4,144 females. Subjects were selected from populations of high school students, college students, graduate students, medical students, delinquents, psychiatric patients, and other adults. The sample was arbitrarily chosen and the authors admit that "they may not adequately represent general population trends". Test users should be very cautious about interpretations of test responses for individuals not adequately represented in the normative group. There are no age norms presented (Teeter,1985).

Alpha coefficients are respectable and modestly high for half of the scales, but for those subtests with lower reliabilities, (ex: A-1 high origence, high intellectence), interpretation should be more conservative. Test-retest information is somewhat limited because of the special characteristics of the samples used. The sample used to compute the test-retest data for females was very small (N=45) and restricted only to college students (Zarske, 1985). As

such, Zarske feels the generalizability of such reliability data to other groups included in the standardization sample is difficult to achieve. He believes further reliability studies using greater numbers from the various groups employed in the standardization sample would improve the psychometric characteristics of the ACL. Reliability Coefficients for the various scales show wide variation (0.34 to 0.95); however, median values in the mid seventies attest to the generally adequate reliabilities for most of the scales.

The ACL manual lists in its appendix the correlational data on the MMPI and CPI as well as several other tests instruments, and a brief section on factor analysis of the various scales. But Zarske (1985) notes that no attempt is made to summarize this data in terms of the ACL's validity as a personality measure. Therefore, the reader must search the text of the manual for support of the test's construct validity.

Alpha estimates of internal consistency for the 37 ACL scales show acceptable median values of 0.76 and 0.75 for males and females, respectively. Reliabilities for the 15 Need Scales and three other scales may be somewhat inflated, according to Fekken (1985). Alpha coefficients were based on the same sample used to modify these 18 scales via selection of items having high correlations with the scale total. The stability of ACL scale scores is quite strong. Six-month test-retest correlations for males showed a median value of

0.65; one-year test-retest correlations for females showed a median value of 0.71.

Construct Validity of the ACL scales appears to be modest. Fekken (1985) states that evidence for discriminant validity is weak overall. The ACL scales tend not to be confounded by either social desirability or vocabulary level, as evidenced by the small and generally insignificant correlations reported in the manual. With the possible exception of the origence-intellectence, however, ACL scales correlate substantially less with validity criteria than with one another.

Family Environment Scale (FES)

The 90-item FES seems to have adequate psychometric properties, (Busch-Rossnagel, 1985). The means of six of the eight item subscales range around 5.5; only the mean for conflict is very low at 3.3. The internal consistencies for the 10 subscales range from 0.61 to 0.78, and the corrected average item-subscale correlations range from 0.27 to 0.44. The 8-week test-retest reliabilities range from 0.68 to 0.86, and the 12 month stabilities range from 0.52 to 0.89.

Busch-Rossnagel (1985) feels these psychometric properties do not carry over into the evidence for validity. She states that the face validity of the FES is good. The wording of each item reflects both the subscale and underlying domain. However, no information is provided about the rationale for selecting the 10 subscales which were included

or the 3 underlying domains. Busch-Rossnagel believes we need to know the relevance of the dimensions assessed by the FES for individual psychological and familial functioning. She feels such a rationale would be most useful for obtaining some evidence of predictive validity.

No validity evidence is given for the goal of discriminating between families. While the subscale means of the distressed family sample are different from that of the normal family sample, no indication is given as to which are significantly different. More importantly, there is no basis for predicting on which subscales certain types of distressed families will differ from the normal sample. Busch-Rossnagel (1985) feels such information and its theoretical foundations are necessary before the FES will really be useful for clinical applications.

Caldwell (1985) reports that Cronback's Alpha was used in computing internal consistency reliability coefficients for each of the ten FES subscales. The lowest correlations were 0.61 and 0.64 for Independence and Achievement Orientation, respectively. Cohesion, Intellectual-Cultural Orientation, and Moral-Religious Emphasis each yielded correlations of 0.78 -- the highest measures of internal consistency. Conflict and Organization yielded correlations of 0.75 and 0.76, respectively. All of these subscale coefficients are satisfactory.

Test-retest reliabilities were computed for the 10 subscales for intervals of 8 weeks, 4 months, and 12 months. Reliability coefficients for six subscales ranged between 0.76 and 0.89 for the 12-month interval. Coefficients for the remaining four subscales were 0.52, 0.63, 0.69, and 0.69. These coefficients were adequate.

Profile stability correlations were also computed for the subscales for different time intervals and demonstrated adequate stability (Caldwell, 1985).

However, Caldwell (1985) notes that despite the extensive research studies contained in the manual, there is no separate section of validity at all. There was only one reference to validity (i.e., construct validity) throughout all studies reported in the manual. There is no data on predictive validity.

Caldwell (1985) states that the FES appears to have "robust face validity". Overall, each item seems relevant to the respondent and is clearly expressed. Each statement tends to appear reasonable. Norms are presented in standard score units, enabling ready comparisons in some instances.

Lambert (1985) reports test-retest reliability (over an eight week period) for Form R of the FES ranged from a low of 0.68 for the Independence subscale to a high of 0.86 for the Cohesion subscale. Test-retest reliabilities over a four-month and twelve-month period ranged from 0.52 for the Independence subscale to 0.91 for the Moral-Religious Emphasis

subscale, indicating a fair amount of stability in the scales over time.

