CODEPENDENCY AND AN ASSESSMENT OF THE FRIEL CODEPENDENT INVENTORY

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ABSTRACT

To evaluate a measure of codependency (the Friel Codependent Assessment Inventory (Friel and Friel 1988)), 200 university students (38% male, 62% female) aged 18 - 40 years completed 4 questionnaires relating to their present and past partnerships with substance abusers; substance abuse in their family of origin; their own present substance use; and codependent traits. The results failed to support any of the 3 predictions: (1) that people who reported more symptoms of codependency would report higher scores on the codependent questionnaire than subjects reporting fewer; (2) that females would report more characteristics of codependency than would males; and (3) that the codependent questionnaire would show similar factors of codependency in students as obtained previously from alcohol and drug centre populations. This suggests that the codependent questionnaire is not a valid measure of codependency; that patterns of codependency are not the same for drug and student populations; and that the commonly reported predominance of women as codependents is not accurate.

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The term codependent can be applied to those individuals who exhibit intrapsychic and interpersonal patterns of behaviour which are related to their past and present interactions with chemically dependent family members. The theory of codependency was developed as a response to clinical observations of families with substance abusing members. The four main patterns of behaviour identified by clinical observations are (1) that children who grew up in families where substance abuse was a problem tended to marry or enter relationships with partners who were substance abusers; (2) that children who grew up in families where substance abuse was a problem tended to have a higher risk of developing substance abuse problems themselves; (3) that children who grew up in families where substance abuse was a problem tended to have higher rates of emotional, physical and stress related problems in adulthood than children who had grown up in families where substance abuse was not a problem; and (4) that these patterns tended to repeat themselves in second and third generations (Woititz 1985). Patterns of behaviour and characteristics of codependent individuals related directly to the four observed outcomes of being raised in a substance abusing family which have been outlined above.

The tendency to marry or enter relationships with substance abusing partners is seen as the result of personality traits intergenerationally transmitted from the individual's family of origin. This infers that individuals enter into relationships with substance abusers because of an innate need to re-enact family of origin dysfunction.

Behaviour patterns related to the development of substance abuse in the codependent are seen as coping mechanisms by which individuals deal with the painful memories of traumatic situations experienced in the family of origin. Individuals who are substance abusers are seen to use substances to cope with underlying codependency traits rather than the substance abuse being a primary issue.

It is suggested that higher rates of emotional, physical and stress related problems in codependents, are post traumatic stress related symptoms associated with trauma in the family of origin. Underlying codependent stress and anxiety therefore has a causal-linear relationship with the development of a wide range of clinically diagnostic entities such as anxiety attacks, phobic and panic disorders, obsessive-compulsive disorders, stress-related physical symptoms, eating disorders and depression. The presence of this wide range of clinical entities are seen as self-defeating behaviours which are part of the codependent individuals personality (Cermack 1986).

Learned behaviour patterns, believed to be intergenerationally perpetuated, combined with underlying stress and anxiety are thought to result in the compulsive disorders and dysfunctional relationships which perpetuate the codependent syndrome.

Thus, codependency as a term described both a diagnostic entity and a psychological concept which refers to both intrapsychic and interpersonal dynamics. While codependent characteristics are believed to exist in most individuals as personality traits, it is not until these traits become excessively rigid and intense that the diagnosis of Codependent Personality disorder can be made (Cermack 1986).

Codependence however is essentially an unresearched and unsubstantiated disorder which has gained support through clincial observation rather than through empirical research. The present researcher has identified three reasons that have hindered the development of codependence as a diagnostic entity to date. These three reasons are (1) the development of codependency as a theoretical construct; (2) the lack of empirical research to establish reliable and valid instruments to measure the construct; and (3) the combination of these two factors in developing models for treatment.

1. To establish codependence as a theoretical construct there needs to be some consensus as to the definition and also some consistency as to the characteristics of codependency. Differences in definitions appear to relate to four specific issues. Firstly, whether codependence has a causal-linear relationship to family influences (family of origin). Secondly, whether codependence is a disease and follows the same type of addictive process as substance abuse. Thirdly, whether codependence is a underlying personality disorder. And fourthly, whether the wider society maintains and/or effects individual codependent behaviour because of its own structure, which is seen as addictive (Wilson-Schaef 1987).

In terms of the characteristics that have been identified within the codependent concept, the large number of physical and emotional attributes as well as behaviours which researchers have linked to the codependency construct has made the development of a simple definition difficult.

2. The development of the concept of codependence has also been hindered by the lack of empirical research leading to reliable and valid instruments for measuring the construct. While the literature on codependency gives a number of examples of codependency scales (Potter-Efron & Potter-Efron 1989), there is a general lack of research supporting codependence as a specific disorder. The complexity of the construct is further highlighted by the literature failing to refine the language used by

theorists and researchers to present definitions and characteristics of codependence. Mendenhall (1989) discusses in depth the effect that confusion with language has on developing methods of assessment and treatment and indicates that it is imperative that the vocabulary within the field become consistent.

3. The third issue of concern that can be identified is an expansion of the above two and is discussed in depth by Calleros (1990). This issue emphasises the related effects of the lack of development of codependence as a theoretical construct, and lack of empirical research to validate adequately assessment instruments, on the construction of coherent and consistent interventions for treatment. The use of large amounts of anecdotal literature in treatment, rather than the development of research based models of interventions, appears to be related to differences in the perspectives of theorists and researchers applying the construct within the context of their own individual theories of the development, effects and characteristics of codependency.

PURPOSE OF THE PRESENT STUDY

There have been a large number of factors linked to the onset, development and outcome of the codependency concept.

The term codependent is used to identify individuals in love/romantic and/or sexual relationships with chemically dependent partners who are participating in the relationship despite negative consequences for the purpose of attempting to deal with their own underlying intrapsychic needs.

The underlying intrapsychic needs are the result of substance abuse and/or other trauma's (ie sexual, emotional abuse) which occurred in the individuals family of origin. Characteristics of codependency are as seen to be coping mechanisms developed by the individual to deal with family of origin trauma.

The objective of the present study is threefold;

(1) To outline the development of codependence as a theoretical construct including a comparison of the definitions of codependency and an attempt to link the numerous characteristics of codependency into a coherent model;

(2) To evaluate an assessment questionnaire (the Friel Codependent Assessment Inventory Friel 1985) to attempt to establish reliability and validity criterions; and

(3) To attempt to confirm Calleros's (1990) research in identifying relevant areas of treatment interventions.

LITERATURE REVIEW

Codependency, a theory describing the development and pervasiveness of a personality disorder, has become established within the chemical dependence field and is being presented to the mental health field as a construct with adequate diagnostic criteria to be included in the proposed Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) of the American Psychological Association. While the characteristics of codependency have been described in detail as the result of clinical observations, empirical research of underlying effects, assessment and treatment are inconclusive. Care needs to be exercised if codependency were to be included in the DSM-IV as a personality disorder with diagnostic criteria, especially in view of the fact that the term is related specifically to women and that it includes a large number of already existing clinical diagnostic entities. Effort would be needed to ensure that the result would not just be the creation of one further label to classify individuals who present with a number of clinically diagnostic entities.

The aim of the present chapter is to discuss the three previously identified reasons that have hindered the development of codependency as a diagnostic entity to date. These three reasons are (1) the development of codependency as a theoretical construct, (2) the lack of empirical research to establish reliable and valid instruments for assessment, and (3) the combination of the above two factors in identifying models for treatment.

CODEPENDENCY: A HISTORICAL CONTEXT

Although the term "codependence" first appeared in the 1970's Cermack (1986), there were theoretical characterisations of spouses of alcoholics beginning to be developed as early as the 1930's. At that time there were three theories espoused within the literature. The disturbed personality hypothesis, the stress theory, and the theory of coping mechanisms.

THE DISTURBED PERSONALITY HYPOTHESIS

This hypothesis assumed that alcoholics spouses suffer from long-standing personality deficits. Based on a psychodynamic model the DPH theory "supports the belief that spouses of alcoholics are psychologically abnormal and have personalities as poorly integrated as their alcoholic husbands or wives" (Harvey & Whitehead 1973, cited in Calleros 1990). To support this theory researchers attempted to identify personality traits in the partners of substance abusers. or more specifically, the wives of substance abusers which would increase the probability that they would choose relationships with substance abusers rather than non-substance abusers (Whalen 1953). Results of these studies however were inconclusive with inadequate

sampling techniques and, for example, the concentration on attempting to label the partners into groups classified as insecure, masochistic, frigid and sadistic (Edwards, Harvey and Whitehead 1973). There are two main implicit assumptions in the DPH theory. Firstly, that women in particular are fixated at psychosexual stages which they will attempt to resolve by marrying and/or entering into relationships with substance abusing partners, and secondly, that if the spouses personality characteristics created a need for an alcoholic partner then the implications of a partner stopping their drinking or substance use would result in a corresponding deterioration in the spouses functioning (Asher & Brissett 1988). This second assumption has been referred to as a "decompensation". Decompensation was believed to occur because marriage to an actively drinking alcoholic or substance abuser was a defence against psychological conflicts. Removal of the spouses defences would result in a disintegration of personality (Calleros 1990). Deterioration in a spouses functioning included the increase in hostility towards the substance abuser and an increase in the spouse attempting to hide their own anxieties and conflicts (Bailey 1959).

The decompensation hypothesis has been rejected in the literature on the basis of research limitations including small samples and anecdotal clinical observation rather than empirical research (Edwards, Harvey and Whitehead 1973). However, the tendency for partners of substance abusers to actively attempt to keep their partner drinking/substance using is still referred to as a codependent characteristic (Cermack 1986).

THE STRESS THEORY

The second hypothesis constructed to characterise spouses of alcoholics was that of the stress theory. The stress theory contends that the psychopathology of the codependent spouse is a mechanism for coping with stress. This theory focuses on characteristics such as depression, anxiety, complaints of physical symptoms and general poor health, which are the direct result of the stress of living with an alcoholic rather than an indication of personal psychopathology. The stress theory emphasises that codependency is a reaction to the spouses alcoholic or substance abusing behaviour and that codependency characteristics are present in the individual as the result of a marriage or partnership rather than the underlying basis of the relationship. Becoming codependent then may be construed as one of a number of life alternatives for individuals in a partnership or marriage to an alcoholic or substance abuser.

Orford (1975 discusses the literature supporting the stress theory. Results of studies cited by Orford (1975) indicate that spouses and children with family of origin

substance abuse show evidence of disturbance when the substance abuser is actively involved in using substances (alcohol and/or other drugs), and that this disturbance lessens when the substance abuser discontinues abuse of the substances. Bailey (1967) found that women whose husbands were not abusing substances (although substance abuse had been a problem earlier in the partnership) reported fewer stress-related symptoms than women whose husbands were currently abusing substances. Jackson (1962) however, found that the changes in the abuse substances did not necessarily relieve stress-related symptoms in the partner of the substance abuser.

Although the research reviewed by Orford (1975) supports the stress-related theory, methodological problems have resulted in inferential results rather than the identification of casual-effect relationships between stress and related effects on the spouse and/or children within the family system. The methodological problems within the research relate to the small samples used, inadequate definitions of substance abuse, the concentration on male substance abusers, the exclusion of women, and the lack of inference in relation to individuals with family of origin substance abuse as opposed to those individuals with no reported family of origin substance abuse (Orford 1975).

COPING MECHANISMS THEORY

The coping mechanisms theory was developed out of the stress theory to attempt to address the question of why some partners of alcoholics and substance abusers do not present with characteristics associated with the stress of living with a substance abusing partner. The assumption was made that these individuals have coping mechanisms which deal with high stress in an effective way. The theory of coping mechanisms contrasts with the disturbed personality theory and the stress theory perspectives, which focus primarily on the deficits of the spouses of substance abusers.

James & Goldman (1971) investigated the coping behaviour of wives of alcoholics. Results indicated that high levels of coping were associated with a negative prognosis for the relationship. The implication of this type of research was reported to be that the techniques that wives use to cope with substance abuse in their partners may actually be counterproductive rather than effective in enabling the individual to function effectively. The validity and reliability of such studies are questionable however, as they do no investigate the family system but concentrate solely on the recall of the wives of the substance abusers.

It is apparent from the previous discussion on the origins of the term codependency that these three theories have a number of similarities and differences. The DPH theory emphasises that codependent individuals suffer from long-standing personality deficits, that codependent individuals will enter relationships and select partners on the basis of underlying codependent needs, and that the codependent will show personality deterioration if their partner is no longer chemically dependent. The stress theory and the coping theory emphasise that individuals become codependent as a response to stress within a family system. Selection of partners is therefore not based on underlying codependent needs. The stress theory indicates a decrease in stress due to changes in the substance abuse of partners, while the coping mechanism theory distinguishes between individuals who will develop codependent characteristics through an inability to cope with stress and those individuals who will not develop codependent characteristics because of adequate coping mechanisms to stressful situations.

