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CODEPENDENCY AND LOCUS OF CONTROL AMONG PRACTISING NURSES

BY

EMILY CHRISTINE ANDREW

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements for the degree of MASTER OF EDUCATION IN COUNSELLING PSYCHOLOGY.

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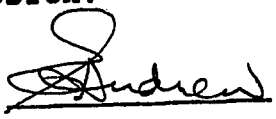
(Signed) 

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The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled "Codependency and Locus of Control among Practising Nurses" submitted by Emily Christine Andrew in partial fulfillment of the requirements for the degree of Master of Education in Counselling Psychology.

E.E.Fox

Margaret Haughey

L.L. Stewin

Date: August, 14 1992

To Michelle J. Worth who journeyed with me every step of the way.

ABSTRACT

Codependency and locus of control is measured in nurses (n = 88) from Alberta and British Columbia with from 1 to 10 years of active hospital-based nursing practice. Specifically, the relationship between the responses on a test of codependency, the Individual Outlook Test (IOT) and the Internal Control Index (ICI), a measure of internal locus of control, is examined. Codependency as per the IOT and locus of control as per the ICI were found to be unrelated (r (88) = .04, p = .37).

The relationship between codependency, as measured by the IOT, and years of service is evaluated and found to not significantly correlate (r (88) = -.13, p = .11). The IOT scores for the nurse sample (n = 88) are compared to the normative group for the IOT (n = 300) and a matched sample (n = 88) drawn from this group. It is concluded that contrary to what is reported in the nursing and codependency literature, nurses are not significantly different from the general population in terms of codependency.

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And finally to Linda Schmidt for her enduring friendship.

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CHAPTER I

Introduction

Codependency is a:

> a persistent, self-defeating pattern of intra- and interpersonal relationships characterized by poor self-worth, dependency, disturbed emotional development, and anxiety, and driven by an extreme external locus of control (Alexander, 1992, p. 39).

Nursing is considered to be a helping profession with the fundamental role of its practitioners being caregiving. It has been suggested that it is this aspect of nursing that makes it attractive as a career choice to codependent individuals (Black, 1981; Covello, 1991; Wegscheider, 1981; Woititz, 1987). The estimate by Snow and Willard (1989) that 80 percent of nurses are codependent has been seen by some as an overstatement and an attempt to pathologize the caring professions (Mallison, 1990). There is little empirical evidence to support the contention that the prevalence of codependency is higher among nurses than in the general population. What is needed is quantitative research to delineate the prevalence and degree of codependency among nurses.

Conducting empirical research on codependency is complicated by two major areas of difficulty evident in the literature. First, there is lack of agreement as to the definition and etiology of codependency. Various views of codependency have been suggested: a behavioral disorder (Whitfield, 1984), a disease model (Cermak, 1984, 1986a, 1986b, 1991), an ego psychology approach (Friel & Friel, 1988; Subby, 1987), a sociological perspective (Wilson Schaef, 1986), and a combined behavioral and intrapsychic view (Wegscheider-Cruse, Cruse & Bougher, 1991). The second difficulty is the lack of a psychometrically sound diagnostic and measurement tool. While several instruments have been developed, there is considerable variability in their validity and reliability (Fischer, Spann & Crawford, 1991; Friel, 1985; Potter Efron & Potter Efron, 1989; Sim, 1991).

One of the primary characteristics of codependent behavior that there is agreement on in the literature is an external locus of control or external referenting (Smalley & Coleman, 1987; Wilson Schaef, 1986; Woititz, 1983). External referenting involves reliance on others to meet emotional needs (Beattie, 1987; Subby, 1987), a constant need for approval and affirmation from others

(Beattie, 1987; McConnell, 1986; Subby, 1987; Whitfield, 1991; Wilson Schaef, 1986; Woititz, 1983), and obtaining a sense of value from outside the self, therefore needing to be needed by others and to feel indispensable to them (Beattie, 1987; Schaeffer, 1987; Subby, 1987; Wilson Schaef, 1986). As selflessness and service to the needs of others are common but often unspoken values held by many nurses, the nursing profession appears to be a milieu in which individuals with external locus of control could meet codependent needs.

In order to examine codependency and locus of control in nurses, psychometrically sound instruments are necessary. While early instruments designed to measure and/or diagnose codependency suffered a number of design problems, the 60-item Individual Outlook Test (60IOT) (Sim, 1991) adheres to the procedures for test development outlined in the American Psychological Association Standards for Educational and Psychological Measurement (APA) (1985). Preliminary findings indicate that the 60IOT is a valid and reliable instrument for measuring codependency (Sim, 1991, p. 32-33). The earlier instruments designed to measure locus of control were also subject to a variety of problems related to format,

response set, and reliability (Duttweiler, 1984). A more reliable instrument for assessing locus of control is the Internal Control Index (ICI) (Duttweiler, 1984).

The purpose of the present research is to determine if practising registered nurses demonstrate a significant degree of codependency. Also, the research has two secondary purposes. The research will be designed to explore the relationship between codependency and external referenting in the nursing sample and, since a number of practising nurses with from one to ten years of service will be tested, changes in codependence and external referenting will be monitored as it relates to years of service.

Belief in the prevalence of codependency among nurses is widespread despite the inadequacies of and the limited amount of research that has been undertaken. The present study provides a basis from which to examine this belief by focusing on the literature as it relates to codependency in the helping professions, specifically nursing, and the relationship of locus of control to codependency. Prevalence of codependency in practising nurses and the relationship of such variables as age, gender, marital status, number of years in active

practice, and locus of control are examined using psychometrically derived instruments. The results of this research are reported and the implications for nursing practice and future research are discussed.

CHAPTER II

Literature Review

Introduction

The concept of codependency is a relatively recent phenomenon in the field of psychology and is still in the process of evolution. As a result, there exist a myriad of definitions, theories of causality, and treatment approaches. Despite the controversy surrounding the concept, codependency is presumed to exist and is considered to be a widespread phenomenon affecting many individuals, particularly those in the helping professions. This literature review is focused upon the evolution and application of the concept of codependency to the helping professions, specifically to nursing. While this will of necessity include a limited discussion of the conceptual development of codependency, readers requiring an indepth delineation of the conceptual and historical development of codependency within the chemical dependency literature are referred to Alexander (1992) and Sim (1991).

Codependence and the Helping Professions

The belief that individuals who are codependent tend to enter the helping professions is a pervasive one in

the literature on codependency. In her description of family roles in the alcoholic family, Black (1981) states that "the child who was busy taking care of everyone else's emotional needs . . . grows up continuing to take care of others, either professionally or personally" (p. 57). Although Black's description referred solely to children of alcoholics, later writers using broader definitions of codependency noted the same belief with respect to various helping professions. For example, Wilson Schaef (1986) contends that most individuals working in centers for addicts and codependents are recovering persons themselves and, in order to increase their professional acceptability and earning power, return to school to obtain degrees in social work, nursing, or psychology (p. 102). Woititz (1987) shares the belief that many adult children of dysfunctional families find themselves in human service occupations and make excellent counselling professionals (pp. 35,107). According to Beattie (1987):

> As professionals began to understand codependency better, more groups of people appear to have it: . . . professional nurses, social workers and others in "helping" professions (p. 30).

Further, it has been suggested that individuals who enter helping professions may do so because helping others is a way of dealing with their own psychological distress (Friel & Friel, 1987; Fausel, 1989).

