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Feminine socialization or codependency

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FEMININE SOCIALIZATION OR CODEPENDENCY

A Project

Presented to the

Faculty of

California State University,

San Bernardino

In Partial Fulfillment

of the Requirements for the Degree

Master of Social Work

By

Anna Claire Trimble

and

Donna Marie Venardos

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ABSTRACT

This descriptive research focused on the impact of feminine and masculine socialization and its' relationship to perceptions of "codependency" within the context of direct social work practice. Feminist critical theory provided a framework from which to examine the equating of traditional helping role expectations with behaviors that have been labelled as pathologically codependent. This perception of helping behaviors personalizes the problem, blaming people for assuming roles which were once considered normal, healthy, and functional, instead of locating the problem within society.

The research sample consisted of 112 social workers (55 male and 57 females.) They responded to questionnaires containing demographic items and a Relational Responsibility (Codependency) Scale designed by the researchers to measure codependency in a hypothetical client.

The data indicated that social workers' assessment support the valuation of "female" behaviors as less desirable or healthy than "male" behaviors. Both male and female social workers labeled helping behaviors as non-pathological.

ASSIGNED RESPONSIBILITIES

This was a group project and a team effort where authors collaborated throughout the project. However, for each phase of the project, certain authors took primary responsibility. These responsibilities were assigned in the manner listed below.

1. Data Collection:

   Assigned Leader Anna Claire Trimble

   Working with Donna Marie Venardos

2. Data Entry and Analysis:

   Assigned Leader Donna Marie Venardos

   Working with Anna Claire Trimble

3. Writing Report and Presentation of Findings:

   a. Introduction and Literature

      Assigned Leader Anna Claire Trimble

      Working with Donna Marie Venardos

   b. Methods

      Assigned Leader Donna Marie Venardos

      Working with Anna Claire Trimble

   c. Results

      Assigned Leader Donna Marie Venardos

      Working with Anna Claire Trimble

   d. Discussion

      Assigned Leader Anna Claire Trimble

      Working with Donna Marie Venardos

ASSIGNED RESPONSIBILITIES (continued)

4. Manuscript Preparation:

Assigned Leader Donna Marie Venardos

Working with Anna Claire Trimble

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Introduction

This research focused on the impact of feminine and masculine socialization and its relationship to perceptions of "codependency" within the context of social work practice. Feminist critical theory supplied a framework from which to examine the equating of traditional female helping role expectations with behaviors that have been labelled as pathologically codependent. The link between codependency, feminine socialization, and helping roles was explored.

Differences in socialization patterns for males and females begin with the first breath of life. Parents' expectations, based on cultural stereotypes and not on actual physical differences, establish and reinforce acceptable gender differences in beliefs, attitudes and behaviors. (Lipman-Blumen, 1984) Studies have shown that even when caregivers state clearly that they have no gender-specific expectations, their selections of items like toys show a strong traditional gender orientation. (Lipman-Blumen, 1984)

These differential socialization patterns continue throughout the individuals's life. Acceptable behaviors for female children emphasize cooperation over competition, and friendships and relations over winning on the playground.

(Gilligan, 1982; Lipman-Blumen, 1984; Krestan & Bepko, 1990) In the home, females are socialized to be nurturing and to support males and younger siblings. As a result, women's spheres of influence are largely in the area of relational issues like resolving psychological and emotional tensions and organizing and administering interpersonal activities. Additionally, much of women's time and physical resources are expected to be spent in maintaining the quality of the physical environment. "Nurturance is a key ingredient in the traditional roles assigned to females: mother, wife, teacher, nurse, baby sitter, secretary, social worker" (Lipman-Blumen, 1984, p.63).

Labeling women's helping behaviors codependent is one way in which positive aspects of female roles are devalued and the male-superior/female-inferior dichotomy is preserved. Behaviors such as showing concern for others over concern for self and taking responsibility for others in general, have been labeled "codependent".

There is no concise and widely accepted clinical definition of codependency. The term "codependent" was originally developed within the context of families experiencing chemical dependency. (Schaef, 1986) Current definitions range from a "pervasive condition" to a "literal disease". Robert Subby (1984) broadened and redefined "codependency" as

> ...an emotional, psychological and behavioral

> condition that develops as a result of an individual's prolonged exposure to, and practice of, a set of oppressive rules--rules which prevent the open expression of feeling as well as the direct discussion of personal and interpersonal problems (Schaef, 1986, p.19).