All three theories suggest that the development of codependency is the direct result of both overtly and covertly learned patterns of dysfunctional behaviour in the family of origin and all three theories emphasise that it is primarily women who will develop codependent symptoms. However, if codependency characteristics are developed through patterns learned in the family of origin then the effects on male children should, one would assume, be the same as those effects on female children. The literature on codependency fails to discuss this implication with any research to date.

Attempts to develop codependency as a theoretical construct have resulted in three main theories which are presently used to describe the patterns of behaviour observed in codependent individuals based on those theories used to describe wives of alcoholics. These three theories are the learned behaviour perspective, the "disease" model, and the personality disorder theory.

The learned behaviour perspective concentrates specifically on learned behaviour patterns from the family of origin and the society within which an individual lives. The "disease" model supports the impact of learned behaviour patterns on the outcome of later codependent development but also emphasises that there is a tendency for some individuals to be susceptible to codependency through fetal alcohol syndrome, genetic and other physiological effects. These two perspectives of learned behaviour and "genetic" predisposition are combined into a theory of "addiction" to codependency which has the same development and effects as addiction to a substance. Codependence from this perspective is conceptualised as a "disease" with corresponding features of onset, progression, and pervasiveness.

The personality disorder theory attempts to make conceptual links between the spouses of substance abusers cognitive, affective, and behavioural characteristics and a personality disorder in line with the American Psychological Associations diagnostic criteria. The personality disorder theory includes the theories of learned patterns of behaviour and "disease", and describes codependency as an "addictive" personality disorder resulting from a dysfunctional family of origin.

2.1 CODEPENDENCY: LEARNED PATTERNS OF BEHAVIOUR

Implicit within the concept of codependency is the assumption that there is a causal-linear relationship between codependence and substance abuse ion the family of origin. This assumption raises two important questions. Firstly, if codependency is the result of family of origin substance abuse what characteristics of children of substance abusers will make them more likely to become involved in relationships with substance abusers themselves? And secondly, if not all codependent individuals have reported family of origin substance abuse, but have been identified as having codependent characteristics once they enter a relationship with a substance abuser, are there similar traits found in codependents who are not primarily children of substance abusers?

There is an accumulation of research and literature on the debilitating effects of substance abuse on family life. The detrimental effects of substance use on children's functioning has been documented by Ackerman 1983; Black 1982; Cork 1982; Cruse-J 1989; Wegscheider 1981; and Woititz 1983, among others. The research points towards specific areas in which children will be affected as a result of growing up in an environment where alcoholism and substance abuse are problems within the home. These life experiences have been broken down into specific concerns related to post traumatic stress (Bogdaniak & Piercy 1987, and Cermack 1986), patterns of coping during childhood and adulthood (Jampolsky 1990; Ryan-Wenger 1992, and Smith 1990), and societal/cultural effects (Wilson-Schaef 1987).

POST TRAUMATIC STRESS-RELATED SYMPTOMS

Intrapsychic and interpersonal patterns of behaviour in the learned behaviour model have been related to post traumatic stress-related symptoms as set out by the DSM-III-R (APA 1987). Codependency therefore can be considered as a stress reaction to emotional changes in a family system as a result of traumatic or shameful events (Mulry 1987). Cermack (1984) hypothesized that adult children of alcoholics will experience a number of post traumatic stress-related symptoms as a result of their family of origin substance abuse. These related symptoms are; a tendency to

re-experience the trauma of their childhood through obsessive thoughts about the family; compulsive re-emergency of behaviour and feelings in response to symbolic equivalents of the trauma; psychic numbing with a sense of isolation; hypervigilance and anxiety; survivor guilt and depression; and an intensification of these symptoms when exposed to events that resemble the original trauma such as withdrawal by others. Compounding the post traumatic stress-related symptoms will be additional codependent symptoms which include the need to exert will-power and control in their present daily lives (Cermack 1984). Research into post traumatic stress-related symptoms in children of substance abusers is based primarily on the relationship of these type of symptoms to physical and sexual abuse. Adult children of substance abusers have not been researched as a group to establish the existence or effects of these post traumatic stress-related symptoms.

COPING DURING CHILDHOOD AND ADULTHOOD

Coping with stressful family life is believed to be facilitated by learning patterns of behaviour which appear to be working for other family members. One of the main themes throughout the literature related to substance abuse is the suggestion that children's coping skills may act as a protection against dysfunctional family interactions. The research into childrens coping skills has suggested that coping skills may be related to differing techniques of coping and also differing coping behaviours within family members. Specific techniques of coping include, emotion-focused coping (methods used to regulate one's emotional response to a stressful situation), problem-focused coping (attempts to change the actual stressor), and palliative coping (behaviours such as ignoring the situation, praying, and hoping the situation will change), (Scavnicly-Mylant, 1990).

Black 1982, Adlers 1974 (cited Cruse 1989), birth order and family systems theory to identify specific role patterns among various childhood reactions observed within substance abusing homes. The first role identified was that of the "responsible one", this child helped to maintain stability, structure, and consistency and is the most typical role for the oldest child. The second role identified was that of the "adaptor", this child was able to adapt to any situation but also isolated themselves from friends and family in the process. The third role identified was that of the "placater", this individual would be likely to be sociable and helpful as their primary goal was to smooth over conflicts especially by diverting attention to themselves. The fourth and final role is that of the acting out child or the "scapegoat", who would take all of the family stress on to themselves by diverting attention on to their own behaviour. Wegscheider (1981), also identifies similar survival roles using family systems theory. Wegscheider's (1981) "roles" include the family hero, usually the oldest child, the

scapegoat, often the second child, the lost child, usually the third child, and the mascot, a role taken on by the youngest child.

Cruse (1989) linked the roles that children take within families and linked them with DSM-III-R (American Psychological Association 1987) criteria for mental disorders. Cruse (1989) found that the child who takes the family hero position will be more likely to experience separation anxiety disorder and eating disorders, while the child identified as the scapegoat will have conduct and oppositional defiant disorder problems. The lost child will experience avoidant disorder, eating disorders and academic skills problems while the mascot will have problems with attention deficit and overanxious disorders. Research supporting these links between coping mechanisms and the DSMIIIR (American Psychological Association 1987) however are not available.

SOCIETAL/CULTURAL INFLUENCES

The literature suggests that societal and cultural influences also model behaviour patterns which are codependent. Codependent behaviours are conceptualised as maladaptive habit patterns which are influenced by the individuals expectations or anticipation of the desired effects of behaviour. The attributions that individuals make in relation to societal/cultural influences are particularly relevant in this perspective of the development of codependency. Urlich (1988) investigated the attributional style of codependents hypothesizing that with regard to negative events, codependents would have more internal, stable and global attributional styles than non-codependents, and with regard to positive events codependents would have more external, unstable and specific attributional styles than non-codependents. Results indicated that there was no difference between codependents and non-codependents in relation to attributional style. Urlich (1988) cautions however that further studies need to be carried out to support the results that attributional style is not a characteristic of codependency as clinical observations suggest that codependents have different styles of interpersonal and intrapsychic relating than normals. Alternative explanations to examine the issue of different styles of relating were not given in the study.

Cruse (1989) emphasises the perspective of an "addictive society" which creates and maintains codependent characteristics in individuals. The cultural components of societal addiction include the school, which does not provide for affective education (WilsonSchaef 1989). The church which provides guide-lines for "correct beliefs" and does not allow for individuals to have alternative theological ideas (Springle 1991 and Wilson Schaef 1989). And organisations which develop codependency, especially in the helping professions of nursing, social work and

psychology, because they support dependency in their clients (Arnold 1990; Cauthorne-Lindstrome & Hrabe 1990; and Martin 1990). The basis of the "societal addiction" theory is family roles developed in childhood. Individuals are believed to continue to act out childhood roles as they move into the work force.

2.2 CODEPENDENCY: DISEASE MODEL

The "disease" of codependence is believed to occur through the effects of fetal alcohol syndrome, other genetic and physiological effects predisposition, and a parallel process of addiction to that of substance abuse.

FETAL ALCOHOL SYNDROME

Budenz (1990) described Fetal Alcohol Syndrome as one of the main causes of codependency suggesting a biological link. Literature supporting the affects of alcohol on the neonate indicate complications such as miscarriage, lower birth rates, altered facial features, mental disability, and learning and motor difficulties (Seilhamer 1990, cited in Daley & Raskin 1991). Specific links to codependency however are not clear. One of the main hypotheses is that the child with fetal alcohol syndrome is more likely to have related hyperactivity (also called minimal brain dysfunction or attention deficit disorder). Characteristics observed in children from homes with family of origin substance abuse indicate difficulty focusing attention, impulsivity. school failure and conduct disorders. These symptoms are believed to continue into adulthood and become compounded with shame and embarrassment as the adult with fetal alcohol syndrome recognises their learning and physical problems (Budenz 1990).

Difficulties with relating fetal alcohol syndrome to codependency include the inability of researchers to distinguish between maternal and paternal factors, the difficulty in separating prenatal factors from genetic factors and the lack of systematic measures to link childhood fetal alcohol syndrome in a causal-effect relationship to later adulthood development (Budenz 1990).

Therefore it would be incorrect to assume a link between fetal alcohol syndrome and the development of codependency without further consideration of the factors confounding the implied casual relationship.

GENETIC EFFECTS

Cruse (cited in Laign 1990) maintains that certain individuals are biologically predisposed to codependency, just alcoholics may be genetically predisposed to alcoholism. The predisposition to codependency is linked to levels of the dopamine neurotransmitter in the brain and the behaviour of the individual which effects the

levels of this neurotransmitter. Self-defeating behaviours are believed to act like drugs to block dopamine re-uptake. The dopamine then floods the system creating a "high". Individuals will experience a "let-down" as all the dopamine is used up resulting in the individual repeating the self-defeating behaviour to feel good. There is however, no support for this genetically predetermined theory of codependency, the basis for which appears to have been established solely on research supporting genetic predisposition to chemical dependence. The theory itself does not explain the physiological way in which the dopamine affects the brain and neither is it clear whether it is the occurrence of the self-defeating behaviours which control dopamine levels or the absence of these behaviours which control the dopamine levels.

Stress has been indicated to be physiological cause of codependent characteristics. Budenz (1990) emphasises that codependency is a reaction to the "flight or fight" chemicals produced within the human body. As these chemicals build up as a response to stress the individual in an effort to cope channels the stress into emotions such as guilt, shame and anger. Increases in the amount of stress experienced and the duration of the stress results in the codependent individual using these emotions as a protection from stress. The codependent will then experience an array of stress-related physical symptoms such as high blood pressure, ulcers and headaches. Budenz (1990) does not emphasise a genetic predisposition to codependency but indicates the relationship as being caused by stress. This theory, like the dopamine theory, has not been subject to research or elaboration and both theories appear to be essentially based on the belief that codependency is a "disease". Cruse (1990) indicates that the disease of codependency is the result of both physiological and genetic predisposition, Budenz (1990) indicates that codependency is the result of stress created by living with a substance abusing partner and that codependency develops as a parallel disease of coping.

ADDICTION

Addiction is defined in the DSM-III-R as a severe form of substance use disorder which requires physiological dependence evidenced by either tolerance or withdrawal (American Psychological Association 1987). Codependency addiction is supported in the literature as having these features. Physiological dependence is characterised by the emotional "high" obtained from participating in self-defeating behaviours (Cermack 1986). Self-defeating behaviours are those patterns of behaviour that the codependent will begin to use if they feel that their control over the environment is lost, for example, compulsions, obsessive thoughts and eating disorders. Withdrawal occurs when the physiological reactions to the self-defeating

behaviours no longer occur and the codependent individual is believed to create alternative self-defeating behaviours to compensate thus indicating the progression and pervasiveness of the "disease" or addiction. For the purposes of discussing codependency the terms disease and addiction are used interchangeably.

The addiction perspective is based on the disturbed personality hypothesis and the codependent is implied to have an addictive personality. The primary characteristic of the codependent personality is the willingness of the codependent to suffer continually from the consequences of the substance abusers behaviour. The codependents role is to spend time and energy in "rescuing" the substance abuser from their own behaviour, creating in the process the need to maintain control of the environment. Control is achieved through compulsive behaviours and the lack of attention to the codependents own emotional and physical needs. Naaken (1988) implies that addiction is a process that involves movement, development and change that will eventually result in an individual forming a dependent relationship with their own personality. How this occurs is not clear although the literature suggests that the reliance on compulsive behaviours becomes the sole focus of the codependent and intrapsychic identity and interpersonal intimacy will no longer be possible (Friel and Friel 1988). Casey (1990) and Capell-Sowder (1984) concentrate their discussions of codependency on the addictive relationship between the chemically dependent individual and the codependent. The implication here is that not only do individuals have personal addictions but that the relationship between them is an addiction in itself. Budenz (1990) supports this view indicating that the relationship between the codependent and the substance abuser have a positive linear relationship in terms of the progression and pervasiveness of their own personal addictions. Casey (1990) has broken this relationship down into three subclasses. The chemically induced mood swings when the addict is full of suppressed rage as they become obsessed with the need to drink or substance abuse again some time in the near future which results in the codependent attempting to "fix" the addicts anger. Loss of self-esteem results when the codependent realises that their attempts do not work. And the "learned behaviour mood swings" where the codependent will begin to integrate the extreme mood swings that they experienced in their families of origin into their own personalities to develop familiar ways of coping. This aspect of codependence concerning addictive relationships has resulted in codependency being referred to as "relationship addiction" (Miller 1989 and Wilson-Schaef 1986), "love addiction" (Bireda 1990; Norwood 1988 and Peabody 1989), "obsessive love addiction" (Forward and Buck 1991), "romance addiction" (Wilson-Schaef 1986), and "sex addiction" (Kasl 1989). While each of these addictions have their own separate foci

on differing aspects of a relationship, they are all categorised under the codependence label as manifestations of individual codependency.

