SURVIVORS OF HIGH-RISK BACKGROUNDS: RESILIENT OR CODEPENDENT?

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ABSTRACT

The purpose of the study was to more closely examine parallels found in two bodies of literature on human adjustment and coping. The first body of literature examined was research and scholarship in the area of resilience, and the other the clinical conceptualization of codependence. Out of these two areas of inquiry, the study focused on their respective perceptions of what constitutes good health: whether wellness is synonomous with a lack of identified pathology, and the differentiation between skilled coping and emotional well-being. The intention of the study was to provide information and direction to prevention and health promotion specialists with respect to the development of programs aimed at enhancing wellness in youth populations. The research was directed by the following question:

Is there a relationship between codependence and resilience?

Sixty-eight individuals in treatment for codependence completed a questionnaire comprised of the Interpersonal Dependency Inventory, (Hirschfeld, Klerman, Gough, Barrett, Korchin, & Chodoff, 1977), an Adult Adaptation

Scale (Werner & Smith, 1992), and the Dysfunctional Attitudes Scale (Weissman, 1979). Principal Component Analysis indicated that two factors appear to underlie these two concepts of resilience and codependence, suggesting that they may be more similar than different. While more research is warranted, speculation allows that resilience and codependence may be the flip side of the same coin.

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a reality instead of a dream.

CHAPTER 1

INTRODUCTION

Recently, a new model for program development based on the concept of *wellness* (as opposed to the more traditional *disease* model) has emerged within health services in Canada. Program emphasis is shifting from a focus on pathology to a focus on health, and to health-enhancing conditions. Further, communities are being encouraged to develop health plans and strategies in response to particular community health needs. It has been argued theoretically that locally planned efforts which emphasize wellness result in a higher level of program success at a lower cost to government.

The Prevention and Health Promotion Branch, which operates within the Ministry of Health and the Ministry Responsible for Seniors in British Columbia, is particularly concerned with the state of health within the youth population of the province. Personnel are presently engaged in the task of researching and evaluating program structures and ideas that are effective in promoting health amongst youth populations. A practical application of this work is the School-Based Prevention program initiative, which operates within school environments, and attempts to raise the level of health and health awareness

amongst young people. This project does not make a distinction between health promotion and prevention strategies, and for all intents and purposes uses the terms 'prevention' and 'health promotion' interchangeably.

Consistent with the wellness focus on health, recent research has examined the concept of *resilience* in children and youth. While the concepts of wellness and resilience are not necessarily synonomous, both concepts direct researchers toward an examination of the personal and environmental sources of social competence and good health. The focus of this research has been on the development of adaptive strengths in children and youth from high-risk environments; as opposed to the development of poor coping mechanisms which are identified as behavioral disorders, or mental and emotional coping disorders (Benard, 1991).

Youth prevention programmers have been interested in this concept of resilience as a potential source of information about how children and youth develop successful coping strategies in stressful environments. Benard (1991) identifies three environmental predictors of this highly desirable quality found in a large number of children from high risk environments: elements of *caring*

and support, high expectations, and *the encouragement of participation*. First, caring and support are essential for the development of trust, a foundational component for human development and bonding (Erikson, 1963). Second, high expectations have been consistently identified in the research as a contributing factor to a sense of optimism and hopefulness, as well as to giving meaning and stability in children's lives (Benard, 1991). Thirdly, encouragement of participation has the effect of acknowledging children as valued participants in the life and work of the family and community, which is important in the development of a positive sense of self-esteem (Benard, 1991). Home and/or school and community environments in which these environmental predictors were found provided opportunities for experiencing health, satisfaction and optimal growth and development in young people, even when risk factors, such as familial addiction, were present within the environment. Benard made some clear suggestions for program development based on these highly successful environmental predictors, which are often referred to as "protective factors" (Werner, 1990; Rutter, 1985). The protective factors listed above appear to shield or protect children from other negative

factors in the environment.

While the concept of protective factors is reasonably straightforward, the meaning of the term 'resilience' is not as clearly understood, particularly with reference to how it has been defined and measured in children and youth. A number of authors have been exploring this concept from a variety of disciplines, most notably in the area of medical and psychiatric research, and within the behavioral sciences (Werner, Biermann, & French, 1971). The focus of their research has been to look at what occurs in the lives of children who attain normal development (i.e., who are not identified as learning disabled, emotionally disturbed, etc., and have not required professional or clinical intervention) in an effort to identify characteristics or conditions that promote and encourage healthy development. A fundamental assumption in this research in a general sense has been that the absence of identified pathology is the same as the presence of health, and that successful coping strategies are the same as healthy development.

The term 'resilience' referred to the ability of an individual to deal successfully with stress in the environment (Werner 1990). Often, it has been assumed

that the absence of distress signs in high stress environments means that children and youth have developed healthy coping mechanisms. For example, if children and youth are not seen by professionals for problems and difficulties, the assumption has been made that there has been adaptation and survival within that environment and the adaptation is healthy.

However, as can be seen in the literature on codependence, survival tactics developed in childhood to cope with high stress environments do not always translate into healthy adult coping skills (Middleton-Moz, 1990). Many qualities attributed to resilient children also characterize the 'overachiever', 'family hero', or 'responsible child' identified in codependency and adult children of alcoholics literature (Black, 1980; Kritsberg, 1986; Woititz, 1983). This role has often been characterized by the manifestation of pleasing behavior and high achievement, as well as outwardly apparent qualities of maturity, dependability, and independence.

There is an anomaly, then, between characteristics defined in the resilience literature as positive adaptive qualities; and the codependence literature, which identifies these coping skills as largely negative or

unhealthy in the sense that they mask other problems. Werner (1992) uses the following adjectives to describe the resilient individuals in her well-known Kauai longitudinal study: "autonomous, resourceful, responsible and achievement-oriented" (p. 56). The codependent role is often characterized by perfectionism, an obsessive preoccupation with achievement, and an overdeveloped sense of responsibility (Mellody, 1989). While different in tone, similar adaptive qualities have been identified within these two different areas of research. The difference is that the resilience research identifies these coping strategies as positive without qualification. The codependency literature asserts that what appears to be healthy coping behavior (i.e. strong survival skills) in children and youth may predispose them toward codependence in adulthood, and is considered not to be a positive outcome. Thus, coping strategies are framed as 'positive' in one orientation and 'negative' in another.

Strategies that work for a child in a high stress environment (such as a home where chemical dependency is present) may become a hindrance in adulthood, particularly in the realm of personal relationships. Specifically, a child who learns to please others in childhood by

deferring gratification of personal needs may be highly vulnerable to engaging in relationships in adulthood where self-sacrifice occurs to a harmful or unhealthy degree. Self-sacrifice to a harmful degree may manifest itself in behaviors which appear successful and healthy, such as career upward mobility, but may represent selling out on the self, or self-sacrificing to please others.

The topic of relationships points to another parallel between these two identified bodies of literature: that being a high level of difficulty with relationships. The codependence literature refers to extreme self-reliance and emotional inaccessability within individuals who assume a 'responsible' role within a dysfunctional family system (Cermak, 1985). This quality may become one of compulsive caretaking and controlling behaviors in adulthood (Mellody, 1989). Clinical observations within codependent populations indicate areas of challenge in treatment to be as follows: moving the focus of attention from the behavior and needs of others to the behavior and needs of self; distinguishing and establishing a self-identity; and clarification of areas of responsibility within relationships.

Interpersonal difficulties with co-workers,

reluctance to make long-term commitments (amongst the resilient male population), and emotional distancing from families of origin were tendencies noted in the resilient population of Kauai (Werner, 1992). As noted above, relationship difficulties are the hallmark of codependence, exacerbated by low self-esteem and poor boundary development (Cermack, 1985). Also, a high level of stress-related illness is noted in both of these populations (Mellody, 1989; Werner, 1992).

It was important to further examine some of these parallels, particularly since managers of prevention programmes are interested in the concept of resilience in children and youth. Of primary importance was the need to question assumptions made in the resilience research. Terms such as 'wellness', 'health', and 'resilience' tend to be used interchangeably in the literature. In practical terms, an examination of the sources of positive attributes is important; and undoubtedly resilience, health and the absence of pathology all have common origins. However, it is questionable as to whether, for example, the absence of pathology can be said to be the same as the presence of a quality of resilience observed in particular children. Therefore, a critical question is

whether resilience in children and youth is synonymous with the absence of identified clinical pathology.

Further, because there appears to be a relationship between the concepts of resilience and codependence with respect to observed behavioral phenomena, (for example, overachievement, pleasing behaviors and difficulty in intimate relationships) further questions emerge. Are resilience and codependence names for the same thing? Are they related, but perhaps different in levels of severity? Is it the case that coping strategies, learned in early years in response to high stress environments, underlie these behavioral similarities, seen in the development of resilience and codependence?

In terms of practice, what are the implications of a better understanding of these concepts for prevention programmers? Is resilience a concept that is helpful or risky in terms of providing a basis for the development of programming? Given this set of critical questions regarding resilience and codependence as they pertain to programming, some initial and exploratory questions warranted investigation as a first step.

