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Chronic Sorrow in Family Members of Addicts: An Investigation of Partners of Addicts and Divorcees to Explore Chronic Sorrow as a Theoretical Understanding of the Experiences of Family Members of Addicts

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CHRONIC SORROW IN FAMILY MEMBERS OF ADDICTS: AN INVESTIGATION
OF PARTNERS OF ADDICTS AND DIVORCEES TO EXPLORE CHRONIC
SORROW AS A THEORETICAL UNDERSTANDING OF THE EXPERIENCES OF
FAMILY MEMBERS OF ADDICTS

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Doctor of Philosophy

by

Victoria Grace Hargenrader McLaughlin

August 2016

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Approved August 2016 by

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ABSTRACT

This study attempted to examine chronic sorrow as a theoretical understanding of the negative psychological symptoms of family members of addicts (FMoAs). Partners of addicts (PoAs) (n = 94) were compared against divorcees (n = 66) for chronic sorrow and codependence. Males (n = 53) and females (n = 107) were also compared for chronic sorrow and codependence. Some hypotheses were supported, such as chronic sorrow increased as codependence increased; female PoAs scored significantly greater than the population mean for chronic sorrow; and male and female divorcee scores were equal to the population mean for chronic sorrow; however some hypotheses were not supported. Additionally, the statistical output appeared to indicate trends among certain groupings of variables: Both codependence and chronic sorrow may have application in a clinical setting for FMoAs, male PoAs consistently scored in the range below female PoAs, codependence was detected in both male divorcee and female PoA subgroups. The clinical application and significance of those findings for future research is explored, such as the influence of a recovery program on negative psychological symptoms of FMoAs.

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CHAPTER ONE - INTRODUCTION

This project sought to justify investigation of chronic sorrow as a conceptual framework for understanding and addressing psychological symptoms of family members of an addict (FMoAs). The literature review reflected the prevalence of addiction and its psychological impact on FMoAs. The chronic, progressive nature of the disease of addiction and the problematic experiences of FMoAs were described. The current conceptual framework for the psychological symptoms of FMoAs—codependence—was inspected. The limitations of codependence were critiqued, including gaps in the definition of codependence, gender prejudice, and risks of considering codependence as a diagnostic label for a pathological state. The construct of chronic sorrow was explained and proposed as a potentially new understanding of the psychological symptoms experienced by FMoAs. Methodology for collection of data was outlined and hypotheses were stated. Results from statistical analyses were reported, and those results were interpreted. Finally, limitations were explored.

Statement of the Problem

The literature estimated that a minimum of 91 million FMoAs might have currently been impacted by a loved one's addiction (Copello, Templeton, & Powell, 2010). The extent of impact on FMoAs was often overlooked in favor of focusing on the addict's disease manifestations (Copello, Templeton, & Powell, 2010; Sakiyama, de Fatima Rato Padin, Canfield, Laranheira, & Sendin Mitsuhiro, 2015). Research

identified many forms of distress in FMoAs as well as medical and psychiatric conditions (Sakiyama, de Fatima Rato Padin, Canfield, Laranheira, & Sendin Mitsuhiro, 2015).

The experience of FMoAs was frequently pathologized as a diagnosis of codependence, an addictive state that directly impacted and operated parallel to the addict's disease (Brackenhoff & Slesnick, 2015; Brooks & McHenry, 2009; Brown & Lewis, 1999; Cox, Ketner, & Blow, 2013; Dear, Roberts, & Lange, 2005; Denning, 2010; Peled & Sacks, 2008; Rotunda & Doman, 2001; Rychtarik & McGillicuddy, 2005; Sarkar, Matoo, Basu, & Gupta, 2015; Timko, Young, & Moos, 2012; Wampler, Downs, & Fischer, 2009); however codependence was broadly and inconsistently defined (Calderwood & Rajesparam, 2014; Cox, Ketner, & Blow, 2013; Kalashian, 1959; Dear, Roberts, & Lange, 2005; Orford, 2014). Additionally, nearly all of the more frequently referenced characteristics of codependence lacked replicated empirical support (Dear, Roberts, & Lange, 2005; Marks, Blore, Hine, & Dear, 2012; Ribeyre, 2014). Codependence was also routinely criticized for gender prejudice; many argued codependence pathologized the experience of being female (Anderson, 1994; Barber, 1997; Calderwood & Rajesparam, 2014; Orford, 2014; Peled & Sacks, 2008; Rotunda & Doman, 2001). A new approach for conceptualizing the negative psychological experiences of FMoAs—through the lens of chronic sorrow—was therefore explored.

Theoretical Rationale

The theory of chronic sorrow was developed to describe the experiences of parents of children with intellectual disabilities (Olshansky, 1962; Vitale & Falco, 2014). The theory was expanded to include the emotional experiences of individuals and caregivers for many chronic illnesses (Burke, Hainsworth, Eakes, & Lindgren, 1992;

Fraley, 1986; Northington, 2000; Scornaienchi, 2003; Whittingham, Wee, Sanders, & Boyd, 2013). Chronic sorrow aimed to shed light on a normal, non-pathological, but distinct grief response when a loss remained present in the life of the griever (Fraley, 1986; Rossheim & McAdams, 2010; Vitale & Falco, 2014). Chronic sorrow was also presented as a cyclic recurrence of negative psychological symptoms that increased in intensity at trigger events across the lifespan (Bonner, Hardy, Guill, McLaughlin, Schweitzer, & Carter, 2006; Burke, Hainsworth, Eakes, & Lindgren, 1992; Scornaienchi, 2003; Vitale & Falco, 2014; Whittingham, Wee, Sanders, & Boyd, 2013). Chronic sorrow asserted the experiences of the ill individual and caregivers were negative psychological symptoms of grief (Fraley, 1986; Rossheim & McAdams, 2010).

The disease of addiction was established as a medical state and characterized as a chronic, progressive, and relapsing brain disease (ASAM, 2011; Bell, Carter, Mathews, Gartner, Lucke, & Hall, 2013; Leshner, 1997; McClellan, Lewis, O'Brien, & Kleber, 2000; Volkow & Fowler, 2000). The theory of chronic sorrow aligned theoretically with the experiences of FMoAs, namely the recurrence of negative psychological symptoms from the impact of consequences from the loved one's addiction, and an unknown end to these experiences (Copello, Templeton, & Powell, 2010). Chronic sorrow was also reported as empirically supported (Burke, Hainsworth, Eakes, & Lindgren, 1992; Scornaienchi, 2003). While gender differences in expression of chronic sorrow were noted, chronic sorrow appeared to be relatively free of gender prejudice, unlike codependence (Scornaienchi, 2003).

Purpose of the Study

This study's purpose was to explore the potential for chronic sorrow as a better lens from which to clinically understand the experiences of FMoAs. If chronic sorrow were supported empirically as a description for the negative psychological symptoms experienced by FMoAs, then chronic sorrow's use for clinical settings could be further explored as a means of helping a population in need of support that enjoys empirical backing. Partners of addicts (PoAs) were sampled in this study, as the literature refers to the partner relationship with more frequency than most other family dynamics.

Definition of Addiction

The word "addiction" was used in this study to include individuals dependent on any chemical substance (ASAM, 2011). Similarly, the word "addiction" did not differentiate between dependence on alcohol or other substances. "Addiction" also only focused on chemical dependence, not pathological behaviors that provide relief and/or reward (2011).

CHAPTER TWO – LITERATURE REVIEW

Introduction

This chapter provided a detailed review of current literature on the extent and experiences of FMoAs, as well as the history of and current understanding of codependence. A critical analysis of codependence is provided, and the theory of chronic sorrow was explored as an alternative framework for understanding the experiences of FMoAs.

Current Prevalence of Addiction in Families

The disease of addiction was stated to impact the entire family; that is to say, the impact was noted in the individual addict as well as FMoAs. Ascertaining the prevalence of impact of addiction on FMoAs was, however, a challenge. Accurate calculations on the number of FMoAs impacted by addiction were lacking (Copello, Templeton, & Powell, 2010). Informal 12-step communities that support friends and FMoAs such as Al-Anon, Nar-Anon, Families Anonymous, and Adult Children of Alcoholics (ACoAs) did not participate in research that would yield such figures, in keeping with the 12-step traditions. Also, even though treatment for addiction historically included FMoAs, data regarding the impact of addiction on FMoAs was not explored in treatment settings until very recently; thus data was often inferred through use of population survey data (2010). For example, the world headquarters for Al-Anon provided estimates of the impact of an individual's alcoholism by utilizing public data from SAHMSA, the US Census, and Gallop polls to conclude that approximately 6.9 individuals (not specifically FMoAs)

were impacted by one alcoholic's disease manifestations (Al-Anon World Headquarters Office, personal communication, Mar 3, 2015).

Data regarding the impact of addiction on FMoAs was also inferred by looking to data referencing the number of addicts in treatment. The prevalence of addiction within families therefore began to be understood by seeking the prevalence of addiction within the general population. The 2013 National Survey on Drug Use and Health (NSDUH), which is sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA) and administered annually, reported an estimate of 21.6 million persons aged 12 or older met the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, (DSM-IV) criteria for substance dependence or abuse, or 8.2 percent of the population (SAMHSA, 2014). Broken down, this figure encompassed their findings that 2.6 million persons were classified with dependence or abuse of both alcohol and illicit drugs, 4.3 million persons were classified with dependence or abuse of illicit drugs but not alcohol, and 14.7 million persons were classified with dependence or abuse of alcohol but not illicit drugs (2014).

The 2013 NSDUH additionally stated that the figure of 21.6 million people classified with substance dependence and abuse were similar to the previous figures of persons that meet criteria for substance dependence and abuse every year of NSDUH administration since 2002, ranging from 20.6 to 22.7 million (2014). Their statement suggested that the 2013 figure of 8.2 percent prevalence for addiction in the United States had remained relatively unchanged for the most recent decade. On a global scale it was estimated that 91 million individuals suffer from addiction overall. At the most conservative of estimates, if the 91 million addicts impacted one FMoA then the impact

of addiction on FMoAs reached figures as large as 91 million as well; however, most practitioners would argue one addict impacted more than one family member. While the best estimates available reflected a widespread prevalence of impact of an addict's disease on FMoAs, these same best estimates were both limited and under-estimated (Copello, Templeton, & Powell, 2010).

Evidence of Negative Psychological Impact on FMoAs

While treatment for addicts historically included FMoAs to support the addict in recovery (White, Kelly, & Roth, 2012), the kinds and extent of impact experienced by FMoAs due to the loved one's addiction was often overlooked (Copello, Templeton, & Powell, 2010; Sakiyama, de Fatima Rato Padin, Canfield, Laranheira, & Sendin Mitsuhiro, 2015). In addition to literature illuminating the profound impact of addiction on FMoAs' lives, there was evidence to suggest that the presence of an addict in a family relationship may result in negative psychological symptoms in FMoAs.

Through the course of an addict's disease progression, literature identified negative psychological impacts on FMoAs in forms of distress that include family tension, stress, worry, and stigma, as well as feelings of guilt, failure, and helplessness (Sakiyama, de Fatima Rato Padin, Canfield, Laranheira, & Sendin Mitsuhiro, 2015). FMoAs also presented with a higher prevalence of medical and psychiatric conditions, namely a strong tendency to develop substance dependence of their own, depression, anxiety and psychological side effects of trauma (2015). Global research additionally supported the consistency of FMoAs' experiences by concluding the impact of addiction on the family was a specific and particular experience that is startlingly similar regardless

of where the affected family was located (Arcidiacono, Velleman, Procentese, Albanesi, & Sommantico, 2009; Copello, Templeton, & Powell, 2010; Orford et al., 2005).

Negative psychological symptoms were present in FMoAs prior to an addict's formal diagnosis of addiction, as well. Data on 25,464 FMoAs in the United States were compared to data of 17,345 family members of diabetics, 19,930 family members of asthmatics, and 20,320 family members that do not have addiction in their families. A year before the ill family members in the addiction, diabetes, and asthmatic groups were diagnosed, the FMoAs were also more likely to be diagnosed with problems such as depression and trauma than family members in the other groups (Copello, Templeton, & Powell, 2010; Ray, Mertens, & Weisner, 2009).

Though effort was made to identify the presence of negative psychological impact of addiction on FMoAs, it proved difficult to concisely and accurately speak to the experience of FMoAs in a clinical setting. It was also difficult to assess the extent of impact of addiction on FMoAs; some may be impacted more directly than others due to proximity, financial support, and the nature of the relationship (Copello, Templeton, & Powell, 2010).

Addiction as a Chronic, Relapsing, and Progressive Disease

The negative psychological impact of addiction on FMoAs and its long duration was not surprising if one took into consideration the nature of addiction as a chronic and relapsing brain disease (ASAM, 2011; Bell, Carter, Mathews, Gartner, Lucke, & Hall, 2013; Leshner, 1997; McClellan, Lewis, O'Brien, & Kleber, 2000; Volkow & Fowler, 2000) rooted in research on genetics and neurobiological changes in brains of animals and humans (Bell, Carter, Mathews, Gartner, Lucke, & Hall, 2013; Volkow & Fowler,

2000; Volkow & Li, 2003). Addiction fits the “organ-dysfunction-symptom” disease model as well. Brain scans support that addiction is housed in the organ of the brain. The brain experiences a dysfunction described as a stress-induced disruption of the pleasure-seeking survival instinct. This dysfunction evokes behavioral symptoms of continued use despite negative consequences and physical symptoms of cravings and a need for progressively increasing amounts of substances to achieve the desired effects (McCauley, 2010).

