

Codependence: Definition and Identification
in the Junior High School

by

Lenore Berscheid

A thesis submitted to the University of Manitoba in partial
fulfillment of the requirements for the degree of Master of
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Running Head: CODEPENDENCE: DEFINITION AND IDENTIFICATION IN JUNIOR HIGH



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Abstract

Codependency, excessive focus on the reaction of others and reliance on one's ability to control others for one's self esteem, was examined in the literature.

A non random sample of fifteen adolescents was studied to determine whether they had or did not have a number of traits of codependency to warrant a diagnosis according to the criteria proposed by Cermak (1986). The families of these fifteen teenagers were examined to determine whether there was an alcohol abusive parent or grandparent. A yes/no diagnosis of codependency was then related to the presence of one or more alcohol abusive parents/grandparents.

Table of Contents

	Page
Abstract	2
Chapter One: Introduction	4
Chapter Two: Review of the Literature	25
Chapter Three: Method	65
Chapter Four: Results and Discussion	89
Chapter Five: Conclusion and Recommendations	107
Table 1: Codependency Traits from the Diagnostic and Statistical Manual of Mental Disorders	111
Table 2: Cermak's Criteria for Codependency	114
Table 3: Codependency Questionnaire Correspondence	116
Figures 1 and 2: Codependency Circles	117
Tables 4 to 10: Codependency Criteria, other authors	119
Figure 3: Codependency Means for Subsets	132
Table 11: ANOVA Summary	133
Table 12: Chi Square	134
Table 13: Frequency Table, Alcohol Abuse and Alcoholism	135
Tables 14a and 14b: Frequencies	136
Tables 15 to 21: Labels, covering letter and questionnaires	140
References	151

Chapter One

Introduction

History of the StudyProfessional background

In August, 1986, I had completed the coursework for a pre-masters and masters degree in Education at the University of Manitoba. My area of specialization was counselling and the degree program had included two counselling practica. Though the coursework had included cursory studies of several counselling methods, the instructors during the practica had focussed on that of Gerard Egan (1982). Egan's method included work at three levels. In level one the counsellor establishes rapport and obtains the story. In level two the counsellor elicits feeling statements by using various empathic cues and responses. In level three future directions and problem solving are achieved. Egan's belief was that problem solving could not occur while feelings were repressed.

It was with the beliefs and skills learned in the counselling program that I undertook the job of school counsellor in a large junior high school in suburban Winnipeg. I also brought to the job several years experience teaching adolescents in grades six to eleven.

Problems

Among the problems encountered at the school were a number

of students in academic failure or near failure who skipped classes, arrived late, spoke rudely, and were well known in the office and detention room. They also drank alcohol on the weekends and some smoked pot and used magic mushrooms. Of those who were referred to the counselling office in the fall of 1986, there were eight grade eight boys who were willing to go along with my wish to see them weekly for an indefinite period. My goal was to keep them talking about the problems they were experiencing in school, at home, and in the community, until they felt comfortable enough to start talking about their feelings. Then according to Egan (1982) problem solving could begin.

The relationships which developed were good. The boys spoke openly, did not mind my getting to know their parents, and went along with my suggestions to draw pictures, make family trees, listen to me read to them, go for walks with me, and talk in groups. Everyone worked hard, but no facility in emotional identification or expression ensued. Even when painful life experiences were spoken of, the boys maintained a stoic posture and claimed not to know what feelings accompanied the events. No great changes occurred in their behavior or their marks during the eight to eighteen months I continued to see them. However, I did learn a great deal about their histories and the histories of their families. I learned that most of the boys had lost a parent to death or divorce, and all of them had at least one

alcohol abusive parent or grandparent. In spite of all the information I gathered, and all my empathic cues, I could not proceed to level two (Egan, 1982).

I experienced frustration and disappointment as a result of "getting nowhere" by the standards of Egan (1982). These substance using adolescent boys, many of them torn by family tragedy and all affected by someone's drinking, seemed to have relegated their feelings to an obscure room within themselves and then locked the door and lost the key. Occasionally a burst of anger would occur followed by a fight with a peer or a parent. These bursts usually accompanied a perceived injustice such as a parent's refusal to extend a curfew or anyone's accusation of something the boy himself said he did not do. The burst of anger and the fight usually seemed extreme for the occasion - an overreaction. Since this anger represented the closest approximation of a feeling expression that I had to work with, I tried to work with that anger. However, the result was that the boy held on to the triggering event as if it were the whole of reality, and this prevented us from moving on. For example, a boy whose father had left the family without explanation would "get mad" at a friend for not returning five dollars. A fight would follow. All of the boy's anger would be channeled into the dispute over five dollars while the boy stoically claimed it did not bother him that his dad had left. This boy would then drink

several bottles of beer, enough to get drunk, and laugh about the fight.

The boys were not in touch with their feelings. Apparently when the one permissible feeling - anger - surfaced, it had to be focussed on something external or superficial. It also seemed that the weekend drinking by the boys was in part self medication for painful feelings (Palmer, 1988).

Search for Relationship

I began to search for some understanding of the relationship between teen substance use, flat affect, and school/behavior problems. The experimental literature was not helpful. Familial depression was found to be related to alcoholism (Kandel et al 1978), and teen substance use was found to be related to relationship with a parent (Barnes, 1984; Kandel et al, 1978). Polk (1984) felt that alcohol use was just one choice made by alienated adolescents. Education programs were not found helpful in curbing adolescent substance use (Goodstadt, Sheppard, Chan, 1982). Nothing was found which shed light on the relationship I sought. I began to read descriptive works by therapists in the chemical dependency field. I felt these presented the same phenomena I was encountering in my school. However, I was not sure I should trust these non-scientific writings.

Attendance at Johnson Institute

The next logical step seemed to be attendance at a program about adolescent substance use. The Johnson Institute in

Minneapolis offered a three week summer school on chemical dependency. It did not focus on adolescent use, but dealt with adult use and then addressed adult use as a family problem. The third week of the summer school was spent in a treatment facility and it was possible to attend such a facility which served adolescents. I attended the summer school in July, 1988.

Fifty one other adult students attended this summer school. They represented many professions such as social work, the ministry, medicine, education, and private counselling. They ranged in age from 20 to 60. Half were recovering alcoholics/addicts, and more than half were adult children of alcoholics. Knowing these other students proved as valuable as hearing the lectures, because I learned over lunches that familial substance abuse affects children and that one way it does so is by stifling feeling expression. The few works written about this were indeed not works of experimental research but descriptions of therapists' experiences.

Several speakers at the summer school addressed chemical dependency as it affects a whole family. Enabling or codependency behaviors were a major focus. These are the behaviors practised by those around a chemical abuser in an attempt to stabilize the family system. Rescuing, blaming and playing the martyr are three of these. Codependency behaviors actually support the substance abuse and take the codependent

person out of touch with his own needs and feelings.

Observations of Teen Addiction Treatment

During the third week, which was spent at Fairview Deaconness Hospital for the treatment of addicts 12 to 17 years of age, it became clear that the children in treatment had much in common with the eight boys I had worked with as a counsellor. Most had an alcoholic parent or grandparent, all had a history of school and behavior problems, all entered treatment unable to express feelings except indignant anger at perceived injustice. A common perceived injustice was their admission to Fairview Deaconness, usually ordered by the courts! During group sessions with the children, counsellors eventually elicited emotional expression - in fact such expression was a sine qua non of recovery. It was only achieved with sobriety and with thirty days of work from morning to night in group and individual therapy. Guided peer pressure was used to confront resistance. For example, a teen in the fourth week of treatment might say to a first week patient, "Don't tell me it didn't bother you when your dad left. You were just stuffing your feelings. That's why you got in a fight over five measly dollars, and that's why you got wasted so often too." Without the chemicals they were used to using, and with the support and confrontation of various people, those children who were believed by staff to be recovering, began to cry and say how they felt.

Treatment lasted four weeks, with the fourth week being family week. Group sessions included all members of four or five families and all of them were guided to feeling expressions. It was stressed that honest expressions of feelings and needs had to replace codependency behaviors such as rescuing, blaming and playing martyr, or else the addicted persons in the families would go right back to stuffing their feelings and using their substances. It was clear that substance abuse commonly occurred in other family members such as parents or grandparents, and that the family pattern of codependency behaviors had often been in place before the teen in treatment had started using. These behaviors had permitted, even encouraged, the teen to use (Mumey, 1984; Schaefer, 1987).

It was made clear that behaviors such as skipping school, coming late, mouthing off to authorities such as teachers, neglecting school work, and getting into fights were among behaviors predictive of substance use in young people. Many parents had defended their children against the school when the calls had first started coming in about dropping marks and poor behavior. This had enabled the use. Members of school teams had acted codependently too, by "blaming" or covering up problems to avoid further confrontation with parents.

Codependency: A New Question

I concluded that the eight boys I had worked with had come

from codependent family systems. Furthermore, I felt that I had been on the right track with them. However, the boys were still using while they came to see me and were spending almost all of their time in their enabling families, the using peer group, and the alternately blaming and rescuing school system. Thus my efforts had been ineffective, drowned out by these influences.

New Question

If indeed these boys and other students like them suffered from a family interaction disorder which could be called codependency, and if their lack of emotional expressiveness was a symptom of this disorder, then there was a new question at hand. How might codependent students be identified and helped to attain greater success in school?

New Tasks

Two tasks seemed appropriate. One was to read the descriptive literature about codependency in order to understand exactly what it was. The other was to make further observations among students to find out just how codependency looked among adolescents. The eight boys had all left the school which only housed grades seven to nine. However, many others who were similar had become known. In the school years 1988-89 and 1989-90, many of these others were invited to join support groups for codependent teens, called by such names as Caretakers Group, Children of Alcoholics Group, Self Esteem Group, Anger Management

Group. I became acquainted with parents and discussed their children's problems with them, and I continued to see students individually.

I laid the observations of writer-therapists over academic and practical knowledge of adolescents (Elkind, 1978; Friedenberg, 1967; Osborne, 1984) and compared everything to my observations in practice. Writers such as Geringer Woititz (1983, 1985), Wegscheider-Cruse (1985), Beattie (1987), Kritisberg (1985), and Black (1981) were helpful. Cermak (1986, 1986) was particularly helpful because he had compiled a set of diagnostic criteria which fit into the framework of the Diagnostic and Statistical Manual of Mental Disorders (DSM 1987) (see Table 1). This was a manual used by helping professionals such as psychiatrists and such community institutions as Manitoba Adolescent Treatment Centre. Since few helping professionals were knowledgeable about chemical issues such as codependency, it seemed useful to frame the study of adolescent codependency in the diagnostic structure of the DSM. I decided to use Cermak's criteria as a focus for further study (see Table 2), comparing my observations to those criteria. This decision did not reflect a preference for the medical model but merely a desire to frame the study in a manner understandable and believable by the existing helping community.

Observations

The codependent adolescent was observed to lack an

experience of an inner self separate from peers and family, intrinsically valuable and worthy of care and development. This lack of experience of self was different in quality from the ordinary adolescent self seeking through trying different roles and bumping up against authority. It had two main presentations. One was like that of the first eight boys. These children played it cool, used substances in grade seven or grade eight, presented as stoic or controlled except during outbursts, did not do well academically, were bored or could not pay attention in school, and had a tight association with a peer group of rigidly similar tastes in music (usually heavy metal), and clothes (old jeans and heavy metal T shirts). Most smoked cigarettes. Many had been in trouble with teachers, parents and the law.

The other presentation of codependent adolescents was much different. These presented fear verging on panic when another person was ignoring them or needing them beyond their capability to fill the needs. The fear seemed to be that the self would literally disappear unless the other could be won back, or unless these endless needs could somehow be met. These students could not cope with abandonment or rejection (Hines Martin, 1989) even by so called friends who frequently sent hate letters or threatening phone calls, stirred up hatred in other students, and demanded sexual or financial favours or many hours of the person's time.

School problems followed the emotional strain. Homework did not get done and punctuality suffered. Then teachers became angry. That sent these students into further paroxysms of anxiety. The needs of the self during this time of trouble were not identified. In fact, during this anxious time, there seemed to be no awareness of a self separate from the "other".

Codependency Circle

Continued observation of the behaviors of the families of these students revealed a circle of codependency or enabling behaviors, and usually there was an alcohol abusive parent or grandparent. A diagram of this circle is found in Figure 1. In this framework the child is not reacted to in a predictable way by members of the family whose behaviors define the circle. In fact, the way a parent in this kind of family reacts to a child usually has nothing to do with the child but relates to where the parent is in the whirling vortex of the control-explode cycle (Figure 1). In a family in which one parent is actively drinking, the cycle revolves around that, but it also exists in families in which the father is workaholic (Robertson, 1988; Robinson, 1989) or the marriage is on the rocks, or one parent is an adult child of an alcoholic. At least three quarters of the time, this cycle is found to have a chemical connection. Within this framework of family behaviors, it appears that school and behavior problems flourish and even become part of the circle.

The child is then blamed for the tensions in the family (Wegscheider-Cruse, 1976).

Among these behaviors, the codependency traits of the adolescent become entrenched: poor or no self esteem, poor self evaluation, anxiety, depression, hypervigilance, substance use, headaches and other ailments, caretaking and rescuing of others, and conversely acting bad (Cermak, 1986). Some codependent teens specialize in the 'control' side of the codependency circle of behaviours, some in the 'explode' side. Some are outstanding in the quiet traits like depression and headaches, others in the noisy traits like acting bad and noisy hypervigilance. Clearly not all of these adolescents play the same kind of role.

Codependent Family Roles

Wegscheider-Cruse (1976) described four roles played by the children in alcoholic families. They were Hero, Scapegoat, Mascot, and Lost Child. The Hero acted like a pseudo parent, responsible, caretaking, people pleasing and perfectionistic. The Scapegoat was the family bad guy, the person upon whose faults and, real or perceived, misdemeanors the family could blame its problems. The Mascot was the joker who provided comic relief, while the Lost Child had no place and simply hid. Roles could shift over time or be combined in one individual.

It seemed clear that the different presentations of codependency I had observed were the manifestation of different

roles in the families. The stoic troublesome boy was the Scapegoat. The crushed student who could not win back the "friend" or do enough for the other was the Hero or Lost Child. In the counselling office I seldom saw a Mascot unless it was a dual role Mascot-Scapegoat, a child who filled both roles. This seemed to happen in the common two child family. In school, a student who was merely funny, even if disruptive, was tolerated in the classroom. If he was also late, mouthy and poor at getting work done, he would more likely be sent to the office or to counselling. Thus, I saw "Bad Kid Mascots", not "Good Kid Mascots". Within the framework of Cermak's (1986) criteria for codependency, and within the framework of the family circle of codependent behaviors, there were different roles which were played. In school slang, what Wegscheider-Cruse described could be termed Good Kid, Bad Kid, Quiet Kid and Jerk.

There were three perspectives from which to view codependent teens: those of codependency circle behaviours, codependency traits and family roles. The diagnosis of adolescent codependency in the school could be approached from any of these perspectives at first before the picture was filled out by means of observations from the other two perspectives.

Defenses

One barrier to diagnosis of codependency in students was the pseudo self esteem with which they often presented. Students

referred by parents or staff frequently told me they did not have any problems. They were able to verbalize eloquently about their intrinsic worth, their need for self care and their separate lives and selves. This was true even of students from quite chaotic or abusive codependent systems who used substances themselves, were failing in school, and had a couple of court appearances lined up! Since the students' behavior belied the words, it seemed that the show of positive self concept was a defense or survival strategy.

Magee (1987) stated that self concept is the best predictor of accomplishment. Therefore it might be deduced that poor accomplishment could relate to poor self concept. Berne (1985) stated that self esteem was built on success, positive statements, and reasonable expectations. Could children feel adequate who did not experience success at school, about whom negative things were said at school and at home, and of whom nothing consistent was expected in families who rescued them one day and hollered at them the next? Searcy (1988) reported that for development of self esteem, children need total acceptance by parents and defined and enforced limits. Wideman and Clarke (1987) stated that only unconditional messages regarding the child's personal value teach children that they are of intrinsic worth. It does not seem possible for adolescents to feel adequate when they live among unpredictable parental moods and

reactions, and receive only negative feedback about their behavior. These sorts of experiences are common to all children who grow up in homes affected by alcohol abuse and parental codependency, and they were experiences of many students I saw in my school. Their stoic self reports of belief in their own worth I believe are attributable to denial.

Melody (1989) in her discussion of boundaries does speak of the families who teach their young that they are superior. Children raised in these families may indeed esteem themselves highly, even too highly. I believe I have observed a small number of these children. The basis for the esteem seems to lie in the family's wealth or business success. However, I believe that most stoic claims to self esteem on the part of students with poor school performance, bad behavior, or poor social skills and networks are manifestations of denial. This denial is probably essential for survival at this lifestage, fraught with change and vulnerability.

Codependency Circle as Teaching Tool

In meetings with parents of codependent students, I used graphic diagrams of the codependency circle of behaviors (Figure 1) in my gathering of information. For example, I might say, "It sounds like what happens in your home is a circle of behaviors that I call a codependency circle. Let me draw one and see if it sounds like what happens in your home. Mom, suppose a few days

have gone by during which your children haven't done their chore. You have avoided bringing it up because at least your husband has been home participating in the family. Then, he gets busy at work again and you begin to get angry inside but you don't say anything to him because you don't want to start anything.

One night he is late for dinner, and when he phones you can tell his work day is ending up at a bar. As you hang up the phone, all your anger from days ago about how you have done everyone's chores all surfaces in an unstoppable torrent. The first child to walk in the door gets it! You yell about the messy bedroom, the uncut lawn, and so on, which you have not seemed bothered about for days and days. You blame the children for your anger, shame them for being irresponsible, and lay guilt on them for causing you stress."

"Then your husband comes home and you let into him. And he tells you he felt you had a blow up coming on and that is why he stopped at the bar. You have a terrible fight and the children slink out to friends' as soon as their rooms are clean."

"The next morning you wake up full of guilt. You decide you are really out of control, a rotten person, lucky anyone will even live with you. For the next week you do everyone's chores in reparation and in fear that if you try to get someone to act responsibly, you will lose your temper again."

When I did this with a mother, a student, or a family, I

tailored the story so that Susan's equestrian lessons, or Mom's university classes were fitted in, and I always did this in a way which made everyone laugh. Occasionally I did it with parents who were helping professionals. These parents sometimes required no more from me: they went straight to a book store, bought books on codependency, read them, and called me back to say that they knew now what was going on.