Therefore, the present research addressed the primary question of whether resilience and codependence are

related concepts, rather than unrelated as suggested in their respective literatures. Specifically, the study examined the following question:

Is there a relationship between codependence and resilience?

It seemed advisable to leave the above question open with regard to the nature of the relationship between the two concepts. It was anticipated that a third measure could provide assistance with respect to the directionality of levels of health determined by codependence and resilience measures. Therefore, the final research design included a measure for depression, a condition related to codependence in the literature (Mellody, 1989). While not considered to be part of the conceptual framework, it was included to illuminate the question of the presence or absence of health within the primary concepts of codependence and resilience.

The present research studied a population self-identified as codependent, and currently in treatment at an outpatient clinic. The codependent sample was measured for levels of interpersonal dependency, for resilience and for dysfunctional attitude tendencies leading to depression. Examining resilience from this different

perspective has yielded a clearer understanding of resilience, which is easily confused with the development of pleasing behaviors and a successful exterior that mask a 'frightened child' within. As Bowlby (1988) says:

> Children and adolescents who grow up without their home base providing the necessary support and encouragement are likely... to find life - especially intimate relationships - difficult, and to be vulnerable in conditions of adversity. In addition, they are likely to have difficulties when they come to marry and have children of their own. It is fortunate, of course, that despite these handicaps some manage to struggle through, though *often at a much greater cost to their emotional life than meets the undiscerning eye. Nor must the fortunate exceptions blind us to the rule* (italics added). (p. 9)

CHAPTER II

REVIEW OF LITERATURE

Resilience

The term 'resilience' is often used in conjunction with the phrase 'protective factors'; which are the positive counterparts to the concepts of 'vulnerability' and 'risk factors'. Resilience, or protective factors, refer to the ways or means used by the individual to handle stress. Resilience refers to individual characteristics, and protective factors refer to both individual and environmental characteristics (Rutter, 1987).

In the past, other names that were used to identify successful coping skills included *invulnerability, invinciblility, hardiness,* and *hopefulness* in children. The use of these terms in the 70's and 80's signalled an important shift in perspective from looking at high-risk factors and pathology in children and environments to looking at the positive adaptations made by many children in adverse situations (Werner, 1990).

The use of these terms grew out of questions asked by many professionals about why some children appear to cope more successfully than others in high-stress environments.

Some of the initial questions posed were as follows:

1. What makes some children able to deal successfully with a seemingly insurmountable amount of environmental stress?
2. Are the differential 'mechanisms' between successful coping and unsuccessful coping inherent in the child or in the environment?
3. Is there a way to operationalize and utilize these 'mechanisms' in the lives of other high-risk children, particularly with respect to prevention programming?

Chandy (1990) says: "There is an increasing awareness... that the key to effective prevention programming will come from the knowledge of those protective factors that promote normal and healthy development among populations, who are considered vulnerable" (p. 1). Noticeably lacking is attention given to possible differences between successful coping and healthy development.

Garmezy (1989), in a forward to Werner's Vulnerable But Invincible, A Longitudinal Study of Resilient Children and Youth, relates some of the history of the development of the concept of resilience in children. He and a number of other behavioral scientists had been interested in

stress, coping and development in children for some time in the seventies. While he and his colleagues were struggling with the ambiguity of concepts such as 'stress' and 'coping', other professionals from the fields of psychiatry and sociology, for example, were also studying coping behaviors observed amongst populations of high-risk children. Research in this area examined the importance of family and social support in coping with adversity and stress (Cohen & Wills, 1985; Holahan & Moos, 1985).

More recently, research from different fields is being pulled together to look at commonalities and differences in what is understood about resilience. Examples of environmental stressors examined by a variety of researchers have been: extreme poverty, familial mental pathologies, and familial alcoholism (Werner, Biermann & Smith, 1971; Bleuler, 1978; & Werner, 1982).

At first, the ability to cope with adverse circumstances was identified as a quality of 'invulnerability'. The observation was made that many children appear almost immune to high levels of environmental stress; frequently attain normal development; and go on to lead satisfying lives (Rutter, 1987). Again, the codependence and adult children of

alcoholics literature articulates a similar concept of immunity to stress, referring to 'psychic numbing' as an important survival mechanism in high stress situations (Middleton-Moz, 1989).

As research in the area of resilience developed, it became clear that this was a relative rather than an absolute quality (Rutter, 1987). Resilience is relative to both environmental and constitutional factors, and varies within a lifespan according to circumstances. A child may be able to handle an inordinate amount of stress at a particular age or stage, but not at another when life processes and circumstances are different (Cohler, 1987). For example, parental alcoholism may be more manageable for a child in Grade Two with a concerned and supportive teacher than in Grade Three, when the child's teacher is rigid and critical. The term 'resilient' thus came into use to reflect another shift in perspective on how children cope with highly stressful environments, as well as a clearer understanding that this 'quality' that researchers were attempting to conceptualize was more dynamic and relational than isolated or static.

Rutter (1987) refers to resilience as "...the term used to describe the positive pole of individual

differences in people's response to stress and adversity", and stresses the notion that it "...cannot be seen as a fixed attribute" (p. 316). He emphasizes that protection lies in the process rather than the variable, and points out that what may act as a protective factor in one situation may in fact be different in another context.

Resilience, measured and perceived by researchers as a positive and adaptive quality, develops as a survival strategy in situations of high stress. For example, a child with minimal or inconsistent supervision due to mental illness in a parent may become proficient in the area of practical life skills. She may, for example, therefore enjoy income generated from being in high demand as a neighbourhood babysitter. What is not clear from the literature is whether these coping strategies are always healthy adaptations, which carry through to high functioning in adulthood.

To date, research that looks at the concept of resilience has been mainly quantitative and longitudinal (Felsman & Vaillant, 1987). Most of the research has been conducted with families with caregiver deficits such as parental alcoholism or psychosis. Newer research examines abandoned, orphaned, and refugee children in various

circumstances and locations (Werner, 1990). Such research points to protective factors found to be universal and cross-cultural under extreme circumstances. They include the following personality characteristics:

1. affectionate, pleasant disposition in infancy with low irritability.
2. active and expressive capacities.
3. demonstrate trust that the caregiver(s) will respond to need.

It has been established by research in this area that more than half of the children born into high stress families develop 'normally'; meaning that they do not appear to have any major impairments, serious disabilities or persistent disorders and are reasonably happy and content with their lives, as measured in the Kauai longitudinal study (Werner, 1990). Again it is necessary to question whether the absence of clinical intervention can be equated with health. In the Kauai longitudinal study (Werner and Smith, 1982) of resilient children there were usually no more children born for at least 20 months after the birth of the child displaying resilient qualities. In addition, often secure attachment occurred when there was another supportive adult available to the

child, such as a grandmother.

Characteristics identified by Benard (1991) as being central to the quality of resilience are: social competence, problem-solving skills, and autonomy. In terms of being social, resilient children appear to have the ability to engage people from an early stage in their lives. They are responsive and often funny, and create a positive pattern in most of their relationships throughout life. Problem-solving skills emerge early in life. As for autonomy, Benard (1991) noted "...a sense of one's own identity and an ability to act independently and exert some control over one's environment." (p. 4) An important feature of autonomy is the ability to separate oneself from the dysfunctional family environment (Anthony, 1974).

Finally, resilient children often appear to have a sense of purpose and a vision of the future. Further, they appear to experience "propitious phases" (Murphy, 1987) in which high amounts of energy become available for recovery and healing from previous adversity. Warmth and persistence are hallmark qualities of resilient children faced with the challenge of cognitive deficits (Moriarty, 1987).

Gender differences in levels of resilience are

apparent in a small portion of the literature (Werner, 1989). According to the Kauai longitudinal studies, female children appear to exhibit higher levels of resilience than male children at certain stages of development. Current understanding of how daughters of alcoholics develop different coping strategies (internalization of anger and anxiety) than sons of alcoholics (who tend to externalize anger and anxiety) raises a question about what is being measured in the resilience research from a gender point of view (Robertson, 1989). This is a particularly interesting point in light of the fact that codependence is a condition identified in proportionately greater numbers of women than men (Robertson, 1989). Qualitative research techniques with daughters of alcoholics have revealed that the 'responsible' role (i.e. internalization of anger and anxiety) is a coping strategy that has been misinterpreted as resilience (Robertson, 1989).

Protective Factors

Prevention programmers are particularly interested in developing strategies that create healthy environments for children. Providing children with the means to develop normally and experience health and satisfaction in life,

despite adverse circumstances, is consistent with the goals of prevention programming and health promotion strategies. Ultimately, the question for prevention programmers is this: is there is a way of facilitating the process of normal, healthy development on a school or community level, especially when the home environment is stressful and unnurturing; and is healthy development co-terminous with all survival strategies observable in children and youth? Protective factor research sheds light on this concern.

