California State University, San Bernardino
CSUSB ScholarWorks

Theses Digitization Project
John M. Pfau Library

1996

# An evaluation of how direct practice clinicians define and operationalize the term codependency

Gail Willhite

Follow this and additional works at: https://scholarworks.lib.csusb.edu/etd-project

Part of the Psychology Commons, and the Substance Abuse and Addiction Commons

Recommended Citation
Willhite, Gail, "An evaluation of how direct practice clinicians define and operationalize the term codependency" (1996). *Theses Digitization Project*. 1131.
https://scholarworks.lib.csusb.edu/etd-project/1131

This Thesis is brought to you for free and open access by the John M. Pfau Library at CSUSB ScholarWorks. It has been accepted for inclusion in Theses Digitization Project by an authorized administrator of CSUSB ScholarWorks. For more information, please contact scholarworks@csusb.edu.

# AN EVALUATION OF HOW DIRECT PRACTICE CLINICIANS DEFINE AND OPERATIONALIZE THE TERM CODEPENDENCY

---

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
Gail Willhite
June 1996

AN EVALUATION OF HOW DIRECT PRACTICE CLINICIANS
DEFINE AND OPERATIONALIZE THE TERM CODEPENDENCY

---

A Project
Presented to the
Faculty of
California State University,
San Bernardino

---

by

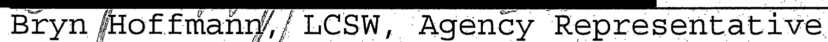
Gail Willhite

June 1996

Approved by:

Dr. Marjorie Hunt, Project Advisor, Social Work — 6/13/96 Date

Dr. Teresa Morris, Chair of Research Sequence,
Social Work



Bryn Hoffmann, LCSW, Agency Representative

## ABSTRACT

This study explored how clinicians in a direct practice setting defined and operationalized the term codependency. The literature indicated that the definition and use of the term codependency had changed dramatically over the past 10 years. The study sample was composed of 14 direct practice clinicians who had completed their graduate degree in either social work, psychology or family therapy. This research was based on the grounded theory perspective with an inductive approach of discovery. Therefore, this research was a post-positivist study of an exploratory nature. The data was gathered and analyzed utilizing both quantitative and qualitative methods. The goal of this study was to provide insights into how direct practice clinicians define and operationalize the term codependency in their practice with clients. The overall goal of this study was to provide insight into how the term codependency was being utilized by clinicians, in the field with clients. The results of this study appear to bear out what was stated in the literature and asked in this study. Namely that, (a) direct practice clinicians do diagnose clients as being codependent, (b) the diagnosis is disproportionately given to females and, (c) the diagnostic criteria differs from clinician to clinician, e.g. - different clinicians define codependency differently.

## ACKNOWLEDGMENTS

I want to thank Dr. Hunt for her help in making this project possible. I also want to thank her for her patience and her expertise.

A special thank you for a dear friend and first year MSW student, Carolyn Jackson, who took several hours of her precious time to write data reduction cards for me. Thank you Carolyn.

And I want to thank God, my family, and other friends without whose support this endeavor would not have been possible.

Last, but certainly not least, a very special "thank you" to Jim Dreher. Jim took several hours one Saturday night copying my file to a 3 1/4 disk and reformatting it. And if that was not enough, he lent me his computer so that I could work on my research project at 2:00 a.m. if I wanted to. Thank you Jim, thank you one and all.

TABLE OF CONTENTS

ABSTRACT ........ iii

ACKNOWLEDGEMENTS ........ iv

LIST OF TABLES ........ vi

INTRODUCTION ........ 1

Problem Statement ........ 1

LITERATURE REVIEW ........ 1

Problem Focus ........ 4

Research Paradigm ........ 4

METHODS ........ 5

Purpose and Design ........ 5

Sampling ........ 5

Data Collection and Instruments ........ 6

Procedure ........ 6

Protection of Human Subjects ........ 8

DATA ANALYSIS ........ 8

RESULTS AND ANALYSIS ........ 10

OPEN CODING ........ 17

DISCUSSION ........ 24

APPENDIX A: Informed Consent ........ 28

APPENDIX B: Debriefing Statement ........ 30

APPENDIX C: Questionnaire ........ 32

REFERENCES ........ 33

LIST OF TABLES


TABLE 1: Age of Participants.......................... 10

TABLE 2: Years in Practice............................ 11

TABLE 3: Degree Held.................................. 12

TABLE 4: Ethnicity.................................... 12

TABLE 5: Area of Expertise............................ 13

TABLE 6: Caseload..................................... 16

TABLE 7: Codependency as a Phenomenon................. 18

TABLE 8: Context in Which Participant Learned
About Codependency........................... 20

