

INVESTIGATION INTO CODEPENDENCY IN SPOUSES OF ALCOHOLICS
- AN EXPLORATORY STUDY

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DECLARATION

This thesis was undertaken in the department of Psychology, University of Natal, Pietermaritzburg and unless otherwise stated in the text, represents the author's own work. This thesis has not been submitted to any other University.

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ABSTRACT

The literature concerning the different theoretical and conceptual approaches to spouses of alcoholics was reviewed. It emerges that codependency may be an important construct with implications for the treatment of couples where one partner is an alcoholic. Five conceptual approaches to codependency were reviewed. This exploratory study then investigated the construct codependency in 37 (2 males) spouses of alcoholics. It looked at the extent to which it could be identified in this sample, and the relationship between codependency and personality, coping style, level of self-esteem and the impact of codependency on the level of alcoholism. The sample consisted of 19 white, 15 indian and 3 "coloured" couples, ranging in age from 23-63 years. All the alcoholics were undergoing in-patient treatment in specialized treatment centres.

The Codependency Assessment Questionnaire (Potter-Efron & Potter-Efron, 1989), the Millon Clinical Multiaxial Inventory (MCMI, Millon, 1984), the Ways of Coping Checklist (WCC, Folkman & Lazarus, 1980), the Self-Esteem Inventories (SEI, Coopersmith, 1987) and the Michigan Alcoholism Screening Test (MAST, Selzer, 1971) were administered. The data analysis compared the couples where the spouse was codependent and where the spouse was non-codependent.

The major findings include the following: Twenty-three spouses were found to be codependent and this was related to characteristics such as self-blame, guilt, fear, prolonged despair, anger, rigidity, impaired identity, confusion and a low self-esteem. Denial was not as prominent as expected from the literature, but was still significantly related. Codependency was also related to coping styles of self-blame and wishful thinking/escape and the personality traits of the dependent, schizoid, avoidant and passive-aggressive personality patterns.

In addition, spouses with codependency showed high levels of anxiety.

All the findings are discussed in the context of conceptualizing codependency as a syndrome as well as the implications for further research and treatment.

I. INTRODUCTION

Alcoholism is a major illness which affects many people and has been identified as the third largest health problem in the U.S.A. (Kaplan & Sadock, 1988). The DSM-III-R (APA, 1987) notes that 13 % of the population will have alcohol-related problems in the U.S.A.. If one considers that alcoholism not only affects the person who has the problem but also the significant persons around him/her, it is clear that a great number of people may be affected. Perhaps the one most affected is the spouse of the alcoholic. Thus it is not surprising that theorists, as early as the nineteen forties, have focused on the spouses of alcoholics (e.g. Price, 1945).

Five theoretical approaches to the spouse of an alcoholic have emerged over the years. Firstly, the disturbed personality approach postulated that she (research has mainly focused on male alcoholics) has a personality disorder which makes her seek an alcoholic marriage to meet her own needs. The stress and sociological approaches emerged almost concurrently with the psychosocial model (Edwards, Harvey & Whitehead, 1973; Magni, 1983; Moos, Finney & Gamble 1982; O'Farrel, Harrison & Cutter, 1981; Schaffer & Tyler, 1979). In addition, theorists have approached alcoholism from a systems perspective by looking at the whole family, not only the spouse. A fifth approach appeared as early as the nineteen forties which hypothesizes that spouses (again mainly female) of alcoholics may be codependent (O'Brien & Gaborit, 1992). This means that they are dependent on the alcoholic being addicted to alcohol. They seem to have a need to care for someone to the exclusion of their own well being to attain their sense of self-esteem.

Despite the early emergence of this approach, the literature reveals little consensus and few uniform definitions regarding codependency. It seems to have been sidelined until the seventies and has only really become prominent in the literature in the late eighties. As a result, until recently, very little

research has been done on codependency and the construct has mainly been based on theoretical hypotheses and clinical observations. If it exists, however, it may have specific consequences. These consequences may include a powerful rationale for including the spouse of the alcoholic in the treatment, as the codependent spouse may play a specific role in the treatment process of the alcoholic. If the hypotheses regarding codependency are correct then the codependent spouse may be expected to sabotage the treatment and rehabilitation of the alcoholic. It may also indicate the nature of the treatment goals for the spouse.

Given that alcoholism is such a major health problem in society, further research of codependency is necessary and long overdue. As Cermak (1986, in Morgan, 1991) states, codependency will remain confined to clinical impressions, merely, if reliable and valid research data is not gathered. It seems that codependency has been subjected to the same varying approaches as has alcoholism itself. Codependency has been defined as a way of relating, a personality disorder, a way of coping, a syndrome and as the pathogenesis of addictions (Cermak, 1984; Loughhead, 1991; Mendenhall, 1989; Morgan, 1991; O'Brien & Gaborit, 1992; Potter-Efron & Potter-Efron, 1989).

With this in mind, the aim of this exploratory study was to investigate the occurrence of codependency in spouses of alcoholics (focusing mainly on male alcoholics) and to clarify the construct by looking at the relationship between codependency and personality patterns, coping styles, self-esteem and the impact on alcoholism. It was expected that codependency could be found in spouses of alcoholics and that this characteristic might enable or maintain the alcoholism.

The sample for this thesis was drawn from two in-patient treatment centres for alcoholism and drug abuse and the codependent spouses in this sample were compared with the non-codependent spouses using all the above factors.

Chapter 2 of this study focuses on conceptualizing alcoholism, reviewing the different approaches to the spouses of alcoholics and noting the previous research done. The aim, questions and hypotheses of this study are outlined in chapter 3, with a description of the instruments used and method of analysis. The results are presented in chapter 4 and discussed in chapter 5. Finally the implications of these findings can be found in the conclusion of this study (chapter 6).

2. LITERATURE REVIEW

2.1. ALCOHOLISM

Although alcoholism does not have a specific diagnostic category in the third revised Diagnostic and Statistical Manual (DSM-III-R, APA, 1987), it is classified under the general term of psychoactive substance use disorder. According to Kaplan and Sadock (1988) the term is commonly used and they define alcoholism as "...a disease marked by the chronic, excessive use of alcohol that produces psychological, interpersonal, and medical problems" (p.221). It seems that the chronicity and the ill effects of excessive alcohol use on any of the major life areas, for example health, occupation, family, social contacts and interpersonal relationships, are the main characteristics of alcoholism which are highlighted by numerous authors in their definitions of alcoholism (Keller, 1958; Kessel & Walton, 1967; Royce, 1981; National Council on Alcoholism, 1976; Trice, 1966). Likewise, Keller (1958) defined alcoholism as: "...a chronic behavioral disorder manifested by repeated drinking of alcoholic beverages in excess of the dietary and social uses of the community and to an extent that interferes with the drinker's health or his social or economic functioning" (p.2).

Why a person would continue to drink alcohol even in the face of detrimental consequences (as noted above) has been addressed by the use of three basic theoretical models. In the medical model alcoholism is considered as a physical illness with a genetic predisposition (Ward, 1983). Thus some people are genetically predisposed to becoming physically addicted to alcohol. In the second theoretical model the cause of alcoholism is explained by viewing it as a symptom resulting from an underlying psychological conflict or personality disorder. Alcoholism is explained in psychoanalytic terms. In the third model the sociological factors which may cause or influence alcoholism are reviewed. Within this model there are three sub-approaches. Firstly, the behaviouristic approach defines alcoholism as a

result of life problems and the fact that the alcohol use is reinforced by the environment. Secondly, there is the family interaction model (or systems) approach which considers alcoholism as a familial illness whereby the family enforces the drinking through mutually reinforcing behaviour of the different family members. The last approach regards alcoholism as caused by stressful life circumstances whereby the person is labelled as suffering from alcoholism due to excessive drinking (Ward, 1983).

From the above definitions of alcoholism and the different approaches to the understanding of alcoholism it becomes clear that it has both social and interpersonal consequences. It is also known that it is a gradual illness which often goes undetected both by the alcoholic and the people around him/her. Gorman and Rooney (1979,b) proposed that alcoholism develops so gradually that it is often well established before the spouse of the alcoholic becomes aware that there is a problem. When it is finally recognized, it may be deliberately concealed and become a closely guarded family secret.

In view of the above, an approach has emerged which looks at the effects of alcoholism on the family, more particularly, the spouse of the alcoholic and how the family and spouse possibly influence the alcoholism of a family member. The effects of alcoholism on the spouse may be marked. Pillay and Vawda (1989) found that over 40% of married women who had a history of parasuicide cited their husbands' abuse of alcohol and the associated violent behaviour as precipitants of their self-destructive acts.

Meeks and Kelly (1970) and Loughead and Young (1991) stress the importance of the family in the aetiology, treatment, and recovery of alcoholism as Meeks and Kelly (1970) propose that other family members might try to sabotage or become part of the treatment as though they have a stake in the illness.

Furthermore, it was found in a study done by Smith (1969) that social stability in the patient's life and the wife's attendance at the spouse's treatment meeting was related to a favourable outcome of treatment. A study done by Wright and Scott (1978) also found that the wife of the alcoholic influenced the treatment outcome; namely that the more treatment she received the more likely the alcoholic was to stay sober. In addition, Hersen, Miller and Eisler (1973) concluded tentatively from a study done with four married alcoholic couples that the wife may reinforce the drinking problem of the alcoholic by giving him more attention when they spoke about the alcohol problem than when talking about other topics. However, generalizations are limited by the sample size.

It seems that as with the aetiology of alcoholism or with psychology as a whole, more than one theoretical model dealing with the effects of alcoholism on the spouse and family and vice versa has emerged. Four of the five theoretical models / approaches used in trying to understand and explain the experiences of the spouses of alcoholics will be outlined in chapter 2.2. with the accompanying research. The fifth theoretical approach, codependency, will follow in chapter 2.3.

2.2. FOUR THEORETICAL APPROACHES TO SPOUSES OF ALCOHOLICS

Since the nineteen thirties a number of approaches to the spouses of alcoholics have emerged. The first approach was the disturbed personality theory which dominated between 1937 and 1959. In the sixties the stress and sociological theories emerged concurrently with the psychosocial model (Edwards, Harvey & Whitehead, 1973; Magni, 1983; Moos, Finney & Gamble 1982; O'Farrel, Harrison & Cutter, 1981; Schaffer & Tyler, 1979). From the seventies onwards theorists started to look at alcoholism from a more systems perspective. Furthermore, the construct codependency conceptualized in the forties by the wives of Alcoholics Anonymous members was defined in 1979 (O'Brien & Gaborit, 1992).

2.2.1. THE DISTURBED PERSONALITY THEORY

According to the disturbed personality theory the wife of an alcoholic is somehow psychologically maladjusted or personality disordered and needs to be married to an alcoholic to fulfil her own neurotic needs (Edwards et al., 1973; Paolino, McCrady & Kogan, 1978; Paolino, McCrady, Diamond & Longabaugh, 1976; Schaffer & Tyler 1979). The DSM-III-R (APA, 1987) and Millon (1981) define personality as a lifelong style of relating, coping, behaving, thinking and feeling about the environment and oneself which is exhibited in a wide range of important social and personal contexts. They propose that one only has a personality disorder if the above styles are inflexible and maladaptive and cause either significant functional impairment or subjective distress. Hence the disturbed personality theory suggests that wives of alcoholics are inflexible in their thinking, feeling, behaviour, coping and relating. It describes the wife of an alcoholic as being fragile, insecure, dependent, interpersonally restricted, hostile, dominant and abnormally anxious with traumatic childhood experiences. It proposes that the wife finds refuge by marrying a weak, needy man, namely, an alcoholic (Paolino, McCrady & Kogan, 1978; Paolino, McCrady, Diamond & Longabaugh, 1976).

A related hypothesis (the decompensation hypothesis) emerged, proposing that if the alcoholic stopped drinking the wife would decompensate as her needs would no longer be met. The wife would then start to show symptoms such as depression, psychological or psychosomatic illness. Some evidence was found that improvement in the alcoholic (sobriety) is sometimes associated with decompensation in the wife (Edwards et al., 1973; Macdonald, 1956).

In accordance with the disturbed personality theory, Whalen (1953) proposed four personality types of wives of alcoholic wives. She based these types solely on clinical observations made in a family agency in Dallas, Texas, U.S.A.. Whalen (1953)

described the wife of an alcoholic as a person who has as poorly an integrated a personality as her husband. Whalen (1953) proposed that the wife of an alcoholic cannot be seen as an innocent bystander or the victim of alcoholism but as someone whose personality is just as responsible as the alcoholic's for the problems experienced. The personality types which Whalen (1953) defined were; firstly, Suffering Susan who needs to punish herself and who uses orderliness and repression of hostile feelings as means of coping. Secondly, there is the Controller who dominates each aspect of life with the alcoholic and who needs the alcoholic to be less adequate than herself. The Waverer is the third type who has a great need to be loved and appreciated and therefore needs a partner who is weak and helpless. In addition, the Waverer is insecure and constantly wavers between leaving her husband and feeling anxious about his comfort and welfare. Lastly, the Punisher is characterized by rivalrous, aggressive and envious attitudes. This woman requires her husband to be in a "down" position in order for her to dominate because she has to be better than men. Whalen (1953) states that these are not the only personality styles but they are the most common.

Interestingly, Bullock and Mudd (1959), who looked at the marital interactions and the interpersonal relationships of alcoholic husbands and their non-alcoholic wives who were attending counselling, only found a picture of a dependent inadequate male with a dominating woman in four of the twenty cases. Strong dependency needs, feelings of inadequacy and the requirement of strong emotional support from the husband were found in only five of the wives. By contrast, Kogan and Jackson (1964) did not find the profile of a dominating, masculine woman in a study of wives of alcoholics. They found that wives of alcoholics differed from wives of non-alcoholics in that they saw themselves as hyper-feminine, submissive and wanting to be led and managed. They experienced their husbands as possessing fewer desirable traits, displaying less emotional warmth and the husbands were characterized as suspicious and distrusting. Likewise, no

psychopathology was demonstrated in a study done by Paolino, McCrady, Diamond and Longabaugh (1976) with forty spouses of hospitalized alcoholics.

Although the adherents of the disturbed personality hypothesis found that wives of alcoholics who sought help were seriously disturbed, the question remained as to whether the disturbance antedated the partner's alcoholism or stemmed from it (Bailey, 1961, in Kogan, Fordyce & Jackson, 1963). In addition, the studies attempting to confirm the disturbed personality model have been based on clinical data and small samples which limit generalization (Edwards et al., 1973).

Ballard (1959) found that there were no significant differences on the MMPI (Minnesota Multiphasic Personality Inventory) between wives of alcoholic couples and wives of non-alcoholic couples who were all undergoing marriage counselling due to marital conflict. Furthermore, there has been little research to further substantiate the disturbed personality hypothesis (Moos, Finney & Gamble, 1982).

It is possible that little research was done with reference to the disturbed personality theory due to the fact that the findings of the research were confusing and discouraging. In addition, the focus changed in the nineteen sixties to a more stress and coping oriented explanation of behaviour. It seems that the research concerning spouses of alcoholics followed the same trend.

2.2.2. THE STRESS / SOCIOLOGICAL THEORIES

According to the stress and sociological theories the pathological behaviour presented by the wife of an alcoholic results from her attempts to resolve the alcoholic crisis and to return the family to its former stability, not from an underlying personality disorder (Gorman & Rooney, 1979, a; Schaffer & Tyler, 1979). It is also seen as a consequence of the stress undergone

as a result of living with an alcoholic (Magni, 1983). In other words the wife of an alcoholic is basically a normal person who shows pathological behaviour because she is trying to cope with a disturbed marriage and a behaviourally dysfunctional partner (Mendenhall, 1989).

Folkman and Lazarus (1980) define coping as "... the cognitive and behavioural efforts made to master, tolerate, or reduce external and internal demands and conflicts among them" (p.223). Coping itself can serve the following two functions; "...the management or alteration of the person-environment relationship that is the source of stress (problem-focused coping) and the regulation of stressful emotions (emotion-focused coping)" (Folkman & Lazarus, 1980, p.223).

According to Folkman and Lazarus (1980), the manner in which a person experiences stress from, and copes with a certain situation is dependent on the appraisal of the situation. By appraisal they refer to finding out what is at stake in the situation, how harmful or challenging it is and which resources and options are available.

According to Edwards et al. (1973), Jackson (1954) was the first to advocate the stress approach. She highlighted the different stages through which a family might go in order to attempt to cope with the drinking of the alcoholic.

She hypothesized that the behaviour of spouses of alcoholics

..(a)serves to release situationally induced tension, and that such behaviour is followed only incidentally by more drinking by the husband; (b) that some of the wife's behaviour is intended to stabilize the family and that, in so doing, it precipitates a situation which leads to further drinking by the husband (Jackson, 1954, p.564).

Thus the behaviour which the wife may present is not intended to fulfil her own needs, as the disturbed personality theory put forward, but an attempt to cope.

Jackson (1954) identified seven stages of adaptation to alcoholism which she based on the descriptions of wives of alcoholics and on how they coped. These stages include behaviour such as avoiding problems, social isolation, self-doubt, resentment and hostility, separation and or reorganization with the sober alcoholic. Lemert (1960) notes that if the family does cope as Jackson (1954) proposes, then "...the behaviour of the wives of alcoholics is in large part a function of changing interaction patterns, not solely a consequence of personality, or personality type..." (p. 679/680).

Jacob and Seilhamer (1982) outlined six problem areas which spouses of alcoholics might have to deal with. They are social isolation, problems with children, economic problems, sexual problems, violence and cultural attitudes and stereotypes. In a study with wives of alcoholics, Jacob and Seilhamer (1982) identified five styles of coping which were used to deal with the above stressors. These were safeguarding family interest, withdrawal within the marriage, attacking, acting out, and protecting the alcoholic husband. The same coping styles (which were identified in 1968 by Orford and Guthrie) were found in a study done with eighty wives of alcoholics by Orford and Guthrie (1976). When investigating the above coping styles, James and Goldman (1971) found that the coping style of withdrawal within marriage was used the most, regardless of the alcoholic drinking stage (abstinent, social drinker, excessive drinker and alcoholism). The attack style was not used during the social drinking and abstinent stage. All the wives used more than one style and all the coping styles were used most frequently during the drinking stage. It also appeared that threats of leaving were the most effective in inducing abstinence.

A study which confirms the stress theory was done by Haberman (1964). This study found that wives of alcoholics who were drinking showed significantly more symptoms as measured by the Index of Psycho-physiological Disturbance than wives of abstinent alcoholics.

However, if spouses of alcoholics showed dysfunctional behaviour due to the stress of living with an alcoholic then this dysfunctional behaviour would abate once the alcoholic stopped drinking. Moos, Finney and Gamble (1982) found that this was not fully the case, as spouses of recovered alcoholics were not functioning as well as spouses of non-alcoholics. Also, in a study performed by Paolino, McCrady and Kogan (1978) it was found that the spouses of alcoholics did not show a significant change over time in their presentation of symptoms (although there was a slight decrease of both anxiety and depression) even with a decrease in drinking.

Possibly due to these variable findings another approach emerged almost simultaneously with the stress approach which attempted to look at both personality and social circumstances. As in the history of psychology the trend shifted from explaining behaviour solely in personality or environmental terms to a more bio-psycho-social approach. Hence the psychosocial theory.

2.2.3. PSYCHOSOCIAL THEORY

Unlike the previous two theories, the psychosocial theory attempts to incorporate both personality variables and social variables in the understanding of the behaviour of the spouse of an alcoholic. It proposes that both the spouse's personality and the social situation to which s/he is exposed will contribute to the spouse's behaviour (O'Farrel et al., 1981). In an attempt to validate this approach O'Farrel et al. (1981) investigated sixty wives of alcoholics, using structured interviews and concerned with the following variables: retrospectively reported data about stressors in the women's childhood associated with

present psychiatric symptomatology and measurement of the degree of marital stress experienced in the last three years. Their findings were that marital stress, non-performance of socio-emotional roles, infidelity, violence and embarrassment by the alcoholic were positively related to the wish to get divorced. Only the women who scored high on childhood shyness and who reported greater verbal abuse from their alcoholic husbands were less close to divorce than those who reported less verbal abuse (O'Farrel et al., 1981).

In another study Kogan, Fordyce and Jackson (1963) found that the wives of alcoholics tended to have higher anxiety index scores (on the MMPI) and generalized personality distress than the wives of non-alcoholics. No particular personality profile was found in either of the two groups. However the wives of the alcoholics did tend to show evidence of disturbances in overall personality functioning. Therefore, Kogan, Fordyce and Jackson (1963) concluded that there is no specific personality disorder in wives of alcoholics and that one should not speak of the ".wife of the alcoholic" (p.237).

Rae and Forbes came to a similar conclusion in 1966 when they administered the MMPI to 26 wives of alcoholics and their husbands, who were receiving treatment. They found that although the wives tended to show a 2-4 (depression and psychopathic deviate) profile it was not pathologically high and the profiles differed significantly. They concluded that a unitary concept of the personality of the alcoholic's wife is untenable.

Kogan and Jackson (1965) endeavoured to support the psychosocial hypothesis by proposing that the wife's personality affects and is affected by living with an alcoholic. They attempted to estimate the relative contributions of presumed preexisting personality traits and of current stress to the emotional disturbance of wives of alcoholics by comparing the personality disturbance among wives of sober alcoholics, active alcoholics and non-alcoholics. They found no significant differences

between the groups although the wives of drinking alcoholics tended to show more personality disturbance. They concluded that "...both personality and stress underlie the occurrence of emotional disturbance in wives in alcoholic marriages" (Kogan & Jackson, 1965, p.493).

In a further study Rae (1972) found that alcoholics who failed treatment tended to have wives with higher Psychopathic Deviate scores on the MMPI than the wives of successful patients. However, the wife's personality type as a prognostic indicator applied only to those marriages which had experienced employment instability and sexual disturbance. Rae (1972) concluded that "...a crucial variable in an alcoholic's prognosis is his wife's capacity appropriately to manage the marital difficulties consequent on his drinking behaviour, and this capacity may be determined by personality factors" (p.611).