As well as being attracted to the helping professions, the prevalence of codependency and codependent behaviors in professionals is also a recurring theme in the literature. According to Dickman (1990), ". . . codependency has become an accepted mode of operation for many therapists and counsellors" (p. 35). Fausel (1989) notes that social workers and other helping professionals

> . . . who have grown up in alcoholic families, or other dysfunctional or high stress families; had close relationships with individuals who were chemically dependent or were chemically dependent ourselves, are particularly susceptible to working out our co-dependency needs on clients (p. 36).

Whitfield (1991) maintains that helping professionals often manifest their codependence by trying to rescue or help others while neglecting themselves (p. 41). This same behavior is evident in physicians as well:

> Codependency by definition often occurs in physicians, particularly those who reach out in the

> extreme. They may eventually sacrifice personal identity to assume the role of healer to submissive patients. Obviously not all physicians are codependent, but enough tend to seek professional and personal gratification through their patients for codependency to be a legitimate concern (Cermak, Keene & Thomas, 1989, p. 134).

Other authors cite similar behaviors in helping professionals but do not explicitly refer to codependency. Professional ministers who have unresolved issues related to their family of origin may exhibit caretaking, rescuing, other-centeredness, and meet the needs of others at the expense of their own needs (Frazier, 1992, p. 10). Frazier's (1992) descriptions of dysfunctional behaviors in those engaged in religious ministry closely match many of the behaviors described as codependent by Beattie (1987) and Wilson Schaef (1986).

Although the belief that helping professions attract and maintain codependents within their ranks is widespread, empirical research to support this belief is lacking in both the psychology and chemical dependence literature.

Codependence and Nursing

Increasing interest in the concept of codependence has been evident in the nursing literature since 1987. In one of the first citations on codependency in nurses, Highland (1987) states that "codependents like to take on the responsibility of 'fixing' the other person's life. They become obsessed and strongly invested in solving the other person's problems" (1987, p. 347). Bennett, Robertson and Ross (1992) state that "codependent behaviors are probably common among nurses just because nursing is a helping profession" (p. 80B). Sherman, Cardea, Gaskill, and Tynan (1989) believe that "codependent behaviors are prevalent within professional nursing practice [by virtue of] the fact that women (who are traditionally assigned the cultural role of caring) constitute the majority of professional nurses" (p. 28). The underlying assumption appears to be that codependent behaviors develop in nurses because they are women in a helping profession. However, Shelly (1991) observed that increasing numbers of nurses come from dysfunctional families (p. 3) and Covello (1991) posits that "codependents are attracted to nursing because it offers an opportunity to care for people in need" (p. 132).

Caring for others is a strongly held nursing value and is likely the underlying motivation for most individuals entering nursing. Sherman et al.(1991) agree that there is an overlap between descriptions of codependent behaviors and ". . . caring behaviors in professional nursing practice" (p. 25). At what point does caring become a codependent behavior? Hall and Wray (1989) suggest that "a nurse who gives more of herself (or himself) than is essential for effective care of her patients (and of herself) is showing classic characteristics of codependency" (p. 1456). Although nursing is a profession that requires its practitioners to place the needs of others before their own needs, codependent nurses

> . . . tend to give, but we tend to give when we have nothing left of ourselves to offer. We care, but we tend to care compulsively. And we have great difficulty allowing others to give to us or care for us. We tend to form non-reciprocal relationships that lack depth and intimacy (Ryan, 1991, p. 13).

Other writers describe similar themes. Codependent nurses, according to Covello (1991) exhibit "a pathological need to be needed . . . " (p. 132) and may

adopt the role of caretaker. A caretaker "feels responsible for all aspects of another's life - even those that lie beyond her professional consideration" (Hall & Wray, 1989. p. 1456). Often learned in her family of origin, the caretaking role when adapted to her professional life may manifest itself in rescuing patients and co-workers.

Not all nursing authors are in agreement that the concept of codependency is a valid one or that it is as prevalent in nurses as it is perceived to be. Webster (1990) comments:

> If depression is the psychiatric equivalent of the common cold, codependency is a raging epidemic. . . Despite (or perhaps because of) the overinclusiveness of the category codependency to encompass every human behavior and a list of predisposing factors that potentially defines all families of origin as dysfunctional, many women (and men) see reflections of themselves in the codependency mirror. . . . Many therapists are mystified and distressed by the popularity of the codependency label" (p. 60).

Other writers, while more accepting of the concept of

codependency, advise caution regarding the widespread acceptance of the label by nurses. Mallison (1990) warns that we are in danger of swimming in overstatement and quotes Patricia Benner who, speaking at the American Nurses' Association Convention in June, 1990, stated that the codependency label is "the latest attempt to pathologise the caring professions. . . . Society has lost the ability to make the distinction between addiction and commitment" (p. 7). Despite these cautions and the paucity of supporting empirical data, codependence continues to be regarded as prevalent among nurses.

The manifestations of codependency are viewed by some authors as harmful to the health and welibeing of the nurse, their patients, and the practice of nursing itself. Nurses ". . . are at high risk for spiritual, emotional and physical burnout" (Ryan, 1991, p. 13), ". . . depression and disillusionment with nursing" (Shelly, 1991. p. 3), and ". . . suicide in the later stages . . . and during times of crisis as the person is cut off from herself and weighted down by the feelings of others" (Zerwekh & Michaels, 1989, p. 119). Codependency is seen as affecting not only the nurse herself but also her

performance in the workplace, thus ultimately having negative consequences for her patients. Williams, Bissell and Sullivan (1991) found that the quality of work performed by codependent physicians and nurses was adversely affected by living with a chemically dependent significant other and resulted in a reduction in the ability to concentrate, absenteeism, errors, and poor judgement (pp. 38-39). Also, attempts to meet the need to be needed may lead codependent nurses to foster dependency in patients, ultimately undermining the patient's need for autonomy and self-sufficiency (Covello, 1991; Highland, 1987; Sherman et al., 1989).

However, the problem of codependence is not restricted to the individuals who work in the health care system. Hospitals themselves are seen to function in the manner of dysfunctional families, thus tend to exacerbate the predisposition toward codependency learned by the individual in the family of origin. There are multiple factors operant in hospital systems that are believed to promote codependency in susceptible individuals. For example, "within hospitals, the rules are frequently rigid and inflexible . . ." (Arnold, 1990b, p. 1581) and there is "inconsistent enforcement of these rules"

(Sorrentino, 1991, p. 50). Hospitals are seen to ". . . limit expression of feelings [and] discourage communication" (Cipkala-Gaffin, Kane, & Cleveland, 1991, p. 62). These factors mirror the conditions in dysfunctional families of origin that initially produced codependency in their members (Subby, 1987).

The actual organizational structure of the institution may also play a role in fostering codependent behaviors. According to Cauthorne-Lindstrom and Hrabe (1990), hospitals are frequently "organized in a rigid, hierarchical structure that emphasizes adherence to the chain of command for direction and communications. Rewards are contingent on performance of approved behaviors" (p. 35). As most codependents experience difficulty with autonomy and self-directedness, this type of organizational structure may reinforce dependent behaviors. In addition, nurses are often rewarded for caring for others at the expense of their own needs. "Nurses who are willing to work extra hours, cover for others, or work well with an abusive physician are considered 'good'. This reward system places the burden on one family member . . ." (Arnold, 1990b, p. 1581). A reward system such as this promotes caretaking by

codependent nurses.

