

## Family Stressors as Predictors of Codependency

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**ABSTRACT.** *Codependency* has been defined as an extreme focus on relationships, caused by a stressful family background (J. L. Fischer, L. Spann, & D. W. Crawford, 1991). In this study the authors assessed the relationship of the Spann-Fischer Codependency Scale (J. L. Fischer et al., 1991) and the Potter-Efron Codependency Assessment (L. A. Potter-Efron & P. S. Potter-Efron, 1989) with self-reported chronic family stress and family background. Students ( $N = 257$ ) completed 2 existing self-report codependency measures and provided family background information. Results indicated that women had higher codependency scores than men on the Spann-Fischer scale. Students with a history of chronic family stress (with an alcoholic, mentally ill, or physically ill parent) had significantly higher codependency scores on both scales. The findings suggest that other types of family stressors, not solely alcoholism, may be predictors of codependency.

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THE CONCEPT OF *CODEPENDENCY* has been approached primarily from a qualitative and clinical standpoint. Many researchers have criticized the ambiguity of studies of codependency (Chiazzi & Liljegren, 1993; Frank & Bland, 1992; Gierymski & Williams, 1986; Gomberg, 1989) because those studies have not measured codependency systematically—they have merely offered suggestions for future research. Thus, much of the existing literature on codependency consists of critical and clinical analyses of the concept, including a variety of possible definitions.

### What Is Codependency?

Unfortunately, although codependency seems to be a disorder that can be experienced by anyone with unhealthy relational patterns, researchers have not

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agreed on a definition. Several authors have offered a somewhat positive perspective on the value of the caregiving qualities that are included in codependency (see next section, "Positive Perspectives on Caregiving"). Frank and Bland (1992) reproduced the following statement from a handbook titled "What Is Codependency?" published by Co-dependents Anonymous, Inc. (1988): "We offer no definition or diagnostic criteria for co-dependency, respectfully allowing psychiatric and psychological professionals to accomplish that task." Many of the more recent researchers agree that codependency involves relationship patterns, with two people meeting each other's needs in dysfunctional ways (O'Brien & Gaborit, 1992). Codependency is considered an excessive preoccupation with the lives of others (O'Brien & Gaborit; Whitfield, 1991, p. 3). Wright and Wright (1991) claimed that the currently favored view of the syndrome is that it is similar to "addictive love" and that the nonaddicted partner in the relationship enables unhealthy behaviors. Wright and Wright also suggested that there may be a certain "kind of person who is likely to become involved in codependent relationships" (1991, p. 439).

Similar to the notion of codependency as addictive love in a relationship, O'Gorman suggested "learned helplessness" as a definition (1993, p. 199), suggesting that this definition will make codependents feel comfortable enough to seek treatment, because the syndrome is learned and can be treated. O'Gorman, like others, considered codependency a relationship disorder. O'Gorman and Oliver-Diaz (1987) suggested in their definition that codependency involves a learning system in which family habits are passed down, one generation teaching those behaviors to the next generation.

Fischer et al. (1991) also provided a definition regarding dysfunctional relationships. They referred to codependency as "a dysfunctional pattern of relating to others with an extreme focus outside of oneself, lack of expression of feelings, and personal meaning derived from relationships with others" (p. 87). Their definition for codependency is the one used in the present study, and the scale that they developed to measure codependency is the one we used in this study.

For this study, codependency was operationally defined according to the scales that were used; however, as we note in the Discussion section, this operational definition is problematic in many ways and may reflect some unconscious gender bias. The inclusion of items that assess caregiving in a scale that is identified as a measure of pathology in effect pathologizes the female caregiving role.

### *Positive Perspectives on Caregiving*

A problem with the existing definitions and measures of codependency has been that they seem to describe caregiving as pathological. A more thoughtful definition of codependency might differentiate between the normal, healthy caretaking role of women and a pathological, extreme focus on relationships. Unfortunately, much of the existing literature fails to make this distinction.

Because codependency has become commonly associated with women's stereotypical caretaking role, the question of whether codependent behavior is typical of all women has been raised. Haaken (1993) suggested that the codependency movement pathologizes the female gender role, including "the insecurities and oppressive conditions that dominate women's lives" (p. 326), in a sense victimizing women as caretakers. Roehling, Koelbel, and Rutgers (1996) hypothesized that codependency is merely a coping strategy women use when faced with environmental stressors, whereas men's coping strategy is conduct disorder. Roehling et al. suggested that from this perspective, codependency, or the female tendency, is the more healthy form of coping. This notion offers a more prosocial perspective on the codependency construct than is typical in much of the existing literature. In general, the question of whether codependency is based on stereotypical feminine traits is becoming prevalent in the more recent literature (Haaken, 1993; Roehling et al., 1996; Tavris, 1992, p. 196). If codependency is based on stereotypical feminine traits, then it is possible that women's higher scores on codependency measures are attributable to their greater preference for the caretaking role. It is unfortunate that some of the existing literature seems to attribute pathologies to women's caregiving behaviors.

