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Prevalence of Codependence in Young Women Seeking Primary Health Care and Associated Risk Factors

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Codependence as a relational problem that often, but not necessarily always, occurs in conjunction with familial alcoholism. Previous research has shown that various etiological factors resulting from recurring stressful circumstances experienced in childhood or adulthood may contribute to this relation. Another factor arises out of the "submission script" that may be assumed by women living within a culture that typically promotes unequal power between women and men. To examine the prevalence of codependence and its predictors, a cross-sectional study was conducted among a population of 845 young women seeking primary health care in Mexico City. Odds ratio prevalence (ORP) was used to estimate the strength of possible association between codependence and exposure to several factors. A prevalence of 25% of codependence was found. Multivariate analysis revealed that women with a submissive cultural script were nearly eight times more likely to develop codependence than those without this programming. Other relevant factors were having a partner with probable alcohol dependence, a father with alcohol problems, physical and sexual mistreatment by a partner, and a history of emotional mistreatment.

Keywords: codependence, transactional analysis, gender, culture

The term "codependence" was originally used to refer to a psychological problem that can occur in individuals who live with an alcoholic (Gómez & Delgado, 2003). Some studies, however, conceptualize codependence as a multidimensional problem influenced by a variety of factors in addition to having an alcoholic in the family (Carson & Baker, 1994; Reyome & Ward, 2007). These include circumstances that are characteristically stressful to children and often prevent the healthy development of personality, thereby encouraging codependence (Fuller & Warner, 2000). Family violence, the early loss of a parent due to death, separation, or abandonment, and the chronic physical or mental illness of a close family member are typical stress factors.

To cope with such losses, children may develop denial as a psychological defense mechanism associated with the compulsive need to imitate adult behavior and assume the behavior of caretakers toward other people, creating the appearance of *premature autonomy* (Viorst, 1987). According to transactional analysis theory, although these defenses enable a person to survive stressful situations in childhood, they remain as fixations of early types of relationships through dissociated ego states in the personality, while arresting "natural" development (Berne, 1961; Schiff et al., 1975). Children do this by adopting survival conclusions known as *early decisions* (Goulding & Goulding, 1979), such as "Hurry up and grow fast in order to help other people solve their problems." These early decisions are transformed into sometimes paradoxical injunctions, like "Don't grow up" or "Grow up fast," "Don't think what you think," "Don't feel what you feel" and "Don't be you." Such internalized *injunctions* (or unconscious beliefs) about what the individual is "supposed" to do can become the basis upon which a personal life script is built (Berne, 1972/1974).

A personal life script is "an unconscious life plan based on a decision taken in childhood, reinforced by the parents, justified by subsequent events, culminating in a chosen alternative" (Berne, 1972/1974, p. 476). The injunctions may enable a person to develop a codependence script acted out in adult life by compulsively repeating the need to become involved in paradoxical affective links (Bowlby, 1979/1986), which in turn involves situations of abuse, rejection, or abandonment, combined with the feeling of "satisfaction" in helping and having been supportive to another (in these cases, abusive) person while simultaneously preserving the affective bond.

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The Problem of Codependence

Codependent persons maintain strong links with their partners, despite the stress, suffering, abuse, and lack of compensation in these relationships. Like substances for addicts, the relationship with their partners becomes "addictive." At one level, the codependent person recognizes that she should abandon the partnership because it is unhealthy, but does not do so because at the same time she denies her problem through some form of self-deception, in which she tends to believe essentially that her happiness depends on changing the other person.

Throughout its evolution, the construct of codependence has created a controversy in the field of clinical work, in addition to being the object of feminist criticism. There is a lack of clinical consensus on the conceptualization of codependence, along with an overgeneralization, oversimplification, and often popularization of the concept (Brown, 1996). Furthermore, feminists have pointed out, among other things, that this concept characterizes female identities as inherently "pathological," based primarily on interpersonal links and relationships (Gilligan, 1982), and indeed makes women as responsible as men for domestic violence (Frank & Golden, 1992).

Summarizing the feminist argument, Cowan and Warren (1994) note that much of the behavior and traits identified as codependent are culturally prescribed to women. Their study found that socially undesirable traits stereotypically associated with females were strongly associated with codependency while positive feminine traits were not. Furthermore, socially undesirable traits were not associated with gender, supporting the idea that codependency is related primarily to traits that are pathological from the standpoint of both genders, that is, traits associated with subservience and subordination.

In this study, we conceptualize codependence as a relational problem; the woman is not viewed as ill, but rather her problem is based on an unconscious script adopted in childhood and based on cultural learning, a script that she is following with her partner. From this perspective, the underlying problem is a cultural one that needs to be addressed in the larger society with men and women educated in behaviors characterizing fair and equal relationships, devoid of power games, where real intimacy can develop through a loving and respectful partnership.

Theoretical Perspectives

In the literature, there are three different theoretical perspectives for dealing with codependence: (1) as an individual psychopathology, expressed as a *personality disorder* (Cermak, 1986); (2) as a problem that arises in the adult children of alcoholics, dealt with from a *family therapy* approach (Brown, 1996; Kritsberg, 1985; Wegscheider & Cruse, 1981); and (3) as a *relationship problem,* resulting from patterns that tend to be adopted in relationships (Noriega, 2004, 2002; Wright & Wright, 1995, 1990, 1991, 1999). Wright and Wright's theory (1995, 1990, 1991, 1999), on which the present study is based, focuses on the characteristics of codependent relationships that usually occur as a relationship pattern rather than in an individual psychopathology or in the characteristics displayed by persons from families with alcohol problems.