Protective factors are seen by many researchers to be "developmental and situational mechanisms" rather than discrete individual elements within environments (Rutter, 1987, p. 317). For example, the presence of a prevention worker in a school might be a positive factor in the life of an at-risk adolescent in the experimental stages of drug use, who forms a connection with that prevention worker and becomes involved in a peer counselling program as a result. Conversely the presence of the prevention worker has little protective impact in the adolescent from a nurturing background that is already well-grounded, for example, in a church community which actively involves youth in community ministry. While suggestions of

applicability are made, there is little or no research investigating direct applications of ideas emerging from the resilience literature (Benard, 1991; Chandy, 1992). The interplay between resilience and protective factors might be clearer if there were a better understanding of the concept of resilience itself.

Protective factors have been defined as those "traits, conditions, situations and episodes that appear to alter - or even reverse - predictions of (negative outcome) and enable individuals to circumvent life stressors" (Segal,1986; Garmezy, 1991). Research in this area has identified factors that exert a protective influence on various levels. What appears to be of primary importance as far as protective factors are concerned is the process or the interaction occurring, rather than the presence or absence of discrete elements in the life situations of children. However, there has been little in-depth study of these protective mechanisms and processes.

For example, supportive relationships are said to be one of the most important protective factors in the lives of children. Little is known about what aspects of a particular relationship make it supportive or not

supportive. A closer look at the nature of relationships in the lives of children and youth may provide important information with regard to the development of protective mechanisms.

Attachment theory, as developed primarily by Bowlby (1982, 1988) has focused on the importance of secure, trustworthy relationships in the lives of developing human beings. While this research concerns itself primarily with the mother-child bond, it also clarifies characteristics of nurturing relationships in a more detailed way than the research on resilience. At the same time, research on resilience broadens the scope of the different kinds of relationships that potentially meet the needs of children in a developmental sense. An example of this is the research that points to the importance of grandparents in the lives of children from single-parent homes (Werner, 1991). The qualities of relationship, identified by Bowlby in research on the mother-child bond, may also occur in other kinds of relationships. This may be particularly important if the primary caregiver is available to the child on an inconsistent basis, due to alcoholism or mental illness.

Almost all research on resilience in children

specifies trusting relationships as secondary only to positive personality characteristics for normal development. Bowlby (1988) would argue that effective nurturing preceeds positive personality characteristics. From this perspective, it is pointed out that even the most charming infant will become troubled and distressed when the caregiving is not responsive and appropriate, and that no infant is capable of development in a vacuum. Therefore, the 'pleasing disposition' identified in the resilience literature, while an important quality in terms of the interactional dynamic between parent and child, may in fact ultimately depend on the presence of relationship. Or, another way to frame this is to hypothesize that a 'pleasing' disposition becomes an inherent part of the personality in a nurturing environment; but is more likely to develop as a manipulative tactic in a negative environment, and subsequently becomes a codependent trait in adulthood.

The primary importance of process is evident when talking about relationships. For example, the presence of a parent in the life of a child does not guarantee that the child's needs for nurturance and safety will be met. Rather, the quality of the relationship determines the

quality of protective factors present in a child's life. In other words the process or interaction between parent and child is of primary importance when it comes to protection and normal development, rather than the fact that a child's environment includes one or more parents. It is not so much the pleasing personality, which could not stand alone, or the presence of a parent as much as the positive interaction that occurs between the parent and child that makes the infant feel secure and able to trust (Bowlby, 1988).

Codependence

Similar to the term 'resilience', the term 'codependence' is used in various theoretical frameworks and in a variety of ways. The present research uses the work of Cermak (1986) as a basis for a definition of codependence:

> Codependence 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 111. (p. 1)

and:

> Power through self-sacrifice lies at the core of codependence. (p. xii)

What distinguishes codependence from resilience conceptually is that codependence emerges from the literature as a clinical concept, and is articulated in written accounts primarily within the confines of popular literature and the self-help movement in the United States and Canada. Little, if any, actual research has been conducted with respect to this concept.

The concept of codependence itself has received criticism from self-in-relation theorists within the Social Work tradition. It is seen from a feminist perspective as a pathologization of women who struggle to cope with and survive abusive relationships (Collins, 1993). The cultural and ecomomic structures which make it difficult for women to leave unhealthy marriages are thus not accounted for in the codependence concept.

Cermack (1986) does not comment on what appears to be an overwhelming number of women as opposed to men that are grappling with issues of codependence in treatment. It appears, therefore, that he either does not view gender as significant in an examination of this phenomenon, or simply has not considered it. Cermack reiterates the view

of codependence that emerges from the field of chemical dependency, identifying excessive rigidity or intensity (i.e. perfectionism) in affected family members where chemical dependence is present.

Wegscheider-Cruse (1985) explains codependence in an environment where addiction is present as "a specific condition that is characterized by preoccupation and extreme dependence (emotionally, socially and sometimes physically) on a person or object. Eventually, this dependence on another person becomes a pathological condition that affects the codependent in all other relationships." The obsession with another person is also accompanied by preoccupation with the addictive behaviors of a significant other, and a compulsive focus on problem-solving recurring difficulties. Again, no reference to gender is made.

In a clinical sense, codependence refers to those in a love relationship with an addict, and/or anyone who has had an addicted parent or even grandparent. The effects of chemical dependence are thus often seen to be multigenerational, with codependence being the expression of how family members attempt to adapt to the pain and chaos of addiction (Woititz, 1983). Another clinical view

is that codependence is a primary rather than a reactive condition, which predisposes individuals toward developing relationships with personality-disordered, chemically dependent, or other codependent and/or impulse-disordered individuals (Cermack, 1986). The fact that what predisposes individuals toward codependence is a family background of chemical dependency is an indicator of the circularity of these definitions.

Mellody (1989) highlights perhaps one of the most important aspects of codependence: the crippling emotional intensity and extremity of reaction in relation to life issues; or, conversely, the extreme lack of affect or emotional experience often referred to as 'psychic numbing' or dissociation. Both extremes are noted in family members dealing with addiction. Rigid control over self and others, as well as the development of pleasing behaviors and culturally approved life goals may mask emotional turmoil, or an emotional void in family members (Mellody, 1989). Another important contribution to current understanding of codependence is Beattie's rendition of the profound pain and sense of victimization experienced within this population. As individuals attempt to accommodate to the demand, codependent traits

develop gradually in response to the chaos of addiction (Beattie, 1987, 1989).

What appears to link codependence to resilience in a definitive sense is the description of traits and behaviors in these conceptual groups. Both the codependence and resilience literature describe adaptive behaviors and coping strategies observed in identified populations that appear to be similar or related in some way. What distinguishes codependence are descriptors that indicate an extremity of behavior, and an enormous amount of emotional pain. Are these unnoticed or unmeasured aspects of resilience as well? Cohler (1987), with references to resilience, states that "personal success may be attained at the cost of spontaneous enjoyment of life" (p. 406). Again, the parallels between observed behaviors in codependent and resilient populations cannot be ignored.

Ecological Theory

Research has identified specific components of resilience, which appear to be generally experienced: social competence, problem-solving skills, a sense of autonomy and a sense of purpose and future. Ecological theory challenges researchers to look at relationships and processes as primary ingredients in development, as well as what is related or processed. This requires viewing the 'protective factors' that accompany and compliment the concept of resilience as being primarily the product of process and relationship, rather than the factors inherent in the person or environment. Similarly, the controlling and perfectionistic behaviors observed in codependents would be seen as relational aspects of addiction, and an accomodation to a demand rather than aberrant behaviors. From both a macro and a micro point of view, the concept of "development-in-context" (Bronfenbrenner, 1979) provides a rich framework for examining human development. Ecological theory looks at "the interconnections between the processes of human development, the environments in which development occurs and the reciprocal relations between the multiple environments within which any person develops" (Glossop, 1988).

A concept emerging out of the literature on ecological theory is that of 'self-righting'. The concept of self-righting focuses the researcher on the capacity of an individual to make the healthiest possible adaptation to a perceived environment (Glossop, 1988). The notion of self-righting is an interesting idea when applied to the concept of resilience, as it opens the doors for healthy development to occur in myriad ways. For instance, a child who does not receive adequate nurturing from a caregiver may be able to form a perception of the relationship needed, even though it is not part of the present environment. When the opportunity to develop a nurturing relationship (with perhaps a teacher or a therapist) does present itself the child/adult may be able to complete the developmental work required for normal, healthy adjustment. Therefore the 'protective factor' in such an individual may be more of a perceptual ability than an actual concrete attribute of the person.

The concept of self-righting may be a crucial one in examining the connection between resilience and codependence. Assuming that children have a natural drive to learn and mature, it is clear that survival mechanisms such as creativity and innovation play an important role

in the developmental process of maturation. Hypothetically, the perception of what is needed for growth and development could precede mimicking behaviors in innovative children who try to create a 'normal' environment for themselves. Along with imitating what is perceived as desirable (i.e. the love and stability experienced in a friend's home, or read about in a book), fantasy in relationships and life events may sustain children for whom reality is a confusing mixture of chaos, neglect and abandonment. Following out of the fantasized nurturing is imitative adjustment. Although the behavioral imitation *appears* to be genuine adaptation, it is not; and in the absence of the experience of a nurturing relationship the opportunity to internalize genuine growth may be lost. It could be hypothesized that adaptation which grows out of a secure grounding has a quality of resilience; while imitative adaptation is more likely to become codependence.

