Portfolio 1: Major Research Project

A Mixed-Methods Exploration of Attachment and Cultural Orientation in Co-dependency

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Submitted to the University of Hertfordshire in partial fulfilment of the requirement of the degree of

Doctor of Clinical Psychology

June 2025

Word Count: 30275

Acknowledgments

I'd like to thank my participants, who bravely shared their stories and made this research possible. A thank you goes to my consultants, who helped ensure that this study remained meaningful to the co-dependent community.

I extend my gratitude to my supervisors Dr Abigail Taiwo and Dr Ben Grey. Your support has kept me going, especially when the goal felt miles away.

I could not have survived this journey without my friends Charlotte, Shaunak, Krishtina, and Alexia. Thank you for sticking with me through the drama, rants, and delays, and for filling my university journey with a blend of banter and wisdom.

To my family, thank you for always believing in me. And to my partner, thank you for standing by the sleep-deprived version of me. Your patience and presence have meant the world.

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Abstract

Co-dependency is associated with poor mental health, yet research remains conceptually inconsistent. The systematic literature review conducted revealed that emerging frameworks increasingly acknowledge developmental disruptions, though most research continues to focus on individual pathology. Co-dependency remains linked to reduced wellbeing, identity and relational difficulties.

Building on this, this study explored the roles of attachment and cultural orientation in predicting co-dependency, and whether cultural orientation moderates the relationship between co-dependency and mental well-being. It also explored the attachment narratives of individuals engaged with a UK Support Group for Co-dependency (SGFC).

A sequential explanatory mixed-methods design was employed. Quantitative data were collected from 328 participants with co-dependency traits, recruited via opportunity sampling. Participants completed measures of co-dependency, attachment style, cultural orientation, and mental well-being. Qualitative data came from semi-structured interviews with six SGFC members, guided by an adapted Dynamic Maturational Model (DMM)-Adult Attachment Interview.

Quantitative results indicated that insecure attachment and horizontal individualism predicted co-dependency. Co-dependency negatively predicted mental well-being, and horizontal collectivism partially mediated this relationship.

Qualitatively, all participants displayed insecure attachment strategies, as identified through DMM coding. Attachment-informed thematic analysis revealed a developmental trajectory across six themes: insecure and unsafe beginnings, living through adversity, the co-dependency backstage, navigating connection and self-protection, co-dependency in action, and empowering vs performative self-growth.

Clinical implications include the need to increase awareness of co-dependency, while acknowledging the current lack of validated screening tools in clinical settings. The development of such measures represents a logical next step. Further recommendations include offering targeted interventions addressing attachment, trauma and defences. Policy implications encompass public awareness campaigns, preventative education, and increased funding for intervention development.

1. INTRODUCTION

1.1 Overview

This mixed methods study explores co-dependency, its impact on wellbeing and its relationship with attachment and cultural orientation. In this chapter, the researcher's personal and epistemological position is presented. An overview of the understanding of co-dependency is provided, with a focus on its historical context, key theories, and the associated mental health outcomes. The discussion will emphasise the relevance of attachment theory and cultural orientation in understanding the complexities of co-dependency, setting the stage for a systematic literature review and the study that will follow.

1.2 Personal and Epistemological Position

Positionality refers to the position that a researcher has chosen to adopt within their study (Holmes, 2020). Considering positionality is fundamental as it influences what the researcher has chosen to investigate and how the research is performed and interpreted (Rowe, 2014). Positionality encompasses the researcher's philosophical assumptions about truth and reality, as well as their personal experiences.

There are various reasons I chose to study co-dependency, informed by my observations of relational dynamics within my family, as well as my own experiences. Growing up as a female in Sicily, a society with strong expectations around caregiving roles within a patriarchal structure, I internalised the need to meet others' needs. Experiences of childhood bullying reinforced this pattern, as seeking external validation became a way to manage my self-esteem.