Contemporary writers view codependency as a progressive disorder which usually worsens over the course of time if left untreated (Alexander, 1992; Friel & Friel, 1988; Snow & Willard, 1989; Whitfield, 1991). The choice of work environment may be a factor in the progression of codependency. According to Sorrentino (1991):

> Health care practitioners may not only exhibit behaviors that are considered dysfunctional for personal well-being, but are apt to find employment in institutions that are made up of persons who exhibit similar problems but who also value and promote continuation of those behaviors. Added to the dysfunctional behaviors that may have existed previously, the organizational culture may further promote this (p. 50).

Therefore, it is likely that nurses who choose to work in inflexible, hierarchically organized health care systems surrounded by rules and regulations that promote codependent behaviors will demonstrate increasing degrees of codependency the longer they remain in these settings. It is these individuals who are at most risk for burnout

and other sequelae of codependency.

Measurement of Codependency

In 1989, Snow and Willard attempted to address the lack of research on the prevalence of codependency among nurses. They developed a 121-item Codependency and Nursing Self-Assessment Inventory and administered it to a group of 138 nurses attending a seminar on codependency in nursing. The reported results indicated that over 80 percent of this sample had codependency issues. However, the authors identified a number of methodological problems with the study. "Strict statistical treatment was not applied to the tool, nor was there a control group" (p. 38). Moreover, the results are not generalizable to the nursing population as a whole, rather they are only representative of the group attending the seminar.

A second instrument was designed by Hall and Wray (1989). This 60-item inventory was adapted from the Friel Co-Dependence Assessment Inventory (Friel & Friel, 1988, p.p. 164-165). No psychometric data was provided for either the original instrument or the adaptation. The Hall and Wray instrument was designed to be used as a self-assessment inventory as were the checklists

presented by Highland (1987), Sherman et al. (1989) and Zerwekh and Michaels (1989). However, it is questionable that the scores derived from these instruments represent a valid and reliable measure of codependency.

In order to obtain valid research findings on the prevalence of codependency among nurses, it is necessary to utilize a psychometrically sound instrument to measure the construct. Two instruments that show a great deal of promise for use in empirical research on codependency have recently been developed. The Spann-Fischer Codependency Scale (SF CDS) was developed to assist in the identification of individuals whose scores place them at risk for psychological and interpersonal dysfunction, to assess progress in treatment, and to be used in research (Fischer, Spann & Crawford, 1991, p. 97). Spann and Fischer (1990) collapsed 18 characteristics of codependency into three areas to define codependency as a:

> psychosocial condition that is manifested through a dysfunctional pattern of relating to others. This pattern is characterized by: extreme focus outside of self, lack of open expression of feelings, and, attempts to derive a sense of purpose through

relationships (p. 27).

Based on this definition a 15-item scale using a Likert format was developed. The scale had good internal consistency with a Cronbach alpha of .86. The Test-retest correlation was .87. Subsequently, the authors added a sixteenth item for which they fail to offer any rationale. The revised scale, the authors claim, demonstrated several kinds of validity: content, construct, concurrent/convergent, and discriminative validity. Factor analysis identified four factors. Factors 1 and 2 relate to focus outside of self and caretaking activities. Factor 3 described the lack of open expression of feelings and Factor 4 related to the sense of purpose through relationships with others (Fischer, Spann & Crawford, 1991, pp. 91-97). However, no information is given as to how the items relate to the criteria selected as representative of the construct or whether the items were weighted in terms of their criticality to the construct. In addition, the samples tested were too small to provide a norm group. These difficulties would suggest that the scale may need further development prior to being used clinically.

A second instrument, the 60-item Individual Outlook

Test (60IOT) developed by Sim (1991) follows many of the procedures for test development outlined in the American Psychological Standards for Educational and Psychological Testing (1985). Sim (1991) selected the following definition of codependency as the basis for the development of the instrument:

> an emotional, behavioral and psychological pattern which develops as a result of prolonged exposure to and practice of a dysfunctional set of family rules. In turn these rules make difficult or impossible the open expression of thoughts and feelings. Normal identity development is thereby interrupted (Subby, 1987, p. 84).

Sim (1991) extracted 117 descriptors of codependency from the literature which were then grouped under 14 main categories. The number of items developed in each category reflected the frequency with which the descriptors appeared in the literature and is therefore reflective of the criticality of the items to the construct. The resultant 60-item scale uses a Likert Scale format. At the time of development, the test has a good internal consistency with a Cronbach alpha of .88. The Test-retest correlation was .89 with a Standard Error

of Measurement of .33. The instrument demonstrated content validity, criterion validity, and discriminant validity (Sim, 1991 pp. 25-37).

Factor analysis yielded five stable factors and, based on these factors, Alexander (1992) proposed that a more specific definition of codependency as measured by the 60IOT is:

> a persistent, self-defeating pattern of intra- and interpersonal relationships characterized by poor self-worth, dependency, disturbed emotional development, and anxiety, and driven by an extreme external locus of control (p. 39).

As this definition encompasses many of the descriptors of codependency cited in the nursing literature, it is considered to be the operational definition of codependency for this research project. As well, the broader scope of the items contained on the 60IOT appears to be suited to research dealing with the prevalence of codependency in nurses.

Locus of Control and Codependence

One of the major characteristics of codependent behavior that has been cited explicitly or implicitly in the literature on codependency is external locus of

control or external referenting. External locus of control is exhibited by codependent individuals in a variety of ways. For example, codependents obtain a sense of value from outside the self, and as a result, need to feel needed and to feel indispensable to others (Beattie, 1987; Schaeffer,1987; Subby, 1987; Wilson Schaef, 1986). This manifestation of external locus of control is a central theme in the nursing literature on codependency as it relates directly to one of the most strongly held values of nurses, the art of caring. According to Mallison (1990),

> one of the most delicate and complex skills of nursing - one that takes intense thought and practice - is the skill of achieving the 'right level' of involvement with a patient. ...Anyone who takes nursing seriously errs on both ends - too little and too much involvement - in the process of developing that skill (p. 7).

The differentiation between this difficult balancing act and codependency lies in the scope and persistence of the behavior at the overinvolvement end of the scale. The nursing literature is replete with references exemplifying how nurses obtain a sense of value through

being needed. "The codependent nurse has a pathologic need to be needed . . . fulfilling others' needs is the only way to have security" (Covello, 1991, p. 132). "She's attracted to people who need her and feels most secure when giving to them . . ." (Hall & Wray, 1989, P. 1456). "Codependent antennae give [nurses] hypersensitivity to the needs of others and hypervigilence for people and things that need to be fixed" (Arnold, 1990b, p. 1538). Nurses ". . . achieve and care and rescue because it is the only way we feel valuable and acceptable as people" (Ryan, 1991, p. 12). Snow and Willard (1989) estimated that less than three percent of the nurses they studied believed that they were valuable simply for who they were (p. 40).

A second manifestation of external locus of control refers to reliance on others to meet emotional needs (Beattie, 1987; Subby, 1987). Zerwekh and Michaels (1989) state ". . . helping other people work through problems can become a quick 'fix' for a co-dependent who thrives on the feelings of others" (p. 119). ". . . Nurses all too frequently get their needs met indirectly by taking care of the wants and needs of others" (Snow & Willard, 1989, p. 43). Neither codependent nurses nor the patients

they care for are well served when nurses attempt to meet their needs in this manner. In fact,

> the codependent nurse's compulsion to help conflicts with the patient's need for autonomy and a return to self sufficiency. She relates unwholesomely to her patients because she's hoping that their gratitude will compensate for her childhood pain (Covello, 1991, p.132).