The debate to conceptualize the problem of codependency as an individual psychopathology versus a generalized problem threatening all children of alcoholics has created considerable controversy. However, in our view codependency is a relational pattern learned within the family, society, and culture, where two individuals are engaged in an unequal relationship. In other words, codependency does not happen when the woman is alone but when she is involved in an affective relationship that triggers a codependent script.

For purposes of this study, codependence was defined as "a relationship problem, characterized by a strong dependency with a partner with psychological problems, evidenced by emotional dissatisfaction and personal suffering, and where the woman focuses her attention on taking care of the needs of her partner and others while discounting her own. It is associated with a denial mechanism, an incomplete development of identity, emotional repression, and a rescuer orientation toward others" (Noriega, 2002, p. 120).

Scripts in Transactional Analysis

This study was based on the theoretical framework of Transactional Analysis, a theory of personality and human relations that supports the existence of relational patterns known as life scripts (Berne, 1972/1974). These scripts are usually the result of learned behaviors in the families of origin, as in the case of cultural scripts, and are the result of *early decisions* made in childhood, essentially as survival strategies.

Scripts are introjections into the personality through "Parent" and "Child" ego states, and although they occur at different stages of development in childhood, they can be evoked through a specific stimulus in the here and now. An ego state is a system of thoughts, feelings, attitudes, and behaviors. Berne (1961) described three ego state systems: Parent, Adult, and Child. Parent ego states are the introjections of authority figures in childhood. Thus, a person in such ego states may think, feel, and behave like any of her parents or grandparents, or according to particular cultural patterns. Adult ego states are the objective thoughts, feelings, and behaviors in the here and now. Child ego states are emotional fixations from stressful situations in childhood which serve to arrest developmental stages and prevent people from breaking their original symbiosis, which would mean psychologically separating from their parents and creating one's own identity.

A common *early decision,* when violence or losses occur within the family, is to "*grow up fast and help others,*" which implies a role inversion in *natural symbiosis.* This means that the first-born daughter in the family often takes a parental role while the father/mother becomes the child in the relationship, thus developing a *secondary symbiosis.* In codependency, the role determined in childhood becomes part of her script, and is unconsciously repeated in life by trying to rescue a partner with problems. Schiff et al. (1975) explain how this dysfunctional family dynamic serves to maintain the symbiosis while preventing the natural development of the child.

Schiff et al. (1975) created the label "*passivity syndrome*" to describe unresolved symbiosis manifested in life through passive behaviors: *doing nothing*, *overadapting*, *agitation and incapacity*, or *violence.* Passivity syndrome and the four passive behaviors identified in transactional analysis theory provide the theoretical bases of the Codependency Instrument (ICOD; Noriega & Ramos, 2002) created for this study. The ICOD measures four factors: a denial mechanism (*doing nothing*), an incomplete development of

identity (*overadaptation*), emotional repression (*agitation*), and a rescuer's orientation toward others (*incapacity or violence*). These behaviors are called passive because they *discount* the possible solution of the problem on four levels: (1) the existence ("I don't have a problem"), (2) the significance ("I do have a problem, but everything will be fine when he changes"), (3) the solution of the problem ("all men are the same"), and (4) her own capacity to resolve the problem ("I can't live alone").

A woman following a codependence script may be easily triggered to do "whatever" she can to "rescue" a partner who has psychological or physical problems, in a way quite similar to what she began to do in her family of origin, in other words, replaying a relational *secondary symbiosis*. These passive behaviors can lead to psychological games in which scripts are played out (Berne, 1964/1967). This occurs through three different positions: *Rescuer*, *Victim,* and *Persecutor* (Karpman, 1968). The codependent person usually *gets hooked* in a game called "*I'm only trying to help you*," from a *Rescuer* position by trying to change a significant other who really does not want to change, but is playing the game from a *Victim* position. After some time both players change their positions in the game. The codependent moves from *rescuer* first to *persecutor* by pushing the other to change, and then finishes the game as a *victim*, usually feeling abused, hopeless, and depressed. The significant other moves first from victim to persecutor, the point at which violence typically occurs, and then will finish the game as a rescuer, usually "behaving well" while again making a promise to change.

These *transactions* are unconsciously based on a repetitive and desperate power struggle between both parties, while they usually live out an unconscious replay of childhood experiences in present time. The codependent person usually ends up in a powerless position while the significant other retakes his dominant position, making both feel bad and confused about the situation in the end, while replaying the same old *script* again and again.

Cultural Scripts

Since codependence is a pattern of behavior that appears to involve women notably more than men (Roehling, Koelbel, & Rutgers, 1996), it has been pointed out that the effects of traditional cultural teachings favoring different complementary life scripts in men and women (Berne, 1972/1974; Steiner, 1974) are also a compelling factor in its development. As in other scripts, codependence is a combination of personal experiences within the family of origin and the social context in which a person grows up. "Many cultural traditions are passed from one generation to another from parent to child. These traditions often reflect a racial and ethnic heritage. They include expectations on how people of an entire culture 'should' walk, talk, think, feel, act, succeed, and fail. They relate to jobs, marriage, child rearing practices and so on. As every person is born into a particular culture, each script usually reflects this heritage" (James & Savary, 1977). Denton Roberts (1983) explains how cultural scripts create a problem of supremacy: "All cultures promote scripts by virtue of the fact that cultures value certain persons more than others. Therefore, injunctions are implicitly passed on by the culture, through the family. These injunctions cause people to grow up with distorted messages about themselves, and their equality" (p. 253).