Though each intoxicating substance has unique characteristics, for nearly 40 years it has been known that all intoxicating substances affect the same neural pathway in the brain: The mesolimbic reward system, also referred to as the pleasure center, which extends from the ventral tegmentum to the nucleus accumbens, and then projects into the limbic system as well as the orbitofrontal cortex (Lashner, 1997; McCauley, 2010). Prolonged substance use resulted in pervasive brain changes even after an individual ceased using, such as changes in brain metabolic activity, receptor availability, gene expression, and responsiveness to environmental cues (1997). Put simply, these changes were chronic, remaining present in the brain across an individual’s lifespan. Addiction further resembled other chronic diseases, characterized often by cycles of relapse and remission (ASAM, 2011) and by difficulty discerning if addiction ever truly resolves (Gonzales, 2007). Addiction lastly was recognized as a progressive disease. The addict’s tolerance increased during the course of their disease, requiring the addict to need progressively greater quantities of substances to achieve the desired effect. While the addict repeatedly sought to achieve “highs”, the addict actually achieved “lows” that became deeper with each cycle (ASAM, 2011). If an addict did not engage in the

“medicine” of recovery (treatment and recovery activities), addiction could result in disability or premature death (2011).

Problematic Experiences of FMoAs

Problematic experiences of FMoAs emerged around addiction in the family. Research supported the presence of several, devastating adverse effects of a loved one’s addiction on the family, to include physical toll, financial strain, interpersonal strain, and social consequences (Sakiyama, de Fatima Rato Padin, Canfield, Laranheira, & Sendin Mitsuhiro, 2015).

FMoAs experienced the physical toll of exhaustion and pain due to ongoing anxiety, worry, and stress, and they may also have experienced substance-induced aggression in the family (Sakiyama, de Fatima Rato Padin, Canfield, Laranheira, & Sendin Mitsuhiro, 2015). The anxiety, worry, and stress may not have reduced in intensity when their addicted loved one was in recovery due to fears of relapse, because relapse often brought about greater intensity of consequences (2015). Often, FMoAs experienced financial strain from efforts to assure the addict did not go without basic needs such as food and housing when the addict spent his/her own money on intoxicating substances. FMoAs often funded legal support when the addict encountered legal consequences and may also have funded the addict’s medical needs, to include sometimes multiple detoxification and rehabilitation treatments (2015). The diverted focus an FMoA likely provided the addict was often felt as neglect by others in the family and other social sources of support. The quality of other relationships experienced strain, which resulted in some FMoAs experiencing isolation in the role of care-taker for the addict (2015). Finally, the state of addiction was stigmatized in society, and by

continuing to care for the addict despite the addict's continued use after negative consequences, FMoAs often experienced the consequences of stigma as well (Orford, Velleman, Copello, Templeton, & Ibanga, 2010; Rychtarik & McGillicuddy, 2005; Sakiyama, de Fatima Rato Padin, Canfield, Laranheira, & Sendin Mitsuhiro, 2015).

Current Understanding of Codependence

The experience of FMoAs was frequently pathologized as a diagnosis of codependence. The FMoA's codependence was believed to directly impact the addict's disease manifestations and to be an addictive state that operates parallel to the addict's diagnosis of addiction (Brackenhoff & Slesnick, 2015; Brown & Lewis, 1999; Cox, Ketner, & Blow, 2013; Denning, 2010; Peled & Sacks, 2008; Rotunda & Doman, 2001; Rychtarik & McGillicuddy, 2005; Sarkar, Matoo, Basu, & Gupta, 2015; Timko, Young, & Moos, 2012; Wampler, Downs, & Fischer, 2009). Additionally, professionals often collectively addressed FMoAs' codependence in the context of impact on addict's use and to the exclusion of the FMoAs' individual needs (Butler & Seedal, 2006; Calderwood & Rajesparam, 2014; Cox, Ketner, & Blow, 2013; Denning, 2010; White, Kelly & Roth, 2012).

Pathology of Codependence

Codependence was associated with a broad array of defining characteristics in informal settings, anecdotal self-help books, clinically, and in peer-reviewed literature. The defining characteristics of codependence varied depending on their origin. Many credited the inception of Al-Anon as the informal starting point for the introduction of codependence, and identified friends and FMoAs as controlling and excessively caretaking, and encouraged them to recover from codependence by detaching lovingly

and accepting they cannot control their family member's disease (Calderwood & Rajesparam, 2014). Others stated the problematic behavior of codependence was promoted even earlier by Alcoholics Anonymous (AA) as FMoAs' overzealous helping that inadvertently supported addictive behavior (Cox, Ketner, & Blow, 2013). More formally, codependence was seen as early as the 1950s in academic discussions that continued into modern times as a wife's personality disorder characterized by undermining the husband's efforts to become sober in a pathological need to be needed (Kalashian, 1959; Orford, 2014). Clinically, codependence was adopted by the addiction field in the 1970s after it emerged ambiguously as a descriptor of an observed role in families affected by addiction (Brooks & McHenry, 2009; Dear, Roberts, & Lange, 2005) and as a description of predictable coping methods and normal psychological reactions employed by a normal individual coping with an abnormal circumstance brought on by a loved one's addiction (Sarkar, Mattoo, Basu, & Gupta, 2013). In light of the continued debate about the defining features of codependence for more than fifty years, the characteristics of codependence were too plentiful to innumerate; however, some definitions were referenced more frequently (Dear, Roberts, & Lange, 2005), and, therefore, exploring more frequently referenced definitions proved most useful in conceptualizing one unified understanding.

Efforts to Define Codependence

Organizationally, the definition put forth by the First Annual Conference on Codependency in 1989 described codependence as an addictive state characterized by “a pattern of painful dependency upon compulsive behaviors and on approval from others in a search for safety, self-worth, and identity. [from which] Recovery is possible” (Dear,

Roberts, & Lange, 2005, pg. 190). In 1990, the National Council on Codependence put forth that codependence was:

A learned behavior, expressed by dependencies on people and things outside of the self; these dependencies include neglecting and diminishing one's own identity. The false self that emerges is often expressed through compulsive habits, addictions, and other disorders that further increase alienation for the person's true identity, fostering a sense of shame. (pg. 190)

In both instances, 'dependency' was put forth as a component; however one definition promoted codependence as a dysfunctional personality characteristic, and the other endorsed codependence as a learned behavior.

Within peer reviewed literature, the 11 most frequently referenced sources for the defining characteristics of codependence came out of anecdotal, best-selling self-help books (Dear, Roberts, & Lange, 2005). When examined thematically, those 11 definitions elicited three major observations: They referenced features of 1) already widely recognized psychological disorders that have diagnostic criteria of their own, namely substance use, stress-related medical illness, anxiety disorders, clinical depression, and 2) manifestations of impulse control disorder, such as eating disorders, gambling, and sexual behavior. All eleven definitions stated codependence was caused by a dysfunctional upbringing, and six defining themes emerged—four second order themes (external focus, self-sacrificing, controlling, and difficulty expressing emotion), and two first order themes (impaired identity and rigidity in attitudes and behavior) (2005).

The first of these themes, external focus, manifested as excessive focus on others, emotional dependence, approval-seeking, happiness depending on others, diffuse boundaries, and sensitivity to criticism (2005). The theme of “self-sacrificing” was described as putting others’ needs before his/her own, doing more than the fair share of labor, and difficulty asserting thoughts or needs (2005). The theme of “controlling” was noted as seeking to control people or events; trying to control things that cannot be controlled; feeling responsible for others’ thoughts, feelings, and behavior; and excessive caretaking, such as fixing others’ problems (2005). The theme of “difficulty in expressing emotion” was posed as difficulty expressing feelings, restricted emotionality, and denial or suppression of feelings (2005). Finally, a person experiencing codependence may have presented with impaired identity development as well as rigid attitudes and behavior (2005).

Still others defined codependence as a phenomenon that encompassed the collective presence of denial, hyper-control, emotional repression, compulsions, self-neglect and a difficulty setting healthy boundaries, symptoms measured by the reliable and valid Codependency Assessment Tool (CODAT) (Ribeyre, 2014). Others further put forth that codependence represented the symptoms of devalued self-esteem, low self-confidence, dependency, depression, anxiety, anger, fear of rejection, increased use of alcohol, relationship issues, and stress-related difficulties (Sarkar, Mattoo, Basu, and Gupta, 2013). The literature reflected the efforts of researchers to look to peer-reviewed, published definitions for a more unified and cohesive understanding codependence, but consensus in understanding codependence appeared to evade the field.

Codependence – Addiction Parallels

Some researchers also asserted codependence was a disease in FMoAs that operated parallel to the addict's chemical addiction (Denning, 2010). Put more plainly, what happened for the addict appeared to correspond with what happened for the FMoA (Brackenhoff & Slesnick, 2015; Brown & Lewis, 1999) in large part because the FMoA based his/her identity and self-esteem on the well-being of the addict and, thus, engaged in controlling behaviors and hyper vigilance (Denning, 2010). For example, while the addict was preoccupied with substances, FMoAs were equally preoccupied with the addict's behavior, and where the addict tried to control his/her own use, FMoAs equally tried to control the addict (Brown & Lewis, 1999; Denning, 2010). Just as the addict experienced an increased tolerance for the substance in his/her disease progression, so too did FMoAs experience an increased tolerance for addictive behavior in life. FMoAs' increased tolerance was achieved through denial of circumstances and emotions, a process which mimicked the denial of circumstances and emotions seen in addicts (Brown & Lewis, 1999). The addict and FMoAs all engaged in impulsivity, excuse-making for addictive behaviors, and developed a false self or mask to cover up the reality of unmanageability that evolved in the family (1999). Finally, just as the addict's meaning in life surrounded his/her substance, the FMoAs' meaning in life surrounded the addict (1999). There were also similar patterns of losses experienced by the addict and FMoAs, such as the loss of money, friends, sleep, hope, opportunities, and quality of family relationships. All of these parallels supported the notion that codependence could meet criteria for an addictive state.

Inattention to Individual FMoA Wellness

Inclusion of family in an addict's recovery has been a practice for the last 150 years and was a known strength for the addict's recovery (White, Kelly, & Roth, 2012); however, many of these family-inclusive models conceptualized FMoAs' unique needs in the collective context of supporting the addict's sobriety. The FMoAs' involvement was often justified by the understanding that FMoAs' codependence could maintain problems and substance use in a dysfunctional family system, so by concurrently alleviating the symptoms of the FMoAs' codependence, the addict could enjoy longer sobriety outcomes (Cox, Ketner, & Blow, 2013). Stated more directly, the FMoA was recruited as a participant in the recovery process and received services by proxy, but did not receive individual attention, was not considered in an individual context, and was not approached prior to the addict seeking services first. For example, one model for couples affected by addiction utilized the pair-bond in attachment theory to elicit simultaneous healing for both partners by raising awareness of mutual impact on one another, helping the non-addicted FMoA realize the impact his/her codependence had on the addict, and helping the addict recognize the FMoA needs to heal from the trauma of addictive behavior (Butler & Seedal, 2006). Some argued that using a family systems approach to support recovery for the addict and resolve codependence in non-addicted FMoAs was appropriate, because codependence was often considered a result of family of origin dynamics, such as substance abuse in family of origin (Calderwood & Rajesparam, 2014; Knudson & Terrell, 2012). Others still proposed the notion of the entire family being in recovery, such as in a 12-step model or an ecologically-based family therapy model (Brackenhoff & Slesnick, 2015). Some models for adult children of addicts (ACoAs) focused on helping ACoAs learn to cope with losses and missed experiences from

childhood, as well as to acknowledge that the deep desire to change was grounded in feelings that there was something wrong with them; however these models were seen to also inadvertently reinforce maladaptive coping skills from their dysfunctional childhood, like using quick-fix problem-solving skills and over-focusing on other's needs, especially FMoAs' needs (Lewchanin & Sweeny, 1997). Though they may not have intended it, those models resulted in focus, again, directed to the addict and diverted away from the FMoAs' needs.

While family-centered models offered a collective approach that included FMoAs, the inclusion was largely to support the addict's sobriety, and the experiences of FMoAs that evince while the addict was in active addiction or the independent needs for FMoAs' own healing or well-being went largely unrecognized (Brackenhoff & Slesnik, 2015). The absence of help available for FMoAs whose addicted loved ones were not in recovery was especially noteworthy.

Shortcomings of Codependence as a Descriptor of the FMOA Experience

Some concerns were consistently raised about the basic construct of codependence. Lack of consensus in defining codependence and lack of agreement on a theoretical model for best clinical understanding of codependence were of concern. More recently, the lack of replicated empirical support for the defining criteria of codependence was discussed (Brackenhoff & Slesnick, 2015; Harkness, 2014; Marks, Blore, Hine, & Dear, 2012; Orford, 2014; Ribeyre, 2014). Perhaps most consistently, the construct of codependence was scrutinized for gender prejudice. Scholars asserted the varying iterations of the construct of codependence ultimately only succeeded in pathologizing the socially promoted role of women as caretakers in families.

Lack of Consistency in Definition and Theory

The broad and varied definitions of codependence circulated in the literature were often identified as inconsistent and therefore should be considered with caution (Calderwood & Rajesparam, 2014; Ribeyre, 2014). An inconsistent definition was of obvious concern for mental health professionals that work with FMoAs, because codependence was frequently administered as a clinical observation or diagnosis despite that it lacked clear diagnostic and differentiating criteria.

