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TEENAGE CODEPENDENCY: A SOCIAL WORKER'S

PERSPECTIVE

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A Project

Presented to the

Faculty of

California State University,

San Bernardino

_____

In Partial Fulfillment

of the Requirements for the Degree

Master of Social Work

_____

by

Diane Jean Ausilio

June 2006

TEENAGE CODEPENDENCY, A SOCIAL WORKER'S

PERSPECTIVE

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June 2006

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ABSTRACT

The concept of codependency has been widely
criticized due to a lack of agreement regarding an
operational definition. A review of the literature
reveals a general agreement as to the core
characteristics of codependency but no agreement as to a
workable definition. Feminist writers object to the
model, suggesting that it pathologizes the traditional
roles women have been expected to follow. Also, the term
codependency is firmly entrenched in society today.
Social Work educators suggest the concept of codependency
raises broad social questions and needs to be critically
evaluated. There is a need to go beyond current research
characterizations of codependency to better examine what
social workers' perceptions and treatment outcomes for
codependent youth and clients seems to be. This study,
qualitative in nature, explored the nature of
codependency and social workers' assessment /
intervention approach with those identified as being
codependent children and families. The author interviewed
8 social workers from two Child Protective Service
agencies in Riverside County. Open-ended interview
questions were developed that expanded upon the social

worker's perspective on codependency as well as the agency's related policy or training on codependency. Findings suggest that social workers agree with the feminist view that female clients are not diseased; their feminine traits are not devalued, and, diagnostic labels are avoided. Rather, parentified children are identified, specifically, youth are assessed for age appropriate behaviors.

ACKNOWLEDGMENTS

DEDICATION

This thesis is in loving memory of my mother, Jeanette Elizabeth Bell who taught me to love life and family the most. Her love, devotion, and sweet Christian Spirit continues to impact our family life. A special dedication to my daughter, Melissa, and her Twin brothers, Joey and Tony, for their boundless, bright, energetic, unconditional love. They are my reason for achieving. They have encouraged me and stood by me; they are my greatest critics and staunchest supporters.

And finally, I dedicate this thesis to the rest of my family since they are my life, and since they are my life, they deserve the dedication. See you in Montana!

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CHAPTER ONE

INTRODUCTION

Problem Statement

The concept of codependency has been widely

criticized due to a lack of agreement regarding an

operational definition. A review of the literature

reveals a general agreement as to the core

characteristics of codependency but no agreement as to a

workable definition (Hands & Dear, 1994). Additionally,

research regarding the concept of codependency is

limited. This has resulted in a codependency movement

expanding without the necessary empirical backing,

leading to much confusion and contradiction within the

literature. Originally, much of the conceptualization

around codependency was associated exclusively with

family members of people who had chemical dependencies

(Crothers & Warren, 1996; Dear & Roberts, 2000;

Potter-Efron & Potter-Effron, 1989; Fuller & Warren,

2000; Stafford, 2001).

The codependency movement represents the creation of

the language of "a syndrome that is difficult to treat

because it is so global and vague in definition...it

perpetuates society's tendency to pathologize behavior typically defined as female, as women's work" (Krestan & Bepko, 1990, p. 230). Presently, the codependent movement has the tendency to blame victims, is regressive and antipolitical, and does not take into account the oppression women have experienced (Anderson, 1994).

Depending on the writer, codependency is defined as an over focus and extreme dependency on others (e.g., Beattie, 1987; Hogg & Frank, 1992; Mellody, Miller & Miller, 1989; Whitfield, 1989), a reactionary process (Beattie, 1987), a spiritual void (Whitfield, 1989), or a disease process (Schaef, 1986). The condition is seen to affect particular individuals and stems from the family of origin (Stafford, 2001).

Although no agreement as to a workable definition exists (Hands & Dear, 1994), some of the core characteristics of codependency include seeking approval, a distortion in identity and purpose, care taking, rescuing, and low self-worth. Inherent in the basic message of codependency is a dysfunctional pattern of relating to others (Krestan & Bepko, 1990). The codependent model emphasizes a dysfunctional pattern of relating to others; meanwhile client strengths and

resilience are ignored. As mentioned earlier, without the necessary empirical backing (Hands & Dear, 1994) the codependency literature may perpetuate a misrepresentation and misunderstanding of what clients are experiencing. Along this line of thinking, a lack of empirical data, or questionable validity of existing data about codependency would ultimately contribute to disempowering an identified codependent client.

Regardless, Stafford (2001) suggests it is prudent to remain objective about the construct of codependency. A concern Stafford speaks about is whether it is ethical to encourage an individual to accept that he or she is codependent and to seek treatment for this "disease" or "health" problem. Another important question is, does it make sense to conduct research on treatment interventions for codependent persons before the construct has achieved a universal operational definition? Social workers, practitioners, and mental health workers do no favor to clients by supporting or developing intervention programs for codependency until they carefully explore and understand what problematic behaviors they are treating (Stafford, 2001).

Furthermore, theories regarding codependency target women. Primarily women are buying books and joining recovery groups, all in hopes of recovering from the "addiction" that self help books and self-proclaimed "experts" claim to have the cure for. These observations are based on clients seen in clinical practice and in workshops, and rest upon the intuition of clinicians and workshop leaders (Fischer, Spann, & Crawford, 1991).

The concept of codependency has been widely criticized from a feminist perspective (Asher & Brissett, 1988; Haakan, 1990; Krestan & Bepko, 1990; Van Wormer, 1995). These female researchers' primary concern is that what has been identified as codependency in our culture is simply the experience of many women (Hands & Dear, 1994). The traditional role of women in our society has been care giving, nurturing, and putting the needs of others first. This role, along with the tendency in the codependent literature to classify codependency as an "illness" or "disease," has been the focus of feminists challenge (Haakan, 1990; Asher & Brissett 1988). What feminists object to is that "the language of codependency blames people, women in particular, for assuming a social role that has previously been viewed as normative and

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functional...defining it as sick" (Krestan & Bepko, 1990, p. 220).

Instead, feminists advocate an alternative understanding of women's and children's developmental paths, specifically the feminist model that views relational qualities as strengths and as pathways for healthy growth and development instead of being identified as weaknesses or defects. These criticisms of codependency challenge workers in the helping profession to question their assumptions regarding the construct of codependency (Babcock & McKay, 1995). Social workers, mental health, health care, education professionals and others working in the field, by applying labels to the female experience, legitimize codependency and blame the victims. Rather, focusing on a strengths model depathologizes the female experience and empowers clients to draw on their own strengths and take action in their lives.

In contrast, the label "Codependency" disempowers and accentuates deficiencies, which is in opposition to the NASW philosophy - client dignity and empowerment (Hepworth, Rooney, & Larsen, 2002). Therefore, because of the increased use of the concept of codependency and its

controversial nature, the opportunity and responsibility has been created for professionals to study this concept (Morgan, 1991). The construct of codependency should be approached carefully because of the ambiguous nature of the concept.

