An examination of the codependency construct: The effects of labeling

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AN EXAMINATION OF THE CODEPENDENCY CONSTRUCT:
THE EFFECTS OF LABELING

DISSERTATION

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the Degree Doctor of Philosophy in the Graduate
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By

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* * * * *

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The term "codependency" recently seems to have assumed a major position in the national vernacular. Volumes about codependency form sections of our bookstores, recovering codependent persons reveal their histories on our talk shows, and self-help gurus offer us quick roads out of our self-destructive codependent patterns. Estimates are that 96% of all Americans suffers from codependency, which is "partly because every form of arguably compulsive behavior is classified as an addiction" (Kaminer, 1992, p. 10). Experts also estimate that one third of Americans has turned to Twelve-Step recovery groups in an effort to resolve issues left by a "dysfunctional" past (Dreyfous, 1992).

As these millions of people come to grips with their codependency, promotion of the concept is now sufficiently widespread to qualify as a genuine social movement, and the resulting financial gains are extensive enough to deem codependency a lucrative industry. Approximately 4,000 self-help manuals are published each year, and sales of motivational audio and videotapes have now reached 50 million dollars (Dreyfous, 1992). One of the top selling
codependency books, Melody Beattie's *Codependent No More*, has enjoyed sales of over 2 million (Kaminer, 1992).  

**History of the Codependency Construct**

Before discussing the ramifications of the codependency phenomenon, the question that must be asked is how did the codependency construct originate? The genesis of the concept of codependency can be traced back to 1784, when one of the signers of the Declaration of Independence, Dr. Benjamin Rush, first described habitual drunkenness as a disease (Katz & Liu, 1991). This idea fell out of favor during the unforgiving Victorian era. Then, in the 1930s and 1940s it was revived, and alcoholism moved from being defined as immoral behavior to being subsumed under the disease umbrella (Krestan & Bepko, 1990). Thereafter, alcoholics were seen as the victims of a biological and psychological process that rendered their behavior uncontrollable.

Soon after this development, a second trend began, which also contributed to the formation of the codependency construct: the family systems movement. Alcoholics now were viewed in a relational context. Their drinking behavior had an impact on the entire family system as well as its individual members, just as their drinking behavior was affected by these same people. Katz and Liu (1991) use the mobile analogy: "when one piece of the mobile is swinging wildly out of control, all the pieces react by moving in ways that will offset the disturbance to the unit as a
whole" (p. 14). Experts began noticing, for example, that children of alcoholic tended to become alcoholics or develop psychological difficulties themselves (Schaef, 1986). It was then necessary to find a term to describe these types of out-of-control, compulsive patterns of behavior that characterized these family members.

According to Melody Beattie, author of Codependent No More (1987), the term "codependency" emerged from the treatment literature in the late 1970s. Originally, codependency described an unhealthy pattern of coping adopted by someone who was closely involved with a chemically dependent person. Other terms were also proposed, such as "co-alcoholic," "para-alcoholic," and "nonalcoholic," but the label "codependent" stuck because of its greater inclusiveness (van Wormer, 1989). This wider generalizability was necessary because experts in the treatment field started realizing that other problems, such as overeating and gambling, paralleled the illness of alcoholism, and could affect family members in a similar fashion.

Since the early 1980s, the term has been expanded and popularized so that it has surpassed its situational boundaries. Beattie (1987) says,

As professionals understood codependency better, more groups of people appeared to have it: adult children of alcoholics; people in relationships with emotionally
or mentally disturbed persons; people in relationships with chronically ill people; parents of children with behavior problems; people in relationships with irresponsible people. (p. 30)

Consequently, a relationship with an alcoholic is no longer the exclusive focus of codependency. A codependent person has become one who has a relationship, personally or professionally, with a "troubled, needy, or dependent person" (Beattie, 1987, p. 31).

This more general definition served to encompass a larger portion of the population. As a result, more and more people have found themselves attending self-help group meetings in church basements and hotel ballrooms. The recovery movement has largely been fueled by those struggling to overcome some manifestation of codependency. Undoubtedly, many people have been helped. However, despite the proclamations and promises of mental health, several theorists have remarked that the concept of codependency carries inherent dangers.

In the sections that follow, several difficulties with the codependency construct will be examined. These difficulties center on the construct's definitional ambiguity, disease conceptualization, association with dependency, addiction quality, and gender bias.
Definitional Ambiguity

One of the potential dangers in the use of the concept of codependency is that a precise definition of the term remains elusive. As noted above, the concept originated with a clearly stated referent and then generated so much momentum that it outgrew its borders. Asher and Brissett (1988) interviewed 52 wives of men diagnosed and treated for alcoholism. The subjects frequently and spontaneously described themselves as codependent, yet could not explain the meaning of the term. The researchers noted little consensus among the subjects with regard to:

- whether or not it [codependency] involved a profound change of self, whether or not it is a disease,
- whether or not it is an innate personal characteristic or a socially acquired role, and whether or not it is a permanent or temporary state of being. (p. 340)

Nevertheless, the subjects appeared to have accepted the reality of the codependency construct quite matter-of-factly.

Among codependency theorists, similar definitional ambiguity can be seen. A sample of proposed definitions will illustrate this point:

"Codependency 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 the diagnosis of Mixed Personality
Disorder as outlined in DSM III" (Cermak, 1986, p. 1).

"A codependent person is one who has let another person's behavior affect him or her, and who is obsessed with controlling that person's behavior" (Beattie, 1987, p. 31).

"I define co-dependency as a primary condition that results from the debilitating physiological stress produced by living in a committed relationship with an alcoholic or drug dependent person" (Mendenhall, 1989, p. 6).

"Codependency is...any suffering and/or dysfunction that is associated with or results from focusing on the needs and behavior of others" (Whitfield, 1989, p. 19).

"A co-dependent is an individual who has been significantly affected in specific ways by current or past involvement in an alcoholic, chemically dependent, or other long-term, stressful family environment. Specific effects include: (a) fear; (b) shame/guilt; (c) prolonged despair; (d) anger; (e) denial; (f) rigidity; (g) impaired identity development; and (h) confusion" (Potter-Efron & Potter-Efron, 1989, p. 39).

"Codependency is a primary disease and a disease within every member of an alcoholic family" (Wegscheider-Cruse, cited in Schaef, 1986, p. 14).

The above explanations disagree with respect to both the etiology and symptomatology of codependency. The only two components that appear repeatedly are (a) notions of
caretaking and responsibility for others, and (b) affliction by association with chemically dependent individuals. An underlying theme is shared by all the definitions, however: codependency is an anathema to personal well-being. It is viewed as a situation or condition in need of remediation.

The harmful consequence of such definitional confusion is that it may cause a globalization of the problem (Krestan & Bepko, 1990). Katz and Liu (1991) cite several codependency proponents who develop the concept to the point where it includes the majority of the population of the United States. Even more sobering is the view that "most mental health professionals are untreated codependents who are actively practicing their disease in their work" (Schaef, 1986, p. 8). Until a clear explication of the construct is reached, more and more people will be able to fit parts of themselves under the codependency rubric. This, in turn, means that more people will erroneously be forced to reinterpret their identities in terms of deficits and dysfunction.

Disease Conceptualization

A second dangerous aspect of the codependency construct lies in its de facto assumption of the disease model of mental disorders. As can be seen in the above definitions, association with a chemically dependent person is agreed upon as one of the most probable precursors to codependency. Several decades ago, when alcoholic behavior became
classified as a disease, and, as family systems theory grew, "it was not a difficult leap to decide that, if the alcoholic has a disease, then so must the other people in the family" (Krestan & Bepko, 1990). In fact, Schaef (1986) notes that "the disease of alcoholism and the disease of codependency (or co-alcoholism or para-alcoholism) is, in essence, the same disease" (p. 29). Mendenhall (1989) goes even further by supporting the observation that "the codependent is sicker than the alcoholic" (p. 13).

Several authors have discussed why codependency is called a disease. Beattie (1987) remarks that it is progressive. Codependent persons react more and more intensely so that eventually even small concerns may trigger "isolation, depression, emotional or physical illness, or suicidal fantasies" (p. 34). In addition, codependent behaviors are habitual and therefore chronic. The self-destructive patterns are repeated without thinking, which causes codependent people either to begin or remain in unhealthy relationships. This self-perpetuation forces the codependent person into a vicious, unending cycle of deterioration. Finally, codependency causes pain. It is a system of thinking, feeling, and behaving that leads a person to react to another's self-destructive behavior by destroying himself or herself as well.
Katz and Liu (1991) offer another similarity between physical sickness and codependency. Both cast the individual in the victim role, as "a person who is powerless over his or her disease and has no responsibility for its onset" (p. 4). Codependency, like cancer, simply happens to the person. Schaef (1986) states that codependency fits the disease concept for the following reasons:

- it has an onset (a point at which the person's life is just not working, usually as a result of an addiction),
- a definable course (the person continues to deteriorate mentally, physically, psychologically, and spiritually), and,
- untreated, has a predictable outcome (death). (p. 10)

Others, such as Cocores (cited in van Wormer, 1989) and Cermak (1986), have recommended that codependency be included in the next version of the Diagnostic and Statistical Manual, which would formalize its disease status.