The span of more than fifty years that the field of addiction counseling spent in pursuit of a definition for codependence was also suspicious. That the field was still not clear about what codependence clinically was and was not; that the field still was not clear about where codependence came from, (family of origin, intrinsic personality, or the result of living with an addict or mentally ill individual); and that the field still was not clear how best to address codependence as its own pathology, all lent strength to the argument from some scholars that codependence as a construct does not even exist (Barber, 1997), or that, at best, it was a matter of social construction (Harkness, 2014) and a poor foundation upon which to design a more effective model for helping FMoAs (Orford, 2014).

Perhaps not surprisingly given the lack of a consistent definition, codependence also had a noteworthy lack of a consistent theoretical framework for clinical application. Many researchers explored codependence in a variety of theoretical frameworks and produced outcomes, however since their operational definitions were not in agreement, it was readily apparent why outcomes across the field for codependence lacked congruence or suggested replicated results. Best practices for clinical application could not be

reasonably explored or developed without first having an agreed upon understanding of codependence upon which to build (Bulloch, 2013; Denning, 2010).

Moreover, many of those theoretical frameworks assumed a willingness from addicts to engage in their recovery and did not take into account FMoAs' need for coping skills when the addict was in active addiction. There were ample reports of the experiences of FMoAs during their loved one's active addiction, but little attention to the need for help, and little was understood about the experiences of FMoAs after their loved ones have sought help, to include coping with the experience of relapse should it occur (Brakenhoff & Slesnick, 2015). While addicts often received education about their disease emergence, progression, and the ongoing process of recovery across the lifespan, FMoAs at best received the same education about the addict's disease across the lifespan, and the instructions of how they may or may not directly impact the addict's disease. That models rarely explore assisting the FMoAs when the addict is in a state of illness or conceptualize the FMoAs' need for help across the lifespan, despite the reported parallels observed, was very telling that the FMoAs' wellness was only considered as an after-effect of an addict first seeking to be well and needing family support.

Limited Replicated Empirical Support

It was a matter of ethics to assure that an assessment of a vulnerable person from a licensed professional was empirically supported and accurately identified; otherwise, harm could be caused to that person, either through misdiagnosis or pathologizing otherwise normal behavior (Denning, 2010). It was thus a comfort that efforts continued to empirically investigate the understanding of codependence. Those explorations,

however, did not yet yield outcomes that resulted in a more unified understanding of codependence (Calderwood & Rajesparam, 2014).

The thematic analysis of the eleven most referenced definitions of codependence prompted the development of the Composite Codependency Scale (CCS) (Dear, Roberts, & Lange, 2005; Marks, Blore, Dear, & Hine, 2012), which was found to have good internal consistency in the overall scale as well as the subscales (Marks, Blore, Dear, & Hine, 2012). One strength of the CCS was that it was built upon popularly utilized definitions in everyday language, which suggested generalizable consensus in defining features. Three of the four second order themes were successfully measured by the CCS as well; but that presented another element of confusion, as to why only three themes and not all four were found to be empirically supported through exploratory factor analysis. The authors proposed the plausible possibility that the fourth theme was absorbed by the other three. Those outcomes suggested something within those four themes in the context of codependence was worth further research; however, the findings were not fully consistent with prior thematic analysis, thus lacked the kind of replication that would lend more confidence to construct characteristics. It was also of importance to reflect that though thematic analysis and subsequent exploratory factor analysis utilized commonly cited definitions of codependence from popular literature, those definitions did not emerge from clinicians who were entrusted with professionally identifying impairment resulting from codependence in clients.

By interviewing addiction counselors, efforts were made to explore the clinical use of codependence in clinical addiction settings (Harkness, 2014; Harkness & Cotrell, 1997). Addiction counselors were asked to describe their understanding of codependence

and also asked to rank-order cards of client vignettes to reflect “low”, “medium”, and “high” levels of codependence (Harkness & Cotrell, 1997). The counselors’ descriptions of codependence reflected an assumption of female gender (1997); however, for the clinical assessments of the vignettes, the counselors categorized vignettes by high, medium, and low levels of codependence in a way that was significantly similar, reliable, and stable (1997). The researchers remained neutral on the subject of exploring what the definition of codependence ultimately was, and they suggested that perhaps codependence was a social construction instead of pathology (Harkness, 2014). They noted that the addiction clinicians interviewed were all able to “describe, operationalize, and assess [codependence] with impressive reliability in clinical practice, and with promising evidence of concurrent, convergent, discriminant, and predictive validity” (2014, pg. 3). This finding is of some comfort, suggesting that within clinical practice there is some consistency in the clinical consideration of codependence as pathology; however, even the consistency in understanding codependence was not necessarily consistent with the many other definitions available within the literature that were empirically explored. Those findings of consistency among clinicians could hold promise as an appropriate beginning to further empirically explore a consistent, clinical understanding of codependence.

Finally, while the CODAT was found to be a reliable and valid tool with replicated results (Ancel & Kabaki, 2009; Hughes-Hammer, Martself, & Zeller, 1998; Ribeyre, 2014), this empirical support needed to be considered within the context of critique of CODAT development. At the time of development in the mid-90s, the CODAT developers conducted a review of primary research published on codependence,

however much of the primary research was only conducted using women (Hughes-Hammer, Martsof, & Zeller, 1998). The researchers acknowledged that the definition of codependence at that time was regularly evolving and that other authors in the field, based on their own clinical experience or research, continued to develop new, unique definitions of codependence (1998); however, the CODAT developers also took the position that research at the time had demonstrated conclusively that codependence was a pervasive problem within the personality (1998), a position that remains disputed. The developers also concluded to design the CODAT for five themes of other focus/ self neglect, low self-worth, hiding the self, medical problems, and family of origin issues based on the literature review, which, they asserted referenced a common core (1998).

Their first sample of 236 for the original 153 item tool was comprised of men and women from outpatient clinics, private practices, inpatient settings, and codependency treatment settings (1998). The second and third samples that took the 153 item tool (for internal consistency and test-retest reliability) were comprised of 32 undergraduate students in psychiatric nursing that took it twice. Internal consistencies of subscales for the second and third administrations ranged between .82-.91 and .83-.91 and the internal consistencies for the first and second times, using Chronbach's alpha, were .97 and .96. The test-retest reliability was analyzed with Pearson's correlation for a total scale of .90, and the test-retest reliability for subscales ranged from .78 to .94 (1998). Finally the 153-item version was administered to 38 professional women (professors, scientists) and 21 women in treatment for codependence for criterion group validity, and the total score for the control group was significantly lower than the codependence group, accounting for 42% of the variance (1998). The CODAT was then reduced to 25 items. The CODAT's

reliability and validity was supported by its translation and administration in the Turkish language to 386 undergraduate students; however only 23 of those 386 participants (4.5%) identified as having family members that struggled with addiction (Ancel & Kabaki, 2009), which was a modest size for a comparison group.

These outcomes were understandably attractive; however, by the developers' own admission, the definition of codependence was still evolving with multiple new perspectives. The symptoms of codependence, including those upon which the CODAT is designed remained under discussion as to whether those symptoms are accurate, generalizable, criteria for identifying codependence (Ribeyre, 2014). If the characteristics employed for the construct of codependence in the tool were not the most appropriate characteristics to define codependence, then the CODAT, while reliable and valid, was not as clinically useful as hoped. Similar arguments about disagreement over appropriate themes to measure to assess codependence were made for the CODAT, Holyoake Codependency Index, the Spann-Fischer Codependency Scale, and the Codependency Questionnaire (Marks, Blore, Dear, & Hine, 2012).

Also worth consideration was how the development of the CODAT didn't explain theoretically why the groups they sampled (psychiatric nursing students, mental health consumers, undergraduate college students, college professors) would contain codependence, and why it was decided to only include women from the groups of psychiatric nursing students and college professors as opposed to continuing to norm the instrument on both genders. While the Turkish sample was very large, only 4.5% (23 students) of participants identified as FMoAs and the sample group might not have been large enough to support construct development (Ancel & Kabaki, 2009). The validity

and reliability of the CODAT could appear to reflect the opinions of other researchers, that the definition of codependence was so broad that it included nearly everyone (96 - 97% of all people) (Wilson-Schaefer, 1986), or simply just didn't exist (Barber 1997). Also of concern for the US version of the CODAT outcomes were the control and codependence groups for criterion validity, which only included women (Hughes-Hammer, Martsof, & Zeller, 1998). The developers did not theoretically explain this decision, neither did they report efforts to minimize gender prejudice in the instrument. That is, the developers did not acknowledge the critique of gender prejudice in codependence for pathologizing female traits that was thoroughly established at the time. It could be argued that the CODAT is gender prejudiced, designed assuming only problems in personalities of females, since reliability and validity was measured only using females at certain stages, seemingly unjustifiably.

Gender Prejudice

One of the more prolific criticisms leveled against codependence was that the myriad of understandings of codependence did not deviate from ultimately resulting in pathologizing socially imposed gender roles for women (Anderson, 1994; Barber, 1997; Calderwood & Rajesparam, 2014; Orford, 2014; Peled & Sacks, 2008; Rotunda & Doman, 2001), evidenced by the literature on codependence that frequently referred exclusively to women or wives (Calderwood & Rajesparam, 2014). Critics argued that society groomed its females to engender characteristics such as caring and care-giving for others and self-sacrificing, and then told those same females that their culturally promoted gender roles were also a state of dysfunction. Some promoted that this dysfunctional feedback loop was itself a source of negative psychological symptoms for

women, because it encouraged women to focus inward on their own failings, which contributed to low self-esteem (Rotunda & Doman, 2001).

For example, relational cultural theory in feminist literature promoted, among other tenets, that women placed value on a sense of connection to family and others (West, 2008). This was a fact proponents of codependence neglected to consider when they insisted on a process of separation, inward reflection, and individualization (Anderson, 1994; Doman & Rotunda, 2001). Instead, proponents of codependence viewed women's attempts to connect with family as a pathologized pattern of excessive care-taking. Others proposed reframing the concept of wives being "addicted" to their dysfunctional relationship, evidenced by excessive care-taking and over-zealous helping, instead as a reflection of the extent of need the addict has during the course of his/her disease progression (Cox, Ketner, & Blow, 2013).

Further, some descriptions of codependence frankly asserted that wives of addicts were at least partially if not fully responsible for the progression of their husband's disease manifestations and that wives suffered from a pathological need for their husbands to remain sick. Accordingly, wives would sabotage their husband's efforts at recovery and thus behaviorally have chosen to live with an addict (Kalashian, 1959; Orford, 2014; Peled & Sacks, 2008). The label alone of "codependence" grew to insinuate a problem in the personality (Orford, 2014), and the label often inferred victimization and carried stigmatization as well (Peled & Sacks, 2008).

When wives of addicts (10 Israeli Jewish women aged 37-55) were interviewed, their responses seemed in theoretical contrast. They expressed feelings of responsibility for their partner's health, as well as efforts to control their partner's drinking and lowered

ability to find self-fulfillment and meaning (Peled & Sacks, 2008), all of which aligned with some alleged characteristics of codependence; however the wives in this instance reported more on their efforts to cope with several losses such as their self-images, social-images, and their ability to find meaning in life, and they focused on the ways they coped with their husband's addictive behavior and the reality of death as a possible outcome for him (Peled & Sacks, 2008). The wives also did not see themselves as having chosen an addict as a partner, but as having had the misfortune of circumstance to have a normal dating experience that could not have predicted marriage to an addict, and therefore focused much of their attention on maintaining their marriage and a sense of normalcy in the home (2008).

When these wives were advised to shift focus from the addict to themselves to improve their general well-being, they instead chose to change focus from the addict to the children (2008). While some argued that was just a shift in object for codependent behavior, Peled and Sacks (2008) proposed the shift of focus to children was a reflection of gender norms, in which self-focus for women could result in feelings of guilt, selfishness, and aggression. By contrast, the self-sacrifice of caring only for the addict was a gesture from wives that could result in an enhanced sense of self-image and social-image by offering care. The action of shifting care from the addict husband to the children for these wives could reflect empowerment, in the sense that the wives sought new meaning in life by preserving self-image and social image and by investing in family relationships that have higher likelihood of healthy interactions, i.e. the children instead of the husband (2008). Of interest as well was that these women were highly aware of their neglect of themselves for the sake of others, which suggested choice and not

pathology (2008). Critics also stated that gender prejudice was why measures of codependence reflect higher levels of codependence in cultures where the gender roles for women were aligned with care-taking (2008).

Potential Risks of Labeling Pathology

Some researchers took the parallels observed between the addict and the FMoA a step further and promoted that the FMoA's codependence caused progression of addiction in the addict, or at the bare minimum that the codependence was at least unhelpful (Denning, 2010). Often the result of thinking that FMoAs' codependence advanced an addict's disease was a perception of blame levied at the FMoA for the role he/she played in the disease manifestation of the addict. Cox, Ketner, and Blow (2013) asserted that therapists who continued to view the non-addicted FMoA as the cause of loved one's addiction could cause further harm to the FMoA who had already suffered many losses. Blaming the FMoA for having a normal and less than perfect reaction to a pathology like addiction resulted in pathologizing the whole family system (Denning, 2010).