Political Context

Presently, there are no clear policies or practices on codependency that are universally agreed upon by clinicians and therapists. However, millions of Americans have been told that they require treatment for the disease of codependence (as cited in Hughes-Hammer, Martsolf, & Zeller, 1998). The current codependent movement as mentioned earlier, fosters the tendency to blame victims, is regressive, and antipolitical, and ignores the experiences of women as members of an oppressed group (Anderson, 1994). Women are defined as relationship addicts and are powerless over their disease. The model does not encourage women to become empowered in their lives in order to make changes. Instead, they involve themselves in the 12-step model where more than likely they will be in recovery forever (Collins, 1993).

Feminist groups opposed to codependency are concerned with the personal and political implications of codependency theory and practice (Babcock & McKay, 1995). The political issue feminists challenge is "the devaluation of self that results from institutional oppression – is reframed as a personal pathology" by those advocating codependency (p. 220). In other words, medicalizing the experience of women is a form of social control that channels political struggles into personal ones.

The feminist struggle in opposing the politics of domination has been weakened by the pathologizing of women (Babcock & McKay, 1995). Feminists suggest that codependency theory and practice divert women's attention, anger, and energy from their oppressive status: the economic, social, and political structures that discriminate against women. In fact, codependency is considered as part of a growing "backlash" against feminism.

Practice Context

Social workers in a variety of practice settings are likely to come into contact with clients identified as codependents. At a macro practice level, the trend has

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been to medicalize codependency by developing a list of criteria for diagnosis, and providing costly treatment for the disease; yet critics of the construct state that it does not have diagnostic discriminative validity (Anderson, 1994). Cermak advocated including codependency in the DSM III – R as a diagnostic category (Stafford, 2001). He justified the inclusion by the fact that "codependency is intended to communicate that a recognizable pattern of traits does exist within most of the members of an alcoholic family" (Hands & Dear, 1994, p. 439). However, it is not universally accepted that such recognizable patterns do exist.

Asher and Brisset (1988) conducted a study on women married to alcoholics; their findings were that the term codependency was ambiguous. Most of the participants could not agree as to what codependency meant – they just knew they had it. These researchers suggest, "professional labeling was seen as a major contributor to this process" (p. 440).

Therefore, it is important that social workers are aware of the diverse codependency definitions, theoretical formulations, and treatment approaches in working with women and children. Considering how

widespread the concept of codependency has been applied in our culture, a lack of an agreed upon diagnosis and treatment outcome in women and children is troublesome.

At a micro practice level social workers cannot form a definitive opinion on codependency founded on a limited database. Therefore, they are left to draw on other sources of knowledge, clinical experience, and self-help meetings to form a basis for whether and how they will use the codependence construct and related self-help groups in working with clients. As a result, inadequate education and training may render social workers ill prepared to effectively work with women and children who are being identified as codependent.

As social workers, the aim is to gently challenge client's negative stories so that they are able to move from despair to action by reducing self-blame and promoting responsibility for change (Hands & Dear, 1994). Left unchallenged, the label "Codependency" stereotypes clients, precluding growth and change.

<div align="center">Purpose of the Study</div>

The purpose of this research project is to explore social workers' definitions of codependency, assessment

of codependency, and types of interventions for codependency, particularly among youth. Learning more about codependent treatment for young clients and families will aid practitioners and mental health workers to focus on appropriate assessment and treatment for teens and families rather than stereotyping and denying them resources and coping strategies (Anderson, 1994). Because there are very few empirical studies on codependency, this study should call attention to what the current codependency movement looks like among families within a clinical setting in Child Welfare Services.

The codependency literature focuses primarily on pathology, a deficit rather than a strength model emphasizing negative family addiction and symptoms. Also, there is very little differentiation between severe pathology and relatively minor problems. Because of the vague boundaries of the construct, the concept is meaningless diagnostically regardless of the trend to medicalize codependency and define it as a disease. Therefore, this study will focus on three of the many issues regarding codependency: social workers' definitions of codependency, assessment for codependency,

and intervention for codependency, particularly among youth.

There is a need to go beyond the ambiguity of codependency, to a clearer definition, which clarifies and comes to terms with what social workers perceive codependency to be. Therefore, the approach we will use in this study is a qualitative descriptive design utilizing semi-structured interviews. The primary means of the qualitative data collection will include semi-structured interviews. The interviews will be tape-recorded to enable subsequent analysis. Data analysis will include content/ interpretive analysis using three linked sub processes: Data Reduction, Data Display, and Conclusion / Verification.

The rationale for selecting a qualitative research method is based on the goal of learning what therapists know, what they think, feel, or prefer and what they have done about codependent behavior. Their attitudes and beliefs will allow us to assess current practices regarding codependency in youth and families in Child Protective Services. This study will help us to understand and challenge the existing problem-focused literature. By failing to clarify the current

codependency dilemma, the social work profession helps to perpetuate myths and misconceptions associated with codependency.

Significance of the Project for Social Work

The helping professions are saturated with psychosocial approaches based on individual, family, and community pathology, deficits, problems, and victimization. Our culture is obsessed with pathology; apparently eighty million Americans are codependent (Saleebey, 1996). In contrast, the strengths perspective proposes a different way of looking at individuals and families. Rather than adopting the disease model of codependency, this study will give insight to practitioners who work with those identified as being codependent children and families, in selecting an effective assessment / intervention approach with that population. This model of practice is based on the idea of resilience, rebound, possibility, and transformation. The information will be valuable in assessing, planning, implementing, and evaluating phases of the generalist intervention model for those clients.

Finally, social work practitioners, educators and the Council on Social Work Education should be concerned with the construct of codependence and not apply it wholesale as an explanation for most behaviors or social problems (Favorini, 1995). "It needs to be more clearly defined in order to operationalize it into appropriate measures accurately reflecting behavior patterns" (p. 829). In our own literature search we did not find this topic addressed in social work journals. The fact that there is a gap in the literature on youth and families is reason for social workers and mental health workers to proceed with caution in providing policy and clinical guidance on codependency. The findings of these interviews will help assess the social workers' definitions of codependency, assessment for codependency, and effective intervention / outcome. Specifically, we are interested in investigating therapists' perceptions and therapeutic effectiveness with codependent youth and families.

Relevancy to Child Welfare Practice

This project is relevant because the research findings are inconsistent, yet the codependent label is

widely applied. Also, a gap exits in the literature on codependent youth and the child welfare agencies' ability to respond effectively to the needs of codependent youth. Agencies that provide services to children, including school social workers, child welfare workers, and child mental health practitioners, should also be concerned with research regarding codependent youth. The lack of data on teenage codependency that may contribute to disempowerment and encourage teenage self-labeling as codependent, demonstrates the need for social workers and clinicians to carefully explore what codependency means to their clients, and labels aside, work to promote the change of problematic behaviors. Therefore, it is important to know to what extent child welfare agencies attempt to meet those needs. Learning more about practitioners' perceptions and treatment outcomes for teenage codependent clients will aid practitioners and mental health workers to focus on appropriate assessment and intervention for youth rather than stereotyping and denying them resources and coping strategies (Anderson, 1994).

CHAPTER TWO

LITERATURE REVIEW

Introduction

Chapter Two consists of a discussion of the relevant literature to this study. This chapter is divided into a section on the history of codependency, a section on the developing definitions of codependency, and a section on theories guiding the conceptualization of codependency.