Ascribing disease characteristics to a behavior pattern is not inherently harmful as long as that pattern is clearly specified and each individual case is cautiously scrutinized to ensure its appropriateness for classification. Unfortunately, the behavior pattern of codependency is vague at best, and many competing theoretical frameworks vie for the privilege of providing the ultimate definition. Yet, despite this equivocation, the label frequently seems to be
applied with abandon.

By classifying so many individuals as codependent, and thereby fitting their problems into a disease category, the unfortunate result is a loss of personal responsibility (Katz & Liu, 1991). If codependency is similar to an infectious agent such that the individual is a victim of uncontrollable circumstances, then what is there to do? The message is that one is powerless, so any attempt to change is futile.

Association with Dependency

A third danger in the codependency construct is its similarity to the term "dependency." Many researchers have studied the dependent personality, and their focus has primarily been on the negative correlates and consequences. Bornstein's (1992) review of this literature enumerated the empirical support for several interpersonal correlates of dependency: suggestibility, yielding to status, compliance with others' expectations, help-seeking, performance anxiety, and affiliation when faced with stress. The relationship between dependency and psychopathology was also discussed. The preponderance of studies found correlations between dependency and (a) depression, (b) alcoholism, (c) tobacco addiction, and (d) obesity. This article thus confirmed the prevailing view that dependency is associated with a number of socially undesirable traits as well as a risk for certain psychological disorders. It can be seen how
Codependency, because of its almost identical terminology, might carry the same negative associations as dependency.

**Addiction Quality**

Codependency also borrows elements from the addictions field. This evolved naturally, as the codependency construct emerged out of the treatment of alcoholics. Presumably, just as an alcoholic is addicted to alcohol, so is the codependent person addicted to relationships, usually self-destructive ones with immature, needy people (Beattie, 1987). It has been suggested that the wife of an alcoholic needed to marry an alcoholic to be happy, and she needed him drinking to feel fulfilled (Krestan & Bepko, 1990). Coleman (1987) compares chemical dependency with interpersonal dependency and then highlights the desperation of codependency by remarking, "Having been unloved, neglected, or abused creates a need for human warmth, caring, and touch that is often beyond fulfillment" (p. 40).

This kind of comparison carries problems. For example, Haaken (1990) points out that the codependent person does not achieve the euphoria from his or her addiction that might be expected. Beattie (1987) has underscored the unnecessary severity of this judgment and commented that "codependents need less harshness in their lives" (p. 32). Another problem is that, according to the medical definition of addiction, if not stopped the addictive behavior will lead to death (Katz & Liu, 1991). It is hard to imagine
anyone dying from relationship addiction. Excessive caretaking may interfere with normal functioning, but it is not a lethal pattern of behavior.

Due to this addiction quality, the codependency literature promotes "working a Twelve Step program" as the most effective method of recovery (e.g., Schaef, 1986). The Twelve Steps require that a person admit powerlessness over relationships and aim towards detachment. However, this provision "vastly oversimplifies problems of human dependency and interdependency" (Haaken, 1990, p. 404). It ignores the element of human nature that prescribes the offering of protection and aid to certain others. As will be explained in the following section, it also fails to consider the social forces that encourage women to assume caretaking responsibilities.

**Discrimination Against Women**

Herein lies the crux of the codependency construct's potentially damaging nature. An interesting trend that Bornstein (1992) uncovered in the dependency literature revolves around gender differences. Women report higher levels of dependency than men, a difference that first appears in childhood and continues through adolescence into adulthood. However, using projective tests, the average dependency scores of men and women are the same. Bornstein's explanation for this discrepancy is that women and men may have similar dependency needs, but society invites only
women to express them overtly. Thus, the expression of dependency is linked with femininity. This observed relationship has also appeared with regard to codependency. Codependency has been termed "women's basic programming" (Kasl, 1989, p. 31). According to the publishing field, the codependency market is 85% female (Kaminer, 1992).

Indeed, although codependency carries all of the elements of dependence, it represent them in the extreme. As a label, it appears to discriminate against women, because the characteristics of codependency are a caricature of women's prescribed social role (van Wormer, 1989). Beattie's (1987) list of the most harmful codependent characteristics reads like an exaggerated description of the stereotypical female role: obsessive helping, caretaking, low self-worth, dependence on people, and other-centeredness. Cermak's (1986) proposed criteria for the "Co-Dependent Personality Disorder" also are more likely to characterize women than men: investment of self-esteem in the ability to control oneself and others under adverse circumstances, assumption of responsibility for meeting others' needs, enmeshment in relationships, depression, anxiety, being the victim of abuse, etc.

In fact, women are socialized to tend to relationships, to assume responsibility for family harmony, and to put the needs and feelings of others ahead of their own (Krestan & Bepko, 1990). It has even been suggested that a woman's
sense of self is developed within her relational networks, so that "connection with others provides a primary context for action and growth" (Kaplan, 1986, p. 235).

However, instead of viewing the tendency for women to value connectedness and maintain even difficult relationships as a strength, the codependency industry sees it as a pathology (Webster, 1990). Wives of alcoholics are depicted as potentially "villainous" (Kokin, 1989, p. 17). One popular belief is to blame the alcoholic's drinking on his mentally ill spouse (Beattie, 1987). Instead of being viewed as responding in a manner consistent with their socialization, women are branded with a label that implies underlying mental disease. In addition, "calling femininity a disease obscures the fact that many women are trapped in abuse by circumstance, not weakness" (Kaminer, 1992, p. 15).

**Effects of Labeling**

Although the potentially dangerous elements of the codependency construct have been noted by the aforementioned theorists, there is only tentative research to suggest that the construct actually causes noticeable damage. Asher and Brissett (1988) found that women married to alcoholics who are exposed to the codependency industry's ideology undergo a process of redefining their identities. The subjects remarked upon the pressure to conform to the codependency label and the guilt that accompanies any resistance on the part of the individual.
The labeling literature speaks to the powerful impact of assuming the designation of "codependent." To the extent that codependent persons are recognized as nonnormative in their behavior, they are considered deviant (Kituse, 1962). This deviance, because it is a creation of society, is responded to by others in a stigmatizing fashion (Becker, 1973). Moreover, the "vicious cycle" labeling process carries important social, political, and moral implications (Schacht, 1985). Studies have shown the presence of labels to have a variety of effects on the individual's behavior (e.g., Goldman, Seever, & Seever, 1982), on the individual's self-perceptions (e.g., Kutner & Brogan, 1985), and on other people's reactions to the individual (e.g., Poole, Regoli, & Pogrebin, 1986). In addition, a label that is applied in childhood (such as "shy") can become an important dimension for making sense of the world (Harris & Wilshire, 1988).

With regard to labels of mental illness, Warner (1985) argues that any person with a sense of self-worth will experience cognitive dissonance when faced with such a diagnosis. Accepting the diagnosis means to conform to the stigmatizing stereotype, which may reduce the individual's self-esteem, eliminate the individual's internal locus of control, and force a low level of functioning. In contrast, the person who reduces dissonance by rejecting the diagnosis may retain his or her self-esteem, internal locus of control, and high level of functioning. Possible support for
this position was provided by Warner, Taylor, Powers, and Hyman (1989), who demonstrated that the level of stigma associated with a mental illness was inversely related to self-esteem. Also, individuals who rejected the label of mental illness tended to display higher self-esteem.

The codependency label, in its definitional ambiguity and societal endorsement, seems almost impossible to reject. To be labeled codependent is increasingly to be judged as sick. The industry rewards people for calling themselves helpless, childish, and addicted, and punishes people who call themselves healthy (they are simply "in denial") (Kaminer, 1992).

Kokin (1989) believes that wives of alcoholics are the scapegoats of society. Although alcoholism is a societal problem, it is the codependent individuals who live with the alcoholic who often appear to carry the blame for the damage caused. Therefore, it can be expected that a person who embraces the codependency label may experience deleterious psychological consequences.

Purpose of this Study

The purpose of this study is to examine empirically the effects of the codependency label. Specifically, it is predicted that individuals who deem themselves codependent will have lower self-esteem, a higher level of depression, an external locus of control, and a more feminine sex-role stereotype, as compared to individuals who share similar
Hypotheses

The following hypotheses are proposed for this study:

Hypothesis 1: Subjects who are assessed as codependent on a codependency measure will score lower on self-esteem, higher on depression, more external on locus of control, and more feminine in sex role orientation, as compared to subjects who are not assessed as codependent.

