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The Association between Codependence and Abstinence from Alcohol Consumption for Individuals with a History of Alcohol Abuse

by

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The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies for acceptance, a thesis entitled "The Association between Codependence and Abstinence from Alcohol Consumption for Individuals with a History of Alcohol Abuse" submitted by Del R. Graff in partial fulfilment of the requirements for the degree of Master of Social Work.

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Abstract

The association between a codependent orientation and time abstaining from alcohol use was examined for 60 recovering alcoholics. The Individual Outlook Test (IOT) and the Brief Michigan Alcoholism Screening Test (B-Mast), modified to past tense, were used. Eighty percent of respondents reported a codependent orientation, with 75% scoring at mild or moderate levels. No significant association was found between a codependent orientation and time abstaining from alcohol use. Gender differences were identified with higher scores for female respondents on two IOT sub-scales; externally derived sense of self worth, and dependency within relationships. The association between a codependent orientation and attendance at Alcoholics Anonymous, Alanon and Codependent's Anonymous were also examined. Findings indicated a small significant association between a codependent orientation and the number of Alcoholics Anonymous meetings attended in the month before participation in this study. Results were discussed including limitations and recommendations for future research.

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Dedication

To my wife, Veronica, whose unwavering love and support made returning to school possible.

To my children, Sharona, Dell Jr., and David, who sacrificed countless hours of family time for their father's education.

To my mother, Marjorie, and my sisters Sandra and Darlene, who taught me about strength, courage, and kindness in the midst of adversity.

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Chapter 1

Introduction

Statement of the Problem

People with alcohol problems have received considerable attention, both in respect to descriptions of the factors contributing to their difficulties and to treatment. In fact Lindstrom (1992) suggests scientific production on alcoholism and its treatment doubles every seven years (p. 1). This is not surprising, as estimates from the Institute of Medicine (1990) suggest a prevalence of alcohol problems at 10% of the population. Unfortunately, based on a review of literature for this study, it appears that less attention has been given to helping people who have achieved recovery from alcohol abuse to improve their quality of life, particularly in relationships.

In addition, studies of families of alcoholics have identified a condition called "codependence" , described as a pattern of intra and interpersonal behaviours harmful to family members (Alexander, 1992). This condition has been expanded to include family members of almost all dysfunctional families (Whitfield, 1989; Beattie, 1987). Prest and Protinsky (1993) report for each person with an alcohol problem, three to five people are seriously affected. This suggests that the prevalence of codependence in the North American population may be between thirty to fifty percent.

Another development in the addictions field is the linkage between alcohol abuse and codependence in the same individual (Mellody, 1989; Whitfield, 1989; Larson, 1985). A number of writers have suggested alcohol problems are a result of individuals being unable to cope with the condition of codependence. For example, Mellody (1989) states, "...the alcoholic and the codependent were trying to solve identical basic symptoms of the same disease - the addict with alcohol or drugs and the codependent with the addictive relationship" (p. xii). She further states, "I believe that for some people, addictions are an outgrowth of core symptoms of codependence...I strongly suggest that men and women in recovery from chemical dependency take a look at whether or not they are codependent as well as addicted" (p.52).

This presumed linkage between codependence and alcohol abuse has been addressed by Charles Whitfield (1989) as having a causal relationship. He states, "Codependency is not only the most common addiction; it is the base out of which all our addictions and compulsions emerge...inside every alcoholic or other drug dependent person is a codependent" (p.19-20).

In addition, there have been suggestions that for people in recovery from alcohol problems, codependence is a condition they will have to address if they want further improvement in their lives. Ernie Larson (1985) suggests that alcoholics are merely codependent people who drink too much, and that once they have learned to not drink, they must learn to change

their codependence, which he describes as self-defeating learned behaviour. Mellody (1989) states, "If alcoholics or addicts do succeed in staying free from substance abuse, they may be very hard to live with and probably quite miserable themselves unless they get in recovery from codependence as well as the chemical addiction" (p. 53).

Questions arise concerning the nature and amount of research data to support the opinions of these writers. A review of journal publications, books, and dissertations from 1985 to 1995 suggests there is little empirical evidence upon which to validate their opinions. In fact, only one source was found that tested individuals recovering from alcohol problems for codependence. In her dissertation, Enid Ross (1993) examined the developmental stages of abstinence for 107 alcoholics. Codependence was one of a number of sub-scales used to measure the symptom intensity of abstinence for alcoholics.

The purpose of this study is to investigate whether there is an association between recovery from alcohol abuse and codependence. This will be done using a cross sectional survey of 60 people with a variety of time periods of recovery from alcohol problems.

Research Questions

There are several research questions which this study will seek to answer:

1. What is the prevalence of a codependent orientation, specifically an externally derived sense of self worth, anxiety, dysfunctional relationships, dysfunctional family of origin, and dependency within relationships?

2. What is the association between a codependent orientation and the amount of time abstained from alcohol consumption?

3. What is the association between demographics such as gender, education, marital status, and age and a codependent orientation?

4. What is the association between frequency of attendance at self help groups such as Alcoholics Anonymous, Alanon, and Codependent's Anonymous and a codependent orientation?

To more fully address these questions, a review of current literature was completed and presented in chapter 2. Theories addressing alcohol problems and codependence were reviewed, along with models of recovery for alcohol problems and codependence. Limitations of these models and the role of self help groups in the recovery process was examined.

In chapter 3, methods are outlined. Survey results are presented in chapter 4. Chapter 5 provides a discussion of the results, limitations, and recommendations for future research.

Chapter 2

Review of related Literature

How do people develop alcohol problems?

The way people develop alcohol problems is an important topic because of the complexity of these problems and the amount of attention given to them. Lindstrom (1992) noted that there were approximately 300 books and 3700 articles published annually about alcoholism and its treatment. This amount of information could be a reflection of how complex alcohol problems are to explain (Chaudron & Wilkinson, 1988), or to treat (Lindstrom, 1992).

Historically, alcohol was used in almost every culture for a variety of purposes ranging from medicinal and spiritual reasons, to food preservation, social interaction, and as an alternative to unhealthy water (Levin, 1990). Although alcohol problems were present in the earliest of societies, there is a surprising lack of empirically verified knowledge about alcohol problems and treatment (Levin, 1990).

Alcohol problems have been described as a bio-psycho-social phenomenon that do not possess a single theoretical structure that can sufficiently explain causal factors in a comprehensive way (Chaudron & Wilkinson, 1988). This view is supported by Levin (1990), the Institute of Medicine (1990), and Lindstrom (1992), who indicate no singular theoretical structure is adequate to explain the causes or to effectively treat people with alcohol problems.

Theories Addressing the Development of Alcohol Problems

Chaudron & Wilkinson (1988) described 11 different theories that deal with alcohol problems. Their premise was that theories have been competitive rather than complimentary because of the tendency by researchers to advocate for a single theory approach to alcohol problems. They suggest it is more beneficial to find ways to integrate theories for alcohol problems because these problems are multi-causal.

Levin (1990), describes 4 groups of theories, some of which are descriptive, others explanatory. These groups include psychoanalytic theories, Jungian theories, Learning theories, and Dynamic theories. Levin (1990) integrates these theories into the bio-psycho-social approach. The bio-psycho-social approach is a theoretical model that states alcohol problems develop because of a complex interaction of biological, psychological and social antecedents and consequences (Lindstrom, 1992). This theoretical model "...provides a framework within which the biological, psychological, and sociocultural approaches to health can be integrated." (Institute of medicine, 1990)

Because of the attention given to biological, psychological and social theories, these groups of theories are discussed in greater detail.

Biological theories

Biological theories suggest that alcohol problems result from physical characteristics of persons. Two key views of this group of theories are that alcoholism is a disease and this disease has a genetic link (Chaudron & Wilkinson, 1988). Two groups of biological theories are the disease and the neurobiological theories.

Disease Theories

Important developments came out of the work of Alcoholics Anonymous in the 1930's and Jellinek's book (1960), "The Disease Concept of Alcoholism". Alcoholic's Anonymous had found some success by viewing alcoholics as having a physical reaction to alcohol. Jellinek's work (1960) concluded that alcoholism was a disease that progressed through these stages: 1) occasional relief drinking, 2) onset of blackouts, 3) grandiose and aggressive behaviour, 4) avoidance and undefinable fears, 5) obsessive drinking in vicious cycles. Five types of alcoholism were identified by Jellinek: alpha; beta; delta; gamma; and epsilon. Alpha alcoholism is characterized by psychological dependence only. Beta alcoholism includes physical symptoms but not physical dependence. Delta alcoholism involves physical dependence but not physical symptoms. Gamma alcoholism involves both physical dependence and physical symptoms. Finally, epsilon alcoholism is characterized by a pattern of binge drinking (Jellinek, 1960).

Genetic theories suggest inter-generational links and hypothesize a genetic difference in those that develop alcohol problems. Although Jellinek viewed alcoholism as a progressive disease, he acknowledged that how it progresses is not clear and concluded that, "...no evidence has ever been produced to show that this heredity had to express itself in inebriety...The inherited constitution is merely a suitable breeding ground for inebriety." (Jellinek, 1944, p. 109)

Since Jellinek's work, numerous studies have been completed to identify hereditary factors. Studies of twins born to alcoholics (Kaij, 1960; Partanen, 1966), of adopted children born to alcoholics (Roe, 1945; Goodwin, Schulsinger, Hermansen, Winokur & Guze, 1973), and of half siblings born to alcoholics (Schuckit, 1972) have been extensively reviewed by Cabaniss (1979) and Murray, Clifford, and Gurling (1983). Cabaniss (1979) concluded that "the evidence for a genetic factor in alcoholism which acts selectively on some individuals and not on others is less than adequate"(p.61). Murray et al. (1983) concluded that there may be a "...modest genetic effect on both normal drinking and alcoholism in men, though similar evidence for women is so far lacking" (p.25).

Neurobiological Theories

While alcoholism has been studied as a disease, the neurological processes that occur for alcoholics are the subject of neurobiological theories of alcoholism.

Neurobiological theories suggest there are three groups

of factors that determine the consumption patterns and effects of alcohol on a person; generating the motivation to consume alcohol, the alteration of physiology resulting from alcohol consumption, and the feedback loops that promote excessive alcohol consumption (Tabbakoff & Hoffman, 1988). These theories support the view that alcoholism can be inherited. Theorists seek to identify what the attributes are that may be inherited. The neurological processes for developing tolerance and physical dependence upon alcohol have been studied extensively using these theories. Tabbakoff & Hoffman (1988) conclude that, consistent with Glatt's (1967) research, situational factors play a predominant role with lower dosage levels of alcohol, but physiological factors assume more importance to continued intake as the dosage of alcohol increases.

Summary of Biological Theories

Biological theories are not without their critics. Peele and Brodsky (1991), challenge many of the conclusions of the disease model of alcoholism as not only inaccurate, but harmful to those with drinking problems. Dreger (1986) stated that alcoholism is not easily explained by the medical model. Szasz (1972) suggested alcoholism is simply a "bad habit" (p.84). He stated, "...if we choose to call bad habits diseases, there is no limit to what we may define as a disease" (p. 84). Leo (1990) stated, "As addictions have been converted into diseases (Alcoholism), bad habits have

been upgraded and transformed into addictions" (p.16). It has been suggested for the medical model to accept that there is a "cure" for alcohol problems, it must first create a "disease" for which to apply the cure (Ehrenreich, 1992).

Biological theories, however, have contributed significantly to the study of alcoholism. The World Health Organization recognized alcoholism as a health problem in 1951 (Heath, 1988). Jellinek's (1960) research of alcoholism as a disease that can progress in predictable ways for certain people has reduced the stigma associated with this problem. Jellinek's work continues to influence treatment for alcohol problems today. Doweiko (1993) states, "Jellinek's theoretical model has become the standard model for alcoholism in the United States. It has been used without significant modification since the time that it was first introduced" (p. 185).

Psychological Theories

Psychological Theories have also made significant contributions to what is known of alcohol problems. Two groups of theories from psychology have been especially helpful; psychoanalytic theories, and personality theories.

Psychoanalytic Theories

Psychoanalytic theories suggest two explanations for alcohol problems. One is that the individual finds the effects of intoxication extremely pleasurable and is willing

to accept quite negative consequences to experience the pleasure of intoxication. The other is that the individual is unable to avoid the consequences of alcohol problems and cannot connect those consequences with alcohol consumption. Barry (1988) suggests that, " Both explanations may contribute to the alcoholism of the same individual"(p.104).

Psychoanalytic theories describe three components of the self; the id, ego and super ego. While Sigmond Freud, considered the father of psychoanalytic theory, wrote little on the subject of alcoholism, his orthodox followers addressed this subject repeatedly. For example, Barry (1988) suggests that alcoholism results in unique conflicts between the components of the self. He demonstrates this view in table 1.

Table 1
Alcoholic and non-alcoholic components of self

	Non-alcoholics		Alcoholics	
	Sober	Intoxicated	Sober	Intoxicated
Id	Striving	Disinhibited	Craving	Triumphant
Superego	Restraining	Weakened	Punishing	Disrupted
ego	Controlling	Exhilarated	Anxious	Overwhelmed

(p.106)

Freud's stages of development, the oral, anal, phallic and genital stages have also been used to explain alcohol problems; alcoholics may have fixations at each of these stages (Barry, 1988). Oral fixations, and anal

fixations were researched by Brown (1965) whereas phallic fixations were researched by Zwerling (1959). Their results were inconclusive in that they were able to provide only a partial explanation for alcoholism. Both were able, however, to establish that early childhood experience was a factor in the development of alcohol problems.

Personality Theories

Another group of theories that has had an impact on what is known about people with alcohol problems are personality theories. Personality theories seek to define the individual characteristics that contribute to particular behaviours (Cox, 1988, pp.144).

Two approaches to studying personality are the intrapsychic tradition and the differential tradition. The intrapsychic tradition is the study of psychological systems within the individual that determine behaviour. The differential tradition investigates individual differences that influence behaviour. Both approaches have been applied to alcohol problems, contributing to the knowledge of personality factors that influence alcoholic behaviour.

Personality theorists have tended to research alcohol problems in three main areas; the personality antecedents of alcoholism, the personality characteristics of alcoholics, and the effects of alcohol abuse on personality (Cox, 1988).

In a study examining antecedents of alcoholism, Krammeier

Hoffman & Loper (1973), tested pre-alcoholics using the Minnesota Multphasic Personality Inventory (MMPI), then re-tested 13 years later. Their findings were that pre-alcoholics were more impulsive, non-conforming, and gregarious than the control group, but were not more maladjusted or psychologically distressed.

Other studies have provided substantial support for the conclusions of Krammeier and his colleagues (1973). Cox and Loper (1983), reported pre-alcoholics to be non-conforming, aggressive and hyperactive. Longitudinal studies have consistently found that pre-alcoholics are independent and rebellious, and do not conform to normal societal values (Zucker & Knoll 1982; Windguard ,Huba & Bentler, 1980).

A number of studies however, report that future alcohol abuse is often not predicted by low self esteem, negative affect or psychopathology (Knop, Teasdale, Schulsinger, & Goodwin, 1985).

In summarizing a review of studies completed, Cox (1988) states, "...some groups of persons who, in the future will become problem drinkers or alcoholics, have personality characteristics that distinguish them from other groups of people" (p.156).

Cox (1985) reports that the antecedents present in pre-alcoholics are also present after the onset of problem drinking. The personality characteristics shown by those with alcohol problems include nonconformity, impulsivity, and

reward seeking behaviour, consistently low self esteem, emotional reactivity, and negative affect, typically having elevated levels of depression, anxiety, and worry (Cox, 1985, p.158). The relationship between drinking and depression, however, is weaker in those who abuse alcohol but may not be alcoholics, which suggests that depression may be a result of drinking rather than an antecedent (Midanik, 1983).

With respect to perception and cognitive style, Witken & Goodenough (1977) found that alcoholics are field dependent, meaning they tend to rely on cues from their external environment for their perceptual style. Rohsenow (1983) found that, in a study on locus of control, alcoholics were consistently more externally controlled than the control group. This area was also examined by Strom & Barone (1993) who hypothesized that self esteem and locus of control were related to the stage of alcohol involvement. They completed two studies, the first of which showed no difference between active alcohol abusers and alcoholics in long term recovery. Their second study included a measure for self-deception. The second study showed active abusers had higher levels of self deception and social desirability than those in both short and long term recovery.

Another study (Petrie, 1967) found that not only do alcoholic's perceptual styles differ from non-alcoholics, but the intensity with which they perceive stimuli that is painful differs as well. Alcoholics perceive painful stimuli more

intensely than non-alcoholics, which suggests they may use alcohol, in part, for it's medicating effect (Cox, 1988).

Two alcoholic personality sub-types have been identified repeatedly. These are the sociopathic, and the distressed neurotic personalities. Sociopathic alcoholics drink over longer periods of time, but more moderately, and do not experience as many or as serious problems as the distressed neurotic type. They tend to drink impulsively and use alcohol for gratification (Cox, 1988).

Distressed neurotic alcoholics are reportedly heavier drinkers, experience more problems, and have more severe impairments than sociopathic alcoholics. They tend to use alcohol as a means to cope with distress (Cox, 1988).

Benson & Wilsnack (1983) identified gender differences related to difficulties accompanying alcohol abuse. They report that women tend to have psychological crises precipitating their alcohol abuse while men tend to have crises subsequent to their alcohol abuse.

Apart from the physiological effects of alcohol on the body, research has been done on the effects of alcohol on personalities of alcoholics. Cox (1988) reported for alcoholics, alcohol consumption did not reduce tension; it increased tension, anxiety and depression. Although people consistently expect alcohol to affect them in positive ways, this does not occur to alcoholics. In fact, when alcoholics consume alcohol,

> the cumulative effect of alcohol is to intensify the drinker's negative affect during the sober state...Problem drinkers also appear to be less able than other people to utilize nonchemical sources of positive affect as an alternative to drinking alcohol. (Cox, 1988 p. 162)

Summary of Psychological Theories

Psychological theories have sought to understand alcohol problems by identifying psychological differences between alcoholics and the normal population.

Psychoanalytic theory has contributed less to understanding the causes of alcoholism than it has to its treatment. Psychoanalytic therapy addressing the internal conflicts and motivations present in alcoholics has been useful. As Barry (1988) states, however, "The psychoanalytic theory of alcoholism is more a historical than a contemporary influence on therapeutic practice" (p.132).

Personality theories have identified antecedents, personality characteristics and effects of alcohol on personalities of alcoholics. As well, these theories have identified personality subtypes which contribute to variations in alcohol consumption.

While psychological theories have contributed significantly to describing a number of internal factors, the success of interventions using theories solely based on psychology has been limited.