2.3 CODEPENDENCY: PERSONALITY DISORDER

The personality disorder perspective of codependency indicates that as alcoholism and drug abuse are believed to be intergenerationally transmitted from the family of origin and that this cycle of perpetuation also occurs in relation to codependency (Woititz 1983), that substance abuse within a family of origin will result in the children from that family of origin growing up with codependency issues, that children from substance abusing homes may develop substance abuse problems themselves but that this substance use is only a symptom of underlying codependency, and that "process" addictions (WilsonSchaef 1989) will be evident if there is no indication of substance abuse. Process addictions include work, sex, relationships, body image, exercise and any other aspect of an individuals life, except substances, which ca be seen to follow the same addictive progression and pervasiveness as substance abuse.

Allcorn (1992) supports the personality disorder model and defines codependency as a "system of learned personality traits that adversely affect knowing others and one's self that leads to the compulsive development and maintenance of painful self-defeating and self-destructive intrapersonal and interpersonal life strategies". Implicit within Allcorn's (1992) definition in relation to substance abuse within a family system is the assumption that a causal linear relationship exists between the family of origin and the development of codependency. If codependency is described as a "system of learned personality traits" (Allcorn 1992), then individuals do not become codependent because they are in a relationship with a substance abuser. Rather they are in a relationship with a substance abuser because they are codependent. Inferring that codependency is an issue of personality traits that "adversely affect knowing others and one's self" (Allcorn 1992) indicates that codependency is an issue of self-identity and interpersonal intimacy. Friel & Friel (1988) support this view stating that "codependency has underlying issues of guilt, shame and fear of abandonment" which are learned by modelling dysfunctional patterns in the family of origin and affect the ability of the individual to achieve self-identity and interpersonal intimacy. Additionally, in relation to the "compulsive development of self-defeating and self-destructive intrapersonal and interpersonal life strategies" (Allcorn 1992) the presence of substance abuse, anxiety and stress disorders, depression, eating and obsessive compulsive disorders, and a large number of other clinical diagnostic entities are seen only as symptoms of underlying codependency.

The personality disorder theory, combined with the "disease" model and the effects of learned behaviour patterns from the family of origin is the rule rather than the exception to describing the characteristics of codependency. For this reason Allcorn's (1992) model gives one of the clearest explanations of the characteristics and effects of Codependency available in the literature to date.

2.4 CHARACTERISTICS OF CODEPENDENCY: ALLCORN'S MODEL

Allcorn's (1992) previously stated definition of codependency emphasises codependency as a rigid intrapersonal system of reinforcing thought processes, distorted feelings, and learned beliefs that interlock to provide self-defeating and self-destructive patterns of behaviour. Allcorn's (1992) definition also focuses on interpersonal behaviour that involves the codependent in tolerating abusive unproductive behaviour from others by avoiding self-assertion and by maintaining control of self and others through accepting responsibility for others needs.

While Allcorn (1992) accepts that codependency is a personality dysfunction, a continuum of thinking and feeling distortions is emphasised in the model which results in self-victimisation that can have limited duration and intensity. Ongoing self-victimisation is therefore a characteristic of the more compulsive end of the continuum and degrees of intrapersonal and interpersonal disorganisation are common. Allcorn (1992) organises the theoretical basis of codependency around a psychodynamic model and a learning model.

The psychodynamic model of codependency provides a theoretical explanation of the intrapsychic origins of codependency. The model highlights two axes, intrapersonal and interpersonal control, which ranges from high to low, and feelings of abandonment versus engulfment. This model identifies high levels of anxiety which are associated with pathological parenting and other conflict ridden aspects of childhood (Sandford & Donovan 1984), and indicates the psychodynamic model as one where codependents live their lives along a continuum. This idea of basic anxiety is a term used by Horney 1959 (cited in Allcorn 1992) to describe an insecure and apprehensive relationship of a child with their respective parent's which form the basis for knowing others and the world within which the child lives.

In terms of a learning model Allcorn (1992) emphasises that the catalyst of codependency is pathologically poor parenting. Poor parenting is believed by Allcorn (1992) to lead to the development of a false sense of self, low self-esteem, poor boundary management, and fears of engulfment and abandonment. Codependency is then re-learned throughout life from the compulsive acting out of dependency needs relative to others.

There are three types of codependents identified in Allcorn's (1992) model, the self-sacrificing type, the dominating type, and the withdrawn type. Each of these types of codependents are not mutually exclusive. Different types may be acted out in differing situations and to different degrees of intensity and duration.

Each of these types of codependents and related issues can be examined in relation to Cermack's (1986) diagnostic criteria for codependency. Cermack (1986) states that "the diagnostic essential features of codependency including;

A. "Continual investment of self esteem in the ability to influence/control feelings and behaviour in self and others in the face of obvious adverse consequences." and

B. "the assumption of responsibility for meeting others needs to the exclusion of acknowledging one's own needs," and

C. "anxiety and boundary distortions in situations of intimacy and separation," and

D. "enmeshment in relationships with personality disordered, drug dependent, and impulse disordered individuals," and

E. "exhibits (in any combination of three or more)
   1. Excessive reliance on denial
   2. Depression
   3. Hypervigilance
   4. Compulsions
   5. Anxiety
   6. Substance abuse
   7. Constriction of emotions (with or without dramatic outbursts)
   8. Has been (or is) the victim or recurrent physical or sexual abuse
   9. Stress related medical illnesses
   10. Has remained in a primary relationship with an active substance abuser for at least two years without seeking outside help.

CRITERION A

CONTINUED INVESTMENT OF SELF-ESTEEM IN THE ABILITY TO CONTROL BOTH ONE-SELF AND OTHERS IN THE FACE OF SERIOUS ADVERSE CONSEQUENCES

Cermack (1986) describes this criterion for diagnosis as "a complex set of behaviours and world views that combines many of the characteristics found in alcohol dependence and dependent personality disorders". The four distinctive elements identified by Cermack (1990) include, a distorted relationship to will power, (the belief that individuals can control their lives by sheer force of will), a confusion of identities, (the rise and fall of an individuals self-esteem based on the success or failure of their partner), denial (the use of suppression, repression, rationalisation, and projection to deny that the behaviour is resulting in negative physical, social and emotional consequences), and general low self-esteem.

Allcorn (1992), distinguishes between the three differing types of codependent. Type 1, the self-sacrificial type attempts to avoid the self-knowledge that controlling behaviour is self-defeating and that others are using them in a demeaning and humiliating way. The Type 1 codependent will work hard and do anything for others so that they will be held in high regard. The assumption for personal responsibility however is not accepted and others must maintain the codependents self esteem by admiring their martyrdom. In contrast the Type 2 codependent will attempt to avoid the knowledge that others are alienated by critical, abusive and overly dominating behaviour. If others do openly react negatively to the abusive behaviour the Type 2 codependents belief that they are unworthy of love and admiration are confirmed. The Type 3 Codependent attempts to avoid the knowledge that being isolated and lonely is painful and loss of self esteem is assured as the codependent actively avoids any confirmation of their worth.

Jampolsky (1990) lists a number of addictive beliefs of the codependent that fit closely with Allcorn's (1992) three types of codependency. In relation to type 1 codependents Jampolsky (1990) states beliefs of "my self-esteem is dependent on my being approved of by everyone on this plant", "I should be involved with and upset about other peoples problems", and "I am weak and need to be dependent on somebody or some thing else". Type 2 codependents have such beliefs as "If I am to consider myself worthwhile, I must excel, achieve, win, and display glowing competence at all times, in all places, and at all costs", and "all things that go wrong in my life are caused by other people". The type 3 codependent will have related irrational beliefs such as "I am limited in what I can do and that happiness that I can achieve" and "If I avoid painful issues and stuff my emotions down, I will be safe and happy".

Mellody (1989) states that "difficulty experiencing appropriate levels of self-esteem" is one of the five core symptoms of codependency. Problems with self-esteem is cited in the literature as one of the main aspects of codependency although it is referred to in different ways. Subby (1987) refers to self-esteem in the Codependent as "other-esteem". Bradshaw (1988) as "shame". Self-esteem, although subject to a lack of research, is implied by all the literature on codependence available at present.

CRITERION B

THE ASSUMPTION OF RESPONSIBILITY FOR MEETING OTHERS NEEDS TO THE EXCLUSION OF ACKNOWLEDGING ONE'S OWN

According to Cermack 1986 the assumption of responsibility for meeting others needs to the exclusion of ones own is a classic symptom of dependent personality disorder. The feeling of fear of abandonment becomes so great that the codependent is unable to distinguish their own needs from people whom they wish to like or love them. Each type of codependent does this in differing ways. The type 1 codependent uses self-sacrifice which must be accepted by others, the type 2 codependent aims at achieving perfection in winning encounters with people to gain admiration and in effect presumes to meet self-needs at the expense of others abandoning in the process the need to be loved, while the type 3 codependent will remain remote and withdrawn avoiding the responsibility of meeting both their own and others needs Allcorn 1992. Mellody (1989) indicates that difficulty acknowledging and meeting their own needs and wants is the second of the five core symptoms of codependency. This criterion of codependency is highly criticised by the womens movement for its lack of acknowledgement of society as one of the main causes of women taking up this role and the inability of the field to recognise taking care of others as a positive aspect of an individuals behaviour (Harper & Capdevilla 1990).

CRITERION C

ANXIETY AND BOUNDARY DISTORTIONS AROUND INTIMACY AND SEPARATION

Criterion C, involving boundary distortions and intimacy issues, is very similar to the DSM III-R borderline personality disorder. Cermack 1986 indicates that if this criterion is especially strong in a codependent individual the distinction between making a diagnosis of codependency Personality disorder and Borderline Personality disorder becomes difficult. The basis of this criterion is that individuals equate intimacy with becoming enmeshed with others in interpersonal relationships. If

interpersonal distance is increased there will be a corresponding fear of abandonment. The distinction between Codependent Personality disorder and that of the Borderline disorder is that Codependents voluntarily ignore their own boundaries in the search for intimacy while Borderline Personality disordered individuals are not believed to possess the ego strength of being able to maintain boundaries in the first place.

The type 1 codependent will personally experience the feelings, pain and problems of others with no regard for personal integrity or action. The type 2 will remain within rigid boundaries and avoid intimacy of any kine by alienating others. Problems are solved by insuring that others will not like them. The type 3 codependent will retreat from others and will avoid both engulfment and abandonment by remaining alone.

Woititz (1985) indicates a number of codependent myths which are the basis for the codependents problem with boundaries. Among these myths are beliefs that "If you find out that I am not perfect you will abandon me", "Being vulnerable always brings negative results", "We must never argue or criticise each other", "In order to be lovable I must be happy all the time" "You must instinctively anticipate my every need desire and wish" and "If we really love each other we will remain together for ever". These beliefs result in the codependent entering three differing types of relationships. The engulfment/abandonment relationship, in which one partner fears abandonment and attempts to keep the other partner close while the other partner fears engulfment and attempts to keep their partner at a distance, the engulfment/engulfment relationship, where both partners fear abandonment and are so enmeshed that they are hardly aware of the outside world, or an abandonment/abandonment relationship, where both partners fear engulfment so remain at a distance that is safe by that at the same time does not enable intimacy (Kristberg 1990). Mellody (1989) indicates that a difficulty setting functional boundaries is the third of the five core symptoms of codependency.

CRITERION D

ENMESHMENT IN RELATIONSHIPS WITH PERSONALITY-DISORDERED, CHEMICALLY DEPENDENT, OTHER CODEPENDENT, AND/OR IMPULSE-DISORDERED INDIVIDUALS

Cermack 1986 states that "codependence is not referenced exclusively to a relationship with an alcoholic or drug addict". Codependents will become attracted to any individual who seems similar to themselves or within whom they see potential that they can change. The type 1 codependent will become involved in relationships which require selfless caring, the type 2 in relationship that are characterised by

aggression and win-lose dynamics. The Type 3 will again avoid relationships altogether resulting in feelings of rejection and worthlessness.

