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# Comparison of Codependency Characteristics of Individuals with and without Dependent Relatives in Terms of Defense Mechanisms, Family Functionality and Attachment Styles

## Bağımlı Akrabası Olan ve Olmayan Bireylerin Eşbağımlılık Özelliklerinin Savunma Mekanizmaları, Aile İşlevselliği ve Bağlanma Stilleri Açısından Karşılaştırılması

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## Abstract

**Objective:** This study aimed to identify both the shared and distinct aspects of the codependency characteristics of individuals with (clinical group, n=56) and without dependent relatives (non-clinical group, n=59) by comparing them in terms of personal (defense-mechanisms), domestic (family-functionality), and relational (attachment-styles) contexts.
**Method:** Codependency Assessment Tool (CODAT), Defense Styles Questionnaire 40 (DSQ-40), Family Assessment Device (FAD), and Relationship Scales Questionnaire (RSQ) were used as data collection tools.
**Results:** The clinical group scored statistically significantly higher on CODAT (other focus/self-neglect, low-self-worth, family-of-origin-issues subscales and total), DSQ-40 (immature-defenses subscale), FAD (failure in problem-solving, communication, role-distribution, affective-responsiveness, affective-involvement, general-functioning subscales and total), RSQ (preoccupied-attachment subscale) than the non-clinical group. The non-clinical group scored significantly higher on the mature-defenses subscale than the clinical group. Immature-defenses, failure in problem-solving and preoccupied-attachment predicted codependency in the clinical group whereas in the non-clinical group, immature-defenses and unhealthy-communication were significant predictors of codependency.
**Conclusion:** Codependency characteristics differ among individuals with and without dependent family members. As immature defenses predicted codependency in both groups, the use of this defense mechanism may be a fundamental feature of codependency.

Keywords: Codependency, defense mechanisms, family functioning, attachment styles

## Öz

**Amaç:** Bu çalışmada, bağımlı yakını olan (klinik grup, n=56) ve olmayan (klinik-olmayan grup, n=59) bireylerin eş-bağımlılık özelliklerinin bireysel (savunma-mekanizmaları), aile içi (aile-işlevselliği) ve ilişkisel (bağlanma-stilleri) açılardan karşılaştırılarak bu bireylerin eş-bağımlılık özelliklerinin ortak ve farklı yönlerinin belirlenmesi amaçlanmıştır.
**Yöntem:** Veri toplama aracı olarak Eş Bağımlılık Belirleme Ölçeği (EşBBÖ), Savunma Biçimleri Testi 40 (SBT-40), Aile Değerlendirme Ölçeği (ADÖ) ve İlişki Ölçekleri Anketi (İÖA) kullanılmıştır.
**Bulgular:** Klinik grubun EşBBÖ (diğerine-odaklanma/kendini-ihmal, düşük-öz-değer, kök-aile-sorunları alt ölçekleri ve toplam puanı); SBT-40 (immatür-savunmalar alt ölçeği); ADÖ (problem-çözmede-başarısızlık, iletişim-sorunları, rol-dağılımı-sorunları, duygusal-tepkisellik, duygusal-ilişki-kurma ve genel-işlevsellik sorunları alt ölçekleri ve toplam puanı); İÖA (saplantılı-bağlanma alt ölçeği) puanlarının klinik-olmayan gruptan; klinik-olmayan grubun ise SBT-40 olgun-savunmalar alt ölçeği puanının klinik gruptan istatistiksel olarak anlamlı düzeyde daha yüksek olduğunu göstermiştir. Klinik grupta immatür savunmaların, problem-çözmede başarısızlığın ve saplantılı-bağlanmanın; klinik-olmayan grupta ise immatür savunmaların ve sağlıksız iletişimin eş-bağımlılığı istatistiksel olarak anlamlı düzeyde yordadığını göstermiştir.
**Sonuç:** Bu bulgular, bağımlı yakını olan ve olmayan bireylerin eş-bağımlılık özelliklerinin farklılık gösterdiğini gözlemleyen önceki araştırmaları desteklemektedir. Ayrıca immatür savunmaların, bireyin bağımlı bir yakını olup olmadığı fark etmeksizin her iki grupta da eş-bağımlılığı yordaması, bu savunma mekanizmasının kullanımının eş-bağımlılığın temel bir özelliği olabileceğine işaret etmektedir.

Anahtar kelimeler: Eş bağımlılık, savunma mekanizmaları, aile işlevselliği, bağlanma stilleri

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# Introduction

The term "codependency" refers to conceptualizing the behavioral patterns exhibited by relatives of dependent family members as well as the dynamics of the relationship formed between them. Nevertheless, subsequent studies have revealed that codependency is not limited to relatives of dependents (1-5). For instance, previous studies reported that codependency can occur both in clinical (a family with an alcoholic family member) and non-clinical (a family with no alcoholic family member) families, but there is a qualitative difference in family functions and relationship characteristics between those families (2). Therefore, the concept of codependency has been broadened to encompass families that include both individuals with problems with substance abuse and individuals without substance abuse but raised in a dysfunctional family structure (6, 7). These prompted researchers to further investigate the various contexts in which codependency arises, expanding beyond the domain of substance abuse (8-14).