TABLE 9: Definition of Codependency.................. 21

TABLE 10: Should Codependency Be Added to the DSM-IV?.. 22

TABLE 11: Assessment Criteria for Codependency........ 23

# INTRODUCTION

## Problem Statement

Over the course of the past several years there have been books, journal and/or magazine articles and numerous television talk shows discussing the phenomenon labeled codependency. Lyon and Greenberg (1991) state, "...codependency appears to be the chic neurosis of our time" (p. 435). So much has been written about this up and coming so-called psychological disorder that many who practice in the fields of psychiatry, psychology and other helping professions, would like to see codependency added to the Diagnostic and Statistical Manual of Mental Disorders as a personality disorder (Collins, 1992, Hogg and Frank, 1992, Lyon and Greenberg, 1991, van Wormer, 1990). But, for the present, codependency is not listed in the DSM-IV. Given this, the purpose of this study was to explore how clinicians in a direct practice setting define and operationalize the term codependency.

# LITERATURE REVIEW

According to van Wormer (1989) codependency literally means, "one who is with, alongside, the (drug) dependent person. The original term was the non-pejorative co-alcoholic utilized by Wegscheider (1981) and Black (1982)...Co-dependency was conceived as a logical reaction to living with a chemically addicted individual" (p. 52).

In addition to the original definition, codependency is now seen primarily as a women's affliction, not always related to being in a relationship with an addict or alcoholic. Collins (1993) and van Wormer (1989) both make a strong case for what they see as an anti-female bias and a "blame-the-victim" mentality when labeling clients codependent. In fact, van Wormer states, "I am increasingly alarmed,...at the extent of labeling that is used with clients with relationship issues, and at the anti-female...bias accompanying this labeling. Co-dependency is overwhelmingly defined as a female affliction" (p. 54, 62). Collins (1993) states, "...The codependency concept, both in its etiology and in current practice, refers to women" (p. 470).

In addition to the original co-addict/co-alcoholic definition of codependency, and the purported anti-female bias, there is a third issue which is discussed in the literature. This third issue is how women are socialized. According to Rice (1992) women are socialized to be codependent. Rice believes that society is set up to teach women to be codependent. He believes that three of our major institutions, namely the family, the church and school actively train women to have no boundaries. He believes that these institutions teach us what to think and feel and what we should know. Rice (1992) calls this, "cultural co-dependency training" (p. 344). Rice states that this

training teaches women that our reference point is outside of ourselves.

In concert with Rice, Hogg and Frank (1992) state, "Gender roles are a critical factor to consider when viewing the emotional needs of people in relationships. In our society, the strategy of giving up one's personhood to achieve love and security is associated with stereotypically feminine gender roles" (p. 372).

Feminist theorists at the Stone Center in Wellesley College are noted for their work in understanding women's developmental paths. "The crux of their work is the assumption that a woman's self develops not as a result of movement away from infant symbiosis and embeddedness, but rather as a part of relationships and in interpersonal connection and interaction...And Miller contended that the goal of development is not an increasing sense of separation but of enhanced connection" (Collins, 1993, p. 473).

The following quote from feminist social worker van Wormer, is perhaps the strongest made against codependency. van Wormer, (1989) argues against the label of codependency saying, "My arguments are two-fold: There is no actual entity that can be called co-dependency, and this label is currently being used in a discriminatory way against women" (p. 5).

Problem Focus

Given the varying definitions of codependency in the literature and discussions as to whether or not such a psychological phenomenon exists and the fact that the literature states clients are assessed as codependent in direct practice agencies, this researcher posed the following research questions, 1) Do clinicians use codependency as a diagnosis?, 2) What diagnostic criteria do they use? and 3) Is there any consistency between different clinicians' definitions?

Research Paradigm

This research was based on the grounded theory perspective with an inductive approach of discovery. Therefore, this research was a post-positivist study of an exploratory nature. This study utilized qualitative techniques by asking a series of open-ended questions of each participant. Qualitative sampling and analysis was chosen, because it allowed for the grounded theory approach to the research questions. Grounded theory allowed the discovery process to take place when doing the research. The objective of this study was to see whether or not clinicians in a direct practice setting assess clients as codependent and what diagnostic criteria they use.

## METHODS

### Purpose and Design

This study used a post-positivist approach from an exploratory, inductive position, in considering the research questions: 1) Are clinicians using codependency as a diagnosis in this agency?, 2) What diagnostic criteria do they use? and 3) Is there any consistency between different clinician's definitions?