Miller 1989; Stafford & Hodgkinson 1991; & Wilson-Schaef 1986; 1987; & 1989, place the major emphasis of the effects of codependence on relationships. The need for individuals to remain in relationships which lack intimacy, which are abusive and which have addictive elements. This aspect of the codependent movement is the one that has appealed primarily to women. The ideal of the perfect relationship within which one can achieve all their goals and develop their potential with another individual to obtain complete self-fulfilment is the goal. The barriers to this goal are unresolved issues from the family of origin which have resulted in women feeling that they are not capable of being loved and settling for relationships in which they feel needed. These women become attracted to needy partners within whom potential for change can be seen. It is up to the women themselves to fix their partner for which they will at some stage receive never ending gratitude. At the same time these women are believed to have created a situation in which they can re-enact the unresolved issues from their family of origin (BellUnger 1988). The one issue not discussed by these theorists is the unknown number of women who come from dysfunctional families of origin and who do not become involved in abusive relationships or develop stress-related medical illness or addictions to substances or other process addictions.

While there is a significant amount of literature related to women with these related problems of codependency there is a scarcity of literature related to the differences between individuals labelled codependent and those from similar backgrounds who are not.

CRITERION E
EXHIBITS (IN ANY COMBINATION OF THREE OR MORE):

EXCESSIVE RELIANCE ON DENIAL

Codependents deny that problems exist as acknowledgment of problems means control is lost and that self reflection is necessary to gain insight into the dimensions of the problem. Negative experiences related to others and to feelings that are felt to be inappropriate and uncontrollable, for example anger, are also denied by the codependent. Self-sacrificial codependents deny that others do not care and respect them and increase their self-sacrificial actions if others express feelings of rejection and dislike towards them. Type 2 dominating codependents deny that alienating others has adverse consequences of abandonment, while type three codependents deny that being lonely is painful by becoming involved in

compulsive and ritualistic behaviour to block attention to the anxiety created by the denial.

Smith (1990) in attempting to explain the codependents distorted thinking patterns indicates several ways in which a codependents distorted thinking results in denial. Among these is the tendency for the codependent to justify and analyse problems resulting in defensive forms of explanations and the intellectualising of problems. The codependent will also tend to minimise problems being vague and non-specific as well as shifting the focus of an issue by re-defining a problem. Smith (1990) also reports that dishonesty is one of the most common characteristics of denial with the codependent making up things that are not true, telling part of the truth with major omissions, and pretending to agree with someone else's plans but having no intention to go along with them. Victim playing is also common among codependents and Smith (1990) states that "the victim player interacts with others to invite either criticism, rescue or enabling behaviour from those around them" pg 46.

Mellody (1989) states that "difficulty owning their own reality is the fourth core symptom of codependency." The problem with denial as one of the main issues of codependency is that individuals do not have the ability to question the labelling of their behaviour because they are in denial. The participation in a "recovery" program for life is thus paramount because individuals are not ultimately able to judge whether they are slipping back into codependency or not.

CONSTRUCTION OF EMOTIONS (WITH OR WITHOUT DRAMATIC OUTBURSTS)

Codependents both constrict emotions that are felt to be negative, for example anger, and loneliness, and also positive feelings such as intimacy and happiness. The Type 1 codependent becomes passive and dependent, the type 2 denies their aggression and negative interpersonal interactions, and the type 3 withdraws from emotional life altogether. Accepting and acknowledging the codependents reality moderately is the fifth core symptom of codependency cited by Mellody 1989. Wegscheider-Cruse (1985) indicates that codependents will tend to make "black and white" judgments and that there is usually always a fear of an outburst of emotion, primarily anger. Codependents then try to remain as stables and neutral as possible controlling their environments to minimise uncontrollable outbursts. The paradox of this criterion is that if an individual does erupt into tears or anger the individual is seen to be in the middle of an uncontrollable codependent stage which is obviously deteriorating as a result of their inability to maintain control. The placement of this criterion on a continuum implies that if individuals are maintaining control then they are rigidly codependent and if they are having periods

that show their inability to maintain control then their codependency is becoming unstable.

DEPRESSION

Depression in codependents arises from the constriction and suppression of feelings and thoughts. Acknowledgment of depression is a problem because the sense of self-control is then lost. Depression has been substituted as a team for codependency in relation to women (Webster 1990). The need for very careful diagnosis of depression as long-standing or situational is apparent, although this distinction is not made within the literature on codependence. Situational depression is seen more as the resurfacing of codependency on a continuum as past issues arise that must be dealt with than an obvious reaction to situation grief and loss in the present life of the individual.

HYPERVIGILANCE

The codependent constantly monitors self and others for problems that may imply loss of self control. Unacceptable feelings and thoughts conflict with the image of the ideal self. Codependents with excessively high standards for both self and others create highly stressful environments where no one is ever good enough. Jampolsky (1990) states that one of the most common codependent beliefs is "If I want safety and peace of mind, I must judge others and be quick to defend myself". To do this the codependent must analyse every person and situation quickly and accurately to enable the categorisation of individuals and situations so that any that are threatening can be attacked immediately. Codependents will then scan the environment for signs of impending disaster resulting in a state of free-floating anxiety.

COMPULSIONS

Codependents act out compulsive behaviours to redirect attention away from feelings and thoughts that are becoming threatening. Compulsions and hypervigilance combined may result in obsessions with perfection. Wegscheider-Cruse (1989) indicates that the first stage of codependency is the seeking out of some sort of change of mood that is pleasurable or relief-producing. Different substances and behaviours will be sort out by different individuals. Compulsive behaviours in this sense are the main focus of the progressive part of addictive codependency and include both substance addictions and process addictions (Wilson Schaef 1987). Process addictions are those that involve behaviours such as

bulimia, anorexia, compulsive eating, gambling workaholism and relationship dependency (Wegscheider-Cruse 1989).

ANXIETY

Allcorn (1992) states that "anxiety is the central psychodynamic experience that energises codependency". Anxiety is always present as codependents move between fears of engulfment and abandonment. Compulsions therefore are seen as the way in which codependents hide their anxiety from others and themselves. Thus codependent anxiety can be seen in a number of forms; free-floating, chronic, panic attacks and phobias.

SUBSTANCE ABUSE

The development of a substance abusing problem is common as codependents attempt to numb their feelings and emotions. Substance use is also used to alter excessive anxiety, depression and self-destructive thoughts. Substance abuse in this sense is an outcome of underlying codependency. Research to date has failed to support the assumption that substance abuse is not the primary issue in individuals who present as having a substance abuse problem and because of their life circumstances are labelled as primary codependent and not addicted to a substance.

HAS BEEN (OR IS) THE VICTIM OF RECURRENT PHYSICAL, EMOTIONAL OR SEXUAL ABUSE

The type 1 codependent is particularly likely to be involved in a relationship where physical, emotional or sexual abuse is current (Allcorn 1992). Abuse is usually minimised and fear of separation and abandonment by the codependent result in the belief that the abuse is deserved. This criterion has two aspects which are blaming in terms of how the codependent is dealing with past and/or present abuse. Although the continuation of a codependent in an abusive relationship can be explained by past abuse it is the individuals inability to deal with this abuse in the correct way that results in further abuse in present relationships. The codependent is then felt to be gaining something from present abuse which they need to confirm their own experiences of what they are worth. The lack of research support for this idea of need to re-enact an individuals abusive past is one of the main reasons that the label of codependency needs to be applied with extreme care.

STRESS-RELATED MEDICAL ILLNESSES

Stress related medical illnesses can occur for two reasons. Firstly, the codependent needs to expand considerable energy in controlling self and others resulting in physiological stress related headaches, hypertension, ulcers, eating disorders and sexual dysfunctions Allcorn (1992). Secondly, poor boundary management contributes to the codependent picking up symptoms from others in the form of hysterical conversions or hypochondria. Wegscheider-Cruse (1989) reports that codependents often suffer from migraines, colitis, intestinal problems and other stress-related illness which occur as a result of the codependents low energy levels, and feelings of powerlessness. Wilson-Schaef (1989) indicates that cancer is a common outcome of codependence but makes this assumption on the basis that stress related illness can be life threatening rather than on the basis of research into the number of codependents with cancer. The causal implication that cancer has a positive linear relationship with codependence places the blame of such life threatening illnesses on the codependents internal lack of ability to uncover their denial and take responsibility for their own lives.

HAS REMAINED IN A PRIMARY RELATIONSHIP WITH AN ACTIVE SUBSTANCE ABUSER FOR AT LEAST TWO YEARS WITHOUT SEEKING OUTSIDE HELP

Cermack (1986) considers two years to be long enough to have developed insight into the action necessary to change or finish a destructive relationship. Beyond this point the codependent is judged to be invested in the relationship and committed to an irresistible course of self-destructive behaviour. Remaining in a primary relationship with a substance abuser is traditionally the main diagnostic criteria for an individual to be labelled codependent. This criteria however does not take into consideration the aspects of emotional and financial links that the codependent may have with the substance abuser. The bias for this criterion as a diagnostic criteria is the believed distorted thinking of the need to change the substance abuser in a way which will reinforce the codependents self-esteem and belief in their need to control others around them.

MODELS OF ASSESSMENT

The literature on codependency characteristics gives a number of examples of codependency scales (Potter-Efron & Potter-Efron 1989). Two of the most frequently cited scales in the literature are presented by Cermack (1986) and Friel (1985). Cermack's (1986) scale essentially consists of open ended questions which make objective scoring difficult. Reliability and validity of the scale have not been investigated to date.

Calleros (1990) bases assessment of codependency on an investigation of the Friel Codependency Assessment Inventory. Through factor analysis Calleros (1990) identifies five dimension on which assessment can be based. They are "perceived incompetence" which measures the extent to which an individual thinks they have sufficient resources to take care of themselves emotionally, or to cope with lifes difficulties, "perceived lack of interpersonal efficacy" which measures the level of skills involved in relating to others, "perceived personal failures" which identifies the individuals level of irrational cognitions and self-defeating belief systems, "perceived lack of support" which measures the extent to which the individual feels that they have inadequate help with day to day living tasks, the extent to which they have time to themselves and the extent to which they assume responsibility for more than their share of the work, and "perceived communication patterns in the family of origin" which measures the individuals recollection of the extent to which expressions of feelings, affection, open discussion of problems, and negative coping styles were modelled in the family of origin.

Potter-Efron & Potter-Efron (1989) have also formulated a codependency assessment inventory which records the self-reports of the following eight groups of characteristics of codependency. Fear, indicated by preoccupation with the problems of others, persistent anxiety, avoidance of interpersonal risk and controlling behaviour. Shame and guilt indicated by persistent feelings of shame related both to one's own and others behaviour, guilt about the problems of others, isolation, self-hatred and the appearance of arrogance and superiority when linked with low self-worth. Prolonged despair, indicated by hopelessness, pessimistic world views, low self-worth and a sense of failure. Anger, indicated by fear of loss of control spiritual anger and passive aggressive behaviour. Denial, indicated by minimisation and the use of justifications that protect others from negative consequences. Rigidity, indicated by cognitive, behaviour, spiritual and affective inflexibility. Impaired Identity Development, indicated by boundary separation difficulty and personal dependency. And Confusion, indicated by persistent uncertainty about what is normal, real and what one is feeling, gullibility and indecisiveness. Again there is no empirical research to support this assessment inventory and the categories of assessment criteria are based solely on clinical observations.

MODELS OF TREATMENT

Calleros (1990) is one of the few researchers who relates treatment of codependency back to an empirically researched model, and in fact identifies six dimensions on which a therapist can base treatment. These dimensions are directly related to the subscales identified from research of the Friel Codependency Assessment Inventory. The first dimension, "perceived incompetence", is treated through helping the individual to identify self-defeating belief systems and changing individual cognitions and behaviours to enable the individual to be more effective in their interpersonal relationships and their daily life style. The second dimension "interpersonal efficacy", can be treated with the use of assertiveness training, and basic communication work. The third dimension "perceived personal failures", can be treated through the establishment of achievable personal goals to link the individuals realistic assessment of their present life position. The fourth dimension "perceived lack of support", involves treatment issues which revolve around identifying areas where the individual is being supported, areas where they need more support, and also in helping the individual to identify others who have a high probability of complying with their request for help. The fifth dimension, "perceived communication patterns in the family of origin", involves treatment through looking at the resolution of family myths and negative coping styles. Parenting skills programs may be used to help break the cycle of perpetuation (Calleros 1990).

Collette (1989) discusses a number of alternative therapy approaches to healing the codependent, and states that "the traditional talk-therapies are limited in their ability to uncover repressed experience which continue to contaminate the present". Therapy methods identified include Reichian therapy, Rolfing, Bioenergetics, Tragering, Rosen Therapy, Feldenkrais, Dance/Movement, Lomi and Breathwork, Gestalt therapy, Meditation and Hypnosis. However, while discussing the process of each of these therapies in detail, Collette (1989), fails to discuss them in relation to the codependency construct. What effects that these therapies have in treating the identified codependent are not clear.