Joseph Kruse (1989) defined codependents as having "a biological predisposition to self-defeating behaviors that alleviate pain. Like drugs, such behaviors as perfectionism or controlling upset the brain's neurochemical balances leaving the codependent craving more [perfectionism and control] to feel normal" (Treadway, 1990, p.40).

"Codependency" has also been identified within the professional helping relationship. Several experts go so far as to state that "...most mental health professionals are untreated codependents who are actively practicing their disease in a way that helps neither them nor their clients" (Schaef, 1986, p.8). Some recognized experts in the field of codependency have noted that helping professions attract a higher proportion of codependent individuals than any other field. "Perhaps we've [helping professionals] just turned our compulsion for caretaking into a career" (Treadway, 1990, p.42).

Social work practitioners' professional roles incorporate the traditional female role components of nurturance (emotional support), relationship administration (providing structure and limits in the clinical setting), and maintenance (making appointments, adjusting the

environment, and making appropriate and timely interventions in the environment). Labeling these components as "codependent" calls into question the social worker's ability to function as an effective professional. (Fausel, 1988; Schaef, 1986; Treadway, 1990).

Estimates of the exact numbers of codependent practitioners are based on dependency figures in the general population. Fausel suggests that "...if professionals are at the same risk as other Americans of being affected by [chemical] dependency...at the minimum, one in three member would have been affected...Translating these figures to the 100,000 members of NASW [National Association of Social Workers], we would be talking about over 30,000 members who are at high risk of being co-dependent" (Fausel, 1989, p.41). In a study of social workers, Bruce Lackie (1983) noted that as many as two thirds had assumed roles in their families of origin that were characterized as "caretakers", "over responsible", the "mediator", the "good child", or the burden bearer. (Lackie, 1983)

Acceptance of the codependency "disease model" of caretaking behaviors undermines professional competency and obscures the meaning of the client-therapist dynamic in arriving at beneficial treatment outcomes. Critical feminist theory provides another perspective for distinguishing between normative helping behaviors and

pathological codependency. In the literature this line is blurred as

> ...the language of codependency personalized the problems and located it in individuals instead of acknowledging that the problem or 'sickness' is in the larger structure itself...[it also] blames people, women in particular, for assuming a social role that has previously been viewed as normative and functional. It takes what was once considered healthy, defining it as sick (Krestan & Bepko, 1990, p. 231).

Patterns of codependent behaviors within relationships are largely the result of socialization. (Gilligan, 1982; Schaef, 1986; Krestan & Bepko, 1990). The use of the disease construct of codependency perpetuates the false dichotomy between male and female relationship styles and the inequitable distribution of power in relationships.

Feminist critical theory stresses the need for a new perspective that values both styles equally and uniquely and achieves a new synthesis in understanding and appreciation. Until changes take place in the underlying paradigms, perceptions, attitudes and behavioral expectations will make achievement of healthy, responsibly balanced relationships an unlikely, if not impossible goal.

Social worker's perceptions of their professional roles and their evaluation of clients and their behaviors were explored in this study. Family of origin patterns and exposure to factors identified as predisposing individuals to be at risk for codependency provide points of comparison with the male and female social workers evaluation of gender

identified behaviors in a hypothetical client. The purpose of this research was to ascertain whether or not social workers take into account female socialization and perceive helping behaviors differently than the literature portrays codependency. To clearly address the sexist nature of the codependent label this study will ask the research question: What is the difference in the way female social workers perceive helping behaviors and the way male social workers perceive helping behaviors?

Since the philosophy of helping behaviors as codependent is prevalent within our society it was believed that response patterns would indicate that social workers identify client helping behaviors as codependent. Therefore, the hypotheses of this research are: 1). Male social workers would define helping behaviors as codependent more frequently than female social workers. 2). Male social workers would label female clients more codependent than female respondents.