Rationale: Regardless of whether a person labels himself or herself as codependent, the behaviors, emotions, and cognitions subsumed under the codependency rubric have their own negative associations. In particular, a person's self-esteem, internal locus of control, and affective state will suffer. In addition, due to the definitional closeness between the codependency construct and the female gender role, the personal characteristics of persons scoring positively as codependent will manifest themselves also in a stereotypically feminine sex-role orientation.

Hypothesis 2: Subjects who self-label as codependent will score lower on self-esteem, higher on depression, more external on locus of control, and more feminine in sex role orientation, as compared to subjects who do not self-label as codependent.
Rationale: Codependency is seen as a disease and an addiction. People who are codependent are viewed as suffering from an illness that is a challenge to remediate. Moreover, the definition of codependency and the description of the stereotypical female gender role are very similar. Thus, when forced to assume this label, subjects will show its effects in their self-esteem, level of depression, locus of control orientation, and sex-role stereotyping.

Hypothesis 3: Among subjects who are assessed as codependent, the subsample who self-label as codependent will score lower on self-esteem, higher on depression, more external on locus of control, and more feminine in sex role orientation, as compared to the subsample who do not self-label as codependent.

Rationale: The harmful consequences of assuming a codependent identity will outweigh the effects of the life circumstances that led to a positive assessment of codependency. To reject the label can potentially serve a self-protective function, which thus allow those persons to preserve their self-esteem, internal locus of control, positive affect, and less feminine sex-role stereotyping to a larger degree than those who embrace the label and its concomitant stigmatization.

Hypothesis 4: A gender difference will exist on the codependency construct such that more women than men will both self-label as codependent and be assessed as
codependent.

Rationale: This gender difference can be expected from the observations that codependency is an extension of the female gender role. The caretaking, relationship-preserving proclivities that characterize codependency are behaviors taught to more women than men through their socialization.
CHAPTER II

METHOD

Design

This study employed a 2 (Codependency) X 2 (Self-Label) design. The Codependency variable included those subjects who scored above a specified cut-off (i.e., two or more "yes" responses on at least five subscales) on the Codependency Assessment, versus those who did not reach that critical score. The two levels of the Self-Label variable are (a) subjects who did not label themselves as codependent, and (b) subjects who did label themselves as codependent.

Subjects

Subjects were drawn from a pool of undergraduate students in Psychology 100, who participated for course credit. The total number of students participating in the study was 93. The sample was composed of 44 men and 49 women. Eighty-nine percent of subjects were Caucasian, 5% African American, 4% Asian American, and 2% Hispanic American. Average age of the subjects was 21.8 years, with a range of 18 to 51 years. All subjects were selected by means of a screening measure, described below.
Instruments

 Screening measure. Seven hundred and eighty-eight Psychology 100 students were given the screening measure (see Appendix A). The screening measure consisted of a 34-item Codependency Assessment (CA) scale (Potter-Efron & Potter-Efron, 1989). This instrument comprises eight subscales considered diagnostic for codependency: fear, shame/guilt, prolonged despair, rage, denial, rigidity, impaired identity development, and confusion. Each subscale contains between three and six questions, to which the respondent answers "yes" or "no". At least two questions in each subscale must be answered "yes" for that subscale to be considered positive for codependency. In addition, a total of five subscales must be positive for the individual to attain a critical score on the CA, thus resulting in a positive assessment of codependency.

The reliability and validity of the CA had yet to be investigated prior to this study. The instrument grew out of the authors' clinical observations, and no data on its use were available. To the authors' knowledge, the CA had not been utilized in other research. Nevertheless, it appeared to possess good face validity and was deemed appropriate for the current study.

Attached to the Codependency Assessment during the screening process were three questions asking (a) if the subject were male or female (48% of the sample was male, 52%
was female), (b) if the subject were familiar with the term codependency (66% of the sample replied affirmatively), and (c) if the subject considered herself or himself to be codependent (7% of the total sample endorsed this item).

**Self-esteem.** The 10-item Rosenberg Self-Esteem Scale (RSE) (Rosenberg, 1965) was used to assess the global self-esteem of all subjects selected for inclusion in the study based on the screening assessment (see Appendix B). Wylie (1989) has reported on various psychometric properties of the RSE. For example, the RSE has been shown to have acceptable test-retest reliability, ranging from .63 to .91. The Cronbach alphas for internal consistency reliability ranged from .77 to .87. Support for the scale's unidimensionality was reported by several sources. The convergent validity coefficient found when correlating the RSE with Coopersmith's Self-Esteem Inventory was .60. Other validity studies showed the RSE to correlate negatively with depressive affect, anxiety, self-derogation, and interpersonal insecurity. The RSE correlated positively with high school students' participation in extracurricular activities and leadership roles (Wylie, 1989).

**Locus of control.** The Reid-Ware Three-Factor Internal-External Scale (RTIS) (Reid & Ware, 1974) examined the subjects' locus of control (see Appendix C). This measure grew out of the body of research that revealed Rotter's original locus of control scale to be multidimensional. The
authors constructed a 45-item forced-choice questionnaire composed of the following three factors: self-control, social systems control, and fatalism. Reid & Ware (1973) report its internal consistency reliability to be .71. With respect to validity, Reid and Ware (1974) found that the self-control and social systems control factors were related to causal attributions. Subjects scoring more internal on either of these two factors tended to see a student who had failed academically as responsible for his failures. In addition, a relationship was found between political participation and internality on the social systems control factor (Reid & Ware, 1974).

Depression. The Beck Depression Inventory (BDI) (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) also was given to those subjects selected from the screening process (see Appendix D). The BDI is a 21-item, self-report measure that is widely used in the assessment of depression. Each item contains four responses, scored 0 to 3. Beck, Steer, and Garbin (1988) performed a meta-analysis of studies targeting the BDI's internal consistency reliability and found the estimates to range from .73 to .92, with a mean of .86. This report also noted that the BDI's test-retest reliabilities have ranged from .48 to .86. The validity of the BDI has been supported by correlations of .55 to .96 between scores on the BDI and clinical diagnoses of depression (Beck et al., 1988). In addition, the measure correlates .65 with
clinician's ratings of depression (Beck et al., 1961).

**Sex role orientation.** Femininity and masculinity was investigated with the Bem Sex-Role Inventory (BSRI) (Bem, 1974) (see Appendix E). The BSRI treats masculinity and femininity as two independent dimensions rather than as two poles of one dimension. Therefore, a person can be high on both dimensions and designated as "androgynous," low on both dimensions and termed "undifferentiated," or high on one dimension and low on the other, called either "feminine" or "masculine." The Original Form of the BSRI consists of 60 adjectives, and the subject indicates whether that characteristic is "never or almost never true," "usually not true," "sometimes but infrequently true," "occasionally true," "often true," "usually true," or "always or almost always true." The Original Form has good test-retest reliability (.76 to .94) as well as high internal consistency reliability (.75 to .87). The validity of the BSRI was supported by research showing sex-typed subjects to prefer sex-appropriate activities and resist sex-inappropriate activities more than androgynous or cross-sex-typed subjects (Bem & Lenney, 1976).

**Alcohol and drug use.** The Michigan Alcoholism Screening Test (MAST) (Selzer, 1971) was administered to all subjects selected from the screening assessment (see Appendix F). Because certain theorists have suggested that codependent persons are at risk for the development of their own
chemical dependency (e.g., Potter-Efron & Potter-Efron, 1989), and because chemical dependency has widespread effects on psychological functioning, the subjects' level of substance use was examined.

The MAST consists of 25 questions designed to measure the presence of symptoms of alcoholism. Answering "yes" to 5 or more items on the MAST is considered indicative of alcoholism, while a score of a 4 is considered indicative of marginal alcoholism. Selzer has shown the MAST to be able to discriminate light drinkers from (a) persons hospitalized for alcoholism, (b) persons convicted of driving under the influence of alcohol, and (c) persons convicted of drunk and disorderly behavior. Selzer further believes that the MAST overcomes the proclivity for alcoholic persons to respond in a socially desirable fashion, as evidenced by the low rate of false negatives in his study.

In addition to the MAST, subjects were asked to indicate (a) how many days during they past month they had at least one drink, (b) how many drinks they had during the past month, and (c) how many times during an average week they have five or more drinks at one sitting. These questions constitute a modified version of Sher, Walitzer, Wood, and Brent's (1991) assessment of alcohol consumption.

Scores from the MAST and the above three questions were combined to form an alcohol use estimate. Subjects received three points for a score of five or more on the MAST. A
median split technique was used on each of the three questions, such that persons scoring above the median received one point. Thus, subjects could score from 0 to 6, with higher scores demonstrating more extensive alcohol consumption. Standardization of the resulting set of scores resulted in a range of 1 to 3.