In Mexico, for example, women may be culturally "programmed" to adopt a submissive attitude in marriage and to accept an unequal degree of power in their relationships with men, while men on the other hand are brought up to dominate women (Castañeda, 2002). As Medina-Mora (1994) notes, marginalized socioeconomic groups are the ones most affected by the "machismo" and "submission" scripts. Lara (1989, 1990) describes the concepts of "machismo" and "submission" ("suffering woman syndrome") to be considered as complementary for both genders. Submission is related to a Mexican cultural concept known as *Marianism*, a cult of the feminine naturally associated with attitudes of suffering and self-denial which teaches that women are spiritually superior to and stronger than men (Lara & Navarro, 1986, 1987). Furthermore, women learn "through a socializing process in their family that men are the center of attention and must be assisted by their mothers and sisters" (Lara, 1993, p. 10). These attitudes, beliefs, and concurrent behaviors are still being played out and transmitted in women as codependency scripts from one generation to the next (Noriega, 2004).

Research conducted with Mexican and other Latin America women living in the United States found that men are viewed as dominators and women as the caretakers in the family system; the combination of machismo/submission has been considered as a relevant factor for domestic violence (Perilla, Bakeman, & Norris, 1994) and codependence in this cultural group (Gómez & Delgado, 2003).

In summary, codependence in Mexican women cannot be conceptualized as solely an individual problem because of its close association with traditional cultural female roles that emphasize submissiveness. The relationship between partners in a couple apparently continues to be considered essentially asymmetrical with regards to power, in a pattern characterized by greater male authority. Nonetheless, the enforcement of cultural scripts varies across time and place, and the scripts for these power relations vary among couples. Although women have traditionally coped with male domination through submission, they have also questioned it (De Oliveira, 1998).

The Present Study

The objectives of this study were to (1) determine the prevalence of codependence in young women who sought primary health care at a Mexico City Health Center, and (2) assess the contribution of selected risk factors to the probability of codependence.

Based on a review of the literature and clinical experience, the following risk factors were hypothesized to be associated with greater likelihood of codependence: a family history of alcoholism; alcohol abuse or alcohol dependence in one's partner; a family history of mistreatment; mistreatment by one's partner; sources of childhood stress including early affective losses; being the first-born daughter; and the adoption of a cultural negative female script.

Hypotheses

This study tested the following hypotheses:

> *Hypothesis 1:* Women with a family history of alcoholism are more likely to display codependence than women without these antecedents.

Hypothesis 2: Women with a partner who abuses alcohol are more likely to display codependence than women without such antecedents.

Hypothesis 3: Women with a family history of mistreatment are more likely to display codependence than women without this background.

Hypothesis 4: Women mistreated by their partner are more likely to display codependence than women without these antecedents.

Hypothesis 5: Women with early affective losses are more likely to display codependence than other women.

Hypothesis 6: First-born daughters are more likely to display codependence than other women.

Hypothesis 7: Women with negative cultural female scripts are more likely to display codependence than other women.

The theory of Transactional Analysis explains the introjection of the original childhood transactions in the ego states, as a transference relational psychodynamic that will be reproduced later in life in other significant relationships as life scripts. In other words, women with a family history of alcoholism and/or mistreatment are vulnerable to repeat this kind of relational pattern with their partner as part of a codependence script. In a similar way, women who suffered early affective losses may be more vulnerable to denial displaying codependence in their relationships in order to avoid more losses in their life. Women who were first-born daughters are more likely to develop a codependence script mainly by emotional repression and the development of a rescuer orientation toward others displayed through psychological games such as "I'm only trying to help you." As a codependence transgenerational script, this kind of transaction may continue developing from one to the next generation (Noriega, 2004).

Method

Participants

The study sample consisted of 845 women admitted from September to October 2002 to the Dr. José Castro Villagrana Health Center, a primary health care facility located in the southeast of Mexico City, which is open to those in the general population without access to social security services. The population using this facility includes men and women of all ages who request medical and dental consultations and psychotherapy. Patients are of lower to middle socioeconomic status.

Design and Procedure

A cross-sectional epidemiological study was designed. Desired sample size was calculated on the basis of estimating a predetermined prevalence of the population of 10% (through the pilot study), with a 3% accuracy and 95% reliability level and offsetting the design effect by adding 100% women to the initial sample calculation ($N = 415$) (Lwanga & Lemeshow, 1991). The final sample consisted of 845 women who were recruited consecutively in the sample as they came in for general medical care. When one of the patients did not wish to participate, the reason for refusal was noted and the next person in line was interviewed. A total of 33 out of 878 consecutively registered patients chose not to answer the questionnaire. The questionnaires were administered face to face by a team of 10 trained psychologists who asked the questions to each woman who in turn wrote their responses on the survey.