Is resilience in fact codependence? If in fact resilience and codependence appear to be different, then in what ways? The aim of the present research study is to specifically explore the relationship between resilience and codependence, using an ecological framework.

CHAPTER 111

METHOD

Research Design

The study was designed to explore the relationship between resilience and codependence. The design of the research project was exploratory and descriptive.

Sample

Individuals currently undergoing treatment for codependence were considered to be a strategic population upon which to base this research for the following reasons. First, most people who have problems with codependence grew up in a traumatic or high risk family situation (Mellody, 1989). It is unusual to work with a person in relationship with a chemically dependent individual who is not from an alcoholic or otherwise high-risk family background. Thus, a sample of codependents provided a population with some consistency in background, both in terms of being a homogeneous group, and in terms of being consistent with other populations studied for resilience. For example, the Kauai longitudinal study examined children from high risk backgrounds periodically between birth and age 30 (Werner, 1992).

Second, as discussed earlier, codependents often

develop a pleasing demeanor to hide their pain and distress, which is often repressed and denied from an early age (Mellody, 1989). The pleasing demeanor is well-received in the outside world, and children of trauma are thus encouraged to continue wearing these exterior masks (Middleton-Moz, 1989). Similarly, resilient children are noted for their 'pleasant dispositions' (Werner, 1990).

Third, Werner (1982) identifies the ability to problem-solve as one of the characteristics of resilience. Therefore, a recovering population was ideal for this type of research, based on the assumption that those who seek help are more engaged in problem solving than those who do not attempt to ameliorate problem areas in their lives. Again, some consistency with populations studied for resilience was maintained. It seemed advisable for two reasons to use an adult population rather than children and youth. First, Werner's (1992) longitudinal research concluded at the time of the participants' thirtieth year. The questionnaire selected to measure resilience (see 'Measures' section below) in this study was extracted from Werner's final piece of research, which was designed for an adult population. The concept of resilience suggests that one overcomes or bounces back from conditions of

childhood, and therefore may only be validly evident in later years.

Finally, unlike resilience, codependence is not a concept normally used with youth populations. An adult population therefore provides the appropriate population to study resilience and codependence. However, while the results of the study were specific to an adult population, it was anticipated that they would be able to inform youth prevention programmers, who want to anticipate issues that impede healthy development in children and youth.

Therefore, the study examined a population of adults actively pursuing recovery from codependence. The participants were clients engaged in a treatment process for codependence at Dallas Society, an agency providing counselling for family chemical dependency in the Greater Victoria area. The agency defined a codependent as a family member who is in relationship with a person or persons who are chemically dependent.

Procedures

The questionnaire developed for the study was administered to clients in treatment for codependence from April, 1993 until October, 1993. Procedures for obtaining ethical approval for the study were followed, including

the completion and submission of the Request for Approval of Proposed Research Involving Human Subjects form at the University of Victoria.

The questionnare was pre-tested on six people. As a result, one minor adjustment was made in the demographics section by including an 'Other' category under marital status.

The sample was obtained through a convenience sampling technique, wherein clients at Dallas Society were informed of the project in various ways. Posters and information sheets were displayed in the waiting room, and individual counsellors informed their clients of the project and supplied interested clients with questionnaires. Clients engaged in group work were supplied with questionnaires and invited to fill them out. In some cases an opportunity was provided in the individual or group session to complete the questionnaires, while in others, clients took the questionnaires home and returned them the following week. It was assumed that potential differences in responses arising out of variation in environment would be minimal. The convenience and comfort of the clients kind enough to complete the questionnaire was considered to be more

important in terms of the accuracy of response than immediate physical environment.

The researcher outlined the required process for completion of the questionnares and supplied an instruction sheet with each questionnaire, to Dallas Society staff members. The staff distributed consent forms (see Appendix A) which informed participants of the goals and objectives of the project. The consent forms included an explanation of why particular questions were being asked (e.g., to find out more about resilience in children and youth), and how the information would be used (e.g., to inform prevention programmers about resilience in children and youth).

The problem of invasion of privacy, particularly with respect to the importance of anonymity and confidentiality, was addressed by assuring participants of their right to both. Responses were identified through a coding system to protect the anonymity of participants. The identity of the researcher remained anonymous, so that clients who knew the researcher on a clinical basis did not feel pressured to participate.

Each participant was given a code number to organize personal data such as age, gender, and marital status.

Data were coded and classified when they were collected to maintain a high level of organization and accuracy.

The researcher also distributed 20 questionnaires to the Alcohol and Drug Programs Quadra Clinic in Victoria, and 20 questionnaires to Pacific Centre for the Family in Colwood. Both agencies offer codependence counselling and group programs similar to what is found at Dallas Society. There were no responses from these two potential data sources.

The return rate on the questionnaires distributed at Dallas Society was 93% (n=68) , demonstrating a high level of motivation and good will on the part of the clients. The unreturned questionnaires were not persued, as it was assumed that clients were exercising their right to refuse participation.

Measures

Three instruments were combined to create an extended questionnare for participants (see Appendix B). The first instrument was developed to measure interpersonal dependency, (Hirschfeld, Klerman, Gough, Barrett, Korchin & Chodoff, 1977) and examines tendencies toward emotioanl reliance on another person, lack of social self-confidence and assertion of autonomy. It was selected as the closest

approximation to a standardized measure for codependence, for which a specific assessment tool has not presently been developed. Based on theories of attachment and object relations, it is also theoretically consistent with the concepts used to frame this project. The Interpersonal Dependency Inventory has good internal consistency, with split-half reliabilities that range from .72 to .91. No test-retest has been reported. While it has fairly good concurrent validity with both the Maudley Personality Inventory and the Symptom Checklist-90 (both measures for general neuroticism), it also correlates with a social desirability scale which suggests that respondents tend to answer based on what they believe is socially desirable.

The second part of the questionnare was taken from the work of E. Werner (1991), and replicated one of the instruments used to measure resilience in her longitudinal studies. This section provided a basis for examining how a population identified as codependent responded to a measure for resilience. Reliability and validity have not been reported for this measure, and it was the only measure available. The content of Werner's questionnaire centers around self-reported levels of satisfaction in various life areas, such as work, education, relationships

and health.

The third section contained a measure entitled the "Dysfunctional Attitude Survey" (Weissman, 1978). This measure was designed to look at how distorted perceptions, beliefs and attitudes predispose individuals to depression, which is often associated with codependence (Weissmann, 1978). The Dysfunctional Attitude Survey (DAS) has excellent internal consistency with alphas ranging from .84 to .92 and test-retest correlations over eight weeks of .80 to .84. The DAS has concurrent validity with other measures of depression and depressive-distortions (Weissman, 1978).

Analysis of Data

The data gathered from the Interpersonal Dependence Inventory, the resilience questionnaire and the Dysfunctional Attitude Scale were scored according to the instructions provided by the authors. The scores were entered into a variable list and tabulated in order to establish means and ranges. Test score results were correlated with demographic data. Relationships between the scores from the three sections were correlated using basic statistics in a chi-square format. The resilience section was entered and processed according to each item.

The results from other two tests were entered and processed according to scores and subscores, rather than each item, as it was anticipated that more meaningful results would be obtained in this manner. Both the Interpersonal Dependence Inventory and the resilience scale had three subscores.

Pearson correlations were also computed on the scores and subscores from the three questionnaires. The original research problem was based on the identification of similarities in the literature between the concepts of resilience and codependence. The question of whether resilience is, in fact, the same as codependence was examined using correlational analysis. As the results from the correlational analysis were somewhat unexpected, further analysis was conducted to explore whether there were underlying factors within resilience, codependence and depression. A principal component analysis was conducted on the test subscores to determine if there were common underlying factors within the codependence, resilience and depression measures and results.

CHAPTER lV

Questionnaire Results

Sample Data

A total of sixty-eight clients participated in the study. As anticipated, the majority of participants were women (n=66), although there were men (n=2) who volunteered. As can be seen from Table 1, over 60% (n=43) of the population was between 32 - 51 years of age, with less than 40% (n=25) under 31 and over 51 years of age.

Table 1: Frequency and Percent of Age Distribution

Age	Frequency(%)
19-31	14 (20.6%)
32-41	23 (33.8%)
42-51	20 (29.4%)
over 52	11 (16.2%)

Table 2 reports that almost 50% (n=33) of the participants were in either a first or a subsequent marriage at the time of the study. Moreover, the largest category in terms of marital status was the subsequent marriage category, indicating that almost 28% of the participants had been married more than once.

Table 2: Frequency and Percent of Marital Status

Marital Status	Frequency (%)
Never Married	12 (17.6%)
First Marriage	14 (20.6%)
Subsequent Marriage	19 (27.9%)
Divorced	12 (17.6%)
Widowed	3 (4.4%)
Other	8 (11.8%)

Time in treatment varied considerably, with over 50% in treatment for over 1 year (see Table 3). Treatment may have occurred in other contexts, rather than solely at Dallas Society.