Social Theories

Social theories suggest that alcohol problems are a result of disruptive social forces that negatively impact people's lives. Poverty, unemployment, family dysfunction, and other factors act as social stressors and alcohol abuse is viewed as an adaptation to the limited growth potential in people's environment (B.C. Ministry of Health, 1995). Three groups of social theories that have had significant impact on what is known about alcohol problems are social learning theories, systems theories and sociocultural theories.

Social Learning Theories

Social learning theories are an extension of classical and operant conditioning theories, based primarily in behavioral psychology. Social learning theories seek to identify the principles and processes that govern the development, maintenance and modification of human behaviour (Wilson, 1988). These theories suggest behaviour is largely determined by response consequences, but add that environmental events and a person's cognitive appraisal to those events also shape behaviour. These theories stress the importance of learning by observation of others and events without actually engaging the events themselves. As well, self regulation, or the ability of a person to regulate behaviour, and reciprocal determinism - the interaction between behaviour, cognitive factors and environmental influences impact learning and behaviour in significant ways

(Wilson, 1988).

One of the major contributions of social learning theories to alcohol treatment was made by Marlatt and Gordon (1985) in analyzing alcoholic relapse. They designed a model of maintenance for alcoholics to remain abstinent from alcohol, with specific strategies to prevent relapse (Marlatt & Gordon, 1985). As well, Stockwell, Hodgson, Rankin, and Taylor (1982) demonstrated that differentiating treatment based on a person's level of dependence is important to treatment outcome. Alcoholics who were not physically dependent responded well to cognitive influence, while those who were physically dependent did not. Moos and Finney (1983) pointed out that learning and reinforcement do not stop with a treatment intervention for outcomes to be effective. Focus should also be on the stressors and reinforcers in the post-treatment environment.

Social learning theorists have also looked at the concept of controlled drinking as a treatment goal. Sanchez-Craig's (1984) conclusions were that, for moderate alcohol abuse, controlled drinking strategies were more effective than abstinence strategies. Hester & Miller (1989) report that social drinking is a viable goal for those not addicted to alcohol or those not having significant problems associated with alcohol use. They suggest that controlled drinking may also be a purposeful goal for alcoholics unwilling to accept abstinence as a goal. They suggest failure to control drinking

may lead alcoholics to the conclusion that abstinence is the only option regarding their alcohol consumption.

Systems Theories

Systems theories provide a conceptual framework for focussing on the pattern, organization, and wholeness of individuals that are connected in some way. Most often systems theories are applied to families (Pearlman, 1988). Systems theories suggest behaviour is shaped and maintained by the ongoing dynamics and interactions of the key systems within which a person is involved (Pearlman, 1988). Systems theories have contributed a number of valuable concepts to the treatment of alcohol problems. These concepts include the idea that a change in one part of a system will result in changes to other parts of the system; that each sub-system has a role and function to serve concerning the whole system, and that the system is more than the sum of it's parts (Pearlman, 1988, p. 290).

Rules play a large part in systems theories, as rules, either explicit or implicit, make the system predictable and consistent (Pearlman, 1988).

Approaches to therapy using systems theories tend to be either strategic or structural. Strategic therapy focusses on communication, behaviour sequences, and interaction patterns repeated over time. Structural therapy looks more at how the system is organized; the hierarchies, alliances, boundaries, and distance within the system. Structural therapy seeks to

restructure the system, while strategic therapy seeks to change the behavioral sequences and interactional patterns of the system (Pearlman, 1988).

Systems theories identified that within families where alcohol problems exist the adaptation of individual roles results in the alcohol problem becoming a stabilizing force rather than a disruptive one. Steinglass (1979) reported that patterns of behaviour between couples where one member had a drinking problem were more predictable when drinking than when sober. As well, defence patterns of alcoholics and their families have been found to be inter-reinforcing. Family members and the addicted person behave in ways that reinforce the continuance of each other's behaviour. McCrady (1981) found that alcoholic couples were not significantly different than other distressed couples in their communication styles, problem solving skills, or use of coercive controls. The only difference was the use of alcohol as a means to address threats to stability, conflict and expression of affect.

Although a strong relationship has been established between improvement in family functioning and improvement in the drinking problem, the nature of that relationship has not been established (Steinglass, 1979). Questions remain as to whether family relationships improve as a result of changes in drinking behaviour or drinking behaviour improves as a result of better family relationships. Wing (1992) found couples perceive their relationship differently when one member has an

alcohol problem. The alcoholic views the relationship as chaotic while the spouse views it as balanced. Wing (1992) further suggests that both alcoholics and their partners go through a process of stages and that joint treatment for alcohol problems improves family relationships.

A contribution of systems theory to alcohol treatment is to link the disease model of alcoholism to systems theory as applied to families. This has resulted in a large number of publications that suggest alcoholism is a family disease (Wiseman, 1991; Barnard, 1990; Wallen, 1992). Wallen (1992) describes family recovery as a developmental process using systems theory and life cycle stages. She suggests families must rebalance roles and expectations for change to be sustained.

The view of alcoholism being a family disease has been challenged, however (Peele & Brodsky, 1991; Davis Kasl, 1992). Davis Kasl (1992) challenges the view that families cause addiction to continue. She suggests that the family is "the transmitter of cultural values that result in addiction and dependency" (p. 64). She further states, "Limiting our view to the family as the source of addiction actually perpetuates addiction...It is convenient for the system that we continue to focus on the shame-based dysfunctional families, because the system is let off the hook" (p. 65).

Sociocultural Theories

While systems theories look at the interactions of systems to address problems, sociocultural theories emphasize the role of cultural and social factors. Sociocultural anthropology is the study of patterns of belief and behaviour among various populations (Heath, 1988). Sociocultural anthropology has contributed much to the study of alcohol problems, yet alcohol problems are still viewed by western societies as individually based. Perhaps the most important contribution, as stated by Heath (1988) is that "...this approach offers valuable opportunities for coherent description of complex situations that might not otherwise be comprehensible...It is also eminently practical, inasmuch as it facilitates insights about education, prevention, and treatment" (p. 358).

Levin (1990) reports early studies of the sociocultural theory identified three variables that influenced alcoholism in a society. The first is the degree to which a society creates inner tension in it's members. The second is society's attitude towards drinking behaviour and the third is the degree to which societies are given alternate ways to cope with psychic stress.

There have been a number of models developed from research using sociocultural theories. The normative model involves studying deviance, labelling, ambivalence and other terms used to describe how a society addresses those who fall

outside the normal range of conduct. The single distribution model refers to the distribution of alcohol consumption in societies and is especially valuable because of the recognition that the line dividing heavy drinkers from problem drinkers is arbitrary. There is little distance separating the consumption patterns between those who are labelled alcoholic, and those who are not. The anxiety model suggests alcohol is used to reduce the anxiety created by society. One type of anxiety described by Heath (1988) is created by the alienation of a population from the norms and other aspects of culture that had been meaningful and valuable to them. A poignant example of this view is First Nations Canadians and the effects of alcohol on their communities.

Some of the research findings of major importance to the addiction field have come from sociocultural theories. For example, in a longitudinal study of nearly 400 males over a 33 year span, Vaillant & Milofsky (1982) identified the two most important factors in determining variance in adult alcoholism were ethnicity and the number of alcoholic relatives. Peele (1985) contends that alcohol abuse is a problem because society fails to regulate appropriate use of it, not because it fails to eliminate use altogether. Peele (1985) states, "In cultures where use of a substance is comfortable, familiar, and socially regulated both as to style of use and appropriate time and place for use, addiction is less likely and may be practically unknown." (p.106)

Doweiko (1993) notes that decisions about alcohol use occur within the context of the culture a person has been exposed to. He states, "These cultural attitudes and beliefs, which have evolved over generations, form the framework within which the individual's decisions about chemical use is made. They also provide a standard by which the individual's chemical use is measured" (p. 177).

Summary of Social Theories

Social theories have contributed to the knowledge base of alcohol problems and of treatment. Social learning theories have been used to develop effective interventions to prevent relapse for alcoholics. Systems theories have provided information about how systems interact with people with alcohol problems. Sociocultural theories suggest culture plays a significant role in how people develop alcohol problems.

Summary of Theories addressing Alcohol Problems

Biological theories, psychological theories, and social theories have all been applied to alcohol problems. These theories have generated information about how people develop alcohol problems and how to help people with alcohol problems. None of these groups of theories, however, can provide sufficient information to completely explain how and why people experience alcohol problems. One reason for this may be as Lindstrom (1992) and Chaudron & Wilkinson (1988) suggest, that people with alcohol problems are so

heterogeneous that no single group of theories is adequate to explain the variance in this group.

Perhaps the best view of these theories of alcohol problems is characterized by Heath (1988) who states, "In attempting to unravel the complexities of alcoholism...we cannot afford to slight biological, psychological, or social variables; it is their complex interaction that demands our cooperative attention" (p.403).

Recovery From Alcohol Problems

Recovery from alcohol problems has received less attention than the descriptions of symptoms and exploration of causes (Tomko, 1988). Because of this, the term "recovery", when applied to alcoholism, has come to mean many things. What began as a very narrow definition where recovery meant abstinence from alcohol use, has evolved to recovery being a multidimensional process. Tomko (1988) suggests the dimensions and outcome of recovery seem to depend on which theoretical framework is being applied. Consequently, both the process and the outcomes of recovery depend upon the model of recovery used.

Three models of recovery that have received various levels of attention are the disease model, the life process model and the developmental model.

The Disease Model of Recovery

The disease model of recovery advocates total abstinence

from any alcohol use for alcoholics. It suggests that, because there are underlying physiological and genetic determinants that produce the disease, treatment is necessary before recovery or abstinence can be maintained. According to Matano & Yalom (1991), because of this view, the alcoholic is not motivationally responsible for his or her behaviour. Both psychological problems and interpersonal problems are a consequence of the disease, rather than a contributor to the cause. They further report that, based on the disease model, "... the interpersonal problems of an addict will for the most part resolve spontaneously following sobriety" (p.271).

The emphasis of treatment for alcohol problems using the disease model of recovery is on achieving and maintaining sobriety through cognitive and behavioral change. The behavioral goals include the elimination of drinking, and modification of behaviour associated with drinking. Cognitive goals include altering beliefs about alcohol use, recognizing the antecedents of alcohol relapse, and developing strategies that will assist in the recovery process (Matano & Yalom, 1991). Additional goals may include the development of social support networks and involvement in self help groups to prevent relapse.

Treatment based on the disease model is usually provided in a highly structured group environment. The treatment environment is most often highly supportive of a particular group of beliefs and behaviours, protected from outside

influence, and sheltered from anxiety and conflict. As Matano and Yalom (1991) state,

> Patients are encouraged by the therapist, and through peer pressure, to subscribe unconditionally to group beliefs about the disease concept of addiction, the individual's inability to control drinking, and the cognitive and behavioral process of recovery. Therapists promote this view with an authoritative, confrontational stance: they stress identification as an addict, deemphasize differences among patients and posit abstinence as the primary topic of discussion (p.272).

When describing the treatment process using the disease model, Manter DuWars (1992) states,

> Alcoholism is a disease of stereotyped thinking and behaviour, which means we hear the same things over and over and over...discussion looks at the daily life of alcoholism treatment; denial, acceptance, relapse, urges to drink, and frustrations of daily living in particular, trying to explore them as entities in themselves, but entities that may reveal handles within the grasp of our treatment (p. xi).

Limitations Of the Disease Model of Recovery

A large number of studies have challenged treatment based on the disease model because of limitations, both with the scope of treatment, and with treatment outcomes (Tucker, Vuchinich, Akiko Gladsjo, 1994; Matano & Yalom, 1991; Levin,

1990; Clarke & Saunders, 1988; Tomko, 1988).

With respect to the scope of treatment, Emener (1993) asked 229 individuals recovering from alcoholism about their perceptions and recommendations for treatment of alcoholism. The services and topic areas recommended were of a much wider range than what the disease model of treatment would support. For example, intra-personal topics recommended included dealing with grief and loss, anger, raising self esteem, men's and women's health issues, stress management, and confidence building. Interpersonal topics included assertiveness training, sexuality and intimacy, and society's expectations of men and women. Skill development topics recommended included employability skills, recreation and leisure skills, parenting skills, and money management skills (p. 55-56). Traditional disease models of treatment would not address this range of topic areas for treatment even though Emener (1993) cites considerable empirical research to support the need to address each of these areas.

As well, Matano and Yalom (1991) report alcohol treatment requires interventions in a larger range than the disease model would suggest. They state,

> ...many clinicians and researchers acknowledge (the disease model's) limitations in explaining the psychological and social experience of the addict...There is growing recognition that many addicts continue to suffer from a variety of interpersonal and psychosocial

> problems following sobriety - problems that, left unchecked, can contribute to relapse. In some cases, these difficulties precede substance abuse, but even those addicts who appeared, prior to addiction, to have relatively intact psychological make-up and social support systems cannot assume that these assets will easily re-emerge following sobriety (p.272).

Treatment outcomes have also formed the basis for challenging the disease model of treatment. The main goal of the disease model of treatment is abstinence from any consumption of alcohol. The accomplishment of this goal has been limited for those who completed treatment. For example, Clarke and Saunders (1988) suggest that treatment outcomes over the preceding thirty year period reveal two facts; of those individuals who acknowledge alcohol problems and request help for it, most do not improve and of those who do improve, more than half return to harmful drinking (pp. 7). They further report that, in a review of hundreds of treatment centres, follow up information showed only 28% of patients remained sober 6 months following treatment, and the number dropped to 7% at a four year follow-up. They also report a success rate, with success being defined as abstinent or still drinking but improved, at just under 26%.

Miller & Hester (1989) report that alcohol treatment programs using the disease model do not reliably produce long term recovery.

As well, Peele & Brodsky (1991) state, "...whatever short term benefits medical, disease oriented treatment produces...for the majority of people, the disadvantages of the disease approach clearly outweigh the advantages from the start" (p. 30). They suggest that the disease model of treatment actually does more harm than good for people. For example, they indicate the disease treatment model sets people up for failure, makes matters worse than they are, stigmatizes, brainwashes, and ignores the rest of the person's problems in favour of blaming them on the disease.

Finally Vaillant (1983) completed follow up with his patients at two years and eight years after treatment. He found that alcoholics who completed treatment had levels of abstinence rates similar to comparable alcoholics who had received no treatment at all.

The disease model of treatment continues to be the dominant model used in treatment centres in North America (Clark & Saunders, 1988). As Mendelson & Mello (1989) suggest however, research over the past five decades has shown significant developments in understanding the antecedents and consequences of alcohol abuse, which are increasingly being addressed in the treatment process.

The Life Process Model of Recovery

The life process model of recovery directly contradicts the more popular disease model. It suggests that alcohol problems are destructive habits and that common sense, self

control training, and life skills development focusing on concrete results leads to successful problem resolution. It suggests three strategies; self assessment, planning and action.

The goals of the life process model can be diverse. They can include abstinence from alcohol, controlled drinking, changes in self, relationships or the environment. Peele and Brodksy (1991) suggest goals must eventually focus on positive achievements, and on areas which have nothing to do with the addiction.

The life process model is viewed as a "natural" way of dealing with alcohol problems (Peele & Brodsky, 1991). The life process model embraces building on strengths, creating positive options, change as a natural life process, and time as an ally because age tends to ameliorate or eliminate bad habits. This model also views alcohol problems as being on a continuum from mild to severe, with larger numbers at mild levels and smaller numbers at severe levels (Peele & Brodsky, 1991).

The life process model suggests that people are more able to improve their alcohol problems independently rather than with help. Peele and Brodsky (1991) state,

> More people quit alcoholism and addiction on their own than do so through treatment, and evidence is that in many cases people trying to quit an addiction are better off attempting it without the help of typical treatment

> programs. There are therapies that work better than disease oriented alcoholism clinics...but you would be hard pressed to find such treatment if you tried (p.9).

The suggestion of natural recovery is supported in research. Tucker, Vuchinich & Akiko Gladsjo (1994) found that over a three year period, environmental factors led to increased levels of abstinence among a group of untreated alcoholics. Further, they suggested there was a high association between natural recovery and the following factors; heightened health concerns and relatively uneventful work situation during the year preceding abstinence, and a reduction in health and legal events in the first year of abstinence.

Limitations of the Life Process Model

The life process model does not take into account the physiological or genetic aspects of alcohol problems. Peele & Brodsky (1991) either dispute or disregard much of the evidence that currently exists. For example, They state, "No biological or genetic mechanisms have been identified that account for addictive behaviour" (p. 26). Further, the life process model view of a common sense approach to self assessment, planned change and action is questionable in light of findings concerning alcoholics in early stages of recovery. Specifically, low tolerance levels concerning anxiety and frustration (Matano & Yalom, 1991), lower levels of self esteem and higher levels of self deception (Strom & Barone,

1993) contribute to the conclusion that the life process model may work better in the later stages of recovery as opposed to earlier stages.

The Developmental Model of Recovery

The developmental model of recovery views alcoholism as a problem where reliance upon alcohol has resulted in a person being unable to resolve normal developmental tasks. Recovery is viewed as a process of stages which involves progressively regaining control over life and resolving developmental issues. Wallen (1993) suggests developmental problems in recovery which require resolution may include issues connected to the current life stage, deficits or issues that originate in earlier life stages, information or skill deficits, experiential deficits, and unconscious conflicts/fixations (pp. 15-16). She identifies with Brown's (1985) four stages in the recovery process; drinking, transition, early recovery and ongoing recovery. According to Wallen (1993), these stages in recovery are similar to Prochaska and DiClemente's (1986) four stages of change; precontemplation, contemplation, action, and maintenance.

The drinking stage is one where the alcoholic is actively using alcohol and denying it is a problem. Wallen (1993) reports that, "The cognitive structures that maintain addiction involve denying that there has been a loss of control over drinking and reinforcing the individual's identity as a non-alcoholic" (p.54).

The transition stage involves a shift from denial to acceptance of the loss of control and acknowledgement of identity as an alcoholic. Wallen (1993) suggests that, at this stage, people need practical information about how to resist drinking and cope with situations arising that may be antecedents to drinking.

The early recovery stage, according to Wallen (1993) is characterized by a more stable continuation of the transition stage with a new logical structure to daily living. Substituting non-alcohol related social patterns, reconciling past denial-related behaviour and sorting out confusing messages about recovery are important at this stage.

The ongoing recovery stage has abstinent supporting behaviour as an integrated process, a process which feels natural. A reduction in rigidity and an increase in self-regulating behaviour allow for greater self exploration, which occurs in this stage (Wallen, 1993).

VanWormer (1987) suggests there are three stages to recovery; early, lasting from one to six months; middle, lasting from 6 months to one year; and ongoing, lasting from one to several years. Her descriptions of these stages are parallel to Wallen's last three stage descriptions.

Limitations of the Developmental Model of Recovery

The developmental model of recovery seeks to reconcile some of the concepts of the disease model with psychological

processes of human development. It is viewed as being complimentary to the disease model of recovery. It may, however, be viewed as an extension of the disease model in that the disease model views abstinence as the goal, while the developmental model identifies abstinence as one of a number of steps in alcoholism recovery (VanWormer, 1987).