The conceptual framework that is widely accepted delineates codependency within three distinct contexts: personal, domestic and relational. The concept of personal context characterizes codependency as a form of individual psychopathology. Within the domestic context, codependency is viewed as a problem that originates in the family system, regardless of the presence of a dependent family member. In the relational context, codependency is considered as a relational problem that arises from maladaptive behavioral patterns stemming from either individual psychopathology, dysfunctional family systems, or both (15). Nevertheless, the implications of codependency traits in individuals with dependent family members and those without, in these three contexts are still not fully understood. Hence, in this study, we aimed to assess codependency in conjunction with personal, familial, and relational factors by considering defense mechanisms as an indicator of the personal context, family functionality as an indicator of the domestic context, and attachment styles as an indicator of the relational context.

The extant literature has established a connection between defense mechanisms, codependency, and dependency, as evidenced by findings indicating that codependent individuals are more prone to employing defense mechanisms similar to those used by dependent individuals, thereby contributing to the maintenance of dependency (1). In a recent study, it was observed that wives of addicted males are more likely to show immature and neurotic defenses compared to the wives of non-addict males (16). This implies that defense mechanisms, particularly immature and neurotic defenses, may have a substantial impact on the characteristics of both dependency and codependency. The existing body of research concerning the domestic context of codependency primarily centers on the functionality of families and provides evidence that families with dependent members tend to display dysfunctional dynamics (17–19). For instance, addicted males were observed to display lower levels of family functionality, problem solving skills, ability to communicate, role playing, emotional responses, affective involvement, and behavioral control in comparison to non-addicted males (17).

The research on the relational context of codependency highlights the association between codependency and maladaptive behavioral patterns, which may arise from individual psychopathology, dysfunctional family systems, or a combination of both. Relatives of a dependent who show elevated levels of codependency were found to exhibit a greater prevalence of maladaptive behaviors and require increased medical intervention when compared to those with lower levels of codependency (20). In order to gain a more comprehensive understanding of the relational dimension of codependency, researchers emphasize the interplay between dependency and attachment styles. Prior research has established a significant correlation between substance abuse and an insecure attachment style, as well as a deficit in the ability to regulate emotions and affect. Those factors have also been identified as being involved in the difficulties encountered in interpersonal communication within the family system (21–23). In a similar vein, the preoccupied-anxious attachment style was found to have a predictive value for codependency (24, 25). On the other hand, contemporary research offers an alternative perspective on codependency concerning the attachment styles of individuals. Studies examining the potential beneficial effect of codependency on caregiving professions that necessitate higher sensitivity to the needs of others, such as nursing, reveal the importance of

distinguishing the positive aspects of interpersonal relationships from the pathological behavioral tendencies associated with codependency (8, 12, 27). Therefore, it seems necessary to further examine the codependency traits exhibited by individuals who do not have dependent relatives.

The main objective of this research was to investigate the codependency characteristics of individuals with dependent relatives (clinical group) and without dependent relatives (non-clinical group). Additionally, this study sought to explore the relationships between codependency and defense mechanisms, family functionality, and attachment styles to identify both the shared and distinct features of codependency within these groups. Our hypothesis posits that codependency can be understood as a continuous spectrum, wherein the presence of dependency contributes to increased levels of codependency, along with various higher deficits in personal, domestic, and relational domains.

# Method

## Study Design and Participants

Ethics committee approval dated 28/05/2019 and numbered 116 from the Haliç University non-interventional clinical research ethics committee and informed consent was obtained from all participants. The dependent group consists of outpatients at the alcohol and drug treatment center of a private hospital in Istanbul. Non-clinical participants were invited to the study via social media accounts and social networks. All participants were informed about the study's purpose, the confidentiality of their personal information, and that they could withdraw from the study whenever they wanted to.

The data were collected from one hundred and nineteen participants with their consent via online Google Forms. However, four participants who did not report their age were excluded from the data set. The analysis was run for 56 participants (clinical group) who have dependent relatives and 59 participants who do not have dependent relatives (non-clinical group). The clinical group of the study consisted of 41 women (73.2%) and 15 men (26.8%) between the ages of 20 and 69 (M = 42.8, SD = 13.7, n = 56), and the non-clinical group of the study consisted of 41 women (69.5%) and 18 men (30.5%) between the ages of 19 and 69 (M = 39.05, SD = 11.5, n = 59). Participants' relationships with the dependents in the clinical group were as follows: 17 were (30.3%) the dependent's children, 14 were (25%) siblings, 11 were (19.6%) fathers, 7 were (12.5%) friends, 5 were (8.9%) spouses, and 2 were (3.5%) girls or boyfriends. Substance preferences of the dependents were 35.7% alcohol (n = 20), 28.6% heroin (n = 16), 19.6% weed (n = 11), 7.1% pills (n = 4), 5.4% volatile substances (n = 3), 1.8% cocaine (n = 1), and 1.8% bonzai (n = 1). We classified participants according to their education level. Participants who have a lower degree than a bachelor's degree are classified as a low-education group. Participants who have a bachelor's degree are classified as a mid-education group, and those who have a higher degree than a bachelor's degree are classified as a high-education group. Of the 56 participants in the clinical group, 57.1% (n = 32) were low, 35.7% (n = 20) were mid, and 7.1% (n = 4) were highly educated. Of the 59 participants in the non-clinical group, 20.3% (n = 12) were low, 49.2% (n = 29) were mid, and 30.5% (n = 18) were highly educated.