It seems that although theorists and researchers in the above three approaches have attempted to find a particular description which would fit the spouse of the alcoholic, be it a personality style, coping style or both, little consensus has been achieved.

The following approach to the spouses of alcoholics moves away from looking only at the individual and considers the family of the alcoholic. It seems that the endeavour to understand the effects of alcoholism on the person(s) closest to him/her and vice versa has evolved from a simplistic unitary approach to a more complicated and multi-dimensional approach. It has evolved from simply looking at the personality of the spouse or the environment to both and the system as a whole.

2.2.4. SYSTEMS APPROACH

The systems approach to alcoholics and their spouses proposed that alcoholism is not an individual illness but that it is part of and significantly related to the family of the alcoholic. The essential feature here is that it is possible that alcoholism may

have adaptive consequences within the family (Davis, Berenson, Steinglass & Davis, 1974; Jacob, Favorini, Meisel & Anderson, 1978; Loughhead & Young, 1991; Meeks & Kelly, 1970; Steinglass, 1982; Vannicelli, Gingerich & Ryback, 1983; Orford, 1975; Wright & Wright, 1991).

Loughhead and Young (1991) stress that the family is the most significant influence in a person's life and that it plays a crucial role in the aetiology, treatment and recovery of alcoholism. Jacob et al. (1978) explain the adaptive consequences of alcoholism by hypothesising that problem drinking persists because it has homeostatic systems benefits. In other words it will be constantly (and perhaps unwittingly) reinforced in the family system. Consequently the family will play a major role in both the aetiology and maintenance of alcoholism, whereby the alcoholic may be the "scapegoat" of the family: "...the alcoholic member of the family might, through his or her drinking, be protecting the family from overwhelming depression or intolerable levels of aggression..." (Steinglass, 1982, p.131).

In accordance with the above, Meeks and Kelly (1970) proposed that the symptoms of alcoholism are better conceptualized as maintained by the disturbed interpersonal relationships within the family rather than only by the sick person/alcoholic.

However, although alcoholism may have adaptive consequences for the family it is clear that these are not necessarily positive. This is perhaps particularly the case for the person closest to the alcoholic, namely the spouse. Although the spouse might be part of the imbalance or dysfunction of the family, s/he is affected by it at the same time (Vannicelli, Gingerich & Ryback, 1983). Wilson (1982) suggests, in fact, that the family dysfunction may be both a cause and effect of alcoholic behaviour (in Erekson & Perkins, 1989). Steinglass (1981) argues that perhaps the manner in which the family members behave adaptively might determine the negative impact of alcoholism on the family.

Likewise, Wright and Wright (1991) highlight the negative consequences of alcoholism on the other family members, stating that the alcoholic may become the dominant influence affecting all the persons in the system and governing the operation of the system as a whole.

Interestingly Orford (1975) highlights the danger of discussing marital problems related to the alcoholism, without considering that these problems might be found in non-alcoholic marriages. He says that we should "...begin to see alcoholism in marriage not as a unique set of circumstances but as a set of circumstances which can be placed within a spectrum of events associated with marriage" (Orford, 1975, p.1541).

The systems approach has the implication that treatment must involve the whole family system. Therefore treatment of the addictive behaviour is not sufficient. Wright and Wright (1991) emphasise this by saying that the techniques used by the family to adapt to the alcoholism can often be repressive, personally stultifying and emotionally crippling. This would then have detrimental effects on the individual's personality. As a result Wright and Wright (1991) highlight the fact that persons who have been involved in a family system dominated by an addiction problem for a long time often experience emotional and interpersonal difficulties far beyond the confines of that system.

This systems approach emphasises the adaptive consequences of alcoholism in the family. The family may either reinforce the alcoholic behaviour, possibly without realizing it, so that the people closest to the alcoholic may need help themselves. Thus this approach stresses the fact that one treats all the significant people involved with the alcoholic.

2.3. CODEPENDENCY

We hence see that the experiences of spouses of alcoholics and how the spouse might possibly affect the alcoholism has been approached from a disturbed personality, stress, psychosocial and systems perspective. A fifth approach has emerged which attempts to conceptualize the behaviour of spouses of alcoholics (Morgan, 1991). This approach has generated the construct of codependency, the focus of this thesis.

The construct codependency was conceptualized by the wives of Alcoholics Anonymous members in the nineteen forties in an attempt to understand the behaviour of spouses of alcoholics and the effects of their behaviour. However, it was only defined in 1979 when a codependent was conceptualized as someone "...who had become dysfunctional as a result of living in a committed relationship with an alcoholic" (O'Brien & Gaborit, 1992, p.129).

According to Morgan (1991) only 20 articles were published on codependency before 1991 and although there seems to be an overabundance of definitions there is a lack of operationalized definitions and theoretical clarity (Morgan, 1991; O'Brien & Gaborit, 1992).

Codependency emerged in the chemical dependency field with the treatment of the families of alcoholics. It seems that the term has evolved from the word co-alcoholic. Co-alcoholism and codependency tend to be used interchangeably to describe the same construct. However, this thesis will adhere to Mendenhall's (1989) distinction between the two terms. He defines a "co-alcoholic" as a person who is in a committed relationship with an alcoholic, but who also suffers from the disease of alcoholism. The term "codependent" should refer to a person living in a committed relationship with an alcoholic but who is not suffering from the disease alcoholism (Mendenhall, 1989).

Apart from the numerous definitions of codependency it is apparent in the literature that although the term emerged in order to conceptualize, theorize and clarify the behaviour of spouses of alcoholics, it followed the same course of development as alcoholism as described in chapter 2.1. Codependency was viewed as a personality disorder and a coping style (Mendenhall, 1989). It has also been perceived as a syndrome (a combination of behaviours that are characteristic of a particular condition), a manner of relating and as part of an addictive process. Moreover, codependency has been conceived away from the chemical dependency field and is viewed as a separate entity which can occur without alcoholism (Fausel, 1988).

The construct codependency will be the main focus of this thesis and the different theoretical approaches to codependency will be outlined below as well as its aetiology and related research.

2.3.1. CODEPENDENCY: A WAY OF RELATING

This approach proposes that where there is a codependent relationship the needs of two people are met in dysfunctional ways (O'Brien & Gaborit, 1992). In the case of alcoholism the alcoholic's needs are met because he is protected from the consequences of his drinking and the wife's needs are met because the alcoholic needs her. As Codependents Anonymous propose, "...codependent people derive their sense of wholeness by receiving liking and approval from others and by solving the problems of, relieving the pain of, and protecting others" (O'Brien & Gaborit, 1992, p. 130). They tend to sacrifice their own values to be close to others and they tend to believe that the quality of their lives depends upon the quality of the lives of other people (Beattie, 1987, in Morgan, 1991; O'Brien & Gaborit, 1992).

Larson, (1987) perceives codependency as an inability to initiate or participate in a loving relationship due to self-defeating and learned behaviours (in Morgan, 1991).

The previous definitions seem to be similar to a dependent personality disorder. Millon (1981) describes dependent personalities as people who are in need of social approval and affection and who are willing to live according to the desires of others. Cermak (1984) recognized the similarity and defined codependency as a personality disorder.

2.3.2. CODEPENDENCY: A PERSONALITY DISORDER

This approach states that codependency is a personality disorder seen in people with a spectrum of stressful life experiences and, perhaps, most reliably seen in those who have been touched directly or indirectly by alcoholism (Cermak, 1984). As with other personality disorders it is an ingrained, inflexible and maladaptive pattern of perceiving, thinking and responding to the environment and oneself which causes either significant impairment in adaptive functioning or subjective distress (Cermak, 1984; DSM-III-R, APA, 1987; Millon, 1981). It is similar to the dependent personality disorder, but differs in the core conflict. The conflict in the dependent personality disorder centres on dependency versus autonomy. In codependency the core issue is control (over the alcoholic). Loss of control is what has to be avoided to control free-floating anxiety (Cermak, 1984).

Millon (1984) describes the dependent personality disorder as a pattern of behaviour in which the individual passively allows others to take full responsibility for significant life activities, a characteristic traceable to the person's lack of self-confidence and to doubts about the ability to function independently.

Cermak (1984) notes that codependency differs from the other personality disorders as it exists both on an individual and on a systems level. It has both intra and interpersonal dynamics and this poses a problem for precise definition. However, Cermak (1986, in Morgan, 1991) offers criteria for the codependent

personality disorder according to the DSM-III-R (APA, 1987) five axial system. He states furthermore, that the diagnosis can only be made when there is identifiable dysfunction. The criteria are:

A. Continues investment of self-esteem in the ability to control both oneself and others in the face of serious adverse consequences.

B. Assumption of responsibility for meeting others' needs to the exclusion of acknowledging one's own.

C. Anxiety and boundary distortions around intimacy and separation.

D. Enmeshment in relationships with personality disorder, chemically dependent, other co-dependent, and/or impulse disordered individuals.

E. Three or more of the following:

1. Excessive reliance on denial.

2. Constriction of emotions (with or without dramatic outburst)

3. Depression

4. Hypervigilance

5. Compulsions

6. Anxiety

7. Substance Abuse

8. Has been (or is) the victim of recurrent physical or sexual abuse

9. Stress-related medical illnesses

10. Has remained in a primary relationship with an active substance abuser for at least two years without seeking outside help (p.724/725).

According to Morgan (1991), the dependent personality disorder differs from the codependent personality disorder in that a codependent person believes that s/he can control the feelings and behaviours of others by sheer force of will. If they fail, they will either try harder or give up and feel hopeless and inadequate. Secondly, there is a confusion of identities,

namely, codependents rely on their partner's success or failure for their self-worth. If their partner is not happy, they feel responsible for making their partner happy. The defenses which they use are denial and rationalization. The codependent individual will reinforce immature defenses in others by mirroring them. In other words they will show the same immature defenses as the alcoholic (Morgan, 1991). In addition, they will tend to neglect themselves to the point of having little self-identity (Whitfield, 1989).

In contrast, a person with a dependent personality does not attempt to control the other person and feels unable to control their own and other's lives. A dependent person is not reliant on the other person for their sense of self-worth, although they do have a low self-esteem, but is reliant on the other person to take total responsibility for their own life. That is, they present as passive, submissive and compliant and need others to make decisions for them (Millon, 1981).

2.3.3. CODEPENDENCY: A COPING STYLE

This approach does not perceive codependency as an ingrained way of dealing with the environment and the self (personality disorder) but as a way in which a person attempts to cope with living with, and being close to an alcoholic, chemical dependent or person with another chronic impairment. Ill health and maladaptive or problematic behaviour results from this. This approach still professes that the codependent is maladaptively preoccupied with another person's life but declares it is stress-induced (Mendenhall, 1989; Whitfield, 1989).

Along the same lines, Wright and Wright (1991) propose that codependency may be a result of a "normal" person attempting to adjust to an extremely difficult partner and life situation and "codependent coping" is used to escape negative feelings (Prest & Storm, 1988, in O'Brien & Gaborit, 1992). It may not be inevitable when living with an alcoholic, but may just be one way

of making sense of an alcoholic marriage (Asher & Brissett, 1988). Thus, codependency possibly does not automatically result from living with an alcoholic, but perhaps develops if there is a predisposition to be dependent.

2.3.4. CODEPENDENCY: A SYNDROME

Some authors do not define codependency as a particular personality profile or coping style but give a description of particular behaviours which they state can be characteristic of the construct codependency (Fisher, Spann and Crawford, in press, in Wright & Wright, 1991; Loughhead, 1991; Potter-Efron & Potter-Efron, 1989; Schaef, 1986, in Fausel, 1988).

According to this approach, codependency is characterized by external referencing, relationship addiction, lack of boundaries in relationships, caretaking, physical illness, self-centredness (believing that everything that happens to a significant other is the result of something you did), over-control, distorted feelings, dishonesty, loosening of ties with reality, a low self-esteem, spiritually disconnected, possibly suicidal ideation, chronic approval and love seeking, fear and rigidity. In addition, the codependent person focuses solely on others, lacks open expression of feelings and attempts to derive a sense of purpose through relationships. Potter-Efron & Potter-Efron (1989) offer a description of and outline characteristics of codependency which could be used in the assessment of codependency:

A co-dependent is an individual who has been significantly affected in specific ways by current or past involvement in an alcoholic, chemically dependent, or other long-term, stressful family environment. Specific effects include: (a) fear; (b) shame/guilt; (c) prolonged despair; (d) anger; (e) denial; (f) rigidity; (g) impaired identity development; and (h) confusion (p.39).

They suggest that the alcoholic family represents the "context" in which codependency can be studied whilst considering the possibility that codependency may also occur in individuals caught in other long-term, highly stressful family environments. They go on to explain the above noted effects.

With the category fear (a), they refer to the unpredictability of life with an alcoholic which may cause fear (fear of a car accident, loss of job, violent outburst, etc). A constant feeling of fear may cause high anxiety, dread and an inability to trust due to continual betrayal by the alcoholic. As a reaction, over controlling behaviours can occur in an attempt to prevent possible disaster.

Shame and guilt (b) are often consequences of alcoholism, as alcoholism is considered by society to be a moral weakness. In order to avoid this humiliation the family may shy away from potential sources of support because they want to hide the dependency, causing the members to rely solely on each other.

Also, with codependency the person finds it difficult to distinguish between the self and the other, causing the codependent to feel ashamed about him/herself due to the behaviour of the alcoholic, as it is a reflection on their own behaviour. Similarly, they may feel guilty for causing the family pain and concentrate solely on their own shortcomings, neglecting the clear problems of others.

Furthermore, due to the painful environment many spouses become chronically angry with the alcoholic, their family, the world, God and themselves. They may blame themselves for continuing to live in the desperate situation, and this might possibly result in self-hatred.

To lessen the feelings of fear, shame and anger, denial is commonly used as a defense mechanism by the codependent. In addition, she/he may become rigid in an attempt to control the

confusion which they may be feeling. She/he may also become rigidly fixated on the alcoholic and his/her behaviour resulting in loss of self-identity.

Potter-Efron and Potter-Efron (1989) have developed a questionnaire based on the above characteristics of codependency which they argue can be used in the assessment of codependency. Further description of the characteristics is given in chapter 3.2.2.2. (page 44) as this questionnaire will be used in this thesis to assess codependency.

2.3.5. CODEPENDENCY: AN ADDICTIVE PROCESS

In this approach Loughead (1991) suggests that codependency might be the psychological dynamic underlying an array of addictive behaviours. Loughead (1991) states that they have similar physiological, attitudinal, and behavioural characteristics. He proposes that all addictions (codependency, alcohol addiction, drug abuse, eating disorders and sexual addiction) have the same purpose, namely to relieve psychic or social pain. Furthermore, the addicted usually has a low self-esteem, lacks a clear identity and has difficulty with interpersonal relationships and intimacy.

Likewise, all of the above addictions/disorders cause problems in the individual's life concerning his/her relationships and society at large. However the addicted often denies reality and uses the substance or behaviour to alleviate distress (Loughead, 1991).

Other authors (Mendenhall, 1989; Schaef, 1986, in Fausel, 1988) feel that codependency, chemical dependency, eating disorders etc. are outcomes of the same basic disease process - the addictive process.

It seems that with this approach, the spouse of an alcoholic who is codependent is subsumed within the disease category of addiction. Specifically, s/he is addicted to the person who is an alcoholic.

2.3.6. CODEPENDENCY: INDEPENDENT OF ALCOHOLISM

The following section focuses on whether codependency can be found without alcoholism or chemical dependency. Morgan (1991), Whitfield (1989) and Wright and Wright (1991) suggest that codependency may exist independently from alcoholism. For example, Whitfield (1989) defines codependency as "any suffering and/or dysfunction that is associated with or results from focusing on the needs and behaviour of others" (p. 19). Hence codependency could, theoretically, occur in any relationship. Wright and Wright (1991), however, provide the prerequisite that it can only occur in a dysfunctional home environment, for example where there is sexual abuse, child abuse, an obsessive-compulsive parent and/or mentally ill parent.

These authors introduce the question as to which environment and what processes cause codependency. According to Morgan (1991) "...it was often enough to grow up in a limiting family environment in which an abusive caregiver was often present" (p.721). The following section deals with this question in more detail.

2.3.7. CODEPENDENCY: WHO BECOMES CODEPENDENT?

It was first proposed that persons who lived in homes where there was drug or alcohol abuse were at risk of becoming codependent. However more recently it has been felt that it can occur in any relationship where there is inordinate concern for the well being of the other partner or parent resulting in the assumption of an excessive degree of responsibility for that partner or parent (Wright & Wright, 1991).

For example, codependency may start developing in childhood when a child believes that she/he is responsible for her/his needs not being met because her/his parent is inconsistent (alcoholic). It is perceived that they have done something wrong and they may sense that the parent needs to be taken care of at the expense of their own feelings and needs. The child believes this due to the fact that they are dependent on their parent for survival and thus need the parent to be well (Mendenhall, 1989).

As an adult, a person will try to cope with the drinking (or problem behaviour) with culturally acceptable methods of problem-solving. The aim is to reduce the pain of the spouse who is drinking (has the problem), to avoid crises resulting from the drinking (the problem) and to protect other family members from the problem. This can result in codependent behaviour whereby the excessive caretaking actually deprives the alcoholic of the awareness that alcohol is creating a problem (Mendenhall, 1989).

According to Wegsscheider-Cruse (1985, in Whitfield, 1989) the people who are especially vulnerable to becoming codependent are people who are in a love or marriage relationship with an alcoholic, who have one or more alcoholic parents or grandparents and/or grew up in an emotionally repressive family. He postulates that codependency originates from the repression of our inner life in order to protect ourselves from being hurt (by the person with the problem behaviour). This is, however, stressful and the long-term stress can in turn cause physical illnesses. He sees it as a "...category under which many, if not most, conditions (mental illness) can be subsumed.." (in Whitfield, 1989, p.29).

According to Loughhead (1991), Mendenhall (1989) and Subby (1984, in Morgan, 1991) the main characteristic of a family with an alcoholic or a family where codependency may develop, is that there is inconsistency and a set of oppressive rules which result in fear of the open expression of feelings as well as the direct discussion of personal and interpersonal problems. It can thus

occur in families where there is sexual abuse, an obsessive-compulsive parent, mentally ill parent, or in a rigid and emotionally repressive home environment (dysfunctional home environment). It is suggested that it evolves from being controlled by an authority figure who behaves in a dogmatic yet inconsistent and often punitive way (Wright & Wright, 1991).

2.3.8. CODEPENDENCY: RESEARCH REVIEW

In reviewing the literature, it was surprising to find only three research studies on codependency (to the knowledge of the author). This is quite remarkable if one considers that it was conceptualized as early as the nineteen forties even though it was only defined in 1979. It seems that the concept has been mainly based on clinical observations, anecdotal reports and hypotheses.

A possible reason why so little research has been done is that although there have been numerous definitions proposed, no real operational definition has been given. Moreover, as Morgan (1991) highlights, there seem to be three levels of meaning of the term codependency which would complicate the issue of research. Firstly, it is used as a didactic tool within the alcoholic family to help normalize feelings in the family and to help focus on their own dysfunctional behaviour. Secondly, it is used as a psychological concept to explain specific human behaviour and thus facilitate communication between professionals. Thirdly, codependency refers to a psychological disorder or disease entity which implies "...that a consistent pattern of traits and behaviours is recognizable across individuals and that these traits and behaviours can create significant dysfunction" (Cermak, 1986, p.3, cited in Morgan, 1991, p. 722).

In addition, Morgan (1991) notes the difficulty of researching codependency by proposing that it belongs to a category of psychological concepts that encompasses both intra-psychic and interpersonal dynamics.

The three research studies that have been conducted are reviewed hereafter:

Prest and Storm (1988) completed a pilot study to compare the current dyadic relationships of compulsive eaters and drinkers. Specifically their interactional patterns and codependent nature were studied. They note from the literature that both compulsive eating and drinking are behaviours which are used to "...avoid feelings and dealing with emotional pain, including boredom, depression, anxiety, frustration, loneliness, anger, sadness, inadequacy and embarrassment" (p.340). This often results in feelings of guilt, shame, remorse, self-loathing, fear of discovery, denial, depression and physical addiction. According to Prest and Storm (1988), the spouse in a relationship with the above person might experience such symptoms as anxiety, depression, insomnia, eating disorders, suicidal gestures and possibly even alcoholism.

In their study they found that the compulsive drinkers, eaters and their spouses all showed a high incidence of compulsive behaviour. This suggests that the spouses as well as the compulsive patients could have come into the relationship with previously developed compulsive behaviours, possibly originating in their families of origin. All of the index patients (binge-eaters and alcoholics) reported often feeling controlled, judged, deprived and /or guilty. Eighty percent of the spouses appeared to only focus on how to cure the patient's condition whilst ignoring communication and sharing. They also predominantly exhibited helping behaviours of the type which enable the compulsive behaviour. Thus they did not allow the index patients to take responsibility for the manner in which they ate or drank.

They continued to deny other problems underlying and contributing to the maintenance of the compulsive behaviour (Prest & Storm, 1988).

The compulsive behaviour included hiding the index patient's behaviours from friends and family, keeping secrets, not talking about the behaviour, consuming less of a specific type of food or alcohol, consuming less overall in order to set an example, encouraging or insisting on exercise (only by the compulsive eating spouses) and insisting on abstinence.

Elements of the construct codependency were found in both groups (spouses of alcoholics and binge eaters), namely such enabling (facilitating the problem) behaviours as having difficulty communicating, having difficulty in resolving conflicts and in dealing with feelings. Prest and Storm (1988) concluded that the couple's relationship

...seems to affect and, in fact, perpetuates the compulsive behaviour, in turn, the index patient's and spouse's compulsive behaviours, as a means of coping with problems and feelings, seem to feed into the couple's manner of relating; and the enabling behaviours of the spouse contribute to, rather than solve the problem (p.348).

Furthermore, the couple tend to organize much of their interaction around the compulsive behaviour of the index patient. Due to the above findings, Prest and Storm (1988) advocated the redefinition of the construct of codependency to include a systemic and interactional view.

In 1988 Asher and Brissett extrapolated a description of codependency from research they conducted with fifty two wives of alcoholics. They examined how the wives defined alcoholism, their own identity and life-style. It was a retrospective exploratory study.