Based on a review of current journals and books, there appears to be a lack of research addressing the developmental model of recovery. Although this model expands the range of areas of treatment from the disease model, it seems there is a still a need to study the outcomes generated from this approach to recovery.

How Do People Develop Codependence Problems?

Codependence is a recent term to describe a number of dynamics in dysfunctional relationships. There is still much confusion and disagreement about the definition of codependence (Tavris, 1990) and about it's legitimacy as a diagnostic entity (Cermak, 1986).

Although there appears to be significant confusion about what codependence is, in the past 15 years codependence has emerged as one of the cornerstones of rehabilitation (Doweiko, 1993).

A number of definitions of codependence have been suggested. Shaef (1986) suggests codependence is a disease with an onset, definable course, and predictable outcome. The disease originates in early childhood at which time people

learn to enter into addictive relationships. Wallen (1993) states,

> Codependency, as originally used, refers to the family systems proposition that once one family member is dependent upon a substance, and the family has organized itself around that dependency, all family members become dependent on the substance or "codependent" because family homeostasis requires its presence (p.88).

Alexander (1992) contends that codependence is,

> ...a persistent, self-defeating pattern of intra- and interpersonal relationships that arises out of a dysfunctional family system and is characterized by poor self worth, dependency, disturbed emotional development, anxiety, and driven by an extreme external locus of control (p.39).

For this study, Alexander's definition was used. This definition is also used by the authors of the Individual Outlook Test (Worth et al, 1993).

Theories of Codependence

Codependence has been viewed as a behavioral problem, a personality disorder, an ego psychology paradigm, a sociological problem, and a combined behavioral intrapsychic problem (Worth et al., 1993). The suggestions about what codependence is and how to deal with it are numerous, and the research is not nearly as firmly established as for theories of alcoholism. Theories that have been put forward have been

challenged; the concept itself has received considerable criticism concerning it's existence. Even so, there is a considerable amount of information that suggests codependence is a significant issue in families who experience problems related to alcohol (Prest & Protinsky, 1993).

Three groups of theories have received particular attention concerning codependence; disease theories, self-in-relation theories and family systems theories.

Disease Theories of Codependence

Disease theories suggest codependence is a disease that originates in children overcompensating for the inadequacies of the parenting they receive due to the family dysfunction (Haaken, 1993). The disease is based on the idea that, as one person becomes dependent upon substances, family members become dependent on that person, creating the condition of codependence. It is also described as a generationally transmitted disease (Haaken, 1993). Mellody (1989) describes the lack of clear understanding that exists. She states,

> Most codependents do not understand much about how the disease works in their lives and how it affects their relationships and their own happiness and self esteem. Although the disease is rampant in our culture, the state of the art in the healing of codependence is so new and primitive that many therapists don't know how to speak to it. They aren't clear about the cause or about the best

way to treat it (p. xxii).

This lack of clear understanding seems to pervade the disease theory of codependence. As Wassmer (1989) states,

> ...addiction is a disease so we are able to predict its course, often with amazing accuracy. Codependency isn't exactly a disease in the strictest sense, because there are no physical causation factors that we know of, but it is close enough to one to be called a disease by workers in the field. Codependency is actually a syndrome, that is a collection of psychological, physical, and behavioral symptoms that present themselves in an equally predictable order in certain kinds of persons in certain kinds of circumstances (p.138).

Mellody (1989) suggests there are five core symptoms of codependency; difficulty experiencing appropriate levels of self esteem, setting functional boundaries, owning our own reality, acknowledging and meeting our own needs and wants, and experiencing and expressing our reality moderately. Mellody (1989) believes the disease comes from family systems that are not nurturing, are abusive or are dysfunctional. She suggests growing up in these types of families leads to the perception that the behaviour modelled within the family is normal, which, "...locks us into the disease of codependence with no way out" (p.5).

The disease theory of codependence has been aligned with the disease concept of alcoholism by Capell-Sowder (1984).

The tolerance of codependent people towards unacceptable behaviour is aligned with the alcoholic's tolerance for alcohol. Similarly, codependent people's loss of control over their emotions is analogous to the alcoholic's loss of control over alcohol.

Whitfield (1984) states, "Codependency is a newly recognized, treatable, diagnostic entity...it is chronic, progressive....Codependency may also be viewed as a 'primary' illness, with a natural history of its own" (p.24).

The concept of codependency being a disease that includes tolerance, loss of control, progression, and causation, has been rigorously challenged by a number of researchers. Wiseman (1975) provided research that clearly contradicts the notions of tolerance and loss of control. In Wiseman's (1975) studies, many wives were not tolerant of alcoholic behaviour, nor were they likely to lose control of their own emotions. In fact, a number of wives adapted in ways that exhibited considerable control over their emotions. Miller (1994) suggests that codependent symptomology varies with a spouse's drinking behaviour. Moos, Finney and Gamble (1985) conclude, "Spouses of alcoholics are basically normal people who are trying to cope with disturbed marriages and behaviourally dysfunctional partners" (p.905).

Miller (1994) reports that while the number of treatment programs for families based on the disease model have grown, there is little empirical evidence to support this approach.

He reports finding only one study (Mcrady, 1989) examining outcomes for codependence treatment using the disease model in the preceding ten year period. Miller's (1994) critique of the disease model of codependency concludes,

> To be successful in helping the family of the alcoholic, it seems the codependency movement will need to be diverted from its present course. Unless important conceptual changes are made, no amount of research and treatment will alleviate the limited impact of this approach (p.344).

Self-In-Relations Theories of Codependence

The self-in-relation theories are grounded in social work and feminist theories. They suggest people naturally seek mutually empathic connections in their primary relationships and that ongoing feelings of disconnection can lead to developmental difficulties. Collins (1993) reports the outcome from disconnected primary relationships is a set of symptoms quite similar to those describing the codependent individual. She notes three distinctions of the self-in-relations theory that are contrary to the disease theory of codependence.

First, the developmental problems resulting from disconnection are not a result of failing to separate from the person with the alcohol problem, as the disease model would contend. Instead, they result from the difficulties experienced by trying to maintain connection in the

relationship while also trying to meet personal needs and desires. Second, self-in-relations theories address the issue of power in relationships. When there are power imbalances in relationships, the person with less power is likely to feel disempowered or victimized. This person is more likely to experience negative developmental outcomes than the person who has the majority of power in the relationship. Third, self-in-relations theories hold that, "The issue is how to create a social context in which growth producing relationships can flourish" (Collins, 1993, p.474).

Self-in-relations theories attack the disease theory of codependence from a feminist view. Babcock (1991) suggests calling a woman "sick" because she is coping with an abusive relationship with an addict is similar to calling the abused woman who stays in an abusive relationship "masochistic".

Other feminists have suggested that the pathology ascribed to codependency are aspects of the traditional female role, and that the codependency literature tells women that femininity is pathology. Further, they suggest the literature indicates women cannot blame society or power imbalances in relationships for their pathology (Babcock, 1991).

Collins (1993) suggests that the limitations of the disease model do not take into account the stereotypical role of women in society. She states,

> ...the depoliticizing and decontextualizing aspects of the codependency concept are problematic at best. At

> worst, the concept fosters the tendency to blame victims. It dangerously encourages a posture that emphasizes how the individual woman is ill, in contrast to a perspective that emphasizes how a woman copes or survives in sick situations and with a limited range of responses given her subordinate status, and the alternatives she perceives herself having in a family and culture that are sexist and oppressive to women (p.473).

Collins (1993) suggests that, because the disease model of codependency has, in her opinion, little empirical evidence to support it, and because the model suggests women label themselves as sick, addicted, or diseased, it should not be adopted by social workers. She indicates social workers do not help clients solve their problems solely through personal insight. Social workers should direct interventions towards the individual in context, a perspective that is more in keeping with self-in-relations theories than disease theories of codependency.

Family Systems Theories of Codependence

Family systems theories seek to examine the systems within which codependency evolves. The basic premises of family systems theories are that relational patterns are learned and passed down from generation to generation. Current behaviour of individuals and families are a result of these patterns; and that the family system is homeostatic in that change in one part of the system affects the entire

system.

These theories suggest that family members of people with alcohol problems have a similar underlying etiology; an intergenerational pattern of dysfunctional emotion and behaviour that seeks to maintain social equilibrium within the family system (Prest & Protinsky, 1993). Wegscheider-Cruse (1984) described codependence as an adaptive response to a sick family system that seeks to protect and enable the alcoholic.

A number of researchers suggest that codependence is something that occurs in people's lives before they are exposed to active alcoholism (Whitfield, 1989). Codependence is viewed as a result of prolonged exposure to a set of oppressive family of origin rules. Cermak (1986) suggests that there is a reciprocal relationship between alcoholism and codependence within the context of the family of origin. One result of this relationship is the view that neither codependence or alcohol addiction can be examined as qualitatively different. In fact there has been some suggestion that the varying symptomatology may mask a common systemic phenomenon (Whitfield, 1989). Prest and Protinsky (1993) suggest because of this common phenomenon, and because codependence includes both intrapsychic and interpersonal dynamics, "...it seems a definition must be based on a conceptualization of codependence as due to both family of origin and current system dysfunction" (p. 355).

Family systems theory contends that emotional systems, triangulation, differentiation, fusion, and personal authority play a role in how families function. Prest and Protinsky (1993) suggest if families have dysfunctional relational patterns, codependence is a result. They state,

> Codependence emerges from the dysfunctional relationships patterns that are primarily rooted in the intergenerational family emotional system. These patterns include anxiety binding mechanisms in the form of triangulation, fusion, compulsive or addictive behaviours; lack of awareness of feelings while focusing externally on another person, activity, or substance; a lack of intergenerational individuation; difficulty with establishing desired levels of interpersonal intimacy or distance; and diminished sense of personal identity and authority. The intergenerational processes are reinforced and transmitted through current relationship functioning (p.359).

Summary of Theories of Codependence

The three theories outlined appear to suggest one common theme; codependence is a result of reactions to something external to the person. The disease theory suggests codependence is a result of reaction to negative early childhood experiences. The self in relations theory suggests codependence results from trying to maintain an emotional connection in dysfunctional relationships. As well, the self

in relations theory recognizes the effect of power imbalances in relationships and the effect of societal oppression of women. Family systems theory suggests codependence results from family members behaving in dysfunctional ways to maintain family equilibrium. It may be that there is not a single theory to sufficiently describe how codependence develops. If so, codependence could be similar to alcoholism in that both are very complex conditions, with heterogeneous populations, where a single theoretical model will not adequately describe all who suffer from them.

Recovery from Codependence

Because codependency is viewed as a relatively new condition, and because its definition remains somewhat unclear, there is a steady focus on whether it really exists as a diagnostic entity (Cermak, 1986). Because of this, it appears that empirical evidence of treatment for codependence is limited. Miller (1994) reports, however, that

> ...the disease model of codependency as philosophy and intervention has increased steadily in popularity. More recently, the delivery of treatment services for family members has increased at a faster rate due to third party financing and aggressive marketing strategies (p.344).

Given the popularity of the codependency movement, the ambiguity of definition, and the challenges to its legitimacy as a diagnostic entity, reviewing existing information

concerning recovery is very important.

There are two views of codependence recovery that seem to dominate the literature; the disease model and the internalized oppression model. The disease model of recovery for codependence, similar to alcoholism, views recovery as the absence of the symptoms of codependent behaviour (Mellody, 1989). The internalized oppression model views recovery as personal and social change towards a more internal locus of control, less oppression, and adoption of feminist ideals (Davis Kasl, 1992). It uses a feminist framework to focus on women and minorities with the goal of changing systems that have negatively affected people who are identified as codependent. This approach externalizes the problem and views oppression as the source of codependency (Davis Kasl, 1992). Consequently, recovery is not only viewed as an individual process. Recovery also includes social change to a less oppressive environment, particularly for women.

The Disease Model of Recovery From Codependence

Mellody (1989) describes the symptoms of codependence as experiencing opposite extremes. For example, she suggests that codependent people either experience very low levels of self esteem or are arrogant and grandiose. In her view, the first step in recovery is acknowledging these symptoms and their effects. She reports that recovery begins with pain, unexpected fears and uncertainties, and that the symptoms of codependency will not go away on their own (p. 198-202). Her

suggestions for recovery include writing how the symptoms of codependence have impacted a person's life, and confronting each symptom in a concrete way. Mellody (1989) uses an analogy to describe her view that codependent people do not find a cure for their disease. She states,

> Recovery from codependence is more like being in remission from something like diabetes. As long as the diabetic continues to follow the prescribed treatment of diet, exercise, and perhaps doses of insulin, he or she can lead as active a life as a nondiabetic...In a similar way, as long as we follow a recovery program, we can lead more healthy, functional lives(p. 205-206).

Alexander (1991) suggests there are two types of codependency; primary and secondary. Primary codependency addresses the relationship with the self, and is particularly concerned with being victimized by past experiences. He states, "It reflects a toxic belief system and perpetuates an illusion of inadequacy and incompetency arising from the negative influences of a dysfunctional family" (p.36).

Secondary codependence concerns unhealthy relationships with others and is a result of dysfunctional communication patterns learned in childhood. Alexander (1991) states, "It reflects a fear of being ourselves and the avoidance of openness and honesty in our transactions with others" (p.36).

According to Alexander (1991), recovery depends upon which type of codependence a person is suffering from. He

acknowledges that most codependent people have both types and advises to work on the primary type first. Recovery from primary codependence involves changing the codependent life script which he describes as the unconscious blueprint for living and the roles played to sustain it. Recovery from secondary codependence involves giving up codependent games and learning new habits of interacting and listening to others. Codependent games are, "...go nowhere, time wasting interactions...which produces great distancing between people" (p.38).

Beattie (1989) describes five stages to recovery from the disease of codependency; survival/denial, reidentification, core issues, reintegration and genesis. The survival/denial stage is a pre-recovery state where coping behaviours are self defeating and people know that something has to change, though they may not know what needs changing. The reidentification stage involves two events. First, people must reidentify themselves as codependent and second, they must surrender and accept their powerlessness over other people. The core issues stage is where people begin to understand the extent to which self defeating behaviour has impacted their lives. They begin to set goals and to experiment with new behaviour, set more functional boundaries and practice new relationship and living skills. The reintegration stage is where people become comfortable with themselves. They learn to respect and care for themselves and learn to have fun in their lives and

relationships. The genesis stage is where the new self emerges with both the freedom and the discipline to live a new spiritual way of life (Beattie, 1989).

Limitations of the Disease Model of Recovery from Codependence

The three main limitations of the disease model of recovery from codependence are the lack of an agreed upon definition of codependence, the lack of empirical evidence to support any of the descriptive features of the disease model (Miller, 1994) and the absence of treatment outcome evaluation for the model. The first two limitations were addressed earlier. The third limitation is, at this point, the most relevant. According to Miller (1994), only one outcome evaluation of the disease model of recovery was found in the last fifteen years, and it had methodology problems that suggested its results were questionable. As Miller (1994) states,

> While accumulating evidence clearly supports consideration of other forms of therapy for the spouse, the disease model of codependency still remains the primary approach to treatment. Its popularity surely is not based on its effectiveness, because this has not been validated empirically (p.343-344).

The Internalized Oppression Model of Recovery From Codependence

Davis Kasl (1992) suggests that codependence is a result of an imbalance of power that has lead to oppression, particularly for women, which is internalized, then regulated by the oppressed themselves. Her definition addresses the disease concept in a very different manner than the disease model. She states,

> Codependency is a disease of inequality - a predictable set of behaviour patterns that people in a subordinate role typically adopt to survive in a dominant culture. Codependence is a euphemism for internalized oppression and includes traits of passivity, compliance, lack of initiative, abandonment of self, and fear of showing power openly (p.279).

Inherent in the definition of this model is the view that an internalized sense of powerlessness is part of the problem, but so is the social culture through which this powerlessness is learned (Davis Kasl, 1992).

Recovery using this model is based on a number of key concepts; seeing codependence as oppressive, externalizing the problem, identifying the need for personal and social remedies, identifying personal strengths, seeking empowerment, taking action and affecting change (Davis Kasl 1992). Davis Kasl (1992) suggests a balance between personal and social change is necessary. She states,

It is also important that the need for personal healing be a significant part of the picture. In early feminist days in the late sixties and early seventies, may have put too much emphasis on looking at the

> inequities of the system and not paid enough attention to the need for personal healing...The process of change involves uncovering the false promises, tricks, deceptions, and negative internalized programming associated with being a woman or person of colour in the United States (p.284, 287).

The internalized oppression model of recovery is supported by Collins (1993) in her review of the person in relations theory. She suggests this model is particularly congruent with social work practice. She states,

> ...a social work orientation to clients and their problems requires an appreciation of, and interventions directed toward, the individual in context. Derivatively, social workers cannot expect women to recover privately without addressing the oppressive forces that contribute to both victimization and the serious relational dysfunctions they experience in their lives (p.474).

Anderson (1994) also advocates both personal and social change concerning codependence. She contends that the term codependence is a label that discourages individual identity and relational connections to the family of origin. She

suggests that,

> ...teaching women that both personal development and social action are essential for positive change in their lives...that in addition to reconnecting with their families of origin and increasing their personal power, they can resolve their difficulties by changing the social and political institutions that created those difficulties" (p. 678, 685).

Limitations of the Internalized Oppression Model of Recovery from Codependence

Similar to the disease model, this model of recovery suffers from the lack of clear definition for the term, codependence. The descriptions of recovery strategies are vague and, based on a review of current literature, outcome studies to provide empirical support for this approach appear minimal. Also similar to the disease model where there is criticism of writer bias because many claim personal experience with codependency, writers addressing this model may have a feminist bias that impacts their view. Davis Kasl (1991), Collins (1993), and Anderson (1994), all suggest similar feminist views with respect to codependence, but none of them provide empirical research to validate their opinions for recovery from codependence.

The Role of Self help Groups in Recovery

In the addictions field, self help groups generally refer to groups that are based on the 12 step model of Alcoholics Anonymous (1976). In the last decade, there has been a large increase in the number of groups that utilize a 12 step model of recovery based on A.A. (Haaken, 1993). There are 12 step groups to address drug problems (Narcotics Anonymous), weight problems (Overeater's Anonymous), emotional problems (Emotions Anonymous), sex problems (Sexaholics Anonymous), gambling problems, (Gambler's Anonymous), problems resulting from relationships with alcoholics (Alanon), problems resulting from growing up with parents who are alcoholics (Adult Children Of Alcoholics), and codependency problems (Codependents Anonymous), to name a few. At this point, three groups are of particular importance concerning their views of recovery, and the impact they have on treatment programs for alcohol problems and codependence. These groups are Alcoholics Anonymous, Alanon, and Codependent's Anonymous.