### Sampling

A social work direct practice setting in the Inland Empire was selected which employs clinicians from the disciplines of social work and psychology. This site provides low-cost counseling services. It is a non-profit, privately operated, public benefit charity and receives funding from San Bernardino County, the United Way and community based programs which generate funds. Private donations, client fees, gifts and grants generate additional revenue in support of their annual budget. This site employs clinicians who tend to be either Licensed Clinical Social Workers (LCSW), Marriage, Family, Child Counselors (MFCC), or hold their Masters of Social Work (MSW) or Masters in Counseling (MS). In addition, the site also has a large student program and employs clinicians who are either interns or residents working towards their MSW and/or MFCC degrees.

Data Collection and Instruments

Data collection was accomplished by conducting a round of interviews with each clinician at the research site who currently hold a completed degree, 14 clinicians altogether. The interviews were focused on a set of 11 questions pertaining to the above stated research questions (See Appendix C for interview questions).

Procedure

To help guard against reticence each interview was set up at the convenience of the clinician to be interviewed. Each interview began with an assurance of confidentiality and anonymity for the clinician and ensuring that informed consent had been obtained. (See Appendix A for Informed Consent Form). After obtaining informed consent, each participant was given a copy of the debriefing statement to read before proceeding with the first interview question. (See Appendix B for Debriefing Statement). First, demographic information about the clinician (i.e., age, ethnicity, degree held, years of practice, area of expertise and areas of special interest) if any, was gathered. Once this information was obtained, the interviewer asked the first question and moved on to the next question when the clinician indicated that he had exhausted his/her input for the previous question. Each interview took approximately 30 minutes to complete.

The interviewer took notes, but also utilized a tape recorder (with permission of the subject) to aid in assuring accuracy and fidelity of data collection. All interviews were transcribed.

The use of this paradigm allowed the researcher to explore the issue of codependency and how clinicians operationalize this issue within their practice, without the researcher seeking to "fit" the issue into a preconceived box, which may have been inaccurate. Given this, this researcher, in order to be a sensitive instrument, was aware of her biases and made a conscious effort to not influence this study. Also, at no time prior to the actual interview was the research study discussed with any of the participants.

To aid objectivity and sensitivity, the researcher used the systematic comparison method as described by Strauss and Corbin (1990, p. 87-90). This technique aided in helping the researcher to remain objective during data collection and data analysis. For example, some who were interviewed stated that codependency is a serious form of psychopathology and it needs to be treated and there were some respondents who said that codependency, as a form of psychopathology, does not exist. The systematic comparison method allowed the researcher to be "open" to the data and be better able to explore it thoroughly.

Protection of Human Subjects

This study had no immediate impact upon the participants (e.g. - additional training, etc.). Each participant's identity was kept confidential utilizing a numbering system known only to the interviewer. This system assured that their answers would have no impact upon their job security or professional status. With regards to the issue of reticence, each interview was set up at the convenience of the clinician participating in the study. Each interview was conducted at a time and site that was convenient for the participant.

## DATA ANALYSIS

Since this was a qualitative study (some quantitative data was gathered, this will be discussed later) data analysis was accomplished by using the open coding method. Open coding is defined as, "the process of breaking down, examining, comparing, conceptualizing, and categorizing data" (Strauss and Corbin, 1990, p. 61). During this process data were broken down into discrete categories, analyzed and compared for differences and similarities. This process utilized open sampling. Open sampling allowed the analysis process to be open to all possibilities.

After the completion of each interview the data gathered were first transcribed. Once transcribing was completed the next step was to categorize those where the

answer was yes, from those where the answer was no (some questions in this study asked ...why or why not). Once this was accomplished the process of open coding began. To ensure thoroughness, first line by line, then sentences or phrases were examined and finally the entire response was examined. The process of open coding continued until all data gathered from the qualitative questions had been examined.

As mentioned earlier, there was a quantitative piece to this research. Three of the questions were simple frequencies: age, years in practice, and how many females and how many males on the clinicians caseload had been assessed as codependent. Univariate analysis was conducted utilizing these variables. The mean and median were calculated for all 3 variables.

To ensure validity, an audit trail was established. Before each interview a manila folder was set up for that interview. A number was placed on the outside of the folder and that number was recorded in a log book along with the name of the individual being interviewed. From that point on all information gathered from that interview, anything related to that interview, received the same number and was placed in that folder. All data reduction cards had the interview number placed on them to ensure the audit trail. The purpose of this audit trail was to ensure that all data reported and information obtained could be traced back to

the original interview from which it came.