They found that there were two common definitional terms of codependency:

1. It was viewed as a form of caretaking and pleasing others.
2. It was conceptualized as an affliction resulting from the association with a chemically dependent person.

However there was lack of consensus concerning codependency in the following:

- (1) whether codependency involves a substantial alteration of one's self,
- (2) whether codependency is an innate personal characteristic or a learned social role,
- (3) whether codependency is unique to alcohol-complicated relationships,
- (4) whether codependency is a disease, and
- (5) whether codependency is a temporary or permanent condition (Asher & Brissett, 1988, p.346 /347).

In the third study, O'Brien and Gaborit (1992) systematically explored the nature of codependency by conceptualizing it as a disorder that exists independently of chemical dependency.

They hypothesized that codependency would show no correlation with chemically dependent significant others and that codependents would be more depressed than non-codependents.

Codependency was measured with the Codependency Inventory (CDI, O'Brien & Gaborit, 1992) and depression with the Beck's Depression Inventory (BDI; Beck, 1967; Beck, Ward, Mendelson, Mock & Erbaugh, 1961, in O'Brien & Gaborit, 1992). Their sample consisted of one hundred and fifteen undergraduate students. No relationship was found between codependency and depression, though people who were in a relationship with a chemical dependent tended to be more depressed. Also, the correlation between the scores on the CDI and the Significant Other's Drug Use Survey (SODS) was not significant indicating that codependency is independent of chemical dependency.

In a factor analysis of the codependency scale, five useful characteristics of codependency were found:

1. Care taking; a need to solve problems of, protect and please others in order to gain a sense of self-worth.
2. External locus of control/ other-referencing; placing interests of others ahead of their own and shaping their lives around others.
3. Surrendering the self in order to connect with others in relationships.
4. Faulty communication skills; assuming things rather than asking.
5. Lack of autonomy; gaining self-esteem through the approval of others.

O'Brien and Gaborit (1992) concluded that codependency is useful in describing certain characteristics and that codependency has characteristics that appear in "normal" or healthy people, but can become problematic when these characteristics start to rule the relationships with others. Also, that "...it is possible that depression may be part of codependency only in those cases in which there is a relationship with a chemically dependent significant other or when the disorder has progressed substantially " (O'Brien & Gaborit, 1992, p.134).

2.3.9. CONCLUSION

In summary, codependency describes the occurrence of a pathological (although this is questioned) dependence on another person to the exclusion of the self. The core characteristics appear to be:

- "frozen feelings" and lack of spontaneity;
- a need to be needed;
- a need to be in control, including an urge to change and control others;
- a willingness to suffer and behave self-sacrificially;
- an exaggerated need for approval from others;

- an inability to maintain clear boundaries between self and significant other;
- fear of abandonment;
- an excessive reliance on denial;
- difficulty trusting;
- difficulty handling conflict;
- depression;
- functional or psychosomatic illness;
- family violence or neglect;
- difficulty giving and receiving love.

According to the literature it seems that the construct codependency is either described as a way of relating, a personality disorder, a coping style, a syndrome, or an addictive process. Wright and Wright (1991), seem to be the first who abandon this unitary approach to codependency by proposing that codependency can be both endogynous and exogynous.

The endogynous codependent harbours internalized attitudes, self-perceptions, and characteristic modes of relating that predispose her/him to become involved in and to maintain relationships with addicted or similarly dysfunctional partner. Exogenous codependency follows a pattern of relationship development along lines that we have described as consistent with the symbolic interactionist approach. [The development of one's generalized conception of self as the product of one's history of interactions with significant others in a wide variety of role relationships.] That is, an individual with essentially **healthy** attitudes and self-perceptions becomes involved with an addicted or similarly dysfunctional person whose problems were not obvious at the onset of the relationship. Codependent forms of relating emerge as the individual attempts to adjust to the difficulties associated with the partner and with the relationship (p. 442/443).

As noted, however, there remains little consensus about the exact conceptualization of codependency, although there is growing consensus that it can occur outside the chemical dependency field. This indicates that codependency might be found across a spectrum of conditions where there is a relationship between two people.

In addition, it is not clear as to how it would affect the behaviour of, for example, the alcoholic. According to different authors it is an enabling behaviour, so one would assume that if the spouse of an alcoholic is codependent, that this would reinforce the drinking of the alcoholic. This question is one of the central points of investigation in this thesis. This will be further delineated in the next chapter.

2.4.CONCLUSION AND RATIONALE FOR INVESTIGATING CODEPENDENCY

As noted earlier, very little research has been done with reference to the construct codependency. In addition, the numerous definitions have contributed to the confusion and lack of consensus regarding the construct. According to Cermak (1986, in Morgan, 1991) codependency will remain confined to clinical impressions if reliable and valid research data is not gathered.

Thus, systematic research in this field is essential, firstly, to clarify the construct and secondly, to investigate the effects of codependency. Also, there is a need to explore the degree to which codependency occurs in spouses of alcoholics.

It is important to investigate the above as it will influence the treatment of alcoholism. It will, for example, be crucial to involve the spouse of an alcoholic in treatment particularly if she is codependent.

This thesis will attempt to investigate the construct of codependency and how it affects the alcoholism. The aim of the research will be delineated in the next chapter.

3. EXPERIMENTAL DESIGN AND METHOD

3.1. AIM, QUESTIONS AND HYPOTHESES

This study is exploratory in nature given the status of the current research and literature on codependency. The broad aim of this study is to investigate whether the construct codependency can be found in spouses of alcoholics and whether there is any relationship between codependency and the level of alcoholism in the alcoholic spouse.

The theory would predict that codependent spouses will enable or maintain the drinking of the alcoholic because they use the same defense mechanisms as the alcoholic and that they protect the alcoholic from the consequences of his/her drinking (Wright & Wright, 1991). It is therefore expected that alcoholics who have codependent spouses will show a higher level of alcoholism.

The Codependency Assessment Questionnaire (CAQ, Potter-Efron and Potter-Efron, 1989) will be used to measure codependency. This questionnaire was chosen due to its availability and the fact that it seems to assess all the hypothesized main characteristics (fear, shame, guilt, prolonged despair, anger, denial, rigidity, impaired identity development and confusion) of codependency identified by the various authors. Since there is no normative data available concerning this questionnaire (Morgan, 1991), the reliability will also be investigated. The Michigan Alcoholism Screening Test (Selzer, 1971) will be used to detect the level of alcoholism of the alcoholic as it is a quantifiable, structured, self-report questionnaire.

In addition, it is hoped that this study might indicate whether codependency is a personality profile/disorder or a coping style.

Folkman and Lazarus's (1980) definition of coping will be used as they provide one of the most comprehensive questionnaires (Ways of Coping Checklist), which measures both behavioural and

cognitive strategies of coping with stressful episodes (Vingerhoets & Flohr, 1984). Two coping styles are distinguished, namely problem-focused, help-seeking and emotion-focused coping.

Personality is conceptualized in terms of Millon's (1981) bio-social-learning theory. Millon (1981) defines personality as an ingrained and habitual way of psychological functioning emerging from childhood. Millon (1981) derived eight basic personality coping patterns (schizoid, avoidant, dependent, histrionic, narcissistic, antisocial, compulsive, passive-aggressive) and three severe personality disorders (borderline, paranoid, schizotypal) according to the nature (positive or negative) and the source (from self or others) of behaviour as well as whether it is passive or active. These personality patterns correspond closely to the personality disorders in the DSM-III-R (APA, 1987). In addition, he has also defined symptom states (e.g. anxiety, dysthymic, alcohol abuse, etc.) which are situationally reactive and represent manifestations of a pathological process (Millon, 1983).

Millon (1983) developed a self-report questionnaire which will be used to assess the personality of both the spouse and the alcoholic. The aim is to investigate whether codependency is in any way related to a particular personality profile of the spouse or the alcoholic. According to the theory, codependents are dependent on the alcoholic for their self-esteem and tend to have symptoms such as depression, anxiety and physical illness. It is therefore expected that spouses who are codependent will score higher on the dependency, dysthymic, anxiety and somatoform scales of the Millon Clinical Multiaxial Inventory (MCMI, 1983).

Likewise, it is expected, as the theory postulates, that the codependent spouse will have a lower self-esteem than the non-codependent spouses. Self-esteem will be measured by the Self-Esteem Inventories (SEI), designed by Coopersmith (1987).

Most of the research concerning spouses of alcoholics has concentrated on women (see chapter 1 and 2). This study likewise focuses mainly on male alcoholics and their spouses (women) as this will allow for some comparison with previous studies.

The literature gives rise to a series of research questions. These as well as the hypotheses for this study are outlined hereafter.

QUESTIONS

1. Does codependency as defined by Potter-Efron and Potter-Efron (1989) and measured by the Codependency Assessment Questionnaire (CAQ, Potter-Efron & Potter-Efron, 1989) occur in a sample of spouses of alcoholics?
2. How is codependency, found in the spouses of alcoholics, related to the level of alcoholism or amount of drinking of the alcoholic as measured by the Michigan Alcoholism Screening Test (MAST, Selzer, 1971)?
3. What is the reliability of the Codependency Assessment Questionnaire (Potter-Efron & Potter-Efron, 1989)?
4. Given that two positive scores on any five sub-scales yield a codependent diagnosis, do all sub-scales of the CAQ contribute to this diagnosis?
5. How are the different sub-scales of the CAQ related to the level of alcoholism as measured by the MAST?
6. Do spouses who are codependent show a particular coping style as measured by the Ways of Coping Checklist (Folkman & Lazarus, 1980)?

7. Do spouses who are codependent show a particular personality profile as measured by the Millon Clinical Multiaxial Inventory (MCMI, Millon, 1983)?
8. Is codependency related to a particular personality profile of the alcoholic as measured by the MCMI (1983)?
9. Is codependency related to a particular coping style of the alcoholic as measured by the WCC (1980)?
10. Is codependency related to a history of alcoholism in the family of origin?
11. Does codependency affect the amount of alcohol consumption of the spouse who is codependent?
12. Do the alcoholic spouses of codependents have a longer drinking problem history than the alcoholic spouses of non-codependents?
13. Do codependent spouses and non-codependent spouses show a different level of self-esteem as measured by the Self-Esteem Inventories (SEI, Coopersmith, 1987)?
14. Is there a difference in the frequency of treatment requests between codependent and non-codependent spouses?
15. Will non-codependent spouses commit their alcoholic spouses for treatment more than codependent spouses?

HYPOTHESES

1. Codependency as measured by the CAQ does occur in spouses of alcoholics.

2. The alcoholics whose spouses are codependent will show a higher level of alcoholism as measured on the MAST than the alcoholics with non-codependent spouses.
3. The total positive scores (yes answers) on the CAQ will be positively related to the level of alcoholism as measured by the MAST.
4. Alcoholics whose spouses are codependent will have been drinking for a longer period than alcoholics with non-codependent spouses.
5. Codependent spouses will have requested professional treatment fewer times than non-codependent spouses.
6. Alcoholics with codependent spouses will consume more alcohol than alcoholics with non-codependent spouses.
7. Codependent spouses will commit their alcoholic spouses to a treatment centre less than non-codependent spouses.
8. Codependent spouses are more likely to have had alcoholics in their family of origin.
9. Codependent spouses will show higher scores than the non-codependent spouses on the following scales of the WCC(1980):
 - wishful thinking/escape,
 - acceptance,
 - emotional withholding,
 - self-blame.
10. Codependent spouses will show lower scores than the non-codependent spouses on the help-seeking and problem-focused scales of the WCC (1980).

11. Codependent spouses will show higher scores than the non-codependent spouses on the following scales of the MCMI (1984):
 - avoidant (2),
 - dependent (3),
 - passive-aggressive (8),
 - anxiety (A),
 - dysthymia (D).

12. Spouses who are codependent will drink less than spouses who are non-codependent.

13. Spouses who are codependent will show a lower level of self-esteem than spouses who are non-codependent.

3.1.1. SAMPLE

Forty-six married couples including couples who were living together, were approached in two different treatment centres for alcoholism in the Province of Natal (Republic of South Africa): 24 couples in the Lulama Treatment Centre (a division of the South African National Council for Alcoholism and Drug Dependence (SANCA) and 22 couples in The Newlands Park Centre (a drug and alcohol rehabilitation centre of the Department of Health Services and Welfare, administrated by the House of Delegates).

At the Lulama treatment centre, 18 of the 24 couples completed the questionnaires fully and at the Newlands Park Centre 19 of the 22 couples. Thus 9 couples were excluded. Of the remaining 37 couples, there were two couples where the wife was the alcoholic (one from each centre). Some of the demographic variables concerning this sample, such as age, length of marriage, standard of education and the amount of alcohol consumed per week (in ml.) are outlined in tables 1 and 2.

TABLE 1: DEMOGRAPHIC VARIABLES 1.

| DEMOGRAPH. VAR. | LULAMA | | NEWLANDS | | RANGE |
|-----------------|---------|-------|----------|-------|--------|
| | A | B | A | B | |
| AGE | 46.79 | 43.94 | 42.28 | 39.33 | 23-63 |
| MARRIAGE LTH. | 20.05 | - | 16.00 | - | 1-39 |
| ED. STANDARD | 8.32 | 8.84 | 5.50 | 5.56 | 1-10 |
| NR/YRS/DRINK | 8.72 | 8.79 | 7.89 | 9.28 | 1-28 |
| AMOUNT ALC/WK | 1421.37 | 45.53 | 1273.63 | 17.00 | 0-7218 |

A = Alcoholic S = Spouse

ED. STANDARD = years of completed school education

NR/YRS/DRINK = Number of years of having a drinking problem

AMOUNT ALC/WK = Amount of alcohol in ml. consumed per week

The number of years of drinking refers to the number of years of drinking according to the alcoholic (alcoholic's column), and the spouse's estimation of the number of years that the alcoholic has had a drinking problem (spouse's column).

TABLE 2: DEMOGRAPHIC VARIABLES 2.

| DEMOGRAPH. VAR 2 | | | | | |
|----------------------|----|---|----|---|-------|
| FREQUENCY | A | S | A | B | TOTAL |
| MARRIAGE | | | | | |
| MARRIED | 12 | | 14 | | 26 |
| DIVORCED/REMAR. | 6 | | 3 | | 9 |
| LIVING TOGETHER | 1 | | 1 | | 2 |
| VOLUNT / COMM | | | | | |
| VOLUNTARY | 19 | | 5 | | 24 |
| COMMITTED | 0 | | 13 | | 13 |
| RACE | | | | | |
| WHITE | 18 | | 1 | | 19 |
| INDIAN | 1 | | 14 | | 15 |
| COLOURED | 0 | | 3 | | 3 |

| | | | | | |
|-----------------------|----|----|----|----|----|
| TERTIARY EDUC. | | | | | |
| NONE | 11 | 15 | 16 | 17 | 59 |
| UNIVERSITY | 2 | 2 | 1 | 0 | 5 |
| DIPLOMA | 5 | 1 | 1 | 1 | 8 |
| OTHER | 1 | 1 | 0 | 0 | 2 |
| OCCUPATION | | | | | |
| UNEMPLOYED | 0 | 2 | 3 | 5 | 10 |
| LABOURER | 6 | 1 | 9 | 8 | 24 |
| BLUE COLLAR | 10 | 14 | 5 | 5 | 34 |
| WHITE COLLAR | 2 | 1 | 0 | 0 | 3 |
| PROFESSIONAL | 1 | 1 | 1 | 0 | 3 |
| TREATMENT | | | | | |
| NIL | 0 | 3 | 0 | 3 | 6 |
| ONCE | 17 | 8 | 6 | 1 | 32 |
| TWICE | 2 | 2 | 9 | 6 | 19 |
| THREE | 0 | 4 | 1 | 5 | 10 |
| FOUR | 0 | 2 | 2 | 2 | 6 |
| FIVE | 0 | 0 | 0 | 1 | 1 |
| FAMILY PROBLEM | | | | | |
| NO ONE | 8 | 17 | 7 | 10 | 42 |
| FATHER | 3 | 2 | 7 | 2 | 14 |
| MOTHER | 3 | 0 | 1 | 1 | 5 |
| BROTHER | 2 | 0 | 2 | 4 | 8 |
| GRANDPARENT | 1 | 0 | 0 | 0 | 1 |
| UNCLE | 2 | 0 | 1 | 1 | 4 |

A = Alcoholic S = Spouse

TREATMENT = Frequency of having requested treatment or professional help for the alcoholism

BLUE COLLAR = Typist, motor mechanic, shop assistant etc.

WHITE COLLAR = Sales representative, manager, accountant clerk etc.

FAMILY PROBLEM = History of alcoholism in family of origin.

3.1.1.1. The Two Treatment Centres

The Lulama Treatment Centre provides in-patient and out-patient treatment for alcohol and drug dependence. The patient must be motivated and the treatment involves both the significant others and the family of the patient. They do not accept patients who suffer from other mental illnesses, for example, schizophrenia.

The treatment programme has a duration of three weeks in which the patients receive: individual therapy, group therapy, occupational therapy, family therapy, spiritual groups, medical lectures, education videos and relaxation sessions. After the in-patient treatment they provide an aftercare programme consisting of groups once a week and if needed, individual therapy. Patients are admitted on a voluntary basis.

The Newlands Park Rehabilitation Centre provides for both voluntary and committed patients. The treatment programme for the voluntary patients is four weeks long and for the committed patients it is 13 weeks in duration or longer, depending on the progress the patient is making. A person can be committed to the treatment centre by the courts due to a criminal act or by a concerned family member. The alcoholic is committed with the help of a social worker. A committed alcoholic does not pay for the treatment.

There are five phases in the treatment, the first of which consists of detoxification in the hospital of the centre. The remaining four phases contain courses in education, assertiveness training, stress-management, problem-solving, relationships and relapse prevention. The family is always seen by a social worker and if necessary, family and/or marital therapy are commenced.

All race groups and both sexes are accepted in the two treatment centres.

3.1.1.2. Sampling Procedure

At the Lulama Treatment Centre the patients were approached in their first week of treatment by their therapist. It was explained to them that research was being conducted concerning the problems experienced by both the alcoholic and their spouse in order to possibly improve the treatment of alcoholics (appendix 1).

If the patient and his/her spouse were willing to participate, they were met by the researcher and were asked to complete the questionnaires provided (see instruments 3.2.). If requested, feedback would be given to the couple (this was requested by two couples).

At the Newlands Park Centre patients were approached with the help of the staff during visiting times on weekends. Feedback was given to one couple at this centre.

3.2. INSTRUMENTS

3.2.1. DEMOGRAPHIC VARIABLES QUESTIONNAIRE

A demographic and biographical questionnaire was used (Joubert, undated, unpublished) for the alcoholics (appendix 2) and a similar one was drawn up for their spouses (appendix 3). These questionnaires include, for example, items referring to the marital status, age, length of marriage, level of education, occupation, number of treatments, amount of alcohol use (in ml.), whether drinking is a problem and the reason for the drinking. Both the alcoholics and the spouses are asked what they think the reason is for the alcoholism. The history of drinking problems in the family of origin is also explored.

The assessment of the amount of alcohol drunk on average per week, follows the SANCA method (H.F. Joubert, personal communication, June 1992). This relies on the alcoholic's estimate of the number of consumptions of beer, wine and spirits per day. Alcohol consumption is then calculated by multiplying the amount consumed (beer, wine or spirits in ml.) by the percentage of alcohol in the beverage. For beer, one consumption is 340 ml. x 0.05%, for spirits a consumption is 25ml. x 0.42% and for wine a consumption is 142ml. x 0.12% (H.F. Joubert, personal communication, June 1992). For example, if a person drinks on average 1.5 bottles of wine a day and 4 tots of gin

this would be: 1075ml. x 0.12% x 7 days + 100ml. x 0.42% x 7 days
= 1197ml. of alcohol consumed in a week.

3.2.2. CODEPENDENCY ASSESSMENT QUESTIONNAIRE (CAQ)

(Potter-Efron & Potter-Efron 1989)

The CAQ is a questionnaire consisting of 34 questions with yes/no answers. The questionnaire consists of eight sub-scales which assess the following codependent traits; fear, shame, prolonged despair, rage, denial, rigidity, impaired identity and confusion. Each have their own number of questions ranging between three to six (appendix 4).

3.2.2.1. Scoring of the CAQ

According to Potter-Efron and Potter-Efron (1989) a person is scored codependent if they have been exposed to a long-term stressful environment, namely living with an alcoholic, chemically dependent person or for example, with someone suffering with a long-term psychiatric or physical illness. In addition, they must show at least five of the characteristics. A person is attributed a characteristic if there are at least two positive responses to two questions on that characteristic.

3.2.2.2. CAQ Sub-Scales

Questions concerning Fear, for example, refer to persistent anxiety and feelings of dread, avoidance of interpersonal risk and controlling behaviour which is repeated and habitual.

The characteristic Shame and Guilt is indicated by symptoms such as persistent feelings of shame related both to own behaviour and behaviour of others, persistent feelings of guilt about the problems of others and isolation from others in order to hide family or personal shame.

Prolonged Despair is indicated for example by despair and hopelessness about changing the current situation, a pessimistic view of the world and a low self-worth and sense of failure that does not reflect the individual's accomplishments.

Rage is reflected by persistent feelings of anger directed toward the user, family or self, fear of loss of control if the individual becomes angry, and passive-aggressive behaviour, especially toward the alcoholic.

Denial is indicated by consistent denial, consistent minimization of the severity of the problem and using justifications which protect the user from negative consequences of the drinking.

With Rigidity Potter-Efron and Potter-Efron (1989) refer to aspects such as cognitive inflexibility, behavioural inflexibility, affective inflexibility and the persistence of singular feelings such as guilt, pity and/or anger.

Impaired Identity development refers to the inability to make claims for oneself or to take care of one's own needs, boundary separation difficulties, person dependency, needing others to validate self-worth and fear of being alone.

Lastly, Confusion is indicated by persistent uncertainty about what is normal and real, indecisiveness and a tendency to identify all feelings as one and the same feeling.