Alcoholics Anonymous

Alcoholics Anonymous is an organization that began in 1935 by two men as a way to recover from alcoholism (Alcoholics Anonymous, 1976). With recovery of the first 100 alcoholics, the book Alcoholics Anonymous was written in 1939 to describe their experiences and the process they undertook to recover from alcoholism. As well, this book, described as "the basic text for our society" (Alcoholics Anonymous, 1976,

p.xi), examines how Alcoholics Anonymous views alcohol problems, spirituality, recovery, spousal relationships where alcoholism exists, how to help alcoholics, and the results alcoholics can expect if they complete the 12 suggested steps. This text also outlines 12 traditions which describes rules for AA groups, their relationships to other AA groups and to other organizations.

The immense growth of Alcoholics Anonymous members, and the popularity of the 12 steps for recovery from alcoholism have had significant impact on treatment for alcohol problems. Doweiko (1993) reports that in the fifty years following it's inception Alcoholics Anonymous grew to more than 50,000 groups in 114 countries and a membership in 1987 of over 1 million. With respect to it's impact on treatment, Doweiko (1993) states, "The self help group, Alcoholics Anonymous has emerged as one of the predominant forces in the field of drug abuse treatment" (p.370). As well, Montgomery, Miller and Tonigan (1995) reports, "Treatment centres throughout the United States rely heavily upon Alcoholics Anonymous as an element of treatment philosophy and as an aftercare resource" (p. 241).

Alcoholics Anonymous views alcoholism as a disease that acts similar to an allergy where, for some people, when alcohol is consumed, it creates a craving for more that evolves into a cycle resulting in alcohol dependence. As stated in Alcoholics Anonymous (1976),

All these, and many others, have one symptom in common:

> they cannot start drinking without developing the phenomenon of craving. This phenomenon, as we have suggested, may be the manifestation of an allergy which differentiates these people, and sets them apart as a distinct entity. It has never been, by any treatment with which we are familiar, permanently eradicated. The only relief we have to suggest is entire abstinence (p. xxviii)

Alcoholics Anonymous suggests the disease of alcoholism has no cure, but it can be arrested through the development and maintenance of spiritual principles. It separates spirituality from religion, maintains personal anonymity at the public level, is self supporting, neither endorses nor opposes any causes, places principles before personalities, places common welfare and unity first, and has equal status amongst it's members (Alcoholics Anonymous, 1976). It's primary purpose is to carry its message of recovery to alcoholics who are suffering.

Doweiko (1993) suggests three main reasons for the effectiveness of AA. It is a social outlet for its members. It shows its members that their problems are not unique, and it offers a predictable path to follow. These are valuable qualities in light of the loneliness, isolation and lack of consistency that accompanies alcohol problems (Doweiko, 1993).

The effectiveness of AA has been significantly examined. Lewis, Dana, and Blevins (1988) suggested involvement with AA

should be viewed as a supportive addition to treatment, but not as treatment in itself. Doweiko (1993) reported that 70% of those who stayed sober the first year in AA will be sober at the end of their second year. As well, 90% of those who were sober at the end of their second year of AA will be sober at the end of their third year.

Peele and Brodsky (1991) have criticized the philosophy of AA because, in their view, there is an absence of evidence to confirm its effectiveness. As well, Osborne and Glaser (1985) suggest AA may not be effective for some people, and is not effective for people coerced into attending by the courts.

In a recent study to examine AA effectiveness, Montgomery and his colleagues (1995) examined the alcohol consumption of a treatment group over a 31 week period following treatment. Particular attention was given to two areas; attendance at AA meetings and level of involvement in the AA group. Montgomery et al (1995) report,

> Our findings suggest, therefore, that it is the extent of involvement or active participation in AA processes, rather than mere attendance at AA meetings, that is associated with more favourable outcomes after treatment...It appears that those who choose to become involved in the 12-step processes of AA following treatment do experience more favourable outcomes (p.245).

Alanon

Alanon was formed in 1951 by wives of alcoholics recovering in AA, who recognized that they experienced problems unique to those involved in relationships to alcoholics. Alanon suggests alcoholism is a family illness and uses the 12 step model as a means of reducing enabling behaviour. Alanon suggests that, by enabling the alcoholic to continue using alcohol, members are inadvertently supporting behaviour they do not want. Reducing enabling behaviour, detaching with love, and taking responsibility for their own feelings and behaviour are goals in Alanon. As Haaken (1993) states,

> The literature continues to stress the necessity of relinquishing blame and anger, not simply because such hostility can be counterproductive, but because the enabler's recovery from her own "disease" is manifested by replacing emotional extremes with emotional detachment and a levelling of feelings (p.336).

Wiseman (1991) suggests the primary benefits gained by involvement in Alanon are; an approach for coping with the anxiety and depression experienced over their husband's drinking, release from responsibility for their husband's behaviour, and a congenial support group (p.189). Secondary gains, according to Wiseman (1991) included being an avenue to feel socially worthy, and acting as an aid to the wife in building a life of her own.

Codependent's Anonymous

Codependent's Anonymous (CODA) emerged as an offshoot of Alanon in the early 1980's. Its purpose is to help people develop and maintain functional relationships. It's membership, unlike Alanon, is not confined to the relatives of alcoholics. CODA is a self help group in its infancy, with no organizationally approved literature beyond pamphlets, and an International Service Office (ISO) that has only been in place for 6 years. The ISO (1989) reports there is expansion of groups nationally and internationally, citing an explosion of new meetings throughout the world is occurring.

Members of CODA recover through practicing the 12 step model modified from Alcoholics Anonymous. They use a disease model of codependence, and suggest it can be manifested over multiple generations. For example, the CODA pamphlet, (1989) states,

> In other words, the original alcoholic or drug dependent person may have been a great grandfather/mother. No one else for three or four generations may actually become alcoholic but most family members within these three or four generations have learned to use a set of behaviours which help them to deal with the emotional pain and stress even to the present time. This set of behaviours eventually become codependency disorders (p. 2).

Because Codependent's Anonymous is so new, and has

received little attention in the social science literature, there is limited information available as to its size, functions, effectiveness, and its place in the addictions field. It is a self help group, however, that seems to be growing very quickly in its membership and in the number of groups being initiated (Mooney et al, 1992).

Conclusions About Alcohol Problems, Codependence and Recovery

A review of the literature addressing alcohol problems and recovery suggests there is no single theoretical model that can account for all alcohol problems or provide beneficial treatment outcomes for all alcoholics. As Lindstrom (1992) reports, the view that, "...there is one population of alcoholics, to be treated by one best approach, resulting in one therapeutic outcome - abstinence...is not a fruitful approach" (p. 115). He suggests that successful approaches to treatment for alcohol problems must address not only biological, psychological, and social factors, but also the interaction between these factors. The Institute of Medicine (1990) report that because no single approach is best for all people with alcohol problems, a wide range of treatment approaches are offered in the United States. They further state,

> The committee is encouraged that these differing approaches are now evolving toward a comprehensive approach, the biopsychosocial model, which recognizes the

contribution of genetic, physiological, psychological, and sociological factors to the etiology and treatment of alcohol problems (p.85).

Although there are no known physiological causes suggested for codependence (Wassmer, 1989), Worth and her colleagues (1993) suggest there are physiological consequences. Most theories of how codependence develops and how to treat it have been either psychological or social. Some theorists advocate a combination of both psychological and social theories should be applied to treatment of the codependent condition (Prest & Protinsky, 1993; Collins, 1993; Davis Kasl, 1992).

There is a growing body of literature that indicates greater success in outcomes, both for recovery from alcohol problems and from codependence, by matching client needs to treatment models. Research of existing studies (Lindstrom, 1992; Miller, 1994) indicate the following for both alcohol and codependency problems:

1. No single treatment is superior for all alcoholics or codependents.
2. No valid evidence exists to conclude that all alcoholics or codependents are alike.
3. Different treatment approaches affect different client populations in different ways producing different results.

This approach starts to reconcile the range of

differences that exist in the theories of alcohol problems and codependence. As well, it offers a practical approach to addressing the heterogeneity of the client groups with these problems.

Treatment outcomes matching client needs to treatment models for alcohol treatment by Lindstrom (1992) and the Institute of Medicine (1990) suggest, in addition to being pragmatic, this approach contributes to better outcomes than any single approach is able to provide.

Studies of treatment outcomes focussed on matching client needs to treatment models for codependence were not found in this literature review. This may be partially due to the lack of agreed upon definition for the condition, to the disagreement over whether or not codependence is a distinct diagnostic entity, or to its relatively recent identification.

Chapter 3

Method

Study Design

This study used a one-group post test only design. This was an exploratory design to examine the association between variables related to codependency and variables related to individuals in recovery from alcohol abuse. The design was chosen because little was known about codependency for individuals in recovery from alcohol abuse.

The choice of an exploratory design is supported by Grinnell (1993) who states the purpose of exploratory designs, "...is to build a foundation of general ideas and tentative theories which can be explored later with more precise and hence more complex research designs and their corresponding data-gathering techniques" (p. 119).

Data was gathered using paper and pencil questionnaires which were completed independently and returned to the researcher.

Sample

The sample for this study consisted of 60 individuals who had a history of alcohol abuse and had abstained from any alcohol consumption for a minimum of 6 months prior to their participation. A non-probability sample was established using a snowball sample strategy. Grinnell (1993) suggests non-probability sampling is appropriate, "...where it is

unfeasible or impossible to draw a probability sampling and non-probability sampling is the only alternative" (p.164). It was not possible to establish a population for people in recovery from alcohol abuse, so non-probability sampling was necessary. As well, because of the anonymity of people in recovery from alcohol abuse, they are sometimes difficult to identify or locate. This was the main reason for using the snowball sampling strategy, as it enabled the researcher to access these individuals with relative ease.

To obtain the sample, the researcher attended 20 open AA meetings and 2 conferences between August 15, 1995 and November 30, 1995. The AA meetings were located in Dawson Creek, Ft. St. John, and Vernon B.C. The conferences were in Calgary, AB. and Vernon B.C.

To access AA members, the researcher approached them after AA meetings had concluded. The most frequent method was to accompany groups of between 2 and 8 AA members for coffee immediately after a meeting. A brief explanation of the study was provided while having coffee. Those who appeared interested were invited to participate in the study and were either given a detailed explanation of the study's purpose and the extent of their participation, or a meeting time was established to provide this information to them. If they chose to participate, arrangements were made to provide them with the questionnaire to complete and return to the researcher. They were also asked if they knew of anyone who

fit the criteria for the study and may want to participate.

For those individuals approached at conferences, the researcher approached them during conference breaks. The invitation to participate, explanation of the study, and arrangements for completing the questionnaire were the same as for AA members after AA meetings.

Forty AA members were asked to participate in the study using this method. Of these, 35 agreed to participate and 5 declined. Of those who declined, 2 gave no reason and 3 stated they did not want to provide information to reveal their identity like a signed consent form.

There were a number of additional AA members, however, who went for coffee after AA meetings and did not consent to participate in the study. They were part of the groups that were provided with a brief explanation of the study's purpose but they were not directly asked to participate. They did not appear to respond either positively or negatively to the explanation provided. Unfortunately, the researcher did not keep track of the number of these AA members or gather any information about their response to the explanation of the study.

The 35 AA members who agreed to participate provided the names of 32 more individuals; 13 AA members and 19 individuals in recovery but not involved with AA. These individuals were contacted by telephone and an explanation of the study was provided. They were asked to participate and if they agreed,

arrangements were made to have them complete the questionnaires and return them to the researcher. Three of these individuals declined to participate without providing a reason for this decision, other than that they did not want to participate.

The initial sample obtained included 48 AA members and 16 individuals in recovery from alcohol abuse but not attending AA meetings. Of these, 4 individuals did not qualify for inclusion because they did not meet the criteria for a history of alcohol abuse.

Within the sample, there were 20 individuals, all AA members, who were acquainted with the researcher prior to their involvement in this study. These acquaintances were a result of the researcher's previous involvement with Alcoholics Anonymous in Dawson Creek and in Vernon B.C. These individuals were approached in the same manner as others who were not previously acquainted with the researcher and all 20 agreed to participate in the study.

Measures

There were two standardized measures used in this study; the Individual Outlook Test (IOT) which is a measure to detect a codependent orientation, and the Brief Michigan Alcoholism Screening Test (B-MAST) (Pokorny, Miller & Kaplan, 1972), which is a measure to detect alcoholism. As well, a number of additional questions were used to determine demographic

information about respondent gender, marital status, age, and education level. Questions about when respondents stopped using alcohol, and attendance at Alcoholics Anonymous meetings, Alanon meetings and Codependent's Anonymous meetings were also asked.

The Individual Outlook Test

The Individual Outlook Test (IOT) was developed by Worth, Sim, Fox & McNab (1993) as a self report measure to assess a codependent orientation in adults. The IOT is a 60 item paper and pencil questionnaire with a reading difficulty at the grade 6 level (Worth et al. p. 8). The IOT has five sub-scales whose sum is calculated to measure the overall codependent orientation of respondents. The sub-scales measure the following: externally derived sense of self worth, anxiety, dysfunctional family of origin, dysfunctional relationships, and dependency within relationships. The sub-scale scores, as well as the overall codependent orientation score, are plotted on a profile with five cutoff points indicating, from lowest to highest; clinical alert, little clinical significance, mild codependent orientation, moderate codependent orientation, or severe codependent orientation.

Reliability of the IOT is good with Cronbach's Alpha coefficients ranging from .87 to .94. Internal consistency coefficients for the IOT are reported at .91, and the test retest reliability at three to four week intervals was .98 indicting a high test retest reliability (Worth et al., 1993,

p. 15 - 16).

Two factorial studies were completed for the IOT which "...indicated five factors underlying the test that correspond to the five main characteristics of codependency" (Worth et al., 1993, p.25). As well, high convergent validity was established by comparing the IOT to the Codependency Questionnaire (Potter-Efron & Potter-Efron, 1989) with a Pearson Product Moment Correlation coefficient of .89, p<.o5. Worth and her colleagues, (1993) report good divergent validity for the IOT as it distinguishes one psychological construct from another well.

The main criticism of the IOT with respect to its psychometric properties is that its developers used a small normative group (n=300), a small matched normative group (n=45), and a small codependent group (n=45), to develop the instrument, its scoring cutoff points, reliability coefficients and validity. In fact, the test retest reliability was established with a sample of only 13 respondents, all graduate students. Worth et al. (1993) suggests further testing is required with a larger, more heterogeneous sample to better establish the test retest reliability of the IOT.

Studies using the IOT are limited because it is a relatively new instrument. The IOT has recently been used in studies to examine the relationship between codependency and self esteem (Rijavec, 1993), codependency among nurses

(Andrew, 1992), and the relationship between codependency and gender and self monitoring behaviour (Vervoot, Korabik & Bellerby, 1993).

The Brief Michigan Alcoholism Screening Test (B-Mast)

The B-Mast (Pokorny et al., 1972) is a 10 item paper and pencil questionnaire to identify alcoholism that was developed from the original Michigan Alcoholism Screening Test (Mast) (Selzer, 1971), which was a 25 item questionnaire. The B-Mast is reported by Pokorny et al. (1972) and Hester & Miller (1989) to have reliability and validity scores comparable to the original Mast which reported high levels of concurrent and discriminant validity (.90) and reliability (.90). Pokorny et al. (1972) reports Pearson Product Moment Correlation scores between the B-mast and the original Mast to range from .95 to .99 indicating the B-Mast is an acceptable alternative to the Mast.

The B-mast has a weighted scoring system with a scoring range of 0 to 29. Although the cutoff point in the score has been 6 for the detection of alcoholism, there has been criticism that this cutoff point is too low, resulting in too many false positives (Hester & Miller, 1989). Hester and Miller (1989) reported that using a cutoff score of 12 or more to detect alcoholism resulted in a sensitivity that was .89 and specificity of .98. For this study, the score of 12 was used as the cutoff point to establish that respondents possessed a history of alcohol abuse.

The B-Mast has been used extensively as a measure for the detection of alcoholism (Hester& Miller, 1989). Recent studies using the B-Mast include a study by Chan, Pristach, & Welte (1994) to test the sensitivity of the B-Mast for clients in three settings; in-patient treatment (n=252), outpatient clinics (n=390) , and the general population (n=993). The B-Mast was reported to be sensitive in detecting alcoholism for all groups, with more sensitivity for the in-patient treatment group, and less sensitivity in the outpatient and general population groups. The B-Mast was also used by Ioane & Attah-Johnson (1992) to detect alcoholism in undergraduate medical students. The authors report the B-Mast was a sensitive instrument for determining alcoholism in their sample.

The B-Mast was used for this study as it exists with two exceptions. First, the existing B-mast referred respondents to answer questions relative to the twelve month period prior to completing the questionnaire. The existing instructions would not suffice for the respondents in this study because most had not consumed alcohol in the last 12 months. The instructions were modified from being "...about your use of alcoholic beverages in the past 12 months" to "...about your use of alcoholic beverages during the last 12 months you used alcohol". Second, the existing B-Mast questions were in the present tense. For this study, because respondents were referring to their alcohol use in the past, questions were altered to past tense. For example, the question "Do you feel

you are a normal drinker?" was altered to, "Did you feel you were a normal drinker?". The B-mast questions were on a one page insert, along with the additional questions addressing how long respondents abstained from alcohol consumption and the frequency of respondent attendance at Alcoholics Anonymous, Alanon, and Codependent's Anonymous meetings. The insert was placed with the consent forms inside the covers of the IOT questionnaire (See Appendix 1).

Data Collection

Participants were shown the questionnaires and given detailed instructions about how to complete it. The researcher showed respondents each page of the questionnaire and identified each area where responses were needed. The researcher responded to questions where clarification was required. The researcher reviewed the consent forms with respondents and answered any questions related to the contents of the consent form. Respondents were then given the questionnaire and consent form to complete on their own, and arrangements were made for returning the completed questionnaire and consent form to the researcher. Respondents were also given an extra consent form to keep for their own records.

One part of the questionnaire asked for each individual's address. Individuals completing the questionnaires were told that if they wanted a summary of the study results, they could

indicate this by putting their address on the questionnaire, and once completed, they would be sent a summary by mail.

Various arrangements were made for returning completed questionnaires to the researcher. The researcher picked up completed questionnaires at respondents homes or places of work. Respondents dropped off the completed questionnaires at the researcher's home or place of work. The researcher met respondents at a pre-determined location such as a coffee shop to pick up completed questionnaires. Completed questionnaires were also returned by respondents bringing them to AA meetings the researcher attended.

Ten respondents did not return completed questionnaires according to the prior arrangements made with the researcher. The researcher contacted these respondents either by telephone or seeing them at AA meetings and new arrangements were made to return the completed questionnaires.