Literature Review

The researchers identified several significant gaps in a review of the codependency literature. These gaps include the lack of a widely accepted definition of the term "codependency" (Beattie, 1987; Krestan & Bepko, 1990; Schaef, 1986), a failure to clearly distinguish the positive aspects from the negative, pathological aspects of helping behaviors, and a failure to locate codependency within the context of underlying historical and socio-political structures. (Haaken, 1993)

Definitions of codependency have tended to reflect a range of medical or disease model orientations. (Schaef, 1986; Subby, 1984; Treadway 1990; Wegscheider-Cruse, 1990) There has also been a disparity in the way male and female experts characterized codependency. Male writers have identified rigid ego boundaries, emotional distance and excessive compliance to parental achievement demands as characteristics. (Bradshaw, 1988) Women writers have identified a lack of ego boundaries and loss of self in relationships as indicators of codependency. (Haaken, 1993)

The lack of a clear definition of codependency was also reflected in the absence of a standardized diagnostic instrument for detecting codependency in the clinical population. Most authors relied on checklists of

symptomatic behaviors that ranged from the clearly pathological (delusions, denial, enmeshment) to behaviors considered normal in most contexts (thinking before speaking). (Mehren, 1992)

Another significant gap in the literature was the lack of any qualification of helping or nurturing behaviors as good or appropriate within normative social roles like mother and wife. (Krestan & Bepko, 1990) As women's social roles have expanded and diversified, the demand for and the benefit to society of nurturing and helping behaviors, predominantly of women, has not changed significantly. (Hochschild, 1990) While the literature notes that males may also experience socialization patterns in their families of origin that result in codependent behaviors, they are all but absent from the disease discussion as adults. (Lackie, 1983)

One of the more curious aspects of the codependency literature is the failure of its adherents to connect the estimated thirty to ninety-four percent of the general population at large who experience codependency with any underlying social structures. (Wegscheider-Cruse, 1990; Haaken, 1993) The majority of authors also failed to critically evaluate the historical development of the codependency movement from the fifties to the present in terms of changing social attitudes. They particularly overlook the tendency to define codependency as a structural

disease when conservative thinking predominates as in the Cold War Era of the 1950's and the retreat from feminist ideals of the 1980's. In contrast, during periods when social structures are being challenged as they were in the 1960's by the women's movement and the civil rights movement, codependency tended to be defined in terms of underlying social structures. (Haaken, 1993)

Feminist critical theory offered an integrated framework for understanding how the disease label of "codependency" perpetuates false dichotomies and sustains an imbalance of power. By locating individual reality within socio-economic and political structures, personal experience can be understood to reflect the status quo distribution of power, resources, and privileges. (Haaken, 1993; Van Den Bergh & Cooper, 1987)

Applying the "codependent" disease label to helping behaviors is one way power is used by "white male society" to control and dominate subordinates, usually women. (Schaef, 1986) By determining what goals are appropriate, controlling what information is relevant, and creating rules that censure female helping behaviors, the individual is easily labelled defective. By locating the problem in the individual and not in society, energy and resources are used to adjust the individual to society, not to challenge and change existing conditions. (Schur, 1984; Van Den Bergh & Cooper, 1987)

The role of the social worker is synonymous with the valued female quality of nurturing, (Lipman-Blumen, 1984) Recent discussions, however, have emphasized impairment in social work roles when helping behaviors are equated with codependence. (Fausel, 1988) Feminist thought and traditional social work share a fundamental concern with relationships between the individual and the community, the balance of personal needs and social needs, and a commitment to human dignity and the individual's right to self-determination.

Feminist ideology differs in calling for changes in the conceptualization of power. In feminist social work, power is redefined as energy of influence, strength, effectiveness, and responsibility. It is facilitative in nature and is widely and infinitely distributed. Feminist social workers seek to empower their clients to action rather than to dominate and control their lives and choices. Whenever possible, the personal power between the client and the feminist social worker is equalized. The social worker is a catalyst, not a dominant expert relating to a submissive client. The client is interdependent with the social worker and both are engaged in a process that will help the client to understand the impact of her or his environmental realities on the client's problem. (Van Den Bergh & Cooper, 1987)

This research project is a descriptive study of the attitudes held by social workers toward client behaviors that are typically identified as codependent and pathological in current literature. Social worker's perceptions of client pathology impair the implementation of treatment models that do not devalue behaviors and subjugate clients. Little research has been done in this critical area of social work practice. The serious lack of alternative paradigms to the disease model for understanding and treating codependency has just begun to be addressed in social work practice. This project represents a first step.