The alcohol use estimate was calculated in order to be used as a covariate. Because codependency often follows from a relationship with a chemically dependent person, it can be expected that subjects in this study might be at risk for their own chemical dependency. Sher et al. (1991) demonstrated that adolescent children of alcoholic families, as compared to adolescent children of non-alcoholic families, were more likely to report heavier alcohol consumption, to suffer more negative consequences, and to receive a lifetime alcohol diagnosis. In addition, the student population in general tends to ingest an amount of alcohol that is above average (Healy, 1992). The use of alcohol and other drugs by adolescents has been linked with a number of psychological effects, such as negative affectivity (Sher et al. 1991), suicidal ideation (Dukes & Lorch, 1989), low self-esteem (Butler, 1982), dissatisfaction with self (Newcomb, Bentler, & Collins, 1986), depression (Pandina & Schuele, 1983), feminine gender role orientation (Horwitz & White, 1987), poor conflict resolution and problems with intimacy (Frank, Jacobson, &
Tuer, 1990). Therefore, it was decided that in order to assess clearly the relationship between codependency and the dependent measures, any variance due to alcohol use must be removed.

Procedure

The initial screening involved administering the CA and its three accompanying questions to 788 Psychology 100 students. The three questions were on a sheet of paper that was attached to the front of the CA, so that the students answered them, tore the sheet off, and turned in their responses immediately. They were asked to take the CA home to be completed at their convenience. They had the option of returning the completed CA either to their TA or to a box in the Psychology 100 central office. Three hundred and fifty-five CAs were returned, representing a 45% return rate. Twenty-four of the students who indicated that they considered themselves codependent did not return a completed CA during the initial screening period. An assistant to the experimenter contacted them by phone and attempted to schedule a time for them to take the CA. Two people had given the wrong phone number and two people were not interested in participating in the study. Consequently, twenty self-labeled "codependent" subjects took the CA under the supervision of the assistant. Subjects then were selected on the basis of their responses to the three questions and CA.
Four groups were formed, comprising (a) subjects who did not self-label as codependent and who did not score above the cut-off on the codependency assessment, (b) subjects who did not self-label as codependent and who did score above the cut-off on the codependency assessment, (c) subjects who did self-label as codependent and did not score above the cut-off on the codependency assessment, and (d) subjects who did self-label as codependent and who did score above the cut-off on the codependency assessment.

Subject selection and distribution resulted in the following sample sizes:

<table>
<thead>
<tr>
<th></th>
<th>no self-label</th>
<th>self-label</th>
</tr>
</thead>
<tbody>
<tr>
<td>assessed as codependent</td>
<td>n = 23</td>
<td>n = 25</td>
</tr>
<tr>
<td>assessed as non-codependent</td>
<td>n = 27</td>
<td>n = 18</td>
</tr>
</tbody>
</table>

After the initial screening, subjects selected for inclusion in the study were contacted by telephone for participation in the second part of the investigation. The second phase involved administering the MAST, the RSE, the RTIS, the BDI, the BSRI, and a demographic questionnaire (see Appendix G). The demographic questionnaire asked for information about subjects' sex, age, participation in support groups, and association with chemically dependent persons. The dependent measures were completely
counterbalanced to control for possible order effects. In addition, all subjects took the CA at the conclusion of the testing period to assess the test-retest reliability of that measure. The CA was administered as the final instrument in order to minimize the chance of subjects having a response set.
CHAPTER III

RESULTS

Results of the statistical analysis of the data will be presented in this section. The first subsection will discuss the reliability and validity of the CA. Next will follow an examination of scores from the four dependent measures. Finally, additional gender differences will be addressed.

Reliability and Validity of the Codependency Assessment

The reliability of the Codependency Assessment was examined first. Scores on the CA taken during the screening period were correlated with scores on the CA taken at the completion of the second part of the study. These two sets of scores were available for 84 subjects. The average interval between the two administrations was five weeks.

The test-retest correlations for each item are presented in Table 1. Thirty-one out of 34 items correlate highly, $p < .01$. Items 12 ("Do you feel yourself denying the basic problems in your family?") , 27 ("Do you tend to see moral issues in black-and-white terms?") , and 31 ("Do you try to 'keep things under control' or 'keep a handle' on situations?") do not correlate significantly, $p > .05$. These three items come from different subscales and seem not to
## Table 1

Test-Retest Correlations by Item

<table>
<thead>
<tr>
<th>Item Number</th>
<th>Subscale</th>
<th>Correlation Coefficient</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Fear</td>
<td>.48</td>
<td>.0001</td>
</tr>
<tr>
<td>2</td>
<td>Rage</td>
<td>.31</td>
<td>.0048</td>
</tr>
<tr>
<td>3</td>
<td>Rigidity</td>
<td>.56</td>
<td>.0001</td>
</tr>
<tr>
<td>4</td>
<td>Confusion</td>
<td>.48</td>
<td>.0001</td>
</tr>
<tr>
<td>5</td>
<td>Fear</td>
<td>.60</td>
<td>.0001</td>
</tr>
<tr>
<td>6</td>
<td>Prolonged Despair</td>
<td>.44</td>
<td>.0001</td>
</tr>
<tr>
<td>7</td>
<td>Rage</td>
<td>.55</td>
<td>.0001</td>
</tr>
<tr>
<td>8</td>
<td>Prolonged Despair</td>
<td>.40</td>
<td>.0002</td>
</tr>
<tr>
<td>9</td>
<td>Rage</td>
<td>.57</td>
<td>.0001</td>
</tr>
<tr>
<td>10</td>
<td>Denial</td>
<td>.40</td>
<td>.0001</td>
</tr>
<tr>
<td>11</td>
<td>Rigidity</td>
<td>.50</td>
<td>.0001</td>
</tr>
<tr>
<td>12</td>
<td>Denial</td>
<td>.05</td>
<td>.6578</td>
</tr>
<tr>
<td>13</td>
<td>Shame/Guilt</td>
<td>.38</td>
<td>.0004</td>
</tr>
<tr>
<td>14</td>
<td>Impaired Identity Development</td>
<td>.56</td>
<td>.0001</td>
</tr>
<tr>
<td>15</td>
<td>Shame/Guilt</td>
<td>.59</td>
<td>.0001</td>
</tr>
<tr>
<td>16</td>
<td>Confusion</td>
<td>.57</td>
<td>.0001</td>
</tr>
<tr>
<td>17</td>
<td>Fear</td>
<td>.61</td>
<td>.0001</td>
</tr>
<tr>
<td>18</td>
<td>Shame/Guilt</td>
<td>.51</td>
<td>.0001</td>
</tr>
<tr>
<td>19</td>
<td>Impaired Identity Development</td>
<td>.64</td>
<td>.0001</td>
</tr>
<tr>
<td>20</td>
<td>Rigidity</td>
<td>.55</td>
<td>.0001</td>
</tr>
<tr>
<td>21</td>
<td>Shame/Guilt</td>
<td>.54</td>
<td>.0001</td>
</tr>
<tr>
<td>22</td>
<td>Shame/Guilt</td>
<td>.63</td>
<td>.0001</td>
</tr>
<tr>
<td>23</td>
<td>Confusion</td>
<td>.57</td>
<td>.0001</td>
</tr>
<tr>
<td>24</td>
<td>Impaired Identity Development</td>
<td>.47</td>
<td>.0001</td>
</tr>
<tr>
<td>25</td>
<td>Prolonged Despair</td>
<td>.53</td>
<td>.0001</td>
</tr>
<tr>
<td>26</td>
<td>Fear</td>
<td>.58</td>
<td>.0001</td>
</tr>
<tr>
<td>27</td>
<td>Rigidity</td>
<td>.19</td>
<td>.0857</td>
</tr>
<tr>
<td>28</td>
<td>Fear</td>
<td>.69</td>
<td>.0001</td>
</tr>
<tr>
<td>29</td>
<td>Impaired Identity Development</td>
<td>.64</td>
<td>.0001</td>
</tr>
<tr>
<td>30</td>
<td>Rage</td>
<td>.70</td>
<td>.0001</td>
</tr>
<tr>
<td>31</td>
<td>Fear</td>
<td>-.03</td>
<td>.8031</td>
</tr>
<tr>
<td>32</td>
<td>Denial</td>
<td>.60</td>
<td>.0001</td>
</tr>
<tr>
<td>33</td>
<td>Confusion</td>
<td>.57</td>
<td>.0001</td>
</tr>
<tr>
<td>34</td>
<td>Confusion</td>
<td>.54</td>
<td>.0001</td>
</tr>
</tbody>
</table>
represent a response pattern among the subjects.