Nor is this behavior conducive to solving the myriad problems faced by today's health care systems. Covello (1991) believes that codependent nurses are "selfishly selfless . . . when we use our energies and skills to milk gratification from a disastrous system rather than change it" (p. 132).

Codependents exhibit external referenting through their constant need for approval and affirmation from others (Beattie, 1987; Subby. 1987; McConnell, 1986; Wilson Schaef, 1986; Woititz, 1983). Nurses, according to Snow and Willard (1989) professionally wear the mask of people pleasing and tolerate inappropriate behaviors to be liked (p. 39). Arnold (1990b) also notes this behavior: "we can easily become people pleasers and lose ourselves in the process" (p. 1583).

With the advance of technology, nursing has become increasingly complex. The demands of caring for patients in institutional settings with their rules, regulations and mountains of paperwork seldom allow nurses to allocate sufficient time or energy to the primary function of nursing: meeting the physical and psychosocial needs of patients. Thus many nurses find it difficult to achieve a sense of satisfaction in the practice of the profession.

> Perpetually trying to please the patients, families, physicians, and administrators, codependents keep on doing what everyone thinks they should be doing, or what makes others happy. . . . Codependents fail to understand why they cannot seem to please everyone. Despite all the hard work, there remains the feeling of being unappreciated; thus codependents never feel good about themselves (Sorrentino, 1991 p. 51).

Finally, codependents do not trust their perceptions, and express their opinions only after determining what others want to hear (Beattie, 1987; McConnell, 1986; Mendenhall, 1989; Smalley & Coleman, 1987; Wilson Schaef, 1986). To be human is to make mistakes. Unfortunately, nurses tend to give only superficial agreement to this

fundamental human characteristic. Instead, nurses are imbued with the myth of infallibility and are harshly critical of themselves when errors occur. They learn early in their education that if rules, procedures and standards are followed there is little possibility of error. As a result, codependent nurses

> . . . do not like situations that are not clear cut. If there is no rule about what is the right way, or we must make up our own minds about what is acceptable behavior, the situation is confusing (Arnold, 1990b, p. 1583).

Confusion is likely to cause a codependent nurse to doubt her clinical judgement in ambiguous situations. Rather than believing in her own perceptions, the nurse is likely to seek corroboration and support for her perceptions from a colleague or supervisor and to seek assistance in decision making. For the codependent nurse, double and even triple checking her decisions and actions is not uncommon. "The very nature of . . . responsibility for decision making and acceptance of accountability for judgements in patient care lends itself to the perpetuation of codependency in managers and department heads" (Sorrentino, 1991, p. 50). This is applicable at

all levels of staffing.

Dealing with problematic patients, families and physicians is a difficult task for the codependent nurse as she is likely to fear "anger, confrontation, personal criticism and authority figures" (Bennett, Robertson & Moss, 1992, p. 80B). As a result, the codependent nurse's interactive style is ". . . geared toward what she thinks others want to hear" (Hall & Wray, 1989, p. 1456).

Given the frequency of these descriptors of external locus of control in the nursing literature, it is likely that nurses who are codependent will also exhibit a marked degree of external locus of control.

Measurement of Locus of Control

Locus of control concerns a person's belief that outcomes are a result of his or her own actions - an internal locus of control, or are contingent on luck, chance or powerful others - an external locus of control (Rotter, 1966). Although several instruments have been developed to measure locus of control, the Rotter Internal-External (I-E) Scale remains the most widely used despite criticism of its format, response set, dimensionality, and low reliability (Duttweiler, 1984). Later instruments appear to be subject to many of the

same problems as the I-E Scale (Lefcourt, 1976; MacDonald, 1973).

In an attempt to address these problems, Duttweiler (1984) developed the Internal Control Index (ICI), a measure of locus of control in adults. To counter the problems created by a forced choice format, a Likert Scale format was used. Response set was controlled for by constructing the questions so that a highly internally oriented individual would answer half the questions at the "usually" end of the scale and the other half at the "rarely" end of the scale. The scale was not designed to measure both internal and external locus of control. It is restricted to measurement of the internal control dimension. The ICI has very good internal consistency with Cronbach alphas of .84 and .84. No test-retest correlations were reported. According to the author, the ICI has fair concurrent validity. Factor analysis yielded two factors, self confidence and autonomous behavior - behavior that is independent of social pressure (Duttweiler, 1984, pp. 211-217). It is believed that the ICI may be a more reliable instrument than the Rotter I-E Scale for measuring locus of control in adults.

As the external world is extremely important to the

codependent and their behaviors tend to reflect a predisposition to express themselves or act in ways that they believe are acceptable to others, it is likely that internal locus of control, as measured by the ICI, will correlate negatively with codependency, as measured by the 60IOT.

Summary

The belief that helping professions attract individuals who are codependent is a pervasive one in the literature despite the lack of empirical research to support this belief. The nursing literature on codependency also embraces, with few exceptions, the belief that codependency affects a large percentage of nurses and impacts negatively on the professional practice of nurses.

A survey of the nursing literature produced only two research studies dealing with codependency among nurses. Unfortunately, the Snow and Willard (1989) study that examines the contemporary concept of codependency is methodologically flawed and its findings can only be applied to the members of the study's sample. The Williams, Bissell and Sullivan (1991) research study on the effects of codependence on physicians and nurses

restricted the scope of the study to include only those individuals with chemically dependent significant others and used an unvalidated survey instrument.

The paucity of empirical research on codependency among nurses is due, in part, to the lack of a valid and reliable instrument with which to measure the construct. The recent development of a psychometrically sound measure of codependency increases the possibility of credible research results. In addition, as most of the literature on codependency contains references to external locus of control, it is important when examining codependency among nurses to determine if there is a relationship between codependence and locus of control.

Research Hypotheses

In the present research, data will be collected on codependence, as measured by the 60IOT, and locus of control, as measured by the ICI, in order to examine the following research hypotheses:

1. Nurses as a group and as individuals will display a greater degree of codependency than the norming group.
2. Codependence will increase with the number of years of active nursing practice.

3. There will be a positive relationship between codependence and external locus of control in practising nurses.

CHAPTER III

Methods and Procedures

Introduction

Owing to the recent development of a psychometrically derived instrument to measure codependency, it is now feasible to conduct empirically sound research designed to investigate the claim that codependency is more prevalent in helping professionals than in the general population. The primary intent of this study is to measure the degree of codependent orientation in a sample of registered nurses using the 60-item Individual Outlook Test.

As an external locus of control is considered to be one of the major characteristics of codependency, individuals with a high degree of codependent orientation are likely to exhibit a correspondingly high external locus of control. Therefore, one of the secondary purposes of this research is to delineate the relationship between codependency and locus of control as measured by the Internal Control Index. As codependency is regarded as progressive in nature and hospitals are viewed as providing a milieu that fosters the development of codependency, the relationship between codependency

and years of active practice is examined. In this chapter, the methods and procedures used to answer the research questions are described and a description of the sample and its selection, data collection, the instruments, and data analysis is presented.

Selection of Subjects

A sample of 88 female and male registered nurses with from one to ten years of active hospital-based nursing practice was obtained using non-probability convenience sampling procedures. In two agencies, a major urban hospital in Alberta and a rural hospital in British Columbia, permission to seek volunteers to participate in the study was obtained from nursing administration and the relevant ethics committees. Additional subjects were obtained via snowball sampling from a medium sized urban hospital in British Columbia. The majority of these subjects were known to the researcher.