### *Criticisms of the Study of Codependency*

The existing literature makes clear the ambiguity of the term *codependency*. Thus, it is not surprising that the word has come to be overused in the self-help literature (Asher & Brissett, 1988; Frank & Bland, 1992; O'Gorman, 1993). Many authors have discussed the need for more systematic research, and then they have noted the overuse of the term (Gomberg, 1989), the labeling (Chiazzi & Liljegren, 1993; Frank & Bland; Gomberg; Van Wormer, 1989), and the self-diagnosis (Asher & Brissett; O'Gorman).

Some of the critics of the concept of codependency have questioned its validity. Chiazzi and Liljegren (1993) referred to codependency as 1 of 11 "taboo topics in addiction treatment" (p. 311). These authors questioned whether codependency is a disease and suggested that it is a self-fulfilling prophecy. Tavris (1992) even suggested that women are "eager" to take on the addiction (p. 203). This position is in agreement with O'Gorman's (1993) definition of codependency as learned helplessness. The codependent individual watches talk shows on television, learns about the popular psychological view of codependency, and in turn becomes codependent.

This perspective relates to the notion that many define themselves as codependent, a topic that has become popular in self-help literature. Frank and Bland (1992) commented that many of their clients self-diagnose codependency. Asher and Brissett (1988) studied wives of alcoholics and found that the participants took the term for granted and used it freely, and that self-labeling occurred

through “retrospective reinterpretation of their lives with their alcoholic husbands” (p. 331). Obviously, it is not uncommon for women to see themselves as displaying deviant behavior according to the concept of codependency (Asher & Brissett; Chiazzi & Liljegren, 1993; Tavis, 1992, p. 197; Van Wormer, 1989). According to Van Wormer, the codependency label is used to discriminate against women.

In addition to contending that codependency is an overused concept, many authors criticize the language used to describe the concept (Gomberg, 1989; Mannion, 1991). Gomberg suggested that the term has been so drastically expanded that it can apply to everyone, and Haaken (1993) stated that the language has become so generalized that it includes “anyone who is often upset or who has emotional difficulties that are manifested interpersonally” (p. 327). Similarly, Mannion claimed that language works to “inflate” the concept. In other words, codependency began as a clinical concept used to describe characteristics related to specific behaviors, but the term has become a common one, used to describe nearly everyone. Mannion stated that this inflation detracts from empirical and clinical usefulness. He also suggested that researchers should use more precise language and place more emphasis on clinical research. Although there does seem to be a great deal of existing clinical research, Mannion’s suggestion for more empirical research is valid because there is certainly an imbalance in the suggestions for systematic work on codependency and the actual completion of this work.

### *Measures of Codependency*

A number of scales have been developed to assess codependency. Existing measures include the following: Codependency Assessment Inventory (CAI; Friel, 1985), Acquaintance Description Form-C3 (ADF-C3; Wright & Wright, 1991), Beck Codependence Assessment Scale (Beck, 1991), A Co-Dependence Test (Kitchens, 1991), Co-dependent Relationship Questionnaire (Kritsberg, 1985), Recovery Potential Survey (Whitfield, 1991), Spann-Fischer Codependency Scale (Fischer et al., 1991), and Potter-Efron Codependency Assessment (Potter-Efron & Potter-Efron, 1989).

The reliability and validity of the CAI have not been thoroughly evaluated, and it is lengthy, consisting of 60 true–false items measuring characteristics of codependency. Although no statistical information was published with this measure, Wright and Wright (1991) found that high scores on this scale were not associated exclusively with codependency. Because no reliability or validity coefficients were reported and the measure was criticized in the existing literature, we did not use it in this study.

The ADF-C3 consists of 27 scales with four items each. The focus is on the close relationships of the codependent, describing codependency as a characteristic of relationships (rather than a personality trait) and as including numerous

components. The authors have noted its limitations and suggested that the Spann-Fischer Codependency Scale is a more "direct measure" of codependency as a personality trait (Wright & Wright, 1991, p. 453).