Table 3: Frequency and Percent of Time in Treatment

Time in Treatment	Frequency (%)
0 - 6 months	15 (22.7%)
7 - 12 months	16 (24.2%)
1 - 3 years	19 (28.8%)
4 - 6 years	5 (7.6%)
Over 6 years	11 (16.7%)

Test Score Results

On the Interpersonal Dependence Inventory (IDI) and the Dysfuctional Attitude Scale (DAS), categories for low, medium and high scores were determined by calculating one-half of the standard deviation from the mean. Three categories corresponded to the resilience scale, which had pre-determined values for low, medium and high scores.

On all three scales, lower scores are associated with

higher levels of health. For example, a score of 117 on the DAS scale is considered to be an indication of greater health than a score of 125. Likewise on the IDI scale, 182 would indicate greater positive adjustment than 235.

Both the IDI and the resilience measure contained three subscores, in addition to a main score. The three categories for subscores on the IDI were: emotional reliance on others; lack of social self-confidence; and assertion of autonomy. The three resilience subscores are: (satisfaction with) work/school; interpersonal relationships; and self-evaluation. Subscore results will be discussed in the third section on Pearson correlations.

In terms of the IDI questionnaire, used to determine levels of codependence, participants in the low (or healthier) category comprised 38.2% (n=26) of the total 68 participants. Another 25% (n=17) fell into the medium range; with 36.8% (n=25) in the high range for codependency. The mean score for the Dallas Society participants was 194.3 compared to mean scores for the original research samples which ranged from 176.3 (normals) to 210.3 (psychiatric patients).

The resilience measure yielded scores falling into two categories only, although three categories

theoretically exist. The low category (healthier) contained 35.3% (n=24) of the respondents; while 64.7% (n=44) of the respondents fell into the medium category for resilience. While the mean scores for Werner's longitudinal study are unavailable, the mean score on the resilience scale was 22.1. The mean score falls into the lower end of the 'moderate' category, beyond the highly resilient scorers, who scored between 14 and 20. This indicates a higher level of resilience for this population and not a distribution across the three categories.

A more even distribution was evident in the DAS scores. Participants in the healthier category comprised 30.9% (n=21) of the total number. The medium category contained 35.3% (n=24) of the respondents, while 33.8% (n=23) fell into the low health category. For non-clinical respondents in the original study, the mean score was approximately 113, while the Dallas Society respondents' mean score was 137.

Results of the data show an interesting difference between resilience scores and the IDI and DAS scores (see Table 4). Whereas both the IDI and DAS scores distribute fairly evenly over the three categories, the resilience score results are distributed across two of the three

categories only.

Table 4: Levels of Health Indicated by Resilience, IDI and DAS Scores

	Least Healthy	Moderate	Most Healthy
IDI	26 (38.2%)	17 (25%)	25 (36.7%)
Resilience		44 (64.8%)	24 (35.2%)
DAS	23 (33.8%)	23 (33.8%)	22 (32.4%)

Correlations Between Test Scores and Demographic Data

None of the results from test score and demographic correlations showed statistical significance. Of particular interest was that levels of health as indicated by the three measures did not increase appreciably relative to time in treatment, as might be expected (IDI: $\underline{x}^2=9.64$, $\underline{p}=.472$; resilience: $\underline{x}^2=10.25$, $\underline{p}=.295$; DAS: $\underline{x}^2=11.85$, $\underline{p}=.068$). Further, levels of health did not appear to increase or decrease according to the age of clients (IDI: $\underline{x}^2=16.16$, $\underline{p}=.441$; resilience: $\underline{x}^2=9.91$, $\underline{p}=.271$; DAS: $\underline{x}^2=21.59$, $\underline{p}=.157$).

The largest numbers of highly resilient clients were

either in a subsequent marriage (n=10), or divorced (n=6), with 'subsequent marriage' being the largest category under marital status. Similarly, the largest number of individuals scoring as low on codependence were those in the 'subsequent marriage' category (n=9).

Relationships Between the Three Measures

As seen in the correlations between test scores and demographics, no relationships of statistical significance were found in correlations between the three scores. However, a point of interest with respect to the highly resilient scorers (n=24), was that almost half (n=11) scored as most healthy on the codependence scale as well. General consistency in health directionality within the three measures was further substantiated by the Pearson correlations reported below.

Pearson Correlations

Correlations among the three main scores will be reported first, followed by documentation of significant relationships between subscores.

The IDI or codependence score was found to be significantly correlated with the resilience score (r=.3714, p=.002). There was a positive association found between score results, indicating that as score values of

codependence increased, score values on the resilience scale also increased. In other words, given instrument coding, the higher the codependence score, the more codependent and less healthy the person. The higher the resilience score, the less resilient and less healthy the person. Therefore, while the score results have a positive value, the two concepts appear to be inversely related to one another. As levels of codependence in individuals increase, their level of resilience decreases.

With regard to the relationship between the IDI and the DAS scores, another positive correlation was found (r=.5336, p=.000). Therefore, it was inferred that the DAS measure gave consistent information with the IDI with regard to levels of health. As IDI scores increased, so did DAS scores. Individuals with higher levels of codependence (as measured by the IDI) had more dysfunctional attitudes or depression.

There was a significant association found between resilience scores and DAS scores (r=.4057, p=.002). As resilience scores increased (indicating a lower level of resilience), so did DAS scores. Therefore, less resilient individuals tended to be more depressed.

Prinicipal Component Analysis

The principal component analysis was performed as a result of determining through previous procedures that all of the participants scored as either highly resilient or moderately resilient. While the Pearson Correlations showed an inverse relationship between levels of codependence and levels of resilience, the data itself suggested that this analysis was not discerning. For instance, it seemed likely that, given the clear inverse relationship indicated by the Pearson Correlations, a population pre-determined as codependent (by virtue of the fact that they were in treatment for the above) would exhibit low health levels on the resilience scale. In particular, participants scoring as the most unhealthy on the codependence scale (n=26) were expected to have poor health outcomes on the resilience scale. Because this relationship was conspicuously absent, and perhaps confirming the notion that the two concepts may be more alike than different, further examination using different and exploratory statistical analyses seemed advisable.

The principal component analysis examined the relationship between the subscores on the measures for codependence and resilience; and subsequently factored in

depression scores. Results indicated that score 1A (emotional reliance on others - IDI), 1B (lack of social self-confidence - IDI), 2B (relationship satisfaction - resilience) and 2C (life satisfaction - resilience) loaded on Factor 1 (see Table 5). Subsequently, the scores for the third measure, the Dysfunctional Attitudes Scale, also factored in as congruent with the Factor 1 cluster. Subscores 1C (assertion of autonomy - IDI) and 2A (education/employment satisfaction - resilience) loaded on Factor 2. Factor 1 represented 71.8% of the variance accounted for, while Factor 2 accounted for 28.2%. Results of the VARIMAX rotatation were consistent with the above findings (see Table 5).

Table 5: Principal Component Analysis on Subscores

	Factor 1	Factor 2
Score 1A	.71726 (36.3%)*	-.28526
(IDI: Emotional Reliance on Others)		
Score 1B	.78121 (18.3%)*	-.19015
(IDI: Lack of Social Self-Confidence)		
Score 1C	-.06364	.76864 (12.4%)*
(IDI: Assertion of Autonomy)		
Score 2A	.26668	.59500 (12.1)*
(Resilience: Education-Employment Satisfaction)		
Score 2B	.63559 (9.3)*	.33197
(Resilience: Relationship Satisfaction)		
Score 2C	.81709 (6.9)*	.29679
(Resilience: Life Satisfaction)		
Score 3	.81709 (4.6)*	-.14971
(DAS: Dysfunctional Attitude Scale)		

* - Percentage of variance per subscore

An examination of the content of the subscores indicates that factor 1 (which underlies score 1A, 1B, 2B, 2C and 3) has a psycho-social aspect, in that it is connected to the perception of self and the ability to function in relationship with others. Factor 2, which underlies score 1C (assertion of autonomy) and 2A (education/employment satisfaction), appears to represent a sense of competence in the world, as well as an emphasis on personal accomplishment.

CHAPTER V

DISCUSSION

This study explored the relationship between two concepts, resilience and codependence. The discussion section will address a number of key issues emerging from the results of the data. Specifically, the difference between the results on the resilience scale and the IDI and DAS will be discussed. A conceptual reformulation and discussion will explore the issues surrounding correlational data results. Next, the concept of resilience in particular will then be re-examined in view of this discussion, followed by a revisitation of the concept of codependence. Clinical implications of this examination will be articulated.

Out of this, results from the principal component analysis will be examined, particularly with respect to the information gleaned from the subscores of the resilience and IDI questionnaires. The ecological framework discussed earlier in this research paper will be considered in light of the results of this study. The discussion will conclude by addressing implications for policy and program development with respect to the concept of resilience, and suggestions with respect to further

research.