Research, Design, and Method

Sample

The sample consisted of three hundred social workers randomly selected from the National Association of Social Workers (NASW) Region F mailing list for the San Bernardino, California area. The questionnaires were divided equally between male and female social workers. Constraints of time and funding influenced the choice of this geographically accessible population.

Data Collection

Questionnaires containing stamped self addressed return mail envelopes were mailed to the sample population. It was requested that the questionnaire be returned within ten days of receipt. Strengths of this data collection method include convenience of distribution and collection of the instrument, elimination of interviewer bias, decreased time consumption for participants, and anonymity in providing socially undesirable answers. Limitations include the fact that 112 out of the 300 questionnaires responded, exclusion of qualitative input, inability to answer questions regarding the instrument, and monetary requirements for reproduction and postage.

Instrument

Social workers perception of helping behaviors were measured by a relational responsibility scale developed by the researchers based upon a prototype found in research literature. The research design was an exploratory survey since there is no known instrument to measure how social workers perceive helping behaviors. Since the researchers developed the instrument (see Appendix A), there is no information regarding validity, reliability or cultural sensitivity available. The instrument contained client identification data which was followed by questions designed for the social worker to measure the level of codependency of the client. No pretesting was done of the instrument.

The instrument contained sixteen questions covering demographic information which the literature revealed could affect socialization and codependency perceptions. The demographics included such items as gender, age, ethnicity, educational and income level, working mother, single parent, birth order and substance abuse in family of origin. The measurement instrument was entitled Relational Responsibility Scale and contained an introductory paragraph explaining the purpose and function of the scale, client information and directions. This was followed by 15 characteristics of the client which the social worker was to asses and rate on a five point Likert scale ranging from over responsible for others to under responsible for others.

The researchers established that three on the Relational Responsibility Scale would indicate "normal" behavior ie. the individual was neither over responsible or under responsible for others. The number one would indicate pathological over responsibility for others (codependency) and five would indicate pathological under responsibility for others (codependency). The numbers two and four would reflect non-pathological codependency.

One hundred fifty male and 150 female social workers were mailed the instrument. Half of the male social workers and half of the female social workers received a male client description and the other half of each gender group received female client descriptions for assessment. One hundred twelve questionnaires were returned which consisted of 55 males respondents and 57 female respondents. Twenty five of the male respondents received male clients to assess and 30 received female clients. Of the 57 female respondents, 33 received male clients and 24 received female clients to assess.

Many problems arose in developing a short comprehensive instrument to measure social workers perceptions of helping behaviors. In light of the popular negative label of codependency and the fact that this is a new area of exploration, it was necessary to use and explain terms which would not prejudice the respondent. Comments on the returned questionnaires indicated that many respondents

found this confusing. Another complaint by the respondents regarding the instrument was the limited client information upon which the respondent had to base the assessment.

The major strength of the instrument lay in the fact that it was short and concise consisting of three pages. This enabled the respondent to complete the questionnaire in 15 minutes or less and return it in the stamped self addressed return envelop. Therefore, very little time or effort was required which resulted in 112 completed instruments being returned.

Procedure

Permission was obtained from NASW California Chapter in Sacramento, California to use the membership list/labels to elicit the random sample of three hundred social workers within Region F. The instruments were mailed to the sample with a cover letter (see Appendix B) explaining the research project and a consent to participate in research form (see Appendix C) which was to be returned with the questionnaire.

Since the research question directly addressed the difference in the way male and female social workers perceived helping behaviors, it was necessary to delineate between male and female respondents the demographic and Relational Responsibility Scale data. Respondents general characteristics were analyzed by frequencies, t-tests, and chisquares obtained from demographic data contained within

the instrument. Quantitative procedures were also used to compare the mean score of the questions between male and female respondents. Mean scores of all questions were also analyzed by the respondents gender and clients gender.