Friel & Friel (1988) base treatment on a model of codependency that uses the psychodynamic notion that what is on the surface (the overt symptoms of addiction, depression, stress disorders, panic attacks, and other clinically diagnostic problems), are tied to issues of inner guilt, shame, and fear of abandonment which are learned in the family of origin. Treatment is then based on "recovery" Friel & Friel 1988. The process of a recovery program for codependents was developed from those already established for the chemically dependent individual. The first step in recovery is to stop practicing actively the behaviour which is seen to be addictive, whether it be a relationship, a substance or what ever is identified by the individual as

the problem. The next step is to identify the underlying codependency issues. These will be primarily issues of identity which requires the individuals past and family of origin to be brought out into the open. Individual psychotherapy plus group psychotherapy is needed in the form of recovery programs such as those developed in Alcoholics Anonymous (AA), Al-Anon, for families of substance abusers, Adult Children of Alcoholics (ACOA), and/or Codependents Anonymous. All treatment programs in effect today and cited in the literature refer to recovery as the basis for codependent treatment (Calleros 1990).

PRESENT STUDY

It is a basic premise that codependency results from being raised in a home where substance abuse was/is a problem, that substance abuse is a symptom of underlying codependency, and that children who grew up in families where substance abuse was a problem tend to marry or enter relationships with partners who are substance abusers. The objective of the present study was to investigate the relationship between these three underlying premises of codependency to attempt to bridge the gap between the lack of research into assessment and treatment of codependency and the literature on the characteristics of codependency. The specific aims of the present study were threefold.

Firstly to investigate the differences between individuals who identified themselves as codependent, (in a love/romantic and/or sexual relationship with a substance abuser for a period of not less than two years Cermack 1989), and those who do not identify as codependent, in terms of their perceptions of substance use in their family of origin and their own present use of substances. The Friel Codependency Assessment Inventory (FCAI) (Friel 1985), presently the only investigated scale of codependent severity indicating high reliability and validity criterions (Calleros 1990), was used to establish the degree of individual codependency on a continuum scale to enable the scores to be compared to individual levels of family of origin substance use and present level of personal substance use. The objective was to establish whether levels of severity of codependency could be correlated with levels of severity of family of origin substance use and present personal substance use.

The second aim of the present study was to attempt to establish whether differences in gender in relation to codependence are supported as indicated by the literature. Male and Females scores on the FCAI were compared with scores on the children of alcoholics screening test (CAST) (Jones 1981) and the Michigan Alcoholic Screening Test (MAST) (Skinner 1979) to indicate patterns of responding that differ between the genders.

The third aim of the study was to expand the research into developing treatment areas for identified codependents. Calleros (1990) has identified five treatment areas on the FCAI. The need to support these five areas of treatment with further research is paramount if the FCAI is to be established as an assessment and treatment tool.

It is important to note that underlying these three specific aims was the implicit assumption that if the characteristics of codependency are as widespread as the literature portrays them to be then using a university population rather than subjects from an alcohol and drug centre should not confound any significant results found

and should support the claims put forward by proponents of the codependency concept rather than refute them.

METHOD

SUBJECTS

Two hundred students enrolled internally at Massey University participated in the research phase of this study. Of these 62% (125) were females ranging in ages from 18 to 45, and 38% (75) were males ranging in ages from 18 to 49.

Subjects were volunteers from first, second and third year psychology papers. University women were selected to compare with previous research which has concentrated solely on participants from alcohol and drug centres. The use of women subjects from alcohol and drug centres has contributed to previous research conclusions that codependents are usually women. The move to establish codependency in the general mental health field requires research into populations who identify with similar issues as those in the alcohol and drug field but who are not direct samples from the limited population of alcohol and drug centres. University men were selected to enable a comparison of gender from the same sample.

MEASURES

Four measures were used in the collection of research data for the study: (1) The Children of Alcoholics Screening test (CAST), chosen to measure subject's family of origin history of substance abuse in their family, (2) the Michigan Alcoholic Screening test (MAST), chosen to measure the subject's own present personal use of substances, (3) the Friel Codependency Assessment Inventory (FCAI), chosen to measure aspects of individual codependency, and (4) a Personal Status Questionnaire (PSQ), to establish the subject's history of relationships with substance abusers (Appendix A).

PSYCHOMETRIC PROPERTIES OF THE MEASURES

THE CHILDREN OF ALCOHOLICS SCREENING TEST (CAST)

The CAST (Jones 1981; Pilaf & Jones 1985) is a Yes/No questionnaire measuring the subjects perceptions, attitudes and feelings surrounding their parents drinking behaviour when they were growing up in a home where drinking was present in the family. The CAST is scored by counting the number of "yes" responses. An individual score or six or more "yes" responses is used to identify the individual as an Adult Child of an Alcoholic (ACOA).

Reliability and Validity statistics of the CAST have indicated criterion validity coefficients of .78 and .79. Split-half reliability coefficients of .98 have also been obtained. Jones (1991) describes two validity studies of the CAST. One study compared clinically diagnosed children of alcoholics with a randomly selected control

group and a group of self-reported children of alcoholics. The control group indicated a mean of .7, as compared to a mean of 17.4 for the diagnosed children of alcoholics and 19.1 for the self-reported children of alcoholics indicating the ability of the questionnaire to discriminate between the samples within a population.

THE MICHIGAN ALCOHOLIC ASSESSMENT INVENTORY (MAST)

The MAST is a 24 true/false questionnaire which measures an individuals self-report index of alcohol involvement. The cutoff points which indicate an individual as having a problem with alcohol differ depending on different researchers. Potter & Williams (1989) indicate that a cutoff score of 4 is adequate, while Selver (1971) recommended 5. More recent publications of the MAST recommend a cutoff point of 4-6 to be suggestive of a problem with alcohol and 7 and above to indicate a definite problem. The exception is when positive answers to questions, 8, 19, & 20 are found as these are indicated to be diagnostic questions. Ross, Gavin & Skinner (1990) support the cutoff points of 13/14 on the MAST to enable the MAST to fit the DSM-III (American Psychological Association 1987), criteria for chemical dependence. For the purpose of the present research the cutoff point of 7 was accepted to reduce the number of false negatives (Type 1 errors). The reasons for this were twofold. Firstly, cutoff points of 7 are those that are usually accepted in Alcohol and Drug centre intake interviews, and secondly, a number of the questions relating to the use of alcohol could result in the subject obtaining scores of 4 or above after one drinking experience and do not substantiate the classification of a problem with drinking.

One adjustment was made to the questionnaire. For the purposes of the present study the inclusion of the words "substance use/user" was placed after the word "drinking" in all questions.

In general the MAST has been cited to be more reliable and valid than other measures of personal substance use. Mischke & Venneri (1987) in assessing the significance of drinking problems of individuals convicted of drinking and driving by counsellors, compared the reliability and validity of the MAST with two other questionnaires, the Mortimer-Filkins questionnaire (MFQ) and the CAGE. Results indicated that the MAST had higher reliability (.84), higher validity (.65), greater test defined agreement with counsellor defined problem drinkers (85%) and a higher rate of test-defined problem drinkers (46%). Friedrich & Loftsgard (1978) investigated the responses of wives and husbands where the husband had been diagnosed as the problem drinker on the MAST and the MacAndrew Scale (MAC). The MAST identified 100% of the husbands as alcoholic while the MAC identified 79% indicating

a higher face validity in the self-reporting of subjects on the MAST as compared to the MAC.

The implications of these results suggest that the MAST can distinguish between different degrees of alcohol abuse but that the extent of pervasiveness of the alcohol abuse needs to be carefully considered. Skinner (1979) found that internal consistency reliability estimates were .90, and that five factors were identified through a factor analysis of the MAST. These factors were, the recognition of an alcohol problem by self and others; legal, work and social problems, help seeking; marital-family problems, and liver pathology. Skinner 1979 in the interpretation of MAST scores stressed a continuum of severity of alcoholic involvement as opposed to the use of the MAST as a diagnostic tool.

Further results suggest that the use of the MAST in establishing the substance abuse of both males and females will not confound the results. Selzer, Gomberg & Nordhoff (1979) found no significant differences between the scores of me and women who were attending a hospital alcoholism program on the MAST. While the men scored significantly higher on 7 of the 24 items 97% of the men and 92% of the women scored over 10. Selzer et al (1979) indicated that the differences on many of the MAST items were logical and predictable for the sex especially in terms of drinking patterns. The differences between males and females are not significant enough to invalidate the resulting scores.

THE FRIEL CODEPENDENCY ASSESSMENT INVENTORY (FCAI)

The Friel Codependency Assessment Inventory consists of 60 true/false descriptive statements regarding the intrapersonal feelings, thoughts and behaviours of codependents in terms of interpersonal relationships. Items are scored in an alternative fashion with a one point score given to every odd item marked false and every even item that is marked true. Subjects can score up to a total of 60 and a minimum of zero.

Friel (1985) reports that scores below 20 indicate an individual with few codependent concerns, scores from 21 - 30 indicate individuals with milk to moderate codependency concerns, scores from 31 - 45 indicate individuals with moderate to severe codependency concerns and those who score 45 and above as individuals with severe codependency concerns.

Calleros (1990) in an investigation of the FCAI found that the scale demonstrated a very high reliability of .92, that the construct and criterion validity were confirmed with group differences being found among codependents and also between codependents and controls, that the validity of the scale was sustained when the effects of daily stress were statistically controlled, and that the emergence

of five subscales (incompetence, efficacy in interaction, personal failures, lack of support, and communication in the family of origin), each had a reliability of .70 or higher.

A number of additional findings as a result were also found as a result of using an extensive demographic questionnaire. Firstly, codependents and control indicated significantly different levels of physical and mental health. Physical and sexual abuse was more prevalent in those codependent groups whose members were adult children of alcoholics (ACOAS). Stress was found to be related to four of the subscales (interpersonal efficacy, lack of support, personal failure, and communication in family of origin) but not in relation to perceived incompetence.

Additionally, Calleros states that "although the codependent group levels of pathology were differentiated by the FCAI, the distribution pattern of scores across the four groups was unanticipated, the highest level of pathology being found among the Adult Children of Alcoholic (ACOA) group only, instead of the codependent and the ACOA group". The 1990 investigation by Calleros is the sole research to date involving this particular inventory.

PERSONAL STATUS QUESTIONNAIRE

This questionnaire was developed specifically for the present research. The questionnaire asked subject 3 sets of questions. Each question was designed to evaluate an individuals past and present love/romantic and/or sexual relationships with substance abusers. Each question also required the subject to record the number of years they were involved in each of these relationships. A cut off point of two years in at least one of these relationships was set to meet Cermacks (1986) criteria for codependency.

A definition describing alcoholics/substance abusers was included at the top of the questionnaire. The definition in question was taken directly from the research conducted by Calleros (1990) and it is important to acknowledge that this definition was specifically used, not only for its simplicity and face validity, but also to allow direct comparisons with Calleros's (1990) findings.

The Personal Status Questionnaire was used specifically in line with criteria set by Calleros (1990) and Cermack 1986 to identify subjects as codependents. This was particularly important in view of the use of codependency as a term to describe individuals who are/have been in relationships with substance abusers.

PROCEDURE

The questionnaires were administered to undergraduate students. Subjects were approached during psychology lectures and asked if they wished to volunteer to fill in a questionnaire on their own time. Subjects were informed that the questionnaire concerned substance use and interpersonal relationships. Informed consent was obtained through a consent form attached to the front of each questionnaire. Subjects were assured that their responses would be treated confidentially and that their names would be detached from the questionnaire as soon as it was received by the researcher. Subjects were also given the opportunity to request a summary of the research if they included their address on the consent form.

Subjects were given the questionnaires to take away with them to allow the students the opportunity to withdraw from the research because of the personal natures of the questionnaire. Subjects were requested to return the questionnaires within a two week period and to hand them in at the Massey University psychology office.

DATA ANALYSIS

The first task of the data analysis was to classify subjects into groups on the basis of the first three questionnaires; the PSQ, the CAST and the MAST. The criteria used to classify subjects into the relevant groups is indicated by table 1. Eight groups were classified, (1) the control group, (2) the family of origin substance abuse only group (ACOA), (3) the substance abusers only group (SA), (4) the family of origin substance abuse and personal substance abuse group (ACOA + SA), (5) the codependent only group (CODEP), (6) the codependent and family of origin substance abuse group (CODEP + ACOA), (7) the codependent and personal substance abuse group (CODEP + SA), and (8) the codependent and family of origin substance abuse and personal substance abuse group (CODEP +ACOA + SA).

Three other groups were classified and became combination groups as they combined various attributes from the above groups for the purpose of examining the underlying posits of the codependency theory that family of origin has a casual-effect relationship with codependency and that substance abuse in an indication of underlying Codependency. These three groups were classified as (1) the total population group (TOTAL), (2) the groups classified as having codependency, family of origin substance abuse, and personal substance abuse (CODEPSALL), and (3) the codependent only, family of origin only, and the codependent and family of origin substance abuse groups (CODEPACOA).