## RESULTS AND ANALYSIS

The first five questions of this study dealt with demographic information relating to the study sample. The information gathered helped to characterize the sample population. Information related to age, years in practice, ethnicity, degree held, area of expertise, and area of special interest were obtained from the sample population.

Table one shows participants ages ranged from 26 to 53 (mean = 35.8 years, md = 1). One participant did not disclose his/her age stating that to do so would go against their cultural norm.

Table 1: Age of Participants

N = 14 (MD=1)

| Age | Frequency |
|---|---|
| 26 | 2 |
| 28 | 2 |
| 33 | 2 |
| 40 | 1 |
| 42 | 2 |
| 47 | 1 |
| 51 | 1 |
| 53 | 2 |

Mean = 35.8 years Median = 36.5 years

The data in Table 2 shows the number of years in practice for each participant. The number of years in practice ranged from less than one year (.5), to 30 years with a median of 5.5 years.

Table 2: Years in Practice

N = 14

| No. of Years | Frequency |
|---|---|
| .5 | 1 |
| 1.5 | 3 |
| 3 | 1 |
| 4 | 1 |
| 5 | 1 |
| 6 | 1 |
| 6.5 | 1 |
| 8 | 1 |
| 13 | 1 |
| 17 | 1 |
| 21 | 1 |
| 30 | 1 |

Mean = 8.5 years Median = 5.5 years

Each individual who participated in this study was asked what degree they held. Table 3 illustrates the varying degrees held by the different participants and the frequency for each degree.

Table 3: Degree Held

N = 14

| Degree | Frequency |
|---|---|
| Masters Clinical Psychology | 1 |
| Masters Counseling Psychology | 2 |
| Master Family Therapy | 2 |
| Masters Marriage, Family, Child Counseling | 2 |
| Master of Social Welfare | 1 |
| Master of Social Work | 6 |
| Ph.D. Clinical Psychology | 2 |

To aid in describing the participants in this study, each was asked to give their ethnicity. Each participant was given license to describe their ethnicity as they define it, they were not held to limited, discrete categories, such as White, Hispanic, Black, etc... Table 4 displays the ethnicity of the participants in this study, taken verbatim from their questionnaire. The data illustrates participants in this study were 86% Caucasian, of varying origins, with the remainder being either African American or Hispanic.

Table 4: Ethnicity

N = 14

| | |
|---|---|
| #1 | Caucasian |
| #2 | White |
| #3 | French, Spanish, Native American, African American |
| #4 | Caucasian - German, English |

| | |
|---|---|
| #5 | Russian, Polish, Jewish |
| #6 | American!! (3/4 Irish, 1/4 German) |
| #7 | Caucasian - German, Native American (Yacqui) |
| #8 | Caucasian |
| #9 | Hispanic |
| #10 | Adopted, Culturally raised by Irish, German, Native American, Biologically |
| #11 | Caucasian, Native American |
| #12 | Italian (Sicilian) |
| #13 | Caucasian |
| #14 | German, Irish, Black Dutch, English |

To further aid in describing the participants in this study sample they were asked what their area of expertise was. Table 5 shows the participants in this study to have had a wide range related to expertise.

Table 5: Area of Expertise

N=14 *

| Area | Frequency |
|---|---|
| Attention Deficit/Hyperactivity Disorder (ADHD) | 2 |
| Administration | 1 |
| Adults molested as children (AMAC) | 3 |
| Anxiety | 1 |
| Any type of client | 1 |
| Borderline Personality Disorder | 1 |
| Children | 2 |
| Couples | 1 |

| | |
|---|---|
| Depression | 2 |
| Depth psychology | 1 |
| Domestic violence | 1 |
| Dream work | 1 |
| Drug and alcohol | 2 |
| Dysfunctional families | 1 |
| Dysfunction in general | 1 |
| Family | 1 |
| Mental Health | 1 |
| Parenting | 2 |
| Play therapy | 1 |
| Severely Emotionally Disturbed Children (SED) | 1 |
| Working with survivors | 1 |
| No area of expertise | 2 |

* Participants were not limited to one area of expertise

Participants in this study were also asked to share their areas of special interest. As was the case with their areas of expertise there was much diversity. The following is a listing of those areas by participant:

#1 ADHD, childhood disorders, depression, AMAC and anxiety disorders

#2 Adolescence and families (clinical), organizational theory

#3 Adults, drug and alcohol, domestic violence, depression, anxiety

#4 Children

#5 Client relationship with self and journal work

#6 Codependency, post-partum depression and marriage

#7 Couple relationships and ADHD

#8 Family systems, depth psychology work and the sociology of labeling deviance

#9 MPD, survivors of sexual abuse, teenagers and college students

#10 Object relations and the Big Disorders

#11 Panic and anxiety disorders, women's issues such as sexuality, gender biases, stereotypes, adolescents who've been abused