Protection of Human Subjects

Permission was obtained from the Human Subjects Review Committee of the University by completing the required application for human subjects research after which the questionnaires were mailed to respondents. The cover letter explained the purpose of the research, expected completion date and where to obtain results. The researchers names, research advisor, and the Social Work Department's phone number and address were provided if the respondents had any question pertaining to the research project. Participants were also informed that the consent forms would be detached from the instrument before the data was analyzed to insure anonymity.

The consent to participate form was attached to each questionnaire which the respondent was to sign and return with the completed instrument. The form explained that participation was voluntary and that all information is confidential and that their identity would not be revealed.

Results

One hundred twelve social workers out of the sample responded, a response rate of 37.3% The respondents consisted of 55 male social workers, a response rate of 36.6%. Fifty seven of the respondents were female social workers, a response rate of 38.0%.

The demographic data (see Table 1) revealed several areas in which both groups of social workers were similar. The majority of the respondents were caucasians (males 74.5%; females 78.9%). The largest proportion of respondents (43.6% of the males and 43.9% of females) identified themselves as LCSW's (Licensed Clinical Social Workers). The majority were in direct practice (males 61.8%; females 80.7%). Family of origin statistics were also comparable. Within both male and female respondents 50.9% reported coming from families where the mother did not work outside the home. For males,78.2% came from two parent families as compared with 70.2% of the females. Alcohol/drug abuse was not present in the majority of respondents families (males 63.6%; females 66.7%).

Significant differences were found between the male and female respondents in age, marital status and number of children. The mean age for males was 49.4 years and the mean age for females was 41.8 years. Males were significantly older than women ($t=3.55$; $p<.001$).

Table 1

Demographic Characteristics

Independent Variables	Male (N=55)		Female (N=57)	
Age (Mean)	49.4 yrs.		41.8 yrs.	
Marital Status				
Single	(n=7)	12.7%	(n=17)	29.8%
Married	(n=41)	74.5%	(n=26)	45.6%
Divorced	(n=6)	10.9%	(n=11)	19.3%
Other	(n=1)	1.8%	(n=3)	5.3%
Ethnicity				
Asian	(n=0)		(n=2)	3.5%
Native American	(n=2)	3.6%	(n=1)	3.6%
Black	(n=2)	3.6%	(n=4)	7.0%
Pacific Islander	(n=1)	1.8%	(n=0)	
Caucasian	(n=41)	74.5%	(n=45)	78.9%
Hispanic	(n=5)	9.1%	(n=3)	5.3%
Other	(n=3)	5.5%	(n=2)	3.5%
Education				
BSW	(n=0)		(n=2)	3.5%
MSW	(n=22)	40.0%	(n=24)	42.1%
DSW	(n=1)	1.8%	(n=0)	
LCSW	(n=24)	43.6%	(n=25)	43.9%
Other	(n=8)	14.5%	(n=6)	10.5%

Table 1. (Continued)

Demographic Characteristics

Independent Variables	Male (N=55)	Female (N=57)
Practice Area		
Direct Practice	(n=34) 61.8%	(n=46) 80.7%
Administration	(n=16) 29.1%	(n=6) 10.5%
Other	(n=4) 7.3%	(n=4) 7.0%
Years in Practice (Mean)	19.3 yrs.	10.8 yrs.
Birth Order (Family of Origin)		
First	(n=17) 30.9%	(n=25) 43.9%
Second	(n=20) 36.4%	(n=11) 19.3%
Third	(n=10) 18.2%	(n=12) 21.1%
Fourth+	(n=8) 14.6%	(n=9) 15.8%
Children		
Yes	(n=41) 74.5%	(n=32) 56.1%
No	(n=14) 25.5%	(n=25) 43.9%
Family of Origin		
Working Mother (No)	(n=28) 51.9%	(n=29) 50.9%
Single Parent (No)	(n=43) 82.7%	(n=40) 72.7%
Substance Abuse (No)	(n=35) 63.6%	(n=38) 67.9%

Almost three-fourths of the male respondents (74.5%) were married as compared to 45.6% of the females. Significantly more males were married than females (chisquare=12.963; p<.001). Significantly more male respondents (74.5%) had children while 56% of female respondents had children. (chisquare=4.177; p<.040).