The risk factors examined were classified into the following categories: (i) Family history of alcoholism. Alcoholism present in parents and/or grandparents; (ii) Partner as an alcohol abuser or partner with probable alcohol dependence. Partner who occasionally gets drunk or partner who is probably an alcoholic; (iii) Family history of mistreatment. Physical, emotional, or sexual abuse between members of the family of origin or to which she was subjected as a child; (iv) Abusive partner. Physical, emotional, or sexual mistreatment by the woman's partner; (v) Early affective losses. Childhood history from birth to age 12, which may have included any combination of the following situations: Death or abandonment by one of the parents, divorce or separation of parents, parental neglect, chronic disabling physical or mental illness of a relative with whom there was daily contact; (vi) First-born daughter. Whether the woman was the oldest sibling; (vii) Cultural female scripts. Cultural life patterns that unconsciously determine one's thinking, feeling, and acting in various situations. These are subclassified into two types: femininity scripts (culturally considered as positive) and submission scripts (culturally considered as negative). Before the analysis, all variables were dichotomized to simplify the interpretation of the data.

Measures

The survey included an ICOD that was developed for use in a larger research project on codependence. Other scales from previous studies were also used and specific items were designed to obtain further relevant information.

ICOD (Noriega & Ramos, 2002). The ICOD was created at the first stage of a larger research project for two reasons: (a) other existing codependence scales were based on theoretical perspectives different from the relational codependence perspective of this research; (b) the existing codependence scales were designed for other countries and not standardized in Mexico.

The ICOD is a screening test designed to detect probable cases of codependency in Mexican women. It was created based on the most relevant bibliography, the clinical experience of the first author, and Transactional Analysis theory, and was previously supported by a pilot study. It consists of 30 items with responses ranging from 0 = *none* to 3 = *a lot* (see Appendix 1).

Two steps were carried out for its validation. The first was aimed at analyzing the factor structure and internal consistency of the instrument. It was carried out in a sample of 230 women ranging from 18 to 65 years of age, who had lived with a heterosexual partner for at least one year, and were attending a health center. A survey was carried out in which the ICOD was self-administered after each participant signed an informed prior consent. The second study aimed to determine the capacity of the instrument to discriminate between cases and noncases of codependency and to define a cut off point to differentiate probable cases from noncases. It was completed by a group of 41 women, 20 of whom had come for psychotherapy for the first time, and 21 who had accompanied them. These women were between 18 and

65 years of age and had cohabited for a minimum of one year with a heterosexual partner. All women answered the ICOD on their own and were also evaluated by two therapists according to the same guidelines in order to further assess them as falling within the category of codependency cases or noncases.

In the first step, a factor analysis with varimax rotation was applied which produced four factors with eigenvalues greater than or equal to 1.00. These values explained 50.8% of the total variance. The instrument remained with the 30 original items grouped according to four conceptually congruent dimensions: Denial Mechanism (e.g., "Do you think that trying to solve the problem with your partner would only make things worse?"), $\alpha = 0.87$; Incomplete Development of Identity (e.g., "Do you usually do what your partner wishes instead of what you want?"), $\alpha = 0.78$; Emotional Repression (e.g., "Do you avoid expressing your feelings for fear of being criticized?"), $\alpha = 0.71$; and Rescuer Orientation (e.g., "Do you regularly do things that should be done by other members of your family?"), $\alpha = 0.71$. The test of internal consistency of the instrument showed a Cronbach's alpha of 0.92.

The second step consisted of an evaluation of assessment consistency based on the judgment of experts, that is, according to the level of agreement between the two psychotherapists. The κ statistics of 0.84 demonstrated a significant level of agreement between them. The test on the validity of the external criteria showed a sensitivity of 76% and a specificity of 69%. To determine the score that would identify probable from nonprobable cases of codependency, a cutoff point of ≥ 32 score was established according to the punctuation in the area under the Roc curve.

Additional scales and items used included the following:

1. *Background Questionnaire* that included questions to identify sociodemographic characteristics of informant, as well as questions to identify age, educational attainment, and occupation of spouse/partner.

2. *Antecedents of alcohol consumption* were assessed by the *TWEAK*, a filter instrument of five items that was initially designed to identify risky alcohol consumption among prenatal populations. In various previous studies in Mexico using 3 as the cutoff point, this instrument yielded a range of sensitivity (true positive cases) from 70% to 79%, and specificity (false negative cases) of 75% to 87% (Cherpitel & Borges, 2000).

3. *Adaptations of the following questionnaires:* Background of Alcohol Consumption in Family of Origin (35 items), *Family History of Physical Mistreatment* (12 items), *Family History of Emotional Mistreatment* (3 items), *and Family History of Sexual Mistreatment* (3 items). All the items sought ordinal answers ranging from 0 to 4 and were aimed at investigating these behaviors in parents, siblings, and grandparents. These questionnaires were previously used in a study of sexual violence prevalence and associated problems in a Federal District Health Center in Mexico City (Ramos-Lira, Saltijeral-Méndez, Romero-Mendoza, Caballero-Gutiérrez, & Martínez-Vélez, 2001).

4. *Possible problems with partner.* These were 6 items specially designed for this study to provide information about the participant's perceived relationship with her partner. These questions involved her perception/description of the kind of problem, if any; whether divorce or separation were considered or intended; recognition of a similarity, if any, between her current problems and those of her parents or grandparents; whether psychological support was available to her.

5. *Alcohol Use Disorders Identification Test* to determine the degree of partner's alcohol consumption (De la Fuente & Kershenobich, 1992). This is a three-item questionnaire for testing alcohol abuse in the partner, such as frequency of consumption, number of drinks per occasion, and frequency in having 6 or more drinks per occasion.