## Measures

### Codependency Assessment Tool (CODAT)

The CODAT was developed by Hughes-Hammer et al. to evaluate codependency and adapted to Turkish by Ançel and Kabakçı (28,29). The tool is a 5-point Likert-type scale, consisting of five subscales and 25 items. The subscales include other focus/self-neglect (CODAT-OF), low self-worth (CODAT-LSW), hiding self (CODAT-HS), medical problems (CODAT-MP), and family of origin issues (CODAT-FOI). Participants are asked to rate how often they feel themselves, as indicated by the items on a scale ranging from '1' (never) to '5' (most of the time). Higher scores are indicative of heightened levels of codependency.

### Defense Styles Questionnaire 40 (DSQ-40)

Defense Styles Questionnaire developed by Andrews, Singh and Bond to evaluate the reflections of the

defense mechanisms on the level of consciousness. The questionnaire was adapted to Turkish by Yılmaz, Gençöz and Ak (30, 31). It consists of 40 items that are rated on a 9-point Likert-type scale between "1" (not suitable for me) and "9" (very suitable for me). DSQ-40 includes 20 defenses, which are clustered in three subscales as “immature (DSQ-ID)”, “neurotic (DSQ-ND)” and “mature” (DSQ-MD). Higher scores in each subscale are indicative of the utilization of relevant defense mechanisms.

### McMaster Family Assessment Device (FAD)

The McMaster Family Assessment Device was developed by Epstein, Baldwin, and Bishop to assess the functionality of the family (32). FAD was adapted to Turkish by Bulut (33). FAD consists of 60 items and seven subscales, including problem-solving (FAD-PS), communication (FAD-CM), roles (FAD-RL), affective responsiveness (FAD-AR), affective involvement (FAD-AI), behavior control (FAD-BC), and general functioning (FAD-GF). The scale is a 4-point Likert type and is rated between '1' (exactly agree) and '4' (never agree). Lower scores are indicative of healthy family functioning, while higher scores are indicative of unhealthy family functioning.

### The Relationship Scales Questionnaire (RSQ)

The Relationship Scale Questionnaire was developed by Griffin and Bartholomew to determine attachment styles (34). It was adapted into Turkish by Sumer and Gungor (35). The RSQ questionnaire comprises a total of 30 items, which are further divided into four subscales: secure attachment (RSQ-SA), dismissing attachment (RSQ-DA), preoccupied attachment (RSQ-PA), and fearful attachment (RSQ-FA) styles. The questionnaire is a 7-point Likert-type scale and is rated between '1' (never identifies me) and '7' (completely identifies me). Higher scores on each subscale indicate a higher level of the corresponding attachment style.

## Statistical Analysis

The normal distribution assumption of the data was evaluated based on whether the total and subscale measures and scores of the tasks’ skewness and kurtosis were within the range of ± 2. As the total and subscale scores were normal or close to the normal distribution, it was decided to use parametric tests. Independent samples t-test were administered to reveal group differences. Pearson correlation analysis was conducted to examine the relationship between scales and subscales. In order to determine the predictive values of variables that were significantly correlated with codependency scores of the clinical and non-clinical group, hierarchical multiple linear regression (HMLR) analysis with the stepwise method was performed separately for each group by controlling age, gender, and educational level. All statistical analyses were performed via SPSS 20.

# Results

Independent sample t-tests results showed that the clinical group scored statistically significantly higher on CODAT-FOI, CODAT-TS, DSQ 40-MD, FAD-PS, FAD-CM, FAD-RL, FAD-AR, FAD-AI, FAD-GF, FAD-TS, RSQ-PA than the non-clinical group. Whereas the non-clinical group scored significantly higher on the DSQ 40-ID than the clinical group (Table 1). Pearson correlation analyses results revealed both common and distinctive significant correlations between codependency and defense mechanisms, family functions, and attachment styles of the clinical group (Table 2) and non-clinical group (Table 3). In the clinical group, DSQ-ID, FAD-PS, FAD-PS, FAD-GF, and RSQ-PA were positively; DSQ-MD and RSQ-SA were negatively correlated with codependency (r range from -.39 to .46). In the non-clinical group, DSQ-ID, FAD-PS, FAD-CM, FAD-AR, FAD-GF, and RSQ-SA were positively correlated with codependency (r range from -.10 to .49).

Hierarchical multiple linear regression analysis were run for the clinical and non-clinical groups separately. For the control group. age, gender, and educational level were entered as a control variable in the first regression block, and problem-solving failure, FAD-GF, FAD-RL, DSQ-ID, DSQ-MD, RSQ-SA, and RSQ-PA were entered in the second regression block by using stepwise method (Table 4).