The test-retest correlations for each subscale are presented in Table 2. On all eight subscales, scores from the first and second administrations are highly correlated, \( p < .001 \). The suggested guideline for evaluating an instrument's reliability points to correlations of .70 or greater as being adequate for research purposes (Groth-Marnat, 1990). Thus, it appears that the test-retest reliability of the CA is good.

The internal consistency of the CA was also computed. Scores from all the Codependency Assessments returned during the screening period were included \( (n = 355) \). Cronbach's coefficient alpha for the CA was found to be .97, indicating a high degree of inter-item consistency, or homogeneity.

The concurrent validity of the CA was examined through analysis of the relationship between self-labeling and assessment of codependency. The frequencies are presented in Table 3. A chi square test failed to reach significance, \( (1, N = 355) = 5.68, p > .05 \). Consequently, there seems to be no relationship between the subjects' judgments of themselves as codependent and the likelihood of their scoring codependent on the CA.

This result would seem to call into question the validity of the CA. However, an alternate explanation might involve the fact that no definition of codependency was given to the subjects. When asked to indicate whether or not
<table>
<thead>
<tr>
<th>Subscale (Items)</th>
<th>Correlation Coefficient</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fear (1, 5, 17, 26, 28, 31)</td>
<td>.67</td>
<td>.0001</td>
</tr>
<tr>
<td>Shame/Guilt (13, 15, 18, 21, 22)</td>
<td>.71</td>
<td>.0001</td>
</tr>
<tr>
<td>Prolonged Despair (6, 8, 25)</td>
<td>.70</td>
<td>.0001</td>
</tr>
<tr>
<td>Rage (2, 7, 9, 30)</td>
<td>.53</td>
<td>.0001</td>
</tr>
<tr>
<td>Denial (10, 12, 32)</td>
<td>.63</td>
<td>.0001</td>
</tr>
<tr>
<td>Rigidity (3, 11, 20, 27)</td>
<td>.57</td>
<td>.0001</td>
</tr>
<tr>
<td>Impaired Identity Development (14, 19, 24, 29)</td>
<td>.69</td>
<td>.0001</td>
</tr>
<tr>
<td>Confusion (4, 16, 23, 33, 34)</td>
<td>.86</td>
<td>.0001</td>
</tr>
</tbody>
</table>
Table 3
Number of Subjects by Codependency and Self-Labeling

<table>
<thead>
<tr>
<th></th>
<th>Non-Self-Labeled</th>
<th>Self-Labeled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Codependent</td>
<td>142</td>
<td>23</td>
</tr>
<tr>
<td>Codependent</td>
<td>158</td>
<td>32</td>
</tr>
</tbody>
</table>
they viewed themselves as codependent, the subjects were forced to rely on their own definitions. Perhaps college students' understanding of codependency differs from that of the researchers who developed the CA. This explanation would be consistent with the societal confusion that surrounds the construct of codependency. Because of such definitional ambiguity, one might even expect the result found here.

Analysis of Self-Esteem Scores

Correlations among the dependent measures can be found in Appendix H. Four significant correlations were revealed. Self-esteem scores were significantly related to scores on the depression, locus of control, and sex-role orientation measures. These three correlations were all negative, such that as people scored higher on self-esteem, they also scored less depressed, more external, and less feminine. Conversely, as subjects scored lower on self-esteem, they scored more depressed, more internal, and more feminine. The fourth significant correlation will be discussed below.

A 2 (Codependency) X 2 (Self-Label) X 2 (Gender) ANCOVA was performed on scores from the Rosenberg Self-Esteem Inventory. Means can be found in Table 4. Standardized alcohol use scores were incorporated as the covariate (see Table 5 for means). Results indicated no main effect for Gender, $F(1, 87) = .30, p > .05$. A significant main effect was found for Codependency, $F(1, 88) = 22.46, p < .0001$. While not reaching statistical significance at the
Table 4
Means on the Rosenberg Self-Esteem Inventory

<table>
<thead>
<tr>
<th></th>
<th>RSI Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Codependent</td>
<td></td>
</tr>
<tr>
<td>Non-Self-Labeled</td>
<td>34.5</td>
</tr>
<tr>
<td>Self-Labeled</td>
<td>32.9</td>
</tr>
<tr>
<td>Codependent</td>
<td></td>
</tr>
<tr>
<td>Non-Self-Labeled</td>
<td>29.8</td>
</tr>
<tr>
<td>Self-Labeled</td>
<td>27.3</td>
</tr>
</tbody>
</table>
Table 5
Means on the Alcohol Use Variable

<table>
<thead>
<tr>
<th></th>
<th>Alcohol Use Score</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Not Codependent</strong></td>
<td></td>
</tr>
<tr>
<td>Non-Self-Labeled</td>
<td>1.96</td>
</tr>
<tr>
<td>Self-Labeled</td>
<td>2.22</td>
</tr>
<tr>
<td><strong>Codependent</strong></td>
<td></td>
</tr>
<tr>
<td>Non-Self-Labeled</td>
<td>1.91</td>
</tr>
<tr>
<td>Self-Labeled</td>
<td>2.12</td>
</tr>
</tbody>
</table>
conventional $p < .05$ level, the Self-Label variable did approach significance, $F(1, 88) = 3.42, p > .05$. No significant interaction between Codependency and Self-Label was found, $F(1, 88) = .20, p > .05$.

Post-hoc analysis via the Newman-Keuls test for significance was performed on the main effect for Codependency. This test revealed that those subjects who scored positively on the CA scored significantly lower on the RSI ($M = 29.7$) than those who did not score positively on the CA ($M = 32.3$), $p < .0001$. Thus, subjects who were assessed as codependent had lower self-esteem than subjects who were not assessed as codependent.

The preplanned comparison between self-esteem scores of those subjects assessed as codependent who did self-label as codependent ($M = 27.3$) and those subjects assessed as codependent who did not self-label ($M = 29.8$) was computed via a Least Squares Means test. It revealed no significant difference between the two groups, $p > .05$.

**Analysis of Depression Scores**

A second $2$ (Codependency) x $2$ (Self-Label) x $2$ (Gender) ANCOVA was conducted on scores from the Beck Depression Inventory (see Table 6). As in the above ANCOVA, standardized alcohol use estimates were used as a covariate. Results indicated no significant effect due to Gender $F(1, 85) = .98, p > .05$. Significant main effects were found for Codependency, $F(1, 86) = 6.05, p < .05$, and Self-Label,
Table 6
Means on the Beck Depression Inventory

<table>
<thead>
<tr>
<th></th>
<th>BDI Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Codependent</td>
<td></td>
</tr>
<tr>
<td>Non-Self-Labeled</td>
<td>4.6</td>
</tr>
<tr>
<td>Self-Labeled</td>
<td>9.7</td>
</tr>
<tr>
<td>Codependent</td>
<td></td>
</tr>
<tr>
<td>Non-Self-Labeled</td>
<td>10.5</td>
</tr>
<tr>
<td>Self-Labeled</td>
<td>13.0</td>
</tr>
</tbody>
</table>
The interaction between Codependency and Self-Label was non-significant, $F(1, 86) = .50$, $p > .05$.

Further analysis of the Codependency effect via the Newman-Keuls test for significance revealed that subjects who were assessed as codependent scored significantly higher on the BDI ($M = 11.8$) than subjects who were not assessed as codependent ($M = 6.7$), $p < .05$. Similarly, the Newman-Keuls test for significance conducted on the Self-Label effect showed that subjects who labeled themselves as codependent scored significantly higher on the BDI ($M = 11.6$) than subjects who did not label themselves as codependent ($M = 7.3$), $p < .05$.

The preplanned comparison of depression scores for subjects assessed as codependent who did or did not self-label was performed via the Least Squares Means test. The means for subjects who were assessed as codependent and did self-label ($M = 13.0$) and subjects who were assessed as codependent and did not self-label ($M = 10.5$) were not significantly different, $p > .05$.

**Analysis of Locus of Control Scores**

As can be seen in Appendix H, a fourth significant correlation among the dependent measures occurred between locus of control scores and sex-role orientation. This finding revealed a direct relationship between the two sets of scores, such that subjects scoring more external also
scored more feminine.

A third 2 (Codependency) X 2 (Self-Label) X 2 (Gender) ANCOVA was performed on scores from the Reid-Ware Three Factor Internal-External Scale. Means are displayed in Table 7. Standardized alcohol use estimates were incorporated as the covariate. No significant main effect of Gender was found, \( F(1, 87) = 1.91, p > .05 \), nor was there a significant main effect of Self-Label, \( F(1, 88) = .73, p > .05 \). A significant main effect of Codependency was found, \( F(1, 88) = 13.38, p < .001 \). No significant interaction was revealed between Codependency and Self-Label, \( F(1, 88) = .02, p > .05 \).