3.2.3. MICHIGAN ALCOHOLISM SCREENING TEST (MAST)

(Selzer, 1971)

The Michigan Alcoholism Screening Test (Selzer, 1971) was developed to provide a consistent, quantifiable, structured interview instrument for the detection of alcoholism. It focuses on the control of alcohol intake, medical, legal and psychosocial problems and the involvement with helping agents with reference

to excessive drinking (Selzer, 1971; Selzer, Vinokur & van Rooijen, 1975; Zung, 1982; Zung & Charlampous, 1975).

It originally consisted of 25 questions to which one can answer yes or no. For example: "Do you feel you are a normal drinker?" In 1975 Selzer et al. modified the questionnaire to a 24 item questionnaire and investigated its use as a self-administered questionnaire. They found an internal consistency (reliability) of .95. With regard to validity, coefficients were found ranging from $r = 0.79 - 0.90$. For this validation they used a known alcoholic group and a non-alcoholic group as the criterion groups and a product moment correlation was computed between the total MAST score and the criterion group membership score (1 or 2). In addition, they found that the reliability and validity figures seemed to be relatively unaffected by age and the tendency to deny socially undesirable characteristics. To decrease the amount of false positives of this screening test, Selzer et al. (1975) recommended the following scoring format: "0-4 points for a non-alcoholic score, 5-6 points suggestive of alcoholism (except for a positive response to questions 8, 19 or 20 which are diagnostic), and 7 or more points as indicating alcoholism" (p.122). (Selzer et al. (1975) use the term "diagnostic" to indicate that a positive response to questions 8, 19 or 20 (appendix 5) is indicative of alcoholism.)

The questionnaire provides a total score of the level of alcoholism by adding the scores of all the questions (appendix 5). A maximum score of 53 can be obtained.

Zung (1982) found a high retest reliability ranging from .86 to .90 and an internal consistency reliability ranging from .83 to .91. He found that it was able to detect 88% of the people with alcohol related diagnoses but there was only 58% agreement between the MAST and the psychiatric diagnosis. Zung (1982) stresses that the current MAST screens for life-time problems and not for current problems. Zung (1982) found that the latter is possible if additional questions are added to the MAST, focusing

on the specific time period.

In this study the modified MAST of Selzer et al. (1975) will be used as the aim is to measure the overall level of alcoholism (appendix 5).

3.2.4. WAYS OF COPING CHECKLIST (WCC)

(Folkman and Lazarus, 1980)

Folkman and Lazarus (1980) developed the ways of coping checklist (68 questions: 24 problem-focused, and 40 emotion-focused) for their research on coping. It is a self-report questionnaire with yes/no answer categories.

A factor analysis of the ways of coping checklist produced seven coping factors: one problem-focused, one mixed and five emotion-focused (minimizing threat, using wishful thinking, seeking emotional support, blaming self, and interpreting opportunities for personal growth) (Folkman & Lazarus, 1980). The factor which showed the most consistency over 12 months was the personal growth factor (0.467).

According to Folkman and Lazarus (1981), the WCC checklist measures coping at a concrete behavioural level. However they point out the fact that coping is situationally determined as: "We can study coping consistency at a concrete behavioral level with the full expectation that people will act differently in different contexts because for them to do otherwise would be inappropriate and/or ineffective" (Folkman & Lazarus, 1981, p.458).

With the Ways of Coping Checklist, Vingerhoets and Flohr (1984) found six factors with eigenvalues above 2.0. Varimax rotation gave the following factors; wishful thinking/escape (.83), acceptance (0.67), problem-focused/help-seeking (0.64), withholding (0.59), self-blame (0.71), growth (0.72) which were based on loadings greater than 0.35. (The numbers in brackets

are the reliabilities of the scales made up of WCC items). These factors are well interpretable and explained 34.7 per cent of the variance (Vingerhoets & Flohr, 1984). With the use of the above scales, the WCC became slightly shorter, consisting of 60 items.

In 1987 Eagle indicated that the problem-focused/help-seeking scale incorporated two different coping styles. The former referring to coping strategies related to direct cognitive or behavioural problem-solving efforts and the latter refers to specific help-seeking activity. As a result Eagle (1987) developed a 4-item scale with reference to the help-seeking behaviour, so that a comparison could be made between the other scales and the help-seeking scale alone. The following reliabilities (Cronbach's alpha corrected for the number of items) were found in Eagle's (1987) study: wishful thinking/escape (0.784); acceptance (0.647); problem-focused/help-seeking (0.392); emotional withholding (0.603); self-blame (0.590); growth (0.680); help-seeking (0.698).

3.2.4.1. WCC Sub-Scales

Wishful thinking/escape (15 items, emotion-focused coping) refers to cognitive efforts made to try to escape from, or alleviate emotional discomfort with strategies such as denial, wishful thinking, sleeping more etc.

Acceptance (12 items, emotion-focused) refers to the acceptance of stress or stressful situations after they have occurred. The scale has both cognitive and emotional strategies which attempt to decrease the effects of the stress. (In this scale three items are scored in the reverse direction as they are negatively correlated to acceptance.)

Problem-Focused (14 items, problem-focused) refers to attempting to change or act on the source of the problem. Items are included which pertain to seeking advice, finding alternative solutions and behavioural action.

Emotional Withholding (10 items, emotion-focused) concerns attempts made to control anxiety through the inhibition of emotional pain. It refers to an unwillingness to obtain or accept emotional support from others (being independent), or to express feelings of vulnerability or dependence. (With this scale five items are scored in the reverse direction as they are negatively correlated to emotional withholding.)

Self-Blame (9 items, emotion-focused) reflects the tendency to blame or criticise oneself in stressful situations as one feels one is not able to cope with the situation. The items illustrate a dissatisfaction with one's coping abilities and a wish to be more assertive and stronger.

Growth (7 items, emotion-focused) indicates the tendency to attempt to control the effects of the stressful situation by controlling the meaning of the problems by looking at possible growth and creative potential of stressful situations.

Lastly, Help-seeking (4 items, problem-focused) refers to efforts which are made towards others to receive information and assistance.

In this study, Eagle's (1987) version of the WCC will be used (appendix 6).

3.2.5. MILLON CLINICAL MULTIAXIAL INVENTORY (MCMI) (Millon, 1983)

The MCMI was chosen as the instrument to assess the subject's personality as it was developed to reflect the DSM-III (1980) diagnostic categories of personality disorders/syndromes. It distinguishes between the more enduring personality characteristics (Axis II) and the acute clinical disorders which patients may display (Axis I). Another advantage is that it is shorter than comparable instruments, consisting of only 175 items. It can thus be completed in approximately 20 minutes.

The normative data and transformation scores for the MCMI are based solely on clinical samples and it is only applicable to persons who evidence symptoms or are engaged in a programme of professional psychotherapy or psychodiagnostic evaluation.

3.2.5.1. Administration

The MCMI consists of a self-report questionnaire booklet and an answer sheet with a true or false answer choice. Once the questionnaire has been completed the answers are marked according to the 20 different scales of the instrument. There are three different categories of scales: the Basic Personality Pattern (Axis II) Scales, the Pathological Personality Disorder Scales, and the Clinical Symptom Syndromes (Axis I) Scales. (appendix 8).

3.2.5.2. MCMI Sub-Scales

The Basic Personality Scales reflect relatively enduring and pervasive traits that are characteristic of the person's styles of behaving, perceiving, thinking, feeling and relating to others. There are eight different scales: (1) schizoid, (2) avoidant, (3) dependent, (4) histrionic, (5) narcissistic, (6) antisocial, (7) compulsive and (8) passive-aggressive (appendix 8).

The Pathological Personality Disorder Scales indicate a chronic or periodically severe pathology in the overall structure of personality and consist of three separate scales: (S) schizotypal, (C) borderline and (P) paranoid (appendix 8).

With the Clinical Symptoms Syndromes Scales, symptom disorders, of the reactive kind, are described. These are of substantially shorter duration than the personality disorders. There are 9 different scales: (A) anxiety, (H) somatoform, (N) hypomanic, (D) dysthymic, (B) alcohol abuse, (T) drug abuse, (SS) psychotic thinking, (CC) psychotic depression, and (PP) psychotic delusions (appendix 8).

In addition to the 20 scales, a validity index (V) detects people who failed to cooperate, did not understand the items or were too disturbed to answer relevantly. A weight factor moderates the effects of excessive degrees of defensiveness and self-enhancement or emotional complaining and self-depreciation.

The MCMI provides raw score - BR score equivalents for white males and females, black males and females and hispanic males and females. These equivalents are based on the American population. In this study only the norms of the white population will be used so that any differences found will not be due to differences in norms. This is nevertheless problematic as a South African Population will be scored according to American norms due to South African norms not being available.

3.2.6. SELF-ESTEEM INVENTORIES (SEI) (Coopersmith, 1987)

The Self-Esteem Inventories (adult form, appendix 9) is a questionnaire consisting of 25 items with an answer category of like me or unlike me. Coopersmith (1987) defines self-esteem as "...the evaluation a person makes and customarily maintains of him- or herself" (p. 1). The SEI measures the evaluative attitudes of a person toward him/herself in social, academic and personal areas. The adult form is based on the school form which has been extensively researched (Coopersmith, 1987). The test-retest reliability for the adult form is .80 for men, and .82 for women (researched in a study done with 103 college students). Norms were also found in a study done with 226 college students (appendix 10).

3.3. DATA ANALYSIS

The main aim in this survey study is to compare the alcoholic couples where the spouse is not codependent, and the alcoholic couples where the spouse is codependent. In addition, the relationship between the spouse being codependent or not and the level of alcoholism in the alcoholic will be investigated. Also,

this study will research the relationship between codependency, personality, coping styles and self-esteem.

The data obtained by the questionnaires outlined in chapter 3.2 (Demographic, Codependency Assessment Questionnaire, Michigan Alcoholism Screening Test, Ways of Coping Checklist, Millon Clinical Multiaxial Inventory and Self-esteem Inventories) was analyzed with the Statistical Package for the Social Sciences (SPSS, 1988). Firstly the couples were categorized into either being codependent or non-codependent according to the criteria of the CAQ. The numerous statistical analyses that were performed will be summarized:

1. Descriptive statistics on the demographic variables. The results of which can be found in the description of the sample (chapter 3.1.1.).
2. Correlations between all the scales of the MAST, WCC, CAQ, SEI and MCMI.
3. Reliability analysis was done on the CAQ (question 3). In addition, a total score on the codependency scale was calculated by adding the scores of the eight scales together. This score was used to compare which of the eight scales of the CAQ were related to the total scores obtained on the questionnaire and which were related to being codependent (question 4).
4. Mann-Whitney Tests were used to test hypotheses 4,5,6,9,10,11,12 and to compare the codependent couples with non-codependent couples on the scales of the MCMI and WCC as the Mann-Whitney tests have power that is comparable to the t-test, without making assumptions that are as restrictive. This test was also used to compare the levels of self-esteem (hypothesis 13) and level of alcoholism measured by the MAST between the two groups (hypotheses 2,3), as well as to compare them on some of the demographic variables (e.g. age, number of years drinking).
5. Chi-square tests were used to compare the non-codependent and codependent couples on variables such as race, centre, family of origin drinking problem, treatment requests, etc. (hypotheses 7,8).

4. RESULTS

The results will be outlined according to the different questionnaires. An emphasis will be made on comparing the alcoholics with codependent spouses and the alcoholics with non-codependent spouses and the differences found between the spouses. The significant findings will then be discussed in chapter 5.

4.1. CODEPENDENCY

Twenty three of the thirty seven spouses were found to be codependent according to the CAQ. Notably, the two male spouses were not codependent. Reliability analysis of the Codependency Assessment Questionnaire (Potter-Efron & Potter-Efron, 1989) revealed a reliability (Cronbach's alpha) of .9171. This indicates a high accuracy of the questionnaire as only 15.9% of the variance can be attributed to error (Kerlinger, 1986). This does not necessarily mean that the questionnaire is valid. It could be possible that it is measuring some other construct. However, whichever construct it is measuring (hopefully codependency) it is accurate in measuring it and discriminating between the two groups.

In table 3 the codependent spouses and non-codependent spouses are outlined according to the different means they scored on the different sub-tests of the CAQ and the significance of this difference found by the Mann-Whitney Test (Hays, 1981) which compares the rank means of the scales. (For tests see appendix 11)

The codependent spouses scored significantly higher on all the eight sub-scales. This was especially the case with the sub-scales confusion, and shame. Noteworthy is the fact that the sub-scale denial has the lowest significance and appears to have the lowest score. This indicates that denial might be less prominent than the other characteristics of codependency.

TABLE 3: CODEPENDENCY ASSESSMENT SCALES

| CODEP. ASSESS. | SPOUSE | | | |
|----------------|--------------|--------|-------|--------|
| | MEANS/ SIGN. | NONCOD | CODER | SIGNIF |
| CONFUSION | 0.786 | 3.479 | .0000 | |
| DENIAL | 0.786 | 1.565 | .0156 | |
| FEAR | 3.500 | 5.000 | .0004 | |
| IMPAIRED ID. | 1.143 | 2.565 | .0006 | |
| PROLONGED D. | 0.929 | 2.261 | .0003 | |
| RIGIDITY | 1.071 | 2.956 | .0001 | |
| RAGE | 0.429 | 1.913 | .0001 | |
| SHAME | 1.500 | 3.913 | .0000 | |

A correlational analysis was performed (appendix 12) between the levels of codependence and the different scales to investigate if there were any scales to which being codependent is related. It was found that the scales had the following order of relatedness to codependence (from high to lower) with a significance of 0.001: shame (.7422), confusion (.7401), rigidity (.6804), rage (.6167), prolonged despair (.6007), fear (.5857) and impaired identity (.5765). The scale measuring denial was only related (.3871) with a significance of 0.01.

Thus it would seem that if one is codependent then one scores significantly higher on all the scales of the codependency questionnaire. However, the scale denial seems to be less significantly related to codependency.

4.2. LEVEL OF ALCOHOLISM AND DEMOGRAPHICS

With regard to the level of alcoholism as measured by the MAST (1971) it was found that there was no significant difference between the alcoholics whose spouses were codependent or non-codependent. Similar results were found for the amount of alcohol drunk.

In addition no difference was found between the amount drunk by the codependent spouses and non-codependent spouses.

With regard to the number of years of having had a drinking problem, again no significant differences were found. The spouse did tend to estimate the alcoholic's drinking to have been longer than the alcoholic reported. However a t-test comparing these two means was not significant ($p = .253$). A t-test was performed as it was assumed that the estimation of number of years drinking would be a normal distribution and that both groups would have the same variance.

The alcoholics who had codependent spouses did tend to be significantly younger, although only by approximately three years.

No difference was found concerning the frequency of requesting treatment.

Noteworthy is that couples with a codependent spouse tended to be married for a significantly shorter period of time, approximately 9 years.

A Chi-Square test comparing alcoholics who were voluntarily undergoing treatment (from both Lulama and Newlands Park Rehabilitation Centre) versus those committed (only from the Newlands Park Rehabilitation Centre) revealed that significantly more alcoholics were committed when their spouse was codependent. Possibly this finding was confounded by race or the different treatment centres. However a Chi-Square test comparing race and centre versus codependency did not show any significant differences between the races or the centres in codependency (appendix 13). This means that codependency was found equally in the two treatment centres and between the different races.

Similarly, there was no significant difference between the two groups on having a member of the family of origin with an alcoholic problem.

The Yates correction was not used with the Chi-Square tests as according to Neave and Worthington (1988) the Yates correction is just as likely to worsen, as to improve the approximation and thus the significance (appendix 13).

Some of the above findings are detailed in table 4.

TABLE 4: LEVEL OF ALCOHOLISM AND DEMOGRAPHICS

| ALC/DEMOG | ALCOHOLIC | | | SPOUSE | | |
|--------------|------------|---------|--------------|--------|--------|-------|
| | MEANS/SIGN | NONCOD | CODEP | SIGNIF | NONCOD | CODEP |
| MAST TOTAL | 26.36 | 32.48 | .1724 | - | - | - |
| AMOUNT / ALC | 1769.93 | 1093.57 | .4713 | 16.93 | 40.61 | .7327 |
| YEARS DRINK. | 5.77 | 9.74 | .1044 | 8.43 | 9.39 | .3432 |
| AGE | 46.74 | 43.94 | .0101 | 42.28 | 39.33 | .0846 |
| TREATM. REQ. | 1.29 | 1.65 | .1339 | 1.79 | 2.09 | .5115 |
| LENGTH MARR. | 23.21 | 14.96 | .0249 | - | - | - |
| COMMITTED | * 2 | * 11 | .0382 | - | - | - |

*= Chi-Square (the numbers are actual, not means, and without Yates correction)

Interestingly the total score on the MAST was significantly related to the codependent scales of fear (.5317, p=.001), rigidity (.4361, p=.01), prolonged despair (.3840, p=.01) and the total score on the CAQ (.3911, p=.01). The above refers to both the codependent spouses and non-codependent spouses. Hence it would seem that the higher the level of alcoholism in the alcoholic, the higher the level of fear, rigidity and prolonged despair in the spouse and the more likely she is to answer yes to the questions of the CAQ.

4.3. SELF-ESTEEM AND WAYS OF COPING CHECKLIST

The codependent spouses showed significantly lower self-esteem scores than the non-codependent spouses. The non-codependent spouses exhibited a normal level of self-esteem (50th percentile, appendix 10) and the codependent spouses scores fell within the twentieth percentile (Coopersmith, 1987).

No significant differences were found between the alcoholics on any of the coping styles. The codependent spouses and non-codependent spouses only differed in respect of the self-blame and wishful thinking/escape coping styles. The codependent spouses presented with a higher score indicating that they tend to use these coping styles more than non-codependent spouses. On average it seems that all the other coping styles were used often by both the spouses and alcoholics. The means and the significance of the differences are outlined in table 5. (Mean Ranks in appendix 11)

TABLE 5: WAYS OF COPING CHECKLIST AND SELF-ESTEEM

| WCC/SEI | ALCOHOLIC | | | SPOUSE | | | |
|------------|-----------|--------|-------|---------|---------|-------|--------|
| | MEANS/SIG | NONCOD | CODEP | SIGNIF | NONCOD | CODEP | SIGNIF |
| SELFESTEEM | - | - | - | 70.8571 | 50.3636 | .0013 | |
| ACCEPTANCE | 3.2929 | 3.4609 | .2318 | 3.5786 | 3.5696 | .6479 | |
| EMO/WITHH. | 3.2500 | 3.0217 | .2092 | 2.7714 | 2.9522 | .3228 | |
| GROWTH | 2.9857 | 3.1826 | .3536 | 3.2786 | 3.1652 | .4321 | |
| HELPSEEK. | 2.6286 | 2.8435 | .3293 | 3.2357 | 3.2565 | .9874 | |
| PROB.FOC. | 2.9643 | 3.1174 | .3379 | 3.1929 | 3.3522 | .7652 | |
| SELF BLM. | 3.3929 | 3.4000 | .8751 | 2.4929 | 3.4783 | .0002 | |
| WISH/ESC. | 3.0429 | 3.1826 | .6043 | 2.5714 | 3.1304 | .0073 | |

4.4. PERSONALITY PROFILES (MCMI)

With regard to the basic personality patterns there were no significant differences between the alcoholics who had codependent spouses and those with non-codependent spouses as measured by Mann-Whitney Tests. However, the alcoholics with codependent spouses tended to show a dependent personality pattern (BR>84) with traits of the passive-aggressive, schizoid and avoidant personality patterns (BR>74). The alcoholics with non-codependent spouses did not present with a specific personality pattern, generally scoring lower (but not significantly). They presented with traits of the passive-aggressive, dependent and schizoid personality profiles (BR>74).

Considering the MCMI's of only the two groups of spouses, significant differences were found on the following personality styles: schizoid, avoidant, dependent, narcissistic, compulsive and passive-aggressive. None of the scores were high enough to indicate a specific personality pattern, but evidence was found for the prevalence of traits of the dependent personality style in the codependent spouse. In addition, it was found that codependent spouses scored significantly higher on the schizoid, avoidant and passive-aggressive personality styles. Interestingly, the non-codependent spouse scored significantly higher on the narcissistic and compulsive personality styles (Table 6).

On the personality disorder scales no significant differences were found between the alcoholics with non-codependent and codependent spouses. In addition, only the alcoholics with codependent spouses scored high enough to warrant an indication of a chronic to moderate paranoid personality disorder.

Although significant differences were found between the codependent spouse and non-codependent spouses on the schizotypal and borderline scales (codependents scoring higher), the scores were not sufficient to warrant a diagnosis of the personality disorder. (The significance fell away on the schizotypal scale when the male spouses were left out of the sample). Surprisingly, although the difference was not significant, only the non-codependent spouses scored high enough to warrant a chronic or moderate paranoid personality disorder (Table 6).

With the clinical syndrome symptom scales, the alcoholics with non-codependent spouses scored significantly higher on the anxiety scale (presence of pathological anxiety) than the alcoholics with codependent spouses (presence of anxiety). No other significant differences were found. On both alcohol and drug abuse scales the scores indicated the presence of these symptoms.

Psychotic Depression was the only scale which did not score high enough with the alcoholics with non-codependent spouses to indicate the presence of the symptom.

The codependent spouses scored significantly higher (presence of pathology) on anxiety than the non-codependent spouses (indication of anxiety). Significant differences were also found on the dysthymic, psychotic thinking and psychotic depression scales. The scores of the latter were, however, not sufficient to indicate the presence of the symptom. Although the scores of the codependent spouses indicate the presence of dysthymia it was not high enough with the non-codependent spouses. The score of the codependent spouses on the psychotic thinking scale was indicative of the presence of the symptom but again not for the non-codependent spouses.

For a more detailed depiction of the different profiles see Figures 1 and 2, pages 61 and 62. (The key to the graphs may be found on page 60).