Other noted differences were in the mean years of practice (males 19.3 years; females 10.8 years) and birth order. The majority of males (36.4%) were second in birth order and the majority of females (43.9%) were first born.

The individual mean scores of items on the Relational Responsibility Scale (see Table 2) ranged from 1.91 to 3.0. The total mean score for all questions for male respondents (2.39) and females respondents (2.30) was not significantly different (t=.73; p<.469). This answered the research question of whether or not there is any difference in the way male and female social workers perceive helping behaviors. In addition, this finding did not allow the researchers to reject the null hypothesis that male social workers would not define helping behaviors as codependent more frequently than female social workers.

Mean scores of questions divided according to respondent by client gender (see Table 3). These scores demonstrated that there was no significant difference between the way male social workers (2.50) and female social workers (2.29) assessed male clients (t=1.49; p<.144).

Table 2

Mean Scores from the Relational Responsibility Scale

Question	Male Respondents Male/Female Client N=25 / N=30	Female Respondents Male/Female Client N=33 / N=24
17	2.48 / 2.36	2.51 / 2.39
18	2.32 / 1/96	2.03 / 2.04
19	2.20 / 2.00	2.12 / 2.17
20	2.25 / 2.13	2.30 / 2.21
21	2.87 / 2.60	2.87 / 2.91
22	2.37 / 2.36	2.27 / 2.08
23	2.56 / 2.16	2.51 / 1.95
24	2.73 / 2.50	2.66 / 2.29
25	3.0 / 2.30	2.59 / 2.34
26	2.29 / 2.26	2.18 / 2.21
27	2.08 / 2.16	1.87 / 1.91
28	2.08 / 2.03	2.06 / 1.65
29	2.60 / 2.23	2.42 / 2.17
30	2.62 / 2.43	2.51 / 2.52
31	2.87 / 3.00	2.87 / 2.66

Table 3

Total Mean Score of the Relational Responsibility Scale

	Male Respondents	Female Respondents	T Value	P
Male Clients	2.50	2.29	1.49	<.144
Female Clients	2.35	2.24	.66	<.514

Additionally, no significant differences were found between the mean scores of male social workers (2.35) and female social workers (2.24) in assessing female clients ($t=.66$; $p<.514$). Therefore, the researchers were not able to reject the null hypothesis that male social workers would not label female clients more codependent than female respondents.

Discussion

The results of this study indicate that, despite some significant gender differences in demographic profiles, there is no significant difference in the way male and female social workers define client helping behaviors. They both define these as codependent. This result demonstrates that social workers' attitudes tend to reflect the prevalent valuation of "female" behaviors as less desirable or healthy than "male" behaviors despite their specialized training and advanced education. The results also failed to verify the researchers hypothesis that; one). Male social workers would more frequently define helping behaviors as codependent; and two). male social workers would more often label female clients codependent than would female social workers. The researchers were unable to compare this study with previous studies in the literature because this aspect of direct social work practice has not been addressed. This lack of attention is another indication the "female" behaviors are less valuable or worthy of investigation.

Two unanticipated results of this study were identified. The first of these involved the demographic profile of the sample population. The literature stated that social workers were significantly more likely to have experienced substance abuse in their families of origin compared to the general population. It was suggested that this dynamic would predispose social workers to be at

greater risk for codependency than in the general population. (Fausel, 1988; Lackie, 1983) The study results indicated that 36.4% of respondents had this experience. This was very comparable to the estimated one-third (33.3%) of the general population experiencing substance abuse in their families of origin.

The other unanticipated result was the slightly higher tendency of female social workers to define helping behaviors as more codependent when the client was identified as male. A possible explanation is that helping or "female" behaviors in male clients might suggest a degree of gender role confusion or abnormality when this "women's work" is performed by males.

The researchers were able to identify limitations of this study in four different areas. The instrument and its administration was the primary area of concern. Because participation was unmonitored and voluntary, the response rate was low with only one out of three instruments being returned. This method of administering the instrument also eliminated any researcher control of the setting and the researchers' ability to provide direction or clarification for respondents.

Additionally, the instrument was untested and researchers had no opportunity to adjust the inconsistencies or ambiguities identified by some respondents. The researchers considered that the range of behaviors

represented on the Relational Responsibility Scale too extreme and lacked sufficient normal-range behaviors to elicit more subtle respondent evaluations. Researchers felt that these aspects of the instrument may have contributed to respondent confusion and resistance to participation.