Additionally, laying blame for aspects of addiction on the non-addicted FMoA inadvertently placed a sense of responsibility for the addict's recovery with the non-addicted FMoA, and thus removed the focus from the healing the FMoA may be in need of him/herself and imposed an additional source of distress. Finally, the motivations behind FMoAs' coping skills may not have been pathological (Denning, 2010), as evidenced by continued disagreement about the nature of and the existence of codependence. FMoAs' observed coping methods might have instead been efforts to preserve attachment, family, and community in the face of a problem that was disabling,

thus justifying a different perspective than “codependence parallel to addiction” from which to consider the FMoA’s experiences (2010).

Applying Chronic Sorrow to Understanding the FMoA Experience

There appeared to be a gap between the persisting reports of suffering from FMoAs and the complications within the current understandings of codependence. An exploration of a new understanding for the negative experiences of FMoAs therefore seemed justified. The concept of chronic sorrow, a grief state experienced by chronically ill persons and his/her family members was proposed as a potentially helpful expansion to the framework to conceptualize and address negative psychological symptoms of FMoAs. The defining characteristics of chronic sorrow aligned with many reported experiences of FMoAs. The current understanding of addiction as a chronic, progressive, and recurrent brain disease also appeared to be a match for chronic sorrow criteria. The concept of chronic sorrow in caregivers also enjoyed consistency in empirical outcomes that codependence lacked, and though gender differences were identified in some chronic sorrow experiences, chronic sorrow was reported to lack the gender prejudice fostered within codependence.

Theory of Chronic Sorrow

The theory of chronic sorrow came from grief literature and was originally conceived as a framework for understanding the experiences of parents of children with intellectual disabilities (Olshansky, 1962; Vitale & Falco, 2014). Since then it grew in understanding as a normal, distinct grief response when a loss remained present in the life of the griever (Fraley, 1986; Rossheim & McAdams, 2010; Vitale & Falco, 2014), as in the instance of chronic illness that lasted across the lifespan and when the finality of

death was predicted but unknown. The characteristics of chronic sorrow in a caregiver were explained as negative psychological symptoms of grief (Fraley, 1986; Rossheim & McAdams, 2010), depression, and anxiety (Bonner, Hardy, Guill, McLaughlin, Schweitzer, & Carter, 2006; Rossheim & McAdams, 2010), and feelings of loss and guilt (Fraley, 1986) and uncertainty (Bonner, Hardy, Guill, McLaughlin, Schweitzer, & Carter, 2006). The intensity of psychological symptoms varied over time, pervaded the caregiver's life, was episodic as opposed to constant, and was permanent across the lifespan. Chronic sorrow had cyclic recurrence of negative psychological symptoms that increased in intensity at trigger events across the lifespan (Bonner, Hardy, Guill, McLaughlin, Schweitzer, & Carter, 2006; Burke, Hainsworth, Eakes, & Lindgren, 1992; Scornaienchi, 2003; Vitale & Falco, 2014; Whittingham, Wee, Sanders, & Boyd, 2013).

Chronic sorrow was also distinguishable from similar psychological responses such as unresolved grief and depression (Burke, Hainsworth, Eakes, & Lindgren, 1992). Where unresolved grief and depression were recognized as dysfunctional states, abnormal, and disordered by their nature (i.e., pathological), chronic sorrow was recognized as a normal reaction to loss. While chronic sorrow could be recognized through exclusion criteria, it was not a formal diagnosis because the individual continued to live in a functional state despite his/her negative psychological symptoms. Also, as opposed to a constant state of dysfunction as seen in depression and unresolved grief, negative psychological symptoms of chronic sorrow were experienced for the caregiver periodically at triggering, crisis events and at those times focused on the disparity between reality and loss of normality (1992).

Disparity and Uncertainty

Of importance to understanding the perceived intensity of chronic sorrow was the role disparity played in negative psychological symptoms. Disparity was understood to be the difference between the hopes and dreams the caretaker had for the ill loved one and the reality of the ill loved one's condition and impairments. For parents, this was the loss of hope for the most perfect version of their child (Joseph & Harding, 2012), and for any family member, this was the loss of the ideal relationship and normal milestone activities associated with that ideal relationship (Vitale & Falco, 2014). "Disparity" was described by Whittingham, Wee, Sanders, & Boyd (2013) as the difference between desired and current reality due to a loss. Fraley (1986) described disparity as intense longing for the desired life or state of health for the ill loved one, resentment for the circumstances that resulted in a terminally ill loved one, and guilt evoked by the ill loved one, dead or alive.

"Uncertainty" referred to the experience of acute, recurrent fear of possible illness-related consequences, and it was the feeling of uncertainty that was postulated to engender the negative psychological symptoms of anxiety, grief, and fear in chronic sorrow (Bonner, Hardy, Guill, McLaughlin, Schweitzer, & Carter, 2006). While some caregivers attempted to cope by adjusting their desired reality at trigger events, uncertainty could emerge in the interim in anticipation of how much the desired reality would need to be further adjusted at the next trigger event. "Trigger events" were crises that reminded caregivers of the disparity between desired and current reality (Scornaienchi, 2003).

Chronic Sorrow Alignment with Experiences of FMOAs

The experience of FMoAs has been compared to the experience of a family member who is experiencing a terminal illness or similar lifelong disability (Copello, Templeton, & Powell, 2010). While negative psychological impacts were present prior to identifying addiction in the family (Copello, Templeton, & Powell, 2010; Ray, Mertens, & Weisner, 2009), it was often the revelation of addiction that was the starting point for negative psychological symptoms in FMoAs (Sakiyama, de Fatima Rato Padin, Canfield, Laranheira, & Sendin Mitsuhiro, 2015). When FMoAs developed awareness of the loved one's addiction, this was often the beginning of many forms of distress that emerged when the loved one experienced crises. Similarly with chronic sorrow, it was often the diagnosis of terminal illness that was the initial trigger event for an array of negative emotions that resurfaced through the progression of the loved one's illness (Northington, 2000).

Though addicts may have found healing and rebuilt their lives through recovery, addicts and FMoAs alike remained aware that relapse could happen for the recovering loved one at any time, and that awareness elicited feelings of anxiety, depression, and grief. Similar findings were identified in caregivers of children with sickle cell disease and parents of diabetic children (Northington, 2000; Scornaienchi, 2003). Despite children being periodically in a relative state of stable health, parents often experienced incredible stress in between events due to the unpredictable nature of their children's illnesses and the potential for complications inherent in their children's condition (Northington, 2000; Scornaienchi, 2003). Similarly, FMoAs experienced stress between the addict's relapses. The similarities of FMoAs' stress in between relapses aligned with the understanding of uncertainty and subsequent anxiety, grief, and fear reported in

between trigger events for other chronic illnesses (Bonner, Hardy, Guill, McLaughlin, Schweitzer, & Carter, 2006).

The disease of addiction was not often associated with the phrase “terminal” in the way that cancer or other illnesses were, though treatment for addiction often referenced the deadly nature of addiction, and recovering addicts frequently reported awareness that without recovery addiction would kill them. Addiction was also observed to be like other chronic illnesses (Gonzales, 2007), with shared characteristics of being progressive, episodic, and on-going across the lifespan.

Empirical Support for Chronic Sorrow

There was a paucity of current research for chronic sorrow (Whittingham, Wee, Sanders, & Boyd, 2013); however, Burke, Hainsworth, Eakes, & Lindgren (1992) previously reported five studies where chronic sorrow was identified in populations of parents, which validated the occurrence of chronic sorrow in parents while it refined and operationalized the concept. In 1986, Hainsworth used a grounded theory approach that elicited experiences of parents of children with multiple sclerosis that matched defining characteristics of chronic sorrow, and in 1990, Eakes identified chronic sorrow in professional hospice caregivers using a multi-subject case study approach (Burke, Hainsworth, Eakes, & Lindgren, 1992). The Burke Measure for Chronic Sorrow, an open-ended semi-structured interview assessment, was designed in 1989 using the defining characteristics of chronic sorrow and the experiences of caregivers, and was found to be reliable and valid as well as appropriate for diverse populations (Burke, Hainsworth, Eakes, & Lingren, 1992; Scornaienchi, 2003).

Chronic sorrow was identified in populations of caregivers for many chronic, progressive illnesses where trigger events occurred in episodes that evoked reflection on growing disparity along the lifespan of the individual. They included autism, infertility, cancer, multiple sclerosis, Alzheimer's disease, senile dementia, Parkinson's disease, amputations (Burke, Hainsworth, Eakes, & Lindgren, 1992), lissencephaly, chronically ill or disabled children, (Scornaienchi, 2003), cerebral palsy, epilepsy, neural tube deficits (Whittingham, Wee, Sanders, & Boyd, 2013), premature children (Fraley, 1986; Scornaienchi, 2003), and sickle cell disease (Northington, 2000; Scornaienchi, 2003). Chronic sorrow was also identified in families affected by diabetes as a response to the ongoing, strict regimen and lifestyle changes required to effectively manage the loved one's diabetes, as well as a response to fear of future complications (Scornaienchi, 2003). Additionally, chronic sorrow, unlike codependence, had clearly defined characteristics that also afforded it the luxury of being identified by the presence of characteristics and exclusion criteria (Burke, Hainsworth, Eakes, & Lingren, 1992).

Finally, chronic sorrow appeared relatively free of gender prejudice and instead revealed outcomes that organize around gender, such as the differences between the ways fathers and mothers responded emotionally to news of their children's illness, differences between the ways fathers and mothers responded to trigger events across the child's life span, and differences in the kinds of trigger events that mothers and fathers tended to experience chronic sorrow around (Scornaienchi, 2003).

Taking into account the gaps that existed in the construct of codependence and the need for appropriate help in a widespread population like FMoAs, an investigation into a better established framework for understanding presented as justified. Based on a review

of the literature, chronic sorrow appeared to theoretically align with many defining experiences of FMoAs. Chronic sorrow also enjoyed modest but consistent empirical support and appeared theoretically free of gender prejudice. An investigation into the potential for chronic sorrow as a more viable and more clinically useful theoretical framework for understanding was undertaken.

CHAPTER THREE - METHOD

Introduction

Chapter Three described the research design and methodology of the study. A description of the population and sample studied, data gathering procedures, instrumentation, research hypothesis, and process of data analysis was provided.

Participants

The population sampled for this project was composed of PoAs in the United States. PoAs were known to sometimes be sources of disproportionate support for addicts, and therefore experienced profound effects from a partner's addiction. A sample of divorced individuals in the United States was targeted for comparison with PoAs. While divorced individuals also have experienced loss, it was a loss with a finite end and potentially fewer trigger events that decreased in intensity over time, and therefore a loss that was theoretically different from an ongoing loss with no known end and trigger events that increased in intensity over time. Addicted and divorced adults over the age of 18, and all races, genders, socio-economic status levels, and geographic regions of the United States were eligible to participate in this study. Criteria for inclusion in the sample was that individuals identified as a: (a) PoA, to include a spouse, a registered domestic partner, or a long-term committed partner with no prior history of divorce, or as a (b) divorced individual, including currently divorced, divorced and remarried, or separated individuals with no prior history of addiction. PoAs for all chemical substances, excluding nicotine and caffeine, were eligible participants for this study.

Instruments

The instruments used in this study included a screening form and demographic questionnaire, the revised Kendall Chronic Sorrow Instrument (KCSI-R) (Kendall, 2005), and the Composite Codependency Scale (CCS) (Marks, Blore, Hine, & Dear, 2012).

Screening Form and Demographic Questionnaire

Screening Form. A screening form (Appendix A) was uploaded to Qualtrics, an online survey software tool that collected, coded, and saved data in a format compatible with statistical analysis software programs. The screening form was used to determine eligibility for participation in this study by asking potential participants if they identified as a partner of an addict or as an individual whose divorce has been final for more than one year. Individuals who answered “no” to both questions were not eligible to participate in this study. For clarity, the language of “addict or alcoholic” was used instead of “addict,” since society at large often (erroneously) equated the term “addict” with illegal or prescription drug abuse to the exclusion of alcohol abuse and dependence. When PoA volunteers also identified as divorced, they were also not eligible to participate, and neither were divorced volunteers who identified as PoAs. This was to assure group independence; that is, both groups needed to be non-inclusive of the other. If participants did not identify as either a partner of an addict or alcoholic or as a divorced individual as defined on the screening form, they were informed that they were ineligible to participate and thanked for their willingness.

Demographic Questionnaire. The demographic questionnaire (Appendix A) asked the participants to identify their gender, race, and age. PoAs were asked how long they had been in the relationship with their addicted partner, if their addicted partner was

in recovery, and if their partner is in recovery how long he/she had been in recovery. Divorced individuals were asked how long ago they divorced and if they had since remarried. The operational definition of “partner” was stated as: married, registered domestic partner, long-term romantic cohabitation, and long-term committed romantic relationship in excess of three consecutive months. Finally, the demographic questionnaire asked participants for the age, race, and gender of their addicted or divorced partner.

Revised Kendall Chronic Sorrow Instrument

The revised Kendall Chronic Sorrow Instrument (KCSI-R) (Appendix B) is an 18-item self-report and single factor instrument that measured the phenomenon of chronic sorrow. Permission to use the KCSI-R was obtained from the instrument’s author in writing. This scale aimed to assess an individual’s sense of living with ongoing loss. Each item asked participants to rate their experiences with the loss on a scale of 0 to 6, with response choices including: “Almost Always”, “Frequently”, “Sometimes”, “Not Sure”, “Usually Not”, “Infrequently”, and “Almost Never”. Collectively, the items were congruent with the following attributes of chronic sorrow: intermittent feelings of sadness, feelings of aloneness, feeling that one’s situation is unfair, and an experiential component of disparity between anticipated versus actual life. No modifications were made to this instrument. The KCSI-R was introduced by a paragraph that operationally defined the item language of “The Loss” to be understood as “my partner’s addiction” or “my divorce”.