From the measures listed earlier, we chose only the Spann-Fischer Codependency Scale (representative of the better research-oriented measures) and the Potter-Efron Codependency Assessment (representative of the better clinical approaches to assessment) for the present study. Both instruments implicitly treat codependency as a personality trait, focusing on individual differences. (This study was limited to a personality focus rather than a relationship focus on codependency.) The Spann-Fischer Codependency Scale is already known to be a fairly reliable measure, and Fischer et al. (1991) also presented some evidence of its convergent and discriminant validity. It is a short scale consisting of 16 items, such as "It is hard for me to say no," and "I seem to get into relationships that are painful for me." Responses are given on a 6-point scale ranging from *strongly disagree* to *strongly agree*. This measure focuses on a definition of codependency as a personality trait involving extreme focus outside of oneself, lack of expression of feelings, and personal meaning derived from relationships with others. The higher the score, the greater the codependency of the respondent. The scale has been shown to be internally consistent and reliable (Fischer et al., 1991; Wright & Wright, 1991).

The validity and reliability of the Potter-Efron Codependency Assessment (1989) have recently been assessed by Gotham and Sher (1996). Although it is a clinical assessment, this measure is of reasonable length. It focuses on ways in which a codependent person is affected by family alcoholism or chemical dependence, or by other highly stressful environments. The items measured include fear, shame and guilt, prolonged despair, anger, denial, rigidity, impaired identity development, and confusion. The assessment includes several items for each characteristic (33 in total), and positive answers indicate codependency. Gotham and Sher examined the construct validity of the Potter-Efron scale via factor analysis and by correlating it with family histories of alcoholism and with other more general measures of psychopathology and personality. They found that scores on this codependency measure were significantly higher for persons with a family history of alcoholism, but this relationship was partly explained by the association with other kinds of psychopathology, such as neuroticism. This explanation raises the question of whether codependency is distinct from other, more general kinds of psychopathology.

In the present study, we included both the clinically based scale (the Potter-Efron assessment) and the empirically derived scale (the Spann-Fischer Codependency Scale). These two scales were chosen because they have been used relatively widely in past research, because there is some evidence for their reliability and validity, and because they are based on somewhat different definitions of codependency, derived, respectively, from clinical and empirical research backgrounds.

### *Can Codependency Be Predicted?*

Originally, codependency was associated exclusively with family members of people who had chemical dependencies (Gierynski & Williams, 1986; O'Brien & Gaborit, 1992; O'Gorman, 1993; Van Wormer, 1989), perhaps because the concept was associated with "co-alcoholism" (Whitfield, 1984). It has even been suggested that every member of an alcoholic family is codependent (Gierynski & Williams, 1986). For example, Whitfield (1983) described codependency as trying to control the alcoholic's drinking behavior by protecting or changing the alcoholic, which is obviously difficult. Others have commented on the common usage of the term to describe only spouses of alcoholics (Asher & Brissett, 1988).

However, although the findings of some studies have indicated that codependency is related to alcoholism (Carson & Baker, 1994; Gotham & Sher, 1996), there has been much speculation that codependency is not associated exclusively with alcoholism and chemical dependency (Cermak, 1986, 1987; Gierynski & Williams, 1986; Irwin, 1995; O'Gorman, 1993). Even Cermak (1986), who developed diagnostic criteria for codependency in the style of the *Diagnostic and Statistical Manual* (3rd ed., American Psychiatric Association, 1980), stated that "enmeshment in relationships with personality disordered, other codependents, and/or impulse disorder individuals" is one of his diagnostic criteria. Thus, although the original criteria focused on an association between alcoholic family members and codependency, there may be other conditions relating to codependency. In addition to substance abuse and a primary relationship with a substance abuser, Cermak included recurrent physical or sexual abuse and stress-related medical illness.

Although there has not been a great deal of systematic evidence to support these claims, a study conducted by Carson and Baker (1994) revealed that codependency was associated with childhood abuse (physical, sexual, emotional). In addition, O'Brien and Gaborit (1992) found that codependency can exist independent of chemical dependency. Thus, although codependency is clearly linked to alcoholism, other types of addictions and illnesses in family members have also been linked to codependency. For example, Prest and Storm (1988) found that spouses of compulsive eaters as well as spouses of compulsive drinkers tended to be codependent. Potter-Efron and Potter-Efron (1989) included in their diagnostic definition that the codependent person is involved with "alcoholic, chemically dependent, or other long-term, stressful family environment" (p. 37).