Researchers also identified the small sample size and the lack of a broad geographical distribution as limitations in extrapolating the study results to the larger population. Hopefully, this would have produced a more ethically diverse sample population.

The inadvertent inclusion of the study title on the consent form may have biased respondents by identifying codependency as the topic. This may have prejudiced the social workers' response by imposing a limitation on their use of alternative paradigms for behavioral evaluation.

Despite these limitations, the researchers contend that further research in this subject area is needed to inform direct social work practice and the social worker-client relationship of needed changes in the perceptions of helping behaviors. Valuation of "female" behaviors acquired due to socialization need to be considered when assessing client helping behaviors.

Even though the literature suggests that social workers and feminists share many philosophical tenets, ethical concerns, and values, the implications of this study are that these similarities do not inform direct social work

practice. The social work values of client self-determination, individual empowerment to action, the intrinsic worth and dignity of the individual, the necessity of removing barriers to self-realization, like discrimination, and a recognition of universal human needs are not adequately or consistently applied in the assessment of available knowledge.

In direct social work practice these values are disconnected from clients and their problems. Implications of this study are that this is particularly true when clients are female and when clients, male or female, exhibit behaviors associated with female roles. These values are more likely to be viewed as existing outside of or apart from clinical empirical facts.

Consistent and conscientious application of these values in evaluating information would require clients and social workers to act differently, effect changes in their understanding of and their relationship to each other. By assessing information in the positivist, linear context of the "white male system", common truths and complementary dilemmas remain unrecognized and unexamined.

With women comprising two-thirds of people seeking psychological services, 51% of the general population, and the majority of social workers, integration of knowledge about women is particularly important. (Wetzel, 1986) The causes of women's over representation in the clinical

setting are well documented. (Bird, 1974; Friedman, 1973; Kramer, 1991; Schur, 1984; Wetzel, 1986) Dysfunctional sex roles, sexual biases in psychological and family systems theories, the politics of the client-social worker relationship, the psychological consequences of structural inequality, women's victimization from incest, rape and battering, and the feminization of poverty with its impact on psychological functioning are repeatedly explored in the direct practice literature. Nevertheless, this knowledge remains fragmented and useless within the direct practice context. By adopting a more conscious commitment to applying feminist social work values in the direct practice arena, social workers can establish a new paradigm that balances the values of both male and female world views.

Appendix A

Questionnaire

Demographics

1. Male ___ Female___

2. Age: ____

3. Marital Status

   Single ___ Married ___ Divorced___ Other___

4. Ethnicity: Asian ___ Native American ___ Black ____

   Pacific Islander ___ Caucasian ____

   Hispanic ____ Other ____

5. Educational Level/Credential

   BSW ___ MSW ___ DSW___ LCSW ___ Other ___

6. Income Level: $20,000 - 29,000 ___

   $30,000 - 39,000 ___

   $40,000 - 59,000 ___

   $60,000 + ___

7. Practice Area

   Direct Practice ___ Administration___ Other ___

8. Years in practice ____

9. Number of children: ____

10. Your birth order

    1st ___ 2nd ___ 3rd ___ 4th ___ 5th + ___

11. Mothers education: Less than 12 years ____

High School ____

College ____

Graduate ____

12. Fathers education: Less than 12 years ____

High School ____

College ____

Graduate ____

13. Parents income: $20,000 - 29,000 ___

$30,000 - 39,000 ___

$40,000 - 59,000 ___

$60,000 + ___

14. Working mother (Family of Origin)

Yes ___ No ___

15. Single Parent (Family of Origin more than 5 years)

Yes ___ No ___

16. Alcohol/drug abuse in Family of Origin

Yes ___ No ___

Relational Responsibility Scale

(Female Variation)

This scale is designed to measure the degree of social dysfunction in an individuals relationship with others. The questions in this section measure social workers perceptions of the clients relational responsibility with others on a continuum from over-responsible (OR) for others (1 on the scale) to under-responsible (UR) for others. Please respond to questions based on the folling client information.