The original KCSI was developed under the premise that chronic sorrow was a process of periodically re-experiencing a loss and adapting to a day to day life, wherein

the loss had not been resolved. The KSCI was constructed using the chronic sorrow characteristics to guide the writing of items. Factor analyses and reliability evaluation were used to finalize the instrument's structure. The process for evaluating the KSCI's validity included content, discriminate, convergent, and construct methods. Content validity was supported by asking six experts in chronic sorrow to affirm that the scale's items were congruent with the theoretical understanding of chronic sorrow. Convergent validity was conducted by comparing chronic sorrow with a measure of depression, which resulted in a moderate level correlation ($r = .68$), and discriminant validation reflected a moderate negative correlation between chronic sorrow and general well-being ($r = -.69$).

A multi-trait, multi-method (MTMM) approach was used to further assess construct and content validation. Participants in the MTMM were all female volunteers over 18 years old, and self-identified as either experiencing a personal health concern or being caregivers of someone with a chronic illness or disability. Heterogeneity within the phenomenon of chronic sorrow was sought by recruiting participants from clinics, university campuses, and community members experiencing a broad array of health conditions including HIV/AIDS, Alzheimer's, multiple sclerosis, disabilities, and autism in order to increase generalizability and external validity. Though a sample of at least 200 participants was typically advised for a pilot study (Kendall, 2005; Nunnally & Bernstein, 1994), difficulty accessing the target population resulted in 145 participants recruited for KCSI pilot. Sub-concepts of the pilot study included intensity and frequency of trigger events (and subsequent experiences of chronic sorrow).

Prior to the deletion of items, Chronbach's alpha internal consistency was reported as .96, reflecting strong reliability. The final revision of the instrument resulted in the most parsimonious version of the KSCI (the KCSI-R) with strong Chronbach's alpha reliability ($r = .91$), and produced a normal distribution of scores. Inter-item correlations ranged from .02 to .69, indicating low potential for redundancy of items, and item-scale correlations varied from .42 to .79.

Some correlations noted in the process of revising the KSCI indicated that the length of time since the beginning of the loss and the present could indicate greater symptoms of depression and lower senses of general well-being. Raw scores on the instrument ranged from 0 to 38, "No Chronic Sorrow present"; 39 to 82, "Likely Chronic Sorrow Present"; and 83 and above, "Chronic Sorrow present". The majority of participants in the norming sample scored between 39 and 82, and also scored low on the measure for depression. Those scores lent support to the theoretical distinction and exclusion criteria between chronic sorrow and depression. The scores also lent support to the assertion that adaptive well-being is accomplished between trigger events. Specifically, individuals who scored 83 or higher on the KSCI likely needed help adapting to new trigger events to cope with their ongoing loss (Kendall, 2005).

The Composite Codependency Scale

The Composite Codependency Scale (CCS) was a 19 item self-report, three factor instrument that measured codependent traits (Marks, Blore, Hine, & Dear, 2012). Permission to use the CCS was obtained from the authors in writing. The CCS was developed using the four themes that emerged from a thematic analysis of the 11 most cited definitions of codependence: emotional suppression, self-sacrifice, interpersonal

control, and external focusing. Twenty-eight items were selected for the four themes from appropriate subscales on existing codependence scales in the field: The Holyoke Codependency Index, the Spann-Fischer Codependency Scale, CODAT, and the Codependent Questionnaire. A random sample of 301 participants was compared to a group of 49 active Codependence Anonymous (CoDA) members. Exploratory factor analysis revealed that the external focus theme had been absorbed by the interpersonal control factor. Consequently, though four themes were included, only the three factors of interpersonal control, emotional suppression, and self-sacrifice ultimately emerged, and 19 items were left remaining. Discriminant validity for the scale was supported using descriptive statistics and independent *t*-tests, which after Bonferroni's adjustment reflected that CoDA members scored significantly higher than the general population on the CCS. The CCS was administered along with assessments for depression, anxiety, family dysfunction, stress, narcissism, self-esteem, and emotional expressivity. CCS scores revealed significant shared variance (12% to 40%): Higher codependency scores were associated with greater anxiety, stress, depression, family dysfunction, and were also associated with lower self-esteem, lower narcissistic tendencies, and less emotional expressivity, all of which are consistent with the theoretical understanding of codependence. The total CCS scale produced moderate internal consistency for its various subscales: Self-sacrifice ($\alpha = .77$), interpersonal control ($\alpha = .80$), and emotional suppression ($\alpha = .83$). Test-retest reliability of the CCS was not conducted and is cited in the test manual as a subject of future research. As a result, it was unknown how stable the construct of codependence was.

Procedure

A request to the university's Institutional Review Board (IRB) for the following procedure was submitted via an electronic request process prior to beginning data collection. Once IRB approval was received, the instruments (screening form, demographics questionnaire, KCSI-R, and CCS) were uploaded and launched by Qualtrics, a web-based survey software program. Online distribution of the instruments was administered. Qualtrics randomizer was used, so instruments were administered in the following alternating orders to avoid order effects: 1) Screening Form, Demographic Questionnaire, KCSI-R, & CCS; and 2) Screening Form, Demographic Questionnaire, CCS, & KCSI-R. Purposive sampling of the aforementioned population and subsequent snowball sampling were used to gather data on participants for each target group—PoAs and divorcees. Gender was also targeted, seeking both male and female participants for comparison. The target number for each sub-group had been a minimum of 30 participants; however male divorcees and male PoAs were difficult to recruit. The project was moved forward with 38 female divorcees, 66 female PoAs, 28 male divorcees, and 27 male PoAs, which resulted in a total of 159 total participants. Participants were recruited through professional listservs (e.g., ASERVIC, ASGW, IOOAC, CESNET, Craigslist), online social networking media platforms, (e.g., Facebook, LinkedIn) and nominations by friends, family, and colleagues. In addition, all friends, family, and colleagues and listserv members were asked to share the link to the survey instruments with their friends, family, and colleagues.

Employees at partial hospitalization facilities for rehabilitation of addicts were invited to participate in the study through inter-office email, through a shared link to the informed consent form and instruments, and through paper copies. Employees who did

not regularly use computers as part of their job duties were invited to fill out a paper copy of the instruments. One facility also agreed to distribute the link via the alumni listserv. These participants were also asked to consider sharing the survey to achieve a snowball sample. Data collected by paper copies were manually input by the researcher into the final SPSS spreadsheet of raw data downloaded from Qualtrics.

Organizations such as Al-Anon and Nar-Anon were not approached out of respect for their traditions. These organizations historically did not participate in research because they viewed research as “outside business”; that is, as a practice that distracted FMoAs from focusing on recovery from codependence. For participants who identified as members of Al-Anon or Nar-Anon, a statement was added at the beginning of the assessment affirming that their participation in this study was on the basis of their independent choice and not within the context of their community membership and involvement. In addition, demographic information about those individuals’ involvement in 12-step communities was not requested, again out of respect for those communities’ traditions of anonymity.

Data were statistically analyzed after a sufficient number of eligible persons for each group (PoAs, divorcees, males, and females) participated. Data collected through Qualtrics was analyzed using SPSS statistical software for descriptive statistics as well as for purposes of comparison between target groups’ responses on the KCSI-R and CCS. Results from this study were promised to Dr. Linda Baxter, author of the KCSI-R, as well as Dr. Tony Marks, lead author for CCS, in appreciation for their permission to use their instruments in this study.

Hypotheses and Proposed Analyses

Hypothesis One (H1a-H1b)

H1a. Correlations between codependence and chronic sorrow will be moderate (i.e., $> .50$) for both groups. That is, chronic sorrow and codependence are anticipated to be found in both PoAs and divorcees.

H1b. The PoAs' correlation between codependence and chronic sorrow will be significantly greater than the magnitude of the correlation for the divorced group. That is, while chronic sorrow and codependence are anticipated in both groups, the relationship between chronic sorrow and codependence in PoAs is anticipated to be higher than in the divorced group.

Hypothesis Two (H2a-H2b)

H2a. Codependence will be significantly higher in the PoAs group than among the divorced group (significant ANOVA main effect). Also, females in both groups will score higher than males on codependence (gender main effect).

H2b. Chronic sorrow will be significantly higher in the PoAs group than the divorced group (significant ANOVA main effect). Also, female and male scores for chronic sorrow will not differ (non-significant ANOVA main effect). No significant interaction between group and gender is anticipated.

H3a. On the KCSI-R, the PoAs' mean score will be significantly greater than the population mean for males. That is, the chronic sorrow scores for male PoAs will be significantly greater than the average score for individuals experiencing ongoing loss on the KCSI-R.

H3b. On the KCSI-R, PoAs' mean score will be significantly greater than the population mean for females. That is, the chronic sorrow scores for female PoAs will be

significantly greater than the average score for individuals experiencing ongoing loss on the KCSI-R.

H3c. On KCSI-R, the divorced mean score will be equal to the population mean for males. That is, the chronic sorrow score for divorced males is anticipated to equal the average score for individuals experiencing ongoing loss on the KCSI-R.

H3d. On KCSI-R, the divorced mean score will be equal to the population mean for females. That is, the chronic sorrow score for divorced females is anticipated to equal the average score for individuals experiencing ongoing loss on the KCSI-R.

H3e. On CSS, the PoAs' mean score will be equal to the population mean for males. That is, the codependence score for male PoAs is anticipated to equal the average score for individuals experiencing codependence on the CCS.

H3f. On CSS, the PoAs' mean score will be greater than the population mean for females. That is, the codependence score for female PoAs is anticipated to be greater the average score for individuals experiencing codependence on the CCS.

H3g. On CSS, the divorced mean score will be less than the population mean for males. That is, the codependence score for divorced males is anticipated to be less than the average score for individuals experiencing codependence on the CCS.

H3h. On CSS, the divorced mean score will be equal to the population mean for females. That is, the codependence score for divorced females is anticipated to be equal to the average score for individuals experiencing codependence on the CCS.

Sample

The number of participants in this sample was 268, and 109 were screened out as ineligible leaving a final sample size of 159. Within this sample, 27 identified as male

PoAs, 66 identified as female PoAs, 28 identified as male divorcees, and 38 identified as female divorcees.

CHAPTER FOUR—RESULTS

The following chapter describes the analyses run to statistically examine the aforementioned hypotheses and the subsequent output. Prior to execution, the reliabilities for each instrument were determined to be strong (KCSI-R, $\alpha = .93$; CCS, $\alpha = .85$). Reliabilities of this magnitude were generally accepted as appropriate for instruments used for research and diagnostic applications (Wasserman & Bracken, 2013). It should be noted that the reliability for the CCS prior to reverse-scoring was $\alpha = .89$; however, the author of the scale advocated use of the instrument without reverse-scoring select items.

Analyses

Pearson correlations were used to explore the relationships between the two dependent variables, codependence and chronic sorrow, among the two groups studied (i.e., divorcees and PoAs), and a Fischer Z test was used to explore the magnitude of the differences between correlations across groups. Two-way ANOVAs were employed to investigate the relationships between each dependent variable and independent variables of gender and group classification. Follow up independent sample *t*-tests were run on significant interactions to further examine the nuances of the relationships between each dependent variable and independent variables of gender and group classification. Finally, a series of one-sample *t*-tests were executed to compare population means from each instrument with sample means for codependence and chronic sorrow by gender and group.

Descriptive Statistics

Table 4.1 presents the means and standard deviations for the measures of chronic sorrow and codependence for males and females in the PoA and divorced samples. Each measure met criteria for a normal distribution (i.e., non-significant skewness or kurtosis), except females in the PoA group for the codependence measure, which evidenced a significant negative skewness (skewness = $-.76$; std. error of skewness = $.29$). All groups met the assumptions of homogeneity of variance, given non-significant Levene's tests conducted as part of t -tests and ANOVAs.

<u>Gender and Group</u>		<u>CCS</u>		<u>KCSI-R</u>		
		<u>Sample Size</u>	<u>\bar{x}</u>	<u>SD</u>	<u>Sample Size</u>	<u>\bar{x}</u>
<u>Male</u>						
<u>PoA</u>	(n = 25)	50.12	12.89	(n = 25)	54.96	22.7
<u>Div</u>	(n = 28)	54.61	8.79	(n = 27)	55.81	20.86
<u>Female</u>						
<u>PoA</u>	(n = 69)	58.49	9.71	(n = 67)	78.7	22.32
<u>Div</u>	(n = 38)	52.97	10.6	(n = 37)	58.65	21.37

Hypothesis Testing

Hypothesis H1a stated that chronic sorrow and codependence would be correlated in the positive direction and to a moderate degree in both the PoAs and divorcee samples, and that the correlation would approximate ($r > .50$). Using Pearson Product Moment correlations, PoAs were found to have a significant positive correlation in the moderate range as hypothesized [$r_{(84)} = .59$; $R^2 = .35$], and divorcees also evidenced a moderate level correlation that approximated the $.50$ criterion, with a correlation between the two

variables of [$r_{(61)} = -.46$; $R^2 = .21$]. Consistent with what was anticipated, as chronic sorrow for this sample increased, codependence also increased.