TABLE 6: MILLON CLINICAL MULTIAXIAL INVENTORY

| MCM I MEANS / SIGNIF | ALCOHOLIC | | | SPOUSE | | |
|-------------------------|-----------|-------|--------|--------|-------|--------|
| | NONCOD | CODEP | SIGNIF | NONCOD | CODEP | SIGNIF |
| SCHIZOID | 74.07 | 78.48 | .7653 | 41.79 | 67.39 | .0010 |
| AVOIDANT | 69.86 | 76.83 | .6605 | 40.64 | 72.48 | .0005 |
| DEPENDENT | 78.79 | 85.61 | .0614 | 54.21 | 79.09 | .0130 |
| HISTRIONIC | 63.79 | 54.57 | .3608 | 48.71 | 40.48 | .1805 |
| NARCISSISTIC | 67.07 | 68.30 | .9875 | 73.50 | 59.87 | .0340 |
| ANTISOCIAL | 71.57 | 69.00 | .7768 | 65.21 | 51.74 | .1022 |
| COMPULSIVE | 47.21 | 46.13 | .8139 | 75.43 | 60.48 | .0316 |
| PASS. AGG. | 83.86 | 80.30 | .2392 | 31.50 | 69.35 | .0012 |
| SCHIZOTYPAL | 58.36 | 60.96 | .7420 | 45.14 | 59.22 | .0293* |
| BORDERLINE | 68.79 | 65.96 | .3551 | 51.64 | 68.78 | .0220 |
| PARANOID | 71.79 | 77.87 | .2274 | 75.29 | 69.09 | .2399 |
| ANXIETY | 91.64 | 82.96 | .0520 | 63.57 | 86.96 | .0127 |
| SOMATOFORM | 70.43 | 67.04 | .4240 | 66.93 | 77.78 | .2527 |
| HYPOMANIC | 65.14 | 63.78 | .8879 | 45.00 | 46.23 | .9373 |
| DYSTHYMIC | 76.50 | 70.78 | .2528 | 45.86 | 79.61 | .0005 |
| ALC. ABUSE | 81.36 | 80.13 | .9002 | 48.21 | 54.17 | .2271 |
| DRUG ABUSE | 78.36 | 83.35 | .4061 | 59.36 | 56.78 | .9875 |
| PSYCH. TH. | 64.86 | 69.61 | .1769 | 50.43 | 67.13 | .0012 |
| PSYCH. DEPR. | 59.93 | 61.35 | .8754 | 47.14 | 59.91 | .0211 |
| PSYCH. DEL. | 66.21 | 71.43 | .1033 | 69.43 | 70.78 | .9126 |

* = Significance falls away when female alcoholics are excluded.

KEY TO FIGURES 1 AND 2

AXIS II

- 1 = Schizoid
- 2 = Avoidant
- 3 = Dependent
- 4 = Histrionic
- 5 = Narcissistic
- 6 = Antisocial
- 7 = Compulsive
- 8 = Passive-Aggressive

AXIS II

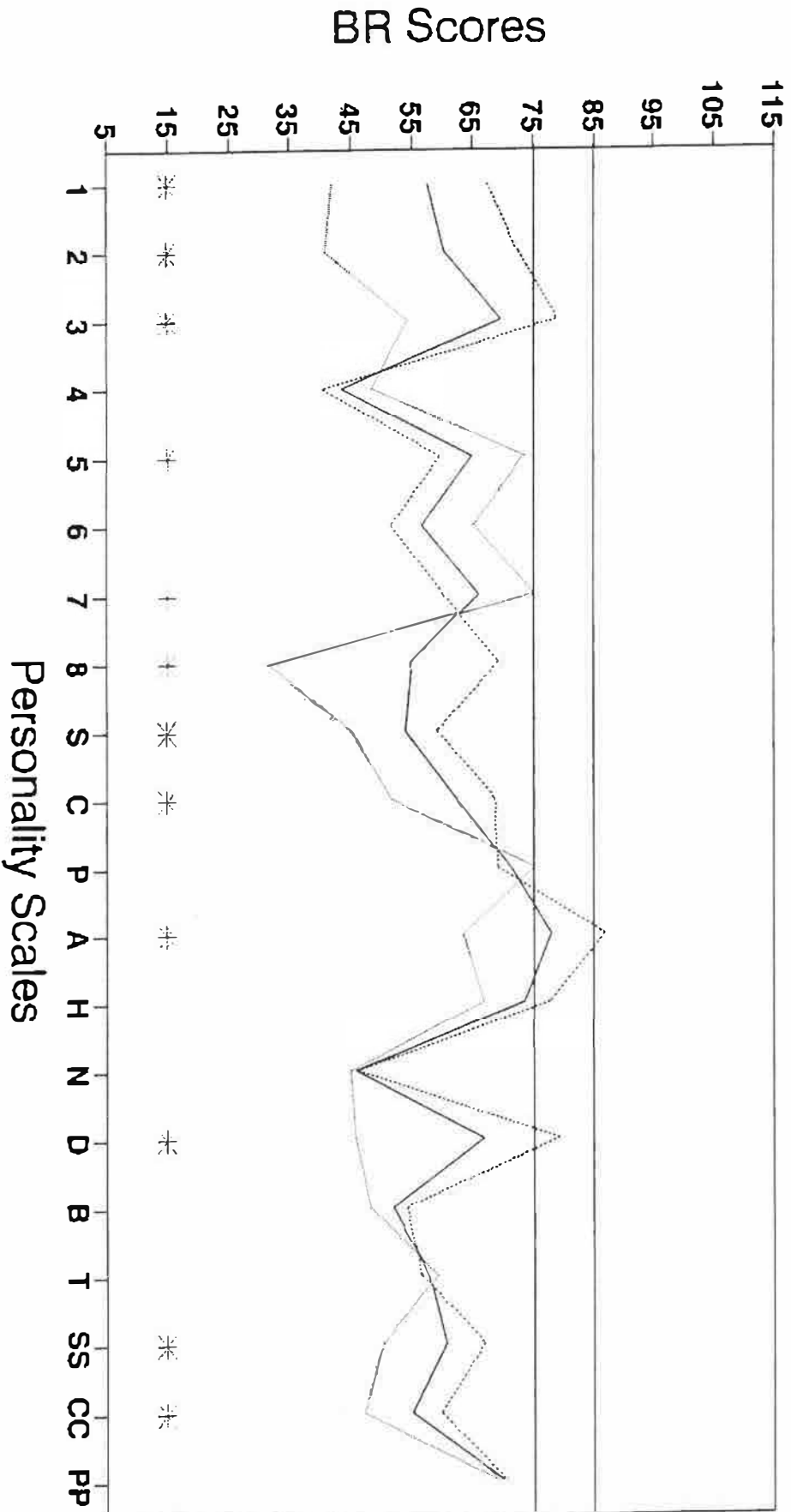
- S = Schizotypal
- C = Borderline
- P = Paranoid

AXIS I

- A = Anxiety
- H = Somatoform
- N = Hypomanic
- D = Dysthymic
- B = Alcohol Abuse
- T = Drug Abuse
- SS = Psychotic Thinking
- CC = Psychotic Depression
- PP = Paranoid Delusions

FIGURE 1: GRAPH DEPICTING THE AVERAGE MCM I SCALE SCORES

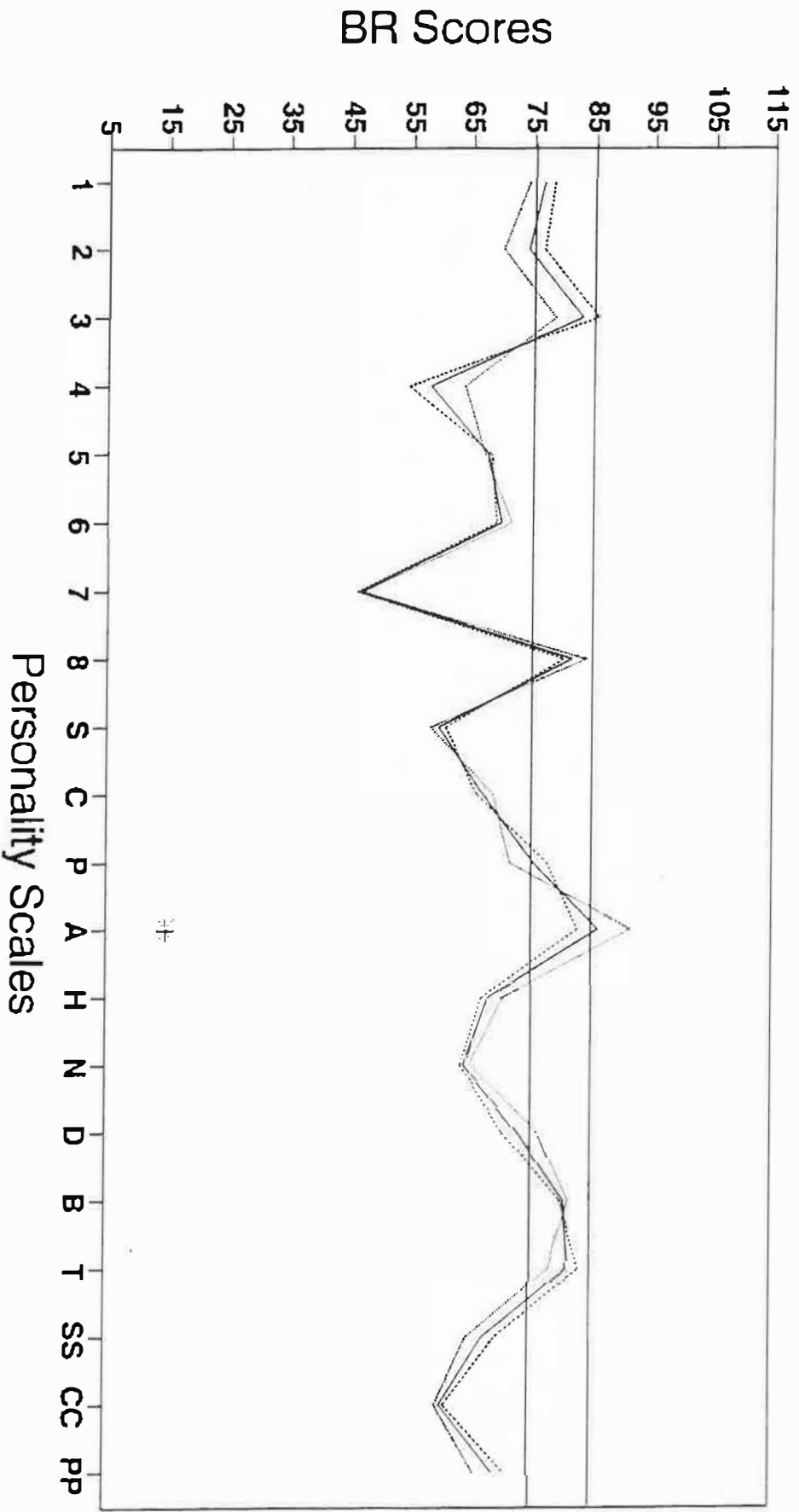
Average MCM I Scale Scores Spouse



— MEAN CODEP ——— NON-CODEP * SIGNIFIC

Average MCM I Scale Scores Alcoholic

FIGURE 2: GRAPH DEPICTING THE AVERAGE MCM I SCALE SCORES



MEAN

CODEP

NON-CODEP

SIGNIFIC

4.5. EXCLUSION OF FEMALE ALCOHOLICS

To investigate if the outcome of the different statistical tests would differ if the two female alcoholics with their spouses were excluded, the tests were run again with the smaller sample. Because the non-codependent sample became smaller (both the male spouses were non-codependent) the scores of significance became slightly less on most of the tests. However, only on the personality scale schizotypal did the significance become markedly smaller resulting in the Mann-Whitney test no longer being significant. It is therefore possible that the male spouses lowered the schizotypal score of the non-codependent spouses, perhaps being less eccentric or different than the female spouses. This will be discussed further together with the other results in chapters 5 and 6.

5. DISCUSSION

The conclusions and findings which follow refer to the subjects studied. If generalizations are made to the general population this will be noted separately.

The discussion will refer back to the questions and hypotheses on pages 36-39, chapter 3.1. The construct codependency in spouses of alcoholics will be discussed, followed by a section looking at the impact of codependency on alcoholism. The third section concentrates on the differences between the alcoholics with non-codependent and codependent spouses. Fourthly, the demographic variables with relation to codependency will be discussed followed by a summary. The last section of chapter five concerns the limitations of this study.

5.1. CODEPENDENCY

With regard to the first question and hypothesis, namely whether, codependency, as defined by Potter-Efron and Potter-Efron (1989) and measured by the Codependency Assessment Questionnaire (Potter-Efron & Potter-Efron, 1989), occurs in spouses of alcoholics; it is clear that it does exist. However, not all the spouses of alcoholics were found to be codependent. This re-emphasises the fact that we cannot speak in general terms of "the spouse of the alcoholic" (Kogan, Fordyce & Jackson, 1963). It seems that only some show codependency. Possibly, as Asher and Brissett (1988) propose, codependency could be one way of making sense of living with an alcoholic. This does not exclude, however, the fact that it may be an endogynous way of relating. Perhaps some of the spouses who scored as codependent had ingrained ways of coping (endogynous) and relating, whilst others had learned to cope this way due to the stressors of living with an alcoholic (exogenous) (Wright & Wright, 1991). This would need further investigation.

The questionnaire itself showed a high reliability (.9171) and was thus able to discriminate between the two different groups (question 3). Further analysis showed that if a spouse was found to be codependent this was positively correlated to all the eight scales of the questionnaire (question 4). In other words, codependency (according to the questionnaire) seems to be associated with feelings of shame and guilt with regard to the alcoholic's behaviour and their own behaviour as well as a sense of "badness" about him/herself and/or self-loathing. In addition, codependents seem to be confused about what is normal and real, confused about their feelings and confused about what they should do (indecisive). A negative and hopeless approach to life as well as feelings of persistent anger and fear (anxiety) are also prominent, with a rigid approach to problem-solving. Codependents also tend to deny the problems in the family, but this is not as positively related to codependency as the aforesaid characteristics. This contradicts the theory that one of the most prominent features of codependency is excessive denial, specifically denying that there is an alcoholic problem or the seriousness of the problem (Cermak 1986, in Morgan 1991; Morgan, 1991; Potter-Efron & Potter-Efron, 1989; Wright & Wright, 1991). This affects the current conceptualization of codependency as it seems that excessive denial of the alcoholic problem may not be as significant as the theory proposes. Perhaps codependency is not so much related to denial of the existence of an alcoholic problem but more to a different form of denial, for example, denying who is responsible for the drinking and the problems experienced. It seems from the above, that codependent spouses feel guilty and ashamed about the alcoholic problem. This has the implication that when one deals with codependency one does not have to convince the spouse that there is a problem but one might have to put the alcoholic problem in a more realistic light. Thus, excessive denial may still be prominent in codependency but needs to be specified in more detail and needs further research.

5.1.1. COPING STYLES OF CODEPENDENT AND NON-CODEPENDENT SPOUSES

With regard to coping, it was hypothesized that codependent spouses would use more wishful thinking/escape, acceptance, emotional withholding and self-blame (question 6, hypothesis 9). It was found that codependent spouses used the coping styles of wishful thinking/escape as well as the inclination to blame themselves for not being able to cope significantly more than the non-codependent spouses. This is possibly related to their feelings of shame and guilt and the codependent's negative approach to life as presented in chapter 5.1. Perhaps codependents deny the reality of the drinking problem with cognitive distortions by blaming themselves for the problems they are experiencing (alcoholic's drinking) and perceiving the problems as something they bring upon themselves because they are not strong enough to cope. Maybe they feel that if they could cope better then the alcoholic would not have to drink. The higher scores on the wishful thinking/escape coping style could be due to these feelings of guilt and self-blame. With the coping style self-blame they strengthen their feelings of guilt and consequently may use wishful thinking/escape as a means of alleviating the stress caused by the guilty feelings.

No difference was found between the spouses on the coping styles of acceptance and emotional withholding. Both spouses tended to acknowledge the existence of the problem and tended to cope by dealing with the stress of the problem (acceptance) and by keeping their feelings to themselves (emotional withholding). This disproves part of hypothesis nine.

Hypothesis ten (codependent spouses will use less help-seeking and problem-focused coping styles) was also disconfirmed as both the codependent spouses and non-codependent spouses used the problem-focused and help-seeking coping styles. Therefore, codependent spouses do seek help and do take direct action to attempt to solve their problems. This is not in accord with the theory which postulates that codependent spouses will tend to

deny their problems and act as if everything is alright, hiding the problem from the outside world. Going for help means letting people know that there is a problem such that it can no longer be a family secret. This is contrary to Whitfield's (1984) proposal that an unbroken rule in the family where there is alcoholism, is that it must be kept a secret. The above seems to confirm the lower correlation with denial. That is to say, if they denied that there was a problem they would not go for help. They do ask for help possibly because they feel at fault.

5.1.2. PERSONALITY PROFILES OF CODEPENDENT AND NON-CODEPENDENT SPOUSES

The basic personality profiles differed significantly between the codependents and non-codependents on several personality variables (question 7). However no basic personality pattern (pathology) was found in this sample. This is in accord with Kogan, Fordyce and Jackson's (1963) and Paolino, McCrady, Diamond and Longabaugh's (1976) findings. The codependent spouses did show evidence of dependent personality traits and the non-codependent spouses showed evidence of traits of the compulsive personality pattern. This is not in accord with Loughhead's (1991) hypothesis that codependent spouses would show compulsive behaviour similar to that of addiction. Specifically, an alcoholic compulsively drinks to alleviate internal stress and pain and a codependent uses compulsions and obsessive thinking in order to keep feelings repressed and the internally experienced pain medicated.

The dependent personality pattern is characterized by a strong need for social approval and affection, a lack of self-confidence, and feelings of being unable to attain one's own rewards. They present as helpless, submissive and compliant (Millon, 1981). The compulsive personality pattern is described as conscientious, inflexible, rigid and unbending. People with this pattern tend to be emotionally constricted and follow social rules and regulations precisely. They tend to be uncompromising

and do not like their routine to be changed (Millon, 1981). Thus, the codependent spouse seems to be more compliant and dependent whereas the non-codependent spouse tends to be more rigid and inflexible. This is possibly due to the fact that the codependent spouses tend to blame themselves for the alcoholic spouse's drinking resulting in their attempting to constantly meet the alcoholic's needs, whereas the non-codependent spouses tend to not take the blame and consequently do not have to comply with the alcoholic's needs.

It is important to note that although the average scores weren't high enough to warrant evidence of traits, the codependent spouses tended to be more aloof, introverted, seclusive and emotionally more bland (Schizoid) than the non-codependent spouses. They also tended to be more oversensitive to social stimuli, isolated and lonely but not daring to expose themselves through fear of humiliation and rejection (Avoidant). In contrast, the non-codependent spouses tended to be more narcissistic and anti-social (despite no evidence of the presence of traits) and showed extremely low passive-aggressive traits (Millon, 1981). This can likewise be explained in that the codependent spouses tend to blame themselves or take on the responsibility of the problems experienced, resulting in feelings of shame and guilt (Wright & Wright, 1991). Consequently they might attempt to avoid interpersonal contact through fear of causing more problems and/or drinking and in fear of further proof that they cannot cope and are at fault. Their feelings of shame and guilt may be related to their hypervigilance as they are expecting rejection and reinforcement of their shame and guilt, especially by the alcoholic. In addition, due to their fear of rejection codependent spouses may be only able to express themselves in a passive-aggressive manner. In contrast, the non-codependent spouses seem to show the opposite profile.

The higher scores (not diagnostic) on the narcissistic and antisocial scales and the lower scores on the passive-aggressive scale may indicate that these spouses might express themselves

clearly and may take care of their own needs, not taking on the alcoholic's problem as the codependent spouse seems to do.

With regard to the pathological personality disorders, the codependent spouses had significantly higher scores on both the schizotypal and the borderline personality disorder. However, the scores were not high enough to warrant any diagnostic significance. Also, the significance on the schizotypal scale fell away when the two couples with the female alcoholics were excluded.

Although the non-codependent spouses scored just high enough to indicate the presence of a chronic to moderate paranoid personality disorder, no significant difference was found between the codependent and non-codependent spouses. Millon (1981) describes a person with a paranoid personality disorder as mistrustful and suspicious of others together with a marked fear of losing independence. Furthermore, they are seen as persons who project malevolence and weakness onto other people. Perhaps the non-codependent spouses experience the alcoholics as not to be trusted, weak and malicious. In contrast, the codependent spouses seek fault with themselves.

The codependent spouses showed a level of anxiety that is pathological. There was also evidence of the presence of somatic and dysthymic complaints. This contrasts strongly with the non-codependent spouses where there was only a suggestion of some anxiety. Overall, the non-codependent spouses showed far less clinical symptoms. This is similar to Kogan, Fordyce and Jackson's (1963) findings of higher levels of anxiety on the MMPI with spouses of alcoholics and higher levels of distress than in spouses of non-alcoholics. It seems that within the spouses of alcoholics (codependent and non-codependent) the levels may differ. Conceivably this belief that one is to blame for what is happening (being codependent) heightens the level of experienced distress and anxiety. Considering this, hypothesis eleven is confirmed (i.e. Codependent spouses will show higher

scores than the non-codependent spouses on the following scales of the MCMI(1984):-dependent (3), -passive-aggressive (8), -avoidant (2), -anxiety (A), -dysthymia (D)).

5.1.3. SELF-ESTEEM AND DRINKING

As expected the codependent spouses presented significantly lower levels of self-esteem than the non-codependent spouses (question 13 and hypothesis 13). This is in accord with the theory (Fisher, Spann and Crawford, in press, in Wright & Wright, 1991; Loughhead, 1991; Morgan, 1991; Potter-Efron & Potter-Efron, 1989; Schaefer, 1986, in Fausel, 1988; Whitfield, 1984). Likewise, this lower level of self-esteem corresponds with the findings in chapter 5.1.1 and 5.1.2. of dependent traits and a tendency for self-blame in the codependent spouses. Perhaps the proposal in the theory that codependent spouses are reliant on their partners for a sense of self-worth is correct, but it needs further investigation.