Thus, I came to believe that the existence of the codependency circle of behaviors, which by definition existed where honest expressions of needs and feelings had been pre-empted, was a cause of much of the pain and irresponsibility I witnessed in my student clients. I observed this circle in dry families where one or both parents was a child of an alcoholic (Kritsberg, 1988) as well as in families with active abuse and occasionally I saw it in families with no history of substance abuse.

As time went on, if familial substance use became one focus of family meetings, the diagrams of the circle were used to normalize what was going on in the family and to place it in the framework of substance abuse where I felt it was most commonly found. I then explained that both the avoiding and the exploding behaviors lowered the self esteem of everyone. In other words, everyone living this circle felt inadequate or shameful (Fossum and Mason, 1989; Kaufman, 1980). I went on to say that the painful behavior happening in the home would not go away until

the circle of behaviors was interrupted by consistency and honesty. Furthermore, I ventured that if there was any active substance abuse in the family, it would have to be addressed before this consistency and honesty could be learned (Davis, 1987; Mumey, 1984). This did not cause many families to run for treatment (Robinson, 1988). Initial thoughtfulness or agreement was almost always followed by firm denial or an attempt to plan for the breaking of codependency behaviors only around school work.

New Statement of Problem

I came to feel that codependency as a diagnosable pattern of disadvantageous traits which interfered with school success could provide a framework useful in the understanding of many problem students, but that action on it might depend on proof that the pattern of traits was related to familial substance abuse. The denial practised by families with chemical issues might be too great for my opinions alone to have any effect.

This is not to say that every single codependent student had an alcohol/drug abusive family member. Most did, but there were indeed other circumstances in which codependency developed. Families in which a parent was workaholic or chronically ill displayed codependency traits. Incest families did as well. However, it seemed that substance abuse was by far the most outstanding commonalty among codependent families and could not be ignored. Moreover, incest, workaholism and chronic illness were often

found alongside substance abuse (Ackerman, 1989; Hines Martin, 1989).

Need to Heal the Community

There were reasons for seeking proof of the relatedness of student codependency and familiar substance abuse, beyond the hope of leading families to address their chemical issues. At the Johnson Institute it was believed that about 25% of children have an alcoholic parent, that half of chemically dependent people are children of alcoholics, and that 40% of people in the helping professions such as teaching, were children of alcoholics. Almost all of these were codependent (Ackerman, 1989).

Teachers commonly fall into codependent behaviors, avoiding issues because they are busy with so many students at once, but eventually dealing in anger with students whose irresponsibility they have avoided for some time. Honest expressions of need and feeling are not part of the school structure (Friedenberg, 1967). Children are still regularly denied permission to go to the washroom. Children whose parents are divorcing are still berated for not paying attention. Irresponsible students are still often avoided. Classes of two dozen or more do not allow for much individual expression of any kind. The public school system was modeled after the factory in the post industrial revolution. Needing and feeling do not belong in a factory. If indeed the breaking of codependency circles of behavior had anything to do with helping students succeed in school, school staffs would have

to be involved in breaking their own codependency behaviors and replacing them with consistent and honest communications with students.

It has long been known that information programs are ineffective in the prevention of chemical problems (Goodstadt, 1989). Children of alcoholics form the group most highly at risk for future harmful use (Johnson, Leonard, and Jacob, 1989; Tasman, Hales, and Frances, 1989). It would appear sensible to try to identify them early and offset the risks they faced in some fashion. If, as was taught at the Johnson Institute, codependency/enabling behaviors set up and exacerbated the use of substances, and if, once using, children of alcoholics were genetically loaded in favour of addiction (Mumey, 1984; Tasman, Hales and Frances, 1989), then substance abuse prevention had to include large-scale efforts on the part of the whole community to mitigate codependency behaviors (Anderson, 1987).

The purpose of the observations of junior high boys who could not express themselves emotionally had been simply to find out why they lacked that facility. When these observations turned up commonalties regarding alcohol in the family systems, I began to focus on the observations of writer therapists, on the lectures at the Johnson Institute, and the adolescent treatment at Fairview Deaconness Hospital. The purpose of this continued study remained to find out why substance using junior high boys

seemed unable to identify and express their emotions. The answer to this question, given at the Johnson Institute, at Fairview Deaconness Hospital, and by writer therapists, was that the inability to express emotions when found in a person from a family in which alcohol is abused, is one symptom of an interaction disorder presently called codependence. This is the conclusion of the field research portion of this thesis.

This conclusion regarding the inability to express emotion led to the next question: what exactly is codependence as it is described in the limited literature up to 1990? The purpose of the review of the literature was to gain an understanding of codependence as described by chemical dependency counsellors and persons who were recovering from codependence.

Chapter Two

Review of the Literature

The review of the literature had to meet two tightly focussed goals. First, the literature had to be searched for a meaning of codependency upon which several writers agreed. Second, this meaning needed a recognized diagnostic structure.

The reason for these goals was that both the term and the concept of codependency were new. In 1988 the word was unknown as a descriptor for use in an ERIC or Medline computer search except as a phenomenon in chemistry. By 1990 the word existed as a descriptor but called up only three articles in a ERIC search and two in the Medline search. In the counselling community, family therapists and counsellors of adult children of alcoholics used the word throughout the decade of the nineteen eighties. Almost all of the descriptive literature on codependency was published during the nineteen eighties in the field of chemical dependency (Cermak, 1986).

Because Cermak (1986) had described codependency in a manner which approximated the phenomenon I observed among my student clients, and because he had structured his description in the fashion of the widely used Diagnostic and Statistical Manual of Mental Disorders, the review of the literature began with a brief review of his criteria. Following this, each criterion was

sought among the personality disorders in the Diagnostic and Statistical Manual of Mental Disorders to establish that what Cermak (1986) described could indeed be found within the diagnostic structure which exists in the community. It is a medical model, but since there is no educational model at the present time, it was important at least to use some recognized model.

Next, the descriptions of several other writers were examined and compared to the Cermak (1986) criteria to make sure that there was a common concept of codependency.

I did not find any studies of adolescent codependency.

Cermak's Criteria

Cermak (1986) stated that codependency is characterized by fourteen traits, and requires for diagnosis the first four on his list as well as any three of the remaining ten. The first four are labeled A, B, C, and D, while the last ten are designed E one through 10. The entire list is found in Table 2. As Cermak (1986) pointed out, personality traits become disorders when they are inflexible, disadvantageous socially, or stress producing. Like all personality disorders in the Diagnostic and Statistical Manual of Mental Disorders, codependency would be diagnosed not upon the identification of traits alone, but upon the identification of dysfunction caused by intensity or rigidity of traits.

There were four elements in criterion A (Cermak, 1986). These were distorted relationship to willpower, confusion of identities, denial, and low self esteem.

Just as chemically dependent persons in their denial attempt to control their consumption rather than face the fact that they have a problem (Robertson, 1988), so codependents in denial attempt to control the actions of the persons they are addicted to by sheer force of will (Miller, 1989). Unlike persons interdependent on others, codependent persons have no self without the relationship to the other. They are excessively reactive to others (Kritsberg, 1988). They are not sure where they end and the other person begins. There is a confusion of identities, also called boundary confusion (Melody, 1989). If the other is drunk or in a bad mood, the codependent cannot rest. He/she has to tirelessly attempt to soothe, calm, placate or change the other or else lose self in the trap of merely mirroring the other's moods. Codependents use coincidental mood or behavior changes to reaffirm their faith in their belief that they can change the other. If there is no evidence of change, they can reaffirm their own low self esteem. The dysfunction lies in their terror of seeing that they are separate persons not in control of others.

With regard to criterion B (Cermak, 1986), it can simply be said that codependents are caretakers and rescuers. They cannot

sort their needs and wants out of the pile of others' needs and wants. Codependents may act phobically or counterphobically with regard to this and all other traits. The term "phobic", derived from the Greek "phobos" meaning fear and flight, means a "strong fear, dislike, or aversion" (Morris, 1980, p. 985). According to the Diagnostic and Statistical Manual of Mental Disorders, "Avoidance behavior is almost always present in Phobic Disorders..." (p. 235). Thus a person who is afraid that others will only tolerate him or relate to him on the basis of what he does will caretake and rescue and over service the persons with whom he wants a relationship. What he is avoiding in his fear is rejection or abandonment. Sometimes, however - notice that avoidance behavior is almost always present, not always present, -the person with the fear will deal with it by facing it in the extreme. A person with a phobia about heights may take up sky diving. This is a counterphobic reaction. In codependents who fear that others will reject them unless they caretake and rescue, one counterphobic reaction would be withdrawal from people. Another would be treating others badly to invite rejection.

Cermak stated, "Counterphobic behavior is the other side of the coin...Rather than take the chance of being abandoned, (he) refuses to get involved at all" (1986, p. 18).

Codependents then deny their needs and wishes for the sake

of connectedness to others, or else react in opposite fashion, avoiding others, believing social intercourse incompatible with even having needs and wishes. A third presentation is manipulation and control (Cermak, 1986).

Criterion C is "Anxiety and boundary distortions around intimacy and separation" (Cermak, 1986, p. 11). Because codependent persons do not know where they end and other people begin, they equate closeness with compliance and intimacy with fusion (Miller, 1989). They tend to mirror others in all things, even opinions, or else in the reverse they are belligerent and oppositional. Both reactions reflect fear of abandonment. One is a phobic reaction, the other a counterphobic reaction. In relationships, codependents tend to see in black or white: they are either very close friends or they are enemies.

Criterion D is "Enmeshment in relationships with personality disordered, chemically dependent, codependent, or impulse disordered persons" (Cermak, 1986, p. 11). Adolescent defense mechanisms like projection, rationalization, and denial are not left behind in a process of maturation. Because codependent persons give away their power and let others provide their self esteem (Palmer, 1989), they attract others who want that kind of power. These are people with a narcissistic need to be special as chemically dependent and personality disordered people do (Cermak, 1986).

For a diagnosis of codependence, Cermak requires identification of three or more traits from the ten listed in section E. The first of these, excessive reliance on denial, is a tactic of survival in face of the scary feelings which one would experience if one admitted reality. For example, a parent's alcoholism may be denied because to admit it would be to face the fear that the parent was out of control. This denial is selective, hence not psychotic, and it is unconscious. Denial provides pretend security. It is seldom relinquished except in the face of great pain.

The second trait in section E is constriction of emotion. Persons in an unpredictable environment learn not to feel in an effort to convince themselves that they are in control and safe. If a person's environment is very chaotic and there is abuse, this not feeling can devolve into a state resembling chronic shock (Kritsberg, 1988). At the extreme end of environmental chaos and abuse can be found the child who does not bond with an adult and who therefore does not learn to feel except to be filled with rage (Magic, McKelvey, 1987). More commonly, people with constricted emotions have experienced various degrees of unresolved grief and loss. To admit to this would be to acknowledge that one's control over people and events was incomplete.

Section E next lists hypervigilance which is a survival

strategy on the part of people who for physical or emotional safety need to be alert to others' every mood change or nonverbal cue (Greenleaf, 1984). Since codependents react, rather than act as independent persons, being hypervigilant also provides the self with moment by moment feedback about how to react! This is easy to spot in the classroom among children who hear footsteps three classrooms away, distant traffic, and breathing, and therefore cannot concentrate on arithmetic.

Compulsions, listed next, are distractions people provide themselves so they can avoid feeling. Some compulsions are stealing, eating, vomiting, talking and cleaning. Codependents are commonly compulsive.

Anxiety, the next section E trait, sometimes takes the form of phobias or inadequacy attacks, and includes anxiety about one's very existence. It results from not having a firm sense of self and so needing relatedness to others at any cost. It is anxiety producing to endlessly mirror another's needs, values, opinions, and moods, and feel that one always has to be in control of others' behavior. The anxiety of the codependent may become freefloating and all-encompassing (Cermak, 1986).

Further in section E (Cermak, 1986), are the final four traits, namely substance abuse, past physical or sexual abuse, stress related medical illness, and remaining in a primary relationship with an active substance abuser for at least two

years. This last trait, better called a situation, is definitional from the points of view of some authors. Black (1981) spoke of children of alcoholics, and Geringer-Woititz (1983) spoke of adult children of alcoholics in the years prior to the use of the word 'codependency'. Greenleaf (1984) called the children of alcoholics para alcoholics. Living with an alcoholic by definition was believed by many writers to cause behaviors, actions and reactions which match Cermak's (1986) description of codependency (Hines Martin, 1989; Kritsberg, 1988). Ackerman (1989), however, found 8% of daughters of alcoholics unaffected.

Traits are only problems if they are problems. Cermak (1986) described his method of separating traits from problems. If a wife plans a birthday party for her husband and her motivation is to give him a fun time, her action is helpful and not problematic even though it is a caretaking action. If her motivation is to control how he celebrates his birthday, it is a problem. Moreover, if she sees celebrating her husband's birthday as a need she owns, the action is not unhealthy. If she is acting solely to fill his needs, and secretly resents putting on the party, this is unhealthy, codependent action. Further, if she does the planning with a sense of herself as a separate person, able to give the gift of a celebration, the caretaking act of planning the party does not have the codependent colour it would have had she stewed over every detail as she tried to read the mind of her husband and predict his

every wish with regard to food, decorations and guests.

The criteria described by Cermak (1986) for the diagnosis of codependency exist in the Diagnostic and Statistical Manual of Mental Disorders. In its most recently revised form, this manual is referred to as the DSM111R (1987). The traits can be found among the traits for various personality disorders. A psychiatrist using the diagnostic structure of the manual can make a diagnosis of "Personality Disorder Not Otherwise Specified" (DSM111R, 1986, p. 358) by listing traits of more than one of the personality disorders. The psychiatrist would then be shopping among the lists of traits describing various personality disorders, gathering traits appropriate to the patient who has "significant impairment in social or occupational functioning, or subjective stress" (DSM111R, 1987, p. 358).

A list of traits found among those describing various personality disorders in the DSM111R which also describe codependency as Cermak described it (Cermak, 1986) can be found in Table 1. Past sexual abuse appears to be missing in this list but present in Cermak's (1986) list, until one reflects that under Histrionic Personality Disorder, criterion two, "is inappropriately sexually seductive" (DSM111R, 1987, p. 349) is taken among helping professionals to indicate past sexual abuse. Substance abuse is considered a possible trait in codependency according to Cermak (1986) but is missing among traits of

personality disorders in the DSM111R likely because it would be seen as self medication rather than a separate trait.

Hypervigilance is not found explicitly among the traits of personality disorders, but it is implicit in the nervous and anxious flavour of many of the personality disorder traits (DSM111R, 1987).

Codependence then "...is a recognizable pattern of personality traits, predictably found within most members of chemically dependent families, which are capable of creating sufficient dysfunction to warrant a diagnosis of (Personality Disorder Not Otherwise Specified) as outlined in DSM111R" (Cermak, 1986, p. 1). This is a medical model definition.

Descriptions of codependency by seven other writer-therapists, most of whom were also recovering from codependency, were then examined for the traits Cermak (1986) described. Each criterion was found in most of the writers' observations of persons they called codependent, para alcoholic, children of alcoholics, or adult children of alcoholics. For lists of criteria of several authors, see Tables 4 through 10.

While Cermak (1986) in criterion A found that codependents seek to control others even when there are negative consequences, and base their self-esteem upon their ability to exercise this control, Greenleaf (1984) stated that (codependents) repress their feelings in order to block others' actions. Beattie (1987)

stated that codependents receive artificial feelings of self worth from helping others. Beattie (1987) went on to say that codependents respond with strong feelings of low self worth to others' failures, and try to control events and people. They try to say and do what they hope will manipulate others into saying and doing what they want. Beattie (1987) felt that this need to control others was responsible for codependents' inability to have fun. Fun, she stated, requires spontaneity and hence a certain amount of vulnerability to loss of control.

Black (1981) referred to codependents as rigid, controlling, and manipulative. Wegscheider-Cruse (1989) stated that codependents try to please others so that others will like them. Cruse (1989) described them as controlling, while Wegscheider-Cruse (1989) said they need to control self and others. Like Beattie (1987), Wegscheider-Cruse (1989) stated that this need to be in control diminished the codependents' ability to have fun.

Geringer-Woitz (1983) observed that adult children of alcoholics overreact to changes they cannot control. Moreover, she said that adult children of alcoholics seek approval and affirmation and fear that they will lose control of their lives (Geringer-Woitz, 1983).

Clearly, the same phenomenon is described by all.

Cermak (1986), in criterion B, stated that codependents take

upon themselves the meeting of others' need to the neglect of their own. Greenleaf (1984) described them as blaming and projecting, which is to say that they do not assume their own responsibilities. This is the counterphobic response. Greenleaf (1984) also described codependents as unforgiving and judgmental which also sounds like the opposite of the caretaking, selfless codependents who judge themselves without mercy (Geringer - Woititz, 1983). These opposite responses are not contradictions. They are the two sides of one coin. Codependents are indeed persons of the black and white (Miller, 1989), or the "all or none" (Whitfield, 1989, p. 68).

Beattie (1987) stated that codependents think and feel responsible for others' thoughts and needs, but that they also feel that others are responsible for them. Black (1981) described the codependent playing the family role of placator as a person trying to fix everyone's problems, sadness, anger and fears. Wegscheider-Cruse (1989) described codependents as making black and white judgments. Her husband, Joe Cruse, whose list of criteria for codependency are found in his wife's book, described the codependent as a caretaker. Geringer-Woititz stated that (codependents) fit one of two extremes; super responsible or super irresponsible.

Intimacy and separation problems characterized by boundary distortions and their resultant anxiety comprised Cermak's (1986)

criterion C. Greenleaf (1984) described codependents' solitariness. He stated that they were excessively reactive to others, and unable to attend to their own interests or relax when others were around. He also described lack of trust. Trust, he believed, never developed because of unpredictable parent behavior and broken promises. Therefore codependents have no comprehension of trust as a value.

Beattie (1987) also stated that codependents were overreactive to others. Their need to find happiness outside the self, she felt, created in the codependent a need to help, a need to solve problems, and a need to have crises. She also described codependents as desperately in need of approval, to such an extent that they continually let people hurt them. Beattie (1987) also observed the lack of trust as well as a loss of trust in God. Black (1981) described codependents as very dependent upon others, with no power of choice in the way they live. These persons may also be isolated and lack the ability to feel close to other human beings.