The time period between when respondents were given the questionnaires and when questionnaires were returned ranged from 2 hours to 12 days. Although specific time periods were not recorded, the majority of respondents returned completed questionnaires in between 4 and 7 days after they received it.

This procedure for collecting data was repeated until the researcher had 60 usable questionnaires completed. There were actually 64 questionnaires completed, with 4 not being used. Four respondents had B-Mast scores of less than 12 which was the cut off point for having a history of alcohol abuse.

As well, approximately 6 respondents did not answer some of the questions or their responses were illegible. In all these cases, the researcher contacted the respondent, usually by telephone, explained the questions that required further response, and was provided with the needed information for their inclusion in the study.

The sample included 31 males and 29 females ranging in age from 21 years old to 56 years old. The mean age of respondents was 39.7 years old. With regard to marital status, 12 respondents were single, 31 were married, 4 were in common-law relationships and 13 were divorced. The range of education reported by respondents was from the grade 5 level to university degree level. The mean number of years of education was 12.3 with 65% of respondents having 12 or more years of formal education.

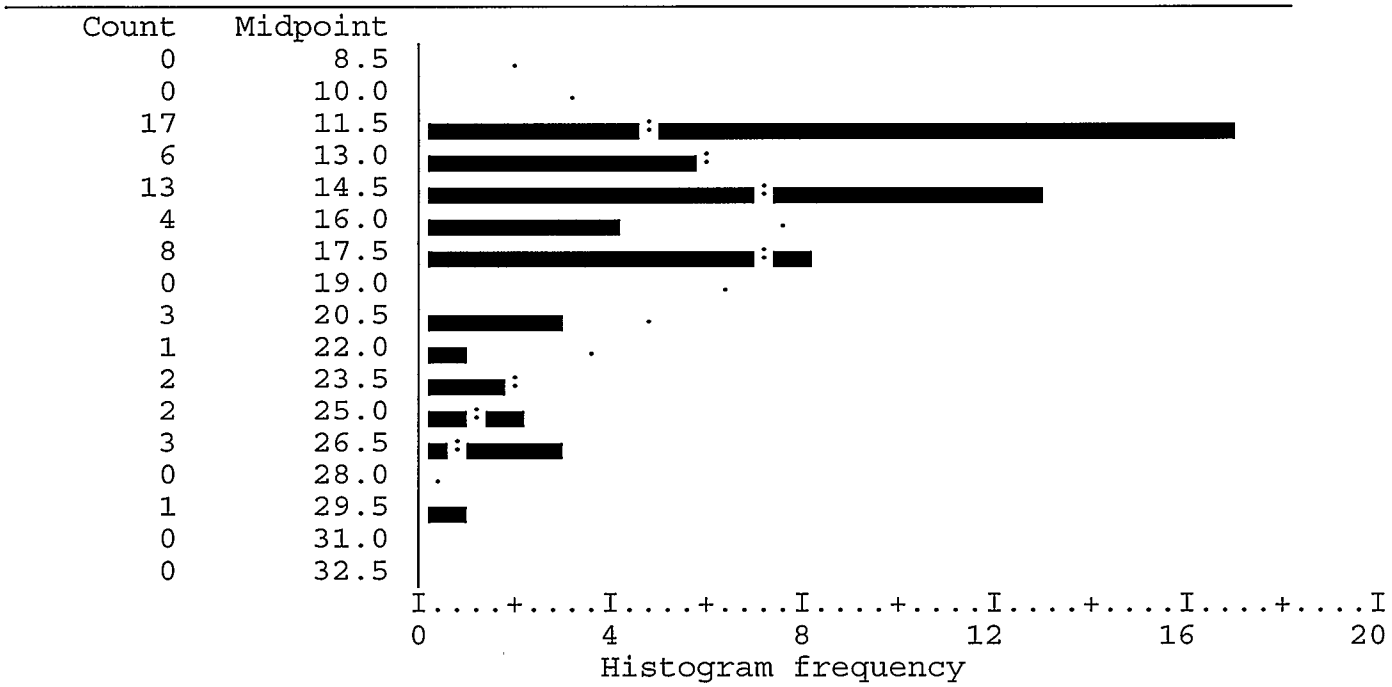
The amount of time respondents reported abstaining from alcohol consumption ranged from 6 months to 20.8 years with a mean of 7.8 years. Responses indicated 48.3% of respondents had less than 6 years of abstinence from alcohol consumption indicating the sample was skewed towards the lower portion of the range specified.

Chapter 4

Results

The results will be discussed relative to the research questions stated earlier. To establish that all respondents had a history of alcohol abuse, each respondent completed the Brief Michigan Alcoholism Screening Test (B-Mast). A cutoff score of 12 or higher was used to determine a history of alcohol abuse. Table 2 shows a histogram of the scoring frequencies for all respondents.

Table 2
B-MAST - Respondent level of alcohol abuse



There was a positively skewed distribution with a mean score of 16.1 and a median score of 14. In fact, 53.3% of B-Mast scores were between 12 and 14 and the level of skewness for this distribution is 1.3 indicating a significant positively skewed distribution. The distribution had a standard deviation of 4.7. The B-Mast scores indicated that the 60 individuals who took part in this study had a history of alcohol abuse.

Research Question #1

What is the prevalence of a codependent orientation, specifically externally derived sense of self worth, anxiety, dysfunctional family of origin, dysfunctional relationships and dependency within relationships in individuals with a history of alcohol abuse?

Codependent Orientation

In the sample, the mean IOT score for a codependent orientation was 175.73 with a standard deviation of 34.2. The median score was 178, and the level of skewness was .383, indicating a fairly normal distribution of scores.

With respect to ordinal levels of codependent orientation in the sample, no respondents scored in the "clinical alert" range (89 to 107). In the "little clinical significance" range (108 to 152), 12 (20%) respondents scored at this level. Twenty six (43.3%) respondents scored in the "mild codependent orientation" range (153 to 185), and 19 (31.7%) respondents

scored in the "moderate codependent orientation" range (186 to 223). Finally, 3 (5%) respondents scored in the "severe codependent orientation" range (224 to 279).

These scores suggest only 20% of the sample do not possess a codependent orientation at any level. Alternatively, only 36.7% of the sample scored at moderate or severe levels for a codependent orientation. The majority of scores were in the mild and moderate levels, which accounted for 45 of 60 respondent scores. The mean, median, and mode (157), however, were all in the "mild codependent orientation" level.

Reliable data on the prevalence of codependence in North America is lacking. Prest & Protinsky (1993) suggest each person with alcoholism directly affects between 3 to 5 other people in negative ways. The resulting condition is codependence. This suggests an estimated prevalence for codependence of between 30 to 50% of the population, based on a population prevalence for alcoholism of 10% (Prest & Protinsky, 1993; Institute of Medicine, 1990).

Prevalence of codependence for this sample, at 80%, was higher than the estimate based on Prest & Protinsky (1993).

Externally Derived Sense of Self Worth

The definition for this sub-scale suggests that "low self esteem appears to result from the reliance on others for self definition and validation" (Worth et al., 1993, p.13).

The mean score for an externally derived sense of self

worth in this sample (n=60) was 53.65 with a standard deviation of 12.51. The median was 54 and the mode was 57. The level of skewness was .148 indicating the distribution of scores to be close to normal.

The levels of externally derived sense of self worth were 1 (1.7%) at the "clinical alert" level (0-29), 22 (36.7%) at the "little clinical significance" level (30 -47), 22 (36.7%) at the "mild" level (48 - 61), 14 (23.3%) at the "moderate" level (62 - 74), and 1 (1.7%) at the "severe" level (75 - 92).

The scores from this sample indicate 38.4% of respondents do not seem to rely in a negative way on others for self definition and validation. Although 61.6% of respondent scores indicated some level of externally derived sense of self worth, only 25% of respondent scores were at moderate or severe levels. The mean, median and mode for the sample were in the mild level.

Anxiety

The items identified in this sub-scale , "...indicate a state of generalized anxiety and despair over which the individual feels little sense of control." (Worth et al., 1993 p.13)

The mean score for the sample (n=60) to indicate anxiety was 39.28 with a standard deviation of 10.18. The median was 39.5 and the level of skewness was .525 indicating a slight positively skewed distribution.

With respect to the levels of anxiety reported in this

sample, 1 (1.7%) scored in the clinic alert level, 17 (28.3%) scored at the little clinical significance level, 24 (40%) scored at the mild level, 17 (28.3%) scored at the moderate level and 1 (1.7%) scored at the severe level.

The scores of this sample, using the ordinal levels outlined by Worth et al (1993) indicate a normal distribution for anxiety. The kurtosis was -.715 indicating a higher concentration of scores towards the middle of the distribution. Similar to both codependent orientation and externally derived sense of self worth, the mean, median and mode for anxiety scores were at the mild level.

Dysfunctional Family of Origin

The items in this sub-scale, "appear to probe an abusive and/or unhappy childhood. The items also appear to reflect the role of the "perfect child" described in codependency literature" (Worth et al., 1993, p. 13).

The mean score for dysfunctional family of origin in this sample was 23.55 with a standard deviation of 6.4. The median score was 23 and the mode was 29. The distribution was slightly negatively skewed with a level of skewness of -.102.

Respondent scores reflect that 5 (8.3%) of the sample scored at the little clinical significance level, 19 (31.7%) scored at the mild level, 30 (50%) scored at the moderate level, and 6 (10%) scored at the severe level. These scores suggest that 60% of the sample reported a moderate or severe prevalence of dysfunctional family of origin. The mean,

median, and mode for this sample all fall into the moderate level for dysfunctional family of origin.

Dysfunctional Relationships

Dysfunctional relationships, "...describe a pattern of interpersonal relationships in which the individual, whether knowingly or otherwise, is manipulated into guilt-producing behaviours to protect a significant other" (Worth et al., 1993, p. 13).

The mean score for dysfunctional relationships in this sample was 23.2, with a standard deviation of 5.22. The median was 23 and the mode was 20. The distribution was positively skewed with a skewness level of .428 and was flatter than normal with a kurtosis of 1.688.

The ordinal levels of dysfunctional relationships for this sample were 1 (1.7%) at the clinical alert level, 12 (20%) at the little clinical significance level, 27 (45%) at the mild level, 17 (28.3%) at the moderate level and 3 (5%) at the severe level. These scores suggest that only 33.3% of this sample scored at the moderate or severe levels for dysfunctional relationships. The mean, median, and mode for this sample all fall into the mild level of prevalence for dysfunctional relationships.

Dependency in Relationships

Dependency in relationships is defined to suggest "...boundary issues that are manifest in a lack of internal direction and sense of self and the need to fill this void by

exclusive involvement with a significant other" (Worth et al., 1993, p. 13).

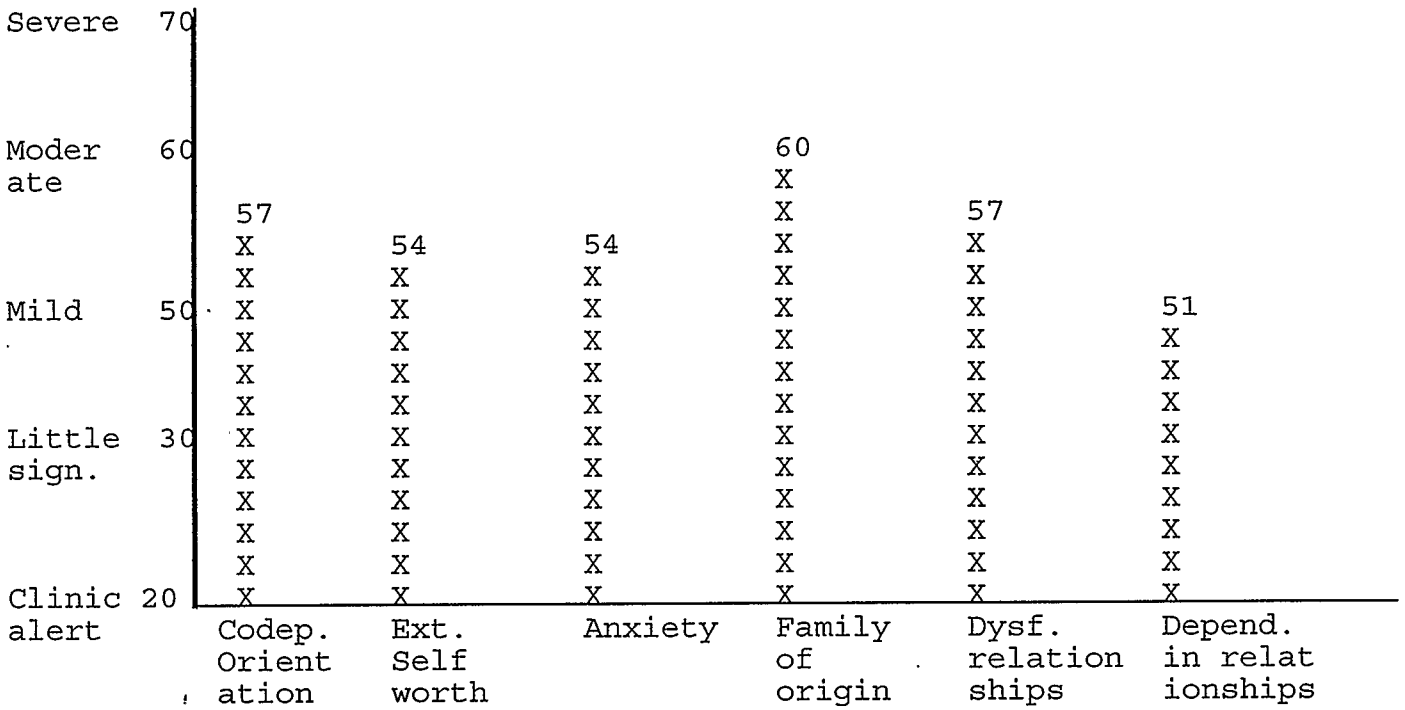
The mean scores for dependency in relationships for this sample were 36.383 with a standard deviation of 6.03. The median was 37 and the mode was 38. The distribution was slightly negatively skewed with a skewness of -.161 and flatter than normal with a kurtosis of 1.099.

The levels of dependency in relationships for the sample were 1 (1.7%) at the clinic alert level, 22 (36.7%) at the little clinical significance level, 31 (51.7%) at the mild level, 3 (5%) at the moderate level, and 3 (5%) at the severe level. The sample scores indicate that only 10% of the sample reported moderate or severe levels of dependency in relationships, while 38.4% reported either mild or little clinical significance levels.

Summary

The mean, median, and mode in the areas of codependent orientation, externally derived sense of self worth, anxiety, dysfunctional relationships and dependency in relationships, were all at mild levels for the sample. This is reflected in table 3. In addition, the sample mean, median, and mode for the dysfunctional family of origin sub-scale were at the moderate level, and were higher than all other sub-scale scores.

Table 3 - Mean Prevalence of Codependent Orientation and sub-scales using Standard T Scores.



N of cases = 60

Research Question #2
What is the association between a codependent orientation and the amount of time individuals have abstained from using alcohol?

The response to this question was determined by asking respondents (n=60) to identify the date that they stopped consuming alcohol, converting their responses to "months of sobriety", and measuring the association of months of sobriety to codependent orientation scores using Pearson product moment correlation coefficients.

The mean amount of sobriety for the sample was 7.8 years

with a standard deviation of 6.17, and the median was 6.3 years. The distribution had a positive skewness of .561, and a kurtosis of -.919 indicating lower frequencies at the higher amounts of sobriety. At lower amounts of sobriety, 20% of the sample reported being sober 1 year or less prior to their participation in this study.

The Pearson product correlation coefficient was used to measure the association between the amount of time respondents abstained from alcohol use and their codependent orientation, including sub-scales. Table 4 reflects the correlation coefficients and significance levels for the association between codependent orientation and length of sobriety.

Table 4

Correlation between IOT sub-scales and length of sobriety

IOT Sub-scale	r Value	Significance (2-tailed)
Codependent orientation	-.0044	.974
Externally derived self worth	.0327	.804
Anxiety	-.1580	.228
Dysfunctional family of origin	.1943	.137
Dysfunctional relationships	.0053	.968
Dependency in relationships	-.0807	.540
N of cases: 60		

With statistical significance at .05 or less, in this sample, there was no significant association between length of sobriety and a codependent orientation. As well, there was no statistically significant relationship between length of sobriety and any of the sub-scales used to determine a codependent orientation. In fact, the strongest relationship to length of sobriety was a dysfunctional family of origin with a correlation coefficient of r=.1943, which Craft (1990) reports as "slight, almost negligible" (p. 95).

Summary

There appears to be no statistically significant association between the length of sobriety and codependent orientation, or any of the sub-scales of the Individual Outlook Test (IOT) for this sample. This would suggest that the length of time that respondents abstain from alcohol consumption has little or no association to their level of codependent orientation.

Research Question #3

What is the association between demographics such as gender, education, marital status, and age, and a codependent orientation?

The information for this question was gathered as part of the questionnaire respondents were asked to complete. It will be addressed in the following order; age, education, sex, and marital status.

Age

The mean age of respondents was 39.7 years with a standard deviation of 10.08 years. The ages of respondents ranged from 21 years to 56 years, with the mean age for males of 40.29 years and of 39.18 years for females. There were 18 (30%) respondents between the ages of 33 to 37 years.

The Pearson correlation coefficient was used to determine whether or not there was an association between the age of respondents and their codependent orientation and sub-scale scores. Table 5 reflects the correlation coefficients and significance levels between a codependent orientation including sub-scales and respondent age.

Table 5

Correlations between IOT sub-scales and respondent age

IOT Subscale	r Value	Significance (2-tailed)
Codependent Orientation	.0492	.709
Externally derived self worth	.0479	.716
Anxiety	-.0570	.665
Dysfunctional family of origin	.1100	.403
Dysfunctional relationships	.2277	.080
Dependency in relationships	.0530	.688

N of cases: 60

There were no statistically significant relationships found between age and codependent orientation or any of the five IOT sub-scales. The strongest association that appeared was between age and the dysfunctional relationships sub-scale ($r = .2277$, $P = .080$).

The correlation coefficients suggest age has little or no association with a codependent orientation or any of it's sub-scales for this sample.

Education

Respondents reported education levels from 5 to 16 years of formal education. In the sample (n=60), 46 (76.6%) respondents reported having between 10 and 14 years of formal education. The mean level of education was 12.3 years with a standard deviation of 2.3 years, and very little variation based on gender.

The Pearson correlation coefficient was used to identify whether or not there was statistically significant relationships between education level and a codependent orientation or its sub-scales for this sample.

Table 6

Correlations between codependent orientation including sub-scales and respondent education

IOT Sub-scale	r Value	Significance (2-tailed)
Codependent orientation	-.1099	.403

Externally derived self worth	.0363	.783
Anxiety	-.1442	.272
Dysfunctional family of origin	-.1477	.260
Dysfunctional relationships	-.0237	.857
Dependency in relationships	-.2371	.068

With statistical significance at .05 or less, the correlation coefficients indicated there were no significant relationships between education and any of the five IOT sub-scales.