No difference was found between the amount drunk by the codependent spouse and non-codependent spouse disconfirming hypothesis twelve that the codependent spouses would drink less. This does not corroborate Prest and Storm's (1988) proposal that codependent spouses would drink less in an attempt to provide an example to the addicted person. It seems that all the spouses drink less than the alcoholic. Therefore, presenting an example to the alcoholic is not be specific to codependency.

5.1.4. SUMMARY

In summary, the codependent spouses differ significantly in several ways from non-codependent spouses in this sample. They can be described as people who are highly confused, tend to feel negative and helpless and have a low self-esteem. They tend to blame themselves and feel guilty about their spouse's problems and have a tendency to be submissive, helpless and compliant. At the same time they seem to be scared of rejection and

humiliation and show high levels of anxiety. As a result perhaps they have the inclination to be withdrawn and aloof as well as hypervigilant and oversensitive to the moods of others. They have persistent feelings of anger but express this in a passive-aggressive manner. In addition, their coping styles involve wishful thinking/escape and self-blame.

In contrast, the non-codependent spouses do not take responsibility for the alcoholism and are less anxious. Furthermore, the non-codependent spouses are less passive-aggressive and seem to be more compulsive.

5.2. THE IMPACT OF CODEPENDENCY ON ALCOHOLISM

No significant relationship was found between the level of alcoholism or amount of drinking in the alcoholic and codependency in the spouse (question 2, hypothesis 2). The number of years of drinking of the alcoholic also did not appear to be related (question 12, hypothesis 4). In addition, alcoholics with codependent spouses did not drink significantly more than alcoholics with non-codependent spouses (hypothesis 6).

This means that none of these hypotheses were confirmed and these findings are in contrast to the proposal that codependent behaviour would enable or maintain the drinking of the alcoholic (Morgan, 1991; O'Brien & Gaborit, 1992; Whitfield, 1984). There is no difference between the drinking of the alcoholics of the two groups of spouses, whereas if the codependent spouses were to enable the alcoholic's drinking one would expect this alcoholic to have drunk for a longer period, possibly drink more, and show a higher level of alcoholism.

This has implications for the treatment of alcoholics and their spouses. Since codependency does not seem to enable alcoholism in this sample, as measured by the level of alcoholism and the amount drunk, it might be concluded that including the spouses in the treatment of alcoholism is not essential.

However, enabling should possibly be measured in a different manner; specifically, the extent to which the alcoholic takes responsibility for his/her behaviour because the codependent spouse seems to take on too much responsibility and perhaps she enables the drinking in this manner. Consequently she would need to be included in the treatment.

It was interesting to find that the total level of alcoholism as measured by the MAST was positively correlated to fear ($p=.001$), rigidity ($p=.01$), prolonged despair ($p=.01$) and the total score to the Codependency Assessment Questionnaire ($p=.01$). This means that although the two categories of the codependent spouses and non-codependent spouses showed no significant difference where it concerned the level of alcoholism in the alcoholic, all the spouses tended to have higher scores on the CAQ if the alcoholic had high scores on the MAST. All the spouses also tended to show higher levels of fear, rigidity and prolonged despair possibly resulting in the higher CAQ score. Thus, the more severe the alcoholism, the more the spouse is afraid, feels helpless and negative and attempts to approach tasks and problems rigidly (question 5 and hypothesis 3). This is an impelling argument to include both codependent and non-codependent spouses of alcoholics in treatment even though they may not enable the alcoholism.

5.3. ALCOHOLICS WITH CODEPENDENT AND NON-CODEPENDENT SPOUSES

Looking at the differences between the alcoholics with codependent spouses and non-codependent spouses no significant differences were found on the coping scales, the basic personality patterns and the personality disorders (questions 8,9). They only differed significantly on the symptom scale of anxiety (MCMII). The alcoholics with non-codependent spouses showed the presence of pathological anxiety whereas the alcoholics with codependent spouses only showed the presence of anxiety. Possibly the codependent spouses, buffered the anxiety felt by the alcoholic because the codependent spouse in this

sample tends to present herself as helpless and compliant thus, perhaps, not confronting the alcoholic but taking on the blame for the problems experienced. In contrast, the non-codependent spouse tends to show more compulsive and narcissistic traits resulting possibly in more confrontation as she tends to be unwilling to compromise, hence the higher anxiety in this group of alcoholics.

Although no significant differences were found between the alcoholics on the personality patterns, the averages found on the MCMI did differ diagnostically (but not statistically). The alcoholic with a codependent spouse appeared to present a dependent personality pattern with traits of the passive-aggressive, schizoid and avoidant personality patterns. Millon (1981) describes persons with the dependent personality pattern as a people who have a strong need for social approval and affection. To attain this they are willing to live in accord with the desires of others to the extent that they often deny their own individuality. They lack self-confidence and feel unable to attain their own rewards and take responsibility for their lives. They need someone else to shoulder the responsibilities and to provide pleasures. Therefore, they present as helpless, submissive and compliant. Often their need for dependency is rationalized through physical illness and/or circumstances, here, perhaps alcoholism.

The most marked traits of the schizoid personality pattern are the aloofness, introvertedness and seclusive nature of the person. They tend to be bland and emotionless. Avoidant personalities tend to be oversensitive to social stimuli and hyper-reactive to moods and feelings of others. They expect rejection and have high levels of anxiety because of this. They tend not to trust others, often have little confidence and tend to be shy and withdrawn. They usually feel lonely and isolated, but dare not expose themselves for fear of being defeated and humiliated. Passive-aggressive personality patterns are characterized by indecisive, fluctuating attitudes and

oppositional behaviours, especially toward authority. Often there is a conflict between being either obediently dependent or defiantly resistant and independent. These people are described as being restless, unstable, erratic, impulsive, and as having a low frustration tolerance.

In summary: it seems that, in this sample, the alcoholic with a codependent spouse can be described as someone who has a low self-esteem, who is dependent on another person for approval, affection and decision making. In addition, they may be withdrawn, isolated and oversensitive to rejection from others. This may result in high levels of anxiety. They also may have a low frustration tolerance, are impulsive and oppositional. Hence the alcoholics showed very similar personality traits to their codependent spouses.

The alcoholics with non-codependent spouses showed traits of the dependent personality pattern (not the pattern itself) and the passive-aggressive personality pattern. The average scores on the schizoid and avoidant personality patterns fell just short of the evidence of traits.

It can therefore, tentatively be concluded that (although in this sample it was not found to be significant) alcoholics with codependent spouses may tend to show higher levels of personality pathology.

5.4. DEMOGRAPHIC VARIABLES

No significant differences were found between the three races concerning the incidence of codependency. This could, however, be due to the size of the sample.

The codependents did not have more members from the family of origin with a history of alcoholism (hypothesis 8). Thus it is highly questionable whether codependency is associated with a history of alcoholism in the family of origin. This does not

confirm the literature which proposes that individuals raised in homes where there was drug or alcohol abuse are at greater risk to develop codependency (Mendenhall, 1989; Wright & Wright, 1991).

Surprisingly, couples where the spouse was codependent tended to have been married, on average for a much shorter period of time than non-codependent couples (difference of ± 9 years) and the alcoholic of the codependent couple tended to be younger than the alcoholic from the non-codependent couple (difference of ± 3 years). See results on page 56. Possibly because the codependent spouses have been married for a shorter period of time they still feel able to change the drinking behaviour of their spouse as they might feel responsible for it and blame themselves. Perhaps the non-codependent spouses, due to time, have learned that they are not responsible and thus are no longer codependent, although one cannot say that they necessarily once were codependent.

Furthermore, no significant differences were found regarding help-seeking. This was not expected as the theory postulates that codependents tend to protect the family and hide the secret of a drinking problem. Therefore, one would predict that they would seek treatment less than non-codependents (question 14, hypothesis 5). Another unexpected finding was that the alcoholics who had been committed were more likely to have a codependent spouse (question 15, hypothesis 7). This finding is, however, probably confounded by the treatment centre, as it only regards the couples from the Newlands Park Rehabilitation Centre where alcoholics can be committed.

The help-seeking aspect refutes the suggestion that codependents rely excessively on denial of the problem. If they did, they would refrain from seeking help. It seems that in this sample they seek help just as much as non-codependent spouses.

5.5. SUMMARY

Two different groups of spouses were clearly identified by the Codependency Assessment Questionnaire (Potter-Efron & Potter-Efron, 1989). Although the validity of the questionnaire is not known, it is presumed to measure codependency. Not all of the spouses were found to be codependent indicating that it may just be one way of making sense of, or relating within an alcoholic marriage. The cause-effect question however remains. It is unclear whether codependency as measured in this study occurs before the alcoholic marriage or developed during it. This needs further investigation, but was not within the scope of this research.

It seems that in this sample feelings of shame, guilt and the tendency to blame oneself for the experienced problems are the main characteristics of codependency, which can possibly be described as a syndrome. In addition, although denial is not as related to codependency as the above characteristics, it may occur, not in the form of denying the existence of a problem, but in the form of denying the source of the problem. Specifically, the codependent tends to blame herself for the problems experienced. Thus the codependent takes on too much responsibility for the re-occurring problems. They appear to be dependent, but not in the classical sense of dependency. They are dependent on the other person for their sense of self-worth to the extent that the other person is well. With true dependency the dependent person is reliant on the other person to make the decisions and shoulder the responsibilities and consequently presents her/himself as helpless and compliant. With codependency it seems that the codependent shoulders the responsibilities and feels good if the other person feels good. If not, then she/he feels it is her/his fault. This is in accord with Morgan's (1991) hypothesis that codependents are dependent for their self-worth on their partner's success or failure.

It seems that they differ from other spouses of alcoholics in that they use more wishful thinking/escape coping styles. This could be explained by the fact that they use excessive self-blame and so the above is stress reducing. In accord with their need for the other to be well and successful and their self-blame tendency, is their hypervigilance and inclination to withdraw, as well as their high levels of anxiety. Watching an alcoholic carefully to make sure that s/he is alright can only be anxiety provoking. Not surprisingly, the alcoholics with codependent spouses have significantly lower levels of anxiety than the alcoholics with non-codependent spouses. This could be due to the codependent spouse taking on the responsibility for the problems whereas the non-codependent spouse tends to find fault with the alcoholic and tends to be more rigid, possibly not buffering the alcoholic from feeling anxious but in fact causing him/her to feel anxious.

Furthermore, codependent spouses seek as much help as non-codependent spouses. Possibly, the non-codependent spouses want the alcoholic to change and the codependent spouses seek relief from their own distress.

The above has significant treatment implications as both the non-codependent and codependent spouses appear to present with certain profiles which may influence the alcoholic and the alcoholism. Specifically, the codependent spouse may inhibit the alcoholic from taking responsibility for his behaviour because she tends to take responsibility for the experienced problems and blames herself. This may buffer the alcoholic from feeling anxious and thus from wishing to change. In contrast, the non-codependent spouse seems to tend to find fault with the alcoholic, which may cause him to feel anxious and the need to drink. Apart from the influence the spouse may have on the alcoholic, it is clear that she herself may be suffering and in need of help. She may for example, suffer from anxiety and somatic complaints.

5.6. LIMITATIONS OF THIS STUDY

The main limitation of this study is the sample itself. The small size (37 couples) and the subjects' help-seeking nature. This means the findings might be an artefact of this group. Specifically, the finding of two distinct groups (codependent and non-codependent) might be idiosyncratic within this particular sample of people who went to the two centres for help.

Also, more pathology or codependency might have been found in the case of help-seeking people perhaps exaggerating their symptoms and tending to answer questions positively in order to validate their need for help to the researcher. However, the MCMI incorporates validity and adjustment scales which control for possible defensiveness, self-enhancement, emotional complaining and self-depreciation, which would have prevented the findings of an elevated pathology with reference to personality.

In addition, Kerlinger (1986) would argue that the sampling was "accidental" (the subjects were acquired by chance) resulting possibly in findings related to people who are willing to participate in research. Therefore, it is not certain that these same findings would be found with non-help-seeking alcoholics. Possibly, the spouses of non-help-seeking alcoholics who are codependent, would present more with denial of the alcoholic problem, which would validate the literature's hypothesis that excessive denial may be a major feature of codependency.

Another limitation of this study is that the spouses were mainly female. It is unknown to what extent the same findings would have been found with male spouses. The two male spouses of this sample were not codependent. The possibility that codependency might be gender specific is a question for further research.

The reliance on questionnaires presents methodological problems which may have influenced the findings. That is to say, a short coming is that one is dependent on the reliability of the

informant. In other words, the question rises how defensively, over-emphatically, and socially desirably the respondent has answered, and how this has affected the results. In addition, a yes/no answer category (of the CAQ) has the possibility that a person may tend to answer either only positively or negatively, which would bias the findings (the SEI controlled for this by reversing some of the statements; appendix 9). In contrast, a Likert type scale or multiple response scale (WCC) presents the possibility of the error of central tendency or end-using. This may have been the case with the Ways of Coping Checklist as on average the responses to the different scales leaned toward the centre (Goldberg, 1992).

A further limitation is that there was no non-alcoholic control group. Research is needed to investigate the occurrence of codependency in other types of samples, for example, as Wright and Wright (1991) note, in families where there is sexual or physical abuse, an obsessive-compulsive parent, mentally ill parent, or a rigid and emotionally repressive home environment. The theory suggests that codependency evolves from being controlled by an authority figure who behaves in a dogmatic yet inconsistent and often punitive way (Wright & Wright, 1991). It would be necessary to explore whether the same distinction of the two groups of spouses can be found in other problematic environments and for that matter, in any family where there is not a dysfunctional partner.

6. CONCLUSION

The main aim of this study was to investigate whether the construct codependency could be found in spouses of alcoholics and if it was in any way related to the level of alcoholism in the alcoholic. It was thought that codependency would enable the alcoholic of the alcoholic. In addition, the relationship between codependency and personality and coping styles was researched in an exploratory manner, in the hope of providing some clarity regarding the construct and of identifying some directions for further research.

It was found that codependency can be identified in spouses of alcoholics but that not all spouses of alcoholics are codependent. (The Codependency Assessment Questionnaire had a reliability of .9171). No relationship was found between being codependent and the level of alcoholism in the alcoholic as measured by the amount drunk, the length of the drinking problem and the total score on the MAST.

However, symptoms of fear, prolonged despair and rigidity in all the spouses, were positively related to the level of alcoholism on the MAST. This indicates that the more severe the alcoholism, the more the spouses experiences feelings of anxiety, is preoccupied with the problems of others, feels unable to trust others, feels hopeless and has a sense of failure. Consequently, they may attempt to control this anxiety and hopelessness by being cognitively, behaviourally and affectively inflexible.

It seems that according to the findings in this sample codependency can best be conceptualized as a syndrome which incorporates both personality traits, coping styles, certain behaviours and symptoms. Here, codependency was highly related to Potter-Efron and Potter-Efron's (1989) characteristics of feelings of shame and guilt with regard to the alcoholic problem, feelings of confusion and identity impairment, rigidity, anger (mostly expressed in a passive-aggressive manner), feelings of

despair and hopelessness and fear or anxiety. Denial, although significantly related, was not as highly related to codependency as the above characteristics.

This study reveals that perhaps someone with codependency takes on too much responsibility for the problem and denies the source of the problem rather than the problem itself. It seems that the codependent spouse might buffer the alcoholic from experiencing anxiety as alcoholics with non-codependent spouses showed significantly higher levels of anxiety. Possibly, in this way, codependency does enable the drinking.

This is in accord with the significant correlation between codependency and the coping styles of blaming oneself for the experienced problems and the seeking of stress alleviation through wishful thinking/escape (dreaming of better times) and self-blame.

As expected, codependent spouses had a significantly lowered self-esteem. Furthermore, codependency was related to dependent, avoidant and schizoid, as well as passive-aggressive personality traits. It was found to be related to high levels of anxiety, dysthymia and somatic complaints.

The construct codependency seems to be useful in distinguishing between two different ways of relating, coping and behaving as spouses of alcoholics. This seems to generate various implications for the treatment of alcoholism, as one would treat an alcoholic with a non-codependent spouse differently to an alcoholic with a codependent spouse. The fact that both people need treatment is clear, especially with regard to the experienced anxiety and feelings of guilt and shame. To treat the one without the other may be detrimental as the non-codependent spouse may be fault finding, distrustful and compulsive in her behaviour which may slow the treatment process. In contrast, the codependent spouse may tend to take on the responsibility for what is happening and thus prevent the

alcoholic from taking responsibility for his own behaviour. The alcoholic with a codependent spouse appears to have a dependent personality pattern which would exacerbate the above process.

Thus, treatment of alcoholism would have to include both the alcoholic and his/her spouse and would have to assess whether the spouse is codependent or not, as this would determine the emphasis of treatment. It seems clear that the relationship between the alcoholic and his spouse needs to be addressed in the treatment. For example, it should be explained to a couple, where the alcoholic has a codependent spouse, that she may be preventing him from taking responsibility for his actions and that he, by enforcing this, colludes with her as he avoids taking responsibility.

However, further research is still needed, especially with regard to the aetiology of codependency, namely whether it develops due to living with an alcoholic, in other stressful environments, or whether it develops in early childhood. Perhaps Wright and Wright's (1991) distinction of endogenous and exogenous codependency could be of use in trying to clarify the above problem. "The endogenous codependent harbours internalized attitudes, self-perceptions, and characteristic modes of relating that predispose her/him to become involved in and to maintain relationships with addicted or similarly dysfunctional partners" (Wright & Wright, 1991, p.442). With exogenous codependency they refer to a person who, with

...essentially **healthy** attitudes and self-perceptions becomes involved with an addicted or similarly dysfunctional person whose problems were not obvious at the onset of the relationship. Codependent forms of relating emerge as the individual attempts to adjust to the difficulties associated with the partner and with the relationship (p.443).

This distinction argues that codependency can evolve from both early childhood and from living in a stressful environment. This implies that the end product, specifically the syndrome codependency, is the same, regardless of its origin. Nevertheless, the aetiology is of importance in treatment. If the codependency is an ingrained manner of relating, the person may need more intensive and prolonged treatment compared to codependency as a result of living in a dysfunctional environment. This indicates the need for longitudinal studies of codependency.

Further questions which need to be investigated are:

1. Whether the same results are to be found in a bigger sample.
2. Whether codependency can also be found in the alcoholics who have codependent spouses.
3. Whether codependency can be found in persons/spouses outside the alcoholic dependency field and in other chemical dependent couples.
4. Whether the low self-esteem in the codependents is a reflection of self-esteem in the normal population and thus not specific to codependency.
5. Whether codependency does enable alcoholism. Perhaps if the level of alcoholism is measured differently, this relationship may emerge more clearly.
6. Whether codependency can be found in male spouses of alcoholics.
7. Whether codependent people have dysfunctional early family environments other than alcoholism.
8. The concept of denial in codependency needs further clarification.
9. To what extent do the codependent / non-codependent spouse's and alcoholic's perception of the reason for the alcoholism differ.
10. In what manner codependent persons attain their sense of self-worth.
11. Whether codependency can be identified across cultures.

In general, perhaps Cermak's (1986) proposal of a DSM-III description of codependency is useful. Categorizing it as a syndrome which incorporates personality, coping styles, specific behaviours and symptoms may be the answer in clarifying and defining the construct. In this manner it can be inclusive of all the different approaches, resulting in a more bio-psycho-social approach.

Although this research has given some clarity to the construct codependency, it has given rise to numerous questions for further investigation. Further research is needed to answer these questions as this study has found that the spouses of alcoholics need to be included in treatment. With further research it may become clearer as to the manner in which they should be included and what this treatment should involve.

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APPENDIX 1.

Dear Sir/ Madam,

Thank you for your interest in this research.

I am doing my masters in Clinical Psychology, and as part of my studies I am doing research into the problems experienced by people who have a drinking problem, and the problems experienced by their spouses.

This research is endorsed and supervised by the Psychology Department of the University of Natal.

The aim of this research is to gain a better knowledge of the problems experienced in this area with the hope to be able to provide a better treatment approach to people with alcohol problems and their spouses.

Your participation will involve the completion of a number of questionnaires which will take up about an hour to an hour and a half of your time.

All the questionnaires will be held in the strictest of confidence and no one other than the researchers will have access to this information.

All results concerning the research will be anonymous and no names will occur in any reports.

If so desired the researchers will be more than happy to provide you with feedback concerning the questionnaires which you will fill in.

We would appreciate your cooperation and would like to thank you in advance for your time.

Yours faithfully,

Marchiene B.W. van der Veen
(Clinical Psychology M1 Student)

supervised by,

Vernon Solomon
(Clinical Psychologist)

APPENDIX 2: DEMOGRAPHIC QUESTIONNAIRE FOR ALCOHOLICS
 (H.F. Joubert, undated, unpublished)
QUESTIONNAIRE 1

1. Age: _____
2. Marital Status: _____
 If married, were you ever divorced? Yes / No
3. Number of children: _____
4. Academic Qualifications: _____
5. Occupation: _____
6. Language of Preference: English / Afrikaans / Other
7. State number of times you've been for treatment in a clinic, up to and including the present: _____
8. When did you last undergo treatment in a clinic: _____
9. Approximately how old were you when you had your first alcoholic drink: _____
10. Which type of liquor do (did) you prefer: _____
11. Do you have any blood relatives whom you regard as being or having been a problem drinker or an alcoholic? Yes / No

If yes, tick the appropriate ones.

Father Mother Brother Sister
 Grandparents Aunts/Uncles Cousins

12. For a typical week, how much alcohol would you consume for each week day?
 State the quantity of each of the following you would consume. The following formula is used for the purpose of this question:
 1 Beer = 340ml ("Dumpie") 1 Wine = 142ml (One glass)
 1 Spirits = 25ml ("Single" Whisky, Brandy etc)

| | SUN | MON | TUE | WED | THUR | FRI | SAT |
|---------|-----|-----|-----|-----|------|-----|-----|
| BEER | | | | | | | |
| WINE | | | | | | | |
| SPIRITS | | | | | | | |

13. When did drinking first begin to be a problem for you: _____ years ago.

14. What, to your knowledge is the main reason for your drinking: _____

15. Are you aware of any thoughts, emotions, feelings or anything inside of you or a specific situation which led to an urge or need to drink: _____

THANK YOU FOR YOUR TIME!