TABLE 1:

CRITERIA FOR THE CLASSIFICATION OF SUBJECTS INTO EXPERIMENTAL AND CONTROL GROUPS

SCORES ON CAST	SCORES ON MAST	SCORES ON THE THREE PSQ QUESTIONS	RESULTING GROUP THAT THE SUBJECT WAS CLASSIFIED INTO	NUMBER OF SUBJECTS IN EACH GROUP
≤ 5	≤ 6	NO FOR ALL QUESTIONS	CONTROL GROUP	90 (45%)
≥ 6	≤ 6	NO FOR ALL QUESTIONS	ADULT CHILDREN OF ALCOHOLIC GROUP	21 (10.5%)
≤ 5	≥ 7	NO FOR ALL QUESTIONS	SUBSTANCE ABUSING GROUP	18 (9.0%)
≥ 6	≥ 7	NO FOR ALL QUESTIONS	ADULT CHILDREN OF ALCOHOLIC + SUBSTANCE ABUSING GROUP	15 (7.5%)
≤ 5	≤ 6	YES FOR ANY/ALL OF THE THREE SETS OF QUESTIONS	CODEPENDENT ONLY GROUP	27 (13.5%)
≥ 6	≤ 6	YES FOR ANY/ALL OF THE THREE SETS OF QUESTIONS	CODEPENDENT + ADULT CHILDREN OF ALCOHOLIC GROUP	11 (5.5%)
≤ 5	≥ 7	YES FOR ANY/ALL OF THE THREE SETS OF QUESTIONS	CODEPENDENT + SUBSTANCE ABUSING GROUP	6 (3.0%)
≥ 6	≥ 7	YES FOR ANY/ALL OF THE THREE SETS OF QUESTIONS	CODEPENDENT + ADULT CHILDREN OF ALCOHOLIC + SUBSTANCE ABUSING GROUP	10 (5.0%

Once the Subjects had been classified into their relevant groups descriptive statistics were used to describe the scores of each of the first 8 groups on the FCAI (codependent inventory). Within group differences were described using an analysis of variance (ANOVA).

Descriptive statistics were also used to compare female and male differences on the FCAI. An ANOVA measured the differences between males and females on the TOTAL group, (total population), and gender on the FCAI (codependent inventory). Two "a priori" contrasts were also performed. The first was to describe (a) the COPDEPSALL group, (codependent plus family of origin substance abuse plus personal substance abuse groups), and gender differences on the FCAI, and the second to describe (b) the CODEPACOA group (codependent only, family of origin substance abuse only, and codependent and family of origin substance abuse), and gender differences on the FCAI.

A partial regression then looked at nine correlations. The first three correlations looked at the relationship between the TOTAL group, the CODEPSALL group, and the CODEPACOA group levels on the FCAI holding scores on the CAST, (family of origin substance abuse inventory), constant. The reason for holding the CAST constant was to describe the relationship between personal substance abuse and codependence. If substance abuse is an indication of underlying codependency then a positive linear relationship would be predicted. The second group of partial regressions were calculated on the CAST and the FCAI holding the MAST constant for the three groups described above. If family of origin substance abuse has a casual-effect relationship with codependency then a positive linear relationship would be predicted even with the exclusion of symptoms of codependency such as personal substance abuse. The final group of partial regressions were calculated on the CAST and the MAST holding the FCAI constant for the same three groups described above. The reason for holding the FCAI constant was to investigate the relationship between family or origin substance abuse and personal substance abuse. If family of origin has a cause-effect relationship to codependency and personal substance abuse is a symptom of codependency, and hence family or origin substance abuse then a positive linear relationship would also be predicted.

In an attempt to replicate the analysis of Calleros (1990) a principal components factor analysis was performed on the FCAI (codependent inventory), using orthogonal (varimax) rotation. Three factor analyses were performed using the TOTAL group, the CODEPSALL group, and the CODEPACOA group.

In summary, the data analysis addressed the following hypotheses:

H_1: Among codependents, those who score positively on the PSQ, (classified as codependent), equal to 7 and above on the MAST, (classified as substance abusers), and equal to 6 or above on the CAST, (classified as having family of origin substance abuse), will score significantly higher on the FCAI (codependent inventory) than those who are only codependents (codeps), only have family of origin substance abuse (ACOA) or only have personal substance abuse (SA). That is codependents who have multiple symptoms related to codependency, family of origin substance abuse and personal substance abuse) will indicate more codependent characteristics, (indicated by higher scores on the FCAI), than subjects who have only one symptom of codependency.

H_2: Codependents who score high on the FCAI for codependence will show correspondingly high levels of scores on the MAST (personal substance abuse inventory) and the CAST (family of origin substance abuse inventory). That is a positive linear relationship is predicted between the FCAI and the MAST, the FCAI and the CAST, and the MAST and the CAST.

H_3: Female codependents will score significantly higher on the FCAI, (codependent inventory), than males who are identified as codependent. That is female codependents will report more characteristics of codependency, (as indicated by higher scores on the FCAI), than male codependents.

H_4: Factor analysis of the FCAI will confirm the factors identified by Calleros (1990). That is;

(a) a sample of university students will show similar patterns of codependency characteristics when evaluated as the previously identified alcohol and drug centre subjects;

(b) a sub-sample of codependents (CODEPSALL) within a student population will show similar patterns of codependency characteristics when evaluated as the previously identified alcohol and drug centre subjects;

(c) a sub-sample of codependents (CODEPACOA) within a student population will show similar patterns of codependency characteristics when evaluated as the previously identified alcohol and drug centre subjects.

RESULTS

The distribution of subjects into groups as a result of the screening procedure resulted in about half, 45% (90), of the subjects were placed in (a) the control group with no report of a relationship with a substance abuser, no family of origin substance abuse, and no personal substance abuse; 10.5% (21) into (b) the ACOA (family of origin substance abuse) group only; 9.0% (18) into (c) the SA (personal substance abuse) group only; 7.5% (15) into (d) the ACOA and SA (family of origin substance abuse and personal substance abuse) group; 13.5% (27) into (e) the codependent (relationship with a substance abuser for a period of at least two years) only group, 5.5% (11) into (f) the ACOA and Codependent (family of origin substance abuse and relationship with a substance abuser for at least two years) group, 3.0% (6) into (g) the SA and Codependent (personal substance abuse and a relationship with a substance abuser for at least two years) group; 5.0% (10) into (h) the ACOA and SA and Codependent (family of origin substance abuse and personal substance abuse and a relationship with a substance abuser for at least two years) group; and, 1.0% (2) into (i) the missing group (incomplete data).

Hypothesis 1 (number of symptoms) was investigated with a comparison of the group means of each group with scores on the FCAI (codependent inventory). Results are indicated by Figure 1. The analysis of variance *[F(7,190)=1.56 p=.15]* indicated no significant difference was found between the groups with only codependence (CODEP), only family of origin substance abuse (ACOA), and only personal substance abuse (SA), as compared to the multiple symptoms groups (codependence and family of origin substance abuse (CODEP + ACOA), family of origin substance abuse and personal substance abuse (ACOA + SA), codependent and personal substance abuse (CODEP + ACOA) (Figure 2). Therefore there is no evidence that any one of the above mentioned groups, (Groups 1-8) have more codependent characteristics as identified by the FCAI (codependent inventory) than any of the other groups (groups 1-8) suggesting that either the FCAI is unable to distinguish between groups with differing levels of codependence or that the population is not an adequate sample to reflect codependency characteristics.

Hypothesis 2, (Codependents who score high on codependency, will show corresponding high levels of scores related to family of origin substance abuse, and personal substance abuse), found that for the three groups, the TOTAL group (all subjects N=198), the CODEPSALL GROUP (all subjects who indicated codependency, family of origin substance abuse, and personal substance abuse N=108) and the CODEPACOA group (codependents only, family of origin substance abuse only, and codependent + family or origin substance abuse N=59), there were no significant relationships found between the FCAI (codependent inventory) and the

DIFFERING SUBJECT GROUP MEAN AND STANDARD DEVIATION

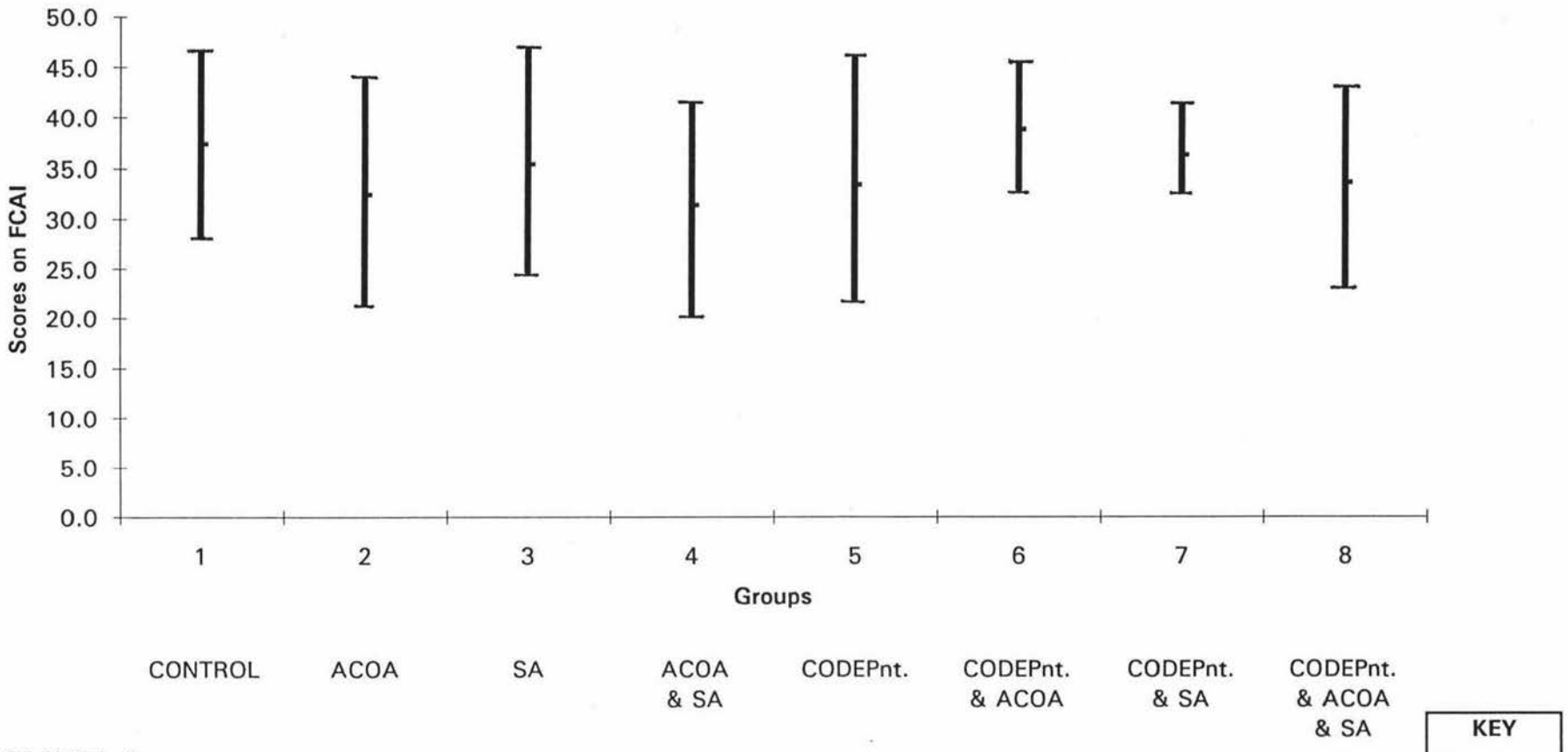

FIGURE 1:

A Comparison of each Subject Group with resulting overall Mean Scores and Standard Deviations on the FCAI.

MAST (personal substance abuse inventory) *[r(197)=-.03 p=.70] [r(107) =.025 p=.80]* and *[r(58) =-.045 p=.64]* respectively for above groups. Additionally, no significant relationship was found between the above groups, (the TOTAL GROUP, the CODEPSALL GROUP and the CODEPACOA group), when compared to the FCAI and to the CAST (family of origin substance abuse inventory), with results of *[r(197)=-.11 p=.12] [r(107)=-.045 p=.64]* and *[r(58) =.035 p=.80]* respectively for the above three groups.

Two of the groups however, (the TOTAL group and the CODEPACOA group) did show a significant relationship with the MAST (personal substance abuse inventory) and the CAST (family of origin substance abuse), with results of *[r(197)=.22 p=.002]* and *[r(58)=.37 p=.004]* respectively. The low correlations of (TOTAL group *r=4%*) and (CODEPACOA *r=7%*) for the two groups suggest that the relationship for both groups is not important even if stable. The CODEPSALL group in contrast did not show a significant relationship between the MAST and the CAST [r(107)=.02 p=.87]. Therefore, the results indicate that from a selection of 198 psychology students (TOTAL group), those reporting higher levels of family of origin substance abuse (CAST) do not report higher levels of codependency (FCAI), those reporting higher levels of personal substance abuse (SA) do not report corresponding higher levels of codependence (FCAI), but that there is a small but unimportant relationship between those reporting higher levels of personal substance abuse (MAST) and higher levels of family of origin substance abuse (CAST). Additionally from 108 psychology students (CODEPSALL group) those reporting higher levels of family of origin substance abuse (CAST) do not report higher levels of codependency (FCAI), those reporting higher levels of personal substance abuse (SA) do not report higher levels of codependency (FCAI), and that those who report higher levels of family of origin substance abuse (CAST) do not report corresponding high levels of personal substance abuse (MAST). With regards to the 59 psychology students in the third group (CODEPACOA), those who reported higher levels of family of origin substance abuse (CAST) do not report higher levels of codependency (FCAI), those who report higher levels of personal substance abuse (MAST) do not report higher levels of codependency (FCAI), and those who report higher levels of family of origin substance abuse (CAST) report a corresponding small but unimportant relationship with reporting of the personal substance abuse (MAST).