Wegscheider-Cruse (1985) spoke of exaggerated patterns of dependence on things and people outside the self, such that codependents have little self identity. She went on to describe problems with intimacy, inability to know what normal behavior is, exaggerated need for approval, fear of abandonment, and fear of loss of control. Geringer-Woitz (1983) stated that

codependents have difficulty with intimate relationships, feel different from other people, and guess at what normal behavior is. Geringer-Woititz (1983) summed up the codependent's fear of abandonment by saying that the unspoken fear is, "You'll leave me anyway" (p. 82).

All of these writers except Greenleaf (1984) and Black (1981) have observed adult codependents. In the above observations, which correspond to Cermak's (1986) criterion C, none of the writers addressed the counterphobic response so common in adolescent codependents I have observed. Their troubles with intimacy are often met with the counterphobic response which can best be described in their vernacular; "screw you."

Cermak (1986) in criterion D stated that codependents became enmeshed with chemically dependent or codependent people or those who were impulse disordered. Greenleaf (1984) considered this a definitional circumstance. Beattie (1987) described codependents as those who formed relationships with needy people and felt compelled to do things for them.

Black (1981) said that children of alcoholics were prone to marry those who were or who would become alcoholic. She observed that sensitive, acting-out children sought out peers of low self esteem. These peers may have been codependent children, and it was likely that the sensitive, acting-out children were as well.

Wegscheider-Cruse (1985) talked about the tendency of

codependents to look for people to care for. She also stated that half of children of alcoholics marry alcoholics while those who do not are prone to promiscuity and confused sexual identity. These trends indicate the codependents' preference for relationships with chemically dependent, codependent and impulse disordered persons.

Cruse (cited in Węscheider-Cruse, 1985), stated that codependents display peer worship, the state of spouse surrogate, undying loyalty, and relationship problems. The picture in all of the observations is of codependents as persons without firm personal boundaries to protect them from entanglements with others who will take advantage of them, and maneuver them into situations in which they will end up meeting everyone else's needs but not their own.

Cermak (1986) cited denial as a codependency trait. Greenleaf (1984) called this lying. Greenleaf (1984) also stated that codependents use grandiosity as a defense, preserving their egos from collapse. This grandiosity may be based on fantasies of future success or revenge. Beattie (1987) said that codependents ignore, pretend, lie and believe lies. She stated that codependents do not say what they mean or mean what they say, but rather cover up and protect the problem.

Black (1981) said that children of alcoholics experience memory loss. Moreover, she stated that alcoholic families

strictly followed the unstated rule of family silence, which is a lifestyle built on denial. Wegscheider-Cruse (1985) stated that codependents denied their anger. She observed that codependents practise lying, exaggerating, denial, and delusion.

Geringer-Woititz (1983) found that codependents lied even when it would have been easy to tell the truth..

Cermak (1986) stated that a trait of codependency was repression of emotions, and that some codependents also had dramatic occasional outbursts of emotion. Greenleaf (1984) described (codependents) as possessing flattened affect. This means that the normal range of emotional, or affective, expression, which would include sadness, surprise, joy and other various expressions does not exist. Instead, there is a flat tone to their expressions. They are stoic instead of sad, indifferent instead of surprised, and rigidly accepting instead of joyful.

Beattie (1987) said that codependents appear rigid and controlling, putting thoughts and feelings out of their awareness because of fear and guilt. She also observed that they may have violent temper outbursts. Black (1981) stated that children of alcoholics have difficulty identifying and expressing feelings, and that they become controlling and rigid. However, she observed that beneath this exterior, codependents suffered anger and guilt. The unspoken family rules (Black, 1981) which forbade

feeling or talking prevented the expression of these emotions.

Wegscheider-Cruse (1987) stated that codependents are angry and guilty but do not express it because they are practising emotional repression. Geringer-Woititz (1983) also stated that codependents repress their anger.

Depression is one of Cermak's (1986) traits found among codependents. Greenleaf (1984) discussed depression and pointed out that for a child who has never experienced consistent love and responses from adults, depression is not the outcropping of loss, but an indication of deprivation. It is the baseline of experience, intrinsic to the personality and therefore much more serious in terms of recovery. Wegscheider-Cruse (1976) in her discussion of roles played by members of the alcoholic family spoke of the Lost Child, the child whose role it is to hide and not be in the way. Suicidality has been found to be higher among codependents who have played this role (Acavedo, 1989) and might indicate that these children have intrinsically depressed personalities such as Greenleaf (1984) described.

Beattie (1987) stated that codependents could be depressed or suicidal or sick. Black (1981) also observed depression in children of alcoholics who, as has been stated, are by definition codependent (Cermak, 1986). Geringer-Woititz (1983) observed that codependents experience a fear that nothing matters anyway, and that this fear grows out of a depressed attitude

which is learned in the alcoholic family.

Cermak's (1986) trait E-4 was hypervigilance. Among school-aged children this presents itself as inattention and hyperactivity, and upon closer examination is found to be an acute awareness of every single event and object in the environment which prevents the individual from concentrating on a task. Greenleaf (1984) described codependents as disruptive. He explained it by observing that codependents have never experienced logical consequences to their own or to their parents' behavior. Their models, moreover, may be models of disruptive behavior. Further, he believed that children behaving in a disruptive fashion may actually be seeking limits by behaving in this way. Whitfield (1984) called this behavior hyperactive.

It is interesting to note that hypervigilance is not a trait noted by many writers. It is, however, one of the most outstanding traits of codependent adolescents in my experience.

Criterion E-5 in Cermak (1986) was the presence of compulsions among codependents. Beattie (1987) observed that codependents become workaholics, spend money compulsively, overeat, develop eating disorders, talk compulsively, and are loyal to their compulsions. Wegscheider-Cruse described codependents as behaving compulsively also. She particularly noticed eating related compulsions such as compulsive eating,

obesity, and anorexia.

Cermak's (1986) criterion E-6 was anxiety. Whitfield (1984) also observed that anxiety was a trait of codependents. Greenleaf (1984) did not use the word anxiety but implied it in his description of codependents as depressed, deprived, helpless, lonely and confused about their roles. Beattie (1987) stated that codependents feel "...terribly anxious about problems and people; (they) worry, (lose) sleep", and wonder whether others like them (p. 39).

Black said that children of alcoholics suffered a pervasive feeling of fear and guilt, which I believe would be anxiety producing, though Black does not use the word 'anxiety'. Wegscheider-Cruse (1985) stated that codependents suffer anxiety about making changes, and fear of abandonment. Geringer-Woitz (1983) felt that fear was so central to the state of adult children of alcoholics that she described them in terms of ten fears which are found in Table 9. It is clear that a state of anxiety exists in codependents. Beyond the fact that the word anxiety is used by several writers, it is implicit in many other criteria as well. One who is hyperaware, compulsive, depressed, and repressive of emotions is surely implicitly anxious, I believe.

Cermak's (1986) criterion E-7 was the use of substances which he felt was a trait often found among codependents. Greenleaf (1984) linked codependence in adults and children with

alcoholism or other chemical dependence, as did Whitfield (1984). Beattie (1987) stated that children of alcoholics are at high risk to become alcoholic, and this has been proven empirically (Tasman, Hales and Frances, 1989).

Cermak did not include other addictions in his (1986) criterion E-7. Possibly he would intend those to be included under compulsions. However, it must be noted that workaholism is cited as a trait of codependents by Wegscheider-Cruse (1985) and by Cruse (cited in Wegscheider-Cruse, 1985).

A history of physical or sexual abuse was observed by Cermak (1986) to be common to many codependents. Greenleaf (1984) stated that there was a relationship between family violence and neglect and family codependence. Beattie (1987) found that codependents have often been victims of sexual, physical, or emotional abuse, neglect and abandonment. Black (1981) reported that histories of children of alcoholics frequently include physical, sexual and verbal abuse. Most child incest cases, according to Wegscheider-Cruse (1985) take place in alcoholic homes.

Ackerman (1989) in a study of 624 adult children of alcoholics and 585 non-adult children found that 19% of the adult children experienced child sexual abuse while only 5% of the non-adult children experienced such abuse. Child physical abuse was reported by 31% of the adult children and 9% of the non-adult

children. Coleman (1990) reported physical abuse and sexual abuse two to four times higher in children of chemically dependent parents.

Stress-related illness is Cermak's (1986) second last trait of codependency. Whitfield (1984) stated that codependents suffer from functional or psychosomatic illness while Beattie (1987) said that they were often depressed or sick. Black (1981) found that children of alcoholics frequently had physical problems related to stress such as headaches, stomach aches, asthma bed wetting. Wegscheider-Cruse (1985) related chronic aches and pains to suppressed anger while Cruse (cited in Wegscheider-Cruse, 1985) stated that codependents may be chronic and sickly.

Cermak's last codependency trait was descriptive of lifestyle. It was having lived with a substance abuser for two years or more without looking for help. Greenleaf (1984) described the child of an alcoholic as a para alcoholic and his description of the para alcoholic was so similar to Cermak's (1986) description of the codependent, it would appear that the two words are interchangeable. Geringer-Woitz (1983) in her description of the adult child of an alcoholic also described the same phenomenon as Cermak (1986) did. It would appear that Greenleaf (1984) and Geringer-Woitz (1983) felt that life with a substance abuser ipso facto caused codependency. Cermak (1986) wrote this criterion as only one of fourteen of which seven were

required for diagnosis. Possibly this contradiction can be reconciled by stating that it is possible but not likely that a child or spouse of a chemically abusive person can live with that person for a length of time such as two years without adopting the pattern of behavior described in this review and called codependency by professionals in the field of chemical dependency. Ackerman (1989) found that 8% of daughters of alcoholics are unaffected.

There were seven other criteria specified by authors other than Cermak (1986). They were insomnia, aggression, shame, difficulty having fun, anger, sexual problems, and the presence of rigid family rules such as do not talk, do not need, do not feel. Each of these can be rationalized in such a way that it actually fits into one of the Cermak (1986) criteria. Insomnia, for example, was believed by Beattie (1987) to exist as a result of worry about others' problems or behaviors. This codependency trait can be viewed as a symptom of anxiety. Aggression, used as a separate codependency trait by Whitfield (1984) can be considered evidence of the intergenerational nature of abuse among some dependents. Wegscheider-Cruse (1985) cited hidden aggression as a codependency trait and stated that frozen anger (in Cermak, 1986, repressed emotion) led to confused, inauthentic interactions such as seeming to give while maintaining control over another.

Shame was a codependency trait observed by Wegscheider-Cruse (1985) and confirmed by Beattie (1987) who said that codependents feel ashamed of who they are. Shame as a familial state of affairs in its own right was described by Kaufman (1980) and Fossum and Mason (1989).

Inability to have fun may be viewed as a need to be in control because to have fun requires a willingness to be surprised. It is mentioned as a separate trait by three writers. Beattie (1987) found that codependents take themselves very seriously, and find it difficult to have fun and be spontaneous. Wegscheider-Cruse (1985) cited the inability of codependents to have spontaneous fun, and Geringer-Woitz (1983) stated that adult children of alcoholics tended not to be spontaneous. She also stated that adult children of alcoholics have difficulty having fun and take themselves extremely seriously.

Anger as a separate codependency trait was dealt with at length by Beattie (1987) who felt that recovering from codependency requires one to address buried anger. Wegscheider-Cruse (1985) stated that codependents are filled with suppressed anger and that once in a while this anger manifests itself in hair trigger temper.

The state of being a spouse surrogate, mentioned by Cruse (1985) and the existence of sexual problems (Beattie, 1987) were discussed by Kritsberg (1988) and Hines Martin (1989). Sexually

abused codependents have particularly poor notions about their boundaries (Mellody, 1989), and this could result in sexual problems and the playing of an inappropriate family role like surrogate spouse (Ackerman, 1989; Mellody, 1989).

Family rules were variously expressed by several writers, and all were related. Beattie (1987, p. 31) stated that the rules were, "Don't talk, feel, need, trust, play, rock the boat, or have realistic expectations." Black (1981, p. 24, 28) said that the rules were, "Don't talk, don't trust, don't feel." Black (1981) also stated some rules specific to persons playing certain roles in the family. The responsible child was to stay busy and look good. The adjuster was to follow directions and do what had to be done. It was up to the placator to apologize. Geringer-Woitz felt that the rule for adult children of alcoholics was: do not talk.

Kritsberg (1988) stated that the rules in the alcoholic family were the rules of silence, rigidity, isolation and denial.

It is possible at this point in the review of the limited literature on codependence to state that the phenomenon of codependence described by Cermak (1986) was the same phenomenon described by Beattie (1987), Black (1981), Greenleaf (1984), Whitfield (1984), Wegscheider-Cruse (1989), Cruse (cited in Wegscheider-Cruse, 1989), and Geringer-Woitz (1983) and by all others referenced in this paper.

Mellody (1989) examined codependency from a perspective different from the above writers in its criteria and its focus on personal boundaries. The phenomenon of codependency was the same phenomenon. In fact, Mellody (1989) quoted Cermak (1986) frequently in the book. However, Mellody (1989) did not list observable traits in order to describe codependency. Rather, she spoke of five core symptoms which were general, internal qualities which acted themselves out in specific behaviors. See Table 11 for Mellody's core symptoms and secondary symptoms.

Core symptom one was "Difficulty experiencing appropriate levels of self-esteem" (Mellody, 1989, p. 6). While unconditional love and acceptance by parents teaches children that they are intrinsically valuable, and therefore leads children to value themselves, lack of this love and acceptance leaves children without healthy self esteem. Missing the belief that they are precious no matter what they do, codependent children either do not esteem themselves, or they display grandiosity, which is inappropriately high self esteem. In the latter case, the presentation may be a counterfeit display which covers up feelings of inadequacy. However, grandiosity can also be a misguided self esteem based on absence of a healthy model and misinformation (Mellody and Miller, 1989).

Persons with no self esteem rely on others' positive reactions or positive events to keep them feeling some sense that

they are tolerable people. Two concrete manifestations of this are codependent parents who derive their "self esteem" from their children's accomplishments, and codependent adults who try to esteem themselves on the basis of their possessions, job status or salary. Codependent persons are missing the inner self defined as imperfect but worthy, which can relate to others in both needing and giving ways (Mellody, 1989). These empty persons are nothing without others' feedback, problems, approval, even their abuse. It is as if the codependents are empty balloons until they are empowered by the air of events and people around them (my analogy).

Mellody's core symptom two was, "Difficulty setting functional boundaries" (Mellody, 1989, p. 11). While a child is taught appropriate boundaries by parents who both respect the child's sensitivities and demand that the child respect theirs, a child who is not taught his and others' boundaries cannot relate to others in healthy ways. This latter child does not know where he ends and other people begin (Fossum and Mason, 1989).

Mellody (Mellody and Miller, 1989) divided the boundary system by designating internal and external boundaries. The external boundary, sexual and physical, is necessary to help people act and react appropriate, physically and sexually. The internal boundary system is "...like a filter to protect...thinking, feeling, and behavior. People who have

healthy internal boundaries know that they are responsible for what they think, feel, or do, and that no one else makes them think, feel, or do anything" (Mellody and Miller, 1989, p.39). People who have healthy internal boundaries do not confuse their needs and feelings with those of others, as codependents do who become enmeshed with others.

People with damaged boundaries may be taken advantage of or used by others, and/or they may take advantage of others or abuse them.

Mellody's (1989) core symptom three was "Codependents' difficulty owning one's own reality." Codependents often report that they do not know who they are in terms of their bodies, their thinking, their feelings, and their behavior. Mellody (1989) cited two levels of dysfunction in this regard. At level A, codependents know who they are but do not reveal it for fear of negative feedback. At level B, they do not know. At this level, it is necessary to act out a reality or to withdraw. If the choice made is to act out a reality, chances are this acting out will consist of mirroring others.

The etiology of this core symptom is in the families of origin, where children are ignored, criticized, contradicted, or abandoned when they express their reality. For example, a child who tells his mother that his father is talking funny and that the bathroom smells of vomit, but who hears his mother say in an

annoyed voice, "Your father is not talking funny and the bathroom does not smell of vomit" (my example) learns not to trust his reality. He may also disown his reality. If he tells his mother that his father scares him, and the mother tells him he is stupid for being scared, he will disown the reality of his being scared. Later in life, if he is in a scary situation, he will mirror the feelings and actions of others (Mellody, 1989). In my experience, he may alternately make fun of others who express fear.

"Difficulty acknowledging our own needs and wants" (Mellody, 1989, p. 28), was core symptom four. There were four presentations of this symptom: 1. "I am too dependent. I know my needs or wants but expect other people to take care of them." 2. "I am antidependent. I am unable to acknowledge to myself that I have needs and wants...I'd rather go without...than be vulnerable and ask for help." 3. "I am needless and wantless. Although I have needs or wants, I am not aware of them." 4. I get my needs and wants confused. I know what I want and I get it, but I don't know what I need" (Mellody, 1989, p. 29).

The etiology of codependents' difficulty getting in touch with needs or wants is found in childhood history. Parents who over-served their children, or who abandoned them in times of need, or who gave materially but not emotionally, left those children uncertain about what they need and want.

"Difficulty experiencing and expressing our reality

moderately" is core symptom 5 (Mellody, 1989, p. 35). Mellody (1989) stated that codependents are persons of extremes. This manifests itself in physical extremes such as extreme body weight or dress and in black and white thinking such as is displayed when codependents need others' total agreement to offset feelings of rejection. This inability to be moderate is also illustrated in the emotional arena. Codependents have not learned how to identify and express feelings honestly, so they may be emotionally flat or wildly explosive (Cermak, 1986; Mellody, 1989).

Following the discussion of the five core symptoms, Mellody (1989) stated that there were five secondary symptoms associated with the five core symptoms. These were controlling others for comfort, resentment of others, distorted spirituality, avoiding reality through addiction or illness, and intimacy difficulties.

Codependents attempt to take control of events and people which they cannot or should not try to control. This is a tendency of anyone who has been raised in an unpredictable environment, and it reflects both their fear of being out of control and their lack of appropriate boundaries. In twelve step thinking, codependents in recovery need to learn to let go control of others' actions and reactions just as alcoholics in recovery need to stop trying to control their substance use (H., 1987). Until codependents begin the recovery process, their self esteem continues to depend upon their perceived ability to

control others' actions and reactions. This control is also a way of getting needs met which the codependents cannot or will not deal with honestly. They manipulate others rather than ask for what they need. Fear of abandonment also lies beneath the need to control (Hines Martin, 1989).