#12 Play therapy, molest, dysfunctional family

#13 Working with survivors, sexual molest, alcohol, dysfunctional families

#14 Sexual abuse victims, physical problems related to psychological emotion

In keeping with the research question of, "Do clinicians use codependency as a diagnosis?," participants were asked to disclose the number of female and male clients currently on their caseload and how many of each gender they had assessed as being codependent. Of the 14 participants in this study, 64% are female and 36% are male. The female participants had assessed 50% of their clients as being codependent, while the male participants had assessed 14% of their clients as being codependent. Table 6 reflects their

responses.

Table 6: Caseload

N = 14 (Coda = Assessed as Codependent)

| ID# | Clinician Gender | Adult Female | # Coda | Adult Male | # Coda | Minor Female | # Coda | Minor Male | # Coda |
|---|---|---|---|---|---|---|---|---|---|
| 1 | M | 3 | 1 | 1 | 0 | 2 | 0 | 4 | 0 |
| 2 | F | 17 | 4 | 2 | 0 | 2 | 0 | 2 | 0 |
| 3 | M | 16 | 0 | 16 | 0 | 0 | 0 | 0 | 0 |
| 4 | F | 5 | 3 | 1 | 0 | 0 | 0 | 10 | 0 |
| 5 | M | 0 | 0 | 61 | 0 | 0 | 0 | 0 | 0 |
| 6 | M | 11 | 5 | 5 | 2 | 0 | 0 | 0 | 0 |
| 7 | F | 11 | 11 | 9 | 8 | 0 | 0 | 0 | 0 |
| 8 | F | 8 | 5 | 8 | 2 | 0 | 0 | 0 | 0 |
| 9 | M | 0 | 0 | 8 | 2 | 0 | 0 | 0 | 0 |
| 10 | F | 34 | 0 | 4 | 0 | 3 | 0 | 0 | 0 |
| 11 | F | 19 | 7 | 1 | 0 | 0 | 0 | 0 | 0 |
| 12 | F | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 13 | F | 5 | 4 | 6 | 2 | 6 | 3 | 7 | 2 |
| 14 | F | 16 | 2 | 4 | 0 | 0 | 0 | 0 | 0 |
| | TOTALS: | 147 | 42 | 123 | 16 | 13 | 3 | 23 | 2 |

Grand Total of 306 clients, 20% of which were assessed as codependent

These initial analysis warranted further study. A Chi Square determined that it was more likely that a female client would be assessed as being codependent (Chi Square =

44.16, $p = .05$, with DF = 1).

There was an even split in this sample between those participants who had their degree in Social Work and those who had their degree in either Psychology or Counseling. Of the 132 clients being seen by Social Workers, 10 were assessed as being codependent, as opposed to the 174 clients being seen by other disciplines who had assessed 53 of their clients as codependent.

## OPEN CODING

Qualitative analysis was accomplished using the grounded theory approach to open coding as described by Strauss and Corbin (1990). Initial analysis took place during each interview. During the interview patterns emerged which were later formulated into concepts. From further analysis of these initial concepts categories began to emerge which were later formulated into categories with properties and dimensions associated with them.

As the process of open coding continued each discrete part of the data was analyzed. Responses were grouped according to similarities and then differences for further analysis. As patterns emerged further analysis took place allowing for the discrete conceptualizing of categories and then emergence of properties and dimensions under each category.

During the initial analysis of the data four distinct

categories emerged. These four categories were: (1) "Yes, alcoholic family systems," (2) "Yes, addictions not mentioned," (3) "Yes" and (4) "No." Table 7 graphically displays the results of open coding done on the first question presented to the study participants (See Appendix C).

Table 7: Codependency as a Phenomenon

N = 14

| Category | Property | Dimensional Range |
|---|---|---|
| Yes, alcoholic family systems | roles | interpersonal <---> society |
| | psychological factors | interpersonal <---> society |
| | behavioral | interpersonal <---> society |
| Yes, addictions not mentioned | roles | individual <---> family |
| | psychological factors | individual <---> family |
| | behavioral | individual <---> family |
| Yes | client defined | individual <---> society |
| No | trait common to other pathologies | individual <---> society |

As can be seen by the data in Table 7, there were four discrete categories that emerged from the analysis of the data contained in the responses to Question one (See Appendix C). Fifty-eight percent (58% or 8 people) of the participants thought that codependency exists, but has no relation to drug and alcohol. This is consistent with the current findings of Collins (1993) and Van Wormer (1989) who state that the definition of codependency has changed from

the original non-pejorative co-addict/co-alcoholic, to codependency, which has a wide and inclusive definition not related to drug and/or alcohol issues.