Information on the validity of the subscales comes primarily from the evidence of the significance of the difference between the means of representative and distressed families on the subscales. Additionally, studies of the FES profiles of family members varying with respect to age, family size, length of marriage, and educational and occupational status showed differences in subscales depending on these family background factors. As the FES subscales provide reports of perceptions of family members differing with respect to a variety of social characteristics, there is no effort to identify typical or best families. Consequently ideal or prototypic family profiles are not available as criterion evidence against which correlate family member's perceptions of their families (Lambert, 1985).

Supplemental Research

Friel Co-Dependency Assessment Inventory

Description: The Friel Co-Dependency Assessment Inventory is a self-report inventory consisting of 60 items answered in a true/false format. It was devised to: 1) give objective estimates of severity or degree of co-dependency; 2) allow more specific research and the use of more powerful statistics (ex: calculating the correlation between co-dependency and family variables; 3) measure therapeutic improvement; and 4)

help establish treatment plan and goals. Friel (1985) states that beyond that, it helps us to define and refine the construct of codependency.

The Inventory covers the areas of codependent concerns of:

1) self-care
2) self-criticism
3) secrets
4) "stuckness"
5) boundary issues
6) family of origin
7) feelings identification
8) intimacy
9) physical health
10) autonomy
11) over-responsibility/burnout
12) identity

Scores below 20 indicate few codependent concerns; 21-30 to be mild/moderate; 31-45 moderate/severe, and over 45, severe.

Specifically, in this study it was expected to find that subjects who scored higher (moderate and severe) on the Friel Co-Dependency Assessment Inventory would show similar characteristics on both the Adjective Check List and Moos Family Environment Scale. For example, a larger discrepancy between the Real and Ideal Self scores for people who tested high on the Co-Dependency Assessment Inventory as well as higher scores on the Nurturance scale and Abasement scale on the ACL would be expected. It was also expected that these subjects would also score higher on the Conflict and Control scales of the FES. This was reasoned because much of the research indicates codependents tend to come from

dysfunctional families. Some of the primary characteristics of codependence include low self-esteem, depression, shame, perfectionism, over-responsibility. These characteristics seem to naturally be related to Nurturance and Abasement.

Summary of Previous Research on Friel Codependency Assessment Inventory

The Friel codependency Assessment Inventory has been in existence for approximately five years. The author is currently planning a large-scale factor-analysis of the test items to look at internal structure and validity. He is continuing to collect normative data (Friel, 1985).

The Friel Codependency Inventory was designed to help in identifying the issues of Adult Children of Alcoholics and Codependency. It has been used in both research and clinical work. It is also suggested as a useful tool for people to begin identifying for themselves the problems that they need to work on (Friel and Friel, 1988). The author, John Friel, admits this inventory is still in the developmental stage and asks other researchers to share their own data and results gathered via this inventory.

Hall and Wray (1989) have advocated the use of this inventory by nurses who may be suffering from the negative effects of codependency, which seems to be a likely occurrence due to the nature of nursing itself. Hall and Wray believe the first step in leading a healthy life is to first recognize

unhealthy behavior. This inventory is believed to by instrumental in accomplishing this goal.

Zerwekh and Michaels (1989) also advocate the use of the Friel Codependency Assessment Inventory in evaluating codependency. While the authors state that this is not a standardized tool, they believe that a "preponderance of positive responses might indicate a problem".

In correspondence with the author, John Friel, he reports initial reliability figures using KR-20 were in the range of 0.83 to 0.85 on "fairly homogeneous samples with somewhat restricted range". The Codependent Assessment Inventory does not have a validity scale; however, Friel recommends using the L and K scales from the MMPI for this purpose. This underscores the lack of empirical data on codependency in the current literature. Cermak (1986) asserts that definitions of codependence often follow a metaphoric approach and these definitions have failed to coalesce into an integrated conceptual framework that is able to be tested empirically.

The L and K scales of the MMPI were added to the Friel Codependency inventory and form a part of the validity scales. The L scale was originally constructed to detect a deliberate and rather unsophisticated attempt on the part of the subjects to present themselves in a favorable light. The L scale items deal with minor flaws and weaknesses to which most people are willing to admit. However, individuals who are deliberately trying to present themselves in a very favorable way are not

willing to admit even minor shortcomings. The result is that such people produce high L scale scores (Graham, 1987).

When the L scale score is higher than would be expected when appropriate demographic variables are taken into account, this may suggest a defensive test-taking attitude. In addition to this, high L scale scores have been found empirically to be associated with some other important extra-test attitudes and behaviors. Therefore, high scores tend to be overly conventional and socially conforming. They are unoriginal in their thinking and inflexible in their approaches to problems. In addition, they have a poor tolerance for stress and pressure. They are rigid and moralistic and overevaluate their worth. They utilize repression and denial excessively, and they appear to have little or no insight into their own motivations. Also, they have little awareness of the consequences to other people of their behavior (Graham, 1987).

The K scale was developed as a more subtle and more effective (as compared to the L scale) index of attempts by testees to deny psychopathology and to present themselves in a favorable light or, conversely, to exaggerate psychopathology and to try to appear in a very unfavorable light. High scores on the K scale thus were thought to be associated with a defensive approach to the test, whereas low scores were indicative of unusual frankness and self-criticality (Graham, 1987).

The 30 items on the K scale cover several different content areas in which a person can deny problems (e.g. hostility, suspiciousness about motivations of other people, family dissention, lack of self-confidence, excessive worry). The K scale items tend to be much more subtle than items in the L scale; therefore, it is less likely that a defensive person will recognize the purpose of the items and will be able to avoid detection (Graham, 1987).