Like Beattie (1987), Mellody (1989) believed that codependents are filled with simmering anger. They are angry at perceived blows to their self esteem by others' reactions or behavior, angry at being taken advantage of when they could not say no, angry because they have misinterpreted events or statements, and angry because they have never expressed anger at times in their past when they were being truly hurt. Mellody (1989) also believed that "Children absorb feelings such as shame, rage, fear and pain from the adult who is abusing them. These feelings remain within the person into adulthood and are called 'carried' feelings because they've been carried forward from childhood...When you are having this form of codependent feeling reality, you feel overwhelmed and out of control" (p. 38).

Thus, Mellody's (1989) core and secondary symptoms of codependency described the same phenomenon as Cermak (1986) described. The two Cermak traits not explicitly discussed by Mellody (1989) are hypervigilance and two years of life with a chemically dependent or codependent person. Hypervigilance is implicit in Mellody's (1989) description of the codependents'

need to control others, and of their mirroring others' opinions and moods. With regard to two years of life with a chemically dependent or codependent person, Mellody (1989) simply approached the whole subject with the assumption that codependent people have been abused. By this she meant that the environment in which they were raised was "less than nurturing" (Mellody, 1989, p. xx).

Further search of the literature for discussions of the phenomenon called codependence (by that name or any other), led me to popular psychology. In the decade of the nineteen eighties, a number of popular psychology books and self help books described painful personal traits which resembled codependency though that word was not used. Some of these were The Wendy Dilemma (Kiley, 1984), Your Erroneous Zones (Dyer, 1976), The Pleasers (Leman, 1987), and The Cinderella Complex (Dowling, 1981). All of the writers of these books advocated self care, definition of personal needs and feelings, and the casting off of the yokes of people pleasing, depression, dependency, and the living of life through others' actions and reactions. Dowling (1981) came closest to describing the phenomenon of codependency, and it seemed worthwhile to report her discussions in this review. They are essentially discussions of her life story.

Dowling (1981) began with her own realization that she would "...like to live, marsupialized, within the skin of another"

(Dowling, 1981, p. 1). She interpreted this as a desire to be taken care of, but it could be seen as the codependent's tendency to give away power and to let someone else provide one's self esteem (Palmer, 1989). She recalled saying, "I don't really have any convictions. I don't really know what I believe" (Dowling, 1981, p. 3). This can be seen as the codependent's need to mirror someone else (Mellody, 1989).

Once settled in with her boyfriend, after her divorce and spate of single parenthood, Dowling (1981) was oddly comfortable with the mindless job of typing her boyfriend's manuscripts. She was comfortable in the role of caretaker. It does not seem, from a reader's point of view, odd for her to fit into this role after having filled the same role in her former marriage with an alcoholic manic depressive (Cermak, 1986). In this new relationship, she suffered panic attacks: a sign of codependent anxiety.

Dowling (1981) stated that, "Like Cinderella, women today are still waiting for something external to transform their lives" (p. 21). She went on to say, of separated women, "Having no men at home, no husbands, (they were) frightened, insecure" (Dowling, 1981, p. 25). These descriptions appear to focus on codependent persons who need external approval for their self esteem (Mellody, 1989). Dowling (1981) reported that she always felt that (her) place was behind somebody, where she felt safe. Codependents commonly feel real only when linked up with their

stuff, or their chemical, the other persons who need and complete them (Miller, 1989).

Dowling (1981, p. 34,35) quoted Helen Deutsch who wrote:

(Women) seem to be easily influenceable and adapt themselves to their companions and understand them.

They are the loveliest and most unaggressive of helpmates and want to remain in that role: they do not insist on their rights - quite to the contrary....they are always willing to renounce their own achievements without feeling that they are sacrificing anything, and they rejoice in the achievement of their companions....They have an extraordinary need of support when engaged in any activity directed outward... (1944, cited in Dowling, 1981)

While Dowling believed this reflected women's desire to be dependent, it indicates low self esteem, fear of independence and such a poor sense of self that one needs to reflect the other to feel real and worthy. (It goes without saying that religion and society have held this up as ideal feminine behavior. Is it dysfunctional? Only if it interferes with one's relationships, occupation, or ability to live with only a manageable amount of stress (Cermak, 1986). To overcome this dependence, if it is perceived to be disadvantageous, requires more than willpower and information, because it is itself an addiction...an undue focus,

denied and protected.)

Dowling (1981) observed that displaced homemakers in a shelter had lost, along with their husbands, their sense of identity. As one woman put it, after her love left, "It begins to feel as if I don't exist" (Dowling, 1981, p. 47). However, where Dowling saw this as a woman's not wanting to take care of herself, in the framework of the addictive system, the woman is focussed on the other and his needs. In other words, she is codependent.

Many other descriptors in Cinderella Complex (Dowling, 1981) fit criteria for codependence...feeling inadequate, fear of others' anger/criticism, fear of stating one's needs, eagerness to please, not asking directly for what one wants, approval seeking manifested by tentative styles of speech, lives ruled by fear, phobia, loneliness, avoidance of intimacy for fear of losing oneself, not acting but reacting, expecting to be recognized for sacrifices, expecting others to read your mind and know what you need without being told, caretaking, approval seeking as motivation for accomplishment, changing opinions if someone disagrees with you, high affiliative needs, seeking control, low self esteem, niceness...nonchallenging, nonconfronting, noncomplaining, people pleasing, helplessness, fusion, fixing the other, denial, sexual dysfunction, self blame, can't trust/need/feel, tired and depressed.

Dowling came closest to describing the addictive nature of codependent when in Chapter Seven she said that in order to spring free, one could not move on willpower. One tends to stay in a situation because the "need to subordinate yourself is in direct opposition to (the need) to succeed...If you are in conflict you marry because of a compulsive...need to be loved, wanted, approved of and taken care of" (Dowling, 1981, p. 228).

Codependence, like any addiction, is a compulsive manner of behavior. In the words of the Alcoholics Anonymous motto, any addiction is cunning, baffling, and powerful.

It seems logical that after the tumult of self discovery and liberation which occurred across the western world during the nineteen sixties and early seventies, there would emerge a popular literature which would urge common people to throw off shackles of various kinds and discover themselves. That some of this popular literature would describe painful personal situations resembling the phenomenon which chemical dependency counsellors came to call codependency, should come as no surprise. The Johnson Institute estimates that 20 to 25% of American children have an alcoholic parent. Ontario Addictions Research Foundation found that 23% of Canadian children also have an alcoholic parent. If most of these emerge from their families acting in codependent ways, there have been millions of North American codependents around for along time, easily observable by

popular psychology writers.

What is perhaps surprising is the failure of the psychiatric community to notice this newly defined behavior pattern. Mellody (1989) searched the literature and found only a few references to dependency personality disorder. This included a 1950 work by psychiatrist Horney, Neurosis in Human Behavior. Horney (1950) spoke of dependency issues. She stated that healthy adults were to a great extent independent except that for survival they needed physical and emotional support. Healthy adults thus are interdependent. This healthy state goes wrong when one seeks others not for support but for a sense of oneself. When this happens, relationships become compulsive and the person takes on a dependent role, or conversely, a tone of rebellion and withdrawal from others. Horney (1950) described this dependence as characterized by inflexibility in relating, abdication of responsibility for one's life, intolerance, depression, rage, vindictiveness when one's demands on others are not met, indiscriminate sacrifice of one's own best interest, magical belief that one will find an answer to life's problems through others.

The neurotic person believed (Horney, 1950) that meaning in life and sense of self as well as security, could only be achieved through the strength and caring of others. The movement of the neurotic person towards others actually was

enmeshment, a wish to lose oneself in the being of the other. Therefore, these neurotic people valued their own helplessness, humility, loveableness and lack of strength and autonomy.

The neurotically dependent person (Horney, 1950), as justification for his/her demand of total devotion by another, offers his or her total devotion and sacrifice. This is reminiscent of Wegscheider-Cruse's (1985) criterion for codependency which she called hidden aggression. A codependent displaying hidden aggression appears to give, but actually seeks to control the other by implicitly requiring total giving in return.

Mellody (1989) reflected that what is, in normal people, a desire to be loved, becomes in the neurotic Horney (1950) described, a desperate drive and claim on others. It is not surprising then that Horney (1950) stated that the last stage of the progression of this neurosis was morbid dependency.

Not until 1980 did the Diagnostic and Statistical Manual of Mental Disorders classify dependency as a separate personality disorder (Millan, 1984, cited in Mellody, 1989). Yet as early as 1913, Kraepelin (1913, cited in Mellody, 1989) discussed dependent patients in terms of their irresoluteness of will and the ease with which others could seduce them.

In retrospect, it would seem that early discussions of the dependent or neurotically dependent personality would have

quickly led to discussions of the codependent personality. The former can be viewed as one presentation of the latter as Melody pointed out when she stated that there were four categories of difficulty in the codependents' acknowledging needs and wants:

1. "I am too dependent. I know my needs or wants but expect other people to take care of them for me, and I wait, expecting them to know to do so as I do not take care of them myself."
2. "I am anti dependent..."
3. "I am needless and wantless..."
4. "I get my wants and needs confused..." (1989, p. 29)

However, up to 1990, the psychiatric literature has not reflected the existence of codependency, but only of dependent personality disorder. As well, of course, there are scattered among the criteria for various other personality disorders in the Diagnostic and Statistical Manual of Mental Disorders, the other criteria for what Cermak suggests be called codependency personality disorder (Cermak, 1986).

Tasman, Hales, and Frances (1989), in the eighth edition of the Review of Psychiatry, dedicated over one hundred pages to alcoholism. The word codependency was never used. In the discussion of treatment, it was not even suggested that prognosis was better in the event of parallel family treatment for addiction supportive behaviors. There is a suggestion in one essay (Frances, Galanter and Miller, in Tasman, Hales and

Frances, 1989) that a network of friends may be helpful to the recovering alcoholic, and that, "Unlike family members involved in system-oriented family therapy, network members are not led to expect personal symptom relief or self-realization" (p. 353). This is all there is in over one hundred pages to suggest that there might be dysfunction in family members of alcoholics.

There are several references in the review to the higher risk of alcoholism endured by children of alcoholics. However, the only faint sign of hope existing in this review (Tasman, Hale and Frances, 1989) to indicate that familial alcoholism is being noticed in the psychiatric community in terms of its relationship to personality disorder, is a mention in an essay on borderline personality disorder (Gunderson and Zanarini in Tasman, Hales and Frances, 1989). "Moreover, they found that a sufficiently high rate of substance abuse (35%) in the first degree relatives of the patients with Borderline Personality Disorder suggests a possible linkage to substance abuse disorders" (p. 36).

(Szasz [1974] suggested that the concept of mental illness, into which the medical model fits addiction and codependency, is merely reification or cultural interpretation. Peele (1989) stated that the interpretation of addiction as illness makes the so called addict helpless. There is much to be said for a deeper

examination of Szasz and Peele in further study of codependence. For the present, the reasons for framing this description of codependence in the context of Cermak's (1986) criteria have already been stated.)

The conclusion of the review of the literature is that there is a pattern of behavior called codependence, described by a number of writer therapists and recovering codependents, which may be summed up by the criteria outlined by Cermak (1986). That pattern closely matched the behaviors of junior high school students I had observed who came from families in which a parent or grandparent abused alcohol. The next questions then emerged: was it possible to diagnose codependency in adolescents using an instrument based on Cermak's (1986) list of codependency traits? Furthermore, could it be determined whether the existence of codependence in an adolescent was related to parental or grandparental alcohol abuse? Answering these two questions became the purpose of the last part of the thesis.

Chapter Three

Method

Subjects

Student subjects were chosen from the student body of the junior high school in which I am employed as school counsellor. The Ethics Committee required that they be chosen from among the students I knew well, and whose parent(s) I also knew well. Thirty-five students fell into this category.

When an announcement appeared in the student bulletin asking that these 35 students come to my office, 20 presented themselves: eight males and twelve females in grades seven, eight and nine.

According to the directions from the Ethics Committee, each student was asked, "Would you be willing to fill in some questionnaires for me, to help in my research? They will be very personal. You will do them privately at home and mail them to me at the University of Manitoba."

All of the students said yes. Therefore, the following was said, "Would you give me permission to ask your parent(s) to do some questionnaires for the study too?" Again, all of the students said yes, and therefore, a parent of each child was contacted by telephone and asked the following, "Would you be willing to receive and consider completing for research purposes,

some questionnaires of a very personal nature?" The Ethics Committee required that the personal nature of the questions be stressed. Parents and students were also informed verbally that they could call me with questions at any time, they could leave out any parts, and they could quit part way through for any reason. These permissions were given in order that no subject be placed in a position of distress as a result of having to respond to questions which caused discomfort.

All of the parents contacted agreed to receive the questionnaires (see Tables 17 through 21), to consider completing them, and if there was a second parent in the home, to consider inviting the second parent to complete a set also. Parental permission for the students to complete the questionnaires was to be implicit since the return of permission letter would compromise anonymity. No one was to sign names on the questionnaires. The parent who examined the questionnaires would by handing the student set over to the child, implicitly allow that child to complete them.

Hand delivery of the family packages followed. Each family received a large envelope with the parent(s) name(s) on it. Inside was a stamped brown envelope addressed to "Berscheid Study, Faculty of Education (Ed. Psych.), University of Manitoba". Inside this there were two or three sealable white envelopes, depending on whether there were one or two parents in the home.

On each white envelope was a label (see Table 15) explaining that respondents should call me at home or at school in the event of questions or distress. The labels also stated that the respondent should fill in the papers privately, seal the envelope privately, and replace the white envelope inside the brown one. There was also a covering letter in the package (see Table 16). A last item in the package was a stamped white envelope addressed to "Yes, send a survey summary", my home address. Respondents wishing a summary filled in a return address of their choice and mailed this envelope.

In due time, I received sixteen family packages. Each was opened and numbered. A chart was made, with family responses numbered and lettered (M for mother, D for father, S for student, male or female) across the top and the questionnaire items down the side. Information from the complete chart was read into the University of Manitoba mainframe computer.

One family package was discarded because of ambiguities in the responses to one questionnaire. Of the fifteen student respondents remaining, three were male, eleven were female, and one did not enter sex. As had been stated, they were all in junior high at the time of the study, that is, in grades seven, eight, or nine, and they were 12 to 15 years of age.

All respondents lived in the suburban area of Winnipeg which comprises the catchment area of my school. The population of

this area is economically and socially diverse. Housing varies from low cost apartments and cooperative townhouses, through modest single family homes, to large, new and expensive houses. The catchment area is bordered by farmland on the south and west sides.

Instruments

The Children of Alcoholics Screening Test (CAST) (Table 17)

This instrument, the Children of Alcoholics Screening Test, was developed by J. W. Jones and published by Family Recovery Press in Chicago, 1981. It can be used to identify children of alcoholics at any age. One yes answer out of thirty indicates a child of non-alcoholic parents. Two to five yes answers indicate a child of a "problem user", and six or more identify a child of an alcoholic.

In one study by Jones in 1982, the C.A.S.T. was administered anonymously to 82 clinically diagnosed children of alcoholics, 15 self reported children of alcoholics, and 118 control group children who were selected at random.

It was found in Chi-square analyses that all 30 items significantly discriminated children of alcoholics (COA's) from control group children. Children of alcoholics scored significantly higher on the C.A.S.T. than control group children.

The diagnosed COA's and self reported COA's did not differ

in responses and so were combined. These 97 children of alcoholics were scored 2, and 118 control group children were scored 1. These group scores were correlated with the total C.A.S.T. scores, to obtain a validity coefficient of .78.

Six or more yes answers reliably identified 100 percent of both groups of children of alcoholics (Pilat and Jones, 1984/85).

The Codependence Questionnaire

Cermak's (1986) criteria for diagnosing codependency in adults were used to build a questionnaire for the identification of adolescent codependency (see Tables 18 and 20). Simultaneous juggling acts were required. Since the students would rate themselves, the questions on the student questionnaire had to be related to Cermak's criteria as they occurred in real adolescent life. The wording of the items had to facilitate students' understanding and make them able to find themselves on a scale. The questionnaire then had to be reworked to make a report of the students' traits possible by the parents. It was felt that parents might identify in their children traits which the children either might not see in themselves, or might minimize. In one case, self identification of anxiety, it was felt that some adolescents might maximize, so the trait was included only in the parents' questionnaire. In other cases, identification of some aspects of some traits was so clearly internal and personal, a question was included only in the student questionnaire.

A student's codependency total was the total number of traits he/she self identified added to the traits identified by the parents only. Identification of a trait was indicated by the circling of "always" or "sometimes" on the scale, where the choices were, "always", "sometimes", "seldom", "no", or by the circling of yes if the choices were "yes/no".

A straight "yes/no" answer was too black and white for most of the questions. Most codependency traits can be best understood as existing on a continuum, with the traits causing problems only on one end. Because subjects eventually had to be judged as having or not having seven traits, however, a yes or no response to the presence of a trait did have to materialize. Hence the scale, "always", "sometimes", "seldom", "no" was used. "Sometimes" would provide a response appropriate for those who acknowledged the presence of a trait on a regular or noticeable basis, but who for reasons of reality or an inner need to minimize, would not choose "always" and might avoid a response like "often" or "usually". The response "seldom" would accommodate those who acknowledged the presence of a trait but found it less present, less obtrusive, less problematic than those who had chosen "sometimes".

Those questions felt to need a black or white answer were left as "yes/no" questions.

Cermak's criteria were the best to use because they are

written in such a way that they could be included in the next DSM. A study into this area had to fit into existing diagnostic structures in order to be credible by the community of helping professionals. Use of these criteria did not signify belief that codependency is a disease needing medical treatment.

Cermak's criterion A, "Continued investment of self esteem in the ability to control both oneself and others in the face of serious adverse consequences" (Cermak, 1986, p. 11) was determined by the following questions to students:

1. a. Do you get anxious if your friends or anyone else doesn't approve of you, or of something you do?

Always	Sometimes	Seldom	No
--------	-----------	--------	----

b. Do you feel uncomfortable if you don't get your way?

Always	Sometimes	Seldom	No
--------	-----------	--------	----

c. Do you ever get stubborn or act angry, or manipulate your friends or parents, to help get your way?

Always	Sometimes	Seldom	No
--------	-----------	--------	----

d. Do you ever purposely do something to get someone mad, even if you'll be grounded, or punished, or a friend will be really upset?