Further analysis of the Codependency main effect was conducted through a Newman-Keuls test of the group means. This test revealed that subjects who were assessed as codependent scored significantly more externally (\( M = 3.5 \)) than subjects who were not assessed as codependent (\( M = 2.2 \)), \( p < .001 \).

A preplanned comparison of locus of control scores among subjects who were assessed as codependent and did or did not self-label was next examined. The groups means were not found to be significantly different, according to a Least Squares Means test, \( p > .05 \). Thus, subjects assessed as codependent who did self-label (\( M = 3.7 \)) did not score significantly different from subjects assessed as codependent who did not self-label (\( M = 3.3 \)), \( p > .05 \).
### Table 7
Means on the Reid-Ware Three-Factor Internal-External Scale

<table>
<thead>
<tr>
<th></th>
<th>RTIS Score</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Not Codependent</strong></td>
<td></td>
</tr>
<tr>
<td>Non-Self-Labeled</td>
<td>2.0</td>
</tr>
<tr>
<td>Self-Labeled</td>
<td>2.3</td>
</tr>
<tr>
<td><strong>Codependent</strong></td>
<td></td>
</tr>
<tr>
<td>Non-Self-Labeled</td>
<td>3.3</td>
</tr>
<tr>
<td>Self-Labeled</td>
<td>3.7</td>
</tr>
</tbody>
</table>
Analysis of Sex Role Orientation Scores

A fourth 2 (Codependency) X 2 (Self-Label) X 2 (Gender) ANCOVA was conducted on scores from the Bem Sex Role Inventory. Means are displayed in Table 8. The analyses computed utilized standard scores derived from the difference between the masculinity and femininity subscales on the BSRI, such that higher scores indicate a more feminine sex-role orientation. Again, standardized alcohol use estimates were used as the covariate. A significant main effect due to Gender resulted, F(1, 70) = 7.57, p < .01, as did a main effect due to Codependency, F(1, 70) = 10.04, p < .01. The Self-Label variable approached significance, F(1, 70) = 3.80, p > .05. The interaction between Codependency and Self-Label failed to attain significance, F(1, 70) = .82, p > .05.

Further analyses of the main effects via the Newman-Keuls test for significance showed that female subjects scored higher (M = 55.4) than male subjects (M = 47.4), p < .01. Higher scores on the BSRI indicate a more feminine sex role orientation. Moreover, a Newman-Keuls test of Codependency revealed subjects assessed as codependent scored higher (M = 55.9) than subjects not assessed as codependent (M = 47.5), p < .01. In addition, a Newman-Keuls test of the groups means for those subjects who did (M = 56.2) or did not (M = 49.0) self-label was indeed found to be significant, p < .05.
Table 8
Means on the Bem Sex-Role Inventory

<table>
<thead>
<tr>
<th></th>
<th>BSRI Score</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Not Codependent</strong></td>
<td></td>
</tr>
<tr>
<td>Non-Self-Labeled</td>
<td>46.8</td>
</tr>
<tr>
<td>Self-Labeled</td>
<td>49.2</td>
</tr>
<tr>
<td><strong>Codependent</strong></td>
<td></td>
</tr>
<tr>
<td>Non-Self-Labeled</td>
<td>52.0</td>
</tr>
<tr>
<td>Self-Labeled</td>
<td>58.6</td>
</tr>
</tbody>
</table>
A preplanned comparison to investigate the interaction between Codependency and Self-Label via the Least Squares Means test was found to attain significance. Subjects assessed as codependent who did self-label as codependent scored significantly higher on the BSRI (M = 58.6) than subjects assessed as codependent who did not self-label (M = 52.0), p < .05. The former group, then, appears to possess a more feminine sex-role orientation than the latter group.

Analysis of Further Gender Differences

The next analyses involved the comparative frequencies with which male and female subjects both labeled themselves as codependent and were assessed as codependent by the CA. Frequencies can be found in Table 9. Subjects included in this table were those who participated in this study as well as those who returned a CA during the initial screening period but were not chosen for participation. It can be seen that more women were assessed as codependent than assessed as not codependent. The reverse was true for men. Also, among both women and men, more students labeled themselves as not codependent than labeled themselves as codependent.

Two chi square tests were computed. The chi square analysis of the relationship between Codependency and Gender was significant, $\chi^2 (1, N = 355) = 8.96, p < .01$. This result indicates that more women than men scored codependent on the CA. The chi square analysis of the relationship between Self-Label and Gender was not
Table 9
Number of Codependent and Self-Labeled Subjects by Gender

<table>
<thead>
<tr>
<th></th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Codependency (N = 355)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Codependent</td>
<td>112</td>
<td>78</td>
</tr>
<tr>
<td>Not Codependent</td>
<td>71</td>
<td>94</td>
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significant, $\chi^2 (1, N = 355) = 1.15$, $p > .05$, suggesting that women are no more likely to label themselves codependent than are men. There appears, then, to be a relationship between assessment of codependency and gender but not between gender and self-labeling.
CHAPTER IV
DISCUSSION

Further explanation and interpretation of the results will focus on several elements. The general pattern of the data will be presented first, followed by discussion of the psychometric properties of the Codependency Assessment scale. Next, the implications of the results for the Codependency and Self-Label variables will be presented. These explications will be organized around each dependent measure in succession.

Relationship of Results to Hypotheses

The general pattern of results from this investigation seem to lend limited support for the hypotheses. Hypothesis 1 predicted that subjects assessed as codependent would score lower on self-esteem, higher on depression, more external on locus of control, and more feminine on sex-role orientation, as compared to subjects not assessed as codependent. This hypothesis was strongly supported. On all four dependent measures, codependent subjects were significantly different from non-codependent subjects. These differences were all in the predicted directions.
Hypothesis 2, which proposed differences between subjects who self-label as codependent and subjects who did not self-label as such, received only partial support. Self-labeled subjects scored significantly higher on depression than non-self-labeled subjects. Two additional analyses on the measures of self-esteem and sex role orientation, though not statistically significant, did show a trend in the predicted directions (p = .07 and p = .055, respectively).

Hypothesis 3 considered the interaction between the Self-Label and Codependency variables. It proposed that among the codependent subjects, those who self-labeled as codependent would appear different on the four dependent measures than those who did not self-label. This hypothesis was partially supported. On the BSRI, the former group was found to be significantly more feminine than the latter group. For the other three instruments, group means were in the expected directions, although the differences were not great enough to reach statistical significance.

Hypothesis 4, which made predictions about gender differences, was also partially supported. The data showed that significantly more women than men scored codependent on the CA, but there was no difference between the numbers of women and men who labeled themselves as codependent.
Psychometric Properties of the Codependency Assessment Measure

The psychometric properties of the Codependency Assessment indicate a high test-retest reliability. It would appear as if the feelings, thoughts, and behaviors assessed by this instrument are consistent and stable, with exceptions being made for the three non-significantly related items. For example, a person who is described by the CA as "confused" and "fearful" probably will be characterized in a similar manner over time.

The validity of the CA presents a somewhat more complex picture. Although the face validity of the CA appears to be good, the concurrent validity of the CA seems to be low, as indicated by the lack of relationship between the Codependency and Self-Label variables. People who identified themselves as codependent were no more likely to score codependent than people who did not identify themselves as codependent. However, what this result does support is the ambiguity that surrounds the codependency construct. As stated at the beginning of this paper, considerable definitional disorder marks the codependency field. The definitions held by some of the subjects appear to be unrelated to the definition presented in the CA. The inability of codependency experts to reach consensus may account for this finding.
Meaning of the Codependency Construct

What is perhaps curious is that the harmful consequences expected from this lack of definitional consensus were not found. Krestan and Bepko (1990) believed that codependency would become a globalized problem. At least within this sample, college students seem to have escaped such globalization. Only 1 out of every 14 persons screened called themselves codependent. Some have estimated that the majority of the population is codependent (e.g., Kaminer, 1992), but it appears that these students have not joined in proclaiming the message. It would be interesting to know what factors have kept them insulated.

Although most of the students screened did not designate themselves as codependent, 54% did in fact score codependent on the CA. Perhaps people are unwilling to acknowledge their codependency outright, but do admit to the elements of it. The presentation of the entire construct might be too threatening for some people to embrace it. As mentioned in the introduction, codependency carries many negative associations. It is conceptualized, for example, as a disease, as an obstacle to personal well-being, and as an addiction. It should not be surprising, then, that people are hesitant to stand up and be counted among the deviant.

Interestingly, the concept of codependency as deviant is contradicted by the results obtained in this study. Deviance, in a statistical sense, refers to that which is
far removed from average (Becker, 1973). Characteristics that are deviant are ones that few people display. Yet whereas codependency is supposedly deviant, the results of this study suggest it is also the norm as operationalized by the CA. Perhaps codependency should not be seen as a psychological aberration but as a description of a certain combination of human traits.