"When a K scale score is higher than is typically expected for a person's socioeconomic status, the possibility of a deliberate attempt to deny problems and psychopathology and thereby to appear in a favorable light or the possibility of all false responding should be considered" (Graham, 1987). High K scale scorers may be trying to maintain an appearance of adequacy, control, and effectiveness. High scorers tend to be shy and inhibited, and they are hesitant about becoming involved emotionally with other people. They are also intolerant and unaccepting of unconventional beliefs and behavior in other people. They lack self-insight and self-understanding (Graham, 1987).

In this study, it was hoped that by using the Friel Codependency Assessment Inventory in conjunction with the Adjective Check List, terms could be better operationally defined as well as determining if codependent individuals are more likely to enter helping professions than business-oriented professions.

Research Design

The design of this study was causal-comparitive in nature. The primary focus was whether or not students majoring in three "helping professions" (nursing, social work, and psychology) exhibited more codependent characteristics (as measured by Friel Co-Dependency Assessment Inventory) than students majoring in business-oriented fields. This provided data to test research hypothesis #1.

To test research hypotheses #'s 2,3,4,5 and 6 post-test comparisons were made on: 1) the discrepancy between Real and Ideal Self on the ACL, 2) the Nurturance and Abasement scales of the ACL, and 3) the Conflict and Control Scales of the FES.

Research Hypotheses

1. Students majoring in nursing, social work, and psychology will display significantly ($p<0.05$) more codependent characteristics as measured by the Friel Co-Dependency Assessment Inventory than students majoring in business-oriented fields.

2. Students majoring in nursing, social work, and psychology will show a larger discrepancy between Real and Ideal Self as measured by the Ideal Self Scale on the Adjective Check List than students majoring in business-oriented fields. The larger discrepancy may point to some characteristics displayed by many people who are codependent, such as perfectionism and low self-esteem.

3. Students majoring in nursing, social work, and psychology will score significantly ($p.<0.05$) higher on the Nurturance scale of the Adjective Check List than students majoring in business-oriented fields.

4). Students majoring in nursing, social work, and psychology will score significantly ($p<0.05$) higher on the Abasement scale of the Adjective Check List than students majoring in business-oriented fields.

5). Students majoring in nursing, social work, and psychology will score significantly ($p<0.05$) higher on the Conflict scale of the Moos Family Environment Scale than students majoring in business-oriented fields.

6). Students majoring in nursing, social work, and psychology will score significantly ($p<0.05$) higher on the Control scale of the Moos Family Environment Scale than students majoring in business-oriented fields.

Statistical Analysis

The statistical technique used in this study was a Multivariate Analysis of Variance (MANOVA). This is the appropriate statistic to use when measuring the same subjects on different variables, as was done in this study. The four groups of subjects were tested and compared on the basis of the Friel Co-Dependency Assessment Inventory, two scales of the ACL, and two scales of the FES. A planned comparison using Dunnette technique was also planned since there are

several different questions that were to be answered (i.e. by different scales on the FES and ACL).

Human Subjects Research Committee

There is a great deal of current literature on codependency but little empirical data. There is also much concern in the literature dealing with the codependent helping professional. A codependent professional not only suffers personal consequences but may inhibit their client's growth and recovery.

It was believed that this study could facilitate an increase in self-awareness and understanding for the subjects. This would enhance their own development and decrease the likelihood of the negative consequences of codependence for both themselves and their clients.

No reasonable possibility of causing physical harm to subjects could be forseen. However, it is possible that some subjects could be emotionally upset by examining their personal characteristics (as per ACL and Co-Dependency Assessment Inventory) or the nature of their family of origin (as per FES). The risks are believed to be minimal and should be out weighed by the potential benefits of increased self-awareness and self-understanding.

Informed consent of all subjects was obtained and documented on the consent form. All subjects were volunteers who were informed of their right to decline to participate in the study or withdraw in full or in part at any time. The

results were be kept confidential with the subjects being told that they could discuss their test results with the researcher, if they chose to do so. None took advantage of that possibility.

Chapter 4

Analysis of Results

A multivariate analysis of variance (MANOVA) with nursing, psychology, business, and social work students as the independent variables and the Friel Codependency Inventory (FCDI), the Ideal Self Scale, Nurturance scale, and Abasement scale of the ACL; the Conflict and Control scales on the FES as the dependent variables, were used for this study.

Wilks' Lambda was significant at 0.005 so a univariate analysis (ANOVA) was performed which is displayed in TABLE I and showed a significant effect for only the K scale ($F=.034$ $p<.05$). Therefore the difference on the K scale was examined for wholly significant difference (WSD). Since a priori conditions existed a specific contrast for nursing, social work, and psychology by business was performed. A Dunnette comparison was performed since there was a planned contrast of nursing and business students, social work and business students, and psychology and business students.(See TABLE I)

Research Hypothesis #1

Students majoring in nursing, psychology, and social work will display more codependent characteristics as measured by the (FCDI) than students majoring in business oriented fields.

Table I

Univariate F-tests with (3,156) D. F.