History of Codependency

Early on, alcoholism was looked upon as being immoral. However, alcoholism began to be seen as diagnosable and treatable, eventually being medicalized for economic and political gains (Krestan & Bepko, 1990). By medicalizing addiction, an alcoholic was no longer regarded as one lacking in self-control but rather as an individual with a disease. This shift to the disease concept resulted in a growing demand for treatment (Krestan & Bepko, 1990). In the same manner, attempts to introduce the concept of codependency in the *DSM-IV* (Tavris, 1990) were designed to medicalize and thereby legitimize codependency as well. It is important to note that the physicians, who endorsed codependency without

substantiated research, added to the popularization of this concept. The concept codependency became "popularized (for mass consumption) and medicalized (for mass treatment)" (Babcock & Mckay, 1995, p. 126).

Definitions of Codependency

What is codependency? There are diverse definitions, theoretical formulations, and treatment approaches, all in the absence of systematic research on codependency. The understanding of the symptoms and dynamics of codependency emerged in the field of chemical dependency as the treatment of the families of alcoholics began. The term most likely evolved from "co-alcoholic" (Morgan, 1991). Despite the fact that a label like codependency has been applied, the true nature and clear definition of the disease has yet to be found. Because the definitions are ambiguous, it seems as though everyone has at least one of the symptoms. The lack of an agreed upon operational definition in the codependency literature hinders the feasibility of codependency as a useful construct; therefore, the concept of codependency has been widely criticized (Prest & Protinsky, 1993).

The following is a brief review of definitions, which show different levels of meaning being derived from competing theoretical frameworks according to Cermak (as cited in Morgan, 1991). Several researchers seem to agree that codependency is a disease that is characterized by an over focus and extreme dependency on others, which is said to be the result of low personal worth and being out of touch with inner feelings (e.g., Beattie, 1987; Hoff & Frank, 1992; Mellody, Miller, & Miller, 1989; Whitfield, 1989).

Schaef (1986) emphasizes codependency as being a disease process, which she refers to as the "addictive process." For example, a food or chemical becomes a process addiction because the use of the substance follows a progressive, identifiable pattern with a likely outcome not unlike a medical disease such as diabetes. Schaef goes on to say that the function of an addiction is to keep us out of touch with reality and that the process is unhealthy, abnormal and systemic in society.

Beattie (1987) makes the claim that codependents have an obsession to control and calls it a reactionary process, meaning that codependent individuals react to the problems, pain, lives, and behaviors of themselves

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and others and that they need to learn how not to react but instead act in healthier ways (Beattie, 1987). Friel and Friel refer to codependency as an overreaction to external events while ignoring inner feelings, and they suggest codependency originates in the family of origin (as cited in Stafford, 2001). In other words, codependency is a developmental process and the symptoms such as inappropriate guilt are learned within the family unit.

When describing codependency, Cermak refers to enmeshed relationships, over-responsibility and the inability to acknowledge one's own needs (Stafford, 2001). He proposed adding the construct of codependency to the *Diagnostic and Statistical Manual of Mental Disorders III* of the American Psychiatric Association suggesting the definition of codependency is a mixed personality disorder. This is interesting in that personality disorders are generally known to be recognizable by age 16 and highly resistant to change; the literature however, has demonstrated that adult children of alcoholics (codependents) improve quite rapidly in therapy (Anderson, 1994). Johnson expanded Cermak's view by adding denial to the construct of

codependency, meaning that denying feelings is a learned behavior that is characteristic of codependency (as cited in Stafford, 2001). In addition, Larsen suggested codependency is a result of "self-defeating" learned behaviors that make it difficult to share in intimate relationships; therefore codependents lack the necessary skills for building and maintaining healthy relationships (Morgan, 1991).

Other researchers use a family systems approach to explain codependency (e.g., Prest & Protinsky, 1993; Subby, as cited in Morgan, 1991). They theorize that codependency originates in the family emotional system; that is patterns of compulsive or addictive behavior, lack of awareness of one's inner feelings and a lack of individuation are passed along in family relationships. In addition to this, Subby combines ego psychology with family systems to define codependency as a result of oppressive rules and a lack of expressed feelings (Morgan, 1991).

However, the definition of codependency is controversial. Asher and Brisset (1988) challenge the concept of codependency calling it a "ploy to pathologize women," and they state that therapists, by applying the

label to clients, legitimize codependency and blame the victims. Similarly, Horney suggests women are socialized to nurture, yet criticized for "being overly involved emotionally" with family members (as cited in Stafford, 2001). These diverse definitions contribute to the confusion about the meaning of codependency and demonstrate the need for empirical rather than descriptive data on codependency.

Theories Guiding Conceptualization

Feminist Perspective on Codependency

According to Krestan and Bepko (1990), women are ascribed more pathology in this culture than men, which accounts for codependent treatment programs being filled more often than not with women. In the past, a woman's role was to attend to the needs of the family, to focus on relationships, and to put the needs of others first. She would lose herself in over responsibility, which was traditionally accepted in family life; however, this has come to be called a sickness or codependency in contemporary society. Krestan and Bepko speak about codependency evolving into a "mythology" that suggests women are diseased social bearers of pathology (1990).

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Feminists prefer to view codependency as a complementary imbalance in a relationship. In other words, if one person is doing too much for the other, that person becomes over responsible and continues in that role, and hence the other person is under-responsible. Our culture socializes women to be overly responsible emotionally as well as in caring for the family. Meanwhile, they are looked upon as being dependent upon men and shamed for nurturing their families. Feminists reject blaming the "over responsible" partner; rather they promote mutual responsibility and an understanding that both partners can achieve healthy interdependence (Krestan & Bepko, 1990). Over responsibility has achieved the label codependency. Krestan and Bepko suggest it is far more effective to talk about over or under responsibility and a need for change in behavior, rather than blaming a partner that needs to recover from her disease of codependency (1990).

Because of the characteristics we attribute to codependency, the label places blame on people, women in particular (Krestan & Bepko, 1990). Pathologizing feminine characteristics in turn allows for a shifting of blame. Feminists view this line of thinking as "a shift

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from describing the problem to ascribing pathology"
(Krestan & Bepko, 1990, p. 218). Krestan and Bepko
suggest that pathologizing the spouse and children as
sick takes responsibility away from the male alcoholic
(1990). To look at the wife as being stronger and
healthier threatens the balance of power in traditional
families and changes the status quo. The codependent
label pathologizes and oppresses women and overlooks male
accountability (1990). Feminists object to a model that
pathologizes women, rather they support an alternative
interpretation of the behavior used to support the theory
of codependency (Babcock & McKay, 1995).

Continuing this line of research, Cowan et al.
(1995) examined the relationship between codependency and
loss of self with measures of power. They criticized the
current literature on codependency for neglecting the
issue of power and suggest that it "reinforces
victim-blame and a disregard of context" (1995, p. 232).
The results of their study showed that the data was
consistent with the feminist view that codependency and
loss of self are associated with power although not
unique to women. Kasl (1989) points out that for any
dominant group to maintain its position, it must control

the subordinate group by diminishing its power. Miller (1989) explains how males are defined as dominants and females as subordinates. Subordinates are encouraged to develop characteristics that please dominants: submissiveness, passivity, dependency, and inability to act, decide or think. Researchers agree that a dominant group determines a culture's philosophy, morality, social theory, and even its science therefore, legitimizing the existence of inequality in society (e.g., Jack & Dill, 1992; Kasl, 1989; Miller, 1989).