**Table 1. Independent samples t-test results on the comparison of the clinical and non-clinical groups' CODAT, DSQ-40, FAD, and RSQ scores**

| SCALES | Study Groups | $\bar{x}$ | sd | t | df | *p* | Cohen's d |
|---|---|---|---|---|---|---|---|
| CODAT-OF | 1 | 14.61 | 5.28 | 2.89 | 113 | .005 | 4.79 |
| | 2 | 12.02 | 4.27 | | | | |
| CODAT-LSW | 1 | 14.34 | 5.87 | 3.67 | 113 | .000 | 4.90 |
| | 2 | 10.98 | 3.77 | | | | |
| CODAT-HS | 1 | 13.21 | 3.88 | 0.49 | 113 | .625 | 3.83 |
| | 2 | 12.86 | 3.77 | | | | |
| CODAT-MP | 1 | 7.89 | 3.66 | 1.25 | 113 | .214 | 3.17 |
| | 2 | 7.15 | 2.63 | | | | |
| CODAT-FOI | 1 | 16.30 | 4.49 | 6.70 | 113 | .000 | 4.29 |
| | 2 | 10.93 | 4.10 | | | | |
| CODAT-TS | 1 | 66.36 | 15.04 | 4.72 | 113 | .000 | 14.08 |
| | 2 | 53.95 | 13.11 | | | | |
| DSQ 40-ID | 1 | 103.96 | 23.85 | 2.81 | 113 | .006 | 22.68 |
| | 2 | 92.08 | 21.50 | | | | |
| DSQ 40-ND | 1 | 39.14 | 9.01 | 1.06 | 113 | .290 | 8.06 |
| | 2 | 37.54 | 7.04 | | | | |
| DSQ 40-MD | 1 | 41.29 | 10.85 | -3.20 | 113 | .002 | 10.14 |
| | 2 | 47.34 | 9.42 | | | | |
| DSQ 40-TS | 1 | 184.39 | 32.10 | 1.37 | 113 | .173 | 29.01 |
| | 2 | 176.97 | 25.75 | | | | |
| FAD-PS | 1 | 16.14 | 4.18 | 4.72 | 113 | .000 | 4.26 |
| | 2 | 12.39 | 4.33 | | | | |
| FAD-CM | 1 | 21.93 | 5.24 | 5.07 | 113 | .000 | 5.10 |
| | 2 | 17.10 | 4.96 | | | | |
| FAD-RL | 1 | 26.88 | 5.30 | 4.41 | 113 | .000 | 5.18 |
| | 2 | 22.61 | 5.06 | | | | |
| FAD-AR | 1 | 13.88 | 4.51 | 4.56 | 113 | .000 | 3.98 |
| | 2 | 10.49 | 3.40 | | | | |
| FAD-AI | 1 | 16.82 | 2.80 | 2.16 | 113 | .000 | 2.37 |
| | 2 | 15.86 | 1.88 | | | | |
| FAD-BC | 1 | 20.18 | 3.34 | 1.72 | 113 | .089 | 3.41 |
| | 2 | 19.08 | 3.49 | | | | |
| FAD-GF | 1 | 28.59 | 6.95 | 4.96 | 113 | .000 | 7.18 |
| | 2 | 21.95 | 7.39 | | | | |
| FAD-TS | 1 | 144.41 | 24.27 | 5.36 | 113 | .000 | 24.93 |
| | 2 | 119.49 | 25.55 | | | | |
| RSQ-FA | 1 | 16.96 | 5.55 | 1.06 | 113 | .293 | 5.33 |
| | 2 | 15.92 | 5.10 | | | | |
| RSQ-DA | 1 | 22.55 | 4.20 | -0.41 | 113 | .683 | 3.85 |
| | 2 | 22.85 | 3.49 | | | | |
| RSQ-SA | 1 | 20.18 | 5.31 | 0.06 | 113 | .954 | 5.51 |
| | 2 | 20.12 | 5.68 | | | | |
| RSQ-PA | 1 | 16.91 | 4.83 | 2.18 | 113 | .032 | 4.41 |
| | 2 | 15.12 | 3.97 | | | | |
| RSQ-TS | 1 | 76.61 | 8.56 | 1.57 | 113 | .120 | 8.92 |
| | 2 | 74.00 | 9.26 | | | | |

Note 1. 1 = Clinical Group (n =56). 2 = Non-clinical Group (n =59).

Note 2. CODAT-OF: Codependency Assessment Tool-Other Focus. CODAT-LSW: Codependency Assessment Tool-Low-Self-Worth. CODAT-HS: Codependency Assessment Tool-Hiding Self. CODAT-MP: Codependency Assessment Tool-Medical Problems. CODAT-FOI: Codependency Assessment Tool-Family Of Origin Issues. CODAT-TS: Codependency Assessment Tool-Total Score. DSQ-40: Defense Styles Questionnaire-40. DSQ-40-ID: Immature Defenses. DSQ-40-ND: Neurotic Defenses. DSQ-40-MD: Mature Defenses. FAD: McMaster Family Assessment Device. FAD-PS: Problem Solving. FAD-CM: Communication. FAD-RL: Roles. FAD-AR: Affective Responsiveness. FAD-AI: Affective Involvement. FAD-BC: Behavior Control. FAD-GF: General Functioning. RSQ: Relationship Scales Questionnaire. RSQ-SA: Secure Attachment. RSQ-FA: Fearful Attachment. RSQ-PA: Preoccupied Attachment. RSQ-DA: Dismissing Attachment.