The gender bias of the codependency construct was partially supported by the data. Female subjects were no more likely to label themselves as codependent than were male subjects; however, female subjects were assessed as codependent more frequently than males. The former finding can be explained by reiterating that considerable definitional ambiguity surrounds codependency. Both female and male subjects seem to have employed their own idiosyncratic concepts of the term when given the opportunity to identify themselves.

With respect to the finding that females were assessed as codependent on the CA more often than males, it should be noted that 61% of women in the sample scored codependent, compared to 45% of the men. This result supports and extends the research of Fisher and Beer (1990), which showed that female high school students displayed more codependent attributes than male high school students. It appears, then, that it is easier for females than for males to ascribe to the feelings, thoughts, and behaviors subsumed by
codependency. Thus, the Potter-Efrons' definition of codependency as represented in the CA appears to be biased towards women.

Interpretation of Codependency Results

Analyses pertaining to the Codependency variable yielded several significant results. First, the data indicated that subjects who scored positively on the CA had a significantly lower level of self-esteem than subjects who did not score positively on the CA. This result would be expected given certain questions on the CA that tapped into subjects' self-esteem (e.g., "Do you sometimes hate yourself?", "Do you have a sense of low self-worth or failure that does not reflect your skills and accomplishments?", "Do you need to have another person around in order for you to feel worthwhile?"). Nevertheless, the CA encompassed many other dimensions such as fear, shame, denial, and identity development, and a subject had to score critically on several in order to be assessed as codependent. Therefore, it can be stated that codependency, as defined by the CA, is associated with lower self-esteem.

This result is consistent with the way in which codependency develops, as posited by theorists in the field. According to their literature, codependency develops in people who are intimately associated with someone who abuses alcohol or other drugs. The kinds of experiences that people then accumulate would be expected to have a negative impact
on self-esteem. Fisher and Beer (1990) note that "codependent persons live in a world of disaster" (p. 1001). Beattie (1987), who refers to codependent behaviors as "self-torture," remarks, "No wonder codependents are crazy. Who wouldn't be, after living with the people they've lived with?" (p. 5). She also describes the resulting codependent self-concept: "We think we're stupid, incompetent, untalented, and, in many cases, unlovable. We think our thoughts are wrong and inappropriate. We think our feelings are wrong and inappropriate" (p. 109). This pattern is particularly likely to characterize people who grow up in families in which at least one parent is chemically dependent (Wotitz, 1983). In the present study, 16% of the sample stated that they had at least one substance abusing parent.

The causal sequence proposed, then, is that through unhealthy relationships people develop codependency and low self-esteem. However, the causality may also work in the opposite direction: codependency and the lack of self-esteem may predispose someone to maintaining a long-term involvement with a substance abuser. This scenario also is included in codependency texts. Beattie (1987) mentions that "Many codependents (1) stay in relationships that don't work, (2) tolerate abuse to keep people loving them, (3) often seek love from people incapable of loving, and (4) don't take time to see if other people are good for them"
(p. 41). Coleman (1987) cites an even more dangerous consequence when he states, "Violence is all too common in chemically dependent and codependent relationships" (p. 48). Further research is needed to identify the causal mechanisms operating in the relationship between codependency and low self-worth.

Another significant finding of the present study involved depression scores. Subjects who scored codependent on the CA had higher levels of depression than subjects who did not score codependent on the CA. Again, the CA does include some questions aimed at the subject's affective state (e.g., "Do you often have anxious feelings or worry about what will happen next?", "Do you often feel hopeless about changing the current situation?", "Do you tend to be pessimistic about the world in general?"). However, simply being depressed would probably not result in a positive score on the CA, because of the necessity of scoring critically on at least five of its eight dimensions.

As with self-esteem, the relationship between codependency and depression has been mentioned by experts in the field. Bogdaniak and Piercy (1987) have noticed that among adolescents who seek out support groups for help in dealing with parental alcoholism, depression is the frequent result of "mourning the loss of the parent who could have been" (p. 579). Hughes (1977) demonstrated empirically that adolescents with one or two alcoholic parents had
significantly higher scores on the negative scales of the Profile of Mood States than adolescents without an alcoholic parent. Among health care workers, codependency is associated not only with depression but with use of antidepressant medication as well (Williams, Bissell, & Sullivan, 1991).

The causal sequence proposed in two of these studies seems to be that codependency and depression are the consequences of growing up with an alcoholic parent. It should be mentioned, however, that codependency can also contribute to depression by placing the person at risk for unhealthy romantic relationships. Williams et al. found that their sample listed spouses, ex-spouses, and lovers as having the most effect on their functioning. Parents were the next group to be listed most often. According to one theorist who believes that codependency is a disease and hence progressive, in the context of these unhealthy relationships, the later stages of codependency can lead to depression, withdrawal, isolation, hopelessness, and even thoughts of suicide (Whitfield, 1989).

Interestingly, the phenomenon of learned helplessness could describe life with a substance abuser. Steinglass (1987, cited in Haaken) provided data demonstrating that a family's identity becomes "alcoholic" only when alcohol use was associated with unpredictable and destructive behavior. Research has shown that learned helplessness is engendered
by situations in which aversive events are uncontrollable and unpredictable, which can lead to depression (Seligman, 1975). Further research is needed to investigate whether this mechanism accounts for the relationship between depression and codependency.

A third variable that the present study investigated was locus of control. Significant results for Codependency were found here. Subjects who scored codependent on the CA had a significantly more external locus of control than subjects who did not score codependent on the CA. This variable figures into discussions of codependency less than depression and self-esteem, but a logical relationship can be seen to exist. Locus of control, as originally defined by Rotter (1966), refers to a person's expectations as to what factors dictate their life circumstances: do outside forces control what happens to them, or do they have the control themselves? One would anticipate that growing up in a dysfunctional family or maintaining a long-term involvement with a chemically dependent person would erode a person's sense of control over his or her life.

One of the few characteristics of codependency that most experts accept is excessive caretaking and responsibility for others. Codependent persons are said to view the needs of their significant others as more important than their own needs (e.g., Schaef, 1986). Therefore, they acquire a tendency to focus outside themselves for their
goals and rewards. Whitfield (1989) calls codependence "an addiction to looking elsewhere" (p. 22). Assuming responsibility for someone who is dependent on alcohol or other drugs would be predicted to lead to a feeling of futility, because chemically dependent people will have bad things happen to them. The caretaker's sense of personal effectiveness will then suffer. One of the questions included in a codependency self-assessment pamphlet sent to all faculty, staff, and students at the Ohio State University queried, "Do you feel utterly defeated, that nothing you can say or do will influence the problem user?" No matter how hard she or he tries, the best that can occur is that the significant other continues to drink or ingest drugs with no immediate deleterious effects. Although it is not known whether the codependent subjects in the present study were associated with a substance abuser, it can be seen how such a situation could lead to an external locus of control.

A second consideration might further explain the relationship between locus of control and codependency. As mentioned at the beginning of this paper, many self-help groups are directed at codependent people. As Kaminer (1992) points out, Twelve-Step groups require all members to admit their powerlessness over the source of their addiction, to surrender their individual will, and to submit to a higher being. For example, the Twelve Steps of Alcoholics Anonymous
begin

1. We admitted we were powerless over alcohol - that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood Him. (Schaef, 1986, p. 30)

The message is that the codependent person is ineffective in managing his or her own affairs, so he or she must turn them over to God in order to be successful and happy. Moreover, the recovery movement encourages people, once they have resigned personal agency, to look to outside sources (e.g., authors of books, leaders of workshops) for guidance on how to be (Katz & Liu, 1991). It can be seen how such self-surrender and devaluation of individual authority necessitates a person's sacrifice of his or her internal locus of control. The sample in the present study was at least partly composed of people who attended self-help groups (n = 74; 21%).

The fourth variable that was investigated with respect to the Codependency factor was sex-role orientation. People who scored codependent on the CA were significantly more feminine than people who did not score codependent on the CA. This result is consistent with the aforementioned similarity between the set of codependent characteristics
and the stereotypical female role. Codependency includes caretaking, emotional sensitivity, concern for others, passivity, permeable personal boundaries, and seeking connectedness. Granted, these qualities are exaggerated to the extreme, but they nevertheless read like a description of traditional femininity. The association of codependency with femininity is further seen in the analysis of responses to the CA. More women than men answered "yes" on 28 out of 34 questions.