Kasl (1989) compares codependency to inequality, suggesting that perhaps codependency reflects inequality in a relationship as opposed to a personality disorder. A relationship lacking in reciprocity displays conditions of inequality and subordination. Conversely, when reciprocity exists in the relationship, the relationship can be observed as having equal power (Cowan, Bommersbach, & Curtis, 1995). Furthermore, it has been shown that inequality in a relationship plays a role in judgments of codependent persons. Loring and Cowan (1997) speak about the relationship as having pathology within it, in other words, having inequality and subordination as much as the individual. Rather than recognizing

inequality in a frustrating nonreciprocal relationship, an individual may find it easier to label oneself codependent.

Feminist Criticism of Family Systems Theory

The framework of codependency had its theoretical origin in the school of family systems theory, according to Babcock and McKay (1995). Several researchers suggest that family systems theory is the context, which is in agreement with the current theories about the nature of codependency. Examples of relevant concepts include emotional system, individuation, and fusion (e.g., Prest & Protinsky, 1993; Tavris, 1990; Whitfield, 1989). Family systems theory regards each family member as reciprocating and influencing the other. Family theorists target the family unit as being the source of all problems and place responsibility and blame for any problem equally among family members (1995). The family is viewed as a set of interrelated parts; a change in one part of the system affects the rest of the system. Therefore, the goal is a balance of individuality and togetherness in the entire family system (Prest & Protinsky, 1993).

Based on family systems theory, codependency emerges from dysfunctional relationship patterns that are primarily rooted in the family emotional system. An example of these patterns include: lack of awareness of ones' own feelings, difficulty establishing levels of intimacy or distance, and diminished sense of personal identity (Prest & Protinsky, 1993). When a member of a family becomes addicted, the spouse becomes the rescuer, problem solver, or martyr (Tavris, 1990). Family systems theory underscores the need for responsibility by both partners in changing patterns they have developed. Lerner, a family systems therapist (as cited in Tavris, 1990) suggests that it is normal to want to help a family member or friend in need although it becomes problematic when a woman becomes entangled in relationships and loses focus on herself. These individuals are not seen as having a clear sense of self and operate from a more emotionally reactive basis (Prest & Protinsky, 1993).

Although family systems theory has enriched mental health and family treatment considerably, feminist criticism of this approach is similar to that of codependency. Specifically, power is a major issue. Feminists suggest that system theorists overlook the

different social bases of power within the family (e.g.,
Haaken, 1990; Babcock & McKay, 1995). As has been noted,
feminists also argue that the label codependency
reinforces male race and class privilege and maintains
oppressive power relations (Babcock & McKay, 1995).

Secondly, feminists are claiming that family system
therapists reinforce traditional male-female gender roles
that depreciate qualities like dependency, nurturing and
emotional expressiveness (Babcock & McKay, 1995).
Furthermore, they argued that family therapy showed bias
in favor of masculine values such as autonomy,
independence and control, while devaluing nurturing more
associated with females (Goldenberg & Goldenberg, 2000).
Following along these lines, feminists speak about
codependency labeling gender roles women have been
encouraged and trained to follow as pathological (Krestan
& Bepko, 1990).

Third, the feminist family systems view in the
1980's was concerned about inequality. Typical Family
Therapy may benefit the family, however, not necessarily
the female members. Rather, society's sexism was
perpetuated by therapists who endorsed cultural
expectations such as remaining in a marriage was best for

a woman, a husband's career was more important, childrearing was a mother's responsibility, and that the husband has greater needs than her own (Goldenberg & Goldenberg, 2000).

Likewise, feminists suggest codependency is a symptom of inequality in a relationship (Kasl, 1989). As mentioned earlier, Miller (1989) suggests that males are defined as dominants and females as subordinates. Subordinates are encouraged to develop characteristics that please dominants: submissiveness, passivity, dependency and inability to act, decide or think.

Finally, feminists emphasize the importance of working towards the equalization of responsibility within the family and to replace an over focus by others in women with a healthy focus on self (Krestan & Bepko, 1989). The feminist criticism of codependency calls for an expanded view of systematic research that is responsive to people's experiences and that works toward eliminating the pathologization the female experience.

Feminist Approach to Family Systems Theory

There is no single theoretical framework entitled Feminist Family Therapy according to Babcock and McKay (1995). Rather, therapists who regard themselves as

feminists may practice from a variety of approaches with families. The feminist approach to Family Systems Therapy in the late 1980's attempted to correct gender bias by challenging the social, cultural, historic, economic and political conditions that shaped not only development and experiences of women but also their relationships with men.

Today, the feminist approach to family therapy is a perspective on gender relations. Feminists address gender and power imbalances in their clients' lives. As a result, gender role changes in recent decades have had a powerful impact on family functioning. In order to understand how an individual or a family functions it is important not only to examine gender, but also cultural and ethnic factors, which are regarded as influencing attitudes and behavior (Goldenberg & Goldenberg, 2000).

Much of what is identified as codependent behavior is also seen to overlap with cultural expectations of women that have traditionally been both valued and encouraged; however, enormous changes in family form and structure have taken place in the last two decades, making these traditional cultural expectations archaic.

Social Workers' Critique of the
Concept of Codependency

Sandra Anderson PhD, ACSW, LCSW, professor at the

Graduate School of Social Work, Portland State University

(1994) critiqued the concept of codependency and

suggested it raises broad social questions and needs to

be critically evaluated. In discussing the validity of

the diagnosis of codependency, the author points out that

the concept does not have diagnostic discriminative

validity. Another problem Anderson (1994) addresses is

the codependent movement and self-help literature

pathologizing the female experience. In other words

traditional roles that women have been trained and

expected to follow are seen as pathology. As others have

noted, Anderson concludes that focusing on the needs of

the family, nurturing/care taking qualities are described

as being over-involved; not taking care of herself,

having poor boundaries, and putting the needs of others

before herself are viewed as codependency.

In contrast, a distinctly different approach, the

empowerment model (Anderson, 1994) communicates to female

clients that they are not diseased; their feminine traits

are not devalued; and, diagnostic labels are avoided. The

emphasis is on client's inner strength and spiritual power. The client is helped to understand the impact of cultural factors and gender socialization on her life and problems. Collins (1993) suggests social workers direct interventions toward the individual in context rather than foster a model that suggests females must label themselves as sick or diseased to challenge the context that disempowers them. This advice is in line with social work's emphasis on client dignity and empowerment.

The codependent model is not a model that social workers should adopt argues Collins (1993). The author states that there is virtually no empirical support for the codependency construct. Additionally, it is not useful to label relationship behavior as a disease, nor is it useful to encourage individuals to develop emotionally and behaviorally only by following a 12-step program, proclaiming they are powerless over their disease. Finally, social workers should challenge the codependency model because it advocates a disease process, which avoids naming and discussing injustices of the relational contexts of which they are a part.