6. *National Addictions Survey items.* (Encuesta Nacional de Adicciones, 1998) to determine alcohol dependence or addiction according to the American Psychiatric Association (1994), *Diagnostic and statistical manual of mental disorders* (4th. ed). These are 12 items to identify possible alcohol dependence in the partner, the possible answers being "yes," "no," and "I don't know." These items seek information about difficulties in being able to stop drinking in spite of a desire to quit, as due to emotional or psychological problems, violence, accidents or health problems, or in spite of problems at work, with friends, and in the family derived from level of alcohol consumption.

7. *Questionnaire on Physical Violence (10 items), Emotional Violence (12 items),* and Sexual Violence by Partner (12 items). Designed for a study on domestic violence against women in three sectors of the population in Guadalajara (Ramírez Rodríguez & Patiño Guerra, 1997). The items were meant to assess the presence of different behaviors in the partner of a physical, emotional, or sexual nature, with or without alcohol consumption.

8. *Early affective losses in informant.* These are 13 items designed exclusively for this study to obtain information about death of a parent, parental neglect, separation of parents, abandonment by a parent, chronic disabling physical or mental illness of a close relative.

9. *Informant's place in birth order among siblings.* These are three items specially designed for this study to get information about the number of siblings in the family, to know if the informant was the first-born daughter in the family and her placement in the birth order in relation to the number of siblings.

10. *"Feminine" and "Submission" Scales from the Masculinity and Femininity Inventory (IMAFE)* (Lara-Cantu, 1993). The IMAFE was used in this study to analyze the cultural feminine scripts. This inventory was created based on Bem's Sex Role Inventory (BSRI; Bem, 1974) and other items designed by the author from literature about

Table 1
Sociodemographic Description of Sample (N = *845)*

Continuous variables	*M*	*SE*	Minimum	Maximum
Age	31	6.80	20	47
Years married or living with partner	10.15	6.44	2	30
Number of offspring	2.13	1.12	0	7
Age of husband/partner	34.42	8.39	18	80
Categorical variables	*F*		%	
Marital status				
Married	585		68.2	
Living together	260		31.8	
Able to read and write				
Yes	817		96.8	
No	28		3.2	
Educational attainment				
Did not go to school	21		2.4	
Failed to complete elementary school	87		10.0	
Completed elementary school	145		17.7	
Failed to complete middle school	55		6.3	
Completed middle school	175		21.1	
Failed to complete high school	68		7.7	
Completed high school	75		8.5	
Technical degree	147		18.1	
Bachelor's degree/graduate degree	72		8.2	
Occupation				
Housewife	701		81.2	
Occasionally employed	69		8.9	
Employed	75		9.9	
Monthly household income				
Less than one minimum salary	75		9.4	
One minimum salary	271		31.6	
Two minimum salaries	252		29.4	
Between three and five minimum salaries	192		22.6	
Between six and nine minimum salaries	44		5.8	
Ten or more minimum salaries	11		1.2	
Husband able to read and write				
Yes	831		97.3	
No	14		2.7	
Husband/partner's educational attainment				
Did not go to school	16		1.8	
Failed to complete elementary school	58		7.6	
Completed elementary school	121		14.6	
Failed to complete middle school	62		7.1	
Completed middle school	211		24.2	
Failed to complete high school	85		9.7	
Completed high school	102		12.8	
Technical degree	60		7.4	
Bachelor's degree/graduate degree	130		14.8	
Husband/partner's occupation				
Occasionally employed	335		40.1	
Employed	510		59.9	

Mexican stereotypes for both sexes. This test is used for self-description and for description of expectations, ideals, and gender stereotypes. The IMAFE has four scales: "Masculine," "Feminine," "Machismo," and "Submission." Each scale is composed of 15 items, either positive or negative masculine and feminine features, with answers in a range of seven possibilities from "I'm never or almost never like this" to "I'm always or almost always like this." For this study only the "Feminine" (e.g., affectionate, tender, friendly, comprehensive, sensitive to the needs of others, etc.) and "Submission" (e.g., conformist, passive, shy, don't like to take risks, undecided, etc.) scales were used. The reliability coefficients of the instrument, as applied to different populations of men and women in Mexico, lie within a range of 0.74 to 0.92. It has been used to make various comparisons of the personality features of men and women who come from varying socioeconomic and cultural groups (Lara, 1989, 1990; Lara, Medina-Mora, & Gutiérrez, 1988; Lara & Navarro, 1986, 1987).

Ethical Considerations

The following actions were taken to meet ethical guidelines mandated by the General Health Law Regulations in Health Re-

search. The survey was undertaken with the authorization of the Health Center Director. Each woman signed an informed consent sheet once she had been told about the objective of the survey and the fact that confidentiality and anonymity of the answers would be guaranteed. A commitment was made to the participants by the researchers to submit a written summary of the research results, on request, at the end of the study. The survey was immediately suspended if a participant did not wish to continue. At the end, each participant was given a list of support centers for alcoholism and domestic violence in Mexico City.

Methods of Statistical Analysis

The information extracted from the survey was analyzed through bivariate and multivariate techniques. The ORP was used to estimate the strength of association between the cases of codependence described and each of the exposure factors.

The dependent variable (codependence) and all the independent variables (exposure factors) were dichotomized to carry out univariate and multivariate analyses of unconditional logistical regression, in order to estimate the possibility of codependence, deriving the odds ratio (OR) from the exponential of the regression coefficients. The multivariate models were constructed on the basis of the stepwise (forward) method by Wald statistics.