Hypothesis 3 (gender differences) was investigated by obtaining descriptive statistics for the previously mentioned three main groups (the TOTAL group, the CODEPSALL group, and the CODEPACOA group). Results indicated that for the three groups this means males *(35.5, SD=10.0)* females *(35.0, SD=10.0)*, males *(33.7, SD=11.0)* females *(34.0, SD=11.0)* and males *(33.0, SD=12.5)* females *(34.5,*

FIGURE 2:

Difference between groups with more than one symptom of codependency and those with two or more symptoms relation to the number of codependent characteristices identified by the FCAI.

Analysis of Variance

Source	Sum of Squares	D F	Mean Squares	F	Sig
Between Groups	1063.6424	7	151.9489	1.5620	0.1490
Within Groups	18482.9485	190	97.2787		
	Eta = 0.2333		Eta = 0.0544		

SD=10.0) respectively, obtained were almost identical reflecting a similarity in reporting for the males and females in each group on the FCAI (codependent inventory). Not surprisingly, the ANOVA between the males and females were *[F=(1,196)=.08 p=.80] [F(1,107)=.04 p=.64]* and *[F(1,58)=.07 p=.68]* respectively for the three groups.

The final hypothesis (to support Calleros 1990 factors of the FCAI for assessment and treatment) involved three factor analyses of the three main groups (the TOTAL group, the CODEPSALL group, and the CODEPACOA group). Results identified 19 factors, (4 with eigenvalues equal to or above 2), 19 factors, (7 with eigenvalues equal to or above 2), and 21 factors, (17 with eigenvalues equal to or above 2) for each of the groups respectively. Eigenvalues of equal to or above 2 were set to allow comparisons with Calleros's (1990) research. The variance and cumulative variance for each factor loadings of factors set at .40 or above as previously suggested by Calleros 1990) are presented in Table 2.

The total variance unaccounted for, Calleros 62.4, TOTAL group *71.8*, CODEPSALL group *60.3*, and CODEPACOA *48.3*, indicate a large proportion of the questions were not significant in the construction of the factors from each scale. The questions of the FCAI (codependent inventory) failed to correlate into the similar factors as identified by Calleros's (1990). Further there was no similarity between the factors in a comparison of the three specific groups outlined above. Additionally there was no coherent pattern to the factors which were identified. For this reason it was decided by the researcher not to present such a large amount of uncorrelated data within the study.

TABLE 2:

COMPARISON OF CALLEROS'S (1990) FACTORS IN RELATION TO NUMBER OF FACTORS AND RELATED STATISTICAL CORRELATION

	CALLEROS			TOTAL GROUP			CODEPSALL GROUP			CODEPACOA GROUP		
	EIGEN	VAR	CUM VAR	EIGEN	VAR	CUM VAR	EIGEN	VAR	CUM VAR	EIGEN	VAR	CUM VAR
Factor 1	11.5	19.2	19.2	9.0	14.9	14.9	9.5	15.9	15.9	10.8	18.0	18.0
Factor 2	3.2	5.3	24.5	3.5	5.8	20.7	3.8	6.4	22.2	4.4	7.3	25.3
Factor 3	3.0	5.0	29.5	2.4	4.1	24.8	3.1	5.1	27.4	3.7	6.3	31.6
Factor 4	2.7	4.4	34.0	2.4	3.3	28.8	2.6	4.4	31.8	3.0	4.9	36.5
Factor 5	2.2	3.7	37.6				2.5	4.2	35.9	2.5	4.2	40.7
Factor 6							2.3	3.8	39.7	2.4	4.0	44.6
Factor 7							2.1	3.5	43.3	2.1	3.6	48.2
Factor 8										2.1	3.5	151.7
Variance Unaccounted for			62.4			71.8			60.3			48.3

DISCUSSION

Four hypotheses were investigated in the present study with the intent of investigating three of the underlying posits of the theory of codependency; (a) that those identified as codependent and who also have family of origin substance abuse and problems with person use of substances will have higher degrees of codependency, (significantly higher scores of the FCAI), than those who are just codependent, just substance abusers or who have only family of origin substance abuse, (b) that codependent's who score high on the FCAI (codependent inventory) will show corresponding high scores on the CAST (family of origin substance abuse inventory) and the MAST (personal substance abuse inventory) because of the positive-linear relationship that is indicated to exist between codependency, family of origin substance abuse, and personal substance abuse, and (c) that female codependents will score significantly higher on the FCAI, (codependent inventory), than males as the majority of the literature has failed to identify codependency as being a major issue for men. These three posits were investigated with Hypotheses 1 - 3 respectively. The fourth hypothesis investigated was whether the FCAI (codependent inventory), through factor analysis, would substantiate Calleros's (1990) finding that codependency can be assessed and treated in relation to five underlying factors ("perceived incompetence", "perceived lack of interpersonal efficacy", "perceived lack of support", "perceived personal failures", and "perceived communication patterns" in the family of origin).

The results of the present study have failed to support each of the four presented hypotheses. The analysis of variance for Hypothesis 1, (number of symptoms), indicated a non-significant relationship between scores on the FCAI (codependent inventory) and the number of self-reported codependent symptoms in each of the relevant groups. The partial regression analysis, Hypothesis 2 (that codependents who score high on the FCAI will show corresponding levels of high scores on the CAST and the MAST for the three populations), indicated a small significant but unimportant relationship between scores on the MAST (substance abuse inventory), and the CAST (family of origin inventory), for the TOTAL group and the CODEPACOA group. Insignificant relationships were also found for the TOTAL group, the CODEPSALL group, and the CODEPACOA group, on the FCAI (codependent inventory) and the MAST (substance abuse inventory), and on the FCAI (codependent inventory) and the CAST (family of origin inventory). Hypothesis 3, (gender differences), for the three sub-samples of the population indicated no significant differences between gender and scores on the FCAI (codependent inventory).

Hypothesis 4, (factor analysis of the TOTAL group, CODEPSALL group, and the CODEPACOA group), failed to support the results found by Calleros (1990) and also failed to indicate any particular factor structure for this particular population of university subjects. Additionally large amounts of unaccounted for variance was obtained with respect to all three groups.

The present research has failed to support the four hypotheses. Each of the hypotheses will be discussed in relation to their related implications.

HYPOTHESIS 1

CODEPENDENT'S WHO HAVE FAMILY OF ORIGIN SUBSTANCE ABUSE AND PROBLEMS WITH PERSONAL SUBSTANCE ABUSE WILL SCORE HIGHER ON THE FCAI THAN THOSE WHO ARE ONLY CODEPENDENTS, ONLY SUBSTANCE ABUSERS OR HAVE ONLY FAMILY OF ORIGIN SUBSTANCE ABUSE HISTORIES.

One of the main underlying themes throughout the literature relates to the implication that relationships with chemically dependent partners are associated with parental (family of origin) substance abuse. Although the literature on chemical dependency and family systems support this view empirical research is lacking and clinical observation is the basis on which this premise is made. The primary value of this specific hypothesis was to attempt to support the literature based on this clinical observation. Because codependent individuals who have family of origin substance abuse histories were children of substance abusers before they began to be characterised by codependent traits there is a cause-effect relationship implied. One of the main questions put forward in the literature review relating to this cause-effect relationship was whether codependent's are predisposed to relationships with substance abusers because of their family of origin.

The question asked by this hypothesis was whether codependent's with family of origin substance abuse would score higher on an inventory of codependency than individuals who self-reported no family of origin substance abuse, and whether codependent's who were experiencing personal problems with substance abuse themselves would score higher on a codependent characteristic inventory since substance abuse is implicated as having an underlying codependency basis. The hypothesis was not supported. Although codependent's with family of origin substance abuse had the highest mean *(M=39.0)* the standard deviation or range of scores was consistent with all the other groups. The control group showed the next highest mean *(M=37.0)* rather than the codependent plus family of origin plus substance abuser group *(M=32.5)*. This group in fact showed the lowest mean except for the family of origin substance abuse and personal substance

abuse only group (M=31.5). The ANOVA also indicated lack of support for the hypothesis *[F(1.56)=1,197p=.15].*

It is important to note however that the lack of support for the posit that multiple symptoms of codependency will result in higher degrees of codependent characteristics identified may be due to the FCAI (codependent inventory) itself. The relationship of family of origin substance abuse and personal substance abuse may be significant but the FCAI may not be able to describe the existence of such a relationship. Further, it may be that the population differences between the present research and Calleros (1990) research are more significant than anticipated. Subjects who have approach an Alcohol and Drug centre with concerns related to their own or a family members substance abuse may have higher levels of sensitivity to the FCAI resulting in a tendency to self-report the negative and self-blaming characteristics on the FCAI because of situational issues rather than scoring items as they usually felt.

One further issue related to self-reporting on the FCAI question structure itself. The number of double-negatives in the questionnaire requires careful reading and the possibility of mistakes. The repeating of questions throughout the questionnaire and the change from negative to positive in the way they are framed resulted in several subjects asking if there was a lie scale incorporated. Subjects also expressed a reluctance to confirm the substance abuse of a partner, a parent, or themselves. Twenty-four subjects wrote postscripts to sections of the questionnaire stating that although their responses indicated substance abuse by a partner, a parent, or themselves it wasn't actually a fact, or that, even when the scores on the CAST and the MAST were in the high range, that they or their parent were not actually alcoholics or substance abusers, they just drunk/used drugs too much. The question must be asked whether subjects from Alcohol and Drug centres are more likely to be aware of the relevant issues and did not change their responses in relation to the way they wish to appear on the questionnaires.

HYPOTHESIS 2

CODEPENDENT'S WHO SCORE HIGH ON THE FCAI (THE CODEPENDENT INVENTORY) WILL SHOW CORRESPONDING LEVELS OF SCORES ON THE CAST (THE FAMILY OF ORIGIN SUBSTANCE ABUSE INVENTORY) AND THE MAST (THE PERSONAL SUBSTANCE ABUSE INVENTORY).

The second implicit assumption of the codependent literature is that there are degrees of codependency. A continuum of the degree of characteristic effects on the individual, as suggested in the literature (Allcorn 1992), suggests that individuals

who indicate higher degrees of family of origin substance abuse and higher degrees of personal substance abuse will indicate higher degree of codependency symptoms. For this specific hypothesis it was predicted that individuals with high codependency scores, (high scores on the FCAI), will show corresponding degrees of scores on the MAST and the CAST. The primary value of this question relates to the ability of the FCAI to be linked to the MAST and the CAST. If it is possible to do so the lack of codependency inventories available may be offset by the ability of individuals scores on the MAST and the CAST to indicate possible degree of codependence.

Results indicated that in a comparison of the three populations the regression lines were significant and did not support a linear relationship between scores on the inventories. A small but unimportant relationship found between the MAST and the CAST suggests that personal substance abuse and family of origin substance abuse have a stable relationship even though it is small.

The results have indicated that the FCAI (codependent inventory) does not indicate a continuum related to family of origin substance abuse or personal substance abuse. However, in consideration of the issues related to the structure of the questionnaire and the population as previously discussed it may be the FCAI (codependent inventory), that is unable to reflect the relationship between these variables rather than the non-existence of an actual relationship.

HYPOTHESIS 3

GENDER DIFFERENCES WILL BE FOUND ON THE FCAI. FEMALES WILL SCORE SIGNIFICANTLY HIGHER THAN MALES.

The primary value of this question is to investigate whether there is credence to the implicit assumption that women are more likely to become codependent than men. Although the literature does not explicitly state that men should be excluded from the codependency label the research implications point directly towards women and the literature emphasises women as being characterised by codependent symptoms rather than men. The reasons for this are not presented in any literature to date.

The results indicated that there was no significant difference between the scores of women and the scores of men on the FCAI. Although three populations were investigated the means and standard deviations were similar ranging from male *35.5* and female *35.0 (SD 10.0 for both)* on the FCAI for the total population, male *33.7* and female *34.0 (SD 11.0 for both)* on the FCAI for the CODEPSALL group, and males *33.0* and females *34.5 (SD 12.5 & 10.0 respectively)* on the FCAI for the CODEPACOA group. The analysis of variance *[F(1,197)=.08p=.80]*

[F(1,107)=.04p=.64] *[F(1,58)=.07p=.68]* respectively, indicated no significant difference between genders.

Here again it is possible that the FCAI, (codependency inventory), itself was unable to identify codependency in this specific population, however, differences in score would still have been predicted on the premise that if there are differences related to males and females in relation to the way that they view personal substance abuse and family of origin substance abuse.