Twenty-eight percent (28% or 4 people) of the participants thought that codependency exists, but only in relation to drug and alcohol addiction. This is consistent with Black (1982) and Wegscheider (1981) who have written about codependency as it relates to drug and alcohol issues. Black (1982 and Wegscheider (1981) state, "Codependency was conceived as a logical reaction to living with a chemically addicted individual" (p. 52).

Seven percent (7% or 1 person) of the participants thought that codependency is defined by the client. They did not have a personal concept of codependency. As they explained it in the interview they did not use it at all, but if a client said to them "I'm codependent, or I think I'm codependent" the clinician asked the client to give them their definition and the clinician used that definition. The remaining seven percent (7% or 1 person) thought codependency does not exist at all.

Question 2 (See Appendix C) asked participants to disclose where they had first learned about the term codependency. Table 8 graphically illustrates their responses.

Table 8: Context in Which Participant Learned About Codependency

N=14

| Category | Property | Dimensional Range |
| --- | --- | --- |
| Additions mentioned | Education | formal <---> informal |
| | Masters Program | formal <---> informal |
| | Internship | formal <---> informal |
| | Books | formal <---> informal |
| | Tapes on Codependency | formal <---> informal |
| Work | County Mental Health Employment | individual <---> agency |
| Personal | Addiction | personal <---> family systems |
| | Codependency Mtgs | personal <---> family systems |
| | Television | personal <---> family systems |
| Unsure | No property | no range |

One can see by the data in Table 8 that there appears to be a fairly even split between those participants who learned about codependency through education, whether formal or informal and those who learned about it through personal experience. The remainder learned about it either through work or were not sure where they had learned about it.

Question 3 asked participants to share how they define the term codependency (See Appendix C). Table 9 displays their responses in terms of categories, properties and dimensional range. Again, the majority of participants (78%) defined it in terms of not being related to drug and alcohol issues. This was in keeping with the literature. As mentioned earlier Collins (1993) and van Wormer (1989) have seen a continuing trend in movement away from the

original definition of codependency.

Table 9: Definition of Codependency

N = 14

| Category | Property | Dimensional Range |
|---|---|---|
| Addictions mentioned | relationship | individual <--> institutions |
| | mental health | healthy <--> pathology |
| | self-concept | internal <--> external locus of control |
| | caretaking | personal needs met <--> not met |
| | interpersonal sacrifice | siblings <--> all others |
| | personal boundaries | healthy <--> symbiosis |
| | object relations | separation-individuation <--> symbiosis |
| Addictions mentioned | set of behaviors | not specified |
| | caretaking | control <--> lack of control |
| | | satisfactions <--> dissatisfaction/ depression |
| Undefined | term is meaningless | |

Question 4 (See Appendix C) asked participants to make a determination if they thought codependency should be added to DSM-IV and to explain their answer. Sixty-four percent (64% or 9 individuals) of the participants stated that they did not think codependency should be added to the DSM-IV as a diagnostic category. As shown by Table 10 their reasons varied from items such as, "codependency is covered by other diagnoses categories" to, the DSM-IV is a "necessary beast." Twenty-eight percent (28% or 4 individuals) stated that it

should be added. Their reasons ranged from it being an AXIS I diagnosis, to AXIS II personality disorder. And, seven percent (7% or 1 individual) saw the DSM-IV as "necessary beast," utilized for the purposes of being able to bill insurance companies.

Table 10: Should Codependency Be Added to the DSM-IV?

N = 14

| Category | Property | Dimensional Range |
|---|---|---|
| Addictions mentioned | mental health | healthy <-->pathology |
| | | trait <-->AXIS II PD |
| | | diagnostic label <-->DSM-IV thrown out |
| | behavior | individual <-->family systems |
| Addictions not mentioned | mental health | covered under other disorders <-->V-Code |
| | cultural | individual <-->society |
| | behavior | individual <-->society |
| | mental health | AXIS I <-->V-Code |
| DSM-IV is necessary beast | | |

Participants were asked to share what criteria they used to come to an assessment that a client of theirs was codependent. Again the data reflect the current trend away from drug and alcohol issues when defining codependency.