The sample was composed of 82 female registered nurses and 6 male registered nurses. The age range was from 22 years to 51 years with a mean age of 31.82 years. Subjects had from 1 to 10 years of active hospital-based nursing practice with a mean number of years of practice of 5.18.

Packages containing an information sheet, consent form, 60IOT, ICI, 2 computer answer sheets, and a demographic data sheet requesting information on the subject's age, gender, marital status, and number of years of active practice were distributed to the subjects. Subjects were requested to complete the consent form using their actual name and to seal it in a separate envelope provided for that purpose. A codename chosen by the subject and unknown to the researcher, was used on the demographic data sheet, 60IOT and ICI answer sheets. Consent forms were collected separately from the codenamed data. As the items in the 60IOT and the ICI pertain to life experiences, attitudes, feelings and behaviors, the researcher chose to describe the instruments from this perspective rather than labelling them as measures of codependency and locus of control to control for possible subject biases and response sets. As well, subjects were informed that they could discontinue participation at any time. In the Alberta hospital, packages were circulated to unit managers for distribution to subjects who volunteered to participate in the study. Non-random, non-representative sampling procedures and the limited number of males are both

acknowledged as limitations to the extent to which the results of this research can be generalized.

Instruments

The 60-item Individual Outlook Test

The 60IOT (Appendix A) was designed to measure codependent orientation. Codependency as measured by this instrument is defined as:

> . . . a persistent, self-defeating pattern of intra- and interpersonal relationships characterized by poor self-worth, dependency, disturbed emotional development, and anxiety, and driven by an extreme external locus of control (Alexander, 1992, p. 39).

The norm group for the 60IOT was extended by Alexander (1992) (n = 168) and by Worth (1992) (n = 25) for a total of n = 300. It consists of 111 male and 189 females aged from 18 to 74 years of age (Worth, 1992, p. 43). Both urban and rural populations are represented and socioeconomic status figures were acceptably close to the figures for the City of Edmonton as reported by Elley (1961) for a random sample of 400.

Validity of the 60IOT.

Content validity of the 60IOT is based on adherence to the specific content described in the codependency

literature and acceptance of only those items that were acceptable to three competent judges (Sim, 1991. p. 32). Criterion validity was established by comparing the scores of professionally diagnosed codependents (n =45) to the scores of a matched sample drawn from the norm group (n =45). The codependent's scores were significantly higher (M = 189.02, SD = 39.57) than the scores of the matched sample (M = 153.60, SD = 27.15) (Worth, 1992, p. 54).

Factor analysis of the 60IOT resulted in five stable factors which are congruent with the codependency literature. These factors, self esteem, dysfunctional relationships, external locus of control/dependency within relationships, dysfunctional family of origin, and anxiety account for 27 percent of the common variance (Alexander, 1992, p. 35). Thus, the instrument is considered to have construct validity.

Reliability of the 60IOT.

The test-retest Pearson Product Moment Correlation for the 60IOT is r (300) = .98, SEm = 4.26 and an internal consistency Cronbach Alpha Coefficient of r = .91 (Worth, 1992, p. 46).

Scoring the 60IOT

Responses to the 60IOT items were made on a five point Likert type scale and recorded on a computer scanned answer sheet. The items were weighted 5, 4, 3, 2, and 1, from strongly agree to strongly disagree, with the exception of 6 items (2, 5, 12, 18, 28, and 46). These items have reverse weightings to control for response set bias. The reverse weightings were accounted for at the time of scoring. Scores on the 60IOT range from a minimum of 60 to a maximum of 300. The higher the total raw score, the greater is the degree of codependent orientation.

The Internal Control Index

The ICI (Appendix B), a measure of locus of control in adults, is based on the variables that are most relevant to internal locus of control: cognitive processing, autonomy, resistance to influence attempts, delay of gratification, and self confidence (Duttweiler, 1984, p. 211). This 28-item instrument was field tested by Duttweiler on 648 individuals, 173 males and 508 females, ranging in age from under 20 years to over 50 years. Means for the demographic categories of age, gender, race, educational level and socioeconomic status were

calculated. While there were some statistical differences between the means of these demographic categories, they were considered to be too small to be of practical importance (Duttweiler, p. 217).

Validity of the ICI.

Content validity of the ICI was established by developing test items based on the nomological network that pertained to internal locus of control. A moderate, but significant negative Pearson Product Moment Correlation (r = -0.385) was found between scores on the ICI and Mirel's Factor I of the Rotter I-E Scale. As the Rotter scale is a measure of external locus of control, a negative correlation is indicative of convergent validity.

Construct validity was established through factor analysis. Two factors were extracted. Factor 1, confidence in one's own ability or self confidence accounted for 76.9 percent of the common variance. Factor 2, autonomous behavior or behavior that is relatively independent of social reinforcement or social pressure accounted for 23.1 percent of the common variance (Duttweiler, 1984, p. 212).

Reliability of the ICI.

Cronbach Alphas reliability coefficients for the ICI were $\underline{r}$ = .84 and $\underline{r}$ = .85. No test-retest correlations were reported (Duttweiler, 1984, p. 213).

Scoring the ICI.

Response alternatives for the ICI items fall along a five point Likert type scale from rarely to usually. Responses were recorded separately on a computer scored answer sheet. Individuals with a highly internal locus of control are expected to answer approximately one half of the items at the usually end of the scale and the other half at the rarely end of the scale. Responses were weighted 1, 2, 3, 4, 5, for items 3, 5, 7, 9, 10, 12, 13, 15, 16, 18, 20, 21, 25, and 28. The remaining items were reverse weighted. Weightings were accounted for at the time of scoring. The score range is 28 to 140. The greater the score, the more internally oriented is the individual in terms of locus of control. Because it is external locus of control that is associated with codependency, subjects with greater codependent orientation are expected to attain lower scores on the ICI, resulting in a negative correlation between scores on the 60IOT and ICI.

Administration Time and Conditions

Subjects were asked to self administer the 60IOT and the ICI in a quiet setting outside working hours. Some subjects chose to complete the questionnaires at work during break time. Suggested completion time ranged from 30 to 45 minutes, however some subjects reported that they were able to complete both instruments in 20 minutes.

Statistical Analysis

Pearson Product-Moment Correlation Coefficients were used to determine the relationship between the IOT score and the ICI score, the IOT score and age, the IOT score and years of active practice.

T-tests were used to determine if there were significant differences between the mean IOT and age scores for the nurses sample (n = [illegible] the norming group (n = 300), and a matched sample drawn from the norming group (n = 88).

CHAPTER IV

Findings and Conclusions

Introduction

In this chapter the research hypotheses are restated and the findings pertaining to each hypothesis are presented. The results of the data analysis are reported and conclusions about each hypothesis are stated. Since the norming group of 300 individuals for the Individual Outlook Test (IOT) represented a greater range of age segments of the general population than did the nurse sample, a matched sample was drawn for comparison. Hence, results comparing the 88 nurses with the 300 subject norming group for the IOT are reported. Then a second set of data is offered wherein the 88 nurses are compared to 88 matched subjects drawn from the norming group (n = 300).

Hypothesis 1

Nurses as a group and as individuals will display a greater degree of codependency than the norming group.