Variable	Hypoth. SS	Error SS	Hypoth. MS	Error MS	F	Sig of F
CONF	3.31875	550.42500	1.10625	3.52837	.31353	.816
CONT	38.46875	835.12500	12.82292	5.35337	2.39530	.070
ISS	590.76875	24519.2250	196.92292	157.17452	1.25289	.293
AB	363.81875	10523.8750	121.27292	67.46074	1.79768	.150
NURT	533.06875	15872.2750	177.68958	101.74535	1.74641	.160
FCDI	347.91875	16776.5250	115.97292	107.54183	1.07840	.360
L	34.51875	755.67500	11.50625	4.84407	2.37533	.072
K	144.27500	2529.70000	48.09167	16.21603	2.96569	.034

Table II

Summaries of FCDI CODEPENDENCY

By levels of GR GROUP

Variable	Value	Label	Mean	Std Dev	Cases
For Entire Population			29.2313	10.3779	160
GR	1.00	NURSES	29.5750	10.8720	40
GR	2.00	PSYCHOLOGY	31.4000	10.1471	40
GR	3.00	BUSINESS	28.5750	9.4892	40
GR	4.00	SOCIAL WORK	27.3750	10.9068	40

Total Cases = 160

Analysis of Variance

Source	Sum of Squares	D.F.	Mean Square	F	Sig.
Between Groups	347.9188	3	115.9729	1.0784	.3600
Within Groups	16776.5250	156	107.5418		

Eta = .1425 Eta Squared = .0203

Table II displays cell means and standard deviations and ANOVA for comparing the helping professions to Business students on the FCDI. The Dunnette Comparison was not significant ($t=0.3, p<.05$) and therefore this hypothesis was rejected.

Research Hypothesis #2

Students majoring in nursing, psychology, and social work will show a larger discrepancy between Real and Ideal Self as measured by the Ideal Self Scale of the Adjective Check List than students majoring in business oriented fields. Table III displays cell means, standard deviations, and ANOVA for comparing helping professions and business students on the Ideal self Scale. The Dunnette comparison of the groups on the Ideal Self Scale of the Adjective Check List was not significant ($t=0.32$, $p<.05$) therefore this hypothesis was rejected.

Research Hypothesis #3

Students majoring in nursing, psychology, and social work will score higher on the Nurturance scale of the Adjective Check List than students majoring in business oriented fields. Table IV displays cell means and standard deviations and ANOVA for comparing the helping profession to business students on Nurturance. The Dunnette Comparison was not significant ($t=0.95$, $p<.05$) therefore this hypothesis was rejected.

Research Hypothesis #4

Students majoring in nursing, psychology, and social work will score higher on the Abasement scale of the Adjective

Table III

Summaries of ISS IDEAL SELF SCALE

By levels of GR GROUP

Variable	Value	Label	Mean	Std Dev	Cases
For Entire Population			17.3063	12.5668	160
GR	1.00	NURSES	16.9250	12.9187	40
GR	2.00	PSYCHOLOGY	20.5500	11.6662	40
GR	3.00	BUSINESS	15.9250	13.5446	40
GR	4.00	SOCIAL WORK	15.8250	11.9269	40

Total Cases = 160

Value	Label	Mean	Std Dev	Sum of Sq	Cases
1.00	NURSES	16.9250	12.9187	6508.7750	40
2.00	PSYCHOLOGY	20.5500	11.6662	5307.9000	40
3.00	BUSINESS	15.9250	13.5446	7154.7750	40
4.00	SOCIAL WORK	15.8250	11.9269	5547.7750	40
Within Groups Total		17.3063	12.5369	24519.2250	160

Analysis of Variance

Source	Sum of Squares	D.F.	Mean Square	F	Sig.
Between Groups	590.7688	3	196.9229	1.2529	.2926
Within Groups	24519.2250	156	157.1745		

Eta = .1534 Eta Squared = .0235

Table IV

Summaries of NURT NURTURANCE

By levels of GR GROUP

Variable	Value	Label	Mean	Std Dev	Cases
For Entire Population			50.7813	10.1577	160
GR	1.00	NURSES	51.8000	10.1203	40
GR	2.00	PSYCHOLOGY	53.2500	8.3351	40
GR	3.00	BUSINESS	49.2750	8.5034	40
GR	4.00	SOCIAL WORK	48.8000	12.7585	40

Total Cases = 160

Analysis of Variance

Source	Sum of Squares	D.F.	Mean Square	F	Sig.
Between Groups	533.0688	3	177.6896	1.7464	.1598
Within Groups	15872.2750	156	101.7454		

Eta = .1803 Eta Squared = .0325

Check List than students in business oriented fields. Table V displays the cell means, standard deviations, and ANOVA for Abasement comparing helping professions and business students to business students. The Dunnette comparison was not significant ($t=0.95$, $p<.05$). The fourth hypothesis was therefore rejected.

Research Hypothesis #5

Students majoring in nursing, psychology, and social work will score higher on the Conflict scale of the Moos Family Environment Scale (FES) than students majoring in business oriented fields. Table VI displays cell means and standard deviations, and ANOVA for comparing helping professions to business students on conflict scale of the FES. The Dunnette comparison was not significant ($t=0.48$, $p<.05$). This hypothesis was also rejected.

Research Hypothesis #6

Students majoring in nursing, psychology, and social work will score higher on the Control scale of the Moos Family Environment scale than students majoring in business oriented fields. Table VII displays cell means, standard deviations, and ANOVA for comparing the helping profession and business students on Control of the FES. The Dunnette comparison was not significant ($t=1.71$, $p<.05$) therefore this hypothesis was rejected. (See TABLE VII)

Table V

Summaries of AB ABASEMENT

By levels of GR GROUP

Variable	Value	Label	Mean	Std Dev	Cases
For Entire Population			47.5438	8.2750	160
GR	1.00	NURSES	47.6000	7.0157	40
GR	2.00	PSYCHOLOGY	49.2000	8.2344	40
GR	3.00	BUSINESS	48.2500	7.9542	40
GR	4.00	SOCIAL WORK	45.1250	9.4630	40

Total Cases = 160

Analysis of Variance

Source	Sum of Squares	D.F.	Mean Square	F	Sig.
Between Groups	363.8187	3	121.2729	1.7977	.1499
Within Groups	10523.8750	156	67.4607		

Eta = .1828 Eta Squared = .0334

Two additional Dunnette comparisons were conducted on the L and K Scales of the MMPI which were incorporated into the FCDI as labeled Behavioral Assessment Inventory for the purpose of this study. Table VIII displays cell means and standard deviation and ANOVA for comparing helping profession and business students on the L Scale. Table IX displays similar data for the K scale.