**Interpretation of Self-Label Results**

Examination of the Self-Label variable also yields several meaningful findings. First, subjects who labeled themselves codependent were significantly more depressed than subjects who did not label themselves codependent. A possible explanation for this result speaks to the strength of the codependency label. It has already been stated that the term codependency bears a negative valence. Codependency is seen as a pathology, and to be codependent is to carry a stigma. Warner et al. (1989) have discussed the loss of functioning that would be anticipated among people who accept a label of mental illness. The results of the present study could be seen as evidence of this detrimental outcome. When a person accepts that she or he is codependent, she or he must also accept the concomitant damaging implications. Depression, then, is an emotional effect of assuming that one has a disease.
However, an alternative explanation might be that people who are depressed are more prone to adopting the codependency classification than people whose affective states are more positive. Instead of depression being the consequence, as proposed in the above account, perhaps it is the cause. A depressed person searching for a reason why she or he is depressed might scan the possibilities as represented in her or his life. Codependency is such a ubiquitous phenomenon that most depressed individuals would be likely to entertain it as a possibility. Then, because codependency is such an all-encompassing, ambiguous concept, it would be reasonable for this depressed person to seize upon codependency as the basis for her or his depression. It is unclear whether in the present study acceptance of the codependency label is the cause or the effect of depression. Future research is needed to determine the direction of causality.

In two analyses, the Self-Label variable approached significance. The self-esteem scores of subjects who labeled themselves codependent were lower in absolute terms than those of subjects who did not label themselves codependent ($M = 28.5$ and 33.9, respectively). This trend can be interpreted similarly to the difference in depression scores between the two groups, although the lack of statistical significance suggests caution in doing so. People who assume a codependent designation would be predicted to suffer a
blow to their self-esteem. In addition, people whose self-esteem is already low might tend to adopt the codependent tag more easily.

The second trend involved scores on the sex-role inventory. People who identified themselves as codependent were more feminine than people who did not identify themselves as codependent. This finding, although non-significant statistically, is consistent with the similar natures of codependency and the stereotypical female gender role.

With regard to sex-role orientation, an interesting interaction between the Codependency and Self-Label variables was revealed. Among the subjects who attained a critical score on the CA, those who self-identified as codependent were significantly more feminine than those who did not self-identify as codependent. This difference held for both female and male subjects.

A potential explanation for this result would have to explain why the codependent self-labeled subjects were more feminine than the codependent non-self-labeled subjects, given no difference between these two groups among the non-codependent subjects. All subjects who scored positively on the CA can be assumed to have had experienced similar damaging events during their lives. Therefore, the difference between the self-labeled and the non-self-labeled subjects is accounted for by the label itself. Defining
oneself according to the characteristics of codependency perhaps is easier for someone who already adheres to elements of the traditional female gender role. Codependent people already display feminine qualities, and those who adopt the classification are more feminine still. It seems likely, then, that those who reject the label do so because they are more masculine.

**Limitations of the Present Study**

One limitation of this research is the relatively small sample size. The dearth of college students who were willing to label themselves as codependent precluded a larger sample size. Of the 788 students screened, only 56 labeled themselves as codependent. Several of the trends that approached significance might have attained it had more subjects been involved.

The Codependency Assessment measure presents another shortcoming. Because no past data was available on its use, it lacks an history from which to draw information about its reliability and validity. The current investigation demonstrated its reliability, but was inconclusive with regard to validity. Although no better codependency assessment device exists yet, the use of the CA is problematic.

Another possible limitation of the present investigation is its neglect of definitional clarity with respect to self-labeling. During the data collection
process, a number of subjects remarked to the examiner that their perspectives knew only that codependency had something to do with substance abuse. Because no definition was given to the subjects, considerable opportunity was available for them to distort the term's meaning. The benefit was that no person felt excluded, yet the danger was in allowing truly non-codependent people to designate themselves as such, which might have obscured the accuracy of the findings.

A final issue to note when discussing limitations is external validity. Subjects were drawn from the Psychology 100 pool, so they were all university students. The representativeness of university students is questionable. As already mentioned, differences may exist between this sample and the more general population, especially concerning their definitions of codependency. A sample drawn from the larger population would have greater external validity than the current sample.

**Directions for Future Research**

Future research might incorporate several considerations. First, a larger sample size, drawn from the general population would enhance both accuracy of results and external validity. In addition, examining specific populations might be instructive. It would be interesting to investigate the self-esteem, depression, locus of control, and sex-role orientation of self-help group members, for example. One such study has demonstrated that membership in
such a group has positive effects, especially concerning self-esteem (Hughes, 1977). Others have noted that the comfort of Twelve-Step groups lies in "the hope of connecting with a source of goodness and benevolent control amidst a world dominated by chaotic, destructive forces" (Haaken, 1990). Group membership entitles the codependent person to sympathy, understanding, enlightenment, and a sense of belonging to an elite (Kaminer, 1992). However, group members also are encouraged to assume self-blame and to explore their victimization while being discouraged from independent thinking (van Wormer, 1990). Future studies could compare the mental well-being of codependent group members with codependent people who do not belong to such a group.

Future research also should consider asking subjects to describe their own working definitions of codependency. As noted above, the small number of subjects labeling themselves as codependent would seem to indicate that the subjects used more narrow definitions than those offered in the literature. By presenting a definition before asking whether or not the subject would self-label, more precision could be reached in understanding the type of sample included in the study.
Implications for Counseling

The results of this study seem to encourage caution when utilizing the term "codependency." Well-intentioned therapists, familiar with the codependency literature, might be likely to describe their depressed, overly responsible, female clients as codependent. They might even recommend a particular codependency book, tape, or self-help group. These therapists might want to rethink this practice. The above limitations notwithstanding, the results of the present study, taken as a whole, indicate that the codependency construct carries detrimental effects. People who score codependent are worse off in many ways than their counterparts who are not codependent. In addition, people who embrace the codependency classification are also less emotionally healthy than those who reject it. With regard to gender issues, the term appears to contain bias against traditional femininity. It would behoove professionals in the mental health field to employ the term only after careful examination of its implications.

Counselors who are not familiar with the codependency construct and its controversial nature might want to consider raising their awareness. They will probably be introduced to clients who describe themselves as codependent, and it is important that they seek to understand both (a) what definition the client employs and (b) what effect this label has had. Knowledge about the
ambiguity surrounding the construct as well as the list of potential effects would aid the counselor in this search.

Perhaps it is time to slow the pace at which the movement is gaining momentum. It seems appropriate that researchers and theorists in the field should continue to examine the concept of codependency with a critical eye.
LIST OF REFERENCES


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Appendix B

Rosenberg Self-Esteem Inventory

These statements describe how you may or may not feel about yourself. Please read each statement and then circle the number that corresponds to how much you agree or disagree with that statement for yourself.

1. I feel that I'm a person of worth, at least on an equal plane with others.
   _____ Strongly agree
   _____ Agree
   _____ Disagree
   _____ Strongly disagree

2. I feel that I have a number of good qualities.
   _____ Strongly agree
   _____ Agree
   _____ Disagree
   _____ Strongly disagree

3. All in all, I am inclined to feel that I am a failure.
   _____ Strongly agree
   _____ Agree
   _____ Disagree
   _____ Strongly disagree

4. I am able to do things as well as most other people.
   _____ Strongly agree
   _____ Agree
   _____ Disagree
   _____ Strongly disagree

5. I feel I do not have much to be proud of.
   _____ Strongly agree
   _____ Agree
   _____ Disagree
   _____ Strongly disagree
6. I take a positive attitude toward myself.
   _____ Strongly agree
   _____ Agree
   _____ Disagree
   _____ Strongly disagree

7. On the whole, I am satisfied with myself.
   _____ Strongly agree
   _____ Agree
   _____ Disagree
   _____ Strongly disagree

8. I wish I could have more respect for myself.
   _____ Strongly agree
   _____ Agree
   _____ Disagree
   _____ Strongly disagree

9. I certainly feel useless at times.
   _____ Strongly agree
   _____ Agree
   _____ Disagree
   _____ Strongly disagree

10. At times I think I am no good at all.
    _____ Strongly agree
    _____ Agree
    _____ Disagree
    _____ Strongly disagree
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84-85
86-87
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Appendix G

Demographic Questionnaire

1. Sex (check one): ___Male  ___Female

2. Date of Birth: __________________
   (Month/Day/Year)

3. Have you ever attended a meeting of a self-help or support group? (check one) ___Yes  ___No

4. If you answered "Yes" to #3:
   a. What was(were) the name(s) of the group(s)? ___________________________
   b. How many meetings did you attend? _______________________

5. Have you ever been associated with someone who you believed had a problem with alcohol or other drugs? (check one) ___Yes  ___No

6. If you answered "Yes" to #5:
   a. What was the relationship of the person(s) to you (i.e., father, sister, close friend, spouse, teacher, etc.)?
      ___________________________
   b. Is that person still closely involved in your life? (check one) ___Yes  ___No
### Appendix H

#### Correlations Among the Covariate and Dependent Measures

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