**Table 2. Pearson correlations of CODAT total score with DSQ-40. FAD and RSQ subscale scores of the clinical group**

| | CODAT-TS | DSQ 40-ID | DSQ 40-ND | DSQ 40-MD | FAD-PS | FAD-CM | FAD-RL | FAD-AR | FAD-AI | FAD-BC | FAD-GF | RSQ-SA | RSQ-FA | RSQ-PA | RSQ-DA |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| CODAT-TS | - | .46** | .16 | -.34** | .31* | .14 | .41** | .05 | -.07 | .12 | .33* | -.39** | .14 | .43** | -.17 |
| DSQ 40-ID | | - | .56** | -.02 | -.14 | .04 | .24 | .23 | .26 | .34** | .04 | -.45** | .34** | .11 | .04 |
| DSQ 40-ND | | | - | .18 | -.31* | -.24 | .01 | -.20 | .12 | .10 | -.31* | -.26 | .25 | .18 | -.01 |
| DSQ 40-MD | | | | - | -.40** | -.36** | -.25 | -.09 | .11 | -.25 | -.38** | .29* | .02 | -.16 | .32* |
| FAD-PS | | | | | - | .55** | .54** | .37** | -.14 | .08 | .77** | -.13 | -.12 | .05 | -.38** |
| FAD-CM | | | | | | - | .69** | .73** | .06 | .26 | .75** | -.17 | .16 | .02 | -.15 |
| FAD-RL | | | | | | | - | .62** | .28 | .40** | .71** | -.38** | .25 | .18 | -.16 |
| FAD-AR | | | | | | | | - | .37** | .32* | .65** | -.33* | .23 | -.11 | -.17 |
| FAD-AI | | | | | | | | | - | .24 | .08 | -.18 | .01 | -.12 | -.01 |
| FAD-BC | | | | | | | | | | - | .28* | -.28* | .17 | -.15 | .04 |
| FAD-GF | | | | | | | | | | | - | -.24 | .11 | -.01 | -.16 |
| RSQ-SA | | | | | | | | | | | | - | -.52** | -.20 | .11 |
| RSQ-FA | | | | | | | | | | | | | - | .25 | .09 |
| RSQ-PA | | | | | | | | | | | | | | - | -.21 |
| RSQ-DA | | | | | | | | | | | | | | | - |

Note 1. CODAT-TS: Codependency Assessment Tool- Total Score. DSQ 40: Defense Styles Questionnaire 40. DSQ 40-ID: Immature Defenses. DSQ 40-ND: Neurotic Defenses. DSQ 40-MD: Mature Defenses. FAD: McMaster Family Assessment Device. FAD-PS: Problem Solving. FAD-CM: Communication. FAD-RL: Roles. FAD-AR: Affective Responsiveness. FAD-AI: Affective Involvement. FAD-BC: Behavior Control. FAD-GF: General Functioning. RSQ: Relationship Scales Questionnaire. RSQ-SA: Secure Attachment. RSQ-FA: Fearful Attachment. RSQ-PA: Preoccupied Attachment. RSQ-DA: Dismissing Attachment.

Note 2. *p < 0.05; **p < 0.01

Note 3. Increasing the McMaster Family Assessment Device scores indicate that unhealthy family functions increase.

In Model 1, age, gender, and education level did not significantly contribute to codependency ($p > .05$). After controlling age, gender, and education level, the results show that in Model 2, DSQ-ID explained 22% of the variance in codependency alone in the clinical group. After FAD-PS was added, explained variance increased 15% in Model 3. Lastly, adding RSQ-PA increased explained variance 11% in Model 4. Accordingly, DSQ-ID ($\beta = .47$, $p = .000$), FAD-PS ($\beta = .36$, $p = .002$) and RSQ-PA ($\beta = .35$, $p = .002$) as the predictors of codependency, final model explained 48% of the codependency total variance significantly ($F(1, 49) = 7.44$, $p = .000$).

**Table 3. Pearson correlations of CODAT total score with DSQ-40. FAD and RSQ subscale scores of the non-clinical group**

| | CODAT-TS | DSQ 40-ID | DSQ 40-ND | DSQ 40-MD | FAD-PS | FAD-CM | FAD-RL | FAD-AR | FAD-AI | FAD-BC | FAD-GF | RSQ-SA | RSQ-FA | RSQ-PA | RSQ-DA |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| CODAT-TS | - | .41** | -.01 | -.10 | .37** | .49** | .25 | .39** | .23 | .16 | .40** | .32* | .13 | .26 | .03 |
| DSQ 40-ID | | - | .15 | -.09 | .13 | .11 | .25 | .14 | -.02 | .11 | .27* | .04 | .29* | .15 | -.01 |
| DSQ 40-ND | | | - | .41** | -.38** | -.37** | -.27* | -.34** | -.26 | -.14 | -.32* | .13 | -.05 | -.20 | .02 |
| DSQ 40-MD | | | | - | -.41** | -.29* | -.39** | -.31* | -.06 | -.29* | -.46** | .01 | -.15 | -.12 | .08 |
| FAD-PS | | | | | - | .82** | .66** | .81** | .41** | .46** | .83** | .17 | -.01 | .22 | -.09 |
| FAD-CM | | | | | | - | .63** | .77** | .42** | .45** | .79** | .19 | .03 | .29* | -.10 |
| FAD-RL | | | | | | | - | .59** | .27* | .61** | .77** | .07 | -.06 | .36** | -.17 |
| FAD-AR | | | | | | | | - | .40** | .39** | .83** | .09 | .08 | .11 | -.07 |
| FAD-AI | | | | | | | | | - | .18 | .45** | .08 | -.02 | .26* | .21 |
| FAD-BC | | | | | | | | | | - | .49** | .09 | -.12 | .04 | -.05 |
| FAD-GF | | | | | | | | | | | - | .13 | .09 | .18 | -.07 |
| RSQ-SA | | | | | | | | | | | | - | -.50** | .27* | -.07 |
| RSQ-FA | | | | | | | | | | | | | - | .03 | .37** |
| RSQ-PA | | | | | | | | | | | | | | - | .15 |
| RSQ-DA | | | | | | | | | | | | | | | - |