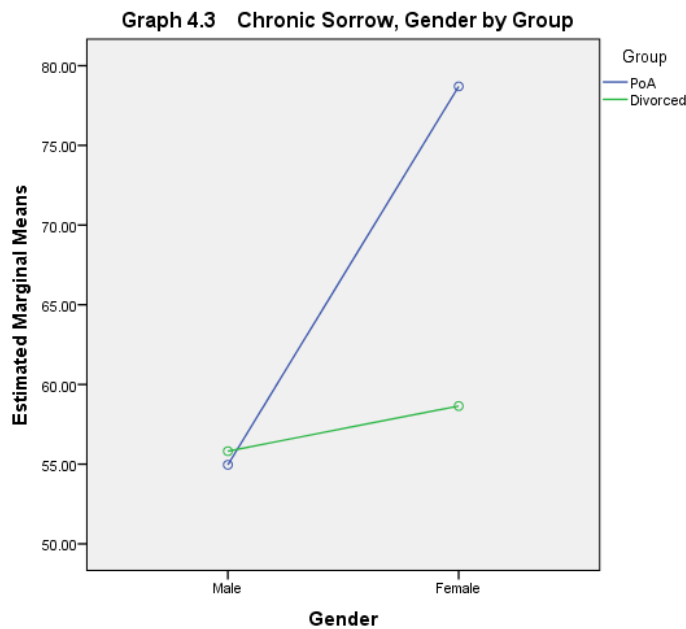
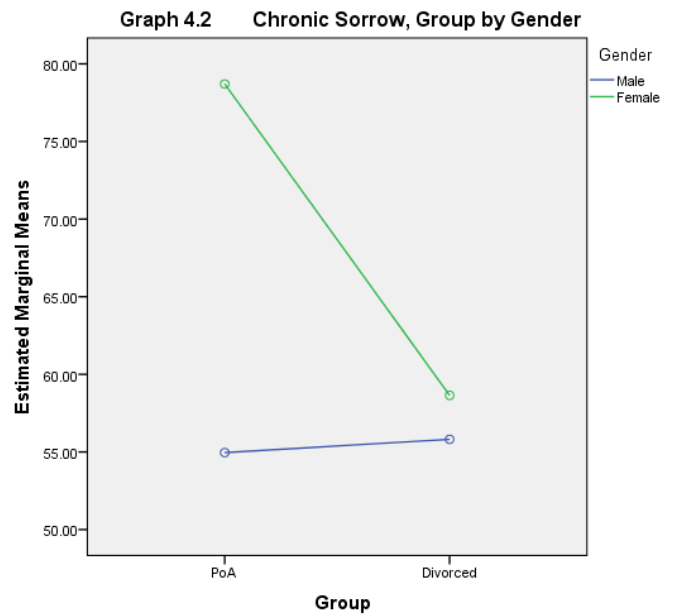
Hypothesis H1b stated that the magnitude of the correlation between chronic sorrow and codependence in PoAs was anticipated to be higher than the magnitude of that correlation for the divorced group. A Fischer Z test was conducted between the magnitude of the PoA and divorcee correlations, which produced an outcome of $Z = 1.07$, $p > .05$. Contrary to what was hypothesized, no significant difference was found between the magnitude of the correlations for PoAs and divorcees between chronic sorrow and codependence. In other words, chronic sorrow and codependence did not correlate significantly higher among the PoAs than among the divorcees as hypothesized.

Hypothesis H2a stated that codependence would be significantly higher in the PoA group than among the divorced group, and that females in both groups would score higher than males in both groups on codependence. A two-way ANOVA was conducted using the codependence total test score as the dependent variable, and gender and group membership (i.e., PoA and divorcees) as independent variables. The ANOVA run for this hypothesis resulted in a non-significant Levene's test [$F_{(3, 156)} = 1.58$, ns]; therefore the assumption of equal variances was met. Neither gender nor group factors produced significant main effects [Gender, $F_{(1, 156)} = 3.65$, ns; Group, $F_{(1, 156)} = .09$, ns]; however, the two-way gender by group interaction was significant, indicating a disordinal interaction, ie, one kind of effect on one condition and a different effect on another condition [$F_{(1, 156)} = 8.05$, $p \leq .05$]. Follow up analyses on the significant interaction, using independent sample *t*-tests revealed that all groups met the assumptions of homogeneity of variance. The mean codependence scores for males in this sample were

not significant [$t_{(51)} = -1.49$, ns]. The mean codependence scores for females, however, were significant [$t_{(105)} = 2.72$, $p \leq .05$]. Additionally, the codependence scores for the divorced group were non-significant [$t_{(64)} = .66$, ns] but the codependence scores for PoAs were identified as significant [$t_{(92)} = -3.37$, $p \leq .05$]. Thus, the subgroup of interest that emerged was the female PoAs, where significance of gender and experience of being a PoA overlapped.

Hypothesis H2b stated that chronic sorrow would be significantly greater among the PoA group than among the divorced group, that male and female scores for chronic sorrow would not differ, and that no significant interaction between group and gender was anticipated. A two-way ANOVA was conducted using the chronic sorrow total test score as the dependent variable, and gender (male and female) and group (PoA and divorcees) as independent variables (i.e., factors). The ANOVA run for this hypotheses resulted in a non-significant Levene's test [$F_{(3, 152)} = .17$, ns], and therefore the assumption of equal variances was met. While gender and group factors did independently produce significant main effects [Gender, $F_{(1, 152)} = 12.36$, $p \leq .05$; Group, $F_{(1, 152)} = 6.45$, $p \leq .05$], those outcomes were disregarded because the two-way gender by group interaction was significant [Gender by Group, $F_{(1, 152)} = 7.65$, $p \leq .05$], and therefore superseded the significance of both main effects. Follow up analyses on the significant interaction using independent sample t -tests were run, and all groups were found to have met the assumptions of homogeneity of variance. Chronic sorrow scores among all males were non-significant [$t_{(50)} = -.14$, ns]; chronic sorrow scores among all females, however, were significantly high [$t_{(102)} = 4.45$, $p \leq .05$]. Also, all PoAs were found to score significantly low for chronic sorrow [$t_{(90)} = -4.52$, $p \leq .05$], and all

divorcee scores for chronic sorrow were non-significant [$t_{(62)} = -.53, ns$]; however, Graphs 4.2 and 4.3 demonstrate that PoA scores by gender were significantly different. Similarly to H2a, the gender-by-group interaction of significant interest that emerged was that of female PoAs who scored significantly higher as a subgroup than the remaining three subgroups.



Hypothesis H3a stated that the mean chronic sorrow scores for male PoAs would be significantly greater than the KCSI-R population mean (62.08). The male PoA sample ($M = 54.96$, $SD = 22.70$) scored an average of 7.12 points lower than the norming population of females, which was not statistically significant [*One sample t* ($_{24}$) = -1.57, ns]. Thus, contrary to what was hypothesized, the mean male PoA score for this sample did not differ significantly from the KCSI-R population mean.

Hypothesis H3b stated that the mean chronic sorrow score for female PoAs would be significantly greater than the KCSI-R population mean (62.08). The female PoA sample ($M = 78.70$, $SD = 22.32$) scored an average of 16.62 points above the norming population of females, which was significantly greater than the KCSI-R population mean [*One sample t* ($_{66}$) = 6.10, $p \leq .01$]. This supported the hypothesis that the mean female PoA score was significantly greater than the KCSI-R population mean.

Hypothesis H3c stated that the mean chronic sorrow score for male divorcees in this sample would be equal to the KCSI-R population mean (62.08). The male divorcee sample ($M = 55.81$, $SD = 20.86$) scored an average of 6.27 points below the norming population of females, which did not differ significantly from the KCSI-R population mean [*One sample t* ($_{26}$) = -1.56, ns]. This was consistent with the hypothesis that the mean male divorcee scores would equal the KCSI-R population mean.

Hypothesis H3d stated that the mean chronic sorrow score for female divorcees would equal the KCSI-R population mean (62.08). The female divorcee sample ($M = 58.65$, $SD = 21.37$) scored an average of 3.43 points below the norming population of females, which did not differ significantly from the KCSI-R population mean [*One*

sample t (36) = -.98, ns]. This was consistent with the hypothesis that the mean female divorcee scores would equal the KCSI-R population mean.

Hypothesis H3e stated that the mean codependence score for male PoAs would equal the CCS population mean (58.9), which was calculated from the item mean score reported (Marks, Blore, Dear, Hine, 2009). The male PoA sample (M = 50.12, SD = 12.89) scored an average of 8.78 points below the norming population, which differed significantly from CCS population mean [*One sample t* (24) = -3.40, $p \leq .01$]. Contrary to what was hypothesized, the male PoAs mean score was significantly below the CCS population mean.

Hypothesis H3f stated that the mean codependence score for female PoAs would be greater than the CCS population mean (58.9). The female PoA sample (M = 58.5, SD = 9.71) scored an average of .41 points below the norming population [*One sample t* (68) = -.35, ns]. Contrary to what was hypothesized, female PoAs' mean score in this case was equivalent to the CCS population mean.

Hypothesis H3g stated that the codependence score for female divorcees would be greater than the CCS population mean (58.9). The female divorcee sample (M = 52.97, SD = 10.60) scored an average of 5.93 points below the norming population of females [*One sample t* (37) = -3.45, $p \leq .01$]. Contrary to what was hypothesized, the mean female divorcee CCS was significantly below the CCS population mean.

Hypothesis H3h stated that the mean codependence score for male divorcees would be less than the CCS population mean (58.9). The male divorcee sample (M = 54.61, SD = 8.79) scored an average of 4.29 points below the norming population [*One sample t* (27) = -2.59, ns]. While the average male divorcee scored an average of 4.29

points below the norming population, contrary to what was hypothesized, the average lower mean male divorcee CCS score was not significantly below the CCS population mean.

After completing all proposed and follow up analyses, some hypotheses were supported, and others were not. As anticipated for this sample, chronic sorrow increased as codependence increased; female PoAs scored significantly greater than the population mean for chronic sorrow; and male and female divorcee scores were equal to the population mean for chronic sorrow. Contrary to expectation, however, chronic sorrow and codependence did not correlate significantly higher among the PoAs than among the divorcees; female PoAs emerged as a subgroup with significantly higher codependence and chronic sorrow than the other three subgroups; the mean male PoA score for this sample did not differ significantly from the KCSI-R population mean; male PoAs mean score was significantly below the CCS population mean; female PoAs' mean score in this case was equivalent to the CCS population mean; and the average lower mean male divorcee CCS score was not significantly below the CCS population mean. Additionally, the statistical output outlined above, when considered collectively, appeared to indicate trends among certain groupings of variables. The clinical application and significance of those findings is explored in greater detail in Chapter Five.

CHAPTER FIVE—DISCUSSION

This chapter examined the potential significance of outcomes from analyses conducted in Chapter Four. Specifically, the chapter examined the utility of the findings and explored possible reasons why some hypothesized relationships were not supported. Emergent themes among the outcomes, as well as the study's limitations and implications for practice and future research were considered.

Analysis of the Findings

Hypothesis H1a, which stated that “chronic sorrow and codependence would be correlated in the positive direction and to a moderate degree in both the PoAs and divorcee samples, and that the correlation would approximate (i.e., $r > .50$)” was supported. While a moderate correlation was not strong enough to presume outright that when chronic sorrow was present, codependence also was present, the presence of both chronic sorrow and codependence within both groups appeared to provide a reasonable possibility. H1a was postulated because the theoretical characteristics of chronic sorrow and codependence appeared to align with some of the experiences of loss and history of dysfunction in FMoAs and divorcees. The significance of this finding may lend support to the clinical utility of chronic sorrow for the understanding and treatment of negative psychological symptoms of FMoAs.

Hypothesis H1b, which stated that “the relationship between chronic sorrow and codependence in PoAs was anticipated to be higher than the magnitude of the correlation for the divorced group” was not supported. Codependence and chronic sorrow were not

significantly higher among the PoAs than among the divorcees as hypothesized. H1b was developed because some of the experiences of FMoAs reported in Chapter Two seemed to differ from the experiences of divorcees in the context of chronic sorrow and codependence. For example, FMoAs reported living with chronic illness with no known end in sight and with crisis events that often increased in intensity and frequency over time, an experience that was congruent with characteristics of chronic sorrow noted in Chapter Two. Divorcees, however, experienced a loss with a finite end and with crisis events that theoretically decreased in intensity and frequency over time, an experience that was less congruent with the notion of chronic sorrow. Additionally, FMoAs were noted in Chapter Two to need to increase the amount of engagement as care-takers in synchronicity with the progression of the addicted member's illness and to need to focus on themselves, whereas divorcees began disengaging from their spouse and became more independent as time went on. The current finding may suggest that the constructs of chronic sorrow and codependence were better aligned with the experience of being divorced than originally hypothesized, and that the divorcee population may not have been an effective choice for examining discriminate validity of codependence and chronic sorrow. Alternatively, the POAs and divorcees examined in this study may not have been as mutually exclusive as hoped. To illustrate, participants who identified as divorcees might have been divorced from an addict without realizing that the illness of addiction had been a factor in their failed relationship, or participants that identified as PoAs may have identified themselves out of an inaccurate suspicion of addiction in their partner. These possibilities warrant consideration in future research.