These findings do not completely rule out chemical dependency as a primary factor affecting codependency, but they suggest that other types of environmental stresses could also lead to codependency. This suggestion led us to speculate that other types of family stressors (apart from alcoholism), such as chronic physical or mental illness, could also lead to codependency. Although the presence of an alcoholic person in the family is usually mentioned in the literature on

presumed causes of codependency, there is little empirical research that assesses this relationship (Gomberg, 1989). Roehling et al. (1996) found only a weak correlation between codependency and alcoholism, and that correlation was actually eliminated by controlling for the effects of parental abuse, suggesting that the abuse had a mediating effect on the correlation of codependency with alcoholism. Thus, in the majority of the clinical studies, researchers have explored the idea that codependents tend to grow up in generally stressful family environments (O’Gorman, 1993), not limited to an alcoholic environment, and they become involved in dysfunctional relationships (Fischer et al., 1991; O’Gorman, 1993).

Gender differences have often been assumed in the clinical literature on codependency, such that women are predicted to be more codependent than men. Although Hawks, Bahr, and Wang’s (1994) study of adolescent substance abuse and codependency revealed that gender had insignificant associations with codependency, the clinical literature strongly suggests that women are more codependent than men (Asher & Brissett, 1988; Chiazzi & Liljegren, 1993; O’Gorman, 1993), because women are more stereotypically engaged in the caretaking role than men are.

In addition to gender, it is suggested in the clinical literature that birth order may play a role in codependency. The roles of the eldest child in the family as the “responsible one” (Black, 1986, p. 106) and as the “hero” (Whitfield, 1991, p. 47) include caretaking and providing structure and stability for siblings in an otherwise unstable home environment. This child tends to achieve self-worth through providing organization for others in the family. Thus, first-born children would be most likely to possess codependent characteristics, focusing on others before themselves. There might also be an interaction between gender and birth order, such that birth order effects are stronger for female children.

Codependency may also be a learned pattern based on observation of interactions in the family; therefore, people who have codependent mothers may tend to be higher in codependency. Crothers and Warren (1996) asked students to fill out the Spann-Fischer scale regarding their parents. They found a relationship between codependency of students and the (perceived) codependency of parents (as reported by the student). Direct self-reports from parents were not obtained in that study.

### *The Relationship Between Codependency and Other Personality Measures*

A few empirical studies have revealed that various personality factors are correlated with codependency. Fischer et al. (1991) found self-esteem, external locus of control, anxiety, depression, and masculinity to be significantly related to codependency. Gotham and Sher (1996) found that the Potter-Efron codependency measure was correlated with several measures of psychopathology, including neuroticism. There is also research suggesting that codependency may be related to dependency more generally. Dependency in general has been described

by Bornstein as “a strong desire to obtain and maintain nurturant, supportive relationships” (1992, p. 3). Hinkin and Kahn (1995) found that dependency (assessed with the Minnesota Multiphasic Personality Inventory; Hathaway & McKinley, 1983) was correlated with a measure of codependency. This research (correlating many different personality measures with codependency) suggests some possible problems with the discriminant validity of certain codependency measures. That is, the codependency scales may tap other negative aspects of personality in addition to codependency. In the present study we did not address this issue.

Some other researchers found no relationships between more general negative affect and codependency. For example, O'Brien and Gaborit (1992) found that codependent research participants were not more likely to be depressed than the non-codependent participants.

On the whole, in the majority of the clinical literature, the concept of codependency is criticized. Only a few studies offer empirical evidence. In the present study, we systematically assessed the relationship of codependency with three types of environmental family stress (i.e., alcoholic parent, mentally ill parent, or physically ill parent), gender, birth order, and codependency of the mother. We also compared two measures of codependency that have been widely used in past research (the Potter-Efron and the Spann-Fischer instruments), to see how strong the associations were between the behaviors they measured and these background variables. The purpose of the study was to examine whether codependency can be predicted from gender, birth order, and family stressors (including factors such as alcoholic, mentally ill, or physically ill parent, alone and in combination).

## **Method**

### *Participants*

The sample consisted of 257 undergraduate students (176 women, 81 men, recruited from the subject pool in an introductory psychology course) and 100 of these participants' mothers (in a follow-up study). The 257 student participants ranged in age from 18 to 35; the mean age was 19 years. Of the student participants, 252 were single, 3 were married, and 2 were divorced. The survey response rate was 100% for students and 67% for mothers. Demographic information was not collected for the mothers.