Summary

There is a lack of agreement of a clear definition of codependency and yet researchers have labeled it a "disease" characterized by an over focus and extreme dependency on others (Beattie, 1987; Hoff & Frank, 1992; Mellody, Miller, & Miller, 1989; Whitfield, 1989); an "addictive process" (Schaef, 1986); a "personality disorder" (Stafford, 2001); or a "reactionary process" (Beattie, 1987).

Early on codependency was looked upon as a disease model, which parallels the shift of alcoholism to the disease concept. This shift to the disease concept resulted in a growing demand for treatment (Krestan & Bepko, 1990). Feminists object to medicalizing and legitimizing the construct of codependency because the label places blame on people, women in particular.. Feminists suggest the "disease" concept of codependency pathologizes and oppresses women; rather they address gender and power imbalances in their clients' lives as opposed to a personality disorder (Kasl, 1989). Finally, social workers agree with the feminist view that female clients are not diseased; their feminine traits are not devalued, and, diagnostic labels are avoided (Anderson,

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1994). The emphasis is on clients' inner strength and power; interventions are directed toward the individual in context rather than foster a model that suggests females must label themselves as sick or diseased to challenge the context that disempowers them (Collins, 1993).

As demonstrated, the literature related to the present study is evidence that codependency is not a valid diagnosis, but rather a description of highly diverse symptoms which further fails to provide examples of identified codependent assessments and interventions.

Rather than adopting the disease model of Codependency, the Strengths Perspective proposes a different way of looking at individuals and families. This model of practice is based on the idea of resilience, rebound, possibility, and transformation.

CHAPTER THREE

METHODS

Introduction

This section will present the methods used in
conducting this study. Attention will be given to the
study's design: sampling, the interview instrument, data
collection, procedures, and protection of human subjects
during the course of the study. This chapter will
conclude with an overview of issues pertaining to
qualitative data analysis.

Study Design

This study used a qualitative design utilizing
in-depth interviews with social workers. The interview is
a dialogue between the social worker and interviewer. The
interviewer as an introspective individual must maintain
a balance between planning the interview while remaining
open to innovative inquiry in the process of the study.

There are methodological limitations: the limited
number of social workers interviewed calls into question
the generalizability of the data. Also, there is concern
that the researcher maintains the focus of the interview
without influencing the social workers' interaction.

Sampling

The sample for this study of 8 social workers from two Child Protective Service agencies identified as qualified and suitable participants, specifically, those social workers that more than likely interact with families and youth identified as codependents. For the purposes of selecting study participants, purposive convenience sampling was employed.

The procedure used to recruit participants was by contacting agency supervisors from two Child Protective Agencies in Riverside County. Supervisor's were asked to identify 10 social workers deemed suitable and willing to be interviewed. Eighteen participants were contacted by an introductory letter, requesting their participation in the study. They were given assurances that participation in the study was confidential. A detachable reply slip was included with instructions for participants to return it in a pre-paid envelope. In order to qualify for our study, social workers must be master-level social workers that have some experience with codependency. Participants received a Starbucks gift certificate as compensation for their time.

Data Collection and Instruments

Specifically, this study collected data by way of interviews with social workers from two locations of Child Protective Agencies. All participants received an informed consent, audio recording permission sheet, and a debriefing statement.

The qualitative data collection technique was used with the social worker participants. The primary means of qualitative data collection was semi-structured interviews. The guided interview consisted of a set of general questions that generated further interesting areas of inquiry during the interview. The questions were asked in an open-ended fashion in order to solicit a comprehensive response from the participants. The format for the questions was constructed in a manner to encourage participants to examine past experiences before answering. The questions were presented in a logical order to reveal the most accurate of responses from those interviewed. For example, the instrument began with asking the social worker's perspective on codependency as well as the agency's related policy or training on codependency. The interviews were tape-recorded to facilitate subsequent detailed analysis of responses

(Hilfinger, Fore, Mcloughlin, & Medina, 2005). (Please see Appendix A, for a list of questions to appear on the interview schedule).

Procedures

Eight participants were interviewed for the purposes of this study. The procedure used to recruit participants was contacting agency supervisors from 2 Child Protective Agencies in Riverside County. They were asked to identify 10 social workers deemed suitable and willing to be interviewed. Eighteen participants were contacted by an introductory letter, requesting their participation in the study. They were given assurances that participation in the study was confidential. A detachable reply slip was included with instructions for potential participants to return it in a pre-paid envelope. Eight participants were interviewed at their agency of employment, and other satisfactory locations agreeable to study participants. Following the signing of a consent form and audio permission form, the interviews lasted approximately thirty to forty-five minutes consisting of approximately eleven questions. Interviews with participants occurred over a four-week period approximately twice a week

beginning in March 2006. Upon completion of the interview, participants were given a debriefing statement. At that time participants were able to ask questions and/or discuss any concerns about their participation or the study. All participants were provided with the telephone number of Dr. Smith in the event they wish further information concerning the study, including results. Data analysis and synthesis of the material took place in April 2006.

Protection of Human Subjects

Participants were asked not to disclose their names on tape at any time during the interviews. Pseudonyms were created for them to use during the interviews, thereby no association can be made as to the interviewee's identity and the data recorded from that interview. The interviewer was instructed on ethical conduct in human subject research and subject confidentiality. Interview guides, tapes, and data were stored in a manner so as not to become accessible to others not involved in conducting the study. Upon completion of the study, all interview guides, tapes, and data were destroyed. The project was approved by the

Institutional Review Board, California State University,
San Bernardino.

Data Analysis

This study was a qualitative descriptive study
utilizing a semi structured interview approach (Hilfinger
et al., 2005). Data analysis included content
interpretive analysis, a result of three linked sub
processes: Data Reduction, Data Display, and Conclusion /
Verification. The process of Data Reduction consisted of
reducing the data into a conceptual framework. Notes,
interviews, and tapes were transcribed and a coding
method was designed for further clustering of data into
specific themes for additional data selection and
condensation including ranking, frequency, and
percentages. This involved sorting through the data,
indexing, and describing data strips, and developing
codes via the method of constant comparison (Hilfinger et
al., 2005). Each data strip was examined for differences
and similarities. Data Display consisted of organizing
and compressing information, which allowed conclusion
drawing. Finally, the Conclusion Drawing / Verification
process facilitated synthesis of the data into a form

more easily read for the purposes of this study. The researcher took every precaution to avoid allowing her biases to interfere with the interaction with the participants as well as analysis of the data. Additionally, a journal was kept in which the researcher entered information about schedules, logistics, insights, and reasons for methodological decisions.

Summary

This chapter offered an overview of the methods utilized in conducting this study. The relevant topics discussed were study design, sampling, data collection procedures, and interview guide. Issues regarding protection of human rights were reviewed; specifically, confidentiality and anonymity were protected. Participants were informed and debriefed. Qualitative procedures discussed were followed by qualitative analysis employed for the purposes of this study.

CHAPTER FOUR

RESULTS

Introduction

The data obtained in this chapter was gathered
during face-to-face interviews with Child Welfare
Professionals. Eight professional were interviewed, seven
within Child Protective Services, and one within a
residential treatment facility. Interviews lasted from
thirty to sixty minutes. The results were analyzed, and a
coding method was designed to obtain recurring themes.
During the interview process the participants were asked
about and commented on their attitudes and beliefs toward
codependency as well as the treatment approach to
codependent youth and families. Upon examination of the
information, themes began to emerge from the narrative
data.