Hypothesis H2a, which stated that “codependence would be significantly higher in the PoA group than among the divorced group, and that females in both groups would score higher than males in both groups on codependence” was partially supported. Codependence was not significantly higher among all PoAs, and all females did not score significantly higher than males on codependence; however, the subgroup of female PoAs matched the proposed criteria of having significantly higher codependence scores, as determined from follow-up independent *t*-tests. H2a was developed because codependence characteristics aligned with descriptions of living with an addict, but not necessarily for divorce. Characteristics such as over-reliance on another person for sense of identity and excessive care-taking of another were not considered to be congruent with divorce. Also, H2a was developed because literature within Chapter Two consistently (though not without critique) referenced codependence as a predominantly female condition. Female PoAs may have scored significantly higher than the remaining three subgroups in this sample on codependence because reports of codependence being a common experience for FMoAs are accurate. Despite the criticism that codependence is gender prejudiced, it may be that codependence may be a female experience as suggested. However, another reason the outcomes may have organized around gender could be that the subgroup of male PoAs in the study were noted during recruitment to have overwhelmingly identified as being in recovery and engaging in a 12-step program. The variable of codependence in the male PoA subgroup may not have been detected by the CCS due to active involvement in treatment and consequent remission. While female PoAs in this sample scored higher on codependence than male PoAs, it might not be appropriate to compare these subgroups directly, because it was not known if female

PoAs in this sample were also engaged in a recovery program. It was also unclear from this sample if male PoAs who were not engaged in some form of support such as a 12-step program might have scored higher on symptoms of codependence. The impact of treatment will be identified as an important area of consideration in future research on this topic.

Hypothesis H2b, which stated “chronic sorrow would be significantly greater among the PoA group than among the divorced group, that male and female scores would not differ, and that no significant interaction between group and gender was anticipated” was not supported. However, there was a significant interaction found between the occurrence of chronic sorrow and the subgroup of female PoAs. Chronic sorrow was described as a loss that resulted from crisis events that increased in frequency and intensity over time—a description which was theoretically divergent from a loss such as a divorce which had a finite end and produced crisis events that typically decreased in intensity and frequency over time. Therefore, H2b was developed with the idea that chronic sorrow would occur with greater intensity under the condition of PoA than of divorce. Additionally, no gender differences related to chronic sorrow were anticipated because, as discussed in Chapter Two, the theory of chronic sorrow had been documented as being relatively free of gender prejudice. Follow up independent *t*-tests revealed that chronic sorrow was significantly greater among the female PoA sub-group than among the remaining three subgroups, similar to H2a. One of the reasons for this outcome may have been positive correlation between chronic sorrow and codependence that was noted in H1a. It could be reasoned that a significant codependence score for female PoAs, as noted in H2a, would be accompanied by significant chronic sorrow for female PoAs.

Similar to the discussion of H2a findings, this outcome may also have occurred because the literature noted in Chapter Two, though criticized for its assertion, may have accurately identified the experience of being a female PoA as qualitatively different from other conditions. Additionally, since many of the male PoAs were in their own recovery program, there could have been a higher likelihood that their partner was also in a recovery program, thus resulting in greater coping skills for crisis events and lower chronic sorrow scores for this sample. It may be that the KCSI-R was sensitive to losses when the participant was currently coping with a crisis event, and that chronic sorrow might not be detected in a PoA when addiction was in remission (i.e., when there are fewer, if any, new crisis events).

Hypothesis H3a, which stated “the mean chronic sorrow score for male PoAs would be significantly greater than the KCSI-R population mean,” was not supported; male PoAs scored similarly to the KCSI-R population mean. H3a was developed because the tenets of chronic sorrow appeared to align theoretically with the reported experiences of FMoAs, and, thus, it stood to reason that male PoAs would report greater than average chronic sorrow scores than the population mean. In view of the unanticipated finding, the hypothesis may have been drafted without amply considering the context for KCSI-R design. The KCSI-R was normed on a population of individuals that had to qualify to participate in the norming process by identifying as currently experiencing any kind of personal loss. It may be that chronic sorrow was not a relevant construct for this population, and that this was a false hypothesis. However, as noted in discussion of H2b above, the study’s failure to support this hypothesis could also be due to the fact that because an overwhelming majority of male PoAs in this sample were actively engaged in

a program of recovery, they already had access to support and coping skills for crisis events as they occurred, such as coping with the disparity between their original hopes and dreams with the current reality and coping with the experience of uncertainty in the future. This is, once again, an area for which continued research is recommended.

Hypothesis H3b, which stated “the mean chronic sorrow score for female PoAs would be significantly greater than the KCSI-R population mean,” was supported. The significance of this anticipated finding is that future efforts to include chronic sorrow into the treatment planning of female PoAs and possibly also female FMoAs may be appropriate and justified. H3b was formulated because the experience of loss as it pertained to living with a person experiencing addiction was theoretically congruent with the unique loss of chronic sorrow; therefore it was assumed that chronic sorrow score for PoAs would be high. H3b was also formulated to specifically examine chronic sorrow along the variable of gender, given that the literature touted chronic sorrow as relatively free from gender prejudice compared to codependence. It was thus hypothesized in H3a and H3b that both male and female PoAs would score similarly to each other and significantly higher than the population mean for KCSI-R due to the reported absence of gender prejudice and the shared condition of being a PoA. The finding that male PoAs scored consistently with the population mean and female PoAs scored significantly higher than the population mean for KCSI-R was unanticipated. This may have been because the KCSI-R was normed on females and was, thus, more sensitive to the experience of chronic sorrow in females. The difference in male and female chronic sorrow scores may also have been because the 12-step programs the male PoAs were involved with had helped them cope with negative psychological symptoms of loss.

Hypothesis H3c, which stated “that the mean chronic sorrow score for male divorcees in this sample would be equal to the KCSI-R population mean,” was supported. H3c was formulated because divorce is not typically a chronic, progressive experience across the lifespan and is, instead, more reflective of an immediate loss. It therefore seemed reasonable that participants would rank their loss of divorce in congruence with the KCSI-R population mean, which was normed on women who had recently experienced a personal loss. H3c was also formulated because the construct of chronic sorrow was not reported to experience gender prejudice, so the experience of loss was anticipated to score within the normal range without the influence of gender. This outcome suggested that, as anticipated, male divorcees had a loss experience that was, *at times*, theoretically congruent with chronic sorrow. Male divorcees at the time of the divorce may have experienced disparity between what was hoped for originally and current reality with measurable frequency. However, divorce is a singular event, and over time the male divorcees’ uncertainty about the future may have resolved as new life patterns were established and the propensity for chronic sorrow subsided.

Hypothesis H3d, which stated “the mean chronic sorrow score for female divorcees would equal the KCSI-R population mean,” was supported. Similar to H3c, H3d was developed based on the assumption that a one-time loss that progresses in severity over time would be successfully measured in a population of divorcees. Also H3d was developed specifically for comparison to H3c on the variable of gender. Since chronic sorrow was reported to be relatively free of gender prejudice compared to codependence, chronic sorrow scores consistent with the population norm would have been anticipated for both divorced men and women, and H3c and H3d appeared to

support this claim in the literature. For this sample, male and female divorcees did not differ from the population mean on the KCSI-R measure for chronic sorrow. This finding lends support to the claim that the construct of chronic sorrow was relatively free of gender prejudice. An absence of gender prejudice may support chronic sorrow's clinical utility over the construct of codependence as well, which was so often accused of gender prejudice.

Lastly, H3c and H3d were developed to act as comparison to H3a and H3b, comparing divorcees by gender to PoAs by gender. Given that the literature in Chapter Two described chronic sorrow as free of gender prejudice and codependence as rife with it, it was anticipated that both male and female divorcees would score relatively equal to one another on the KCSI-R, and that both male and female PoAs would score similar to one another on the KCSI-R as well, thus reflecting no difference between the two groups based on gender. That a gender difference between male and female PoAs was detected but not among male and female divorcees was unexpected. These findings, when considered together, could lend quantitative support to the argument noted in Chapter Two that female PoAs have a qualitatively different experience than male PoAs. The findings could also support the notion that chronic sorrow is relatively free from gender prejudice, and that the KCSI-R merely detected the reported difference in magnitude of experience between male and female PoAs. It was of interest that the subgroup of male PoAs presented an unexpected variable—their involvement in a 12-step process. Whereas the chronic sorrow scores for male and female PoAs differed in this study, it was unclear whether the scores between subgroups would align across gender in the

future if controls were in place for the effect of the unexpected variable of engagement in a 12-step program.

Hypothesis H3e, which stated “the mean codependence score for male PoAs would equal the CCS population mean,” was not supported, and in fact, male PoAs scored significantly below the CCS population mean. H3e was formulated because codependence was identified in Chapter Two literature as the hallmark experience for FMoAs, but predominantly for females. Thus, it seemed appropriate to anticipate that the CCS would detect a score of codependence in male PoAs that was average as opposed to high. As stated previously, the unanticipated variable of 12-step involvement within the subgroup of male PoAs may have mitigated the presence of symptoms of codependence for this sample of male PoAs. However, it could also be that the male PoAs in this sample simply did not experience codependence. H3e was formulated around the arguments in the literature that challenged the notion of codependence as a predominantly female FMoA experience, and the hypothesis would, perhaps, have been more wisely drafted to reflect a *lower* rather than equal level of codependence in male PoAs. It also may have been that H3e detected a gender norm for males who had not been socially groomed to feel a sense of responsibility to care for others the way females in society were socially groomed, or that male PoAs were more likely to negatively judge the addict for what appeared to be poor choices as opposed to female PoAs who might be more likely to consider the addict compassionately. These possibilities are relevant topics for future study.

Hypothesis H3f, which stated “the mean codependence score for female PoAs would be greater than the CCS population mean”, was not supported; female PoAs in this

sample scored nearly equal to the CCS population mean. This hypothesis was generated from the literature examined in Chapter Two that identified female FMoAs as having higher levels of codependence than male FMoAs. H3e and H3f succeeded in demonstrating that female PoAs scored higher than males on codependence; however, the magnitudes to which codependence was identified in each subgroup were not as anticipated. H3e and H3f assumed that codependence scores for female PoAs would be high, and male PoA scores would be moderate. In retrospect, this hypothesis may have been inaccurate. It may have been more reasonable to hypothesize that female PoAs would score nearly equally to the population mean on an instrument that was normed on a population of members for Codependents Anonymous (CoDA), a community support group that utilizes 12-step processes to inform their practices. However, if that hypothesis were to prove true, it would dispute the previously suggested rationale for lower than anticipated codependence and chronic sorrow scores in male PoAs due to their 12-step involvement. Either 12-step involvement reduced negative psychological symptoms or did not; this may be an area worthy of future study.

Hypothesis H3g, which stated “the codependence score for female divorcees would be greater than the CCS population mean,” was not supported. Female divorcees scored significantly below the CCS population mean. H3g was generated as a means of testing the findings cited in Chapter Two that codependence was a predominantly female experience that might unnecessarily pathologize the experience of being female. Thus, codependence was anticipated to be found among female divorcees, by virtue of their gender and having experienced loss through divorce. It was unexpected that female divorcee scores would reflect low to no codependence as they did in this sample. This

outcome could have occurred because claims that codependence are a predominantly female experience are most frequently referenced within the specific context of family addiction. Research has suggested that divorce is more frequently requested by females due to women experiencing lower marital satisfaction than men (Jackson, Miller, Oka, & Henry, 2014). The experience of a divorced female may, thus, differ significantly from the experience of codependence. For example, a female divorcee may focus more on herself than others and may consequently experience higher sense of self-worth and stronger sense of identity. Instead of seeking to control a partner, a female divorcee may let go of the partner and the circumstances of dysfunctional marriage. In future research hypothesis H3g might potentially be revised to reflect the assumption that codependence would not be anticipated in a population of female divorcees.

Hypothesis H3h, which stated “the mean codependence score for male divorcees would be less than the CCS population mean,” was not supported. Male divorcee scores did not differ significantly from the CCS population mean. Similar to H3g, H3h was generated as a means of testing the assertions in the literature that codependence was a predominantly female experience, often observed in the context of FMoAs. Given those assertions, codependence was hypothesized to not be substantially present in male divorcees. Several alternative hypotheses could explain this unanticipated outcome. The outcome may have been due to limited information existing on the nature of divorce and its influence on divorcees based on gender. Divorce was chosen as a comparison group because it was seen to be a one-time loss that was in theoretical contrast to the characteristics of codependence. As noted above, divorce is understood to be requested more often by females. It could have been that the impact of divorce prompted male

divorcees to pay greater attention to the needs of others as a means to avoid future relationship losses. The impact of divorce may also have generated a desire for male divorcees to foster controlled environments in an effort to prevent unwanted outcomes such as partner filing divorce. On the other hand, the unanticipated outcome may have occurred because the experience of codependence is simply not as gender prejudiced as it is accused of being. Additionally, it could be that codependence organizes around gender depending on the circumstance, for example, occurring predominantly among females within the context of addiction, and predominantly among males within the context of divorce. Perhaps male divorcees are more excessive in their focus on care-giving opportunities due to the nature of divorce often resulting in children living with the mother: resultantly, they seek creative ways to be involved with absent family members. Or, perhaps male divorcees lose a sense of personal identity after a divorce which they view as a failure as a man, husband, and/or father. These alternative hypotheses may warrant consideration in future research efforts.