The Dunnette comparison for L was not significant ($t=1.2$, $p<.05$). However, the Dunnette comparison for K was significant ($t=2.79$, $p<.05$). Apparently the helping profession students are significantly different from business students as measured by the K scale, even though all groups measured in the below average range. This is an apparent artifact of the study since the L and K scales were used soley for validation purposes of the FCDI, as suggested by its author, John Friel.

Table VI

Summaries of CONF CONFLICT

			Mean	Std Dev	Cases
For Entire Population			2.8188	1.8662	160
By levels of	GR	GROUP			
GR	1.00	NURSES	2.9750	2.0938	40
GR	2.00	PSYCHOLOGY	2.6750	1.8312	40
GR	3.00	BUSINESS	2.6750	1.9400	40
GR	4.00	SOCIAL WORK	2.9500	1.6164	40

Total Cases = 160

Analysis of Variance

Source	Sum of Squares	D.F.	Mean Square	F	Sig.
Between Groups	3.3188	3	1.1063	.3135	.8156
Within Groups	550.4250	156	3.5284		

Table VII

Summaries of CONT CONTROL

By levels of GR GROUP

Variable	Value	Label	Mean	Std Dev	Cases
For Entire Population			4.0938	2.3440	160
GR	1.00	NURSES	4.8250	2.3082	40
GR	2.00	PSYCHOLOGY	3.8000	2.3116	40
GR	3.00	BUSINESS	3.5250	2.2531	40
GR	4.00	SOCIAL WORK	4.2250	2.3803	40

Total Cases = 160

Analysis of Variance

Source	Sum of Squares	D.F.	Mean Square	F	Sig.
Between Groups	38.4688	3	12.8229	2.3953	.0704
Within Groups	835.1250	156	5.3534		

Table VIII

Summaries of L LIE SCALE

By levels of GR GROUP

Variable	Value	Label	Mean	Std Dev	Cases
For Entire Population			3.7938	2.2293	160
GR	1.00	NURSES	3.8000	1.9108	40
GR	2.00	PSYCHOLOGY	3.4250	1.6469	40
GR	3.00	BUSINESS	3.4000	1.8920	40
GR	4.00	SOCIAL WORK	4.5500	3.0714	40

Analysis of Variance

Source	Sum of Squares	D.F.	Mean Square	F	Sig.
Between Groups	34.5187	3	11.5062	2.3753	.0722
Within Groups	755.6750	156	4.8441		

Table IX

Summaries of K VALIDITY SCALE

By levels of GR GROUP

Variable	Value	Label	Mean	Std Dev	Cases
For Entire Population			10.1125	4.1009	160
GR	1.00	NURSES	10.9500	3.3355	40
GR	2.00	PSYCHOLOGY	10.4500	4.0506	40
GR	3.00	BUSINESS	8.5000	3.8564	40
GR	4.00	SOCIAL WORK	10.5500	4.7391	40

Total Cases = 160

Analysis of Variance

Source	Sum of Squares	D.F.	Mean Square	F	Sig.
Between Groups	44.2750	3	48.0917	2.9657	.0339
Within Groups	2529.7000	156	16.2160		

Eta = .2323 Eta Squared = .0540

Chapter 5

Summary

Chemical dependency is an illness of dependence on intoxicating substances. Codependency is a companion illness classically occurring in persons who are (or have been) in close relationships with chemically dependent persons (Mulry, 1987). However, Subby (1987) does not link codependency solely with chemical dependency. His focus is on growing up in a family where the rules are oppressive.

According to Erickson (1988) approximately 25 percent of adult children of alcoholics choose a career in the helping professions. Fausel (1986) believes that from 30,000 to 170,000 people involved in the helping professions are at high risk of becoming codependent.

Fausel (1986) states that "most mental health professionals are untreated codependents who are actively practicing their disease in their work in a way that helps neither them nor their clients". Whitfield (1984) believes nearly all untreated or untrained people in the general population are to some degree codependent. He adds that approximately 80 percent of all helping professionals remain untrained in this area. He feels that a major reason for this

is that the faculty and administrators of professional schools are themselves untrained and/or untreated codependent professionals.

These are very serious charges in my opinion, and if accurate, both clients and counselors are being short-changed. This study was therefore designed to: 1) determine if students going into three of the "helping professions" displayed more codependent characteristics than business students and, 2) attempt to provide empirical data to support the concept of codependency.

The only currently available tool to specifically measure codependency is the Friel Codependency Assessment Inventory, which has been in existence for approximately six years. Friel (1985) cautions that though care should be taken in interpreting these test scores, he feels it does help to focus on areas in a person's life which may be "troublesome". This inventory is still in the developmental stages and there is as of now, no validity data available. The author, John Friel, suggested that the L and K scales of the MMPI should be used for purposes of validity. Therefore, these items were combined with the items on the Codependency Inventory to construct a one hundred item scale, which was named the Behavioral Assessment Inventory for the purposes of this study.