Nurse subjects were matched with a sample (n = 88) from the norming group (n= 300) along gender, age, and marital status. Matching procedures were performed manually by the researcher who was uninformed at that

point as to the IOT scores. The matched sample drawn from the norming group consisted of 6 males and 82 females ranging in age from 22 to 50 years, with a mean age of 31.81 years and a SD of 7.14 years. The nurse sample, 6 males, 82 females, ranged in age from 22 to 51 years with a mean age of 31.98 years and a SD of 7.12 years.

Norming Group and Matched Sample

To ascertain if the matched sample was representative of the norming group in terms of age and IOT scores, comparisons were made using t-tests. A one sample t-test comparing the mean age of the matched sample from the norming group with the mean age of the norming group was completed. Table 1 shows that the mean age of the matched sample was significantly different from the mean age of the norming group.

Table 1

Comparison of the Means for Age of the Matched Sample and the Norming Group

Group	N	Mean	S.D.	Degrees of Freedom	T	P (2-tail)
Matched Sample	88	31.82	7.14	87	4.464	<.0001
Norming	300	35.21	11.37			

Group

This significant difference in the means for age was not unexpected. The age range for the norming group was from 18 to 74 years. As nurses require a minimum of 2 years to complete their nursing education, it is unlikely that they will be less than 20 years of age prior to entering practice. By limiting the number of years of active nursing practice of the nurse subjects to ten years or less, the age range of the nurse subjects was lowered thereby limiting the age range of the matched sample. As a result, the matched sample from the norming group is not representative of the total norming group in terms of age. This was not considered to affect IOT scores as Worth (1992) found no significant correlation between age and IOT score ($r(300) = .03$, $p = .278$).

A one sample t-test comparing the mean IOT scores of the norming group with the mean IOT scores of the matched sample was performed. Table 2 shows that the matched sample mean IOT score was not significantly different from the norming group mean IOT score. The means are not significantly different which indicates that the matched sample is representative of the norming group in terms of IOT scores.

Table 2

Comparison of the Means of the IOT Scores of the Matched Sample and the Norming Group

Groups	N	Mean	S.D.	Degrees of Freedom	T	P (2-tail)
Matched Sample	88	155.68	29.64			
				87	.45	.6539
Norming Group	300	157.10	30.16			

Norming Group and the Nurse Sample

To determine if the nurse sample differed significantly from the norming group as a whole in terms of IOT scores, a one sample t-test comparing mean IOT scores of the norming group and the nurse sample was performed. Table 3 shows that there was no significant difference between the mean IOT scores of the two groups. Because there is no significant difference between the mean IOT scores, it can be concluded that the codependent orientation of the nurse sample is not different from that of the norming group as a whole.

Table 3

Comparison of the Means of the IOT Scores of the Nurse Sample and the Norming Group

Group	N	Mean	S.D.	Degrees of Freedom	T	p (2-tail)
Nurse Sample	88	155.91	31.42	87	.357	.7223
Norming Group	300	157.10	30.16			

For purposes of comparison, the percentage of individuals whose IOT scores fell one standard deviation (SD = 30.16) or more above the norming group mean ($\underline{M}$ = 157.10) were calculated for the norming group and the nurse sample. The percentage of individuals whose IOT scores were 187 or higher was comparable for both groups, accounting for 16.3% of the norming group and 16.9% of the nurse sample.

Nurse Sample and Matched Sample

Although an attempt was made to select individuals from the norming group who were an identical match to the nurse sample in terms of gender, age, and marital status, an identical age match was not possible in all cases. To determine if the mean age of the nurse sample differed

significantly from the mean age of the matched sample, a dependent measures t-test was performed. Table 4 shows that there was no significant difference between the means for age in the two samples.

Table 4

Comparison of the Means for Age of the Matched Sample and the Nurse Sample

Group	N	Mean	S.D.	Degrees of Freedom	T	P (2-tail)
Matched Sample	88	31.82	7.14	87	1.305	.1953
Nurse Sample	88	31.89	7.12			

Because there is no significant difference between the mean age scores, it can be concluded that age of the nurses is not different from the matched sample subjects.

A dependent measures t-test was performed to determine if there was a significant difference between the mean IOT scores of the nurse sample and the matched sample. Table 5 shows that the mean IOT score of the nurse sample was not significantly different from the mean IOT score of the matched sample.

Table 5

Comparison of the Means of the IOT Scores of the Matched Sample and the Nurse Sample

Group	N	Mean	S.D.	Degrees of Freedom	T	P (2-tail)
Matched Sample	88	155.68	29.64	87	.055	.9562
Nurse Sample	88	155.91	31.42			

As there is no significant difference between the mean IOT scores, it can be concluded that the codependent orientation of the nurse sample is not different from the matched sample.

Conclusion.

Hypothesis 1 is rejected. The sample of nurses in this study did not display a greater degree of codependency, either individually or as a group, than the norming group. This was demonstrated by the absence of significant differences between the mean IOT score of the nurse sample and the mean IOT scores of the norming group and the matched sample.

Hypothesis 2

Codependence will increase with the number of years of active nursing practice.

The nurses in this sample (n = 88) had from one to ten years of active hospital-based nursing practice (M = 5.18, SD = 3.01). Where a subject indicated an additional portion of a year, the year was rounded up if the portion was equal to or greater than 0.5. Table 6 shows the distribution of nurses for each year of practice.

Table 6

Distribution of Nurses by Years of Active Hospital-Based Nursing Practice

	Years of Active Practice										
Nurses	1	2	3	4	5	6	7	8	9	10	Total
Female	9	8	11	14	10	4	3	6	4	13	82
Male	1		1	1			1	1		1	6
Total	10	8	12	15	10	4	4	7	4	14	88

Results

The Pearson Product-Moment Correlation was used to determine if there was a relationship between codependency and number of years of active nursing practice. The resulting coefficient, r(88) = -.13, p = .11, indicates that codependency is not significantly

correlated to the number of years of active nursing practice.

Conclusion.

Hypothesis 2 is rejected. The nurses in this sample did not exhibit increased codependence with increased years of active practice as indicated by the nonsignificant correlation coefficient.

Hypothesis 3

There will be a positive relationship between codependence and external referenting in practising nurses.

To test hypothesis 3, scores on the Internal Control Index (ICI) were calculated and correlated with the IOT scores. As the ICI measures internal locus of control, it was predicted that there would be a significant negative correlation of ICI scores to IOT scores if the nurses in this sample exhibit external locus of control.

Results

The Pearson Product-Moment Correlation coefficient of r (88) = .04, p = .37 indicates that there is no significant relationship between codependence and internal locus of control among the nurses in this sample. Codependency and locus of control are not

correlated in this sample.

Conclusion.

Hypothesis 3 is rejected. External referenting is not related to codependence in this sample of nurses as indicated by the nonsignificant correlation coefficient.

Summary of Findings

1. There were no significant differences between the mean IOT score of the nurse sample and the mean IOT scores of the matched sample and the norming group. It was concluded that the degree of codependency exhibited by the nurses in this sample was not greater than the norming group.
2. Codependence was not significantly correlated with the number of years of active hospital-based nursing practice. Thus codependence does not increase with the number of years of active nursing practice.
3. The correlation between codependence and internal locus of control was nonsignificant. A predicted significant negative correlation between codependency and internal locus of control was not found. External referenting and codependency were not related in this sample of nurses.