With respect to the original research question, individuals who scored as highly resilient did not score high on codependence in a measurement sense. Further, clients who scored as highly resilient also scored as less depressed; whereas clients who scored as highly codependent also scored high on the depression scale. Overall, then, with respect to scoring, the population tended to score consistently in terms of levels of health. What is interesting about these results is that the population studied was already identified as codependent, and that overall the population scored as moderately or highly resilient. Therefore, some conceptual reformulation appears necessary.

With reference to Table 4 on page 56, a number of possibilities emerge with respect to interpreting the difference in the three test score results. Of particular interest is the fact that the resilience score results were distributed across two of the three categories only. It is possible that the categorization parameters are different in the resilience questionnaire than the other two measures, in terms of what is defined as 'moderate' or 'healthy'. The fact that the population under study shows

up as less healthy than the 'normal' or control groups cited by both the IDI and DAS studies (Hirschfield, 1977; Weissmann, 1978) underlines the discrepancy between these results and the resilience results, which point to a relatively high level of life satisfaction and hopefulness in this population. While such a discrepancy could be attributed to a variation in categorization, it might be expected that if this were the case the difference would be less dramatic.

A second possibility is that while the IDI and DAS measure levels of health or emotional well-being, the resilience scale is measuring something different, perhaps the ability to deal with high levels of stress. An interesting question emerging out of this possibility is: are emotional health and good adaptation and coping skills the same thing, or are they perhaps very different? Perhaps the individuals represented in this study are extraordinarily good at coping (as evidenced by the healthy and moderately healthy resilience scores), yet tend to score as less healthy on measures of emotional health and well-being, due to inordinate amounts of environmental stress and relationship difficulties. This possibility is supported by the relatively healthy mean

score ($\underline{m}$ = 22) with respect to resilience found in this population.

This is congruent with the quote from Bowlby (1988) with respect to the "price" (p. 11) that children in high stress environments pay for their efforts at coping with and adjusting to chaotic or unreliable environments. Bowlby asserts that the emotional cost is not always visible in the lives of individuals who appear to cope well. Further, these results support the observation that there may be a strong developmental link between high acheivement (or resilience) in children and youth, and difficulties related to codependence in adulthood, as suggested in the literature (Black, 1990; Kritsberg, 1986; Middleton-Moz,1990; Woititz, 1983).

With respect to the conceptual and behavioral similarities found in the resilience and codependence literature, it could be construed that what is being observed are similar coping behaviors from differing research theoretical perspectives. This is quite a different understanding than what was received from a review of the literature, wherein no connection between these two concepts was ever made. For example, an educational orientation might examine coping strategies

from a learning or developmental perspective (and call it resilience), whereas a medical point of view might be inclined to look at coping in relation to situational pathology (hence codependence).

This is a critical point in terms of the development of a clinical understanding of adaptive strategies. The polarization effect of attaching positive and negative values to coping strategies in various contexts may not be helpful to clients in recovery. Instead, clients may need to develop a description of their coping strategies, make sense of how they have attempted to handle adverse circumstances and then revise the ways in which they apply strategies in everyday life. An approach such as this allows individuals to take credit for their 'resilience' and make sense of the painfulness associated with codependence. Seen in this light, the concept of codependence, while helpful on one level, can also create a blind spot in the ability of observers to discern both the strengths and vulnerabilities in individuals coping with addiction in their families. Given that most individuals labelled (by self or others) as codependent are women, it would appear that a rather enormous disservice has been done to women coping with extremely

difficult situations. The development of this concept has made invisible to themselves and others their courage, strength and competence (Collins, 1993).

The field of research around resilience, therefore, may be viewed as building an understanding of the positive aspects of coping behaviors; whereas, the clinical development of the concept of codependence may represent the negative pole of adaptive strategies. One (resilience) interprets behaviors through a solution-oriented lens, and the other (codependence) has a problem-solving orientation. The key point of interest here is that while the behaviors are similar - the context of the behavior may in fact determine whether a strategy takes on a positive or negative value. Or, to refine this concept even further, it could be said that it is the relationship between the behavior and the context that determines the value of the strategy. Ecological theory provides a context for this conceptualization (Bronfenbrenner 1979). This notion is supported by the clear directionality of the data on a score by score basis, where levels of health across the three questionnaires correlate at a statistically significant level.

Moreover, the fact that the original population is in

treatment for codependence sheds an interesting light on the resilience questionnaire results. A population of people experiencing enough difficulty to enter treatment might, in traditional thinking, be expected to have lower levels of resilience than demonstrated in this sample. In fact, it may be more accurate to describe this sample as a group of extraordinary copers, who have coping behaviors which serve them well in the difficult context of addiction. The result of the relationship between the coping behavior and the addiction context is an extraordinary amount of pain, a decrease in self-esteem, and/or an increase in depressive tendencies.

With respect to the original thesis question, resilience and codependence appear to be as much alike as different with respect to outward qualities or characteristics, as seen in the literature. The question remains as to whether this is a reflection of the measurement tools, or a valid commentary on the population under study. Further exploration of the question of whether the tools are actually measuring what they claim to measure, especially with respect to resilience, might clarify this issue. This is especially significant in view of the absence of validity and reliability parameters

for the resilience measure.

Principal Component Analysis

As mentioned in the Results section, principal component analysis indicates that the concepts of codependence and resilience, as evidenced by scores 1A (emotional reliance on others), 1B (lack of social self-confidence), 2B (relationship satisfaction), 2C (life satisfaction) and 3 (Dysfunctional Attitude Scale) represent one factor; while 1C (assertion of autonomy) and 2A (employment /education satisfaction) represent another factor. With respect to factor 1, there appears to be a 'socio-emotional' factor that underlies both the concepts of resilience and codependence, as well as depression (DAS). This factor appears to refer to the feelings of individuals toward the place they hold in relation to the world around them, and particularly to the value or significance that their presence has for other people in their life and family context. Self-identity and self-esteem are significant with respect to this socio-emotional factor, but do not account for the relational aspects identified by score 1A (emotional reliance on others) or 2B (relationship satisfaction). The significance of this factor is naturally accounted for in

the ecological view of human development (Bronfenbrenner, 1979). Here, the relationship between self and life context is of primary importance with respect to health and general well-being. It could be interpreted that Factor 1 refers to the emotional aspect of health articulated earlier in the study, as distinguished from coping abilities.

Another factor, perhaps 'competence', appears to underlie the subscores which account for autonomy, and educational and career satisfaction. Autonomy via educational and career satisfaction suggest being able to do things by oneself, and to find satisfaction in personal accomplishments. Also, it could be surmised that individuals who experience life difficulties in an interpersonal sense are able to exert more control with respect to autonomous personal decisions, and are thus able to experience greater satisfaction in this area of life. Factor 2 could be interpreted to be more closely connected to coping abilities than to emotional health and well-being.

The principal component analysis, therefore, substantiates the original research question with respect to similarities between codependence and resilience. The

relationship between the subscores indicate that they are manifestations of two underlying factors, one of which appears to be of a socio-emotional nature, and the second of a competency-based nature. With five factors (emotional reliance on others, lack of social self-confidence, relationship satisfaction, life satisfaction and the Dysfunctional Attitudes Scale) lining up together, the results point in the direction of the significance of self in relation to others with respect to this population, which is consistent with themes that emerged from the review of the literature (Beardsley & Podorefsky, 1988; Bowlby, 1988; Bronfenbrenner, 1979; Collins, 1993; Werner, 1992).

Both the resilience and codependence literature come into existence as a result of the challenges of survivors of high stress environments to enter fully into satisfying and productive adulthood. Primarily, what creates the challenge for these individuals is difficulty in personal relationships, whether they are with mentally ill parents, alcoholic spouses or other types of relationships where normal trust is not possible.

With respect to the original research questions, principal component analysis appears to support the idea

that both codependence and resilience are conceptualizations of coping behaviors arising out of a similar circumstance: that of a high stress environment. Individuals in these circumstances develop strengths with respect to adaptation and coping; but may carry emotional pain, and experience higher levels of anxiety and depression than others. Moreover, it is possible for researchers to overlook the presence of anxiety and/or depression in survivors of high risk environments, given that they appear to be (and are) highly competent and resourceful people. Therefore, it is extremely important that researchers correct the assumption that a lack of identified pathology in resilient populations is synonomous with the presence of health.

Implications for Policy and Program Development

As can be seen from the above discussion, the concept of resilience is not straightforward. It is nevertheless an intriguing concept that has engendered new ways of thinking about stress and coping. The positive attributes inherent in this concept make it an attractive descriptor for qualities observed in individuals with particular strengths.

Unfortunately, there appears to be enough question

with respect to the positive and negative poles of coping behaviors (ie the close association with the concept of codependence) to seriously question the wisdom of developing prevention programming based on this concept without further research. It is important to reach a more thorough level of understanding of the dynamics of resilience before encouraging youth to participate in programs designed to 'enhance' or 'increase' resilience. The present research only begins to identify the complexities of coping behaviors, and the relationship of these behaviors to the overall well-being of the individual. What is clear from the research is that individuals can be good 'copers' (or resilient), and still suffer from emotional pain and depressive symptoms. Encouragement of this type of development in youth would be sadly remiss, indeed.