The literature seems to indicate that people working in the "helping professions" displayed more codependent

characteristics than people in business related fields (Fausel, 1988; Whitfield, 1984 & 1980; Kijek, 1988). On this basis, it was theorized that people were drawn to the helping professions because they already possessed these codependent characteristics before they entered the field rather than becoming codependent after working in the field.

Much of the literature dealt specifically with two professions, nursing and social work (Erickson, 1988; Fausel, 1988). On that basis, these two groups were included in the study, along with psychology students, many of whom enter helping professions. The fourth group of subjects was composed of students majoring in various business-related fields. None of the studies which were discovered attempted to actually compare people in "helping professions" with those in business.

There is a great deal of descriptive data related to codependency but little empirical data. For this reason, two well-known and frequently used inventories were used: The Adjective Check List and the Moos Family Environment Scale. The Adjective Check List was chosen because it contains several scales that would seem to describe some of the attributes connected to codependence. According to Kritsberg (1988), even though adult children of alcoholics (ACOA's) do not share the same mental, physical, or behavioral characteristics, they do share the same underlying emotional states. One of the outstanding characteristics of ACOA's is

their caretaking behavior. Schaef (1986), indicated that codependents excel in caretaking behavior; they need to be needed and frequently assume the role of martyr. Weddle and Wishon (1986) add that many ACOA's have an overdeveloped sense of responsibility and live life from the viewpoint of helping others and seeking "victims" for this purpose. Going on these criteria, it was hypothesized that people going into "helping professions" would score above average on the Nurturance scale of the Adjective Check List. This hypothesis was not supported by the data. Only the psychology students displayed a significantly higher ($F=.038, p<.05$) score than business students on nurturance. The ACL manual (Gough and Heilbrun, 1983) defines nurturance as follows: "Nurturance is to engage in behaviors that provide material or emotional benefits to others". The high-scorer appears to like people; to have a cooperative, unaffected, and tactful social manner; and to be sympathetic and supportive in temperament. The low-scorer avoids close ties, is wary of others, and is dubious of other's intentions and defensive of his/her own intentions.

Weddle and Wishon (1986) also characterize ACOA's as people who judge themselves harshly due to poor self-esteem. Therefore, it was reasoned that codependent individuals would score above average on the Abasement scale of the Adjective Check List. This hypothesis was not supported by the data however. According to Gough and Heilbrun (1983) abasement means "to express feelings of inferiority through self-

criticism, guilt or social impotence". The high-scorers on abasement ask for little, submit to the wishes and demands of others, and avoid conflict at all costs. The interpersonal world is viewed with worry and foreboding, and others are seen as stronger, more effective, and more deserving. The low-scorers are assertively self-confident and respond quickly; they insist on obtaining what they judge to be their just rewards.

The Ideal Self Scale is also related to self esteem issues. Gough and Heilbrun (1983) state that the real self reflects immediate circumstances, the experiences and self-characterizations incorporated in the individual's current phenomenology. The ideal self delineates the future by setting goals to which the individual aspires. Subjective distress will occur if the discrepancies between real and ideal are too great or if the ideal is mostly composed of utopian attributes. Because codependents tend to be perfectionists, it was hypothesized that there would be a larger discrepancy between Real and Ideal on the Ideal Self Scale in the helping professions students than business students. This hypothesis was not supported by the data.

The Moos Family Environment Scale was chosen because the whole emphasis on codependence is viewed from a family systems perspective. For example, Mulry (1987) believes codependency is a companion illness classically occurring in persons who

are (or have been) in close relationships with chemically dependent persons.

For many dysfunctional families, the issues of conflict and control are major issues. Schaef (1986) notes that many ACOA's attempt to control even the uncontrollable. As for conflict, there are many examples of both overt and covert conflict apparent in dysfunctional families.

The Conflict subscale of the Family Environment Scale measures the amount of openly expressed anger, aggression, and conflict among family members, for example: the frequency of fights, whether they sometimes get so angry that they throw things, and how often they criticize each other (Moos, 1989). A score of "0" is "considerably below average; "1" well below average, "2" below average, "3 to 4" average, "5" above average, "6" well above average, and "7 to 9" considerably above average.

Group	Means	"0"	"1"	"2"	"3-4"	"5"	"6"	"7-9"
Nurses	2.9750	6	8	5	10	8	2	1
Psychology	2.6750	3	9	10	12	3	2	1
Business	2.6750	5	5	11	13	1	3	2
Social Work	2.9500	2	6	9	17	4	1	1

Therefore, the mean score for all students was in the upper limits of the "below average" range for Conflict. There was no significant difference between students in the helping professions and business.

The Control subscale assesses the extent to which set rules and procedures are used to run family life, for example: how often one family member makes the decisions, how set the ways of doing things are at home and how much emphasis is on following rules in the family. Through research, it was found that members from distressed families score higher on the Conflict and Control scales when compared to those from normal families (Moos, 1989). Similar to the Conflict scales, "0" to "1" is considerably below average, "2" well below average, "3" below average, "4 to 5" average, "6" above average, "7" well above average, "8 to 9" considerably above average.

Group	Means	"0-1"	"2"	"3"	"4-5"	"6"	"7"	"8-9"
Nurses	4.82	3	4	5	12	6	4	6
Psychology	3.80	7	7	6	8	5	5	2
Business	3.52	8	9	3	13	2	3	2
Social Work	4.22	5	6	2	16	2	5	4

All fall in the "below average" to "average" range. Only the nurses as a separate group showed a significant difference (.013, $p<.05$) on control compared to business.