Always	Sometimes	Seldom	No
--------	-----------	--------	----

Parts a and b are designed to identify uncomfortable feelings associated with diminished self esteem, when one cannot control another's reaction (a) or action (b). This may be experienced as

an actual threat to the existence of the self, causing fear and even panic in an adolescent. In practise, these appear to be the most outstanding feelings responses on the part of children whose self esteem is vested in the control of others. Such feelings do not manifest themselves in children who lose control of themselves. This may be the reverse of what occurs in adult codependents, or at least, the reverse of what is manifested. Possibly the adolescent is not yet able to assume a reflective stance and judge his loss of self control. Perhaps because loss of self control is more acceptable for youngsters than for adults in this culture, there is less remorse in the youngsters. Perhaps there is as much remorse in the children but they repress this to salvage their self esteem. In any case, no question was written to identify loss of self esteem around loss of self control. The occurrence of compulsivity, reported as a factual occurrence followed by regret with no inferential link to self esteem, is found in question 9 of the student sheet and corresponds with Cermak's criterion E-5.

Parts c and d of number 1 relate to the student's attempts to control others in the face of adverse consequences. Item 1.d is designed to identify the counterphobic response to approval seeking, mentioned in item 1.a. This response indicated that the control of the other is extremely important, implicitly therefore

that one's self esteem depends on it. It also signals, as do all four items in number 1, that this person has no clear vision of self as separate from the other. This boundary issue is best dealt with by Mellody (1989). The codependent person does not have low self esteem; that person does not esteem self as a separate entity at all. Therefore that person has the need to control others' actions and reactions, in order to eke out some fleeting sense of adequacy.

The questions to parents for Cermak's criterion A are:

1. a. Is this child an approval seeker? That is, does he or she get anxious if your approval, or that of a friend or other valued person, is in doubt?

Always	Sometimes	Seldom	No
--------	-----------	--------	----

b. Does this child try to control others to a greater than normal extent? For example, is this child very stubborn, demanding or manipulative?

Always	Sometimes	Seldom	No
--------	-----------	--------	----

c. Does this child do things to deliberately upset you, even if there is a consequence in store?

Always	Sometimes	Seldom	No
--------	-----------	--------	----

This omits "Do you feel uncomfortable if you don't get your own way?" because that is an internal, personal evaluation. Item 1.b is written from a more global perspective, acknowledging the parent's wider experiences of what is normal in adolescence, and asking them to compare these characteristics in their children to

what is normal. Item 1. a and c are the same as the student's a and d reworded for perspective only.

Cermak's criterion B is "assumption of responsibility for meeting others' needs to the exclusion of acknowledging one's own" (Cermak, 1986, p. 11). Question 2 on the students' sheet said,

2. a. Do you worry about other peoples' problems and forget about your own problems or responsibilities?

Always Sometimes Seldom No

b. Do you do things for others and then realize there is something of your own you didn't get done?

Always Sometimes Seldom No

In a, what was sought was identification of worry as a behavior evidencing assumption of another's responsibilities. In b it was the doing of things others are responsible for doing instead of doing what one is responsible for doing oneself. It is a truism that codependents take responsibility for what they are not responsible for and fail to take responsibility for what they are responsible for (Woititz, 1983). This is very true of adolescents. On the parents' sheet these questions were reworded for perspective only.

Adolescents displaying caretaking tendencies do not necessarily take any action toward fixing others' problems.

However, the emotional burden of worrying about the pickles others get into is commonly so great that the children cannot get homework done, cry a lot, cannot eat, or sleep, and cannot go on with life. When it comes to action, the caretaking tendency is most startling in the sexual arena, where girls who need to not have sex, have it anyway with boys who say they need it. The girls assume the responsibility of meeting the boys' needs to the exclusion of acknowledging their own needs.

Another counterphobic reaction to the need to caretake is social withdrawal. There is no question here to identify that because one could not be worded which would differentiate social withdrawal as a counterphobic response to a desire for connectedness with others from shyness or normal introversion.

Cermak's criterion C says, "Anxiety and boundary distortions around intimacy and separation" (Cermak, 1986, p. 11). In the student questionnaire, question 3 asks,

3. a. Do you ever try to keep a friend even when the friend isn't nice to you?

Always	Sometimes	Seldom	No
--------	-----------	--------	----

b. If a friend stops talking to you, do you think it's your fault and try to get the friend back?

Always	Sometimes	Seldom	No
--------	-----------	--------	----

c. Do you have trouble making friends?

Always	Sometimes	Seldom	No
--------	-----------	--------	----

Codependent adolescents have immoderate relationships. Either they are enmeshed or they are enemies, and either party or both parties can move from one position to the other within an hour. In Junior High counselling practise, girls present commonly with problems related to this phenomenon. Codependent boys are not as forthcoming about their feelings of rejection. Boys seem cooler about relationships in general, but they will become enmeshed with girls, and can become instantly depressed if the girls break up or "dump them". The questions in item 3 apply to both sexes, but there is no doubt that girls make more of an issue of a and b, so that boys may underreport those parts of the question.

The parents' item three omits "If a friend stops talking to you, do you think it's your fault and try to get the friend back?" because this requires a personal evaluation. The other two parts of the question are the same on the parents' questionnaire.

Cermak's criterion D is "Enmeshment in relationships with personality disordered, chemically dependent, codependent or impulse disordered persons" (Cermak, 1986, p. 11). Question 4 on the student questionnaire meant to identify enmeshment with peers of this type. The question said,

4. a. Do you hang around with people your friends, parents or teachers would think are a bad influence?

Yes No

b. Do you have friends who drink or smoke pot?

Yes No

c. Do you have friends who shoplift or steal?

Yes No

d. Do you have friends who lie to their parents?

Yes No

e. Do you have friends who need you and tell you their troubles, but don't listen to your needs and troubles?

Yes No

The parents' questions were the same, telescoped into three parts.

The most outstanding and influential enmeshments with these types of persons would be enmeshments with family members, because from 12 to 15 years of age one is just beginning to break away from the embrace of the family. However, it was not judged wise to write items which would require these kinds of judgements about family members. Item 14 on the parents' questionnaire asked whether this child had lived with a substance abuser for two years, and this is a criterion in its own right. In the student questionnaire, it is omitted and the information supplied

by a CAST score of 2 or more. That is as close as the package comes to assessing enmeshments with personality disordered, chemically dependent, codependent or impulse disordered persons.

It is necessary to note at this point that Cermak's criteria E-1 through E-10 correspond with items 5 through 14 on the parents' questionnaire. The students' questionnaire omits numbers 10 and 14. The correspondence can be found in Table 3.

Cermak's criterion E-1 is reliance on denial, which is a survival tactic. The irony is that there can be an element of denial in the entire self report process used in this study. It was hoped that cross evaluation by parents would compensate for this, but of course parents in a codependent system have their own denial. The questionnaire is clearly inferior to a diagnosis in counselling followed by completion of the CAST.

To identify E-1, students were asked, "Do you lie, change your story, or act innocent?" Parents were asked, "Does this child lie, fib, or change the story?" It was felt that the response "Seldom" would provide an appropriate answer for those who did these things in a normal adolescent quantity and fashion. For those who would respond "Always" or "Sometimes", these traits would be frequent enough to be considered coping mechanisms, hence codependency traits.

Criterion E-2 is "Constriction of emotion with possible

dramatic outbursts" (Cermak, 1986, p. 11). The parents were asked whether the child had difficulty expressing feelings. For the student questionnaire, the question was split, asking not only about expression of emotion, but further saying, "Do you have trouble deciding how you feel?" This is not a question an observer, even a parent, can assess. Some adolescents think they can express their emotions because they get angry. However, displaying anger is not evidence of an ability to express emotions. Therefore the other question was added.

An item was not used to identify dramatic outbursts. Adolescence usually entails periods of outburst, intrinsic to the process of self identification and pulling away from parents. Only in counselling can these normal outbursts be differentiated from the sort that occur after emotional repression.

Criterion E-3 is "Depression". Like dramatic outbursts, some depression is normal during this period, signalling hormonal changes, and the person's inner turmoil and need to change (Geddes, 1985). The parents were asked whether the children displayed depression beyond what would be expected of a normal teen. The students were asked whether they became depressed for more than a day or two. This wording was hoped to communicate the degree of depression that was meant.

Criterion E-4 was "Hypervigilance", which is an inability to

concentrate on one task because one is attentive to all cues in the environment. Like so many codependency traits, it is a survival mechanism for children from families in which moods and actions are not predictable. Students were asked, "Do you have trouble concentrating, more than most people?" Again the establishment of a line of normalcy was essential since adolescence is not a time of optimum concentration. (As the item was written, it called to mind a former male client whose concentration was impaired through Grade Nine by his fear that he would have an erection when the bell rang, and when he stood up people would notice. Bells ring every 38 minutes at my school, and his marks were very poor that year.)

Parents were asked a different question, including in its construction the attentiveness to all things which prevented the attentiveness to one task. "Does this child pay attention to so many things around him/her that he/she can't settle down and concentrate?"

Criterion E-5 is "Compulsivity". Compulsivity is not the same as thoughtlessness, and it was felt that the choice "Seldom" would identify normal occasional adolescent thoughtlessness and impulsive overeating, fibbing, swatting a sibling, or lying about a missing loonie. In the student question, I explained compulsivity rather than use the word; "Do you ever do something

without stopping to think and then regret it?" In the choice, I added drinking and smoking pot to the parents' choices, since the parents would not likely know if those activities were done compulsively at this age.

Criterion E-6 is "Anxiety". This is another trait common in adolescence. In practise, some students express it extremely, or act it out in nervous habits, and some stoically deny it and cover it up with activities, acting out, or macho. Because of this tendency of teens to overreport or underreport anxiety, the identification of it as a trait owned by the students, was left to an item on the parents' questionnaires only. It simply said, "Is this child anxious?" and the responses were yes and no, counting on the parents' adult perspective to categorize the children as anxious if their anxiety was out of the ordinary.

Criterion E-7 is "Substance abuse", and since at age 12 to 15 any use is abuse, students and parents were asked, "Do you/Does this child drink or smoke pot?"

Criterion E-8 is "Sexual or physical abuse". Sexual abuse, especially familial, ongoing sexual abuse, is highly related to codependency (Mellody, 1989). Parents were asked, "Has this child ever been sexually or physically abused?" Students were asked, "Have you ever been sexually touched or hurt by anyone?" because familial sexual and physical abuse are questions on the family trauma questionnaire. Any sexual abuse, and physical

abuse from either questionnaire counted as a yes answer to this criterion.

E-9 is "Stress related medical illness". Students were asked whether a doctor had related a physical problem to stress, while parents were asked, "Has this child any stress related medical illness?" This item differentiated between adults' judgement, experience and knowledge, and the children's, and therefore the children's answer required report of a doctor's diagnosis.

E-10 is "Living with a substance abuser for two years without seeking help." For a child, there is no seeking help, as the child takes the adult behavior for normal. Therefore, just living with the abuser identifies the criterion. If a student scored 2 or more on the CAST, this was counted as a yes to the criterion, and if one of the parents answered yes to question 14, the child received a yes for the criterion. As with all questions, report by either the child or a parent was counted as a yes for that child for that criterion.

As stated earlier, Cermak's criteria were used to develop this questionnaire because they fit into an existing diagnostic structure, the DSM. Moreover, as discussed in the review of the literature, all but two traits (substance use and sexual abuse history) attributed by Cermak to codependency can be found among the Criteria for Personality Disorders in the DSM, where one can

shop among the various disorders and come up with one built of various traits and call it "Personality Disorder Not Otherwise Specified" (DSM111R, 1986). Codependency, then, can already be diagnosed via the DSM111R under this title.

The Shame Scale (Table 19 #2, 21 #2)

Two flavours of codependency were felt to be missing from the codependency questionnaire. One was anger and the other was shame, in the sense of self evaluation as intrinsically inadequate. For exploratory purposes, a shame scale was designed to measure respondents' shame. Four angry or shameful feeling statements were composed, and paralleled with four positive statements, and respondents were asked to check off those which applied to them. To score this, the number of checkmarks next to the negative feelings was counted, and this was the shame score. The total possible then was four.

Please check those that apply.

I have to work really hard to be good enough _____

I'm an OK person just as I am _____

If I'm angry I can just say so and work things out _____

If I ever let my anger out, I'd be afraid what would happen _____

I think I'll find someone who'll love me and share my life _____

I wonder if anyone will ever marry me _____

When I think about the real me what I mostly feel is shame
or inadequacy _____

I know the real me is imperfect but alright _____

It was felt that if only respondents with CAST scores of 2 or more had shame scores, or at least, shame scores of 3 or 4,

there should be an exploratory test for significance.

The Trauma Questionnaire (Table 19 #1, 21 #1)

Family traumas which might have caused unpredictability in families, or might have prevented the meeting of children's needs in the family, were identified by respondents. Had any of these occurred only in the families of students with high codependency scores, a relationship of significance should have been sought.

Students were asked:

Have you experienced any of the following in your family so far:

Please check:

- Death of a parent or brother or sister _____
- Moving to a new country or city, accompanied by serious difficulty for your parents or you _____
- Someone in your home being sometimes very depressed _____
- Fear caused by racial, religious, or ethnic prejudice _____
- Sexual abuse _____
- Physical abuse _____
- Emotional abuse, such as being yelled at or put down a lot _____
- Anything else that could be called trauma _____

Parents were asked:

Did your family (the family in which you lived as a child growing up) experience any of the following?

Please check:

- Untimely death of a parent, when you were a dependent child _____
- Immigration to a new country, with financial, social, or language problems _____
- Manic depressive illness of anyone living in the home _____
- Persistent fear caused by racial, religious, or ethnic prejudice _____
- Sexual abuse, including incest _____
- Physical abuse _____
- Emotional abuse or emotional deprivation _____
- Any other situation which caused your environment to be unpredictable (please describe) _____

Any other state of affairs which resulted in your needs, as you now see them, not being met sufficiently for you to grow up with a sense of who you were and a sense that you deserved to be here on earth, just as you are. (Again, please describe the state of affairs which resulted in these basic needs not being met.) _____

The sexual abuse item was worded thus because there is misunderstanding about the meaning of incest. Incest is any familial sexual abuse.

Design

This was a descriptive study with quantitative elements. Self report surveys were used to determine the current status with respect to the following variables: alcohol abuse in parents and grandparents as measured by the Children of Alcoholics Screening Test (Jones, 1984/5) and the total number of codependency traits of each child. The number of codependency traits was determined by adding the number of items on the codependency questionnaire to which each student answered "Always" or "Sometimes" to the number of items to which their parents had answered "Always" or "Sometimes" when they did not identify themselves as having any part of that trait "Always" or "Sometimes". In other words, identification of one section of a trait by either a parent or the child, caused the child to be considered to have that trait.

A total of seven traits was considered to provide the

classification of codependency for the purpose of this study. Cermak (1986) required the first four and any three of the last ten traits for diagnosis. However, since the first four are the most difficult to identify without interviews, it was decided to accept any seven for this study.

Information respecting two other variables was sought for exploratory reasons. These were the existence of various traumas in the family history, which could have caused unpredictability in the family milieu and/or prevented the meeting of the needs of growing children in the family, and the presence in parents and children of shameful feelings, namely, fear of their own anger and feelings of inadequacy. Self report for trauma and shame items was achieved by checking off appropriate responses. Blank lines were left in the trauma questionnaire for items other than found in the questionnaire. Trauma reports were examined individually with particular attention to incest. The shameful feelings identified were added to provide a shame scale score of zero through four.

Procedure

In order to determine whether there was any significance in the total number of codependency traits (codependency totals) of the children, the following procedure was used: five subsets of the total sample were designated, and the mean codependency total for each subset was found. The subsets were as follows:

- a) the subset of students who had alcohol abusive parent(s) but not grandparent(s), that is, those students who had CAST scores of two or more, but whose parent(s) had CAST scores of zero or one;
- b) the subset of students who had alcohol abusive parents but no grandparents, that is, the students who had CAST scores of zero or one, but who had one parent or two parents with a CAST score of two or more;
- c) the subset of students who had alcohol abusive parent(s) and grandparent(s), that is, the students with CAST scores of two or more who also had a parent or two parents with a CAST score of two or more;
- d) the subset of students with neither alcohol abusive parent nor grandparent, that is, the students with CAST scores of zero or one whose parents also had CAST scores of zero or one; and
- e) the subset of students who have neither alcohol abusive parent nor grandparent whose family questionnaires contained no report of incest.

Subset e) was used because familial sexual abuse, incest, is related to codependency in the literature, as is alcoholism (Mellody, 1989). Thus the presence of non alcohol-related incest in subset d) could distort the mean of codependency traits in subset d).

A one way analysis of variance (ANOVA) was performed on the

means of the subsets to determine whether familial alcohol abuse had a significant effect on the codependency totals of the children. A significance level of .05 was chosen (see Table 11, Figure 3).

A Chi square was conducted with respect to yes/no diagnosis for codependency (seven traits) and yes/no presence of alcohol abuse in a parent or grandparent, that is yes/no score of two or more on the CAST of either the student or either of the parents. A significance level of .05 was chosen (see Table 12).

Frequency counts were conducted on item by item responses to the trauma and codependency questionnaires, and on the totals of only of the other two questionnaires, the shame scale and the CAST (see Tables 14a, 14b).

Chapter Four

Results and Discussion

Results

Total number of codependency traits for each student was obtained by adding the number of student self identified traits to the number of traits the student did not self identify but which the parents identified as being owned by the student.

Five subsets of students were identified:

- a) those with alcohol abuse or alcoholic parent(s); that is, those with CAST scores of 2 or more;
- b) those with alcohol abusive or alcoholic grandparent(s); that is, those whose parent(s) had CAST scores of 2 or more;
- c) those with alcohol abusive or alcoholic parent(s) and grandparent(s).
- d) those with neither an alcohol abusive nor alcoholic parent or grandparent;
- e) those from group d) who had no parent with a history of incest.

Analysis of variance was then performed on the means of the subsets to determine whether there was any significance in the difference between the means of these subsets of students (see Table 11). A significance of .05 was sought.

The overall ANOVA was significant ($F(4,13)=4.66$; $p=.0148$).

A post hoc test (Duncan) revealed a significant difference between family pattern c) in which the students had both an alcohol abusive or alcoholic parent or grandparent, and family patterns d) and e), in which the student had no alcohol abusive or alcoholic parent or grandparent (see Figure 3).

Chi Square

Students' codependency totals were classified as yes or no: those with totals of seven or more were classified yes for codependency, while those with totals of six or less were classified no for codependency. Students were also classified yes or no with regard to their having or not having an alcohol abusive or alcoholic parent or grandparent. A student was classified yes for this if he or she or one of his or her parents scored 2 or more on the Children of Alcoholics Screening Test. Scores of 0 or 1 on the part of the student and parent(s) resulted in a classification of no for this. Then a Chi square test was performed (see Table 12). The Chi square test was significant ($\chi^2(1)=6.516$; $p=.011$).