### *Measures*

The students filled out a questionnaire that consisted of demographic information, codependency scales, and assessments of three types of family stress (physical illness, mental illness, and alcoholism). The demographic items included sex, age, marital status, and birth order.



The Spann-Fischer Codependency Scale and the Potter-Efron Codependency Assessment were used to measure codependency. Regarding internal reliability, Fischer et al. (1991) reported a Cronbach alpha of .77 for the Spann-Fischer scale; Gotham and Sher (1996) reported a Cronbach alpha of .87 for the Potter-Efron scale. Other kinds of family stressors were assessed via student self-report. One question asked whether either parent had any chronic physical illness (such as cancer, heart disease, diabetes, multiple sclerosis, and so forth). A second question asked whether either parent had any chronic mental illness (such as schizophrenia, severe depression, bipolar disorder, and so forth). These questions were developed for this study and had not been used in past research.

To measure alcoholism of both mother and father, we used the long form of the Michigan Alcoholism Screening Test (MAST; Selzer, 1971). In a review of six past studies that used this scale, Gibbs (1983) found that the MAST had good internal reliability, with Cronbach's alpha ranging from .83 to .93. The students filled out versions of this scale, revised so that the questions referred to the parent instead of the self—for example, "Do friends or relatives think of your mother as a normal drinker?" The response format for each item was *yes*, *no*, or *don't know*; the total score on the MAST was the number of yes responses for alcohol problems. On the basis of preliminary internal reliability analysis, two items were dropped because they had poor correlations with the overall scale and thus lowered the Cronbach alpha reliability.

The mothers and fathers were divided into groups according to the following criterion: If the student reported 17 or more yes responses on the list of 23 alcohol-related problems, the parent was classified as alcoholic. Parents with fewer than 17 problems reported were classified as not alcoholic. This decision was based in part on the shape of the distribution of MAST scores for parents; scores of 17 and above were clearly in the upper tail of this distribution. This criterion differs from the cutoff used in past research with the MAST (Selzer, 1971), in which people were classified as alcoholic even if they exhibited a small number of symptoms; in our study, only those with large numbers of reported problems were classified as alcoholics. We used the longer version of the MAST and a more stringent cutoff because Gibbs (1983) noted that inconsistent results in past research may have been attributable to over-diagnosis of alcoholism.

The mothers filled out only the Spann-Fischer Codependency Scale. This measure was included to assess whether participant codependency could be predicted from the mother's codependency. (The limitations of assessing only mothers' codependency are addressed in the Discussion section.)

### *Procedure*

The questionnaires were administered to students in groups of 25 to 35. On the last page of the questionnaire, each student was provided with a blank address label for his or her mother's address. It was explained to the students that

it was purely voluntary to provide this information. A total of 149 of the 257 participants provided their mothers' addresses, including identification numbers on the address labels. Labels were matched to surveys by the identification numbers only; the students were assured that no names would be matched. Mothers were sent a copy of the Spann-Fischer Codependency Scale and a stamped return envelope. One hundred of the 149 mothers contacted in this follow-up study responded.

## Results

### *Reliability of the Scales*

Internal consistency reliability coefficients (Cronbach's alpha) were computed for each of the scales, to assess whether the reliabilities were comparable to those in past research. The coefficient for the Spann-Fischer Codependency Scale for the students' questionnaires was .75, and for the mothers' questionnaires it was .79. The coefficient for the Potter-Efron codependency assessment was .78. The coefficient for the MAST for mothers was .86, and for fathers it was .85. (The latter two reliabilities are for a slightly modified version of the scale; two items that reduced reliability were deleted from the scale.) Thus, all scales were reasonably reliable and had reliabilities similar to those reported in past research (Fischer et al., 1991; Gotham & Sher, 1996).

### *Correlation Between the Spann-Fischer and the Potter-Efron Scales*

A correlation between the two codependency scales was computed to assess how similar they were,  $r = .695, p < .01$ . This finding suggests that the two scales are moderately positively related; they seem to detect similar, but not identical, aspects of codependency.