CHAPTER V

Discussion and Limitations

Introduction

The literature is full of speculation that nurses as individuals are attracted to the nursing profession because of character or personality factors (Black, 1981; Wilson Schaef, 1986; Woititz, 1987; Beattie, 1987). Some of these personality factors are viewed almost as character flaws or defects and labelled as codependency (Friel & Friel, 1987; van Wormer, 1989; Whitfield, 1991; Ryan, 1991; Covello, 1991).

When subjected to an objective, empirical research study, as in the present investigation, nurses were found not to differ from the general population in terms of codependency. Specifically, directional hypotheses based upon the literature failed to be confirmed empirically. Some explanations for these findings are offered.

Discussion

Nurses not Different in Terms of Codependency

One of the most pervasive and enduring values underlying the professional practice of nursing is caring for others. Caring behavior involves valuing the individual as uniquely human and accepting that

uniqueness (College of New Caledonia, 1988). Caring can be viewed in the global sense - the valuing of humanity as a whole, but in order to operationalize caring in actual daily practice, it must be translated into practical realities implemented on a person to person level. Martocchio (1987) points out that the nurse as professional cannot be separated from the nurse as person. Professional competence alone is not sufficient since "the nurse who withholds part of the self is unlikely to allow the patient to emerge as a whole, or to comprehend [the absence of] . . . wholeness if it does not emerge" (p.25). Thus it is the characteristics of the nurse as a person that are critical in the establishment of trust (Davies & Oberle, 1990, P. 93) which is essential to therapeutic nurse-patient relationships.

While caring requires involvement with a patient, the level of involvement required for "maximum impact differs with each patient" (Mallison, 1990, p. 7). Achieving a balance between over and under-involvement is a difficult skill to learn but it is the ability to achieve and hold this balance that is critical in determining if the nurse is codependent or not. Examples of professional caring behaviors include: placing the needs of patient before

the needs of self. Professional caring also involves fostering and supporting the development of others, and being aware of and responsive to the needs of others - patients, their families, colleagues and co-workers. Many of these caring behaviors do resemble codependent behaviors. The nurse who continuously places the needs of patients, coworkers, and the organization before her own needs is exhibiting codependency (Hall & Wray, 1989; Arnold, 1990a; Ryan, 1991; Covello, 1991). In contrast, the nurse who, for the most part, is able to balance the needs of those she cares for and the organization against her own needs for self-care is unlikely to be codependent. Similarly, the nurse who fosters each patient's self-care potential and supports the patient's return to independence maintains a healthy balance between meeting the patient's needs for dependence and independence. It is not always easy to discern the difference between the necessary interdependence of nurse and patient and codependence. One can make a very positive extrapolation from the finding that nurses do not exhibit a greater degree of codependency than the general population. It is professional caring behavior that is integral to nursing as a profession and not

codependency.

Years of Service Do Not Impact Codependency

The literature suggests that the rigid, hierarchical structure of health care organizations resembles the milieu of a dysfunctional family, and thus promotes codependency in susceptible individuals (Arnold, 1990b; Cauthorne-Lindstrom & Hrabe, 1990; Sorrentino, 1991; Cipkala-Gaffin, Kane, & Cleveland, 1991). Moreover, because of the progressive nature of codependency (Friel & Friel, 1988; Whitfield, 1991; Alexander, 1992), nurses with a codependent orientation are likely to become more codependent over time in a dysfunctional organization (Sorrentino, 1990).

No evidence of a relationship between years of practice and codependency was found in this study. Nursing within institutional settings is not a solitary occupation. It requires intense teamwork and co-operation to fulfil the demands made upon the staff. Nurses depend upon each other for professional consultation, assistance with duties requiring more than one person, and monitoring and caring for one another's patients during breaks and emergencies. Klebanoff (1991) notes that "nursing is a network of supportive people among whom is

a shared vision and commitment to care for others in such a way that affirms, not exploits, people" (p. 158). Thus it is likely that the majority of nurses who continue to practice long term in institutional settings develop the ability to function interdependently rather than codependently.

External Referenting Not Descriptive

The expected relationship between external referenting and codependence was not found in this study. There are a number of possible explanations as to why this occurred.

Since the majority of instruments designed to measure locus of control have reliability and validity shortfalls, a highly reliable instrument, the Internal Control Index (ICI) was selected to measure the degree of internal locus of control. Locus of control as described in the codependency literature is a multidimensional construct. While the questions that comprise the ICI address the dimensions related to trust in one's own perceptions, the influence of others on one's opinions, and constant need for approval and affirmation, other dimensions such as: the need to be needed and feel indispensable to others, reliance on others to supply

emotional needs, and emotional dependence are not measured. The ICI may measure too few of these dimensions to allow an accurate assessment of locus of control in its broader context.

Another factor that may have affected subject responses is the social desirability factor. Because of the difficulties produced by the use of the forced choice format, Duttweiler (1984) designed the ICI using a Likert-type format. This design allows the individual who is externally referented to respond in a more socially desirable manner.

While instrumentation may have minimally deflected the results, a more plausible explanation may be found in the changes in nursing that have taken place over the past two decades. The move away from the physician-driven medical model toward the widespread use of nursing models and nursing diagnosis has assisted nurses to define and claim nursing as an autonomous healing profession. As well, the move away from hierarchical models of nursing administration to decentralized models has led to increasing independence in decision making by staff nurses. These changes, in addition to the inclusion of courses on communication skills, assertiveness

techniques, leadership and professional issues in nursing curricula, may be having a major impact on locus of control among today's nurses.

Implications for Practice

With the advance of technology, the practice of nursing has become increasingly complex and difficult. The addition of highly specialized technical skills to the traditional role of caregiving and the fiscal restraints imposed by the rising cost of health care has had a profound impact on nursing. The literature has suggested that stress, depression, burnout and disillusionment with nursing can largely be attributed to codependency among nurses (Zerwekh & Michaels, 1989; Ryan, 1991; Shelly, 1991). The findings of this study indicate that the majority of nurses are not codependent. Nursing is not a "sick" profession and the problems that are apparent in nursing cannot be attributed solely to codependency amongst its practitioners. Simply labelling nurses as codependent is not the answer to a multifaceted problem. Nursing must look elsewhere for solutions if these findings are replicable.

Notwithstanding, codependency issues are likely to be problematic for those individuals who demonstrate

codependent orientation. Although awareness of the codependency construct is growing, it is, at present not included in nursing curricula or textbooks. While it is likely that this deficit will be remedied in the future, increasing knowledge of codependency through continuing education workshops and seminars could benefit those nurses who are presently in practice. Increased awareness of codependency would enhance nurses self-knowledge, assist them to identify codependency issues in their patients, and to plan appropriate interventions.

The findings of this study indicate that approximately 16 percent of nurses are codependent. Thus, it is important that therapists working in employee assistance programs be knowledgable regarding diagnosis and treatment of codependency. In addition, vocational counsellors need to re-examine their belief structure if they operate on the basis of the belief that the majority of candidates for the helping professions are codependent. The majority of nurses simply are not codependent as per this research.

Limitations

Several limitations suggest that caution is needed in generalizing the results of this study. The subjects were

selected by non-probability, convenience sampling and may not reflect a fully representative sample of the population of registered nurses in Canada. As well volunteers may have different characteristics from those who did not choose to participate in the research project. The instruments used in this study were self report-measures. The results obtained using such instruments can be affected by social desirability factors. The sample size and the limited number of male subjects pose further limitations. Therefore, the results of this study are generalizable only to groups of nurses who are similar to the sample.