The L scale of the MMPI was originally constructed to detect a deliberate and rather unsophisticated attempt on the part of subjects to present themselves in a favorable light. The 15 rationally derived L scale items deal with rather minor flaws and weaknesses to which most people are willing to admit. Individuals who falsely try to present themselves in

a favorable way are unwilling to admit even such minor defects and will produce high L scale scores (Graham, 1987).

The average raw score for the MMPI standardization group was 4, however, subsequent research revealed that scores on the L scale are related to educational level, intelligence, socioeconomic status, and psychological sophistication. Better educated, brighter, more sophisticated people from higher social classes score lower on the L scale. The typical L scale raw score for college students, for example is 0 or 1 (Graham, 1987). Since all the subjects were either college students or nursing school students, it was expected that a similar raw score would be found in this sample. The scores in this sample however were higher:

Group	Mean
Nursing	3.80
Psychology	3.42
Social Work	4.55
Business	3.40

Furthermore, high scorers tend to be overly conventional and socially conforming. They are unorganized in their thinking and inflexible in their approaches to problems. In addition, they have poor tolerance for stress and pressure. They are rigid and moralistic and overevaluate their own worth. They utilize repression and denial excessively, and they appear to have little or no insight into their own motivations, (Graham, 1987).

Because of the relationship between L scale scores and demographic variables, such variables must be taken into account when deciding if a score should be considered high. Whereas a raw score of 4 or 5 on the L scale would be about average for a lower middle class laborer of average or below average intelligence, such a score would be considered high for a college-educated person, (Graham, 1987). Characteristics of a person who scores high on the L scale are similar to some of the characteristics associated with codependence. For instance, Schaef (1986) lists fear, rigidity, and judgmentalism as being characteristics of a codependent person.

When early experience with the MMPI indicated that the L scale was quite insensitive to several kinds of test distortion, the K scale was developed as a more subtle and more effective index of attempts by examinees to deny psychopathology and to present themselves in a favorable light or, conversely, to exaggerate psychopathology and to try to appear in a very unfavorable light. High scores on the K scale thus were thought to be associated with a defensive approach to the test, whereas low scores were indicative of unusual frankness and self-criticality (Graham, 1987).

When K scales are lower than expected for socioeconomic status, the possibility of all true responding or a deliberate attempt to present oneself in an unfavorable light should be considered. According to Graham (1987) low scores may

indicate that subjects are exaggerating problems as a plea for help or that they are experiencing confusion that may be either organic or functional in nature.

According to Graham, low scorers tend to be very critical of themselves and of others and to be quite self-dissatisfied. They may be quite ineffective in dealing with problems in their daily lives, and they tend to have little insight into their own motives and behaviors. They are socially conforming and tend to be overly compliant with authority. They are inhibited, retiring, and shallow, and they have a slow personal tempo. They tend to be rather awkward socially and to be blunt and harsh in social interactions. Their outlook toward life is characterized as cynical, skeptical, caustic, and disbelieving, and they tend to be quite suspicious about the motivations of other people.

In interpreting K scale scores, it is essential that a person's socioeconomic status be taken into account. For college students and college-educated people, K scale scores in a T-score range of 55 to 70 should be considered average. Therefore, Graham (1987) states that scores must be greater than 70 to be considered high and less than 55 to be considered low for such people. These are the values that apply to this student sample. The K scale values found in this study however were lower than average:

	Raw Score	T score
Business	X = 8.50	42-44
Psychology	X =10.45	46
Social Work	X =10.55	47
Nursing	X =10.95	47-48

The ANOVA for K scale shows there is a significant difference ($p<.05$) between students in the helping professions and business students, even though all scores fall in the below average range. Here again the descriptors of a person with a low K scale are similar to several codependency characteristics. Friel and Friel (1988) list low self esteem, people-pleasing, and approval-seeking as common characteristics of ACOA's. Hall and Wray (1989) cite perfectionism and denial as common characteristics of codependent nurses which would also correlate with high L scale and low K scale descriptors.

On the Friel Codependency Assessment Inventory (FCDI), the subjects scored in the following manner:

Nurses	X =	29.57
Psychology	X =	31.40
Business	X =	28.57
Social Work	X =	27.37

The author, John Friel (1985) states that scores below 20 indicate few codependent concerns; 21-30 indicate mild/moderate concerns; 31-45 moderate/severe concerns; and over 45 represents severe concerns.

Friel (1985) gives no descriptions to correlate with each measured level of codependency concerns (few, mild, moderate, severe). He states that the following areas of codependent concerns are covered in the FCDI: self-care, self-cricicism, secrets, "stuckness", boundary issues, family of origin, feelings of identification, intimacy, physical health, autonomy, over-responsibility/burn-out, and identity. As a subjects score increases on the FCDI, it seems safe to assume the negative aspects of the above characteristics would be more pronounced.

There was no significant difference between the mean score of the subjects in the three different "helping professions" and business students. All scored in the mild to moderate range of the FCDI except for Psychology students who scored in the lower range of the moderate to severe range and was the only group to score in the range predicted by Research Hypothesis #1.

There are several possible explanations for these findings. One is that people may enter the helping professions and score similarly to people in business related areas, but the longer they remain in the helping professions, the more codependent they become. Further research of a longitudinal nature might provide answers to this question.

Another possible explanation for this finding could be that there is no significant difference in codependent

characteristics between people in helping professions and business people.