Table 11: Assessment Criteria for Codependency

N = 14

| Category | Property | Dimensional Range | |
|---|---|---|---|
| Addictions not mentioned | client/therapist relationship | taking history | <-->client self-concept |
| | | transference | <-->counter transference |
| | | honest | <-->dishonest |
| | relationship | interpersonal | <-->family systems |
| | | dominance | <-->submission |
| | | passive | <-->controlling |
| | individual | healthy | <-->enmeshment |
| | object relations | separation-individuation | <-->narcissistic symbiosis |
| | self-concept | internal | <-->external locus of control |
| | caretaking | personal needs met | <-->not met |
| | family systems | healthy | <-->abusive |
| | behavior | healthy | <-->distructive |
| | Jungian Typology | | |
| | gut feeling | | |
| | supervision | | |
| Addictions mentioned | relationship | interpersonal | <-->society |
| | individual | healthy boundaries | <-->enmeshment |

Ninty-three percent (93% or 13 individuals) did not mention drugs or alcohol as a factor when assessing a client as a codependent. This is in keeping with the current literature which states that codependency is no longer defined as the non-pejorative co-addict/co-alcoholic (van Wormer, 1989). Seven percent (7% or 1 individual) did mention drug/alcohol as a factor when assessing a client for codependency.

# DISCUSSION

The responses gathered in this limited study shed light on how direct practice clinicians defined and operationalized the term codependency. Although the results can not be generalized to the entire population, of practice clinicians, the information gathered has implications for clinicians, as well as clients, in direct practice settings.

In analyzing the data it was observed that the participants in this study had diverse and varying conceptualizations of the phenomenon codependency. When looking at codependency as a phenomenon, there was almost an even split between those clinicians who thought that codependency was related to drug and alcohol and those that did not. There were also similar properties related to the two categories. Those who thought codependency was related to drug and alcohol and those who did not, both thought that it had to do with roles, psychological factors and behavior. But, the dimensional range was different. The participants who thought it was related to drug and alcohol thought the dimensional range was interpersonal <----> society. Those who thought that it was not related to drug and alcohol stated the dimensional range was individual <-----> society. Although the difference may seem subtle, it is actually <u>dramatic</u>. "Interpersonal" implies that the definition lies within relationships and "individual" implies that it lies within the person. This is a significant difference, and

although this can not be generalized to the population because of the limited sample size, it does support the current literature of Collins (1993) and van Wormer (1989) who state that the concept of codependency has moved away from the original non-pejorative label of "co-addict" or "co-alcoholic."

The data reflected a gender bias related to assessing female clients. The results of this study supported the literature (Collins, 1993, van Wormer 1989) which states that codependency is increasingly being used with women and now has an antifemale bias to it. It is interesting to note that it was the female participants in this study who assessed their female clients as being codependent more than their male counterparts did. The results of this study showed that female clients were more likely to be diagnosed as codependent if the clinician was also a female. Sixty-four percent of the participants in this study were female and they had assessed fifty percent of their clients as being codependent.

With regard to the question of whether or not codependency should be added to the DSM-IV, again, responses were varied. However, responses to this query were not consistent with current literature. Only 36% of the participants felt that codependency should be added to the DSM-IV. Collins (1993), Hogg and Frank (1990) stated that many who practice in the helping profession would like to

see codependency added to the DSM-IV. The results of this study, although taken from a limited sample contradict that statement. Sixty-four percent of the participants in this study did not want codependency added to the DSM-IV.

Those participants who felt that codependency should be added to the DSM-IV had a wide range of answers. Some of the participants thought that codependency is a "hard wired illness" and there should be no question as to whether or not it should be in the DSM-IV. Others thought it should be listed as a V-Code and still others thought it should be listed as a personality disorder on AXIS II. And, it is paradoxical that some who thought it should be in the DSM-IV also stated that the DSM-IV should be "thrown out."

The question which addressed the assessment criteria used by the clinicians who participated in this study was the most telling in terms of diversity and reflecting that codependency is no longer seen as the non-pejorative co-addict or co-alcoholic (van Wormer, 1989). Ninety-three percent of the participants did not mention drugs or alcohol as being part of their assessment criteria. Responses ranged from strong theoretical approaches such as Object Relations, to using a "gut feeling." This is a broad range and it provokes the question of how these participants assess other "disorders." Do they use the DSM-IV diagnostic criteria for them or do they use a "gut feeling?"

Although the results of this study can not be

generalized to the population due to the limited sample size, the results do have certain implications for direct practice. Clinicians are assessing clients as codependent and they utilize different criteria. What may be seen as codependency by one clinician, may not be seen as codependency by another. Therefore, given the clinician, a client may or may not be assessed as codependent.