Ten subjects fit into the Yes/Yes portion of the Chi square: Yes, they had an alcohol abusive parent or grandparent, and, yes, they scored 7 or more on the codependency questionnaire. Three subjects fit into the No/No portion. These had neither an alcoholic parent or grandparent nor a codependency total of 7 or more.

One subject fit into each of the other portions of the square: No/Yes and Yes/No. One had no alcohol abusive parent or grandparent but did have a codependency total of more than 7. This subject's mother was an incest survivor. One subject had an alcohol abusive parent or grandparent but a codependency total of less than 7.

Frequency Tables

Frequency of various Children of Alcoholics Screening Test scores can be found in Table 13. Among students, 27% had an alcoholic parent and twenty percent had an alcohol abusive parent. Forty seven percent then had a parent who was alcohol abusive or alcoholic. Among the nine fathers who responded to the questionnaire, only one reported an alcoholic parent, and one an alcohol abusive parent. Among mothers, five or 33% had an alcoholic parent, while one, or 7%, had an alcohol abusive parent.

Frequency of occurrence of various traumas can be found in Table 14a. The sample size was too small for these frequencies to assume any meaning.

Discussion

Limitations of the Study

The main limitation in this study was the small, non-random sample size. Two other factors may also have limited the study. One was the male to female ratio of student respondents: three boys, eleven girls, and one respondent of unstated sex. Early

literature describing codependency-like phenomena dealt with these phenomena as female problems. In order to balance the picture of codependency in the adolescent population, a sexually balanced picture would have been preferable. One could then avoid the criticism that what was being described was a female problem. The other factor which may have limited the study was the fact that all of the subjects were known to me in my capacity as school counsellor. Not all students who know me have problems, but most do. The sample may then have had a higher incidence of all of the problems listed in the questionnaire than a random sample of students would have had.

In spite of these possible limitations, the percentages of subjects having some traits and strengths matched the percentages found by other experts reporting on much larger populations. This was gratifying. For example, the rate of incest and the rate of familial alcoholism and alcohol abuse matched the rates reported by Biedler (1990) and Sobell (1989). Ackerman (1989) found 8% of daughters of alcoholics were unaffected, and this study found one subject out of 11 from families having one or more alcohol abusive members who had a codependency total of less than 7. This 1 out of 11 is 9%. These close matches serve to validate the results in spite of the small sample size.

Factors Mitigating Limitations

A factor which may have mitigated the limitations was the

intergenerational nature of the survey, including the parental evaluation of the students' codependency traits. In the original research plan, questionnaires would have been administered only to students. Under that scheme, grandparental alcoholism and alcohol abuse would have been underreported. This is because some grandparents who had used alcohol abusively in their younger years would have stopped doing so, or else they would not do so in front of the grandchildren, or else when they did their children may have reframed this abuse as illness or aberration. The children would not have been fully aware of abuse. Having the parent(s) complete the Children of Alcoholics Screening Test gave a clear picture of the students' grandparents' alcohol use.

The parents' involvement in the study also allowed for the report of incest in the parents' histories. This gave insights into the frequency with which incest and alcohol abuse occurred together. In the one family in which incest was reported by the mother, but no alcohol abuse was reported, the codependency total of the female child was over seven. This confirms Mellody's (1989) observation that sexual abuse is a precursor to codependency. The study did not reach alcohol abuse on the part of the parents' grandparents, of course. In the case of this mother, the incest could have been committed by an alcohol abusive grandparent or other relative. Larger studies need to be done in this area before the relationship between sexual abuse

and chemicals is understood. In the fifteen families used in this study, three parents reported incest, and two of the three reported parental alcohol abuse or alcoholism. (In the one family which was eliminated, the mother reported incest by an alcohol abusive grandfather. This brings the total incest incidence to four, with three out of the four occurring alongside alcohol abuse or alcoholism.)

The use of parents' checklists for students' codependency traits proved useful because in several cases a parent identified a trait which the student had not identified. This probably provided a more accurate codependency trait total. Ideally, an added checklist, completed by a counsellor trained in this area would be used also. In the questionnaire, traits which posed problems were identified by their presence "Always" or "Sometimes". This left room for overreaction and underreaction on the parts of the students and parents filling out the questionnaires. In a counselling setting, with the same counsellor evaluating a number of possibly codependent clients, the level of anxiety, pain or school problems caused by a trait could be more objectively assessed.

The fact that the families who participated in the study knew me, and trusted me enough to fill out these questionnaires, undoubtedly resulted in more detailed accurate information than would have been procured in any sample other than one chosen for

its close relationship to me. Only four families failed to send in their responses.

Other Aspects

Questions were not left out except by one father who omitted one side of one questionnaire. Therefore, people chose to answer even deeply personal questions rather than leave them out in spite of their having been told it would be permissible to leave out anything found distressing. It is also interesting that I received no phone calls of distress. Many of these families had already seen me during extreme family distress, so my relationship with them was such as to facilitate any necessary distress calls. Yet none came. Either these very personal questions caused no distress, or they went ahead with the questionnaires in spite of the distress.

The shame scale, designed to identify feelings of inadequacy common to codependents, but not elicited by the questions in the codependency check list, was not useful. This was disappointing. I expected that a shame scale score of three or four in a parent or child would be related to a codependency score of seven or more in the child. This was not so. The reason may be that persons who feel inadequate defend themselves against those feelings with a facade of pseudo adequacy. I have seen in practise adults and children who say they feel confident and adequate and able to handle anger when I believe they are lacking

in confidence and sense of adequacy and their angry outbursts belie their words. On the other hand, my reasoning may simply be wrong regarding shame as reflected in my questions.

From the point of view of school problems, it would seem that even several traits existing at the level of "Always" or "Sometimes" would cause stress and distress around academic and social affairs. The highest means among the means of the subsets was that of children who had both alcohol abusive parent(s) and grandparent(s). This mean number of traits was 11.25. These are children with many problems.

It is said among adolescent treatment workers that adolescence itself resembles codependence. Young people at this age typically worry about what their peers think, deny responsibility, and suffer anxiety, to name a few traits. It is a stressful time (Elkind, 1977).

No doubt any study on adolescent codependence has to come to grips with the problem of distinguishing between what is normal adolescence and what is codependency. Furthermore, codependency in systems no doubt exacerbates many of the traits of codependency (Jacyk, 1988) and the traits of adolescence which resemble codependency.

Further Limitations

There are further limitations in this study based on its failure to consider factors of personality and birth order and

other frames for human behavior such as the archetypal myths of Jung and anthropological/sociological viewpoints.

In their treatise on personality types, Keirsey and Bates (1978) discussed the sixteen personality types of Myers and Briggs which in turn fall into the four temperaments of Hippocrates, Adickes, Kretschmer, Spranger, and Adler (Keirsey and Bates, 1978).

In one observation, for example, Keirsey and Bates (1978) stated that, "Unlike the SP (type) who can work on impulse, the NF (type) works toward a vision of perfection: the perfect work of art, the perfect...relationship" (p. 65). The codependency trait of people pleasing perfectionism could possibly be either mistaken for or augmented by this personality trait. Moreover, in the description of the ENFJ (extrovert, intuitive, feeling, judging) personality, the authors state that people of this personality type "...may find themselves feeling responsible for the feelings of others to an extent which places a burden on the relationship" (Keirsey and Bates, 1978, p. 167). This trait resembles codependency as well. Possibly an ENFJ codependent may find particular trouble with those codependency traits which have to do with intimacy. It does bear saying that none of the sixteen personalities described by Keirsey and Bates (1978) as a whole resembles codependency.

With regard to the impact of birth order and behavior, it

can be said that the characteristics of each birth order place resembles one of the alcoholic family roles described by Wegscheider-Cruse (1976). The eldest child according to Leman (1985) can be "perfectionistic, reliable...critical and serious" (p. 14). This description fits that of Wegscheider-Cruse's Family Hero (Wegscheider-Cruse, 1976). The middle child is "independent, extremely loyal to the peer group, has many friends, a maverick" (p. 14). Many scapegoats in families resemble this description (Wegscheider-Cruse, 1976). The younger child according to Leman (1985) is "manipulative, charming, blames others, shows off...(is) precocious, engaging" (p. 14). This child resembles the Family Mascot (Wegscheider-Cruse, 1976).

In practise, it seems that the Family Hero is indeed usually an eldest, while the Scapegoat is frequently the middle child and the Mascot is the youngest. Perhaps the roles of the alcoholic family tend to be birth order roles gone wrong. Or there is a synergistic effect between the two sets of roles.

Guzie and Guzie (1986) in their discussion of Jung's archetypal myths describe one of them, Mother, thus: "Mother finds her identity and fulfillment in helping, cherishing, nurturing and protecting. ...(She) will give of herself, often to the point of exhaustion...". Mother feels most useful and comfortable in a relationship when the other is in need. ...Doing

for those in need is more important and fulfilling than relating to a mature peer who has no need of Mother's nurturing qualities. Mother can suddenly become the martyr when she feels she has been taken for granted. (She) can become subtly manipulative or quite ruthless when her point of view is not recognized or when she has not received her due" (Guzie and Guzie, 1986, pp 13-15).

This description of Mother could be seen as a description of a codependent person. Possibly a codependent woman whose archetypal myth was that of Mother would have a particularly difficult time in recovery because she would be fighting some of her basic tendencies. The key of course is that traits in themselves are not problems. A person happily behaving in the Jungian Mother fashion can be perfectly healthy, not in need of controlling others for self esteem, not suffering psychosomatic illness, and so on. A trait is only a problem if it is a problem.

Clearly there are many windows into the phenomenon described as codependency by specialists in chemical dependency. This complicates the study, but must not be allowed to lead educators into denial of the possibility that much school difficulty has at its root this anomaly of human behavior which is usually fueled by family chemical abuse.

School Problems with Adolescent Codependency

Throughout this study, Cermak's (1986) criteria for codependency have been used because they have been structured in the same way as the personality disorders in the Diagnostic and Statistical Manual of Mental Disorders. I felt it was important, given the dearth of material on codependency, to use the framework of an existing diagnostic structure and to relate codependency as Cermak (1986) did to other personality disorders in terms of criteria. I therefore refer to Cermak's criteria for the purpose of this discussion. The descriptors of other writers can be found in the review of the literature.

How do traits of codependency cause problems for students in school? One must examine codependency traits of students and those of staff members.

In the junior high school the phenomenon of the birds of a feather syndrome is outstanding. Students who come late, skip class, drink on weekends and spend time in detention tend to chum around together. Students who have been caught shoplifting tend to have friends who have shoplifted (Polk, 1984). Badly behaved students, manipulative students, and substance users find each other and form friendships just as described in Cermak's criterion D (Cermak, 1986) (see Table 2). These students and these friendship groups consume hours of administrators' time, teachers' time, and the time of counsellors and resource

teachers. The time is spent trying to control the actions of those non-compliant students.

These noncompliant students have often been viewed as being "out of control". I have spent many hours in planning meetings in which the whole team became stuck discussing whether or not this difficult student could, if he wanted to, control himself. Cermak (1986) says that a codependent person needs to control others for his or her self esteem. It would seem then that many of the difficult and noncompliant adolescents we work with are not "out of control" but "into control". We, the staff members, find those students out of our control! If our self esteem depends upon our ability to control others, as it often does, then we are bound for a power struggle which will have no resolution. We do see many of these clients dropping out of school or being told to leave before they finish high school. Many become drug involved along the way, and some find their way to the criminal justice system and various group homes and detention centres. In the final chapter, Conclusions and Recommendations, I will refer to the behaviorist orientation of the school system and how this orientation sets us up to fail with these clients who need unconditional acceptance rather than behavior modification, to relinquish their death grip on the joy stick of our school game.

All of the ten traits under section E in Cermak (1986) cause

school problems. Denial takes various forms, from outright lying about who stole a lunch or money from a locker, to denial of responsibility. Students who practise denial "Always" or "Sometimes" do not organize and complete assignments. Inside themselves, they deny that the assignment will take the whole week, so they deny that they need to start now. When the due date approaches, they deny that the teacher gave clear directions, deny that they received the papers required, deny that the teacher wanted the final copy that day. On the due date, they deny that they did not do it. They say the dog ate it, or they loaned it to a friend so the friend could copy it. If everything fails, they deny that they care. Denial in all its shapes is a school problem in a product oriented system such as ours. There can be no doubt that denial and other problem behaviors are magnified by the structure of the school system.

Constriction of emotion actually helps the school a great deal. Twenty five students in rows keeping their needs and feelings hidden is exactly what every teacher wants to see Monday morning. It is just those dramatic outbursts that cause problems. These happen in fist fights and other hot squabbles, common enough in normal adolescence but emotionally and physically damaging when they involve children with pent up emotion. The student who periodically 'loses it' and tells a teacher to "ef off" before storming out of the room is disruptive

and upsetting to the teacher, administrator and other students alike. Physically abusive students and those who will not stop talking or moving drain school staff and make it difficult for those staff members to stay healthy interactionally.

Depression in adolescents is common. The classroom problems it causes are a commentary on the product oriented school. Teachers most often become aware of a depressed student when assignments stop coming in and marks go down. Some depressions occur because of the break up of peer enmeshments. I have dealt with suicidality following peer enmeshment breakup. I have also had clients who were depressed following physical or sexual abuse or neglect. Teenage depressions occur before parents' marriage breakups and during parents' depressions. In many cases, the students start using alcohol during these depressions. Then the depressions last a long time. Some depressions are alcohol problems in disguise (Guebaly, 1990). Certainly all adolescent depressions beyond those short lived down periods which herald change (Geddes, 1985) cause learning problems and are a cause for concern in school.

Hypervigilance is paying attention to everything so that one can concentrate on nothing. It is very common among children of alcoholics. Hypervigilance is a survival strategy for which children are berated in the classroom. Children who are hypervigilant may sit quietly and not concentrate or they may

fly around the room and in either case the trait is an outstanding school problem. It is related to others such as not being organized and not getting homework done.

Compulsions such as lying, stealing, hitting and talking present school problems. Teachers with compulsive children spend an inordinate amount of time managing and disciplining and trying to control things. This is exactly what a codependent spouse does with the behavior of the alcoholic, which is compulsive. The unpredictability of the compulsive person's behavior can start a codependency circle of behavior (see Figures 1 and 2) in which the teacher tries to keep the lid on by avoiding the issue and trying to keep an eye out at all times in order to control the behavior, but then finally explodes with anger. The teacher may explode on the class, or on individuals, blaming and shaming and threatening. Or the teacher may erupt in the principal's office. The teacher may also get sick or depressed. There is still the unspoken belief in the system that if the teacher cannot control the class, the teacher is the one with the problem. The school system and the community have not come to grips with compulsive children, many of whom meet the requirements for a diagnosis of conduct disorder in the Diagnostic and Statistical Manual of Mental Disorders. The presence of these children in the schools is one factor in creation and continuation of codependency in the school system. Peele (1985, 1989) and Szasz (1974) would have us

view compulsivity in light of cultural factors and personal power rather than as diseases over which the so called victim has no control.

Anxiety, substance use, and history of abuse are codependency traits which may not directly affect school or classroom. Indirectly, however, they take their toll in diminished attention to learning, absenteeism and depression. Occasionally a child will have an attack of anxiety and have to be taken from class. Occasionally a child's abuse history will surface in class in a way that causes a problem. One example of this would be inappropriate disclosure. Recently I had a client who diverted attention in class by telling about her past abuse. This stopped the teacher from requiring her to complete work and it gained some attention from peers. In junior high students sometimes come to class impaired by substances or hung over from yesterday's impairment.

Stress related medical illness can cause school problems by virtue of long or frequent absences. Sometimes these illnesses are the start of a period of school avoidance. It is difficult to distinguish between headaches and school phobia when a student has been away for weeks. In my junior high, which houses about 650 students, there are two or three cases per year of students who miss weeks or months of attendance at school for reasons of headaches, stomach aches, not feeling well and school phobia.

Others miss occasional days or weeks of school for these reasons but it is not known how many absentees are missing due to stress related illness.

Cermak's (1986) final criterion is two years of life with a substance abuser. According to the Ontario Addiction Research Foundation, 23% of Canadian children have an alcoholic parent. Others have substance abusive siblings. The school problems incurred by these children, besides the problems of codependence in general, are problems related to missed sleep, neglect, all kinds of abuse, and poor nutrition. Children of alcoholics sometimes do not learn skills of prediction because they live in an unpredictable environment. They therefore have reading problems. Children of alcoholics often grow up without a model of organization and follow through, so they come to school unable to organize or follow through on learning tasks and assignments. The school problems of children of alcoholics, above and beyond the problems caused by their traits of codependence, are many. They have been discussed by Black (1981), Robinson (1990), and Ackerman (1986), though no serious work has been done in the area.

Codependency traits, while present in most adolescents to some degree, are present in diagnostic numbers in adolescents who are the children and grandchildren of alcoholics and alcohol abusers. They cause school problems and therefore, this syndrome should be addressed in schools.

Chapter Five

Conclusions and Recommendations

Three stages of data collection occurred in the formation of this thesis. The first was the two years of field research at the junior high school. During this portion, some experimental and descriptive research was read, and I attended the Johnson Institute for studies on chemical dependency and codependency which included a week's internship at Fairview Deaconness Hospital for the treatment of chemically dependent and codependent teens. The second stage of data collection was the review of the literature. The third stage was the development and administration of the codependency questionnaires to sixteen teens and their parents along with the Children of Alcoholics Screening Test.

The purpose of the first stage of data collection was to attempt to explain the inability of substance using teenage boys to identify and express themselves emotionally. The conclusion at the end of this stage was that this inability was related to familial alcohol abuse, and that it was one piece of an interaction disorder termed codependence by chemical dependency counsellors.

The purpose of the second stage of data collection was to discover whether among writer therapists and recovering

codependents there was a definition of codependence agreeable to all. The conclusion of this portion of the data collection was that indeed, all of the writers examined were describing the same phenomenon. This phenomenon matched that observed among junior high school students who had an alcohol abusive parent or grandparent.

The purposes of the third stage of data collection were as follows: first to discover whether it were possible to diagnose codependency in adolescents using an instrument based on Cermak's (1986) list of codependency traits; second, to determine quantitatively whether the existence of codependence in adolescents was related to parental and or grandparental alcohol abuse.