These correlation coefficients indicate education had little to no significant association with a codependent orientation or any of the IOT sub-scales for this sample.

Sex

There were 31 males and 29 females in the sample. To address the question of whether respondent's sex was associated with a codependent orientation or its sub-scale scores, independent T-tests were completed. Table 7 shows the T-test results.

Table 7

T-tests of codependent orientation including sub-scales and respondent sex

Variable	N	Mean	SD	T Value	df	2-tail Prob.
Codependent Orientation						
Males	31	168.84	31.9	-1.64	58	.107

Females	29	183.1	35.6			
Ext. Derived self worth						
Males	31	50.42	12.2	-2.13	58	.037
Females	29	57.1	12.1			
Anxiety						
Males	31	38.06	9.1	-.96	58	.342
Females	29	40.59	11.2			
Dysf. Family of origin						
Males	31	23.1	6.13	-.56	58	.575
Females	29	24.03	6.74			
Dysf. relationships						
Males	31	23.1	4.6	-.16	58	.876
Females	29	23.31	5.9			
Depend. in Relationships						
Males	31	34.8	6.7	-2.16	58	.035
Females	29	38.07	4.77			

With statistical significance established at the .05 level or less, there appears to be a statistically significant relationship between respondent sex and externally derived sense of self worth. As well, there appears to be a statistically significant relationship between respondent sex and dependency within relationships. The t-test suggests it is unlikely that the difference between these two sub-scale scores for males and females in the sample is due to chance. Both these sub-scales had mean scores for females that were

higher than for males. The T-test indicates respondent sex is significantly associated with these two sub-scales and the mean scores suggest females are more likely to score at higher levels than males.

There does not appear to be significant relationships between respondent's sex and a codependent orientation, anxiety, dysfunctional family of origin, or dysfunctional relationships.

Marital Status

In the sample, 31 (51.7%) respondents were married, 13 (21.7%) were divorced, 12 (20%) were single, and 4 (6.7%) were in common law relationships. No respondents reported being widowed.

To identify whether there was an association between marital status and a codependent orientation or it's sub-scales, a oneway analysis of variance test was used. Table 8 summarizes the results of this test.

Table 8

Oneway ANOVA of codependent orientation including sub-scales and marital status

Variable	Source	df	SS	MS	F	P
Codependent Orientation						
	Between Groups	3	3512.05	1170.68	1.001	.3992
	Within Groups	56	65485.7	1169.4		
	Total	59	68997.73			

Externally Derived Self Worth					
Between Groups	3	429.78	143.26	.9113	.4415
Within Groups	56	8803.87	157.212		
Total	59	9233.65			
Anxiety					
Between Groups	3	375.75	125.25	1.2227	.31
Within Groups	56	5736.43	102.44		
Total	59	6112.18			
Dysf. Family of Origin					
Between Groups	3	19.994	6.665	.1557	.9256
Within Groups	56	2396.86	42.801		
Total	59	2416.8			
Dysf. Relationships					
Between Groups	3	130.12	43.37	1.6439	.1896
Within Groups	56	1477.48	26.38		
Total	59	1607.6			
Depend. Within Relationships					
Between Groups	3	165.85	55.284	1.5633	.2084
Within Groups	56	1980.33	35.363		
Total	59	2146.18			

To be statistically significant, the F ratio requires a significance level of $P<.05$. The F ratios and probabilities indicated in Table 8 suggest there were no statistically

significant associations between a codependent orientation or any of it's sub-scales and marital status for this sample.

Summary

To summarize the response to this research question, age, education, gender, or marital status do not appear to be associated with a codependent orientation. The only statistically significant associations identified were between respondent sex and 2 of the IOT subscales: externally derived sense of self worth and dependence within relationships. These associations suggest females in the sample appear more likely than males to rely on others for self definition. As well, females in the sample appear more likely than males to experience a "...lack of internal direction and sense of self, and the need to fill this void by exclusive involvement with a significant other" (Worth et al., 1993, p. 13).

Research Question #4

What is the association between frequency of attendance at Alcoholics Anonymous, Alanon, and Codependent's Anonymous and a codependent orientation?

Respondents were asked about whether they had ever attended Alcoholics Anonymous, Alanon, or Codependent's Anonymous. Responses indicated 48 (80%) of 60 respondents had attended Alcoholics Anonymous, 13 (21.7%) had attended Alanon, and 13 (21.7%) had attended Codependent's Anonymous.

Of the 13 respondents who had ever attended Alanon, and the 13 who had ever attended Codependent's Anonymous, 6 respondents had attended both groups.

Respondents were also asked about how frequently they attended these self help groups in the last month and the last six months before completing the questionnaire.

Alcoholics Anonymous

Of those respondents who had attended Alcoholics anonymous (n=48), the mean number of meetings attended in the last month was 8.9 with a standard deviation of 7.628 and a positive skewness of 1.074. The mean number of AA meetings attended in the last 6 months was 53.5 with a standard deviation of 47.368 and a positive skewness of 1.226. Of the 48 respondents who had ever attended Alcoholics Anonymous, 38 (79.2%) attended 12 meetings or less in the last month. In the last 6 months, 34 (70.8%) respondents attended 60 meetings or less.

To identify whether there was an association between a codependent orientation or it's sub-scales and respondents ever attending Alcoholics Anonymous, independent T-tests were used. Table 9 summarizes the results of these tests.

Table 9

T-test of codependent orientation including sub-scales and ever attending Alcoholics Anonymous

Variable	N	Mean	SD	T Value	df	2-tail sign.
Codependent Orientation						
Attended	48	176.25	35.82	.23	58	.817
Never attended	12	173.667	27.998			

Ext. Derived Self Worth						
Attended	48	53.79	13.536	.24	31.4	.810
Never attended	12	53.083	7.49			
Anxiety						
Attended	48	38.75	10.654	-.81	58	.422
Never attended	12	41.42	8.028			
Dysf. Family of Origin						
Attended	48	24.48	6.233	2.33	58	.023
Never attended	12	19.833	5.906			
Dysf. relationships						
Attended	48	23.56	5.29	1.08	58	.286
Never attended	12	21.75	4.864			
Depend. Within Relationships						
Attended	48	36.08	6.105	-.77	58	.446
Never attended	12	37.58	5.823			

Note. Levene's Test for equality of variances for the externally derived sense of self worth sub-scale was F=4.542 with P=.037 so the unequal T value, degrees of freedom, and 2-tailed significance were used.

Using a .05 level or less for establishing statistical significance, there appeared to be no significant association between a codependent orientation and whether respondents had ever attended Alcoholics Anonymous. The only sub-scale to have a significant association to respondents ever attending Alcoholics Anonymous was a dysfunctional family of origin.

Responses indicated respondents who had attended AA meetings were more likely to report a moderate or severe dysfunctional family of origin than those who had not attended AA meetings.

To determine whether or not there was an association between frequency of attendance at AA meetings and a codependent orientation, the Pearson correlation was used. Only respondents who had ever attended AA meetings were included (n=48). Correlations were based on the number of AA meetings reported in the last month and last 6 months and codependent orientation, including sub-scale scores. Results of these tests are summarized in Table 10.

Table 10

Correlations between codependent orientation including sub-scales and frequency of attendance at Alcoholics Anonymous

IOT Sub-scale	r Value	Significance (2-tail)
Codependent Orientation		
Last Month	.3792	.008
Last 6 months	.2664	.067
Ext. Derived Self Worth		
Last Month	.3472	.016
Last 6 Months	.2438	.095
Anxiety		
Last Month	.3275	.023
Last 6 Months	.2133	.145

Dysf. Family of Origin		
Last Month	.2324	.112
Last 6 Months	.3236	.025
Dysf. Relationships		
Last Month	.3294	.022
Last 6 Months	.1880	.201
Depend. Within Relationships		
Last Month	.3890	.006
Last 6 Months	.1373	.352

Using a significance level of .05 or less, responses indicated small, but significant relationships existed between the frequency of AA meetings attended in the last month and a codependent orientation ($r = .3792$, $P = .008$), an externally derived sense of self worth ($r = .3472$, $P = .016$), anxiety ($r = .3275$, $P = .023$) and dependency in relationships ($r = .3890$, $P = .006$).

As well, a small, but significant relationship appeared between frequency of AA meetings attended in the last 6 months and the dysfunctional family of origin score ($r = .3235$, $P = .025$).

These correlation coefficients suggest respondents who attended AA meetings more frequently in the last month were somewhat more likely to have a higher codependent orientation, externally derived sense of self worth, anxiety, and dependency in relationships than those who attended AA

meetings less frequently in the same time period.

The correlation coefficients also suggest respondents who attended AA meetings more frequently in the last 6 months were somewhat more likely to report higher dysfunctional family of origin scores than those who attended less AA meetings in the same time period.

Alanon

Of the 13 respondents who ever attended Alanon, 10 had not attended any meetings in the month prior to completing the questionnaire. In the last month, 1 attended 1 meeting, and 2 attended 4 meetings. In the last six months, 6 respondents reported not attending any meetings, 3 reported attending one meeting, 2 reported attending 2 meetings and 2 reported attending 9 meetings. The mean number of Alanon meetings for these 13 respondents in the last six months was just under 2.

To identify whether there was an association between a codependent orientation including its subscales and respondents ever attending Alanon, independent T-tests were used. Table 11 summarizes the results of these tests.

Table 11

T-tests of codependent orientation including sub-scales and ever attending Alanon

Variable	N	Mean	SD	T Value	Df	2-tail sign.
Codependent Orientation						
Attended	13	168.61	39.297	-.85	58	.401
Never attended	47	177.702	32.845			
Ext. Derived Self Worth						
Attended	13	52.0	14.54	-.53	58	.595
Never attended	47	54.11	12.026			
Anxiety						
Attended	13	36.384	11.11	-1.16	58	.249
Never attended	47	40.085	9.88			
Dysf. Family of Origin						
Attended	13	21.46	7.287	-1.34	58	.186
Never attended	47	24.128	6.092			
Dysf. Relationships						
Attended	13	22.69	5.75	-.39	58	.695
Never attended	47	23.34	5.12			
Depend. Within Relationships						
Attended	13	36.08	5.575	-.21	58	.838
Never attended	47	36.47	6.164			

N of cases: 60

The T-test scores and significance levels suggest there were no statistically significant associations between respondents ever attending Alanon and a codependent orientation or any of the sub-scales tested.

To determine the association between the frequency of attendance at Alanon meetings and a codependent orientation, the Pearson correlation coefficient was used. Respondents reported their attendance at Alanon meetings in the last month and last 6 months prior to their participation in this study. Only those respondents who had ever attended Alanon were included. Table 12 summarizes the results of these tests.

Table 12

Correlations between a codependent orientation including sub-scales and frequency of attendance at Alanon

Sub-scale	r Value	Significance (2-tail)
Codependent Orientation		
Last Month	-.0533	.863
Last 6 Months	.0957	.756
Ext. Derived Self Worth		
Last Month	-.1036	.852
Last 6 Months	.0657	.831
Anxiety		
Last Month	-.0576	.852
Last 6 Months	.0916	.766

Dysf. Family of Origin		
Last Month	.0601	.845
Last 6 Months	.1434	.640
Dysf. Relationships		
Last Month	-.2157	.479
Last 6 Months	-.1271	.679
Depend. Within Relationships		
Last Month	.1485	.628
Last 6 Months	.2563	.398
N of cases: 13		

There were no statistically significant associations found between frequency of attendance at Alanon in the last month or last six months and a codependent orientation, or it's sub-scales.

Codependent's Anonymous

Of the 13 respondents that ever attended Codependent's Anonymous, 6 had not attended meetings in the last month, 5 attended 1 meeting, 1 attended 2 meetings and 1 attended 4 meetings. In the last six months, 2 attended no meetings, 7 attended 1 meeting, 1 attended 16 meetings, and 3 attended between 20 and 30 meetings. The mean number of meetings for these 13 respondents in the last 6 months was between 7 and 8, though the standard deviation was large, at 11.125 indicating a large variation in the number of meetings attended.

To identify whether there was an association between a codependent orientation including sub-scales and respondents ever attending Codependent's Anonymous, independent T-tests were used. Table 13 summarizes the results of these tests.

Table 13

T-tests of codependent orientation and ever attending Codependent's Anonymous

Variable	N	Mean	SD	T Value	DF	2-tail sign.
Codependent Orientation						
Attended	13	168.0	27.785	-.92	58	.361
Never Attended	47	177.87	35.735			
Ext. Derived Self Worth						
Attended	13	53.08	12.632	-.19	58	.854
Never Attended	47	53.81	12.61			
Anxiety						
Attended	13	36.54	8.12	-1.10	58	.276
Never Attended	47	40.043	10.628			
Dysf. Family of Origin						
Attended	13	22.38	5.824	-.74	58	.463
Never Attended	47	23.87	6.573			
Dysf. Relationships						
Attended	13	23.0	4.0	-.15	58	.878
Never Attended	47	23.255	5.546			

Depend. Within Relationships						
Attended	13	34.54	4.446	-1.25	58	.216
Never Attended	47	36.894	6.346			

N of cases: 60

With a significance level of .05 or less, there did not appear to be significant relationships between respondents ever attending Codependent's Anonymous and a codependent orientation or any of the sub-scales tested.

To determine the association between frequency of attendance at Codependent's Anonymous and a codependent orientation, the Pearson correlation coefficient was used. Respondents reported the frequency of attendance at Codependents Anonymous in the last month and last 6 months prior to their participation in this study. Only respondents who had ever attended Codependent's Anonymous were included (n=13). Table 14 summarizes the results of these tests.

Table 14

Correlations between codependent orientation including sub-scales and frequency of attendance at Codependent's Anonymous

Sub-scale	r Value	Significance (2-tail)
Codependent Orientation		
Last Month	-.0210	.946
Last 6 Months	.2648	.382

Ext. Derived self Worth		
Last Month	-.2126	.486
Last 6 Months	-.0039	.99
Anxiety		
Last Month	-.1250	.684
Last 6 Months	.3235	.281
Dysf. Family of Origin		
Last Month	.3725	.210
Last 6 Months	.4655	.109
Dysf. Relationships		
Last Month	.0911	.767
Last 6 Months	.2154	.480
Depend. Within Relationships		
Last Month	.1815	.553
Last 6 Months	.0483	.875

N of cases: 13

Results indicated there were no significant associations between the frequency of attendance at Codependent's Anonymous, in the last month or last six months, and a codependent orientation or it's sub-scales.

Summary

To summarize the response to this research question, there appeared to be a statistically significant association between whether respondents ever attended Alcoholics Anonymous and their scores on the dysfunctional family of origin sub-

scale. Respondents who attended Alcoholics Anonymous appeared more likely to report higher levels regarding their family of origin than those who never attended AA meetings.

As well, small but statistically significant associations were found between frequency of AA meetings in the last month and a codependent orientation, externally derived sense of self worth, anxiety, and dependency in relationships. Respondents who attended AA meetings more frequently in the last month appeared to have a higher codependent orientation, externally derived sense of self worth, anxiety, and dependency in relationships than respondents who reported less frequent attendance at AA meetings in the last month.

No statistically significant associations were found between respondent's ever attending Alanon or Codependent's Anonymous meetings and a codependent orientation or any of the IOT sub-scales. As well, no significant associations were found between frequency of attendance at Alanon or Codependent's Anonymous and a codependent orientation or any of the IOT sub-scales.

Chapter 5

Discussion

The purpose of this study was to identify whether an association existed between codependence and recovery from alcohol abuse. As well, this study sought to identify areas for future study concerning alcohol problems and codependence.

To achieve this, four research questions were addressed. A review of current literature was completed and a cross sectional survey was completed of 60 respondents who were recovering from alcohol abuse. The results of this survey were used to identify 1) the prevalence of a codependent orientation in the sample, 2) the association between a codependent orientation and abstinence from alcohol use, 3) the association between a codependent orientation and selected demographics, and 4) the association between a codependent orientation and attendance at self help groups.

Eighty percent of this sample reported some level of a codependent orientation. The large majority of respondents (75%) reported either mild or moderate levels of a codependent orientation. The mean, median and mode in this sample for a codependent orientation were all at the mild level.

Estimates of prevalence for a codependent orientation in the North American population are inconclusive. Whitfield (1984) suggested codependence was rampant amongst institutional and political systems and later (1989) stated

codependence is the most common addiction people develop. Shaef (1986) suggested North Americans live in a codependent society. Prest & Protinsky (1993) suggest codependence has been associated with alcoholism, eating disorders, gambling, sexual addiction, and adult children of alcoholics. Prest & Protinsky (1993) suggest for each alcoholic, between 3 and 5 people are negatively affected by alcoholic behaviour.

These suggestions about the prevalence of a codependent orientation in North America indicate a significant prevalence exists but do not identify any specific population percentages. The Institute of Medicine (1990) states 10% of the North American population abuse alcohol. If the negative affect attributed to between 3 and 5 other people (Prest & Protinsky, 1993) can be defined as codependence, the North American prevalence may be between 30 and 50% of the population.

This study showed a high frequency of codependent orientation (80%) for this sample. The lack of reliable prevalence information for other populations, however, suggests comparisons between this sample and others is not possible.

Sub-scale scores for externally derived sense of self worth, anxiety, dysfunctional relationships, and dependency in relationships all had means, medians and modes which were at mild levels. The dysfunctional family of origin sub-scale mean, median, and mode were at the moderate level.

Higher dysfunctional family of origin scores appear consistent with Lindstrom (1992) and Vaillant & Milofsky's (1982) view that alcoholism in relatives is associated with alcoholism for individuals. As well, O'Conner, Berry, Inaba, Weiss, & Morrison (1994) reported 21.6% of men and 60.98% of women in their sample of alcoholics had experienced childhood sexual abuse. It is therefore, not surprising that respondents in recovery from alcohol problems score higher than other groups on a scale measuring a dysfunctional family of origin involving an abusive or unhappy childhood. Vaillant & Milofsky (1982) reported, however, that alcoholism in adulthood was not associated with an unhappy childhood. They reported that family history of alcoholism, cultural attitudes, and drinking practices were more predictive of alcohol problems in adulthood than an unhappy childhood.

There was no statistically significant association between a codependent orientation and the amount of time respondents had abstained from alcohol use. Because the survey examined only time abstaining from alcohol use, there is no way to be more conclusive about this information.

It could be hypothesized that if all alcoholics are codependent (Whitfield 1989; Larson, 1985), and if recovery from codependence and alcohol problems can occur independently (Mellody, 1989), and if recovery occurs at a consistent pace for all alcoholics, then the longer a person stays sober, the less codependent he or she should be.

In this sample, all respondents did not report a codependent orientation, and no information, beyond time abstaining from alcohol use, was known about their recovery. The only conclusion possible was that, for this sample, a codependent orientation was not significantly associated with time abstaining from alcohol use.