Note 1. CODAT-TS: Codependency Assessment Tool- Total Score. DSQ 40: Defense Styles Questionnaire 40. DSQ 40-ID: Immature Defenses. DSQ 40-ND: Neurotic Defenses. DSQ 40-MD: Mature Defenses. FAD: McMaster Family Assessment Device. FAD-PS: Problem Solving. FAD-CM: Communication. FAD-RL: Roles. FAD-AR: Affective Responsiveness. FAD-AI: Affective Involvement. FAD-BC: Behavior Control. FAD-GF: General Functioning. RSQ: Relationship Scales Questionnaire. RSQ-SA: Secure Attachment. RSQ-FA: Fearful Attachment. RSQ-PA: Preoccupied Attachment. RSQ-DA: Dismissing Attachment.

Note 2. *p < 0.05; **p < 0.01

Note 3. Increasing the McMaster Family Assessment Device scores indicate that unhealthy family functions increase

For the non-clinical group, age, gender, and educational level were entered as a control variable in the first regression block, and FAD-PS, FAD-CM, FAD-AR, FAD-GF, DSQ-ID, and RSQ-SA styles were entered in the second regression block by using stepwise method (Table 5). In Model 1, the contribution of age and gender to the model was non-significant (p = .05). However, results showed that education level significantly contributed to codependency (β = .39, p = .007) in non-clinical group. After controlling age, gender, and education level, in Model 2, DSQ-ID explained 32% of the variance in codependency alone in the non-clinical group. In Model 3, after FAD-CM entered the model, the explained variance increased 12%. Thus, DSQ-ID (β = .40, p = .000) and FAD-CM (β = .39, p = .001) significantly contributed the final model and explained 44% of the variance of codependency (F(1, 53) = 8.55, p = .000).

**Table 4. Results of hierarchical multiple linear regression analysis predicting codependency in clinical group by controlling age, gender and education level**

| Model | Control Variable | Predictors | B | SE | β | t | p |
|---|---|---|---|---|---|---|---|
| 1 | Age | | 0.10 | 0.16 | .09 | 0.60 | .548 |
| | Gender | | 2.45 | 4.91 | .07 | 0.50 | .620 |
| | Education Level | | 0.30 | 3.50 | .01 | 0.08 | .933 |
| 2 | Age | | 0.10 | 0.15 | .09 | 0.66 | .511 |
| | Gender | | 0.91 | 4.44 | .03 | 0.21 | .838 |
| | Education Level | | -0.16 | 3.15 | -.01 | -0.05 | .960 |
| | | DSQ 40-ID | 0.29 | 0.08 | .45 | 3.63 | .001 |
| 3 | Age | | 0.13 | 0.13 | .12 | 0.94 | .350 |
| | Gender | | -0.51 | 4.05 | -.02 | -0.13 | .900 |
| | Education Level | | 3.21 | 3.02 | .13 | 1.06 | .294 |
| | | DSQ 40-ID | 0.32 | 0.07 | .51 | 4.43 | .000 |
| | | FAD-PS | 1.49 | 0.43 | .41 | 3.44 | .001 |
| 4 | Age | | 0.06 | 0.13 | .05 | 0.46 | .648 |
| | Gender | | 0.21 | 3.73 | .01 | 0.06 | .955 |
| | Education Level | | 0.73 | 2.89 | .03 | 0.25 | .801 |
| | | DSQ 40-ID | 0.29 | 0.07 | .47 | 4.41 | .000 |
| | | FAD-PS | 1.29 | 0.40 | .36 | 3.22 | .002 |
| | | RSQ-PA | 1.08 | 0.34 | .35 | 3.19 | .002 |

| Model Statistics | R | $R^2$ | $\Delta R^2$ | F | ΔF | *p* | Durbin Watson |
|---|---|---|---|---|---|---|---|
| Model 1 | .13 | .02 | .02 | 0.29 | 0.29 | .832 | 2.37 |
| Model 2 | .47 | .22 | .20 | 3.56 | 13.18 | .012 | |
| Model 3 | .61 | .37 | .15 | 5.82 | 11.82 | .000 | |
| Model 4 | .69 | .48 | .11 | 7.44 | 10.19 | .000 | |

Note 1. Dependent Variable = Codependency Assessment Tool-Total Score.