The first conclusion of the third, quantitative portion of the thesis is that the phenomenon of codependency described by Cermak (1986) and others can be diagnosed in adolescents. The instrument designed for this study, while a modest first effort, did differentiate subjects in terms of their number of codependency traits (at or above 7/at or below 6). The second conclusion was that the existence of seven or more codependency traits in students was positively related to parental/grandparental alcohol abuse.

The recommendations which have risen out of the conclusions of all three portions of this paper are four. First, there is a need for more study into the area of adolescent codependency. Because all of the traits listed by Cermak (1986) cause school problems directly or indirectly, and because the traits existed in greater numbers among the children in this study who had alcohol abusive parent(s) and/or grandparent(s) it would serve the school community well to investigate all of the problems of children and grandchildren of alcohol abusive people. Second, as part of this further study, I recommend that history taking by all helping professionals working with school children include a history of family substance use/abuse as far back as possible. Other events and conditions which are or become associated with codependency, such as incest, should be included too, in order that a fuller picture of children with codependency traits may be developed.

My third recommendation is that professionals working with school children educate themselves about all aspects of chemical dependency and codependency in order that further field studies in this area become possible and once complete can be made useful for the better service of children.

Not every codependent child comes from a home in which someone abuses alcohol. Therefore a fourth recommendation is

that new basic assumptions about behavior can and must grow out of an understanding of codependency and these assumptions must be applied to work with codependent individuals regardless of their family history. Often we will never know whether there is alcohol abuse in a family. On an individual student level, it will not matter. A child, for example, who needs to control others for his/her self esteem will be seen differently by those who understand codependency than by those who do not, and the forthcoming treatment will be different. Some system wide changes affecting all children could grow out of new basic assumptions based upon new understanding.

Tables and Figures

Table 1

Codependency traits, found among Traits of Personality Disorders from the Diagnostic and Statistical Manual of Mental Disorders. Third Edition revised, 1987, published by the American Psychiatric Association.

From Borderline Personality Disorder 301.83:

1. "a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of overidealization and devaluation";
3. "affective instability: marked shifts from baseline mood to depression, irritability or anxiety, usually lasting a few hours and only rarely more than a few days";
4. "inappropriate, intense anger or lack of control of anger";
6. "marked and persistent identity disturbance manifested by uncertainty about at least two of the following: self image,...long term goals,...type of friends desired, preferred values";
7. "chronic feelings of emptiness or boredom"; and
8. "frantic efforts to avoid real or imagined abandonment.

This disorder is frequently accompanied by many features of other personality disorders" (DSM111R, 1987, p. 347).

(table continues)

From Histrionic Personality Disorder 301.50:

1. "constantly seeks or demands reassurance, approval or praise";
2. "is inappropriately sexually seductive..."; and
6. "displays rapidly shifting and shallow expression of emotions.

Persons with this disorder often act out a role, such as victim" (DSM111R, 1987, p. 349).

From Narcissistic Personality Disorder, 301.81:

1. "reacts to criticism with feeling of rage, shame or humiliation, even if not expressed, fragile self esteem, preoccupation with others' regard, rationalizing or lying to cover up personal deficits, depressed mood" (DSM111R, 1987, p. 351).

From Avoidant Personality Disorder, 301.82:

-"a pervasive pattern of social discomfort, a fear of negative evaluation..."
-"easily hurt by criticism and devastated by the slightest hint of disapproval" (DSM111R, 1987, p. 352).

(table continues)

From Dependent Personality Disorder, 301.60:

1. "is unable to make everyday decisions without an excessive amount of advice or reassurance from others";
2. "allows others to make most of his or her important decisions";
3. "agrees with people even when he or she believes they are wrong, because of fear of being rejected";
4. "has difficulty initiating projects or doing things on his or her own";
5. "volunteers to do things that are unpleasant or demeaning in order to get people to like him or her";
7. "feels devastated or helpless when close relationships end";
8. "is frequently preoccupied with fears of being abandoned";
9. "is easily hurt by criticism or disapproval" (DSM111R, 1987, p. 354).

From Obsessive Compulsive Personality Disorder 301.40:

11. "perfectionism";
5. "indecisiveness";
6. "...inflexibility...".

The other-directedness of the codependent clearly emerged in these disorders. Interestingly, there was no information available according to DSM111R about familial patterns in individuals suffering from these personality disorders.

Table 2

Timmen Cermak's Criteria for Codependency.

Diagnosis depends upon presence of the first four traits and three of the other traits.

- a) "continued 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 disordered, 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 outbursts)
 - 3. Depressions
 - 4. Hypervigilance
 - 5. Compulsions
 - 6. Anxiety
 - 7. Substance abuse

(table continues)

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" (Cermak, 1986, p. 11).

Table 3

Codependency Questionnaire Correspondence

Cermak's Criterion	Number on Parents' Sheets	Number on Students' Sheet
E-1	5	5
E-2	6	6
E-3	7	7
E-4	8	8
E-5	9	9
E-6	10	- trait assigned by parents only
E-7	11	10
E-8	12	11 physical abuse reported in trauma section
E-9	13	12
E-10	14	See CAST:2 or more is yes

Figure 1

The Codependency Circle

1. individuals avoid issues
 2. bail others out of responsibilities in order to keep peace or out of martyrdom. Repress feelings and needs. Tolerate abuse.
 3. grow inwardly more angry and full of pain from buried anger
 4. then explode into any of the following: violence, binging, depression, substance use, screaming, blaming, shaming, or compulsions. They lose control of the intensity of their reaction.
 5. then lay guilt on others for their behavior. Their lowered self esteem makes it necessary for them to deny ownership.
 6. they act self pitying, self righteous and martyr-like
 7. then are filled with guilt, the pain of which causes them to
 8. resolve to stop the explosions, to control them. This they do by attempting to put the lid on, so they go back to avoiding, bailing, repressing and tolerating instead of addressing issues.
- When honest expressions of needs, feelings, and perceptions are pre-empted

Figure 2

The Codependency Circle in School

Issues are avoided

Teachers seek to
control kids and get
them to work.

Role of school is debated, but
school staff disagree and
anyway have no power.

When schools are systems,
not communities, needs and
feelings are pre-empted and
behavior and products are sought.
Then...

Blaming, shaming, ignoring,
occur, by teachers of children,
by teachers of each other,
by administration of teachers.

When explosions occur, someone
is to blame, problems are
punished, mediated, sidestepped.
Tension is released temporarily.

Feelings of dehumanization,
depression, grief and
anger are repressed.

Table 4

Greenleaf's Criteria for Codependence/Para Alcoholism

- P. 10 of Codependence, An emerging issue. Health Communications, 1984.
1. They repress their feelings in order to block other peoples' actions. (Cermak A)
 2. Grandiosity is a defense, vital in preserving nascent ego from collapse. Often based on fantasies of future success/revenge. (Cermak E-1)
 3. Lack of trust, no comprehension of trust as a value. (Cermak C)
 4. Blaming/projecting. (Cermak B) (This is the counterphobic response.)
 5. Judgmental, nonforgiving. (Cermak A, B and C can be seen here.)
 6. Lying. (Cermak E-1)
 7. Depression (in children stems not from loss but from deprivation) (Cermak E-2)
 8. Flattened affect. (Cermak E-2)
 9. Solitariness, excessively reactive to others, unable to attend to own interests or relax if others are around. (Cermak C)
 10. Disruptive. (Cermak E-10)

Table 5

Whitfield's Criteria

P. 46 of Codependence, An emerging issue. Health Communications. (1984).

1. Behavioral or psychological symptoms such as anxiety (Cermak E-6), depression (Cermak E-3), insomnia, hyperactivity (Cermak E-4), or aggression (Cermak E-2).
2. Functional or psychosomatic illness. (Cermak E-9)
3. Family violent or neglect. (Cermak E-8)
4. Alcoholism or other chemical dependence. (Cermak E-7)

Table 6

Beattie's Criteria

From Codependent No More. (1987).

1. Think and feel responsible for others' feelings, thoughts, needs and (conversely) believe others are responsible for others and blame others (p. 37,41). (Cermak B)
2. Excessively reactive to others (p. 33,37). Need crises, someone to help or problems to solve, look for happiness outside self (p. 39,41). (Cermak C) Desperately seek approval (p. 41). Keep letting people hurt them (p. 43). Loss of trust in God (p. 43). Sex problems (p. 44).
3. Form relationships with needy people (p. 31,37) and feel compelled to fix things for them. (Cermak D)
4. Have been victims of sexual, physical or emotional abuse, neglect, abandonment, alcoholism. (Cermak E-8)
5. Ashamed of who they are (p. 38). Have been shamed for feeling angry (p. 43).
6. Get artificial feelings of self worth from helping others, and strong feelings of low self worth from others' failures and problems (p. 39). Try to control people and events (p. 40,41). Try to say what they hope will make people do what they want them to do (p. 42). (Cermak A)

(table continues)

7. Appear rigid and controlled (p. 39). Push thoughts and feelings out of their awareness because of fear and guilt (p. 43) or have violent temper outbursts. (Cermak E-2)
8. Lose sleep over problems or others' behavior (p. 39).
9. Feel terribly anxious about problems and people (p. 39). Worry, lose sleep. Worry whether others will like them (p. 41). (Cermak E-6)
10. Denial. Ignore, pretend, lie and believe lies (p. 40). Don't say what they mean or mean what they say (p. 42). Cover up, lie, protect the problem (p. 45). (Cermak E-1)
11. Became workaholics, spend money compulsively, overeat, have eating disorders (p. 40). Talk too much (p. 42). Loyal to compulsions (p. 45). (Cermak E-5)
12. Depressed or sick. (Cermak E-9)
13. Can't have fun: take selves too seriously (p. 42). Difficult to have fun and be spontaneous (p. 44).
14. Angry (p. 1,13,43).
15. May abuse or neglect their children (p. 45). Become violent.
16. May become addicted to alcohol and other drugs (p. 45). (Cermak E-7)

(table continues)

17. Stay in relationships that don't work. Tolerate abuse to keep people loving them. Feel trapped in relationships (p. 41).

(Cermak E-10)

18. Find it difficult to get to the point and aren't sure what the point is (p. 42). Stay busy so they don't have to think about things, get confused, watch problems get worse, pretend things aren't happening (p. 40). (Cermak E-4)

Table 7

Black's Description of Children of Alcoholics

From her book, It Will Never Happen to Me. (1981).

1. A child of an alcoholic is at high risk to become alcoholic (p. xv). (Cermak E-7)
2. Children of alcoholics are often prone to marry those who are or become alcoholics (p. xv). A sensitive, acting-out child may gravitate to peers of low self esteem (p. 22). (Cermak D)
3. Children of alcoholics often have difficulties identifying and expressing feelings (p. xvi). They become very rigid and controlling. They have anger and guilt (p. 83-88). (Cermak E-2)
4. Rigid and controlling (p. xvi). Manipulative (p. 89) (Cermak A)
5. Overly dependent on others. Feel no power of choice in the way they live (p. xvi). They are isolated and frequently do not have the ability to feel close or be intimate with another human being (Repeat After Me, p. 6).
6. A pervasive sense of fear and guilt. (Cermak E-6)
7. Depression (p. xvi) (Cermak E-3)
8. Physical problems related to stress, headaches, stomach aches, asthma, bedwetting (Repeat After Me, p. 6) (Cermak E-9)

(table continues)

9. Alcoholic family is inconsistent and unpredictable (p. 5).
The child of an alcoholic has a short attention span or inability to concentrate. (Cermak E-4)
10. Physical or sexual abuse or verbal harassment (p. 146-167).
(Cermak E-8)
11. Memory loss (Repeat After Me, p.6) (Cermak E-1)
12. The person who plays the role of placater will try to fix sadness, fears, angers and problems of all (p. 18). Always apologizes. (Cermak B)

Table 8

Criteria for Codependency of Sharon Wegscheider-Cruse

From her book, Adult Children and Spirituality Seekers. (1985)

1. Exaggerated dependent patterns, dependent on people and things outside the self along with neglect of the self to the point of having little self identity (p. 2). (Cermak C)
Problems with intimacy (p. 3). Inability to know what normal behavior is (p. 3). Exaggerated need for approval. Fear of abandonment. Fear of loss of control (p. 13).
2. Inability to have spontaneous fun (p. 3).
3. Wanting to please others so others will like them (p. 3).
Need to control self and others. (Cermak A)
4. Confusion about making decisions (p. 3). (Cermak E-4)
5. Anxiety about making changes (p. 3). Fear of abandonment (p. 3) (Cermak E-6)
6. Denial of anger (p. 3). Lies and exaggeration, denial and delusion (p. 8). Hydrochondriasis (p. 25) (Cermak E-1)
7. Black and white judgments (p. 3).
8. Tendency to look for people to take care of. Stuck relationships (p. 25). Half of children of alcoholics marry alcoholics. Others may become promiscuous or have confused sexual identity (p. 39). (Cermak D)

(table continues)

9. Compulsive eating (p. 5). Compulsive behavior (p. 10). Eating disorders (p. 25). (Cermak E-5)
10. Emotional repression (p. 11). (Cermak E-2)
11. Chronic aches and pains related to stress and anger (p. 18,19,25). Anger (p. 12). Suppressed anger, hair-trigger temper, avoiding people, rapid weight fluctuations. (Cermak E-9)
12. Hidden aggression (p. 13 and following). Frozen anger leads to confused inauthentic human interactions, seeming to give but keeping someone in your clutches. For example, giving candy to an obese person, procrastinating, coming late, and helplessness.
13. Shame, low self worth (p. 17).
14. Workaholic (p. 25). (Cermak E-7)

Also found in Wegscheider-Cruse's book is a list of criteria composed by her husband, Joe Cruse. Joe Cruse's criteria follow:

1. Controlling (p. 106) (Cermak A)
2. Caretaker (p. 106) (Cermak B)
3. Codependent has relationship problems, peer worship, can be a spouse surrogate, and has undying loyalty (p. 106) (Cermak D)
4. Workaholicism (p. 106) (Cermak E-7)
5. Spouse surrogate (p. 106) (Cermak E-8)
6. Chronic and sickly (p. 106) (Cermak E-9)
7. Anorexic, overweight, or perfectionistic (p. 106)(Cermak E-5)
8. The codependent according to Cruse has undying loyalty (p. 106). (Cermak E-10)

Table 9

Janet Geringer-Woitz's Criteria for Codependency

From her book, Adult Children of Alcoholics (1983, p 4).

Traits

1. Adult children of alcoholics guess at what normal behavior is.
2. Adult children of alcoholics have difficulty following a project through from beginning to end.
3. Adult children of alcoholics lie when it would be just as easy to tell the truth.
4. Adult children of alcoholics judge themselves without mercy.
5. Adult children of alcoholics have difficulty having fun.
6. Adult children of alcoholics take themselves very seriously.
7. Adult children of alcoholics have difficulty with intimate relationships.
8. Adult children of alcoholics overreact to changes over which they have no control.
9. Adult children of alcoholics constantly seek approval and affirmation.
10. Adult children of alcoholics usually feel that they are different from other people.

(table continues)

11. Adult children of alcoholics are super responsible or super irresponsible.
12. Adult children of alcoholics are extremely loyal, even in the face of evidence that the loyalty is undeserved.
13. Adult children of alcoholics are impulsive. They tend to lock themselves into a course of action without giving serious consideration to alternative behaviors or possible consequences. This impulsivity leads to confusion, self-loathing, and loss of control over their environment. In addition, they spend an excessive amount of energy cleaning up the mess.

Fears

1. I am afraid that I will hurt you.
2. The person you see does not exist.
3. I'll lose control of my life.
4. It doesn't matter anyway.
5. It's not real.
6. You'll see how angry I am.
7. I am ashamed of who I am.
8. You will get to know me and find out that I am not loveable.
9. I want to be comfortable.
10. You'll leave me anyway.

Table 10

Mellody: Five Core Symptoms of Codependence

1. "Difficulty Experiencing Appropriate Levels of Self-Esteem" (Mellody, 1989, p. 6)
2. "Difficulty Setting Functional Boundaries" (Mellody, 1989, p. 11)
3. "Difficulty Owning Our Own Reality" (Mellody, 1989, p. 21)
4. "Difficulty Acknowledging and Meeting Our Own Needs and Wants" (Mellody, 1989, p. 28)
5. "Difficulty Experiencing and Expressing Our Reality Moderately" (Mellody, 1989, p. 35)

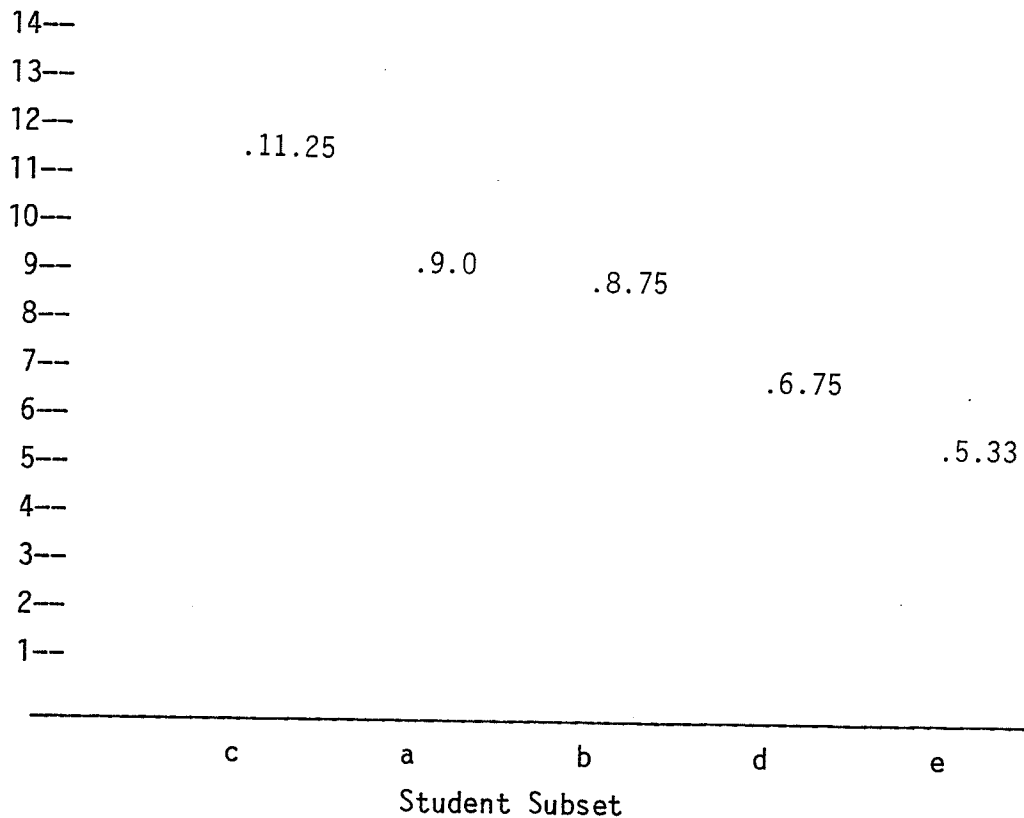
Five Secondary Symptoms of Codependence

1. "Negative control: we give ourselves permission to determine someone else's reality for our own comfort";
2. "Resentment: we have a need to get even or punish someone for perceived blows to our self-esteem that cause us shame about ourselves";
3. "Distorted or nonexistent spirituality: we have difficulty experiencing connection to a Power greater than ourselves";

(table continues)

4. "Avoiding reality: we use addictions, physical illness, or mental illness to avoid facing what is going on with us and other important people in our lives";
5. "Impaired ability to sustain intimacy: we have difficulty sharing who we are with others and hearing others as they share who they are with us without interfering with their sharing process or what they share" (Mellody, 1989, p. 43).