HYPOTHESIS 4

FACTOR ANALYSIS OF THE FCAI WILL CONFIRM THE FACTORS IDENTIFIED BY CALLEROS (1990) FOR ASSESSMENT AND TREATMENT OF CODEPENDENCE.

Factor analysis of the FCAI to identify the underlying factor component's of the questionnaire was indicated by Calleros (1990) to be a significant step towards the identification and development of treatment models for codependent individuals. The present research has failed to support the factors identified by Calleros (1990) for the specific population of university students. The implications of this are that the population sample may not be distinguishing codependent characteristics which have previously been identified in and alcohol and drug centre sample even though the characteristics of family of origin substance abuse and personal substance abuse were present; that the questionnaire itself does not represent codependent characteristics that are self-reported by the university population; or a combination of the above two factors.

Further the failure of the factor analytic technique to rotate indicates that larger numbers of subject's may be necessary to obtain reliable results using this particular factor analytical technique.

RECOMMENDATIONS AND CONCLUSIONS

One of the most significant concerns that has been raised within the present research is the use of the term codependent to describe individuals in the general mental health population. An important question that must be asked by those involved in clinical work in the codependent field is whether the term codependent should be applied with such ease to individuals outside of an alcohol and drug centre setting. The concept of codependence itself appears to be well established within the alcohol and drug centre field and treatment interventions and assessments have in this context been applied with some degree of consistency. The movement of the concept into the women's movement however seems to be from a lack of understanding of the term codependence rather than because of

sudden identification of women to issues concerned with substance abuse, either personal or in the family of origin. The diagnostic criteria outlined do appear on the surface to have some degree of research consistency, however it is important to acknowledge that the research is based on clinical observations and not on any well developed theoretical basis.

The concept of codependence is further underminded by the lack of empirical research both within and outside of the chemical dependence field. As a result of a lack of assessment, treatment interventions, and underlying theoretical basis, training in the area of codependence can not be more than extremely minimal.

Assumptions related to gender differences, multiple causes, and characteristics must be subject to extensive research with large numbers of the general population before conclusions can be drawn as to the validity of such a construct.

Cultural issues, attributions, daily stress, dual diagnosis of the so called self-defeating behaviours, and organisational and societal effects which are suggested to be related to codependency, are all areas of research which must be carefully considered.

The use of assessment tools such as the FCAI can not be used without careful consideration of the ethical implications of labelling individuals with vague personality disorders must be a primary issue.

It is therefore apparent that the codependency concept is one of the most under research and potentially misleading terms that has been presented in the literature to date.

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APPENDIX A: **RESEARCH QUESTIONNAIRES**

Dear Participant:

Thank you for your interest in helping with this research project. You are asked to participate in a study which will investigate certain aspects of substance use and interpersonal relationships.

All data collected are strictly anonymous. Do no put your name on the questionnaires. This Page will be separated from the finished questionnaires as soon as the researcher receives them back. Your participation in this research project will be confidential.

At any stage during the filling out of these questionnaires you may decide that you do not wish to continue in this particular research project and at this time you are welcome to withdraw either by informing the researcher or discontinuing to fill in the forms.

Again thank you for your help. If you are interested in the outcome of this study, fill in your address below and a summary will be sent to you upon completion.

NAME_____

STREET_____

CITY_____

Please read and Sign

INFORMED CONSENT FORM

I am participating in this research project voluntarily and give permission for the researcher to use the data. I understand that all personal data are anonymous and that my participation in the study is confidential.

SIGNATURE DATE

_____

PERSONAL STATUS QUESTIONNAIRE

Please fill in the following:

DEFINITION: An Alcoholic or drug abuser is someone who has experienced personal, relationship and/or job/career **problems** connected to alcohol or drug use.

If you are living with your husband/wife, boyfriend/girlfriend or partner, is he/she an alcoholic or drug abuser according to the definition given above?

YES _____ NO_____ NOT APPLICABLE _____

How long have you been in a living arrangement with this person? Please state in terms of Years ie. under one Year, one year, two Years etc.

TIME IN TERMS OF YEARS _____

Have you been/are you now, in a relationship with a significant other who was/is an alcohol and/or drug abuser according to the above definition but with whom you were/are not living?

YES _____ NO _____ NOT APPLICABLE _____

If YES how long were you in this relationship for? ie. under one year, one year, two years etc?

TIME IN YEARS _____

Have you been in more than one relationship with a significant other who was an alcohol and/or drug abuser according to the above definition?

YES _____ NO _____ NOT APPLICABLE _____

If YES how many of these type of relationships have you been involved in and for what period of time did each of these relationships last?

_____

_____

_____

Please state your age and gender. Please remember not to put your name on this page.

AGE _____ GENDER _____

QUESTIONNAIRE TWO

Please answer the questions below that best describe your feelings, behaviour, and experiences related to your childhood experiences. Answer all questions by either circling YES or NO.

Y N Have you ever thought that one of your parents had a drinking problem?

Y N Did you ever encourage one of your parents to quit drinking?

Y N Did you ever feel alone, scared, nervous, angry or frustrated because a parent was not able to stop drinking?

Y N Did you ever argue with a parent when he/she was drinking?

Y N Did you ever threaten to run away from home because of a parents drinking?

Y N Has a parent ever yelled at or hit you or other family members when drinking?

Y N Have you ever heard your parents fight when one of them was drunk?

Y N Did you ever feel like hiding or emptying a parents bottle of liquor?

Y N Did you ever protect another family member from a parent who was drinking?

Y N Do many of your thoughts revolve around a problem drinking parent or difficulties that arise because of his or her drinking?

Y N Did you ever wish that a parent would stop drinking?

Y N Did you ever feel responsible for and guilty about a parents drinking?

Y N Did you ever fear that your parents would get divorced due to alcohol misuse?

Y N Have you ever withdrawn from and avoided activities and friends because of embarrassment and shame over a parent's drinking?

Y N Did you ever feel caught in the middle of an argument of fight between a problem drinking parent and your other parent?

Y N Did you ever feel that you made a parent drink alcohol?

Y N Have you ever felt that a problem drinking parent did not really love you?

Y N Did you ever resent a parent's drinking?

Y N Have you ever worried about a parent's health because of his or her drinking?

Y N Have you ever been blamed for a parent's drinking?

Y N Did you ever think that your father was an alcoholic?

Y N Did you ever wish that your home could be more like the homes of your friends who did not have a parent with a drinking problem?

Y N Did you ever think your mother was a alcoholic?

Y N Did you ever wish that you could talk to someone who could understand and help alcohol-related problems in your family?

Y N Did you ever fight with your brothers and sisters about a parent's drinking?

Y N Have you ever felt sick, cried, or had a "knot" in your stomach after worrying about a parents drinking?

Y N Did you ever take over any chores and duties at home that were usually done by a parent before he or she developed a drinking problem?

QUESTIONNAIRE THREE

Please answer the following questions by circling YES or NO. These questions relate to your own personal drinking/substance use.

Y N Do you feel you a normal drinker/substance user? (By normal we mean you use alcohol/substance less than or as much as most other people).

Y N Have you ever awakened the morning after some drinking/substance use the **night** before and found that you could not remember a part of the evening?

Y N Does your wife, husband, a parent, brother, near relative or significant other ever worry or complain about your drinking/substance use?

Y N Can you stop drinking/substance using without a struggle after one or two drinks or after one or two smokes etc.

Y N Do you ever feel guilty about your drinking/substance use?

Y N Do friends or relatives think you are a normal drinker/substance user?

Y N Are you able to stop drinking/substance using when you want to?

Y N Have you ever attended a meeting of Alcoholics Anonymous/Narcotics Anonymous?

Y N Have you ever got into physical fights when drinking/substance using?

Y N Has drinking/substance using ever created problems between you and your wife, husband, parent, relative or significant other?

Y N Has your wife, husband, parent or significant other ever gone to anyone for help about your drinking/substance use?

Y N Have you ever lost friends because of your drinking/substance use?

Y N Have you ever got into trouble at work because of your drinking/substance use?

Y N Have you ever lost a job because of your drinking/substance use?

Y N Have you ever neglected your obligations, your family, or your work for two days or more in a row because you were drinking/substance using?

Y N Do you drink/use a substance before noon very often?

Y N Have you ever been told that you have liver trouble? ie, Cirrhosis?

Y N After heaving drinking/substance using have you ever had delirium tremens (DTS) or severe shaking, or heard voices or seen things that weren't really there?

Y N Have you ever gone to anyone for help about your drinking/substance using?

Y N Have you ever been in hospital because of drinking/substance using?

Y N Have you ever been seen at a psychiatric or mental health clinic or gone to any doctor, social worker, or clergyman for help with any emotional problem, where drinking/substance using was a part of the problem?

Y N Have you ever been a patient in a psychiatric hospital or in a Psychiatric ward of a general hospital where drinking/substance use was part of the problem that resulted in hospitalisation?

Y N Have you ever been arrested for drunken driving, driving while intoxicated, or driving under the influence of alcoholic beverages or other substances?

Y N Have you ever been arrested, even for a few hours, because of the drinking/substance using behaviour?

QUESTIONNAIRE FOUR

Below are a number of questions dealing with how you feel about yourself, your life and those around you. As you answer each question, remember that there are no right or wrong answers. Take each question as it comes and answer as you usually feel. Each question is to be answered either true or false.

T F I make enough time to do things just for myself each week.

T F I spend lots of time criticising myself after an interaction with someone.

T F I would not be embarrassed if people knew certain things about me.

T F Sometimes I just feel that I waste a lot of time and don't get anywhere.

T F I take good enough care of myself.

T F It is usually best not to tell someone they bother you; it only causes fights and gets everyone upset.

T F I am happy about the way my family communicated when I was growing up.

T F Sometimes I don't know how I really feel.

T F I am very satisfied with my intimate love life.

T F I've been feeling tired lately.

T F When I was growing up my family liked to talk openly about problems.

T F I often look happy when I am sad or angry.

T F I am satisfied with the number and type of relationships I have in my life.

T F Even if I had the time and money to do it, I would feel uncomfortable taking a vacation by myself.

T F I have enough help with everything that I must do each day.

T F I wish that I could accomplish a lot more than I do now.

T F My family taught me to express feelings and affection openly when I was growing up.

T F It is hard for me to talk to someone in authority, ie boss, teacher ,etc.

T F When I am in a relationship that becomes too confusing and complicated, I have no trouble getting out of it.

T F I sometimes feel pretty confused about who I am and where I want to go with my life.

T F I am satisfied with the way that I take care of my own needs.

T F I am not satisfied with my career.

T F I usually handle my problems calmly and directly.

T F I hold back my feelings much of the time because I don't want to hurt other people or have them think less of me.

T F I don't feel like I'm in a "rut" very often.

T F I am not satisfied with my friendships.

T F When someone hurts my feelings or does something that I don't like, I have little difficulty telling them about it.

T F When a close friend or relative asks for my help more than I'd like, I usually say "yes" anyway.

T F I love to face new problems and am good at finding solutions to these.

T F I do not feel good about my childhood.

T F I am not concerned about my health a lot.

T F I often feel like no one really knows me.

T F I feel calm and peaceful most of the time.

T F I find it difficult to ask for what I want.

T F I don't let people take advantage of me more than I'd like.

T F I am dissatisfied with at least one of my close relationships.

T F I make major decisions quite easily.

T F I don't trust myself in new situations as much as I'd like.

T F I am very good at knowing when to speak up, and when to go along with others wishes.

T F I wish I had more time away from my work.

T F I am as spontaneous as I'd like to be.

T F Being alone is a problem for me.

T F When someone I love is bothering me, I have no problem telling them so.

T F I often have so many things going at once that I'm really not doing justice to any one of them.

T F I am very comfortable letting others into my life and revealing the "real me" to them.

T F I apologise to others too much for what I do or say.

T F I have no problem telling people I am angry with them.

T F There's so much to do and not enough time. Sometimes I'd like to leave it all behind me.

T F I have few regrets about what I have done with my life.

T F I tend to think of others more than I do myself.

T F More often than not, my life has gone the way that I wanted it to.

T F People admire me because I'm so understanding of others, even when they do something that annoys me.

T F I am comfortable with my sexuality.

T F I sometimes feel embarrassed by behaviours of those close to me.

T F The important people in my life know the "real" me, and I am okay with them knowing.

T F I do my share of work, and often do quite a bit more.

T F I do not feel that everything would fall apart without my efforts and attention.

T F I do too much for other people and then later wonder why I do so.

T F I am happy about the way my family coped with problems when I was growing up.

T F I wish that I had more people to do things with.

PLEASE DETACH THIS SHEET AND TAKE IT AWAY WITH YOU:

There is the possibility that after completing these questionnaires that you as a subject have become aware that drinking/substance use may be a problem for you that you are concerned about. The following addresses are those of agencies which may be contacted if you are concerned about a drinking/substance use problem. Please make use of these contact numbers if you feel you need to.

ALCOHOL AND DRUG CENTRE
PALMERSTON NORTH

MASSEY UNIVERSITY
COUNSELLING CENTRE
PALMERSTON NORTH