Results

The descriptive analysis of the sample yielded the following sociodemographic data: means of 31 years of age ($SE = 6.80$), 10.15 ($SE = 6.44$) years of marriage or living with one's partner, 2.13 ($SE = 1.12$) children, and 34.42 ($SE = 8.39$) age of spouse or partner (see Table 1).

A frequency analysis revealed a codependence prevalence rate of 25%. The multivariate models found that for the sociodemographic control variables, women who were able to read and write but did not complete middle school proved to have a 3.7 times greater risk of developing codependence in comparison with women who completed middle school or more. In this analysis, the "educational attainment" variable was associated with a lower probability of codependence (OR = .544) and may operate as a protective factor (see Table 2).

Women with a partner with probable alcohol dependence had a risk 4.7 times higher of displaying codependence than women without this type of partner. Likewise, women who had a father who drank too much (alcohol problems) had a 1.9 times greater risk of developing codependence than women with fathers without this problem. In the case of family history of alcoholism in which the father was the drinking parent (father with alcohol problems), in spite of an OR value of 1.9, the relationship was not statistically significant. The "paternal and maternal grandparents with alcohol problems" variable proved not to reach a level of significance in the multivariate model (see Table 3).

Women whose partners had mistreated them physically presented a 3.6 times greater risk of codependence compared with women without this type of partner. Women who had been sexually mistreated by their partners had a 4.2 times higher risk of displaying codependence than women without this problem. With regard to "family history of emotional mistreatment," the results showed that these women had a 2.3 times higher risk of codependence than women without this background. The "history of physical or sexual mistreatment" variables proved nonsignificant in the multivariate model (see Table 4).

The results obtained through Model 4 (see Table 5) show that women with negative cultural scripts, that is, with submission scripts, were 7.6 times more likely to develop codependence, compared to women who did not introject these scripts. Women with affective losses in childhood were 2.6 times more likely to display codependence compared to women who had not suffered these losses. The "first-born daughter" variable was not statistically significant, and was thus not included in the model.

Table 6 shows the joint effect of the variables of all the models when they are controlled for the effects of others, producing the following changes. The risk of developing codependence in women with a "partner with probable alcohol dependence" fell from 4.7 to 3, while it rose for those with "fathers with alcohol problems" from 1.9 to 2.3. For women who suffered "physical mistreatment by their partners" the risk fell from 3.6 to 2.9, whereas among those who experienced "sexual mistreatment by their partners" it fell from 4.2 to 3.1, and in the cases of "history of emotional mistreatment" it fell from 2.3 to 1.9. As for submission scripts, the risk also fell from 7.6 to 7. In this last model, the variables "affective losses," "literacy in women," and "educational attainment" did not reach significance.

Discussion

These analyses reveal a high prevalence of codependence (25%) among the assessed population, a representative sample of 845 Mexican women (Noriega, 2002); in other words, one in four women seeking primary health care met the criteria for probable cases. The data here confirm the view of codependence as a

Table 2
Model 1: Association Between Sociodemographic Variables and Codependence

	Codependence					
	Unadjusted			Adjusted		
Variables	OR	95% CI	*p*	OR	95% CI	*p*
"Woman's literacy" (failed to complete middle school)	4.691	1.999–11.010	<.0001	3.706	1.363–10.081	<.010
"Woman's educational attainment" (completed middle school or more)	.564	.395–.754	<0001	.544	.352–.838	<.006

Note. OR = odds ratio; CI = confidence interval. Variables tested in model: "marital status," "number of offspring," "woman's literacy," "educational attainment," "occupation," and "partner's educational attainment."

Table 3
Model 2: Association Between Alcohol Variables and Codependence

Hypothesis: Women with a family history of alcoholism and/or a partner who abuses alcohol are more likely to display codependence than women without these antecedents

	Codependence					
	Unadjusted			Adjusted		
Variables	OR	95% CI	*p*	OR	95% CI	*p*
Partner with probable alcohol dependence	4.829	3.238–7.201	<.0001	4.705	2.640–8.385	<.0001
Father with alcohol problems	1.413	1.000–1.998	<.050	1.890	1.128–3.164	<.016

Note. OR = odds ratio; CI = confidence interval. Variables tested in model: "partner who abuses alcohol," "partner with probable alcohol dependence," "father with alcohol problems," and "grandparents with alcohol problems."

widespread social and psychological problem for those women who seek help at the primary care level.

The term codependence has been derived from the observation of a pattern of problem-laden behaviors within a partnership established between two people, one of whom is dependent on a mind-altering substance—in particular alcohol. In contrast, this study demonstrates the application of the concept to other relationships. The critical factor appears to be a relationship based on a bond of suffering and conflict with a person who is physically or emotionally incapacitated and does nothing to solve his or her problem. In such a relationship the codependent person tries to rescue the other, disregarding concerns about one's self in the process while at the same time the other fails to take the necessary steps to heal.

These data support an urgent need for further study of the effects of social and relational phenomena on the psychological development of young women, in particular phenomena that contribute to the etiology of codependence and the public issue of family violence. The findings of this study show that codependence can be predicted by a set of variables: partner factors, childhood factors, and cultural factors related to a submission script.

Partner Factors

Women who reported having a partner with probable alcohol dependence were nearly five times more at risk of being codependent than those whose partners did not have this problem. Alcohol abuse alone, which means the partner becoming occasionally drunk, and not the partner's dependence on alcohol, did not play a significant role.