### *Comparison of Stressed and Unstressed Families*

We had predicted that codependency scores would be higher for participants with alcoholic, physically ill, or mentally ill parents. A family was described as "stressed" if one or both parents had any of the following problems: alcoholism, chronic physical illness, or chronic mental illness. A family was described as "unstressed" if none of these parent problems were reported. When these three types of stress were grouped together into this broader "family stressor" variable, the differences in codependency were significant for both scales. The mean codependency scores for participants with family stress were higher than for those without family stress,  $t(255) = 2.43, p = .016$ , for the Spann-Fischer scale;  $t(255) = 2.47, p = .014$ , for the Potter-Efron scale (see Table 1). Thus, when alcoholic, physically ill, or mentally ill parent variables were combined into the family

**TABLE 1**  
**Comparison of Codependency Scores of Students**  
**From Stressed and Unstressed Families**

Variable	<i>M</i>	<i>SD</i>	<i>t</i>	<i>p</i>
<i>Spann-Fischer Codependency Scale</i>				
Stressed	46.59	10.30	2.43	.016
Unstressed	43.50	9.60		
<i>Potter-Efron Codependency Assessment</i>				
Stressed	42.31	5.18	2.47	.014
Unstressed	40.66	5.20		

stressor variable, both scales revealed a significantly higher mean codependency score for participants from a stressful family environment.

#### *Comparisons of Female and Male Participants*

Female students were expected to have higher codependency scores than male students. The mean Spann-Fischer codependency scores were significantly higher for the women than for the men (see Table 2),  $t(255) = 2.87, p = .004$ . The mean Potter-Efron codependency scores showed a slight gender difference in the same direction, but this trend was not statistically significant,  $t(255) = 1.44, p = .152$ .

#### *Additional Analyses*

Student birth order and mothers' codependency scores were also assessed in relation to student codependency scores. None of these variables were significantly related to codependency.

We performed one-way analyses of variance (ANOVAs) to see whether scores on the Spann-Fischer scale or the Potter-Efron scale differed across birth order; no significant differences were found. In addition, because we thought that gender and birth order might interact with various types of family stressors (such that first-born and/or female children might be more vulnerable to the effects of environmental stress in the family), we also conducted factorial ANOVAs to predict each of the two codependency measures, from the following combinations of factors: Student Gender  $\times$  Family Dysfunction, Student Gender  $\times$  Student Birth Order, and Student Gender  $\times$  Student Birth Order  $\times$  Family Stress. None of the main effects or interactions for these analyses were significant (except the main effects for sex and family stress that were reported earlier).

**TABLE 2**  
**Comparison of Codependency Scores of Men and Women**

Gender	<i>M</i>	<i>SD</i>	<i>t</i>	<i>p</i>
<i>Spann-Fischer Codependency Scale</i>				
Men	42.07	9.07	2.87	.004
Women	45.86	10.16		
<i>Potter-Efron Codependency Assessment</i>				
Men	40.59	5.10	1.44	.152
Women	41.60	5.29		

**TABLE 3**  
**Correlations Among the Codependency Measures**

Measure	1	2	3	4	5
1. SF-M	1.00	.164	.175	.062	-.014
2. SF-S		1.00	.695**	-.095	-.075
3. PE-S			1.00	-.123*	-.060
4. MAST-M				1.00	.213**
5. MAST-F					1.00

*Note.* SF-M is the Spann-Fischer codependency score for the mother. SF-S is the Spann-Fischer codependency score for the student. PE-S is the Potter-Efron codependency score for the student. MAST-M is the Michigan Alcoholism Screening Test information reported about the mother by the student. MAST-F is the Michigan Alcoholism Screening Test information reported about the father by the student.

\* $p < .05$ . \*\* $p < .01$ .

In addition, we predicted that codependency scores of the 100 mothers who participated in the follow-up study would be correlated with codependency of student participants (daughter, son, or both). We predicted that daughters would tend to have codependency scores more similar to their mothers' scores. However, the correlation coefficients for the mothers' Spann-Fischer codependency scores with those of all student participants, daughters only, and sons only were not statistically significant (see Table 3). In addition, correlation analyses were performed on the mothers' Spann-Fischer codependency scores with the Potter-Efron codependency scores of students. No significant correlations were found.

The three types of family stress (alcoholic parent, mentally ill parent, and physically ill parent) were also examined separately to see if each one alone was related to codependency. Although previous research suggests that these factors

might affect codependency, *t* tests revealed no significant relationships between codependency scores on either scale and the presence or absence of these factors. However, although the three family stressor variables were insignificant individually, there was a significant relationship with codependency when the variables were combined.

### Discussion

Two important findings were obtained in this study. As predicted, students from families with environmental stress (families with an alcoholic, physically ill, or mentally ill parent) tended to be more codependent than those from families without environmental stress. Second, as predicted, female students in the study tended to be more codependent than male students—but only according to scores on the Spann-Fischer scale, not on the Potter-Efron scale.