Perhaps where the research does point is to the importance of developing a more thorough understanding of how to encourage resilience, <u>as well as</u> attend to the emotional needs of children in high stress environments. In fact, a focus on the emotional needs of high-risk youth may inadvertantly encourage the development of resilient qualities, given the original parameters discussed with

respect to resilience. Second only to nature or temperament, supportive relationships were identified as a critical factor in the lives of many children displaying qualities of resilience (Werner, 1990). Supportive relationships, of course, are the foundation for emotional security and support in both children and adults. Perhaps applying this understanding to relationships with addicts - the presence of which creates the very antithesis of emotional support - sheds some light on the results of the codependent population discussed above. Perhaps also it becomes clearer why codependents are known to be deeply appreciative of the service they receive from outpatient clinics. For many, it is the first time that they are heard, understood and validated with respect to the painful depressive symptoms that they experience.

Children and youth growing up in stressful environments need adults who are clear about what fosters healthy development. Their needs challenge programmers to thoroughly study and research all avenues of enquiry into the relationships between families, schools and communities, and what encourages health and wholeness within these environments. They need adults who model good coping and emotional health in the context of a

meaningfully connected environment. Quick-fix gimmicks and trendy concepts will encourage the mimicking of true health, which appears to break down in adulthood, as evidenced in codependent populations.

Suggestions For Further Research

What appears to be critical from the above research is a further exploration of the relationship between behaviors and environments, and how the interaction between these two phenomena creates the dynamic of adaptive success and/or failure within the life context of the person across the lifespan. Ethnographic research may provide the type of detailed information that is required to inform further research of a more experimental nature. For example, it might be useful to select a life stressor that several individuals have experienced in common for a closer examination. A detailed interview may highlight differences and commonalities in the interelationships between the point of development, inherent strengths, the stressful event, and the significance of other factors (ie number and frequency of other stressful events) in the life context of various individuals.

Perhaps most importantly, researchers need to be wary of the tendency for perceived phenomena to be shaped by

the discipline lens that is applied, whether educational, psychological or another orientation. Interdisciplinary research addresses the danger of isolation of various orientations; increases the liklihood of conceptual accuracy; and enriches research in general. To date, the concept of codependence in particular exemplifies the negative aspects of a narrow focus on pathology. Current research emphasizes the importance of viewing behaviors in the context of the life situation, and the importance of naming strengths as well as vulnerabilities (Collins, 1993).

Therefore, it is suggested that researchers:

1. continue to expand and clarify an understanding of resilience, using a variety of research methods, with one informing another.
2. be aware of findings from other disciplines, with a focus on human development. This allows for a synthesis of ideas as an important balance to the traditional academic focus on analysis of observed human phenomena.
3. reformulate the clinical concept of codependence to more accurately reflect both the strengths and the vulnerabilities observed in individuals affected by someone else's substance abuse.

Conclusion

The particular challenges facing children and youth from high-risk environments need special attention on the part of researchers and prevention programmers. Further interdisciplinary research in the area of resilience, coping strategies, and emotional well-being shows promise with respect to gaining a better understanding of the developmental needs of children, as well as in placing a positive emphasis on both problem-solving and solution-finding. At this point, research indicates that an emphasis on a better understanding of relational processes in the lives of individuals may be important in the understanding and application of protective factors. Also, emphasis on the availability of supportive relationships - particularly for children in families coping with addiction, mental illness or other types of abandonment dynamics -needs further exploration. Policy and program development based on thorough research practices will potentially yield thoughtful, well-planned approaches to maximizing opportunities for children and youth from high risk environments to reach their full capacity for health and well-being.

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APPENDIX A

Consent Form for Questionnaire

Survivors of High Risk Family Backgrounds: Resilient or Codependent?

Consent Form

I,_____, client at Dallas Society, am willing to participate in the present research project examining resilience and codependency. I am prepared to fill out a questionnaire, which will take approximately one hour, to the best of my ability. It is my understanding that my identity will be protected and that my answers will be treated as confidential. I also understand that the results of the study will be coded in an anonymous manner, and that all identifying information will be destroyed upon completion of the study. If I have any questions regarding the study I will contact Dallas Society at 727-3544.

Signature:_____

Date: _____

I.D.#:__ __ __

APPENDIX B

Research Questionnaire

Instructions

Please complete the following questionnaire. Find the response that is most representative of you and your situation. There are no right or wrong answers. Try to record your initial response to each question; and then proceed to the next question. Do not spend too much time on any one question.

Date_____ Code No._____

Questionnaire

Section 1

Please read each statement and decide whether or not it is characteristic of your attitudes, feelings or behavior. Then assign a rating to every statement, using the values given below:

4 = Very characteristic of me.
3 = Quite characteristic of me.
2 = Somewhat characteristic of me.
1 = Not characteristic of me.

____ 1. I prefer to be by myself.
____ 2. When I have a decision to make, I always ask for advice.
____ 3. I do my best work when I know it will be appreciated.
____ 4. I can't stand being fussed over when I am sick.
____ 5. I would rather be a follower than a leader.
____ 6. I believe people could do a lot more for me if they wanted to.
____ 7. As a child, pleasing my parents was very important to me.
____ 8. I don't need other people to make me feel good.
____ 9. Disapproval by someone I care about is very painful for me.

4 = Very characteristic of me
3 = Quite characteristic of me
2 = Somewhat characteristic of me
1 = Not characteristic of me

____10. I feel confident of my ability to deal with most of the personal problems I am likely to meet in life.
____11. I'm the only person I want to please.
____12. The idea of losing a close friend is terrifying to me.
____13. I am quick to agree with the opinions expressed by others.
____14. I rely only on myself.
____15. I would be completely lost if I didn't have someone special.
____16. I get upset when someone discovers a mistake I made.
____17. It is hard for me to ask someone a favour.
____18. I hate it when people offer me sympathy.
____19. I easily get discouraged when I don't get what I want from others.
____20. In an argument, I give in easily.
____21. I don't need much from people.
____22. I must have one person who is very special to me.
____23. When I go to a party, I expect that the other people will like me.
____24. I feel better when I know someone else is in command.
____25. When I am sick, I prefer that my friends leave me alone.
____26. I'm never happier than when people say I've done a good job.
____27. It is hard for me to make up my mind about a TV show or movie until I know what other people think.
____28. I am willing to disregard other people's feelings in order to accomplish something that's important to me.
____29. I need to have one person that puts me above all others.
____30. In social situations I tend to be very self-conscious.
____31. I don't need anyone.
____32. I have a lot of trouble making decisions by myself.
____33. I tend to imagine the worst when a loved one doesn't arrive home when expected.

4 = Very characteristic of me
3 = Quite characteristic of me
2 = Somewhat characteristic of me
1 = Not characteristic of me

____34. Even when things go wrong I can get along without asking for help from my friends.
____35. I tend to expect too much from others.
____36. I don't like to buy clothes by myself.
____37. I tend to be a loner.
____38. I feel that I never really get all that I need from people.
____39. When I meet new people, I'm afraid that I won't do the right thing.
____40. Even if most people turned against me, I could still go on if someone I love stood by me.
____41. I would rather stay free of involvements with others than to risk disappointments.
____42. What people think of me doesn't affect how I feel.
____43. I think that most people don't realize how easily they can hurt me.
____44. I am very confident about my own judgement.
____45. I have always had a terrible fear that I will lose the love and support of the people I desperately need.
____46. I don't have what it takes to be a good leader.
____47. I would feel helpless if deserted by someone I love.
____48. What other people say doesn't bother me.

Section 2

Some of the following questions require a short description, which you may provide on the appropriate line. For the rest, please indicate with an 'X' the response that represents your situation most accurately.

1. What is your present job?_____

_____

_____

2. How satisfied are you with your work?

_____[1]Mostly satisfied
_____[2]Somewhat satisfied/Somewhat dissatisfied
_____[3]Mostly dissatisfied

3. What has been difficult or stressful about your work?
_____[1]Not interesting
_____[2]Poor work conditions
_____[3]Social, interpersonal difficulties at work
_____[4]Interferes with family/social life
_____[5]Financial (poor pay, lack of advancement)
_____[6]Other:
Describe_____
_____[7]No difficulties

4.(a) Did you have any more schooling beyond high school?
_____[1]Yes [If yes, go to Question 4(b).]
_____[2]No [If no, go to Question 5.]

(b) If yes, what kind?
_____[1]Technical training (i.e., mechanic, secretarial)
_____[2]Junior college
_____[3]College/university
_____[4]Graduate or professional school
_____[5]Other:
Describe_____

5. How satisfied were you with your acheivement in school?
_____[1]Mostly satisfied
_____[2]Somewhat satisfied/Somewhat dissatisfied
_____[3]Mostly dissatisfied

6. How do you feel about your marriage or relationship?
_____[1]Mostly satisfied
_____[2]Somewhat satisfied/Somewhat dissatisfied
_____[3]Mostly dissatisfied
_____[4]Have no current relationship

7. How satisfied are you with your present relationship with your children?
_____[1]Mostly satisfied
_____[2]Somewhat satisfied/Somewhat dissatisfied
_____[3]Mostly dissatisfied
_____[4]I have no children

8.(a) Is your father still alive?
_____[1]Yes [If yes, go to Question 8(b).]
_____[2]No [If no, go to Question 9.]