Emergent Themes and Areas of Interest

The previous discussion of hypotheses rationales, outcomes, and possible reasons for the outcomes reflected some noteworthy themes, albeit themes that are noteworthy with caution. While the aim of this study was to determine whether chronic sorrow might be a stronger theoretical lens through which to understand the negative psychological symptoms of FMoAs, it seems that both codependence and chronic sorrow may have application in a clinical setting for FMoAs, depending on the circumstance. This is very exciting, since, as noted in Chapter Two, the negative psychological experiences of FMoAs have previously only been understood through the lens of codependence. As

anticipated, chronic sorrow was successfully detected in both male and female PoAs, thus chronic sorrow holds the potential to be an approach to understanding the experiences of PoAs and possibly also FMoAs that is less influenced by a gender prejudice than codependence. Above all, chronic sorrow holds the potential to be another tool in the tool-belt for clinicians when treating FMoAs.

Another theme observed in the outcomes was that regardless of the dependent variable (chronic sorrow or codependence), male PoAs consistently scored in the range below female PoAs, which was consistent with the common assumption that the negative psychological symptoms for female PoAs were greater in intensity than for male PoAs. This contributed to the current knowledge base by quantitatively indicating that effective clinical interventions for FMoAs might need to be considered within the context of gender. This finding also challenged the strength of the argument that treatment for codependence for female FMoAs was rooted in gender prejudice, given that supposedly gender-neutral chronic sorrow, as well as codependence, evidenced higher in female PoAs than male PoAs.

It is noteworthy that in Chapter Two, some authors argued that codependence may not even exist; whereas, in this study codependence was detected in groups of both female PoAs and male divorcees. Interestingly, the reason for the finding of codependence in two participant groups in this study is uncertain, and may add confusion rather than clarification with regard to the question of codependence's existence. For example, the argument could be made that this finding supported the existence of codependence, by identifying a phenomenon that may be more circumstantial than originally considered. The counter-argument could also be made that this finding further

supported that codependence was such a broadly defined condition that it could include anyone, even unanticipated populations. While the CCS measure was reliable and chosen for its method of development that would support greatest potential for validity, it may or may not measure the phenomenon of codependence.

Of additional interest was the fact that codependence was detected in both male divorcee and female PoA subgroups. It seems that these two subgroups may have shared some traits that would be worthy of future research. Specifically, they were both in the position of being a “bystander” to trauma inflicted by another individual (i.e., the trauma a female PoA experiences from living with an addict, and the trauma a male divorcee experiences from abandonment by the female divorcee). The notion that codependence may be a result of impact from trauma by another lends partial credibility to arguments in the previous literature that promote codependence as a family of origin issue. Perhaps the experience of trauma brought forth by a trusted other is at the core of the experience of codependence. This finding offers potentially valuable insight into furthering the development of the construct of codependence for reliable, clinical use.

That codependence was identified in male divorcees and female PoAs is of further interest, because the presence of codependence in male divorcees contrasted greatly with the literature presented in Chapter Two that conceptualized codependence as a predominantly female experience. Codependence explorations to this point have attempted to be generalizable to a broad population, such as family members of addicts. However, it seems that general categories such as “PoA” or “female” may be too broad, given that it was specific to the interaction between gender and circumstance that codependence was identified. Codependence as a clinical construct may benefit from

researchers and practitioners paying greater attention to commonalities in more specified circumstances which might help identify diagnostic and exclusion criteria more clearly.

Although codependence was organized around female PoAs in this study, it would seem hasty to expand the construct of codependence as being applicable to all female FMoAs. Other family relationships, such as that of sons, daughters, brothers, sisters, mothers, and father of addicts might be worthy of exploration in the context of codependence to further develop clarity of the construct of codependence for clinical utility. For example, it is understandable that codependence in this sample organized around gender, since marital partnership was the dynamic explored. However, it could be that codependence among children of addicts or adult children of addicts would be less apt to organize around gender. Birth order and gender might be worthy areas of future exploration in conjunction with codependence in children of addicts.

Limitations

Themes from this project were considered with caution due to several limitations. Limitations of this research process were primarily in the areas of instrumentation and unintended participant variables. Those limitations are discussed in more detail below.

Instrumentation

One limitation in this study was that the KCSI-R, the only known quantitative instrument for measuring chronic sorrow, was normed using only females. The instrument author's choice to norming the instrument only on females who had suffered a recent loss increased the likelihood of identifying chronic sorrow characteristics; however, it raises questions regarding the instrument's generalizability. Because the

KCSI-R was normed using only female participants, there is the possibility that it might only be sensitive to female expression of chronic sorrow.

Another limitation with instrumentation in this study was that while a reliability estimate was available for the CCS, the validity of the CCS has not yet been determined. The instrument authors stated clearly in publication that the CCS was still under development. Using an instrument that was still under development may not have yielded the most accurate possible outcomes, as the CCS may or may not have been appropriately sensitive to alleged codependence traits at this stage of development.

Sampling

Some variables in the populations from which the samples were drawn were noted as possibly influencing the results acquired in this study--in particular, the possibility of over-representation of mental health professionals as participants and the potential influence of the recovery program that the large majority of male PoAs were noted to be actively engaged in at the time they participated.

Mental Health Professionals. A limitation with regard to the participants of this study may be that by sharing the invitation to participate on multiple counselor listservs and among counselors at community agencies, the data collected may disproportionately reflect the effects of addiction on PoAs and divorcees who are also mental health professionals. As noted in Chapter Two, mental health professionals are reported to have a greater likelihood for codependence than the general population; they are reportedly attracted to the field by a compulsive need to help others as part of their sense of identity. Mental health professionals, due to their training and education, may also have different, more normative attitudes toward addiction or divorce than the general population due to

the nature of their occupation and may, thus, in this study have produced research outcomes that differ from the general population. Additionally, asking friends, family, and colleagues, may also have disproportionately recruited helping professionals, given that the researcher also identified as a mental health professional and may therefore have attracted a network of professional individuals with an increased propensity for codependence.

Male PoAs in Recovery. Results of this study reflected non-significant codependence in male PoAs compared to significant codependence in female PoAs. That was consistent with the literature citing codependence among FMoAs as a largely female experience; however, the subgroup of male PoAs for this project was notably difficult to recruit for participation and ended up being recruited in person-to-person interactions. By virtue of this personal interaction, it was learned that an overwhelming majority of male PoAs who volunteered were also participants in 12-step recovery programs; whereas, it could not be determined whether female PoAs who volunteered shared that 12-step membership commonality. It was possible that since the male PoAs were already engaged in their own 12-step healing process, the CCS may have detected the remission of alleged symptoms of codependence, thus producing lower CCS scores. Although the outcomes of the study included gender differences that are consistent with those noted in Chapter Two, those outcomes need to be considered with caution, as the sample group may have included the variable of 12-step program involvement that could have impacted the presence of codependence in male PoAs.

Future Research Recommendations

Several recommendations for future research are suggested. Further research into the construct of codependence and gender as it relates to other family roles, such as parent, sibling, and child of an addict would be worthwhile to investigate. Future studies could determine if codependence continues to organize consistently around gender for those roles, and to what extent codependence is an appropriate descriptor for their respective experiences in the differing roles. Similar exploration of family roles and gender related to the construct of chronic sorrow is recommended. The experience of codependence in interpersonal dynamics where gender is less likely to be an organizing agent, such as a supervisor/supervisee, mother/daughter, father/son might also be a productive research endeavor. Additionally, the codependence detected in male divorcees may indicate that codependence organizes around gender depending on the specific circumstance. A future clinical outcome study investigating the impact of addressing chronic sorrow in the treatment of PoAs is recommended in order to measure the chronic sorrow construct's clinical utility. Such a study might allow for exploration into general well-being outcomes for PoAs when treatment for chronic sorrow is included in the treatment plan. An investigation into the experience of male divorcees and codependence emerged as an area worthy of future exploration as well. The recommended focus of that research would be on which aspects of the experiences of divorce for males and females do or do not align with the theory of codependence, and why codependence might have been detected in a sample of male divorcees but not in a sample of female divorcees. Finally, the influence of a recovery program on the presence of codependence also may be worthy of future research. Specifically this research should examine samples of males

and females that do and do not participate in recovery programs for comparison on scores for codependence.

Conclusion

The aim of this study was to explore the potential for chronic sorrow to act as a descriptor for the experiences of FMoAs. After a review of current, relevant, and landmark literature, collecting data, and examining the current research findings, further exploration into the clinical utility and application of chronic sorrow in serving FMoAs appears to be justified and is, thus, recommended. The finding of gender differences in intensity of chronic sorrow among PoAs lends support to the literature noted in Chapter Two claiming that female PoAs experience their loved one's addiction differently than male PoAs. Despite the arguments against codependence as pathology, further research into the construct of codependence for clinical utility also appears justified, given that it was so consistently identified in the subgroup of female PoAs. This consistency between many of the largely qualitative research findings presented in Chapter Two and the quantitative outcomes from this study would seem to provide justification for continued inquiry into both the nature of codependence and its relationship to chronic sorrow. Above all, results of this research suggest something very welcome in the field of addictions treatment, which is the possibility that another option, or "tool" (i.e., chronic sorrow) may exist for therapists to use when attempting to understand and assist FMoAs, a neglected population of people in great need of good help.

Appendix A

Screening Form

1 Do you identify as a partner of an addict or alcoholic?

Yes

No

(If “No”, skip to #4)

2 Is your partner in recovery for their addiction or alcoholism?

Yes

No

Sometimes

3 How long have you been in this relationship, in years? (Then skip to #7)

4 Do you identify as a divorced individual?

Yes

No

(If “No”, Thank you for participating. You are not eligible for this study)

5 How long ago was your divorce, in years?

6 Have you remarried since your divorce?

Yes

No

Demographics Questionnaire

7 What is your age?

25 or under

26-40

41-55

56 or older

8 What is your gender?

Male

Female

9 How would you classify yourself?

Arab

Asian/Pacific Islander

Black

Caucasian/White

Hispanic

Indigenous or Aboriginal

Latino

Multiracial

Would rather not say

Other

10 What is your current household income in US dollars?

Under \$10,000

\$10,000-\$19,999

\$20,000-\$29,999

\$30,000-\$39,999

\$40,000-\$49,999

\$50,000-\$74,999

\$75,000-\$99,999

\$100,000-\$150,000

Over \$150,000

11 What is your geographic region?

NorthEast

SouthEast

MidWest

SouthWest

West

12 What is the gender of your addict partner, alcoholic partner, or divorced partner?

Male

Female

13 What is your addict partner, alcoholic partner, or divorced partner's age?

25 or under

26-40

41-55

56 or older

14 How would your addict partner, alcoholic partner, or divorced partner classify themselves?

Arab

Asian/Pacific Islander

Black

Caucasian/White

Hispanic

Indigenous or Aboriginal

Latino

Multiracial

Would rather not say

Other

Appendix B

Kendall Chronic Sorrow Instrument

Please provide responses on a scale of 0-6, “Almost Never” to “Almost Always”

- 1 I think about the loss as if it had just happened.
- 2 I feel saddened when I think of the loss.
- 3 I feel just as sad when I think of the loss as I did when the loss first happened.
- 4 I feel like crying when something reminds me of the loss.
- 5 I feel full of sorrow.
- 6 I feel sadness when I am reminded of the loss.
- 7 I feel saddened by things that other people see as unimportant or minor.
- 8 I feel full of sorrow when I think about what might or could have been if the loss had not happened.
- 9 I feel that the sadness related to the loss comes and goes.
- 10 I feel that I have to give up things in my life because of the loss.
- 11 I feel that I have control over my life situation.
- 12 I feel my life is not the same as I had hoped or dreamed it would be because of the loss.
- 13 I think about what my life might have or could have been when I am reminded of the loss.
- 14 I feel alone during times that I feel sadness related to the loss.
- 15 I feel that I have enough energy to deal with my life.
- 16 The changes in my life because of the loss are unfair.
- 17 I believe that life is unfair.
- 18 I feel older than my age because of the loss.

Appendix C

The Composite Codependency Scale (CCS)

Marks, A. D. G., Blore, R. L., Hine, D.W., & Dear, G. (2012). Development and Validation of a Revised Measure of Codependency. *Australian Journal of Psychology*, 64, 119-127.

Please indicate the extent to which you agree with each of the following statements on a scale of 1 (*strongly disagree*) to 5 (*strongly agree*):

- 1 Because it is selfish, I cannot put my own needs before the needs of others
- 2 I try to control events and people through helplessness, guilt, coercion, threats, advice-giving, manipulation, or domination
- 3 It makes me uncomfortable to share my feelings with others
- 4 It is my responsibility to devote my energies to helping loved ones solve their problems
- 5 What I feel isn't important as long as those I love are okay
- 6 I feel compelled or forced to help people solve their problems (i.e., offering advice)
- 7 I am very open with others about my feelings, no matter what they are
- 8 I keep my feelings to myself and put up a good front
- 9 I push painful thoughts and feelings out of my awareness
- 10 My mood is fairly stable and unaffected by the problems and moods of those close to me
- 11 I try to control events and how other people should behave
- 12 Feelings often build up inside me that I do not express
- 13 I always put the needs of my family before my own needs
- 14 No matter what happens the family always comes first
- 15 I become afraid to let other people be who they are and allow events to happen naturally
- 16 I often put the needs of others ahead of my own
- 17 I feel that without my effort and attention, everything would fall apart
- 18 I live too much by other people's standards
- 19 I keep my emotions under tight control

*#7 and #10 are reverse scored

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