Yet a third possible explanation deals with the accuracy of the label "Codependent". Cermak (1986) raises the question of whether codependence is a real "disease". He points out that there is currently no agreed upon set of criteria for assessing codependency. Cermak believes that without such criteria, no standards exist for assessing the presence and depth of pathology, for developing appropriate plans, or for evaluating the effectiveness of therapy. He states that unless we begin gathering reliable and valid research data, codependence will remain "confined to clinical impression and anecdotes".

Lastly, even though the Friel Codependency Inventory was presented under a different title, the contents were unchanged and some of the items are easy to falsify if an individual wanted to fake "good" (or for that matter, "bad") on it. The author, in personal correspondence to this researcher, states it is possible to be truly "codependent" and still have a low score on the test, especially if the client is still in the strong denial stage. It is entirely possible that students just learning a profession they want to enter may have strong denial about their codependency patterns. Denial is also a defense mechanism used frequently by codependents.

Friel (1985) freely admits that his Codependency Inventory is still in the experimental phase of development.

It seems that the characteristics of a person who scores in the low range on the K scale are similar to a person with codependent characteristics. The results from this study would seem to support his position. In addition to this, characteristics of a person who scores high on the L scale are in many ways similar to low scores on the K scale. Therefore these people are also similar to a person with codependent characteristics which would also serve to support Friel's Codependency Assessment Inventory.

None of the five research hypotheses was supported. If it is agreed that the concept of codependency is sound, then the question of empirically and operationally defining "codependence" must be addressed.

Limitations

The literature indicates that denial may be one of the characteristics of codependence. Hall and Wray (1989) report that denial may be evidenced in codependent nurses by: 1) refusing to adknowledge anything painful in their lives; 2) keeping busy to ignore or repress all problems and difficulties, and/or; 3) becoming workaholics or developing other addictions. In addition, Whitfield (1980), cautions that if caregivers (a title which encompasses many helping professionals) are enablers or codependents themselves they may deny, cover up, and perpetuate the disease of alcoholism.

Denial was not one of the variables utilized by this study. Future studies may involve the use of denial in

relation to codependence. For instance, in examining the FES, it was noted that several participants said there was no conflict in their family. This is most likely not realistic: all people have some degree of conflict in their lives. Some measure to assess the degree of denial used by subjects should be devised.

Another limitation of this study was that no in depth biological data as to alcoholism or family dysfunction was obtained. In the future, it would be wise to collect such data to assess the degree of dysfunction and codependence.

Conclusions and Recommendations

Neither the Abasement, Nurturance, nor the Ideal Self Scales of the ACL nor the Conflict and Control scales of the FES showed any significant difference between students in helping professions and business students. These findings may indicate that even though the selection of these tests and scales was based soundly on the literature, their use did not properly support the hypotheses. No progress was made as far as operationally defining codependence with the variables used in this study.

As previously suggested, an area of future research might be a longitudinal study comparing people in helping professions as students at both the beginning and end of their training, then later still when they are actually employed in the field. A follow up study to this research might be to

test the faculty who are teaching the students' major field to determine their rating on the codependence scale.

A further area of research might be to examine the difference (if any) between adult children of alcoholics (ACOA's) who are codependent and people who are codependent but are not ACOA's. As Kritsberg (1985) points out, he believes all ACOA's are codependent, but that not all codependent people are ACOA's. This is due to the fact that many codependents are raised in nonalcoholic dysfunctional family systems or learn codependent behavior when they become involved in unhealthy relationships. Making this distinction between codependent ACOA's and other types of codependents may prove useful. In this study, no biographical data as to alcoholism or family dysfunction was obtained.

The stated concerns of many researchers in the field (Fausel, 1986, Whitfield, 1984, Erickson, 1988) that address issues of codependency in the helping professions were not supported by this study. In the future a study comparing only social work and nursing students on an individual basis might produce more significant results. For instance, nursing students were found to score significantly higher on the control scales of the FES. The inclusion of psychology students in the helping professions may have produced a confounding effect, since there are many areas in psychology that are not "helping" specialties, such as industrial and organizational or experimental psychology. However, it must

be noted that psychology was the only group to score in the moderate to severe range of the FCDI.

APPENDIX A.

CONSENT FORM

CONSENT FORM

This consent form is to request your voluntary participation in a study. Please read the following information. Then, if your are willing to participate, sign the section marked "Informed and Voluntary Consent to Participate".

Purpose of the Study

The purpose of this study is to examine the characteristics of students in nursing, psychology, social work, and business-related fields as measured by several instruments.

Amount of Time Involved for Subjects

Testing time will be approximately 1 1/2 to 2 hours. All subjects will be asked to complete three different assessment tools: 1) The Adjective Checklist (Real and Ideal forms)--300 adjectives and adjectival phrases commonly used to describe a person's attributes. 2) The Moos Family Environment Scale--a 90 item scale, answered in a true/false manner that measures the social environment characteristics of all families. 3) The Behavior Assessment Inventory--a 100 item questionaire in a true/false format.

Impact on Subjects

This study could provide an increase in self-awareness and understanding for the subjects. I do not believe there could in any way be a harmful effect on the subjects.

Assurance of Confidentiality

You will be asked to provide only your age, sex, major, and year of study. In this manner complete anonymity is assured.

Assurance of Voluntary Participation

Participation in this study is strictly voluntary. Subjects are guaranteed the right to decline to participate or to withdraw at any time, and their grades will not in any way be affected by their participation.

Availability of Results

Karen H. Barnett
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I have been informed and agree to participate in the study outlined above. My right to decline to participate or to withdraw in part or in whole at any time has been guaranteed.

Volunteer _____ Date _____

Researcher _____ Date _____

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