Women with a partner who mistreated them either sexually or physically were almost four times more at risk of being codependent. Emotional mistreatment by partner proved to be nonsignificant in multivariate analysis, which is congruent with differential vulnerability of a child in comparison with an adult as far as emotional mistreatment is concerned. However, this problem must be examined in greater depth using other techniques, given that qualitative studies on the issue report severe emotional damage in women who have been exposed to prolonged emotional abuse (Chang, 1996).

Childhood Factors

Both clinical and popular literature (Kritsberg, 1985; Woititz, 1983) indicate that having a family history of alcoholism predisposes people to developing codependence. The data obtained in this study coincide with this statement only with reference to a history of the father's alcoholism, in which case the risk is twice as high. A history of alcoholism by a grandparent did not prove to be statistically significant. These results suggest the possibility of women's lack of memory or lack of information about the life of her grandparents.

Women with a family history of emotional mistreatment were twice as much at risk of being codependent than those who had not

Table 4
Model 3: Association Between Mistreatment Variables and Codependence

Hypothesis: Women with a family history of mistreatment and/or an abusive partner are more likely to display codependence than women without these antecedents

	Codependence					
	Unadjusted			Adjusted		
Variables	OR	95% CI	*p*	OR	95% CI	*p*
Physical mistreatment by partner	3.873	2.776–5.402	<.0001	3.643	2.242–5.918	<.0001
Sexual mistreatment by partner	6.200	4.287–8.968	<.0001	4.167	2.453–7.077	<.0001
History of emotional mistreatment	2.857	2.019–4.042	<.0001	2.280	1.366–3.803	<.002

Note. OR = odds ratio; CI = confidence interval. Variables tested in model: "physical mistreatment by partner," "emotional mistreatment by partner," "sexual mistreatment by partner," "physical mistreatment by mother," "history of emotional mistreatment," and "history of sexual mistreatment."

Table 5
Model 4: Association Between Cultural Scripts, Early Affective Losses, and Codependence

Hypothesis: Women with negative cultural female scripts, early affective losses and first-born daughters are more likely to display codependence than women without these factors.

	Codependence					
	Unadjusted			Adjusted		
Variables	OR	95% CI	*p*	OR	95% CI	*p*
Submission scripts (negative)	8.275	5.674–12.067	<.0001	7.627	4.594–12.662	<.0001
Early affective losses	2.749	1.863–4.054	<.0001	2.571	1.487–4.444	<.001

Note. OR = odds ratio; CI = confidence interval. Variables tested in model: "femininity scripts" (cultural positive), "submission scripts" (cultural negative), "early affective losses," and "first-born daughter."

suffered emotional mistreatment during their childhood. This suggests a greater vulnerability when relating to a partner with alcohol or violence problems when the woman has experienced intimidation or devaluation at an early age. It is important to note that both a family history of physical mistreatment and sexual mistreatment were excluded from the multivariate models, despite having yielded significant values in the bivariate analysis. This explains the relationship that exists between the three types of mistreatment, in which emotional mistreatment is always present and therefore extremely important. Hopefully, researchers will continue to examine the effects of emotional mistreatment of women, as this type of mistreatment may occur independently or in conjunction with other violations, leaving no physical traces yet resulting in profound emotional wounding. A sad fact is that severe verbal abuse and other nonphysical mistreatments are often regarded as culturally "normal" in our society (Cervantes, Ramos, Romero, & Saltijeral, 1994).

Women who experienced affective losses in their childhood, due to the premature death, abandonment, separation or negligence of one of their parents, or neglect due to the chronic physical or mental illness of a relative during childhood, were almost three times more at risk of being codependent than women who had not experienced these circumstances.

When early losses occur, there is usually an inversion of the roles played by members of the family, in which the oldest sibling often occupies the role of the absent father. The consequence is an alteration or bypassing of normal childhood developmental tasks, for example, to take care of siblings and depressed family members while acquiring premature responsibilities (James, 1981; Schiff et al., 1975). In this study, however, the "first-born daughter" variable, one of the exposure factors that it sought to test, did not prove significant. This infers that any child in the family, regardless of birth order, can experience such developmental "gaps" or losses, often with accompanying emotional damage, frequently expressed in unusual fears and anxieties.

Cultural Factors

The main generator of codependence found in this study was a submissive cultural script. The results obtained in the multivariate analysis showed that women following this script were nearly eight times more vulnerable to developing codependence than those without this programming. However, the characteristics of positive female cultural scripts, through their affective expressions, failed to show any association with codependence. This finding therefore questions the assumption that "being a woman" is in itself a risk factor for codependence. To the contrary, the fact of assuming a certain position or role in a partnership power struggle places the woman at risk of becoming codependent with her partner. This strongly implies that codependence does not stigmatize women, as some authors have suggested (Appel, 1991; Granello & Beamish, 1998), but rather that it is a term which, if properly used, enables one to recognize and examine a growing

Table 6
Model 5: Association Between the Joint Effect of the Variables of All Models and Codependence

	Codependence					
	Unadjusted			Adjusted		
Variables	OR	95% CI	*p*	OR	95% CI	*p*
Partner with probable alcohol dependence	2.082	1.504–2.882	<.001	3.032	1.491–6.167	<.002
Father with alcohol problems	1.413	1.000–1.998	<.050	2.372	1.281–4.394	<.006
Physical mistreatment by partner	4.408	2.524–7.699	<.0001	2.892	1.618–5.169	<.0001
Sexual mistreatment by partner	6.200	4.287–8.968	<.0001	3.138	1.621–6.077	<.001
History of emotional mistreatment	2.857	2.019–4.042	<.0001	1.909	1.028–3.546	<.041
Submission scripts	8.275	5.674–12.067	<.0001	6.983	3.939–12.379	<.0001

Note. OR = odds ratio; CI = confidence interval. Variables tested in model: "probable alcohol dependence in partner," "father with alcohol problems," "physical mistreatment of partner," "sexual mistreatment of partner," "history of emotional mistreatment," "submission scripts," "early affective losses."

problem that affects women's emotional development in a social context and that continues to promote gender inequality (Cowan, Bommersbach, & Curtis, 1995).