Note 2. DSQ 40-ID = Defense Styles Questionnaire 40-Immature Defenses. FAD-PS = McMaster Family Assessment Tool-Problem Solving. RSQ-PA = Relationship Scales Questionnaire-Preoccupied Attachment.

Note 3. Increasing FAD scores indicate increasing unhealthy family functions.

**Table 5. Results of hierarchical multiple linear regression analysis predicting codependency in non-clinical group by controlling age, gender and education level**

| Model | Control Variable | Predictors | B | SE | *β* | *t* | *p* |
|---|---|---|---|---|---|---|---|
| 1 | Age | | 0.13 | 0.16 | .12 | 0.82 | .417 |
| | Gender | | 3.37 | 3.61 | .12 | 0.93 | .356 |
| | Education Level | | 7.17 | 2.58 | .39 | 2.78 | .007 |
| 2 | Age | | 0.21 | 0.14 | .18 | 1.46 | .151 |
| | Gender | | 1.50 | 3.26 | .05 | 0.46 | .648 |
| | Education Level | | 7.93 | 2.31 | .43 | 3.44 | .001 |
| | | DSQ 40-ID | 0.27 | 0.07 | .44 | 3.88 | .000 |
| 3 | Age | | 0.24 | 0.13 | .21 | 1.82 | .074 |
| | Gender | | 0.96 | 2.98 | .03 | 0.32 | .749 |
| | Education Level | | 5.43 | 2.22 | .29 | 2.44 | .018 |
| | | DSQ 40-ID | 0.24 | 0.06 | .40 | 3.80 | .000 |
| | | FAD-CM | 1.02 | 0.29 | .39 | 3.47 | .001 |

| Model Statistics | R | $R^2$ | $\Delta R^2$ | F | ΔF | *p* | Durbin Watson |
|---|---|---|---|---|---|---|---|
| Model 1 | .36 | .13 | .13 | 2.77 | 2.77 | .050 | 2.10 |
| Model 2 | .56 | .32 | .19 | 6.37 | 15.02 | .000 | |
| Model 3 | .66 | .44 | .12 | 8.55 | 12.07 | .000 | |

Note 1. Dependent Variable = Codependency Assessment Tool-Total Score.

Note 2. DSQ 40-ID = Defense Styles Questionnaire 40 Immature Defenses. FAD-CM = McMaster Family Assessment Tool-Communication.

Note 3. Increasing FAD scores indicate increasing unhealthy family functions.

## Discussion

The objective of this study was to examine the codependency characteristics of individuals with and without dependent relatives, with a focus on identifying both the common and unique aspects of codependency within those two groups. Accordingly, we conducted a comparative analysis of individuals concerning personal (defense mechanisms), domestic (family-functionality), and relational (attachment-styles) factors, which align with the existing definition of codependency as established by prior researchers.

The present study examined the correlations of defense mechanisms, family functionality, and attachment styles with codependency in both clinical and non-clinical groups. The present findings demonstrate shared as well as distinct correlations between these variables and codependency among those groups. In the clinical group, codependency was positively linked to failure in problem-solving, role distribution, and general family functioning. Within the non-clinical group, codependency exhibited positive associations with failure in problem-solving, communication, affective responsiveness, and general functioning. These findings are consistent with prior research, which showed that codependent individuals were unable to establish a functional connection with their family members (17–19). It must be noted that the present findings showed that, in contrast to the clinical group, the non-clinical group did not exhibit a significant correlation between failure in role distribution within the family and codependency. Furthermore, it exhibited a significant association with failure in both communication and affective responsiveness. In accordance with the McMaster Model of Family Functioning, the findings of this study indicate that deficient problem-solving skills, reduced family functionality, ineffective communication strategies, and maladaptive emotional responses to situations contribute to the escalation of codependency in the absence of a dependent family member.

The present results showed that as codependency increase, the use of immature defense mechanisms becomes more frequent. This result is in line with previous research, which revealed that dependent relatives mainly use immature defense mechanisms such as reflection and denial to cope with dependency (16, 39). Moreover, since codependency levels increase in the clinical group, the use of mature defense mechanisms becomes less prevalent. This finding suggests that codependent individuals, both with and without dependent relatives, use immature defenses to deal with stressful situations in general. However, codependent individuals who have dependent relatives may be unable to use mature defenses in the face of situations that threaten their resilience.

Individuals who display a preoccupied attachment style are characterized by the experience of emotions related to feelings of inadequacy and worthlessness, perceiving themselves as lacking in deservingness of love, developing unrealistic expectations for relationships, exerting control over the relationship dynamics, and seeking validation from others (20). Consistent with previous studies examining the relationship between codependency and preoccupied attachment (25, 26), the current findings indicate a positive association between these two constructs. Furthermore, the findings of this study indicate a positive association between secure attachment and codependency within the non-clinical population. The present outcome can be construed in light of previous research conducted through a meta-analysis examining the longitudinal connections between substance use and interpersonal attachment security. Notably, a prior study discovered a noteworthy prospective correlation between earlier attachment experiences and subsequent substance use (22). Suggesting a correlation between individuals with less secure attachment relationships and a heightened propensity for substance use. Moreover, it revealed a stronger association between early attachment and subsequent substance use compared to the link between early substance use and later attachment.