This result seems to contrast with the conclusion of Ross (1993) who reported that, after 10 years of recovery, there was a decrease in codependent characteristics for alcoholics. For this sample, comparisons of respondents at 5, 10, and 15 years of recovery indicated no significant trend for change concerning a codependent orientation.

In this sample, there appeared to be no significant association between a codependent orientation and age, education, marital status or gender. The only significant associations identified were between respondent sex, and 2 of the IOT sub-scales: externally derived sense of self worth and dependence in relationships.

Results from this sample suggest women appear more likely than men to rely on others for self definition and are more likely to have "...a lack of internal direction and sense of self, and the need to fill this void by exclusive involvement with a significant other" (Worth et al., 1993, p.13).

This result is consistent with McLachlan, Walderman, Birchmore, and Marsdon (1979) who concluded that female alcoholics had lower self esteem than male alcoholics and that

treatment must first be aimed at improving self esteem for women. Lindstrom (1992) suggested that, while female alcoholism is less socially acceptable than male alcoholism, there are few established facts about treatment for women alcoholics. Doweiko (1993) confirms that women alcoholics have received little research attention and contends that this may be related to the social stigma attached to female alcoholics.

In addition, numerous researchers (Collins, 1993; Babcock, 1991; Davis Kasl, 1992; Anderson, 1994) indicate codependence is a term whose definition implies traditional feminine values are dysfunctional. These researchers suggest that societal oppression of women has contributed to this view of codependence.

Differences in scores between males and females on sub-scales for externally derived self worth and dependence on others for self definition may be a reflection of traditional female roles. As well, the IOT sub-scales could reflect scores that are oriented towards stereotypical female roles. Although the IOT Manual (Worth et al., 1993) suggests IOT scores are not affected by gender, the condition of codependence has been criticized as a predominantly female condition (Collins, 1993; Babcock, 1991). It may be that the differences in scores between genders on these two sub-scales are attributable to scales that measure conditions found in stereotypical female roles.

Whether or not respondents ever attended at Alcoholics Anonymous meetings did not seem to be associated with a codependent orientation. There was a moderate significant association between ever attending AA and a dysfunctional family of origin. This is consistent with Lindstrom (1992) who reported that AA attendance was more important for unstable alcoholics and those who attended AA regularly tended to have a more problematic lifestyle. It is reasonable to believe that those alcoholics who have more problematic lifestyles are more likely to score higher on a scale for dysfunctional family of origin.

The dysfunctional family of origin scale did not discriminate between an abusive or unhappy childhood and a family history of alcoholism. It is uncertain if elevated scores on this sub-scale are from respondents reporting an abusive or unhappy childhood because of family alcoholism. An unhappy childhood because of family alcoholism has been identified as a predictor of adult alcoholism. An unhappy childhood without a family history of alcoholism has not been identified as a predictor of adult alcoholism (Vaillant & Milofsky, 1982).

It is difficult to be conclusive about potential reasons for the association between ever attending Alcoholics Anonymous and the dysfunctional family of origin sub-scale scores. There were no measures in this study to test whether respondents attending AA had a more problematic lifestyle than

those who did not attend AA. As well, there was no information collected about whether family alcoholism contributed to an abusive or unhappy childhood. The only conclusion possible is that respondents who attended Alcoholics Anonymous tended to score higher on the dysfunctional family of origin scale than respondents who did not attend Alcoholics Anonymous.

There was a small significant association between frequency of attendance at AA meetings in the last month and a codependent orientation, externally derived sense of self worth, anxiety, and dependency in relationships.

Montgomery and his colleagues (1995) reported that attendance at AA meetings was not a predictor of positive outcomes concerning alcohol use. They suggested positive outcomes were related to the level of involvement in AA groups. Involvement meant participation in working on the 12 steps and in group activities. As well, Tonigan et al. (1995) stated that there was variation for AA groups in the topics discussed and the social environment they create. This study did not address either the level of respondent involvement in their AA groups, variation of topics, or social environment in AA meetings. Only information about the frequency of attendance at AA meetings in the last month, and last 6 months prior to participation in this study was gathered.

Elevated levels of anxiety for recovering alcoholics is not unusual. For most alcoholics, anxiety tends to be a

situational condition that is alleviated within the first three or four months of recovery (Doweiko, 1993). Alcoholics have been reported as possessing higher than usual levels of anxiety disorder (Doweiko, 1993; Institute of Medicine, 1990), a condition which generally is not alleviated with abstinance from alcohol use. As well, personality theorists have identified anxiety as a characteristic of alcoholics (Cox, 1985), and alcohol abuse as an effort to reduce anxiety for some people (Cox, 1988). Elevated levels of anxiety was not found to be an antecedent for future alcohol abuse, yet elevated levels of anxiety were found in alcoholics seeking treatment (Krammeier et al., 1979).

The possible reasons for an association between frequency of AA meetings in the last month and anxiety are uncertain.

Strom & Barone (1993) stated that active alcohol abusers reported higher scores on self esteem and self deception than those in early recovery (3 to 6 months). They reported that those in late recovery (more than 1 year) had higher self esteem scores and lower self deception scores than either the active abuser or early recovery groups. This result appears in contrast to the sample who reported a mean of 7.8 years of recovery, yet scored high on a sub-scale measuring self worth resulting from reliance on others. A high score on this sub-scale suggests "low self esteem appears to result from reliance on others for self-definition and validation" (Worth et al, 1993, p. 13). It should be noted that this association

was small (r=.3472) but significant at the .01 level.

It is important to distinguish the difference between reliance on others for self definition and reliance on others in Alcoholics Anonymous. Generally, reliance on others for self definition may result in low self esteem (Worth et al, 1993). For alcoholics in AA, reliance on others for self definition may be a contributing factor to their ability to abstain from drinking. Lindstrom (1992) states,

> With excessive and prolonged drinking the alcoholic develops an injured sense of self resulting in alternating attitudes of self-serving grandiosity and wallowing in self pity. AA confronts the alcoholic's conviction that he can solve his life problems alone, or worse still, that they are not solvable at all. It helps him to see that the self never functions as a solitary entity (p. 95-96).

In addition, Alcoholics Anonymous (1976) states,

> Selfishness - self-centredness! That, we think, is the root of our troubles...So our troubles, we think, are basically of our own making. They arise out of ourselves, and the alcoholic is an extreme example of self will run riot, though he usually doesn't think so. Above everything, we alcoholics must be rid of this selfishness. We must, or it kills us (pp. 62).

These statements suggest reliance on something other than self is an important factor in Alcoholics Anonymous.

Alcoholics Anonymous (1976) suggests this reliance should be on a higher power though it does not specify that this higher power must be God. The AA group can be used as a higher power.

In this study, elevated scores for externally derived sense of self worth and dependency in relationships may reflect the views of Alcoholics Anonymous about the role of self for alcoholics in recovery. Both sub-scales measure sources of self definition; one through reliance on others, and the other through a relationship with a significant other. Recovering alcoholics in AA may score higher on these sub-scales because they have learned in AA their recovery depends on their reliance upon a power external to themselves.

Limitations of this Study

This study used a non-probability sample which does not allow generalizing results to the population of people with alcohol problems or any other population. Tonigan et al. (1995) reported that non-probability sampling poses difficulties concerning generalization in most studies that include AA members (p. 619). Doweiko (1993) suggests there is a surprising lack of research into what factors make AA effective and of research involving AA where results can be generalized.

Results from this study must be reviewed with caution because parametric tests were used for data analysis. Parametric tests require three conditions to be met for

results of their use to be reliable. These tests require: 1) a normal population distribution of the variable, 2) the drawing of independent samples, and 3) at least one variable at the interval or ratio level (Weinbach & Grinnell, 1987, p. 107). One of these conditions, the drawing of an independent sample, was not met for this study.

As well, this study did not address a number of potential intervening variables such as whether or not respondents had ever received in-patient or out-patient treatment for alcohol problems or problems related to codependence. Other potential intervening variables included socio-economic status, the amount of personal growth work respondents had accomplished in recovery, and the amount of information respondents had about codependence prior to their participation.

In addition, there was not a measure for social desirability responses which Strom & Barone (1993) suggest occur frequently when testing alcoholics in recovery. This may be especially important as 20 respondents were known to the researcher prior to their participation.

In addition, the alteration of the B-Mast to past tense may have had an impact on responses. Three possible indications of this were identified. First, over 70% of respondents who scored 12 on the B-Mast answered yes to, "Did you go to anyone for help about your drinking?", which has a weighted score of 5 points. Second, the researcher was told by 3 respondents the B-Mast questions were hard to answer

because it had been so long since they had drank alcohol, suggesting difficulty remembering. Third, because the cutoff score for inclusion was elevated from 6 to 12, four respondents were not included as they scored less than 12 on the B-Mast.

The Individual Outlook Test, though reported to be psychometrically sound, used a small (N=300) normative group, a small matched normal sample (n=45) and a small codependent sample (n=45) to identify cutoff points for a codependent orientation and the 5 sub-scales. Mean scores for all scales were identified using the matched normal sample and codependent sample. The IOT is a relatively new test to measure a codependent orientation so few studies using this test have been published.

Finally, there were a number of areas where additional information could have been helpful regarding this study's results. One example includes the absence of reliable data on the prevalence of a codependent orientation in the North American population. Another includes a lack of information about respondents level of involvement in Alcoholics Anonymous. A third example is the lack of information about family histories of alcoholism for the sample.

Recommendations for Future Research

While there are many potential areas for future research, a number of questions, based on this study, come to mind as being especially useful.

1. What factors, apart from time abstaining from alcohol use, contribute to a higher levels of codependent orientation in some recovering alcoholics but not in others?

2. What affect does treatment such as in-patient or out-patient counselling for alcohol problems have on a codependent orientation for people in recovery from alcohol problems?

3. How does a codependent orientation for people in recovery from alcohol problems influence their use of resources such as counselling, self help groups or social supports?

4. What specific factors contribute to the association between frequency of attendance at AA meetings and a codependent orientation?

People in recovery from alcohol problems, and those charged with the responsibility to help them, would benefit if these research questions were answered. Further attention to difficulties faced by recovering alcoholics is needed. Allocating resources to help recovering alcoholics address identified problems could produce numerous positive results. Potential results could include increased rates of long term recovery, improved family and social relationships, and

improved quality of life for recovering alcoholics.

Considerable attention has been given to helping people with alcohol problems begin their recovery. More attention from researchers and the field of alcoholism treatment needs to be placed on assisting to improve the quality of life for people with alcohol problems once they know how to live without drinking alcohol.

References

Alcoholics Anonymous. (1976). (3rd ed.). New York: Alcoholics Anonymous World Services.

Alexander, D. (1992). Measuring codependency: construct validation of the individual outlook test. Unpublished master's thesis, University of Alberta, Edmonton.

Alexander, J., Alexander, R., (1991). Recovery plus freedom from co-dependency. Deerfield Beach: Health Communications.

Anderson, S. C. (1994). A critical analysis of the concept of codependency. Social Work, 39(6), 677-685.

Babcock, M. (1991). Who are the real co-dependents? Focus: Education Professionals in Family Recovery, 14, 28-45.

Barnard, C. P. (1990). Families with an alcoholic member. New York: Human Sciences.

Barry, H. (1988). Psychoanalytic theory of alcoholism. In C. Chaudron & D Wilkinson (Eds.), Theories on Alcoholism (pp 103-141). Toronto: Addiction Research Foundation.

Beattie, M. (1989). Beyond codependency. New York: Hazelton.

Benson, C. S., & Wilsnack, S. C. (1983). Gender differences in alcoholic personality characteristics and life experience. In W. Cox (Ed.), Identifying and Measuring Alcoholic Personality Characteristics (pp 53-68). San Fransisco: Jossey-Bass.

British Columbia Ministry of Health (1995). Biopsychosocial paper. (Research Report). Victoria B.C.

Brown, S. (1985). Treating the alcoholic. New York: John Wiley & Sons.

Browne, W. J. (1965). The alcoholic bout as an acting out. Psychoanalytic Quarterly, 34, 420-437.

Cabaniss, N. (1979). Is alcoholism and inherited disorder? An evaluation of twin, half-sibling and adoption studies of drinking behaviour. Unpublished seniors honours thesis, Princeton University.

Capell-Sowder, K. (1984). On being addicted to the addict. Focus on the Family and Chemical Dependency,7, 14-15.

Cermak, T. L. (1986). Diagnosing and treating codependence. Minneapolis: Johnson Institute.

Chaudron, C. D., & Wilkinson, D. A. (Eds.). (1988). Theories on alcoholism. Toronto: Addiction Research Foundation.

Clarke, J. C., Saunders, J. B. (1988). Alcoholism and problem drinking: Theories and treatment. Toronto: Permagon.

Collins, B.G. (1993). Reconstruing codependency using self in relation theory: a feminist perspective. Social Work, 38(4), 470-477.

Cox, W. M. (1988). Personality theory. In C. Chaudron & D. Wilkinson (Eds.), Theories on alcoholism (pp 143-172). Toronto: Addiction Research Foundation.

Cox, W. M. (1985). Personality correlates of substance abuse. In M. Galizio & S Maiso (Eds.), Determinants of substance abuse: Biological, psychological and environmental factors. New York:Plenum.

Cox, W. M., & Loper, R. G. (1983). Identifying prealcoholic personality characteristics. In W. Cox (Ed.), Identifying and measuring alcoholic personality characteristics (pp 5 -17). San Fransisco: Jossey-Bass.

Craft, J. L. (1990). (2nd. ed.). Statistics and data analysis for social workers. Peacock: Itasca, Illinois.

Davis Kasl, C. (1992). Many roads, one journey. New York: Harper Collins.

Dennison, S. J. (1993). Diagnosing chemical dependency. Springfield: Thomas.

Doweiko, H. E. (1993). Concepts of chemical dependency. (2nd ed.) Belmont: Wadsworth.

Dreiger, R. M. (1986). Does anyone really believe that alcoholism is a disease? American Psychologist, 37, 322.

Ehrenreich, B. (1992). Stamping out a dreaded scourge. Time, 137(7), 88.

Emener, W.G. (1993). Persons recovering from alcoholism and other drugs: A study of their experiences with, perceptions of, and recommendations for treatment. Journal of Applied Rehabilitation Counselling, 24(1), 47-57.

Glaser, F. B., Diesenhaus, H. I. (Eds.). (1990). Broadening the base of treatment for alcohol problems. Washington D.C.: National Academy Press.

Glatt, M. M. (1967). The question of moderate drinking despite loss of control. British Journal of Addiction, 62,267-274.

Goldstein, G. (1976). Perceptual and cognitive deficit in alcoholics. In G. Goldstein & C. Neuringer (Eds.), Empirical Studies of Alcoholism (pp 115-152). Cambridge Ma.: Ballinger.

Goodwin, D. W., Schulsinger, F., Hermansen, L.,Winokur, G., & Guze, S. B. (1973). Alcohol problems in adoptees raised apart from alcoholic biological parents. Archives of General Psychiatry,28, 238-243.

Grinnell, R.M. (1993). (4th ed.) Social work research and evaluation. Peacock: Itasca, Illinois.

Haaken, J. (1993). From Alanon to ACOA: Codependence and the reconstruction of caregiving. Signs, 18(2), 321-345.

Heath, D. B. (1988). Emerging anthropological theory and models of alcohol use and alcoholism. In C. Chaudron & D. Wilkinson (Eds.), Theories on Alcoholism (pp. 353-410). Toronto: Addiction Research Foundation.

Hester, R. K., & Miller, W. R. (1989). Self-control training. In R. Hester & W. Miller (Eds.), Handbook of alcoholism treatment approaches. New York: Pergamon.

Jellinek, E. M. (1944). Heredity of the Alcoholic. In Alcohol, Science And Society (pp.105-114). New Haven Ct.: Quarterly Journal of Studies On Alcohol.

Jellinek, E. M. (1960). The disease concept of alcoholism. New Haven Ct.:College & University Press.

Kaij, L. (1960). Alcoholism in twins: Studies on the etiology and sequels of abuse of alcohol. Stockholm: Almquist & Wiksell.

Kammeier, M.L., Hoffmann, H., & Loper, R. G. (1973). Personality characteristics of alcoholics as college freshmen and at time of treatment. Quarterly Journal of Studies on Alcohol, 34, 390-399.

Knop, J., Teasdale, T. W., Schulsinger, F., & Goodwin, D. W. (1985). A prospective study of young men at high risk for alcoholism: School behaviour and achievement. Journal of Studies on Alcohol, 46, 273-278.

Leo, J. (1990). The it's-not-my-fault syndrome. U.S. News & World Report, 109(12), 16.

Levin, J. D. (1990). Alcoholism: A bio-psycho-social approach. New York: Hemisphere.

Lewis, J. A., Dana, R. Q., & Blevins, G. A. (1988). Substance abuse counselling. Pacific Grove: Brooks/Cole.

Lindstrom, L. (1992). Managing alcoholism: Matching treatment to clients. New York: Oxford.

Manter Duwars, G. (1992). White knuckles and wishful thinking. Toronto: Hogrefe & Huber.

Marlatt, G. A., & Gordon, J. (1985). Relapse prevention. New York: Guilford.

Matano, R. A., & Yalom, I. D. (1991). Approaches to chemical dependency: Chemical dependency and interactive group therapy - a synthesis. International Journal of Group Psychotherapy,41(3), 269-293.

McCrady, B. S. (1989). Outcomes of family-involved alcoholism treatment. In M. Galanter (Ed.), Recent developments in alcoholism (vol.7, pp 165-82). New York:Plenum.

McCrady, B. S. (1981). Treating the alcoholic marriage. American Journal of Family Therapy, 9, 87-89.

McLachlan, J. F. C., Walderman, R. L., Birchmore, D. F., and Marsden, L. R. (1979). Self evaluation, role satisfaction, and anxiety in the woman alcoholic, The International Journal of Addictions, 14, 809-832.

Mclaughlin, R. J., Baer, P. E., Burnside, M. A., & Pokorny, A. D. (1985). Psychosocial correlates of alcohol use at two age levels during adolescence. Journal of Studies on Alcohol, 46, 212-218.

Mellody, P., Wells Miller, A., Miller, J. K., (1989). Facing codependence. New York: HarperCollins.

Mendelson, J. H., & Mello, N. K. (1989). Studies of alcohol: Past, present, and future. Journal of Studies on Alcohol, 50, 293-296.

Midanik, L. (1983). Alcohol problems and depressive symptoms in a national survey. Psychological Constructs of Alcohol and Substance Abuse. New York: Haworth.

Miller, K. J. (1994). The codependency concept: Does it offer a solution for the spouses of alcoholics? Journal of Substance Abuse Treatment, 11(4), 339-345.