The participants in this study who were Social Workers assessed fewer clients as codependent than did those clinicians from the disciplines of psychology, family therapy or counseling. As mentioned earlier in the results section, out of 132 clients seen by Social Workers only 10 were assessed as being codependent, whereas out of 174 clients seen by the other disciplines 53 were assessed as being codependent. Further research is warranted. It would be interesting to see where the real difference lies. Is it in the theory and practice of Social Work, as compared to other disciplines, or does the difference lay in the clients?

APPENDIX A

INFORMED CONSENT

The study in which you are about to participate is designed to investigate how direct practice clinicians define and operationalize the term codependency. This study is being conducted by Gail Willhite under the supervision of Dr. Marjorie Hunt, Professor of Social Work. This study has been approved by the Human Subjects Committee of the Department of Social Work at California State University, San Bernardino.

In this study you will be interviewed and asked a set of questions related to the topic of codependency. Some demographic information will be asked of you, such as, number of years in practice, and highest level of education.

Please be assured that any information you provide will be held in strict confidence by the researchers. At no time will your name be reported along with your responses. All data will be reported in group form only. At the conclusion of this study, you may receive a report of the results.

Please understand that your participation in this research is totally voluntary and you are free to withdraw at any time during this study without penalty, and to remove any data at any time during this study.

I acknowledge that I 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.

______________________________ ______________

Participants, Signature Date

______________________________ ______________

Researcher's Signature Date

## APPENDIX B

## DEBRIEFING STATEMENT

Over the course of the past several years there have been books, journal and/or magazine articles and numerous television talk shows discussing the phenomenon labeled codependency. Lyon and Greenberg (1991) state, "...codependency appears to be the chic neurosis of our time" (p. 435). So much as been written about this up and coming so-called psychological disorder that many who practice in the fields of psychiatry, psychology and other helping professions, would like to see codependency added to the Diagnostic and Statistical Manual of Mental Disorders as a personality disorder (Collins, 1993, Hogg and Frank, 1992, Lyon and Greenberg, 1991, van Wormer, 1989). But, for the present, codependency is not listed in the DSM-IV. Given this, the purpose of this study is to explore how clinicians in a direct practice setting define and operationalize the term codependency.

It is requested, for methodological reasons, that you not reveal the nature of this study to other potential subjects, namely other practitioners in this agency.

If, during the course of this study, personal issues surface, you may wish to contact a 12-Step group such as Alanon or Codependents Anonymous or a private counselor to assist you to work through said issues. To locate a 12-Step meeting in your area you may call 1-800-222-5465.

The results of this study may be obtained by contacting Gail Willhite at 909-880-5501. If you have any questions concerning this study you may contact Gail Willhite or her research advisor, Dr. Marjorie Hunt, at California State University, San Bernardino, 909-880-5501.

## APPENDIX C

## QUESTIONNAIRE

Age:

Ethnicity:

Degree Held:

Years in Practice:

Area of Expertise:

Areas of Special Interest:

1) Do you think there is such a phenomenon as codependency? Why or why not?

2) In what context did you first learn of the phenomenon of codependency?

3) How do you define codependency?

4) Currently the DSM-IV does not include codependency as a form of psychopathology, do you think it should be included? Please explain.

5) What criteria do you use to come to an assessment that a client is codependent?

6) Given your present case-load, how many clients are male and how many are female and of each gender how many have you assessed as being codependent?

## REFERENCES


Collins, Barbara G. (1993). Reconstructing Codependency Using Self-in-Relation Theory: A Feminist Perspective. Social Work, 38:470-475.

Guba (1990). The Paradigm Dialogue. Newbury Park: Sage p. 17-27.

Hogg, James Andrew & Frank, Mary Lou (1992). Toward an Interpersonal Model of Codependence and Contradependence. Journal of Counseling & Development, (70), 371-375.

Lyon, Deborah & Greenberg, Jeff (1991). Evidence of Codependency in Women With an Alcoholic Parent: Helping Out Mr. Wrong. Journal of Personality and Social Psychology, (61), 435-439.

Rice, John Steadmen (1992). Discursive Formation, Life Stories, and The Emergence of Co-dependency: "Power/Knowledge" and the Search for Identity. The Sociological Quarterly, (33), 337-364.

Rubin, Allen & Babbie, Earl (1993). Research Methods for Social Work (2nd ed.). California: Brooks/Cole.

Strauss, Anselm and Corbin, Juliet (1990). Basics of Qualitative Research. California: Sage Publications, Inc.

van Wormer, Katherine (1989). Co-dependency: Implications for Women in Therapy. Women and Therapy, (8), 51-63.