Figure 3

Codependency Means for Subsets

- c: Mean codependency traits of children with alcohol abusive or alcoholic parent(s) and grandparent(s).
- a: Mean of children with alcohol abusive or alcoholic parent(s).
- b: Mean of children with alcoholic abusive or alcoholic grandparent(s).
- d: Mean of children with no alcohol abusive or alcoholic parent(s) or grandparent(s).
- e: Mean of children with no alcohol abusive or alcoholic parent(s) or grandparent(s) and no parents with incest history.

Table 11

ANOVA Summary

Source	SS	df	MS	F	p
Family Pattern	73.083	4	18,270	4.66	0.0148
Error	50.916	13	3.916		
Total	124.00	17			

Table 12

Chi Square

	No	Yes	Total	df 1	^x Value 6.516	Prob. 0.011
No	3	1	4			
Yes	1	10	11			
Total	4	11	15			

Table 13

Frequency of Alcohol Abuse and Alcoholism

	Parent(s) Non Abusive* CAST 0 or 1	Parent(s) Abusive* CAST 2-5	Parent(s) Alcoholic* CAST 6 or more
Mother n = 15	9 (60%)	1 (7%)	5 (33%)
Father n = 9	7 (78%)	1 (11%)	1 (11%)
Student n = 15	8 (53%)	3 (20%)	4 (27%)

* As determined by Children of Alcoholics Screening Test
(Pilat and Jones, 1982).

0 - 1 indicates child of non alcoholic, non alcohol abusive
parent(s)

2 - 5 indicates child of alcohol abusive parent(s)

6 or more indicates child of alcoholic parent(s)

Table 14a

Summary of Responses to Trauma Questions and Students'Codependency Totals

1MDS D	2MDS	3MS	4MDS D	5MDS	6MS	7MS	8MS M	
S				S				1. Untimely death of parent
S			M S		S			2. Problem move
M								3. Depression in family member
								4. Incest
								5. Physical abuse
M S	M S	S	S		S	S		6. Emotional abuse
M	M		S		S			7. Fear/unpredictability
M	M							8. Other factors preventing needs being met
M1 D1 S1	M1		S2 D1	S4	M4	S3	M3 S1	9. Shame score
8 no sex stated	10 male	4 fem	11 fem	10 fem	8 fem	6 fem	9 male	10. Codependency score and sex of child
M17	M17		S3 D5	M8 D17 S7	M2	S25	M18	11. CAST if not 0-1

M = Mother
D = Dad
S = Student

(table continues)

Codependence

137

9MS	11MDS	12MS	13MDS	14MDS M	15MDS	16MDS M	
		M, S S	M				1. Untimely death of parent
			S			S	2. Problem move
			M			M	3. Depression in family memb
M			S			M, S	4. Incest
M		M, S	MDS			M, S	5. Physical abuse
M, S		M	D				6. Emotional abuse
		M, S	M, D				7. Fear/unpredictability
							8. Other factors preventing needs being met
M3 S2	S3	M4 S4	M4 S2	S1	M1 S2	M1	9. Shame score
11 fem	6 male	11 fem	11 fem	6 fem	10 fem	13 male	10. Codependency score and sex of child
M20 S20		S12			S3	M7 S4	11. CAST if not 0-1

M = Mother
D = Dad
S = Student

Table 14b

Frequency of Yes (Always or Sometimes)

Responses to Questions on Codependency Questionnaire on the part of Mothers (n=15), Fathers (n=8) and Students (n=15).

See Tables 18 and 20 for Codependency Questionnaires.

Mothers: Identifying trait in child

	<u>Yes</u>	<u>No</u>
C1	10	5
C2	10	5
C3	6	9
C4	6	9
C5	7	8
C6	11	4
C7	1	14
C8	9	6
C9	7	8
C10	3	12
C11	1	14
C12	0	15
C13	3	12
C14	2	13

Fathers: Identifying trait in child

	<u>Yes</u>	<u>No</u>
C1	4	4
C2	7	1
C3	5	3
C4	5	3
C5	4	4
C6	4	4
C7	3	5
C8	6	2
C9	2	6
C10	3	5
C11	1	7
C12	0	8
C13	0	8
C14	0	8

(table continues)

Students: Self-identified unless otherwise stated

	<u>Yes</u>	<u>No</u>
C1	11	4
C2	11	4
C3	7	8
C4	15	0
C5	11	4
C6	12	3
C7	6	9
C8	11	4
C9	15	0
C10	3	12 (identified only by parent report)
C11	4	11
C12	3	12
C13	3	12
C14	7	8 (identified by CAST score of 2 or more)

Table 15

Labels for Envelopes Containing Questionnaires

PARENT'S ENVELOPE: Enclosed please find two pages of questions, both sides of which are printed. One side has questions about your child. Please answer as best you can how you see that child. The rest applies to you and your family of origin, the family in which you were raised.

You are to do this freely and without duress, leaving out anything you are not comfortable answering. If you need help or want to discuss anything for any reason, call me at

When you are finished, put back the questionnaires and seal the envelope yourself. Your answers are private and you are not accountable to anyone for them. Put the white envelope back in the stamped brown envelope addressed to the university.

If there are two parents in your home, I have included two parent envelopes. Participation by the second parent is optional, but would certainly be appreciated if it were possible.

Thank you very much for your help.

STUDENT'S ENVELOPE: Enclosed are two pages of questions, both sides printed. You should fill them out in private, if you are willing to do them. You may leave out any question you do not want to answer, or that you do not understand. Do not put your name on anything. If you need help, or you want to talk about anything on the sheets, phone me at home (), or see me at school. If you want to talk to a different counsellor, I will find you one.

When you are finished with the sheets, fold them up and put them back in the white envelope. Seal it. No one else should see your answers. Put your white envelope in the stamped brown envelope addressed to the university.

Thank you very much for your help.

Table 16

Lenore Berscheid
Faculty of Education (Ed. Psych.)
University of Manitoba
R3T 2N2
May 22, 1990

Dear Parent and Student,

This letter follows our conversation during which you agreed to read and consider completing some very personal questions and mailing them to me anonymously to help me in my masters degree research.

I very much appreciate your help in this. I must stress to you that if any question is distressful to you, you should omit it or phone me (). I am available to you at all times during the next ten days. Furthermore, I want to remind you that your papers are not to be marked in any identifying way because this study is to be anonymous.

If you would like me to send you a copy of a summary of the study once it is complete, please mail the stamped envelope provided, with any address you choose on the back. You may use your own, or arrange to have it delivered to the home or office of a friend.

If after reading these questions, you decide not to complete them, or if only parts are completed, please mail the whole package back to me anyhow. Whatever you have done will be fine. I would like to have the whole thing back nine days after you receive it. Naturally in the end I will not know who has completed what, and I will simply appreciate the consideration and participation of all of you.

When you are through with them, each set of questions should go back in the white envelope they were in. All the white envelopes then go back into the stamped brown envelope addressed to the University. Please seal this and mail it.

I cannot stress enough that if there is any distress attached to this you can call me to talk about it. You can also stop doing the questions. If any distress is caused that you would rather talk to another professional about, I can refer you to someone. Students doing this can come to see me in school privately.

Thank you.
Yours truly,

Lenore Berscheid

Table 17

Children of Alcoholics Screening Test

Please check () the answer below that best describes your feelings, behavior, and experiences related to a parent's alcohol use. Take your time and be as accurate as possible. Answer all 30 questions by checking either "Yes" or "No".

Sex: Male _____ Female _____ Age _____

Yes	No	Questions
_____	_____	1. Have you ever thought that one of your parents had a drinking problem?
_____	_____	2. Have you ever lost sleep because of a parent's drinking?
_____	_____	3. Did you ever encourage one of your parents to quit drinking?
_____	_____	4. Did you ever feel alone, scared, nervous, angry or frustrated because a parent was not able to stop drinking?
_____	_____	5. Did you ever argue or fight with a parent when he or she was drinking?
_____	_____	6. Did you ever threaten to run away from home because of a parent's drinking?
_____	_____	7. Has a parent ever yelled at or hit you or other family members when drinking?
_____	_____	8. Have you ever heard your parents fight when one of them was drunk?
_____	_____	9. Did you ever protect another family member from a parent who was drinking?
_____	_____	10. Did you ever feel like hiding or emptying a parent's bottle of liquor?
_____	_____	11. Do many of your thoughts revolve around a problem drinking parent or difficulties that arise because of his or her drinking?
_____	_____	12. Did you ever wish that a parent would stop drinking?
_____	_____	13. Did you ever feel responsible for and guilty about a parent's drinking?
_____	_____	14. Did you ever fear that your parents would get divorced due to alcohol misuse?
_____	_____	15. Have you ever withdrawn from and avoided outside activities and friends because of embarrassment and shame over a parent's drinking problem?
_____	_____	16. Did you ever feel caught in the middle of an argument or fight between a problem drinking parent and your other parent?
_____	_____	17. Did you ever feel that you made a parent drink alcohol?
_____	_____	18. Have you ever felt that a problem drinking parent did not really love you?
_____	_____	19. Did you ever resent a parent's drinking?
_____	_____	20. Have you ever worried about a parent's health because of his or her alcohol use?

(table continues)

- ____ 21. Have you ever been blamed for a parent's drinking?
- ____ 22. Did you ever think your father was an alcoholic?
- ____ 23. Did you ever wish your home could be more like the homes of your friends who did not have a parent with a drinking problem?
- ____ 24. Did a parent ever make promises to you that he or she did not keep because of drinking?
- ____ 25. Did you ever think your mother was an alcoholic?
- ____ 26. Did you ever wish that you could talk to someone who could understand and help the alcohol-related problems in your family?
- ____ 27. Did you ever fight with your brothers and sisters about a parent's drinking?
- ____ 28. Did you ever stay away from home to avoid the drinking parent or your other parent's reaction to the drinking?
- ____ 29. Have you ever felt sick, cried, or had a "knot" in your stomach after worrying about a parent's drinking?
- ____ 30. Did you ever take over any chores and duties at home that were usually done by a parent before he or she developed a drinking problem?

____ TOTAL NUMBER OF "YES" ANSWERS.

Table 18

STUDENT'S SELF CHECK FOR CODEPENDENCY TRAITSPlease circle
your choice.

1. a. Do you get anxious if your friends or anyone else doesn't approve of you,
or of something you do?

Always	Sometimes	Seldom	No
--------	-----------	--------	----
- b. Do you feel uncomfortable if you don't get your way?

Always	Sometimes	Seldom	No
--------	-----------	--------	----
- c. Do you ever get stubborn, or act angry, or manipulate your friends or parents,
to help get your way?

Always	Sometimes	Seldom	No
--------	-----------	--------	----
- d. Do you ever purposely do something to get someone mad, even if you'll be grounded,
or punished, or a friend will be really upset?

Always	Sometimes	Seldom	No
--------	-----------	--------	----
2. a. Do you worry about other peoples' problems and forget about your own problems
or responsibilities?

Always	Sometimes	Seldom	No
--------	-----------	--------	----
- b. Do you do things for others and then realize there is something of your own you
didn't get done?

Always	Sometimes	Seldom	No
--------	-----------	--------	----
3. a. Do you ever try to keep a friend even when the friend isn't nice to you?

Always	Sometimes	Seldom	No
--------	-----------	--------	----
- b. If a friend stops talking to you, do you think it's your fault and try to get
the friend back?

Always	Sometimes	Seldom	No
--------	-----------	--------	----
- c. Do you have trouble making friends?

Always	Sometimes	Seldom	No
--------	-----------	--------	----

(table continue

4. a. Do you hang around with people your friends, parents or teachers would think are a bad influence?

Yes No

- b. Do you have friends who drink or smoke pot? Yes No

- c. Do you have friends who shoplift or steal? Yes No

- d. Do you have friends who lie to their parents? Yes No

- e. Do you have friends who need you and tell you their troubles, but don't listen to your needs and troubles?

Yes No

5. Do you lie, or change your story, or act innocent?

Always Sometimes Seldom No

6. Do you have trouble deciding how you feel?

Always Sometimes Seldom No

- Do you have trouble telling someone how you feel?

Always Sometimes Seldom No

7. Do you get depressed for more than a day or two?

Always Sometimes Seldom No

8. Do you have more trouble concentrating than most people?

Always Sometimes Seldom No

9. Do you ever do something without stopping to think and then regret it?

Yes No

Circle any of the following things you may have done like this, compulsively:

eat too much lie steal drink alcohol smoke pot

other _____

10. Do you drink or smoke pot? Yes No

11. Have you ever been sexually touched by anyone or hurt by anyone?

Yes No

12. Have you ever had a physical problem a doctor said might be related to stress?

Yes No

Table 19

OTHER FAMILY TRAUMAS (Student's Sheet)

1. Have you experienced any of the following in your family so far:

Please check:

Death of a parent or brother or sister _____

Moving to a new country or city, accompanied by serious difficulty
for your parents or you _____

Someone in your home being sometimes very depressed _____

Fear caused by racial, religious, or ethnic prejudice _____

Sexual abuse _____

Physical abuse _____

Emotional abuse, such as being yelled at or put down a lot _____

Anything else that could be called a trauma (please say what it is)

2. If any of these feelings apply to you, please check them off:

I have to work really hard to be good enough _____

I'm an OK person just as I am _____

If I'm angry, I can just say so, and work things out _____

If I ever let my anger out, I'd be afraid what would happen _____

I think someday I'll find a really nice person who will share my life _____

I worry about whether anyone will like me enough to spend time with me _____

When I think about the real me I feel like I'm not good enough _____

I'm not perfect, but I'm OK _____

Table 20

PARENTS' CHECKLIST FOR STUDENT'S CODEPENDENCY TRAITSCircle one: **MOTHER** **FATHER**

Please circle your choice:

1. a. Is this child an approval seeker? That is, does he or she get anxious if your approval, or that of a friend or other valued person, is in doubt?

Always	Sometimes	Seldom	No
--------	-----------	--------	----
- b. Does this child try to control others to a greater than normal extent? For example, is this child very stubborn, demanding or manipulative?

Always	Sometimes	Seldom	No
--------	-----------	--------	----
- c. Does this child do things to deliberately upset you, even if there is a consequence in store?

Always	Sometimes	Seldom	No
--------	-----------	--------	----
2. a. Does this child worry about others' problems and forget about his or her own needs and responsibilities?

Always	Sometimes	Seldom	No
--------	-----------	--------	----
- b. Does this child do things for others and not get things done for himself?

Always	Sometimes	Seldom	No
--------	-----------	--------	----
3. a. Does this child hang on to friends no matter how he or she is treated?

Always	Sometimes	Seldom	No
--------	-----------	--------	----
- b. Does this child have trouble making or keeping friends?

Always	Sometimes	Seldom	No
--------	-----------	--------	----
4. a. Does this child hang around with people who are not a good influence?

Always	Sometimes	Seldom	No
--------	-----------	--------	----
- b. Does this child chum with children who drink, steal, or get into trouble?

Always	Sometimes	Seldom	No
--------	-----------	--------	----
- c. Does this child find friends who are needy, or depend upon him or her always?

Always	Sometimes	Seldom	No
--------	-----------	--------	----
5. Does this child lie, fib, or change the story?

Always	Sometimes	Seldom	No
--------	-----------	--------	----
6. Does this child have trouble expressing his or her feelings?

Always	Sometimes	Seldom	No
--------	-----------	--------	----

(table continues)

7. Does this child get depressed beyond what you would expect of a normal teen?
Always Sometimes Seldom No
8. Does this child pay attention to so many things around him/her that he/she can't settle down and concentrate?
Always Sometimes Seldom No
9. Does this child ever act compulsively with regard to eating, lying, stealing, hitting, or any other behavior?
Always Sometimes Seldom No
10. Is this child anxious? Yes No
11. Does this child drink or smoke pot? Yes No
12. Has this child ever been sexually or physically abused? Yes No
13. Has this child any stress related medical illnesses? Yes No
14. Has there been a substance abuser living in the same home as this child for the past two years?
Yes No

Table 21

OTHER FAMILY TRAUMAS (Parents' Sheet)

1. Did your family (the family in which you lived as a child growing up) experience any of the following?

Please check:

Untimely death of a parent, when you were a dependent child _____

Immigration to a new country, with financial, social, or language problems _____

Manic depressive illness of anyone living in the home _____

Persistent fear caused by racial, religious, or ethnic prejudice _____

Sexual abuse, including incest _____

Physical abuse _____

Emotional abuse or emotional deprivation _____

Any other situation which caused your environment to be unpredictable (please describe)

Any other state of affairs which resulted in your needs, as you now see them, not being met sufficiently for you to grow up with a sense of who you were and a sense that you deserved to be here on earth, just as you were. (Again, please describe the state of affairs which resulted in these basic needs not being met.)

(table continues)

2. Did you come out of your family of origin with any of the following feelings?

Please check those that apply.

I have to work really hard to be good enough _____

I'm an OK person just as I am _____

If I'm angry I can just say so and work things out _____

If I ever let my anger out, I'd be afraid what would happen _____

I think I'll find someone who'll love me and share my life _____

I wonder if anyone will ever marry me _____

When I think about the real me what I mostly feel is shame or inadequacy _____

I know the real me is imperfect but alright _____

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