Montgomery, H. A., Miller, W. R., & Tonigan, J. S. (1995) Does Alcoholics Anonymous involvement predict treatment outcomes? Journal of Substance Abuse Treatment, in press.

Mooney, A. J., Eisenberg, A., Eisenberg, H. (1992). The recovery book. New York: Workman.

Moos, R., & Finney, J. (1983). The expanding scope of alcoholism treatment evaluation. American Psychologist, 38, 1036-1044.

Moos, R., Finney, J., & Gamble, W. (1982). The process of recovery from alcoholism: II. Comparing spouses of alcoholic patients and matched community controls. Journal of Studies on Alcohol, 43, 888-909.

Murray, R. M., Clifford, C. A., & Gurling, H. M. D. (1983). Twin and adoption studies: How good is the evidence for a genetic role? In M. Galanter (Ed.), Recent Developments in Alcoholism (vol. 1). New York: Plenum.

O'Conner, L. E., Berry, J.W., & Inaba, D. (1994). Shame guilt and depression in men and women in recovery from addiction. Journal of Substance Abuse Treatment, 11 (6), 503-510.

Osborne, A.C., & Glaser,F. B. (1985). Evaluating alcoholics anonymous. In T. Bratter & G. Forest (Eds.), Alcoholism and substance abuse: Strategies for clinical intervention. New York: Free Press.

Partanen, J., Bruun, K., & Markkanen, T. (1966). Inheritance of drinking behaviour: A study on intelligence, personality and use of alcohol in adult twins. Helsinki: Finnish Foundation for Alcohol Studies.

Pearlman, S. (1988). Systems theory and alcoholism. In C. Chaudron & D. Wilkinson (Eds.), Theories on alcoholism (pp 289-325). Toronto: Addiction Research Foundation.

Peele, S. (1985). The meaning of addiction. Lexington: D. C. Heath.

Peele, S., Brodsky, A., Arnold, M. (1991). The truth about addiction and recovery. New York: Simon & Schuster.

Petrie, A. (1967). Individuality in pain and suffering. Chicago: University of Chicago Press.

Prest, L. A., & Protinsky, H. (1993). Family systems theory: A unifying framework for codependence. American Journal of Family Therapy, 21(4), 352-360.

Roe, A. (1945). Children of alcoholics raised in foster homes. In Alcohol, Science and Society (pp.115-127). New Haven Ct.: Quarterly Journal of Studies on Alcohol.

Prochaska, J.O. & DiClemente, C.C. (1986). Toward a comprehensive model of change. In W. Miller & N. Heather (Eds.) Treating addictive behaviours. New York: Plenum.

Rohsenow, D. J. (1983). Alcoholics perception of control. In W. Cox (Ed.), Identifying and measuring alcoholic personality characteristics (pp 37-48). San Fransisco: Jossey-Bass.

Ross, E. C. (1993). The developmental stages of abstinence: Characteristics of recovery from alcoholism. Unpublished dissertation. University of Denver.

Sanchez-Craig, M., Annis, H. M., Bornet, A. R., & MacDonald, K. R. (1984). Random assignment to abstinence and controlled drinking: Evaluation of a cognitive-behavioral program for problem drinkers. Journal of Consulting and Clinical Psychology, 52, 390-403.

Schuckit, M. A., Goodwin, D. W., & Winokur, G. (1972). A study of alcoholism in half siblings. American Journal of Psychiatry, 128, 1132-1136.

Shaef, A. (1986). Codependence: Misunderstood - mistreated. San Fransisco: Harper & Row.

Steinglass, P. (1979). An experimental treatment program for alcoholic couples. Journal of Studies on Alcohol, 40, 159 -182.

Stockwell, T. R., Hodgson, R., Rankin, H., & Taylor, C. Alcohol dependence, beliefs and the priming effect. Behaviour Research and Therapy, 20, 513-522.

Strom, J., & Barone, D. F. (1993). Self deception, self esteem and control over drinking at different levels of alcohol involvement. The Journal of Drug Issues,23(4), 705-714.

Szasz, T. S. (1972). Bad habits are not diseases: A refutation of the claim that alcoholism is a disease. Lancet, 2, 83-84.

Tavris, C. (1990). One more guilt trip for women. Minneapolis Star-Tribune, VIII, (341), 21a.

Tomko, M. K. (1988). Recovery: A multidimensional process. Issues in Mental Health Nursing, 9, 139-149.

Tonigan, J. S., Ashcroft, F., Miller, W. (1995). AA group dynamics and 12-step activity. Journal of Studies on Alcohol, Nov. 95, 616-621.

Tucker, J. A., Vuchinich, R. E., & Akiko Gladsjo,J. (1994). Environmental events surrounding natural recovery from alcohol related problems. Journal of Studies on Alcohol, July, 1994, 401-411.

Vaillant, G. E. (1983). The natural history of alcoholism: Causes, patterns, and paths to recovery. Cambridge, Mass.: Harvard University Press.

Vaillant, G. E., & Milofsky, E. S. (1982). The etiology of alcoholism: A prospective viewpoint American Psychologist, 37, 494-503.

VanWormer, K. (1987). Group work with alcoholics in recovery: A phase approach. Social Work with Groups, 10(3), 81-97.

Wallen, J. (1993). Addiction in human development. Billingham, New York: Haworth.

Wassmer, A. (1989). Recovering together. New York: St. Martins.

Wegscheider-Cruse, S. (1984). Codependency: The therapeutic Void. In US journal of drug & alcohol dependency (Eds), Codependency,(pp1-4). Deerfield Beach Fl.: Health Communications.

Whitfield, C. L. (1984). Co-alcoholism: Recognizing a treatable illness. Family and Community Health, 7, 16-24.

Whitfield, C. L. (1989). Codependence: Our most common addiction: Some physical, mental, emotional, and spiritual perspectives. Alcoholism Treatment Quarterly, 6(1), 19-36.

Wilson, G. T. (1988). Alcohol use and abuse: A social learning analysis. In C. Chaudron & D. Wilkinson (Eds.), Theories on Alcoholism (pp239-288). Toronto: Addiction Research Foundation.

Windgard, H. A., Huba, G. J., & Bentler, P. M. (1980). A longitudinal analysis of personality structure and adolescent substance use. Personality and Individual Differences, 1, 259-272.

Wing, D.M. (1992). A field study of couples recovering from alcoholism. Issues in Mental Health Nursing, 13, 333-348.

Wiseman, J. (1991). The other half - Wives of alcoholics and their social-psychological situation. New York: Walter DeGruyter.

Wiseman, J. P. (1975). An alternative role of the wife of an alcoholic in Finland. Journal of Marriage and the Family, 10, 172-179.

Witkin, H. A., & Goodenough, D. R. (1977). Field dependence and interpersonal behaviour. Psychological Bulletin, 84, 661-689.

World Health Organization, Expert committee on mental health. Report of the first session of the Alcoholism Subcommittee. (WHO Technical Report Series 42). Geneva: World Health Organization.

Worth, M. J., Fox, E. E., Sim, L., Macnab, D. (1993). Individual outlook test manual. Edmonton: Psychometrics Canada.

Zucker, R. A., & Noll, R. B. (1982). Precursors and developmental influences on drinking and alcoholism: Etiology from a longitudinal perspective. In Alcohol & Health Monograph 1: Alcohol Consumption and Related Problems (DHHS Publication No.(ADM) 82-1190). Rockville Md.: National Institute on Alcohol Abuse And Alcoholism.

Zwerling, I. (1959). Psychiatric findings in an interdisciplinary study of forty-six alcoholic patients. Quarterly Journal of Studies on Alcohol, 20, 543-554.

Appendix 1

Individual Outlook Test

Brief Michigan Alcoholism Screening Test (modified)

Consent Form

Strongly Disagree (SD)	Disagree (D)	Sometimes Agree/Sometime Disagree (AD)	Agree (A)	Strongly Agree (SA)

41.	I am envious of most of the people I meet.	SD	D	AD	A	SA					
42.	If I am embarrassed or feel foolish, I worry about it for days.	SD	D	AD	A	SA					
43.	Some days there seems to be so many things going wrong that life seems hopeless.	SD	D	AD	A	SA					
44.	Sometimes I have so many thoughts racing through my head that I can't make sense of them.	SD	D	AD	A	SA					
45.	When I meet someone who has a problem, I often try to help them even before they ask.	SD	D	AD	A	SA					
46.	I am never concerned about whether people like me or not.	SD	D	AD	A	SA	R				
47.	I have often gone to see a doctor about my depression.	SD	D	AD	A	SA					
48.	I don't let people get to know the real me.	SD	D	AD	A	SA					
49.	There have been times when my life seemed so depressing that I have thought of ending it.	SD	D	AD	A	SA					
50.	As a child, my parents seldom listened to what I had to say or how I felt.	SD	D	AD	A	SA					
51.	I do not like people criticizing me even if they may be right.	SD	D	AD	A	SA					
52.	When I am alone, I often feel desperate to have company.	SD	D	AD	A	SA					
53.	Most people cannot be truly trusted.	SD	D	AD	A	SA					
54.	It bothers me if my romantic partner wants to go out or do something without me.	SD	D	AD	A	SA					
55.	If someone criticizes me, I tend to believe them and then try to change myself.	SD	D	AD	A	SA					
56.	My feelings and behavior are mostly controlled by the people around me.	SD	D	AD	A	SA					
57.	One of my greatest worries is that some of the people I care about may leave me.	SD	D	AD	A	SA					
58.	I have done things I am not very proud of in order to keep a relationship together.	SD	D	AD	A	SA					
59.	I often feel as though I haven't begun to live yet.	SD	D	AD	A	SA					
60.	I often feel anxious and uptight and can't figure out why.	SD	D	AD	A	SA					
	For counsellor use only	**Raw Score Subtotal**					A3	B3	C3	D3	E3

Total A (A1+A2+A3) _____ **Total B** (B1+B2+B3) _____

Total C (C1+C2+C3) _____ **Total D** (D1+D2+D3) _____

Total E (E1+E2+E3) _____ **TOTAL IOT** (Totals of A+B+C+D+E) _____

IOT

Individual Outlook Test

Laurie A. Sim and Eugene E. Fox

Question Booklet

Identifying Information

Name _____

Address _____

_____

Sex _____

Education _____

Marital Status _____

Date of Birth _____

Age _____

For counsellor use only

Agency _____

Referred by _____

Place of Testing _____

Date of Testing _____

Tested by _____

Instructions

This booklet contains a series of statements that some people might use to describe their outlook on life. Please read each statement and decide how much you agree with it as it relates to you. There are no right or wrong answers, so be sure you are honest with yourself as you rate each statement. Use the following scale:

Strongly Disagree (SD)	Disagree (D)	Sometimes Agree/Sometime Disagree (AD)	Agree (A)	Strongly Agree (SA)

Please mark your answer by circling your response.

Example:	I like warm sunny days.	SD	D	AD	A	(SA)

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PSYCHOMETRICS CANADA LTD.

Strongly Disagree (SD)	Disagree (D)	Sometimes Agree/Sometime Disagree (AD)	Agree (A)	Strongly Agree (SA)

1.	I sometimes feel that I'm not good enough to associate with the people I meet.	SD D AD A SA								
2.	I never try to help people unless I'm asked.	SD D AD A SA								R
3.	I have often done things without thinking them through properly and later regretted my decision	SD D AD A SA								
4.	I feel anxious or tense about something or someone almost all the time.	SD D AD A SA								
5.	I had a happier childhood than most other people.	SD D AD A SA							R	
6.	I have had partners who didn't treat me very well.	SD D AD A SA								
7.	It seems to me I have spent my whole life trying to please others.	SD D AD A SA								
8.	Although I appear strong and capable to others, there is a part of me that isn't strong at all.	SD D AD A SA								
9.	I have been close to people who did illegal things and I found excuses for what they did.	SD D AD A SA								
10.	Often when asked for my opinion, I find out what other people think before I say what I think.	SD D AD A SA								
11.	I often feel there is something bad about me.	SD D AD A SA								
12.	I am not ashamed of my childhood.	SD D AD A SA							R	
13.	I can't remember the last time I felt totally carefree and relaxed.	SD D AD A SA								
14.	Sometimes I don't know who the real me is.	SD D AD A SA								
15.	I have, on many occasions, checked up to see where my partner is when he or she is not with me.	SD D AD A SA								
16.	I tend to believe things people say and often find out later that they have lied.	SD D AD A SA								
17.	I have trouble thinking of the right things to say when in a group of people.	SD D AD A SA								
18.	I feel I fit in at most social gatherings.	SD D AD A SA							R	
19.	I feel best about myself when I'm having a romantic relationship.	SD D AD A SA								
20.	Often, others find things amusing that I don't consider funny.	SD D AD A SA								
		Raw Score Subtotal								
			A1	B1	C1	D1	E1			

21.	Even a small kindness from a person I've had a problem with makes me forgive and forget.	SD D AD A SA								
22.	I don't undertake any project unless I'm pretty sure I'll succeed.	SD D AD A SA								
23.	There are things I have done or had happen to me in the past that I am ashamed to talk about.	SD D AD A SA								
24.	I have often said hurtful things to people I love in order to get them to listen.	SD D AD A SA								
25.	I am embarrassed when people give me compliments but secretly I feel good.	SD D AD A SA								
26.	I can be easily swayed from doing something if others criticize it.	SD D AD A SA								
27.	When things go wrong for others, I blame myself even when I shouldn't.	SD D AD A SA								
28.	I don't worry very much about what the future holds for me.	SD D AD A SA							R	
29.	When I am in a relationship, I am totally involved in it and expect the same from my partner.	SD D AD A SA								
30.	Quite often I lose sleep worrying about people who are important to me.	SD D AD A SA								
31.	I quite often feel as if something dreadful is going to happen.	SD D AD A SA								
32.	When I feel I have insulted a person, I feel ill until I make the matter right.	SD D AD A SA								
33.	I sell myself short and settle for less than the best in romantic partners.	SD D AD A SA								
34.	I have lied to protect people who are important to me.	SD D AD A SA								
35.	I was raised in a family where physical abuse occurred.	SD D AD A SA								
36.	I need a lot of reassurance that people like me.	SD D AD A SA								
37.	It is hard for me to ask for help from someone unless I know I can return the favor.	SD D AD A SA								
38.	When even little things go wrong, I usually get very upset and stay upset until everything is fine again.	SD D AD A SA								
39.	Often I feel so nervous and tense that I feel dizzy.	SD D AD A SA								
40.	I rarely go out or do anything without my partner.	SD D AD A SA								
		Raw Score Subtotal								
			A2	B2	C2	D2	E2			

B-MAST-P

The following questions are about your use of alcoholic beverages during the last 12 months you used alcohol. Carefully read each statement and decide if your answer is "Yes" or "No". Then, circle the appropriate response beside the question. Please answer every question. If you have difficulty with a statement then choose the response that is mostly right.

#	These Questions Refer to the last 12 Months of Your Alcohol Use	Circle Your Response	
1.	Did you feel that you were a normal drinker?	YES	NO
2.	Did friends or relatives think you were a normal drinker?	YES	NO
3.	Did you attend a meeting of Alcoholics Anonymous (AA)?	YES	NO
4.	Did you lose friends or girlfriends/boyfriends because of your drinking?	YES	NO
5.	Did you get into trouble at work because of your drinking?	YES	NO
6.	Did you neglect your obligations, your family or your work for two or more days in a row because your were drinking?	YES	NO
7.	Did you have delirium tremens (DT's), severe shaking, hear voices or see things that were not there after heavy drinking?	YES	NO
8.	Did you go to anyone for help about your drinking?	YES	NO
9.	Were you in a hospital because of drinking?	YES	NO
10.	Did you receive a 24 hour roadside suspension or were you charged for impaired driving?	YES	NO

11. Date you stopped using alcohol (yy / mm / dd) (/ /).
12. Have you attended any of the following groups since you stopped using alcohol:

Alcoholics Anonymous (A.A.) Yes no If yes, how many times in 1a) the last 30 days _____

1b) the last 6 months_____

Alanon Yes No If yes, how many times in 2a) the last 30 days_____

2b) the last 6 months_____

Codependency Anonymous (CODA) Yes No If yes, how many times in 3a) the last 30 days_____

3b) the last 6 months_____

THE ASSOCIATION BETWEEN CODEPENDENCE AND ABSTINENCE FROM ALCOHOL CONSUMPTION FOR INDIVIDUALS WITH A HISTORY OF ALCOHOL ABUSE

CONSENT FORM

code_____

This consent form, a copy of which has been given to you, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, please ask. Please take the time to read this form carefully and to understand any accompanying information.

The purpose of this study is to gain a better understanding of how people in recovery from alcohol abuse behave in relationships with people close to them. Specifically, this study will look at five areas: where you get your self worth, how the family you grew up in worked, how your present relationships work, how much anxiety or fear you have, and how much you depend on the relationships in your life. Your participation in this study will help increase our knowledge about how to assist people in recovery from alcohol abuse with relationships in their lives.

You were invited to participate because you have a history of alcohol abuse that is known to the researcher, and have not drank alcohol for at least the last 6 months. The invitation for you to participate came either from the researcher approaching you directly, or because your name was given to the researcher by someone else, or because you contacted the researcher.

Your participation involves completing a paper and pencil questionnaire that will take about 20 minutes to complete. There are three parts to the questionnaire. One part has 60 questions about your relationships, thoughts, feelings, and opinions. A second part has 10 questions about your past drinking behaviour concerning alcohol, and a third part asks briefly about your characteristics like your education, marital status, age, and your involvement with recovery programs like Alcoholics Anonymous, Narcotics Anonymous, Alanon, etc.

Participation in this study is voluntary. You can withdraw from participation at any time without penalty of any kind. If you choose to participate, there will be no expectations placed on you beyond your completion of the questionnaire.

Participation in this study is a confidential matter between you and the researcher. The consent form is the only written information that identifies you as a participant. All questionnaires will be given a coded number which will be on this consent form. All completed consent forms will be securely kept in a locked file cabinet by the researcher and will be destroyed at the conclusion of this study.

The report generated from this study will be submitted to the University of Calgary as the thesis requirement for the researcher's Master of Social Work degree. The report from this study will not reveal the identity, either directly or indirectly, of any individual who has completed the questionnaire.

A summary of the results of this study will be provided to you upon request and the full results of this study will be made available if requested.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the investigators, sponsors, or involved institutions from their legal and professional responsibilities.

You are free to withdraw from the study at any time. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation. If you have further questions concerning matters related to this research, please contact:

Dell Graff, Thesis Student
home 604-782-8032
work 604-784-2466

or contact

Joe Hudson, Thesis Advisor, University of Calgary, Faculty of Social Work
403-220-6945

If you have any questions concerning your participation in this project, you may also contact the Office of the Vice-President (Research) and ask for Karen McDermid, 403-220-3381.

_____ _____

Participant Date

_____ _____

Investigator/Witness Date

A copy of this consent form has been given to you to keep for your records and reference.