Implications for Research

Given the limitations of this present research, it would be helpful to measure codependency among nurses across Canada using random sampling techniques and ensuring that the sample includes males in proportion to their percentage in nursing in order to refute or uphold the finding in this research that nurses are not more codependent than the general population. Although this research was restricted to practising registered nurses, future research might include licensed practical nurses. Additionally, future research should include nurses who

have more than ten tears of service and who have moved into teaching and administrative roles in nursing. The nursing profession as a whole may have been maligned in the literature and studies across the entire spectrum of nurses would provide an empirical basis for examining the characteristics of nurses more objectively.

While the present sample included nurses from specialty areas, it would be useful to assess the codependent orientation of nurses within specialty subgroups such as: psychiatry, operating room, emergency, and intensive/cardiac care units as the literature suggests that nurses who are codependent are drawn to these specialty areas (Arnold, 1990b). This supposition has not yet been empirically tested.

Construction of an external referenting instrument that contains a larger number of items measuring locus of control in relational issues may provide a better measure of external referenting as it is described in the codependency literature. Future research focused upon the relationship of codependency to self-esteem, depression, burnout, and relational issues such as intimacy and loneliness may expand our understanding of codependency issues among nurses.

Conclusion

As a nurse educator and a counsellor, I found the results of this investigation both surprising and gratifying. Based on the literature, it was expected that a high proportion of nurses in the sample would exhibit a significant degree of codependent orientation with a concomitant external locus of control. It was therefore gratifying to find that, contrary to the statements made in the literature, nurses in this sample were no different from the general population in terms of codependency and that there was no relationship between codependency and external locus of control. It is hoped that future empirical research on codependency among nurses will be undertaken to confirm or refute these findings. In the interim, it would be advisable to view the repeated citing of Snow and Willard's (1989) finding that 80 percent of nurses have codependency issues as empirically unsupported speculation. For now, nurses may be regarded as indistinguishable from the general population in the codependency dimension.

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APPENDIX A

60-ITEM INDIVIDUAL OUTLOOK TEST (IOT)

1. I sometimes feel that I'm not good enough to associate with the people I meet.

2. I never try to help people unless I'm asked.

3. I have often done things without thinking them through properly and later regretted my decision.

4. I feel anxious or tense about something or someone almost all the time.

5. I had a happier childhood than most other people.

6. I have had partners who didn't treat me very well.

7. It seems to me I have spent my whole life trying to please others.

8. Although I appear strong and capable to others, there is a part of me that isn't strong at all.

9. I have been close to people who did illegal things and I found excuses for what they did.

10. Often when asked for my opinion, I found out what other people think before I say what I think.

11. I often feel there is something bad about me.

12. I am not ashamed of my childhood.

13. I can't remember the last time I felt totally carefree and relaxed.

14. Sometimes I don't know who the real me is.

15. I have on many occasions, checked up to see where my partner is when he or she is not with me.

16. I tend to believe things people say and often find out later that they have lied.

17. I have trouble thinking of the right things to say when in a group of people.

18. I feel I fit in at most social gatherings.

19. I feel best about myself when I'm having a romantic relationship.

20. Often, others find things amusing that I don't consider funny.

21. Even a small kindness from a person I've had a problem with, makes me forgive and forget.

22. I don't undertake any project unless I'm pretty sure I'll succeed.

23. There are things I have done or had happen to me in the past that I am ashamed to talk about.

24. I have often said hurtful things to people I love in order to get them to listen.

25. I am embarrassed when people give me compliments but secretly I feel good.

26. I can be easily swayed from doing something if others criticize it.

27. When things go wrong for others, I often blame myself even when I shouldn't.

28. I don't worry very much about what the future holds for me.

29. When I am in a relationship, I am totally involved in it and expect the same from my partner.

30. Quite often I lose sleep worrying about people who are important to me.

31. I quite often feel as if something dreadful is going to happen.

32. When I feel I have insulted a person, I feel ill until I make the matter right.

33. I sell myself short and settle for less than the best in romantic partners.

34. I have lied to protect people who are important to me.

35. I was raised in a family where physical abuse occurred.

36. I need a lot of reassurance that people like me.

37. It is hard for me to ask for help from someone unless I know I can return the favour.

38. When even little things go wrong, I usually get very upset and stay upset until everything is fine again.

39. Often I feel so nervous and tense that I feel dizzy.

40. I rarely go out or do anything without my partner.

41. I am envious of most of the people I meet.

42. If I am embarrassed or feel foolish, I worry about it for days.

43. Some days there seem to be so many things going wrong that life seems hopeless.

44. Sometimes I have so many thoughts racing through my head that I can't make sense out of them.

45. When I meet someone who has a problem, I often try to help them even before they ask.

46. I am never concerned about whether people like me or not.

47. I have often gone to see a doctor about my depression.

48. I don't let people get to know the real me.

49. There have been times when my life has seemed so depressing that I have thought of ending it.

50. As a child, my parents seldom listened to what I had to say or how I felt.

51. I do not like people criticizing me even if they may be right.

52. When I am alone, I often feel desperate to have company.

53. Most people cannot be truly trusted.

54. It bothers me if may romantic partner wants to go out or do something without me.

55. If someone criticizes me, I tend to believe them and then try to change myself.

56. My feelings and behavior are mostly controlled by the people around me.

57. One of my greatest worries is that some of the people I care about may leave me.

58. I have done things I am not very proud of in order to keep a relationship together.

59. I often feel as if I haven't begun to live yet.

60. I often feel anxious and uptight and can't figure out why.

APPENDIX B

INTERNAL CONTROL INDEX (ICI)

1. When faced with a problem, I ___ try to forget it.

2. I ___ need frequent encouragement from others for me to keep working at a difficult task.

3. I ___ like jobs where I can make decisions and be responsible for my own work.

4. I _____ change my opinion when someone I admire disagrees with me.

5. If I want something, I ___ work hard to get it.

6. I ___ prefer to learn the facts about something from someone else rather than have to dig them out for myself.

7. I will ___ accept jobs that require me to supervise others.

8. I ___ have a hard time saying "no" when someone tries to sell me something I don't want.

9. I ___ like to have a say in any decisions made by any group I'm in.

10. I ____ consider the different sides of an issue before making any decisions.

11. What other people think ___ has a great influence on my behavior.

12. Whenever something good happens to me, I ___ feel it is because I've earned it.

13. I ___ enjoy being in a position of leadership.

14. I ___ need someone else to praise my work before I am satisfied with what I have done.

15. I am _____ sure enough of my opinions to try to influence others.

16. When something is going to affect me, I ____ learn as much about it as I can.

17. I _____ decide to do things on the spur of the moment.

18. For me, knowing I've done something well is ___ more important than being praised by someone else.

19. I ___ let other people's demands keep me from doing things I want to do.

20. I ____ stick to my opinions when someone disagrees with me.

21. I ____ do what I feel like doing, not what other people think I ought to do.

22. I _____ get discouraged when doing something that takes a long time to achieve results.

23. When part of a group, I ___ prefer to let other people make all the decisions.

24. When I have a problem, I ____ follow the advice of friends or relatives.

25. I___ enjoy trying to do difficult tasks more than I enjoy trying to do easy tasks.

26. I _____ prefer situations where I can depend on someone else's ability rather than just my own.

27. Having someone important tell me I did a good job is ____ more important to me than feeling I've done a good job.

28. When I'm involved in something, I ____ try to find out all I can about what is going on even when someone else is in charge.