APPENDIX 3: DEMOGRAPHIC QUESTIONNAIRE FOR SPOUSES

QUESTIONNAIRE 1

Please fill in, and or encircle the appropriate answer.

1. Age: _____
2. Education: _____
3. Occupation: _____
4. Employed: yes / no For how long: _____
Income: _____
5. For how long have you been married: _____ years
6. Have you been married before? yes / no
If yes, were you: divorced / widowed
7. How many children do you have? _____
How old are they? _____
8. For how long have you known that your husband has a drinking
problem? _____
9. Have you sought help for your husband's problem before?
yes/no
If yes, how many times, _____
where: _____
when: _____
how long was the treatment: _____
10. Does anyone in your family other than your husband, have a
drinking problem? yes/no
If yes, who? _____
11. Approximately how old were you when you had your first
alcoholic drink? _____
12. Which type of liquor do you prefer? _____
13. For a typical week, how much alcohol would you consume for
each week day?
State the quantity of each of the following you would
consume.
The following formula is used for the purpose of this
question:

1 Beer = 340ml ("Dumple") 1 Wine = 142ml (One glass)
1 Spirits = 25ml ("Single" Whisky, Brandy etc)

| | SUN | MON | TUE | WED | THUR | FRI | SAT |
|---------|-----|-----|-----|-----|------|-----|-----|
| BEER | | | | | | | |
| WINE | | | | | | | |
| SPIRITS | | | | | | | |

14. Has drinking ever been a problem for you? yes/no

If yes, when? _____
 For how long? _____

15. What, to your knowledge is the main reason for your drinking? _____

16. What to your knowledge is the main reason for your husband's drinking? _____

THANK YOU FOR YOUR TIME!

APPENDIX 4: CODEPENDENCY ASSESSMENT QUESTIONNAIRE

(Potter-Efron & Potter-Efron, 1989)

QUESTIONNAIRE 2

The following consists of a number of questions. Please indicate if they apply to you or not.

1. Do you become preoccupied with the problems of others, especially those of your husband? yes/no
2. Do you try to "keep things under control" or "keep a handle" on situations? yes/no
3. Do you take more than your fair share of responsibility for tasks that have to be done? yes/no
4. Are you afraid to approach others directly, in particular your husband? yes/no
5. Do you have anxious feelings or worry about what will happen next? yes/no
6. Do you avoid taking risks with others because it is hard for you to trust? yes/no
7. Do you feel ashamed not only about your behaviour, but also about the behaviour of others, especially your husband? yes/no
8. Do you feel guilty about the problems of others in your family? yes/no
9. Do you withdraw from social contact when you are feeling upset? yes/no
10. Do you sometimes hate yourself? yes/no
11. Do you ever cover up bad feelings about yourself by acting too confidently? yes/no
12. Do you often feel hopeless about changing the current situation? yes/no
13. Do you tend to be pessimistic about the world in general? yes/no
14. Do you have a sense of low self-worth or failure that does not reflect your skills and accomplishments? yes/no
15. Do you feel persistently angry with your husband, other family members or yourself? (please underline the relevant person)? yes/no
16. Are you afraid of losing control if you let yourself get really mad? yes/no

17. Are you angry at God? yes/no
18. Do you ever get back at others in sneaky ways, perhaps without being fully aware of this behaviour at the time? yes/no
19. Do you feel yourself denying the basic problems in your family? yes/no
20. Do you tell yourself that these problems are not that bad? yes/no
21. Do you find reasons to justify the irresponsible behaviour of others in your family? yes/no
22. Do you tend to think in either/or terms when there are problems, instead of looking at many alternatives? yes/no
23. Do you feel troubled if anyone upsets your usual routines? yes/no
24. Do you tend to see moral issues in black-and-white terms? yes/no
25. Do you "get stuck" in certain feelings such as guilt, love or anger (please underline the appropriate)? yes/no
26. Do you have trouble asking for what you want and need? yes/no
27. Do you feel pain right along with another person who is in pain? yes/no
28. Do you need to have another person around in order for you to feel worthwhile? yes/no
29. Do you worry a great amount about how others perceive you? yes/no
30. Do you wonder what it means to be "normal"? yes/no
31. Do you sometimes think that you must be "crazy"? yes/no
32. Do you find it difficult at times to identify what you are feeling? yes/no
33. Do you have a tendency to be taken in by others- to be gullible? yes/no
34. Do you have a hard time making up your mind -are you indecisive? yes/no

THANK YOU FOR YOUR TIME!

APPENDIX 5: MICHIGAN ALCOHOLISM SCREENING TEST

(Selzer, 1971)

QUESTIONNAIRE 2.

Please answer the following questions as honestly and as accurately as possible.

| | YES | NO |
|--|------------------------------------|------------------------------------|
| 1. Do you feel you are a normal drinker? | <input type="checkbox"/> | <input type="checkbox" value="2"/> |
| 2. Have you ever awakened in the morning after some drinking the night before and found that you could not remember a part of the evening? | <input type="checkbox" value="2"/> | <input type="checkbox"/> |
| 3. Does your wife, husband, a parent, or other near relative ever worry or complain about your drinking? | <input type="checkbox" value="1"/> | <input type="checkbox"/> |
| 4. Can you stop drinking without a struggle after one or two drinks? | <input type="checkbox"/> | <input type="checkbox" value="2"/> |
| 5. Do you ever feel guilty about your drinking? | <input type="checkbox" value="1"/> | <input type="checkbox"/> |
| 6. Do friends or relatives think you are a normal drinker? | <input type="checkbox"/> | <input type="checkbox" value="2"/> |
| 7. Are you able to stop drinking when you want to? | <input type="checkbox"/> | <input type="checkbox" value="2"/> |
| 8. Have you ever attended a meeting of Alcoholics Anonymous? | <input type="checkbox" value="5"/> | <input type="checkbox"/> |
| 9. Have you ever gotten into physical fights when drinking ? | <input type="checkbox" value="1"/> | <input type="checkbox"/> |
| 10. Has drinking ever created problems between you and your wife, husband, a parent, or other near relative? | <input type="checkbox" value="2"/> | <input type="checkbox"/> |
| 11. Has your wife, husband, a parent or other relative ever gone to anyone for help about your drinking? | <input type="checkbox" value="2"/> | <input type="checkbox"/> |
| 12. Have you ever lost friends or girlfriends because of your drinking? | <input type="checkbox" value="2"/> | <input type="checkbox"/> |
| 13. Have you ever gotten into trouble at work because of your drinking? | <input type="checkbox" value="2"/> | <input type="checkbox"/> |
| 14. Have you ever lost a job because of drinking? | <input type="checkbox" value="2"/> | <input type="checkbox"/> |

| | YES | NO |
|--|-----|--------------------------|
| 15. Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were drinking? | 2 | <input type="checkbox"/> |
| 16. Do you drink before noon fairly often? | 1 | <input type="checkbox"/> |
| 17. Have you ever been told you have liver trouble? Cirrhosis? | 2 | <input type="checkbox"/> |
| 18. After heavy drinking have you ever had delirium tremens (DTs) or severe shaking, or heard voices or seen things that weren't really there? (<u>Underline those that you have experienced</u>). | 2 | <input type="checkbox"/> |
| 19. Have you ever gone to anyone for help about your drinking? | 5 | <input type="checkbox"/> |
| 20. Have you ever been in a hospital because of drinking? | 5 | <input type="checkbox"/> |
| 21. Have you ever been a patient in a psychiatric hospital or in a psychiatric ward of a general hospital where drinking was part of the problem, that resulted in hospitalization? | 2 | <input type="checkbox"/> |
| 22. Have you ever been seen at a psychiatric or mental health clinic or gone to any doctor, social worker, or clergyman for help with an emotional problem where drinking was part of the problem? | 2 | <input type="checkbox"/> |
| 23. Have you ever been arrested for drunken driving, or driving under the influence of alcoholic beverages? | 2 | <input type="checkbox"/> |
| 24. Have you ever been arrested, even for a few hours, because of other drunken behaviour? | 2 | <input type="checkbox"/> |

TOTAL = 53

(Numbers indicate the score given if that answer is given.)

APPENDIX 6: WAYS OF COPING CHECKLIST

(Folkman & Lazarus, 1980)

QUESTIONNAIRE 3

The following consists of a number of statements concerning how people deal with problems or difficulties. Please indicate on the five point scale how often you use these approaches to deal with the problems you are presently experiencing.

- 1.Waiting to see what will happen.
never very seldom often usually always
- 2.Just taking things one step at a time.
never very seldom often usually always
- 3.Standing your ground and fighting for what you want.
never very seldom often usually always
- 4.Talking to someone who can do something concrete about the problem.
never very seldom often usually always
- 5.Blaming yourself.
never very seldom often usually always
- 6.Feeling you change or grow as a person in a good way.
never very seldom often usually always
- 7.Criticising or lecturing yourself.
never very seldom often usually always
- 8.Avoiding being with people in general.
never very seldom often usually always
- 9.Asking someone you respect for advice and following it.
never very seldom often usually always
- 10.Getting away from it for a while, trying to rest or take a vacation.
never very seldom often usually always
- 11.Getting the person responsible to change his or her mind.
never very seldom often usually always
- 12.Telling yourself things that make you feel better.
never very seldom often usually always
- 13.Wishing you were a stronger person, more optimistic and forceful.
never very seldom often usually always
- 14.Concentrating on something good that can come out of the whole thing.
never very seldom often usually always

15. Maintaining your pride and keeping a stiff upper lip.
never very seldom often usually always
16. Making light of the situation, refusing to get too serious about it.
never very seldom often usually always
17. Accepting, understanding and sympathy for someone.
never very seldom often usually always
18. Coming up with a couple of solutions to the problem.
never very seldom often usually always
19. Rediscovering what is important in life.
never very seldom often usually always
20. Feeling bad that you cannot avoid the problem.
never very seldom often usually always
21. Wishing that you could change the way you feel.
never very seldom often usually always
22. Talking to someone to find out more about the situation.
never very seldom often usually always
23. Hoping a miracle will happen.
never very seldom often usually always
24. Wishing that you could change what has happened.
never very seldom often usually always
25. Thinking about fantastic or unreal things that make you feel better.
never very seldom often usually always
26. Bargaining or compromising to get something positive from the situation.
never very seldom often usually always
27. Changing something so things will turn out alright.
never very seldom often usually always
28. Feeling that time will make a difference, the only thing to do is wait.
never very seldom often usually always
29. Feeling that you came out of the experience better than when you went in.
never very seldom often usually always
30. Accepting your strong feelings but trying not to let them interfere with other things too much.
never very seldom often usually always

31. Trying to make up for some of the bad things that have happened.
never very seldom often usually always
32. Feeling bad that you cannot avoid the problem.
never very seldom often usually always
33. Trying to make yourself feel better by eating, drinking, smoking or taking medication etc.
never very seldom often usually always
34. Realizing that you bring the problem on yourself.
never very seldom often usually always
35. Letting your feelings out somehow.
never very seldom often usually always
36. Doing something totally new that you never would have if this had not happened.
never very seldom often usually always
37. Looking for the silver lining, looking at the bright side of things.
never very seldom often usually always
38. Just concentrating on what you have to do next - the next step.
never very seldom often usually always
39. Keeping others from knowing how bad things are.
never very seldom often usually always
40. Going over the problem again and again in your mind to try and understand it.
never very seldom often usually always
41. Feeling you find new faith or important truth in life.
never very seldom often usually always
42. Taking a big chance or doing something really risky.
never very seldom often usually always
43. Daydreaming or imagining a better time.
never very seldom often usually always
44. Getting angry at the people or things that caused the problem.
never very seldom often usually always
45. Turning to work or substitute activity to take your mind off things.
never very seldom often usually always
46. Accepting the next best thing to things that you wanted.
never very seldom often usually always

47. Being inspired to do something creative.
never very seldom often usually always
48. Talking to someone about how you are feeling.
never very seldom often usually always
49. Sleeping more than usual.
never very seldom often usually always
50. Knowing what has to be done; doubling your efforts and trying harder to make things work.
never very seldom often usually always
51. Taking it out on other people.
never very seldom often usually always
52. Getting professional help and doing what they recommend.
never very seldom often usually always
53. Drawing on your past experiences.
never very seldom often usually always
54. Making a plan of action and following it.
never very seldom often usually always
55. Refusing to believe what had happened. Keeping your feelings to yourself.
never very seldom often usually always
56. Joking about it.
never very seldom often usually always
57. Having fantasies or wishes about how things might turn out.
never very seldom often usually always
58. Trying to forget the whole thing.
never very seldom often usually always
59. Keeping your feelings to yourself.
never very seldom often usually always
60. Not letting it get to you, refusing to think too much about it.
never very seldom often usually always

THANK YOU FOR YOUR TIME!

APPENDIX 7: WAYS OF COPING SUB-SCALES (* = reverse scoring)

1. Wishful-Thinking / Escape

- 1.Waiting to see what will happen.
- 10.Getting away from it for a while, trying to rest or take a vacation.
- 12.Telling yourself things that make you feel better.
- 13.Wishing you were a stronger person.
- 16.Making light of the situation, refusing to get too serious about it.
- 21.Wishing you could change the way you feel.
- 23.Hoping a miracle will happen.
- 28.Feeling that time will make a difference, the only thing to do is wait.
- 32.Feeling bad that you cannot avoid the problem.
- 33.Trying to make yourself feel better by eating, drinking, smoking, taking medication etc.
- 43.Daydreaming or imagining a better time.
- 49.Sleeping more than usual.
- 55.Refusing to believe what has happened. Keeping your feelings to yourself.
- 56.Joking about it.
- 57.Having fantasies or wishes about how things might turn out.
- 58.Trying to forget the whole thing.

2. Acceptance

- 1.Waiting to see what will happen.
- 2.Just taking things one step at a time.
- *8.Avoiding being with people in general.
- 14.Concentrating on something good that can come out of the situation.
- 17.Accepting, understanding and sympathy for someone.
- 26.Bargaining or compromising to get something positive from the situation.
- 31.Trying to make up for some of the bad things that have happened.
- 37.Looking for the silver lining, trying to look at the bright side of things.
- *42.Taking a big chance or doing something risky.
- 45.Turning to work or substitute activity to try and take your mind off things.
- 46.Accepting the next best thing to what you wanted.
- *51.Taking it out on other people.

3. Problem-Focused / Help-Seeking

- 3.Standing your ground and fighting for what you want.
- 4.Talking to someone who can do something concrete about the problem.
- 9.Asking someone you respect for advice and following it.
- 11.Getting the person responsible to change his/her mind.
- 18.Coming up with a couple of difference solutions to the problem.
- 22.Talking to someone to find out more about the situation.
- 27.Changing something so things will turn out alright.

- *28. Feeling that time will make a difference, the only thing to do is wait.
- 38. Just concentrating on what you have to do next, the next step.
- 44. Getting angry at the people or things that caused the problem.
- 50. Knowing what has to be done; doubling your efforts and trying harder to make things work.
- 52. Getting professional help and doing what they recommend.
- 53. Drawing on your past experience.
- 54. Making a plan of action and following it.

4. Emotional Withholding

- *4. Talking to someone who can do something concrete about the problem.
- 8. Avoiding being with people in general.
- *9. Asking someone you respect for advice and following it.
- 15. Maintaining your pride and keeping a stiff upper lip.
- *22. Talking to someone to find out more about the situation.
- *35. Letting your feelings out somehow.
- 39. Keeping others from knowing how bad things are.
- *48. Talking to someone about how you are feeling.
- 58. Trying to forget the whole thing.
- 59. Keeping your feelings to yourself.

5. Self Blame

- 5. Blaming yourself.
- 7. Criticising or lecturing yourself.
- 13. Wishing you were a stronger person, more optimistic and forceful.
- *16. Making light of the situation, refusing to get too serious about it.
- 24. Wishing you could change what has happened.
- 30. Accepting your strong feelings but trying not to let them interfere with other things too much.
- 32. Feeling bad that you cannot avoid the problem.
- 34. Realizing that you bring the problem on yourself.
- 40. Going over the problem again and again in your mind to try to understand it.

6. Growth

- 6. Feeling you change or grow as a person in a good way.
- 14. Concentrating on something good that can come out of the whole thing.
- 19. Rediscovering what is important in life.
- 29. Feeling that time will make a difference, the only thing to do is wait.
- 36. Doing something totally new that you never would do if this had not happened.
- 41. Feeling you find some new faith or some important truth in your life.
- 47. Feeling inspired to do something more creative.

7.Help-Seeking

- 4.Talking to someone who can do something concrete about the problem.
- 9.Asking someone you respect for advice and following it.
- 22.Talking to someone to find out more about the situation.
- 52.Getting professional help and doing what they recommend.

APPENDIX 8: CLINICAL SCALE DESCRIPTIONS OF THE MCMI

(Millon, 1983)

Basic Personality Patterns (Axis II)

This focuses on everyday ways of functioning that characterize the patient even when they are not suffering acute symptoms states. They reflect relatively enduring and pervasive traits that typify patient styles of behaving, perceiving, thinking, feeling and relating to others. The features refer to the premorbid characterological pattern.

Scale 1.: Schizoid (Asocial): 37 items

1. Affectively deficit (e.g., exhibits intrinsic emotional blandness; reports weak affectionate needs and an inability to display enthusiasm or experience pleasure).
2. Mild cognitive slippage (e.g., evidences impoverished and obscure thought processes inappropriate to intellectual level; social communication often tangential and irrelevant).
3. Interpersonal indifference (e.g. possesses minimal "human" interests: prefers a peripheral role in social and family relationships).
4. Behavioural apathy (e.g., experiences fatigue, low energy and lack of vitality; displays deficits in activation, motoric expressiveness and spontaneity).
5. Perceptual insensitivity (e.g., reveals minimal introspection and awareness of self; is impervious to subtleties of everyday social and emotional life).

Scale 2: Avoidant: 41 items

1. Affective dysphoria (e.g., describes a constant and confusing undercurrent of tension, sadness and anger; vacillates between desire for affection, fear and numbness of feeling).
2. Mild cognitive interference (e.g., is bothered and distracted by disruptive inner thoughts; irrelevant and digressive ideation disrupts social communication).
3. Alienated self-image (e.g., describes life as one of social isolation and rejection; devalues self and reports periodic feelings of emptiness and depersonalization).
4. Aversive interpersonal behaviour (e.g., tells of social pan-anxiety and distrust; seeks privacy to avoid anticipated social derogation).
5. Perceptual hypersensitivity (e.g., vigilantly scans for potential threats; over interprets innocuous behaviour as a sign of ridicule and humiliation).

Scale 3. Dependent (Submissive): 33 items

1. Pacific temperament (e.g., is characteristically docile and non-competitive; avoids social tension and interpersonal conflicts).
2. Interpersonal submissiveness (e.g., needs a stronger, nurturing figure, and without one feels anxiously helpless; is often conciliatory, placating, and self-sacrificing).
3. Inadequate self-image (e.g., perceives self as weak, fragile and ineffectual; exhibits lack of confidence by belittling own aptitudes and competencies).

4. Pollyanna cognitive style (e.g., reveals a naive or benign attitude toward interpersonal difficulties; smooths over troubling events).

5. Initiative deficit (e.g., prefers a subdued, uneventful and passive life style; avoids self-assertion and refuses autonomous responsibilities).

Scale 4: Histrionic (Gregarious): 30 items

1. Fickle affectivity (e.g., displays short-lived, dramatic and superficial affects; reports tendency to be easily excited and easily bored).

2. Sociable self-image (e.g., perceives self as gregarious, stimulating and charming; attracts fleeting acquaintances and enjoys rapidly-paced social life).

3. Interpersonal seductiveness (e.g., actively solicits praise and manipulates others to gain attention and approval; exhibits self-dramatizing and childish exhibitionistic behaviours).

4. Cognitive dissociation (e.g., integrates experiences poorly which results in scattered learning and un-examined thought; reveals undependable, erratic and flighty judgment).

5. Immature stimulus-seeking behaviour (e.g., is intolerant of inactivity, leading to unreflected and impulsive responsiveness; describes penchant for momentary excitements, fleeting adventures and short-sighted hedonism).

Scale 5: Narcissistic: 43 items

1. Inflated self-image (e.g., displays pretentious self-assurance and exaggerates achievements; is seen by others as egotistic, haughty and arrogant).

2. Interpersonal exploitiveness (e.g., takes others for granted and uses them to enhance self and indulge desires; expects special favours without assuming reciprocal responsibilities).

3. Cognitive expansiveness (e.g., exhibits immature fantasies and an undisciplined imagination; is minimally constrained by objective reality, takes liberties with facts and often lies to redeem self-illusions).

4. Insouciant temperament (e.g., manifests a general air of nonchalance and imperturbability; appears coolly unimpressible or buoyantly optimistic except when narcissistic confidence is shaken).

5. Deficient social conscience (e.g., flouts conventional rules of shared social living, viewing them as naive or inapplicable to self; reveals a careless disregard for personal integrity and an indifference to the rights of others).

Scale 6: Antisocial (Aggressive): 32 items

1. Hostile affectivity (e.g., has a pugnacious and irascible temper which flares readily into argument and attack; exhibits frequent verbally abusive and physically cruel behaviours).

2. Assertive self-image (e.g., proudly characterizes self as independent, vigorously energetic and hardheaded; values tough, competitive and power-oriented life style).

3. Interpersonal vindictiveness (e.g., reveals satisfaction in derogating and humiliating others; is contemptuous of sentimentality, social compassion and humanistic values).

4. Hyperthymic fearlessness (e.g., exhibits high activation level in impulsive, accelerated and forceful responding; is attracted to and undaunted by danger and punishment).

5. Malevolent projection (e.g., claims that most persons are devious, controlling and punitive; justifies own mistrustful, hostile and vengeful attitudes by ascribing them to others).

Scale 7: Compulsive (Conforming): 42 items

1. Restrained affectivity (e.g., is unrelaxed, tense, joyless and grim; keeps emotional expression under tight control).

2. Conscientious self-image (e.g., sees self as industrious, dependable and efficient; values self-discipline, prudence and loyalty).