Presentation of the Findings

Qualitative analysis was used to examine the
thematic patterns that emerged from the narrative data.
Categories were developed and further refined through the
process of category linking. Thus, groupings were made
and re-examined and adjustments made until the

similarities within the groups of data and the differences between the groups of data achieved a satisfactory level of clarity. The ultimate stage of the process featured the clustering of data into key concepts and themes, which allowed conclusion drawing. The themes generated from the conclusion drawing process were as follows:

Question one asked the participants to share how they define the term codependency. Half of the participants defined codependency as a loss of self. For example, one participant defined codependency as "people getting lost in other peoples' agendas and finding it hard to find the center of their life from which to operate from." Three of the eight participants felt codependency meant enabling the other person. One participant commented, "If you're talking about someone that is codependent with a substance abuser, the codependent person is the person that is part of that disease because they are enabling the person to continue their use and perhaps have as much denial as the person that is using." One participant responded with "they are very enmeshed."

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A major theme emerging from the data was worker concern about the label "codependency" was beyond agreement on a definition, rather the fairness or dignity of the label.

Following are a few examples of the reasons given that were extracted from the narratives. The numeric number used corresponds to the numeric number assigned to the participant at the time of the interview.

#8 "I don't like to use the word because it is so over used and it really labels people…I think they do a disservice to human beings…codependency seems to be such a catchall and what does it really mean?" "It feels like you're weakening them if you call someone codependent; I want people to see you as you, and that you're different and all the things that make you what you are." #3 "I spend a lot more time describing it and talking around it rather than defining it...I would describe it as people getting lost in other peoples' agendas." #8 "The person to me that is codependent has no self and they lose it in the other person." #2 "I think women sometimes, rather than be in a healthy relationship, they don't get into any kind of relationship that's healthy because they're so afraid of being labeled as codependent rather than

just a women who understands what her needs and strengths are."

The second question asked about the age and gender of their codependent clients in the last six months. Half of the participants reported codependency "crosses all ages and gender." One participant stated, "On a whole, the're all codependent"; a similar response was, "Here, at the center, each and every one of them would fit the category of codependent." Another participant reported the age and gender of their codependent clients as female, 25-30 years-old. The eighth participant emphasized, "I have a hard time with the terminology with teenagers... I don't see how a kid could be codependent."

Questions three and four asked participants how they assessed for codependency in youth and families. One half of the participants reported the assessment was similar. Primarily the family dynamics were assessed and roles identified; specifically, care taking and responsibilities were examined.

A major theme emerged during this process; over half of the participants indicated they would assess for age appropriate behavior to identify "parentified youth."

Following are a few examples of the reasons given that were extracted from the narratives. The numeric number used corresponds to the numeric number assigned to the participant at the time of the interview.

#1 I would try to find out from the child…what do you do around the house, who takes care of the children?" #2 "Who does things within the family system? Who cooks, cleans, takes care of the younger brother or sister, dad or mom? A lot of kids get parentified if they are in a chemically dependent family, so they may become codependent without realizing it because of the way the family system works." #3 "A great deal of the teenagers coming into the family program would fit the category of what I would call parentified...they have learned to take care of their parent...or siblings when mom and dad aren't there...they became an adult without being able to do their childhood. A lot of them fit that description of codependency in which they come to understand that their meaning and purpose in life is supply the needs of the adults who are supposed to be supplying the needs for them." #5 "They become parentified to their siblings. I've known little five year olds that know how to cook pancakes...does all the housework and laundry...it's

looking at behaviors on what they're doing. What is

normal typical five-year-old behavior in a household?

What are the responsibilities of that child?" #6 "These

children take care of their siblings, they're cooking the

meals, they're cleaning the house, they're doing things

like that so that their parents don't have to be

responsible any more." #8 "I don't like terminology like

that when I'm working with clients...so for teenagers, I

can't really say, I don't understand the term, I don't

see it that way...codependency seems to be such a

catchall and what does it really mean? It's a modern

slang kind of a deal."

Responses to the fifth question, "What interventions

do you use to treat codependent youth?" revolved around

role changes particularly in parentified youth. "I would

attempt to get them involved in youth type activities and

remove them from the role of being a caretaker." Five of

the eight participants reported a primary intervention is

to help youth explore their feelings, thoughts, behavior,

and reconnect with self. Two participants reported they

refer youth to Alateen. "They can start identifying with

other kids that have experienced the same things...I

would send them to Betty Ford Center Children's Program,

so that they can start identifying that they are not alone." The final response was, "I wouldn't call them codependent, I'd call them a kid in a situation."

Participants were asked in question six, "What interventions do you use to treat codependent families?" Half of the respondents use a family systems approach to assess the family dynamics and identify roles. Intergenerational patterns are examined. "I do a genogram with the family to see how they got to be where they're at and why this family works this way." "Once people become aware of what the dysfunction is, then they can start making changes. Basically, just making each individual member of the system aware that they have choices and what their choices are." Additionally, half of the participants illustrated this by the following statements: "There has to be a willingness to change." "I don't know if you can really change anything if people aren't willing because they have to do the actual footwork." One participant reported "I'm real big on education because I don't treat from a codependent standpoint."

Findings regarding referring a teen/parent to a codependency group did yield a third theme. Six of the

eight participants reported they never refer a teen to a codependency group. Two participants reported they refer "parentified children" to counseling. Additionally, two participants indicated the Desert Region is lacking in available teen programs.

Following are a few examples of the reasons given that were extracted from the narratives. The numeric number used corresponds to the number assigned to the participant at the time of the interview.

#1 "No" #2 "Sadly, there are not a lot of codependency groups. So, a lot of people get codependency and Alanon mixed up and they are totally different entities." #3 "If we have enough teens we'll put them all in one group for them to identify with each other, validate each other's feelings and come to begin to experience their own resources for each in a healthy way and build on their own mutual understanding and being a teenager." #6 "Zero" #7 "No" #8 "No, absolutely no...I don't believe I would do that because I think that is codependent."

Regarding the question about referring parents to codependency groups, four out of the eight participants had nothing to report or did not believe in codependency

groups. Only one of the participants reported they refer a parent to a codependency group. His comments were, "There are not a lot of codependency groups, so a lot of people get codependency and Alanon mixed up and they are totally different entities." The sixth participant reported, "I referred one woman to Alanon and she refused to go; she said, been there, done that." Another participant stated, "I'd rather all females, Hispanics, and 25-35 year-olds attend codependency groups." The eighth participant stated, "Everyone here is here for that very reason and we refer them on to professional and self-help codependency groups."

When asked to describe their agency's policy or training related to codependency in question nine, a fourth theme was generated from the responses. Seven out of the eight participants reported no policy or training related to codependency. One participant stated, "This agency relies on hiring people with their own professional experiences with codependency." One participant felt "the County lacks understanding of the relationship between family systems and codependency."

Following are a few examples of the reasons given that were extracted from the narratives. The numeric

number used corresponds to the number assigned to the participant at the time of the interview.