The client is a 27 year old female. Client is employed, married for 5 years with 2 pre-school children. Client is self-referred to the community mental health center complaining of general malaise and vague feelings of inadequacy and dissatisfaction with marital, parental and employment roles. Presently, client is not experiencing any substantial dysfunction in these roles.

Relational Responsibility Scale

(Male Variation)

This scale is designed to measure the degree of social dysfunction in an individuals relationship with others. The questions in this section measure social workers perceptions of the clients relational responsibility with others on a continuum from over-responsible (OR) for others (1 on the scale) to under-responsible (UR) for others. Please respond to questions based on the folling client information.

The client is a 27 year old male. Client is employed, married for 5 years with 2 pre-school children. Client is self-referred to the community mental health center complaining of general malaise and vague feelings of inadequacy and dissatisfaction with marital, parental and employment roles. Presently, client is not experiencing any substantial dysfunction in these roles.

The following items are characteristics of this client. Please give your assessment of how relationally responsible each characteristic is by circling the number that most clearly reflects your perception of clients behavior.

17. Client anticipates needs of family, friends and/or coworkers.

OR 1 2 3 4 5 UR

18. Client feels anxiety, pity, and/or guilt when others have problems.

OR 1 2 3 4 5 UR

19. Client feels responsible for other people.

OR 1 2 3 4 5 UR

20. Client puts other's need and desires before their own.

OR 1 2 3 4 5 UR

21. Client gains satisfaction from other's successes.

OR 1 2 3 4 5 UR

22. Client has stronger responses to others injustices than injustices to self.

OR 1 2 3 4 5 UR

23. Client feels safest when giving.

OR 1 2 3 4 5 UR

24. Client feels uncomfortable in requesting help.

OR 1 2 3 4 5 UR

25. Client feel unappreciated by others.

OR 1 2 3 4 5 UR

26. Client finds needy people attractive.

OR 1 2 3 4 5 UR

27. Client feels bored, empty or worthless without a crisis to solve or someone to help.

OR 1 2 3 4 5 UR

28. Client over commits self and resources.

OR 1 2 3 4 5 UR

29. Client feels harried and pressured.

OR 1 2 3 4 5 UR

30. Client believes their well being is influenced by others.

OR 1 2 3 4 5 UR

31. Client blames others for the problems in their life.

OR 1 2 3 4 5 UR

Appendix B

Cover Letter

CALIFORNIA STATE UNIVERSITY
SAN BERNARDINO

The California
State University

Dear Social Work Professional:

We are MSW graduate students at California State University, San Bernardino. As many of you may fondly remember, we are in the process of gathering data for our graduate research project. The purpose of this research is to define how male and female social workers perceive helping behaviors in their clients.

The research procedure involves the completion of a three page questionnaire entitled the Relational Responsibility Scale which should take no longer than 15 minutes to complete. Please return the completed questionnaire and the signed consent form in the enclosed envelope within ten days of receipt. The consent form will be detached before the data is analyzed to insure anonimity of respondents and kept on file.

DEPARTMENT
OF
SOCIAL WORK

714/880-5501

The anticipated completion date for this project is June 12, 1993. If you have any questions regarding the outcome, feel free to contact the researchers listed below. The final research project will be on file in the Pfau Library at California State University, San Bernardino.

Thank you for your help and participation in this project.

Claire Trimble
MSW Candidate

_____
Researcher's Signature

Donna Venardos
MSW Candidate

_____
Researcher's Signature

Dr. Teresa Morris
Research Advisor

In Care of:
School of Social Work
5500 University Parkway
San Bernardino, CA 92407
(714) 880-5501

5500 University Parkway, San Bernardino, CA 92407-2397

Appendix C

CONSENT TO PARTICIPATE IN RESEARCH

I consent to serve as a subject in the research project entitled "Feminine Socialization or Codependency". The nature and general purpose of the study have been explained to me.

I understand that my participation is voluntary and that all information is confidential and that my identity will not be revealed. I am free to withdraw consent and to discontinue participation at any time. Any questions that I have about the project will be answered by the researchers listed in the project cover letter which I have been provided and may retain.

On the basis of the above statements, I agree to participate in this project.

_____ _____

Participant's Signature Date

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