3. Interpersonal respectfulness (e.g., exhibits unusual adherence to social conventions and proprieties; prefers polite, formal and correct personal relationships).

4. Cognitive constriction (e.g., constructs world in terms of rules, regulations, hierarchies; is unimaginative, indecisive and upset by unfamiliar or novel ideas and customs).

5. Behavioural rigidity (e.g., keeps to a well-structured, highly regulated and repetitive life pattern; prefers organized, methodical and meticulous work).

Scale 8: Passive-Aggressive (Negativistic): 36 items

1. Labile affectivity (e.g., is frequently irritable and displays erratic moodiness; reports being easily frustrated and explosive).

2. Behavioural contrariness (e.g., frequently exhibits passively-aggressive, petulant and fault finding behaviours; reveals gratification in demoralizing and undermining the pleasures of others).

3. Discontented self-image (e.g., reports feeling misunderstood, unappreciated and demeaned by others; is characteristically pessimistic, disgruntled and disillusioned with life).

4. Deficient regulatory controls (e.g., expresses fleeting thoughts and impulsive emotions in unmodulated form; external stimuli evoke capricious and vacillating reaction).

5. Interpersonal ambivalence (e.g., assumes conflicting and changing roles in social relationships, particularly dependent acquiescence and assertive independence; uses unpredictable and sulking behaviour to provoke edgy discomfort in others).

Pathological Personality Disorders

These scales refer to a chronic or periodically severe pathology in the overall structure of the personality.

Scale 9: Schizotypal (Schizoid): 44 items

1. Social detachment (e.g., prefers life of isolation with minimal personal attachments and obligations; over time, has drifted into increasingly peripheral social and vocational roles).

2. Behavioural eccentricity (e.g., exhibits peculiar habits frequently; is perceived by others as unobtrusively strange or different).

3. Non-delusional autistic thinking (e.g., mixes social communication with personal irrelevancies, obscurities and tangential asides; appears self-absorbed and lost in daydreams with occasional blurring of fantasy and reality).

4. Either (a) anxious wariness (e.g., reports being hypersensitive and apprehensively ill-at-ease, particularly in social encounters; is guarded, suspicious of others and secretive in behaviour); or (b) emotional flatness (e.g., manifests a drab, sluggish, joyless, and spiritless appearance; reveals marked deficiencies in activation and affect).

5. Disquieting estrangement (e.g., reports periods of depersonalization, derealization and dissociation; experiences anxious feelings of emptiness and meaninglessness).

Scale C: Borderline (Cycloid): 44 items

1. Intense endogenous moods (e.g., continually fails to accord mood with external events; is either depressed or excited or has recurring periods of dejection and apathy interspersed with spells of anger, anxiety or euphoria).

2. Dysregulated activation (e.g., experiences desultory energy level and irregular sleep-wake cycle; describes time periods which suggest that affective-activation equilibrium is constantly in jeopardy).

3. Self-condemnatory conscience (e.g., reveals recurring self-mutilating and suicidal thought; periodically redeems moody behaviour through contrition and self-derogation).

4. Dependency anxiety (e.g., is preoccupied with securing affection and maintaining emotional support; reacts intensely to separation and reports haunting fear of isolation and loss).

5. Cognitive-affective ambivalence (e.g., repeatedly struggles to express attitudes contrary to inner feeling; simultaneously experiences conflicting emotions and thoughts toward others, notably love, rage and guilt).

Scale P: Paranoid: 36 items

1. Vigilant mistrust (e.g., exhibits edgy defensiveness against anticipated criticism and deception; conveys extreme suspicion, envy and jealousy of others).

2. Provocative interpersonal behaviour (e.g., displays a disputatious, fractious and abrasive irritability; precipitates exasperation and anger by hostile, deprecatory demeanour).

3. Tenacious autonomy (e.g., expresses fear of losing independence and power of self-determination; is grimly resistant to sources of external influence and control).

4. Mini-delusional cognitions (e.g., distorts events into personally logical but essentially irrational beliefs; embellishes trivial achievements to accord with semi-grandiose self-image).

5. Persecutory self-references (e.g., construes incidental events as critical of self; reveals tendency to magnify minor and personally unrelated tensions into proofs of purposeful deception and malice).

Clinical Symptom Syndromes (Axis 1)

The below mentions symptoms disorders which are mostly of the reactive kind activated by external events. Often there is active pathological process at the time of presentation of the symptoms.

Scale A: Anxiety: 37 items

The high-scoring patient often reports feeling either vaguely apprehensive or specifically phobic, is typically tense, indecisive, restless and tends to complain of a variety of physical discomforts such as tightness, excessive perspiration, ill-defined muscular aches and nausea.

Scale H: Somatoform: 44 items

The high-scoring patient expresses psychological difficulties through somatic channels, reports persistent periods of fatigue and weakness, and may be preoccupied with ill-health and a variety of dramatic, but largely nonspecific pains in different and unrelated regions of the body.

Scale N: Hypomanic: 47 items

The high-scoring patient evidences periods of superficial, elevated but unstable moods, restless overactivity and distractibility, pressured speech, and impulsiveness and irritability.

Scale D: Dysthymic: 36 items

The high-scoring patient remains involved in everyday life, but is downhearted, preoccupied with feelings of discouragement or guilt, exhibits a lack of initiative and behavioural apathy, and frequently voices futility and self-depreciatory comments.

Scale B: Alcohol Abuse: 35 items

The high-scoring patient probably has a history of alcoholism, has made efforts to overcome the difficulty with minimal success, and, as a consequence, experiences considerable discomfort in both family and work settings.

Scale T: Drug Abuse: 46 items

The high-scoring patient probably has a recurrent or recent history of drug abuse, tends to have difficulty in restraining impulses or keeping them within conventional social limits, and displays an inability to manage the personal consequences of these behaviours.

Scale SS: Psychotic Thinking: 33 items

The high-scoring patient, usually classified as "schizophrenic," periodically exhibits incongruous, disorganized or regressive behaviour, often appears confused and disoriented, and occasionally displays inappropriate affects, scattered hallucinations and unsystematic delusions.

Scale CC: Psychotic Depression: 24 items

The high-scoring patient is usually incapable of functioning in a normal environment, is in a severely depressed mood, and expresses a dread of the future and a sense of hopeless resignation. Some exhibit a marked motor retardation, whereas others display an agitated quality, incessantly pacing about and bemoaning their sorry state.

Scale PP: Psychotic Delusions: 16 items

The high-scoring patient, usually considered paranoid, becomes periodically belligerent and often voices irrational, but interconnected sets of delusions of a persecutory or grandiose nature.

(Millon, 1983, p.4/5/6)

APPENDIX 9: SELF-ESTEEM INVENTORIES

(Coopersmith, 1987)

1. Things usually don't bother me.
2. I find it very hard to talk in front of a group.
3. There are lots of things about myself I'd change if I could.
4. I can make up my mind without too much trouble.
5. I'm a lot of fun to be with.
6. I get upset easily at home.
7. It takes me a long time to get used to anything new.
8. I'm popular with persons my own age.
9. My family usually considers my feelings.
10. I give in very easily.
11. My family expects too much of me.
12. It's pretty tough to be me.
13. Things are all mixed up in my life.
14. People usually follow my ideas.
15. I have a low opinion of myself.
16. There are many times when I would like to leave home.
17. I often feel upset with my work.
18. I'm not as nice looking as most people.
19. If I have something to say, I usually say it.
20. My family understands me.
21. Most people are better liked than I am.
22. I usually feel as if my family is pushing me.
23. I often get discouraged with what I am doing.
24. I other wish I were someone else.
25. I can't be depended on.

| | |
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| | 1 |

TOTAL X 4 = 100

APPENDIX 10: SELF-ESTEEM INVENTORIES NORMS

(Coopersmith, 1987)

226 COLLEGE STUDENTS

| <u>SEX</u> | <u>X</u> | <u>SD</u> | <u>N</u> | <u>ALPHA</u> |
|----------------|----------|-----------|----------|--------------|
| MALE | 68.4 | 18.5 | 114 | .79 |
| FEMALE | 71.6 | 19.5 | 112 | .83 |
| CAUCASIAN | 72.3 | 18.3 | 148 | .80 |
| BLACK | 71.2 | 18.4 | 24 | .79 |
| HISPANIC | 64.0 | 19.2 | 13 | .78 |
| ASIAN | 61.6 | 20.0 | 28 | .80 |
| AGE: | | | | |
| 16-19 | 66.7 | 19.2 | 78 | .80 |
| 20-34 | 71.7 | 18.8 | 148 | .81 |
| JUN. COLLEGE | 68.7 | 21.3 | 70 | .85 |
| SAN JOSE STATE | 70.5 | 19.0 | 156 | .79 |
| TOTAL | 70.0 | 19.0 | 226 | .81 |

RAW SCORES PERCENTILE RANKS

| <u>%</u> | <u>SCORE</u> |
|----------|--------------|
| 100 | 100 |
| 95 | 96 |
| 90 | 92 |
| 80 | 88 |
| 75 | 84 |
| 70 | 84 |
| 66 | 84 |
| 60 | 80 |
| 50 | 72 |
| 40 | 68 |
| 33 | 60 |
| 30 | 60 |
| 25 | 56 |
| 20 | 52 |
| 10 | 44 |
| 5 | 36 |
| 0 | 20 |

MEAN = 70

STANDARD DEVIATE = 19

MEAN / ITEM = 2.8

ALPHA REL. = .81

APPENDIX 11: MANN-WHITNEY TESTS

| CAQ | MEAN RANK | MEAN RANK | U | 2 TAILED P |
|--------------|-----------|-----------|------|------------|
| VARIABLE | NON-CODEP | CODEP | | |
| CONFUSION | 8.89 | 25.15 | 19.5 | .0000 |
| DENIAL | 13.71 | 22.22 | 87.0 | .1056 |
| FEAR | 11.18 | 23.76 | 51.5 | .0004 |
| IMPAIRED ID. | 11.50 | 23.57 | 56.0 | .0006 |
| PROLONGED D. | 11.14 | 23.78 | 51.0 | .0003 |
| RIGIDITY | 10.04 | 24.46 | 35.5 | .0001 |
| RAGE | 10.5 | 24.17 | 42.0 | .0001 |
| SHAME | 9.18 | 24.98 | 23.5 | .0000 |

| WCC | MEAN RANK | MEAN RANK | U | 2 TAILED P |
|------------------|-----------|-----------|-------|------------|
| VARIABLE | NON-CODEP | CODEP | | |
| SELF-ESTEEM | 25.57 | 14.00 | 55.0 | .0013 |
| ACCEPTANCE ALC. | 16.29 | 20.65 | 123.0 | .2318 |
| ACCEPTANCE SP. | 20.04 | 18.37 | 146.5 | .6479 |
| EMO. WITHH. ALC. | 21.86 | 17.26 | 121.0 | .2092 |
| EMO. WITHH. SP. | 16.75 | 20.37 | 129.5 | .3228 |
| GROWTH ALC. | 16.89 | 20.28 | 131.5 | .3536 |
| GROWTH SP. | 20.79 | 17.91 | 136.0 | .4321 |
| HELPSEEK ALC. | 16.79 | 20.35 | 130.0 | .3293 |
| HELPSEEK SP. | 18.96 | 19.02 | 160.5 | .9874 |
| PROB. FOC. ALC. | 16.82 | 20.33 | 130.5 | .3379 |
| PROB. FOC. SP. | 18.32 | 19.41 | 151.5 | .7652 |
| SELF BLAME ALC. | 18.64 | 19.22 | 156.0 | .8751 |
| SELF BLAME SP. | 10.46 | 24.20 | 41.5 | .0002 |
| WISH/ESC. ALC. | 17.82 | 19.72 | 144.5 | .6043 |
| WISH/ESC. SP. | 12.89 | 22.72 | 75.5 | .0073 |

| MCM I | MEAN RANK | MEAN RANK | U | 2 TAILED P |
|------------------|-----------|-----------|-------|-----------------|
| VARIABLE | NON-CODEP | CODEP | | |
| 1.SCHIZOID ALC. | 18.32 | 19.41 | 151.5 | .7653 |
| 1.SCHIZOID SP. | 11.54 | 23.54 | 56.5 | .0010 |
| 2.AVOIDANT ALC. | 18.00 | 19.61 | 147.0 | .6605 |
| 2.AVOIDANT SP. | 11.04 | 23.85 | 49.5 | .0005 |
| 3.DEPENDENT ALC. | 14.75 | 21.59 | 101.5 | .0614 |
| 3.DEPENDENT SP. | 13.36 | 22.43 | 82.0 | .0130 |
| 4.HISTRION. ALC. | 21.07 | 17.74 | 132.0 | .3608 |
| 4.HISTRION. SP. | 21.75 | 17.33 | 122.5 | .2253 |
| 5.NARCISS. ALC. | 18.96 | 19.02 | 160.5 | .9875 |
| 5.NARCISS. SP. | 23.82 | 16.07 | 93.5 | .0340 |
| 6.ANTISOC. ALC. | 18.36 | 19.39 | 152.0 | .7768 |
| 6.ANTISOC. SP. | 22.71 | 16.74 | 109.0 | .1022 |
| 7.COMPULS. ALC. | 19.54 | 18.67 | 153.5 | .8139 |
| 7.COMPULS. SP. | 23.89 | 16.02 | 92.5 | .0316 |
| 8.PASS.AG. ALC. | 21.68 | 17.37 | 123.5 | .2392 |
| 8.PASS.AG. SP. | 11.61 | 23.5 | 57.5 | .0012 |
| SCHIZOTYP. ALC. | 18.25 | 19.46 | 150.5 | .7420 |
| SCHIZOTYP. SP. | 14.02 | 22.02 | 91.5 | .0293 .613 * |
| BORDERLINE ALC. | 21.11 | 17.72 | 131.5 | .3551 |
| BORDERLINE SP. | 13.79 | 22.17 | 88.0 | .0220 |
| PARANOID ALC. | 16.25 | 20.67 | 122.5 | .2274 |
| PARANOID SP. | 21.68 | 17.37 | 123.5 | .2399 |
| ANXIETY ALC. | 23.43 | 16.3 | 99.0 | .0520 |
| ANXIETY SP. | 13.32 | 22.46 | 81.5 | .0127 |
| SOMATOFORM ALC. | 20.82 | 17.89 | 135.5 | .4240 |
| SOMATOFORM SP. | 16.39 | 20.59 | 124.5 | .2527 |
| HYPOMANIC ALC. | 18.68 | 19.2 | 156.5 | .8879 |
| HYPOMANIC SP. | 18.82 | 19.11 | 158.5 | .9373 |
| DYSTHYMIC ALC. | 21.61 | 17.41 | 124.5 | .2528 |
| DYSTHYMIC SP. | 11.04 | 23.85 | 49.5 | .0005 |

| | | | | |
|------------------|-------|-------|-------|-------|
| ALC.ABUSE ALC. | 19.29 | 18.83 | 157.0 | .9002 |
| ALC.ABUSE SP. | 16.25 | 20.67 | 122.5 | .2271 |
| DRUG ABUSE ALC. | 17.11 | 20.15 | 134.5 | .4061 |
| DRUG ABUSE SP. | 19.04 | 18.89 | 160.5 | .9875 |
| PSYC.THINK. ALC. | 15.93 | 20.87 | 118.0 | .1769 |
| PSYC.THINK. SP. | 11.61 | 23.5 | 57.5 | .0012 |
| PSYC.DEP. ALC. | 19.36 | 18.78 | 156.0 | .8754 |
| PSYC.DEP. SP. | 13.75 | 22.20 | 87.5 | .0211 |
| PSYC.DEL. ALC. | 15.29 | 21.26 | 109.0 | .1033 |
| PSYC.DEL. SP. | 18.75 | 19.15 | 157.5 | .9126 |

| DEMOGRAPHICS | MEAN RANK | MEAN RANK | U | 2 TAILED P |
|------------------|-----------|-----------|-------|------------|
| VARIABLE | NON-CODEP | CODEP | | |
| MAST | 15.89 | 20.89 | 117.5 | .1724 |
| AMOUNT ALC. ALC. | 20.64 | 18.00 | 138.0 | .4713 |
| AMOUNT ALC. SP. | 18.50 | 19.5 | 154.0 | .7327 |
| NUMBER YRS. ALC. | 14.73 | 20.63 | 100.5 | .1044 |
| AGE ALC. | 24.86 | 15.43 | 79.0 | .0101 |
| AGE SP. | 22.93 | 16.61 | 106.0 | .0846 |
| LENGTH MARRIED | 24.11 | 15.89 | 89.5 | .0249 |
| TREAT REQU. ALC. | 16.07 | 20.78 | 120.0 | .1339 |
| TREAT REQU. SP. | 17.54 | 19.89 | 140.5 | .5115 |
| STD. EDUC. ALC. | 19.11 | 18.93 | 159.5 | .9616 |
| STD. EDUC. SP. | 21.79 | 17.30 | 122.0 | .2068 |
| AGE DRINK. ALC. | 20.68 | 17.98 | 137.5 | .4581 |

APPENDIX 12: CORRELATION MATRIX OF CODEPENDENCY ASSESSMENT QUESTIONNAIRE AND MAST

| COR | COT | CD | FE | SH | PD | RG | DN | RI | II | CF | AT |
|-----|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|
| COT | 1 | .83 | .78 | .87 | .74 | .69 | <u>.39</u> | .85 | .79 | .83 | <u>.39</u> |
| CD | .83 | 1 | .59 | .72 | .60 | .62 | <u>.39</u> | .68 | .58 | .74 | .32 |
| FE | .78 | .59 | 1 | .59 | .54 | .53 | .22 | .68 | .61 | .54 | .53 |
| SH | .87 | .74 | .59 | 1 | .53 | .60 | .19 | .69 | .66 | .77 | .21 |
| PD | .74 | .60 | .54 | .53 | 1 | .56 | .27 | .60 | <u>.45</u> | .54 | <u>.38</u> |
| RG | .69 | .62 | .53 | .60 | .56 | 1 | .04 | .49 | <u>.48</u> | <u>.49</u> | .23 |
| DN | <u>.39</u> | <u>.39</u> | .22 | .19 | .27 | .04 | 1 | .24 | .25 | .32 | .06 |
| RI | .85 | .68 | .68 | .69 | .60 | .49 | .24 | 1 | .75 | .60 | <u>.44</u> |
| II | .79 | .58 | .61 | .66 | <u>.45</u> | <u>.48</u> | .25 | .75 | 1 | .56 | .28 |
| CF | .83 | .74 | .54 | .77 | .54 | <u>.49</u> | .32 | .60 | .56 | 1 | .25 |
| AT | <u>.39</u> | .32 | .53 | .21 | <u>.39</u> | .23 | .06 | .44 | .28 | .25 | 1 |

BOLD = 2-TAILED SIGNIFICANT UNDERLINED=1-TAILED SIGNIFICANT

- COT = CODEPENDENT TOTAL
- CD = CODEPENDENT
- FE = FEAR
- SH = SHAME
- PD = PROLONGED DESPAIR
- RG = RAGE
- DN = DENIAL
- RI = RIGIDITY
- II = IMPAIRED IDENTITY
- CF = CONFUSION
- AT = MAST TOTAL

APPENDIX 13: CHI-SQUARE TESTS

CENTRE VS CODEPENDENCY

| CENTRE | LULAMA | NEWLANDS | ROW TOTAL |
|-------------|-----------|-----------|-----------|
| NON CODEP. | 9 | 5 | 14 / 37.8 |
| CODEPENDENT | 10 | 13 | 23 / 62.2 |
| COLUMN TOT. | 19 / 51.4 | 18 / 48.6 | 37 / 100 |

CHI-SQUARE D.F. SIGNIFICANCE
 1.508124 1 .2194

RACE VS CODEPENDENCY

| CHI-SQ. | WHITES | INDIANS | COLOURED | ROW TOTAL |
|------------|-----------|-----------|----------|-----------|
| NON-CODEP. | 9 | 3 | 2 | 14 / 37.8 |
| CODEPEND. | 10 | 12 | 1 | 23 / 62.2 |
| COL. TOT. | 19 / 51.4 | 15 / 40.5 | 3 / 8.1 | 37 / 100 |

CHI-SQUARE D.F. SIGNIFICANCE
 3.82297 2 .1479

VOLUNTARY / COMMITTED VS CODEPENDENCY

| VOL/COMM | VOLUNTARY | COMMITTED | ROW TOTAL |
|------------|-----------|-----------|-----------|
| NON-CODEP. | 12 | 2 | 14 / 37.8 |
| CODEPEND. | 12 | 11 | 23 / 62.2 |
| COL. TOTAL | 24 / 64.9 | 13 / 35.1 | 37 / 100 |

CHI-SQUARE D.F. SIGNIFICANCE
 4.29575 1 .0382

FAMILY PROBLEM ALCOHOLICS VS CODEPENDENCY

| FAM. PROB. | FATHER | MOTHER | BROTHER | GR. PARENT | UNCLE | NONE | TOTAL |
|------------|-------------|------------|------------|------------|-----------|-------------|-------------|
| NON-CODEP | 5 | 1 | 1 | | 2 | 5 | 14/ 37.8 |
| CODEP. | 5 | 3 | 3 | 1 | 1 | 10 | 23/ 62.2 |
| COL. TOT | 10/ 27.0 | 4/ 10.8 | 4/ 10.8 | 1/ 2.7 | 3/ 8.1 | 15/ 40.6 | 37/ 100 |

CHI-SQUARE D.F. SIGNIFICANCE
 4.75906 6 .5751

FAMILY PROBLEM SPOUSES VS CODEPENDENCY

| FAM. PROB. | FATHER | MOTHER | BROTHER | UNCLE | NONE | ROW TOT. |
|--------------|--------|--------|---------|-------|-------|----------|
| NON-CODEPEND | 1 | | 1 | | 12 | 14/37.8 |
| CODEPENDENT | 3 | 1 | 3 | 1 | 15 | 23/62.2 |
| COLUMN TOTAL | 4/10.8 | 1/2.7 | 4/10.8 | 1/2.7 | 27/73 | 37/100 |

CHI-SQUARE D.F. SIGNIFICANCE
 2.27899 4 .6846