An analysis of the sociodemographic covariates showed that women who failed to complete middle school were almost four times more at risk of being codependent than women who completed middle school or more. In other words, educational attainment appears to serve as a protective factor. These data suggest that an inadequate education is associated with greater vulnerability to abuse in women, in addition to suggesting that educational attainment is an important factor in preventing codependence.

As for the joint effect of all the variables previously analyzed in the other models, the following significant variables proved to be risk factors for developing codependence: "probable alcohol dependence in one's partner," "father with alcohol problems," "physical and/or sexual mistreatment by partner," "history of emotional mistreatment," and "submission scripts." This effect is clinically and conceptually consistent because it reveals codependence as a multidimensional problem where childhood negligence and abandonment are regarded as a sort of emotional mistreatment.

Transactional Analysis offers a theory of personality and a view of human interactions that allows the understanding of how both personal and cultural scripts come about. It facilitates the comprehension of codependent relationships in women in particular by discovering the historical background introjected early into in her ego states. This precludes a woman from establishing limits in her current relationships, as she simultaneously continues to spread her codependent script unwillingly from one generation to the next—by modeling behavior to her children (Noriega, 2004).

Because this is a complex issue that involves various situations affecting the full development of women's individuality, there is a need for further research on codependence in Mexican and Latin American women, as well as cross-cultural comparisons of this phenomenon in other countries. The goal is to reveal a problem that is possibly being denied not only by women themselves but also by society as a whole. Because of the characteristics of the population, this study is only valid for women of a lower middle socioeconomic level. Researchers should repeat this study with Mexican women from a higher socioeconomic bracket in order to be able to compare and generalize results.

Finally, it would be useful to analyze the cases of codependence related to factors not mentioned in this study. In this respect, it would be possible to include other variables capable of producing prolonged stress in women, such as the emotional impact on women of the abuse of power by her partner, her family, and society. An interesting issue for subsequent studies would also be to examine the presence of codependence in other types of familial, social, and work relations, and to develop treatment methods aimed at educating and raising awareness in women, men, and society in general in order to undertake therapeutic treatment and education campaigns that will enable this problem to be solved and preventing its spread into future generations.

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(*Appendix follows*)

Appendix

Codependence Instrument (ICOD)

The following questions are aimed at discovering the specific experiences that you may have lived in your relationship with your partner. Please mark the most appropriate answer with an "*X*."

		Yes		
	No	A little	Regular	Very much
1. Do you justify your partner's faults?	0	1	2	3
2. Do you usually do what your partner wishes instead of what you want?	0	1	2	3
3. Is it really hard for you to make decisions?	0	1	2	3
4. Is it difficult for you to get to know your feelings?	0	1	2	3
5. Do you ignore your own values and convictions in order to accept those of your partner?	0	1	2	3
6. Do you pretend to be happy even though you feel are not?	0	1	2	3
7. Do you take care of your partner's needs before yours?	0	1	2	3
8. Do you try to avoid getting angry for fear of losing control?	0	1	2	3
9. Do you regularly do things that should be done by other members of your family?	0	1	2	3
10. Do you behave as if things were fine in your life, whereas they really are not?	0	1	2	3
11. Do you prefer not to say what's on your mind in order to avoid trouble?	0	1	2	3
12. When you are happy you suddenly fear that something bad may happen?	0	1	2	3
13. Do you feel unprotected at times?	0	1	2	3
14. Is it difficult for you to handle unexpected situations?	0	1	2	3
15. Do you think that trying to solve the problem with your partner would only make things worse?	0	1	2	3
16. Do you believe you have lost the ability to feel?	0	1	2	3
17. Do you fear being alone?	0	1	2	3
18. Do you avoid expressing your opinion when you know it is different from your partner's?	0	1	2	3
19. Do your feel confused by your feelings?	0	1	2	3
20. Do you agree to take care of too many things and later feel overwhelmed by all the work?	0	1	2	3
21. Do you worry too much about other people's problems?	0	1	2	3
22. Does your partner's behaviour make you to be isolated from the rest of the world?	0	1	2	3
23. Do you tolerate being treated rudely by your partner?	0	1	2	3
24. Do you fear your partner becoming angry?	0	1	2	3
25. Do you consent to have sexual intercourse without really wanting to, in order to please your partner?	0	1	2	3
26. Do you suffer from headaches and/or neck and back pain?	0	1	2	3
27. Do you avoid expressing your feelings for fear of being criticized?	0	1	2	3
28. Are you admired for understanding, even if other people do things that irritate you?	0	1	2	3
29. Is it difficult for you to know what you really want to do with your life?	0	1	2	3
30. Is it really hard for you to approve other ways of doing things different from your own?	0	1	2	3

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