(b) If yes, how satisfied are you with your present relationship with your father?

_____[1]Mostly satisfied
_____[2]Somewhat satisfied/Somewhat dissatisfied
_____[3]Mostly dissatisfied

9.(a) Is your mother still alive?
_____[1]Yes [If yes, go to Question 9(b).]
_____[2]No [If no, go to Question 10.]

(b) If yes, how satisfied are you with your present relationship with your mother?
_____[1]Mostly satisfied
_____[2]Somewhat satisfied/Somewhat dissatisfied
_____[3]Mostly dissatisfied

10.(a) Do you have any brothers or sisters?
_____[1]Yes [If yes, go to Question 10(b).]
_____[2]No [If no, go to Question 12.]

(b) If yes, how satisfied are you with your relationship with them?
_____[1]Mostly satisfied
_____[2]Somewhat satisfied/Somewhat dissatisfied
_____[3]Mostly dissatisfied

11. Check the positive aspects of your relationship with your brothers and sisters. Proceed to Question 12 if you do not have brothers or sisters.
_____[1]Financial support
_____[2]Emotional support
_____[3]Shared interests, activities
_____[4]Models, shared values
_____[5]Providers of child care
_____[6]Other: Specify_____
_____[7]Can't think of any

12. How many close friends do you have?
_____[1]Many
_____[2]A few
_____[3]One
_____[4]None [If you have no friends, go to Question 15.]

13. How satisfied are you with your relationship(s) with your friends?
_____[1]Mostly satisfied
_____[2]Somewhat satisfied/Somewhat dissatisfied
_____[3]Mostly dissatisfied

14. Check the positive aspects of your relationship with your friends.

_____[1]Financial support
_____[2]Emotional support
_____[3]Shared interests, activities
_____[4]Models, shared values
_____[5]Providers of child care
_____[6]Other: Specify_____
_____[7]Can't think of any

15.(a) Do you have any major health problems?

_____[1]Yes [If yes, go to Question 15 (b).]
_____[2]No [If no, go to Question 16.]

(b) If so, what health problems?_____
_____

16.(a) Have you gotten help from another person or agency when you had a problem?

_____[1]Yes [If yes, go to Question 16 (b).]
_____[2]No [If no, go to Question 17.]

(b) If yes, who? Check sources of help:

_____[1]Spouse/mate _____[2]Parents _____[3]Siblings
_____[4]Other family members _____[5]Friends
_____[6]Neighbours
_____[7]Teachers, mentors _____[8]Co-workers _____[9]Boss
_____[10]Minister _____[11]Mental health professional(s)
_____[12]Self-help organizations
_____[13]Other:
Specify_____

17. How do you feel generally about yourself as a person at this stage of life?

_____[1]Happy, delighted
_____[2]Mostly satisfied
_____[3]Mixed (about equally satisfied and dissatisfied with different areas of life)
_____[4]Mostly dissatisfied
_____[5]Unhappy

Section 3

This section lists different attitudes or beliefs which people sometimes hold. Read each statement carefully and decide how much you agree or disagree with the statement.

For each of the attitudes, indicate to the left of the item the number that best describes how you think. Be sure to choose only one answer for each attitude. To decide whether a given attitude is typical of your way of looking at things, simply keep in mind what you are like most of the time. Again, there are no right or wrong answers.

7 = Totally agree
6 = Agree very much
5 = Agree slightly
4 = Neutral
3 = Disagree slightly
2 = Disagree very much
1 = Totally disagree

____ 1. It is difficult to be happy unless one is good looking, intelligent, rich and creative.
____ 2. Happiness is more a matter of my attitude towards myself than the way other people feel about me.
____ 3. People will probably think less of me if I make a mistake.
____ 4. If I do not do well all the time, people will not respect me.
____ 5. Taking even a small risk is foolish because the loss is likely to be a disaster.
____ 6. It is possible to gain another person's respect without being especially talented at anything.
____ 7. I cannot be be happy unless most people I know admire me.
____ 8. If a person asks for help, it is a sign of weakness.
____ 9. If I do not do as well as other people, it means I am a weak person.
____10. If I fail at my work, then I am a failure as a person.

7 = Totally agree
6 = Agree very much
5 = Agree slightly
4 = Neutral
3 = Disagree slightly
2 = Disagree very much
1 = Totally disagree

____11. If you cannot do something well, there is little point in doing it at all.
____12. Making mistakes is fine because I can learn from them.
____13. If someone disagrees with me, it probably indicates they don't like me.
____14. If I fail partly, it is as bad as being a complete failure.
____15. If other people know what you are really like, they will think less of you.
____16. I am nothing if a person I love doesn't love me.
____17. One can get pleasure from an activity regardless of the end result.
____18. People should have a chance to succeed before doing anything.
____19. My value as a person depends greatly on what others think of me.
____20. If I don't set the highest standards for myself, I am likely to end up a second-rate person.
____21. If I am to be a worthwhile person, I must be the best in at least one way.
____22. People who have good ideas are better than those who do not.
____23. I should be upset if I make a mistake.
____24. My own opinions of myself are more important than others' opinions of me.
____25. To be a good, moral, worthwhile person I must help everyone who needs it.
____26. If I ask a question, it makes me look stupid.
____27. It is awful to be put down by people important to you.
____28. If you don't have other people to lean on, you are going to be sad.
____29. I can reach important goals without pushing myself.

7 = Totally agree
6 = Agree very much
5 = Agree slightly
4 = Neutral
3 = Disagree slightly
2 = Disagree very much
1 = Totally disagree

____30. It is possible for a person to be scolded and not be upset.
____31. I cannot trust other people because they might be cruel to me.
____32. If others dislike you, you cannot be happy.
____33. It is best to give up your own interests in order to please other people.
____34. My happiness depends more on other people than it does on me.
____35. I do not need the approval of other people in order to be happy.
____36. If a person avoids problems, the problems tend to go away.
____37. I can be happy even if I miss out on the good things in life.
____38. What other people think about me is very important.
____39. Being alone leads to unhappiness.
____40. I can find happiness without being loved by another person.

Section 4
Personal Information
Please mark an 'X' beside the category which best describes you.

1. Sex:
_____[1]Female _____[2]Male

2. Age:
_____[1]19 - 26 years _____[2]27 - 31 years _____[3]32 - 36 years
_____[4]37 - 41 years _____[5]42 - 46 years _____[6]47 - 51 years
_____[7]52 - 56 years _____[8]57 - 61 years _____[9]62 years or over

3. Current Marital Status:

_____ [1]Never married
_____ [2]Married (first marriage)
_____ [3]Married (subsequent marriage)
_____ [4]Divorced
_____ [5]Widowed
_____ [6]Other

4. Current Length of Time in Treatment:

_____ [1]1 - 3 months _____ [2]4 - 6 months _____ [3]7 - 12 months
_____ [4]1 - 3 years _____ [5]4 - 6 years _____ [6]6 or more years

APPENDIX C

Letter of Information Informing Clients of the Study

Dear Interested Participant,

Dallas Society, in conjunction with a graduate student from the University of Victoria, is researching the topic of resilience in children and youth. The purpose of the study is to provide relevant information to prevention programmers with regard to the concept of resilience in children and youth. Resilience can be viewed as the positive and adaptive qualities identified in certain children who live in high stress environments. Many children who are regarded as resilient grow up in homes where addiction is present, and show extraordinary coping ability.

Addiction and other factors associated with high-risk home environments are also connected with the onset of chemical dependency and codependency in youth and adults. The purpose of this research is to clarify what aspects of resilience are similar to codependence, and how these two characteristics are related within a population of individuals in treatment for codependency. It is hoped that this information will assist in developing programmes that encourage resilience in youth, but that avoid inadvertantly encouraging codependence as a coping strategy.

To participate in this research, individuals are requested to fill out the attached questionnaire. The questionnaire is designed to provide information on the basis of self-assessment. It includes measures for qualities of resilience and tendencies toward codependence. Results of the study will be available to participants upon request.

All questionnaires will be coded in an anonymous manner to ensure confidentiality. Participation is voluntary: participants have a right to withdraw at any time. Your treatment process at Dallas Society will in no way be affected by this research.

We appreciate your involvement in this project, and thank you for participating.

Yours truly,
The Dallas Researchers.

VITA

Surname: Armstrong Given Names: Kathleen Elaine

Place of Birth: Outlook, Saskatchewan

Date of Birth: October 15, 1956

Educational Institutions Attended

University of Victoria	1991 to 1994
Simon Fraser University	1978 to 1980
University of Lethbridge	1975 to 1977

Degrees Awarded

B.A.	Simon Fraser University	1980

Honours and Awards

Alcohol and Drug Programs Fellowship Award	1991

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Title of Thesis: Survivors of High-Risk Family Backgrounds: Resilient or Codependent?

Author: [redacted]

KATHLEEN ARMSTRONG

September 19, 1994