#1 "As far as training, unfortunately, I don't really think there is very much…as far as policies, I don't know of any policy at all. As far as I know, it doesn't exist, that doesn't mean it doesn't, but I've never seen it. I've never run across it." #2 "They have no policy, they have no training. The County doesn't understand codependency. There isn't a lot of training. There is some training on chemical dependency at induction, but there is not a whole lot of understanding abut family systems and the way that codependency relates to a lot about what we do other than maybe children being parentified children, but that's only because they're usually coming from chemically dependent families." #3 "This center sort of relies on its' employees and hiring good people, especially in the family program…people with their own professional experiences with codependency." #4 "It is not talked about directly...codependency is kind of like that hush-hush, we don't talk about it anymore." #5 "Most people that work for the agency have a certain level of codependent behavior. Most of them come to the job, not because of

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the money, but because of their past experiences. So, codependence can run pretty rampant in here, especially with counter transference because we can see ourselves in our clients."

Question ten asked participants to express their opinion about the effectiveness of interventions for codependent teens and families. As mentioned earlier, half of the participants had nothing to report on effective interventions for codependency. Two participants reported that codependency was not a focus of treatment; two participants simply said they "didn't know." However, three of the participants felt that interventions for codependency do work. Two participants indicated, "Effective interventions are directly related to the willingness of the client to change…when they see the benefits of change they are ripe…professionals honor that."

Findings regarding the final question, "What concerns do you have regarding the assessment/treatment of codependency?" revealed five of the eight participants were concerned about the label "codependency" because of its diverse definitions. The concerns ranged from, "Not enough information," "The same language in the literature

repeated over 40 years...loses its meaning." "Is it healthy or unhealthy?" and "Women are limited in their choices...they are expected to follow traditional female roles, instead are labeled codependent." One of the participants expressed concerns, "not so much with the assessment of it, but in the treatment of it...unfortunately, our treatment here-our referrals are short range...so the most we have is a year and it's difficult to have any follow through afterwards."

The final themes emerging as significant findings in the transcribed data are: 1) worker concern about the term "codependency" was beyond agreement on a definition, rather the fairness or dignity of the label; 2) effective assessment for young clients involves identifying "parentified youth," family roles, encouraging role change; and the willingness to change; 3) teens are not referred out to codependency groups; and finally, 4) their agencies have no clear policies or training on codependency.

Summary

Four core themes emerged from the transcribed data. These themes addressed the following areas. First, worker

concern about the label "codependency"; secondly, effective assessment for young clients involves identifying "parentified youth," family roles, encouraging role change; and the willingness to change. Third, teens in general are not referred to codependency groups; and fourth, considerable unanimity was found regarding the lack of policy or training on codependency.

CHAPTER FIVE

DISCUSSION

Introduction

Chapter five includes a discussion of the major

findings of the study as they relate to the four core

themes that emerged from the narrative data. A comparison

of these major findings to the current literature are

presented. Also, the limitations of the study are

identified. Recommendations for the field of social work,

policy, and research as well as a synthesis of the study

and avenues for future research are discussed.

Discussion

As mentioned earlier, the purpose of this study was

to explore social workers' definitions of codependency,

assessment of codependency, and types of interventions

for codependency, particularly among youth. The study

also examined social workers' attitudes and beliefs

toward codependency as well as the treatment approach to

codependent youth and families.

Major themes generated from the results of the study

include: 1) worker concern about the term codependency

that goes beyond agreement on a definition, rather the

fairness or dignity of the label; 2) effective assessment

for youth involves identifying "parentified youth"

including family roles, role change, and a willingness to

change; 3) the majority of participants report they do

not refer teenagers to codependency groups; 4) and

finally, there is considerable unanimity regarding the

lack of policy or training on codependency in their

agencies. The discussion below under Comparison of

Findings to Literature - Theme I, Theme II, Theme III,

and Theme IV provide more detail as to the specifics of

these findings.

Comparison of Findings to Literature

Theme I: Definition of Codependency

The findings clearly indicated worker concern about

the label "codependency" was beyond agreement on a

definition, rather the fairness or dignity of the label.

This was in keeping with the literature. Support was

evident for the applicability of Anderson's (1994)

critique of the concept of codependency. Traditional

roles that women have been trained and expected to follow

are seen as pathology such as care giving, nurturing, and

putting the needs of others first. It is clear that the

devaluation of women's roles is unfair and certainly in contrast to social work and its' strength-based approach of empowerment.

Similarly, the concept of codependency has been widely criticized from a feminist perspective (Asher & Brissett, 1988; Haakan, 1990; Krestan & Bepko, 1990; and Van Wormer, 1995). These female researchers' primary concern is that what has been identified as codependency in our culture is simply the experience of many women (Hands & Dear, 1994). What feminist object to is that the language of codependency blames people, women in particular, for assuming a social role that has previously been viewed as normative and functional (Krestan & Bepko, 1990). This echoes other researchers' opinions about the label "codependency" disempowering and accentuating deficiencies, which is in opposition to the NASW philosophy – client dignity and empowerment (Hepworth, Rooney, & Larsen, 2000).

All of the participants interviewed expressed their concerns regarding the true nature or stigma associated with the construct of codependency. Overall, participants were divided as to what codependency meant and could not form a definitive opinion on codependency. Instead, they

report drawing from other sources of knowledge, clinical experience, and self-help meetings to form a basis of how they use the codependency construct and related self-help groups in working with clients.

Theme II: Assessment of Codependency

Over half of the participants indicated they would assess for parentified youth. That is, youth are assessed for age appropriate behaviors. Specifically, care taking and responsibilities were examined. They also indicated they examine family roles and encourage role-change; however, effective treatment includes a willingness to change.

Families receiving services in child welfare agencies have a wide range of problems often times focused on a child's behavior or school performance. Researchers suggest a child's symptoms may become a means to get help for the entire family (Chase, Deming, & Wells, 1998). This echoes the opinions of social workers who indicated rather than relying on a deficit model that pathologizes clients, they examine the family system and the possibility of parentification in the family system. From this perspective, interventions addressing family role reversals are necessary. Specifically, parents must

be helped in taking responsibility and establishing authority for care giving and structuring the child. Additionally, parents are encouraged to get appropriate adult support and learn clear adult-child boundaries to protect their children from excessively worrying about or caring for the parent.

This approach supports the child welfare model of assessing problem areas, identifying strengths, and expecting resiliency. This is consistent with the empowerment model, which communicates to female clients that they are not diseased; their feminine traits are not devalued; and, diagnostic labels are avoided (Anderson, 1994). Rather, the emphasis is on client's inner strength and spiritual power. The client is helped to understand the impact of cultural factors and gender socialization on her life and problems.

As mentioned earlier, Collins (1993) suggests social workers direct interventions toward the individual in context rather than foster a model that suggests females must label themselves as sick or diseased to challenge the context that disempowers them. This advice is in line with social work's emphasis on client dignity and empowerment.

Theme III: Treatment for Codependency

A major portion of the participants reported they never refer a teen to a codependency group. Several participants commented about the lack of resources for teens in the Desert Region. Other participants pointed out the obstacles in service delivery such as program age limits, particularly 16-18 year-olds.