The significant difference in codependency scores for participants from stressed and unstressed family environments suggests that other types of environmental family stress, not exclusively parental alcoholism, may lead to codependency. Thus, parental alcoholism is a condition that apparently is neither necessary nor sufficient for the development of codependency. This finding is consistent with findings of other recent studies, cited in our introduction, that related codependency to several types of family dysfunction or trauma.

It is possible that no significant difference in codependency scores will be found when just one type of family stressor (e.g., alcoholism) is examined because the nonalcoholic parent group probably includes parents with chronic physical or mental illness. That is, when other types of stress, such as chronic illness, are ignored, the unstressed comparison group tends to include parents with other kinds of problems that may also be related to codependency.

The finding of a significant gender difference in codependency on the Spann-Fischer scale but not on the Potter-Efron scale suggests that the different components of codependency tapped by these scales are not reported equally often by men and women. (As was noted previously, the correlation between scores on these two scales was .695, suggesting that these scales define codependency in similar, but not identical, terms.) Specifically, men may be more willing to report that they have certain characteristics that are included in the Potter-Efron scale (e.g., rage, rigidity, denial) than they are to report characteristics that are included in the Spann-Fischer scale (e.g., worry, guilt, painful relationships). Thus, the way codependency is defined by the Spann-Fischer scale seems to be more acceptable to women, and perhaps more consistent with female sex role stereotypes, whereas the definition of codependency in the Potter-Efron scale contains elements that seem somewhat more acceptable to men.

Future researchers could examine why women tend to be significantly more codependent than men (at least when assessed by the Spann-Fischer scale). Some of the existing literature suggests that codependency is more common for women

because it is an “emotional condition of the oppressed” (Haaken, 1990, p. 397). Because women are traditionally known as nurturers and caretakers, they may be more likely to define themselves through their relationships and to view themselves through an external focus. Most of the literature that makes these suggestions, similar to the majority of the codependency literature, is clinical and theoretical rather than empirical. However, it is also possible that men are simply less willing than women to report any kind of psychological symptoms, so their low scores (particularly on the Spann-Fischer scale) could be attributable to denial.

Some of the literature that is critical of the study of the concept of codependency even suggests that the term should be altogether withdrawn, because it has political roots in sexism and the oppression of women and blames spouses for treatment that they are receiving (Van Wormer, 1989). This theory coincides with the idea of codependency as another case of blaming the victim. According to Tavis, the “fatal flaw” of the codependency movement is that it is based on a model of normalcy of men (1992, p. 197). This argument relates to the theory of Roehling et al. (1996) that stereotypical feminine behaviors are considered codependent because women are the subordinates in our society, meaning that the dominant male group exhibits the “normal” behavior, whereas the stereotypical feminine behaviors are labeled deviant. Thus, to avoid such labeling bias, researchers need to acknowledge that it is only when individuals are faced with chronic family stress that these caretaking traits may be exacerbated into behaviors that could be considered unhealthy (Roehling et al., 1996).

On the other hand, Wolin and Wolin (1993) described the potential positive effects of growing up in a troubled family in *The Resilient Self*. Wolin and Wolin suggested that in some cases, chronic family stress or adversity allows for a higher sense of competence achieved through the survivor’s facing the challenge of being raised in “an emotional wasteland” (p. 6). Wolin and Wolin shed a positive light on the individual from a chronically stressed family, and they urged these survivors to avoid labeling themselves as “damaged” and to use the adversity to become strong, resilient adults. These suggestions relate to the notion that the codependency movement has focused primarily on negative feminine traits and has not acknowledged the positive aspects of the caretaking role on which the concept of codependency is based (Haaken, 1993; Roehling et al., 1996; Tavis, 1992, p. 197). Roehling et al. considered codependency as the female coping mechanism for family stress, and they found this behavior to be healthy compared with destructive conduct disorders, which they considered the male coping mechanism for family stress. On the whole, an operational definition could clarify that codependency is strictly an excessive focus outside oneself, and that this unhealthy locus of control may be related to a stressful family environment. This definition would distinguish the concept of codependency from the healthy, stereotypically feminine aspects of the caretaking role.

Except for gender, none of the family background variables (parental alcoholism considered alone, birth order, mother’s codependency) were significantly

related to students' codependency scores. We predicted that first-born children would tend to be more codependent than the other participants, as suggested in the clinical literature. There were no main effects of birth order, nor were there any significant interactions between birth order and gender. There was not even an insignificant trend toward higher codependency for first-born children, so it seems unlikely that larger samples would have yielded significant differences. Thus the hypothesis that the oldest child is particularly vulnerable to codependency was not supported. These findings may imply that the existing codependency measures merely tap stereotypical feminine traits with which women primarily identify, considering that no other background variables seem to be consistently correlated with codependency, with the exception of stressful family background.