Individuals who possess a secure attachment style exhibit characteristic such as a favorable self-perception, the ability to make independent and autonomous choices, the willingness to seek assistance and support, the capacity to communicate effectively, and the capability to form intimate relationships based on love and trust (20, 36). Thus, a secure attachment may serve as a catalyst for an individual's inclination towards altruism and proneness to care for others, which may now be mistakenly conflated with codependency. On

the other hand, as one would expect, the current study revealed negative associations between secure attachment and codependency within the clinical group. This observation aligns with prior research that has posited that individuals who possess secure attachment styles demonstrate the capacity to successfully navigate the dynamics of closeness and distance without excessively depending on others (37).

After controlling for age, gender, and education level, the results of hierarchical multiple regression analysis indicated that codependency in the clinical group was significantly predicted by immature defense mechanisms, failure in problem solving, and a preoccupied attachment style. On the other hand, immature defense mechanisms and unhealthy communication (failure) were significant predictors of codependency in the non-clinical group. Considering problem solving and communication failure (17), and immature defense mechanisms (1, 16, 42) as predictors of codependency, the relevant results are compatible with the previous research. The results of this study provide further evidence, indicating that there are variations in codependency traits between individuals who have dependent family members and those who do not. Moreover, it is noteworthy that the presence of immature defense mechanisms was found to be a significant predictor of codependency in both groups, irrespective of whether the individual had a dependent family member. This finding suggests that the utilization of such defense mechanisms may be an inherent characteristic of codependency.

The concept of family is a fixed system that resists change due to its nature. The results of this study show that family functioning is both a risk and a remedial factor that affects both dependents and family members mutually. It requires patience, tolerance, and creative solution strategies in the presence of dependency among family members. However, family members and relatives of the dependent may unknowingly display behaviors that trigger or encourage alcohol or substance use. While trying to cope with feelings such as guilt and shame, the dependent relative may not realize that they are pacifying the dependent with thoughts of freeing them from addiction. Such dysfunctional behavioral patterns and attitudes interrupt the treatment process and cause the dependent to resist treatment. Therefore, it is important to assess whether the characteristics of family members or close relatives cross the line of interdependence and happen to cause codependency. As a matter of fact, the treatment and recovery process should include determining the mental dynamics of the whole family and organizing the relationship of the dependent with each family member. The findings of this study indicate that identifying and working on immature defense mechanisms, preoccupied attachment styles, and insufficient problem-solving skills in relatives of dependents is important. From a clinical standpoint, this could potentially facilitate the proficient handling of the difficulties that emerge from alcohol or substance use in their relationships with their dependents.

Examining the codependency traits exhibited by individuals in environments beyond substance or alcohol-related domains facilitates an integrated comprehension and acknowledgement of the intricate dynamics involved. Nevertheless, the scarcity of research on codependency conducted among individuals who are not relatives of substance or alcohol dependents, makes it difficult to interpret the present findings. Further investigations on codependent individuals who do not have a dependent relative are required to contrast the results across studies in order to elucidate the fundamental mechanisms underlying both dependency and codependency.

A notable constraint of this study pertains to its reliance on data obtained exclusively from a single center. Future research should incorporate data collection from multiple centers to enhance the generalizability of the results. Additionally, this study utilized a between-group design to investigate the phenomenon of codependency. Nevertheless, this methodology poses challenges in effectively identifying and addressing potential confounding factors that could influence codependency, besides the variables of age, gender, and education level that were considered in our analysis. Hence, it is critical for future researchers to assess and eliminate other confounding factors, such as psychopathological characteristics and personality traits.

In this study, the clinical group consisted of relatives of diverse substance dependents, such as alcohol, weed, and heroin. Further research is necessary to investigate whether codependency characteristics differ among the relatives of particular substance dependents. Thus, future studies should explore the codependency characteristics among individuals and their associations with personal, domestic, and

relational contexts by taking into account the specific substance to which their dependent family member is addicted.

In addition, investigating the relationship between childhood experiences and the characteristics of codependency will also be effective in identifying the developmental characteristics of codependency along with attachment styles. Based on the findings of previous studies and present study, it can be argued that individuals with preoccupied or insecure attachment styles may present a noteworthy vulnerability for the development of codependency, similar to the association observed with substance abuse. In order to enhance the body of evidence pertaining to the direct associations among attachment styles, dependency, and codependency, it is important for future research to integrate longitudinal studies into their methodologies. Besides, additional research is required in order to elucidate the underlying factors contributing to the connections between codependency and both secure and insecure attachment.

In conclusion, alcohol and substance use disorders affect individuals' physical, mental, and cognitive health negatively. It is also a public health concern that threatens individuals' family and social relationships. So it is crucial to include dependent relatives in the recovery process in order to implement effective dependency treatment functionally. But dependent relatives have difficulty coping with stress and anxiety as a consequence of dependency and unwillingly sabotage the treatment and recovery process of the dependent. Therefore, this study focused on codependence in a sample of individuals who have and do not have dependent relatives. Determining predictive factors of codependency in terms of defense mechanisms, attachment styles, and family is important to identify characteristics of codependency. Results suggest that having immature defenses and a preoccupied attachment style and being incapable of solving problems leads to codependency. Assessment of the dependents' relatives in that respect would be helpful for the treatment process of the dependent.

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