Even though the National Mental Health Association (retrieved August, 2005) asserts that codependency affects a spouse, parent, sibling, friend, co-worker, or any member from any dysfunctional family, in my literature search I could not find the topic of codependent youth addressed. According to NMHA (2005) codependency is usually rooted in a person's childhood, therefore, treatment involves exploration into early childhood issues and their relationship to current destructive patterns. A lot of change and growth is necessary for the codependent and his or her family (2005). Regardless, youth programs are missing from the literature (Messias, Fore, McLoughin, & Parra-Medina, (2005). Also, a gap exists in the literature on codependent youth and the child welfare agencies' ability

to respond effectively to the needs of identified codependent youth.

The lack of data on teenage codependency supports the claim that social workers should focus on appropriate assessment and intervention for youth rather than stereotyping and denying them resources and coping strategies (Anderson, 1994).

Theme IV: Policies and Training on Codependency

With regards to Theme IV – Can you describe your agencies policies or training related to codependency, again, the majority of participants reported the absence of policy or training related to codependency in their agencies. In fact, participants perceived the County lacks understanding the relationship between family systems and codependency. This may be, according to the health care administration literature (Cleary, 1994), because of accountability, government agencies are vigilant about health care funds. After reviewing the evidence Cleary (1994) concluded that the recognition of an unvalidated construct and endorsement of its treatment are unjustified at this time. Likewise, Stafford (2001) raised concern about whether it is ethical to encourage an individual to accept that he or she is codependent and

to seek treatment for this "disease" or "health problem."

For these reasons it does not make sense to conduct

research on treatment interventions for codependent

persons before the construct has achieved a universal

operational definition (2001).

It follows that social workers, practitioners, and

mental health workers do no favor to clients by

supporting or developing intervention programs for

codependency until they carefully explore and understand

what problematic behaviors they are treating (Stafford,

2001).

Limitations

This study has several limitations. The limited

number of participants calls into question the

generalizability of the data. The sample was a

convenience sample, therefore, not totally representative

of those professionals working within their respective

agencies. Also, participants were selected by supervisors

within their agency. Therefore, the possibility exists

that participants chosen to participate in the study may

have advocated for the child welfare system, slightly

biasing self-reports as all analyses were qualitative,

and data relied on self-report. However, the quality and

quantity of data generated by the participants in this

study suggests a high level of participant involvement.

Recommendations for Social Work
Practice, Policy and Research

The findings in this study call for the inclusion in

social work education and professional continuing

education of the knowledge and skills needed for social

workers to effectively incorporate the Strengths

Perspective while engaging youth and families in

appropriate assessment and intervention. Rather than

adopting the disease model of Codependency, the Strengths

Perspective proposes a different way of looking at

individuals and families. This model of practice is based

on the idea of resilience, rebound, possibility, and

transformation. This education will be valuable in

assessing, planning, implementing, and evaluating phases

of the generalist intervention model for those clients.

Conclusions

It is important that social workers understand the

labels they offer their clients are extremely powerful.

The implication is the value of encouraging clients to

define themselves in positive constructive terms to
emphasize their strengths over their weaknesses. Once
again, this is in line with the NASW philosophy – client
dignity and empowerment. As has been noted, research has
revealed no empirical support for the codependency
construct as it is currently discussed in the literature.
Until a sound empirical base is established social
workers and mental health workers should proceed with
caution in providing policy and clinical guidance on
codependency.

These findings encourage child welfare
administrators, supervisors, and social workers to
discuss ethical conflicts over encouraging an individual
to accept that he or she is codependent and needs to seek
treatment for the "disease" or "health problem." Rather,
promoting an understanding of the social work model
"parentified children" would help to broaden insight into
possible family dynamics operating, which often
undermines a youth's maturation and individuated
functioning.

Future research should investigate and evaluate
social work programs and groups based on empowerment
principles. There is a need to compare and contrast the

social work model of "parentified youth" with the clinical model of "codependent youth." This could provide significant contributions to the existing literature, and help social workers decide on effective assessment / intervention approaches in treating youth and parents.

APPENDIX A

QUESTIONNAIRE

QUESTIONNAIRE

1. How would you define codependency?

2. If you have had codependent clients in the last 6 months, tell me about their gender and age range.

3. How do you assess for codependency in youth?

4. How do you assess for codependency in adults?

5. Specifically, what interventions do you use to treat codependent youth?

6. Specifically, what intervention do you use to treat codependent families?

7. In the past 6 months, how often have you referred a teen to a codependency group?

8. In the past 6 months, how often have you referred a parent to a codependency group?

9. Can you describe your agency's policies about codependency or training related to codependency?

10. I would like to know your opinion about the effectiveness of interventions for codependent teens and families.

11. What, if any, concerns do you have regarding the assessment or treatment of codependency?

APPENDIX B

INFORMED CONSENT

INFORMED CONSENT

The purpose of this study is to explore practitioners' perception of codependency and assessment for teen codependency. This study is being conducted by Diane Ausilio under the supervision of Dr. Laurie Smith, Assistant Professor of Social Work at California State University, San Bernardino. This study has been reviewed and approved by the Department of Social Work Sub-Committee of the Institutional Review Board of CSUSB.

In this study you will be asked to respond to open-ended interview questions regarding the nature of teenage codependency, social workers' issues and treatment / outcome for teenage codependent clients. The interview should take approximately forty-five minutes to complete. All of your responses will be confidential. At no time will your name be requested during your participation; however, your responses will be recorded so that I may look for themes in yours and other participants' responses. In all reports, your responses will be disguised so they won't identify you. The results of this study will be available in Pfau Library after September, 2006.

Your participation in the study is entirely voluntary. You are free to withdraw your participation at any time during the study without penalty or remove any data at any time. Taking part in this study poses no risks beyond those normally encountered in daily life. Your responses will not affect your employment; your employer will not know whether you participate. If you have any questions or concerns about the study, please feel free to contact Dr. Laurie Smith at (909) 537-7029.

I acknowledge that I have been informed of, and understand the nature and purpose of this study, and I freely consent to participate. I acknowledge that I am at least 18 years of age.

_____   _____
Place an "X" above indicating   Date
Your agreement

APPENDIX C

DEBRIEFING STATEMENT

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This study is designed to explore teenage codependency to expand an understanding of practitioners' issues and therapeutic effectiveness in treating codependent teenagers, and work to promote the change of problematic behaviors in teenagers identified as codependent. Most research has focused on participants in a university setting. Specifically, we are interested in learning more about appropriate assessment and treatment outcome for teenagers. Because there are very few empirical studies on teenage codependency, this study should call attention to what the current codependent movement looks like among teenagers within a clinical setting. Despite the fact that a disease like codependency has struck so many, the true nature and clear definition of the disease has yet to be found. It is hoped that this information will contribute in establishing and legitimizing the meaning of the concept.

The confidentiality of your identity and data results are guaranteed in accordance with professional and ethical guidelines. If you are interested in the results of this study, they will be available at the Pfau Library after September, 2006. Should you have any questions concerning your participation in this study, please contact Assistant Professor, Dr. Laurie Smith at (909) 537-3837

Please do not reveal details about this study to anyone who may be a potential subject, as we will be collecting data over the next few months. Thank you for your participation.

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