Correlations were computed between the codependency scores (on the Spann-Fischer scale) of the students and their mothers. Contrary to our prediction, this correlation was not significant; our data do not suggest that students learn codependent behaviors from their mothers. If we had had a larger sample, then it might have been useful to have looked at student–mother correlations in codependency separately for various subgroups, such as families with or without an alcoholic father. The number of participants in this study, however, was too small to allow such an analysis of subgroups. It would also have been useful to measure father codependency. Because of the prevalence of research on female codependency in the existing literature, we chose to follow-up mothers only.

When each type of environmental family stress was examined separately (e.g., parental alcoholism, parental chronic physical illness, parental chronic mental illness), no statistically significant differences between groups were found. For instance, students with an alcoholic parent were not significantly more codependent than students without an alcoholic parent. The directions of all mean differences showed nonsignificant trends in the predicted direction (such that students with any kind of parental alcoholism or illness reported slightly higher codependency). However, the numbers of cases in these subgroups (such as students with a chronically mentally ill parent) were very small; not obtaining significant differences might have been attributable to lack of statistical power or partly to the fact that the group without a mentally ill parent included families with other types of stress, such as alcoholism and physical illness.

#### *Limitations of the Present Study and Implications for Future Research*

The idea that a stressful family environment tends to predict higher codependency scores was supported by the findings of this study. However, this study had several limitations.

One limitation is the use of a college student sample, which limits generalizability. Future researchers could measure levels of codependency in an older, married sample.

The validities of some of the measures have not been determined. Even when standardized measures, such as the MAST, were used, the modifications in scoring may have changed the validity of that measure. The scoring on the MAST was modified such that a higher cutoff score was used to classify parents as alcoholic; this procedure may enable avoidance of the problem of over-diagnosis noted by some earlier researchers (Gibbs, 1983), but we do not have information about the validity of this modified scoring procedure. The other types of family stress were assessed by just one question each, asking about chronic mental illness and chronic physical illness of parents. These questions were answered by students with respect to their parents. It would be helpful to obtain more data on family background directly from parents as a check on accuracy.

In addition, administration of the follow-up survey to fathers as well as mothers is crucial to future research. The exclusion of fathers is one of the most prominent limitations of the existing study, especially when considering the potential for gender bias in the existing literature. It would have been useful to assess the relation of father codependency and chronically ill mother (i.e., alcoholic, physically ill, or mentally ill mother). These data could shed more insight on the possibility that gender mediates any relationship with codependency.

Because it is possible that the codependency construct is disproportionately focused on negative stereotypical feminine traits, this potential for labeling bias should be explored in future research. Development of more sophisticated codependency measures could systematically address the question of why women tend to score higher on the codependency instruments than men do. More sensitive measures could also distinguish between positive forms of caregiving and negative and pathological relationship patterns.

It would also be desirable for future researchers to obtain more information about the nature of parents' health problems, the severity of those problems, and how recently they occurred, as well as to use measures of parental abuse and childhood trauma in general (see Irwin, 1995), separate from the specific label of alcoholism, or mental or physical illness. It would be of interest to assess whether the presence of one chronically ill or alcoholic parent may be compensated for in some cases by the presence of a more healthy or unstressed parent.

This study did not assess other measures of psychopathology and how they may be related to codependency (as in Gotham & Sher, 1996); inclusion of such measures in future research will make it possible to evaluate the extent to which codependency is a unique personality characteristic, distinguishable from more general types of dependency or neuroticism. This information would address the question of whether "codependence is best regarded as a psychological disorder, as a personality trait, or as a social condition" (Irwin, 1995, p. 659).

Because of the limited sample size, only limited analysis of subgroups (e.g., students with or without a chronically mentally ill parent) was possible. Larger samples would be highly desirable in future research in order to explore how various types of chronic family stress are related to codependency.



### *Summary of Implications for Future Research*

This study provided significant evidence that several different types of environmental family stress (such as chronic mental or physical illness, as well as alcoholism) may be related to codependency. Therefore, it seems that other types of stress (not limited to alcoholism) may be among the factors that lead to codependency. In future research, more detailed information about family background should be obtained from larger numbers of participants; codependency of both parents should be measured; and labeling bias in the literature should be systematically addressed.

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