While co-dependent behaviours provided a sense of purpose and connection, they also limited my sense of self, at times leading me to tolerate abusive behaviours. Hearing relatives label my family as "co-dependent" resonated with me, but it also invoked feelings of shame. These experiences inform my epistemological stance and interest in co-dependency.

Considering my positionality entails an obligation to engage in self-reflexivity which involves an ongoing process of critical self-reflection on how my background, values, and beliefs may shape

this research (Soedirgo & Glas, 2020). Reflexivity is particularly relevant to co-dependency research due to its highly relational nature, where personal biases may influence interpretation. Acknowledging my own assumptions, I am committed to maintaining a balanced perspective.

This study adopts a pragmatic epistemological stance, prioritising practical implications over a singular philosophical viewpoint (Morgan, 2014). Pragmatism rejects rigid dualities, understanding phenomena as products of dynamic, context-bound interactions (Dewey, 1929). While acknowledging an external reality, pragmatism emphasises relationality, seeing knowledge as co-constructed through interaction rather than derived from isolated principles (DeForge & Shaw, 2012). This makes it well-suited to studying co-dependency, which cannot be fully understood through isolated psychological or cultural lenses but instead requires an appreciation of how these interact within individuals' lived experiences. Pragmatism supports a pluralistic, adaptable approach (Tashakkori, 2010), supporting a mixed method design integrating multiple perspectives.

My hope is that this research can enhance our understanding of co-dependency by integrating psychological insights with real-life experiences, while recognising the opportunities and limitations of applying a broad label. By examining co-dependency's association to attachment and cultural orientation, this study aims to inform therapeutic approaches, whether through engagement with peer support groups or therapeutic interventions. This pragmatic focus supports the goal of offering actionable insights that address the unique needs of those seeking support for co-dependency, ultimately promoting more flexible and accessible paths to personal growth.

1.3 Key Terms

Key terms are presented in Table 1. These will be used throughout the research.

Table 1

Definition of the Key Terms used in this Study

Key Term	Definition	Alternative/Related Terms
Co-dependency	A phenomenon involving emotional reliance on others at the expense of personal well-being. (Wright & Wright, 1991). Often associated with living with an alcoholic family member	Codependency, co-dependence, codependence. Broader terms linked to co-dependency include love/relationship addiction, affective dependence, symbiosis.
Attachment Theory	A psychological framework describing how early relationships shape relational patterns and emotional responses in adulthood (Bowlby, 1969).	
Attachment Anxiety	A dimension of attachment style where individuals have an intense fear of abandonment and often worry about their caregiver or partner's responsiveness and commitment. People with high attachment anxiety tend to crave closeness, validation, and reassurance in relationships (Ainsworth et al., 1978).	Anxious attachment, preoccupied attachment, fearful attachment, type C (Coercive) attachment.
Attachment Avoidance	A dimension of attachment style in which individuals tend to distance themselves from close relationships, often due to discomfort with intimacy and reliance on others. This style is characterised by self-reliance, emotional suppression, and an aversion to closeness (Ainsworth et al., 1978).	Dismissive attachment, avoidant attachment, Type A (compulsive) attachment.
Cultural Orientation	An individual's personal alignment with specific cultural values, often reflecting broader societal norms and traditions. This orientation shapes how a person approaches relationships, autonomy, and social expectations.	Cultural schema
Vertical Individualism	A cultural orientation that values personal achievement with an acceptance of hierarchy, where individuals strive to distinguish themselves within a social ranking.	
Horizontal Individualism	A cultural orientation that rejects hierarchy, valuing personal autonomy, self-reliance and independence.	
Vertical Collectivism	A cultural orientation that values group goals and social harmony, emphasising hierarchy and respect for authority within the group.	
Horizontal Collectivism	A cultural orientation that prioritises equality and interdependence within the group, focusing on close, supportive relationships without strict hierarchy.	
Schema	Enduring cognitive and emotional patterns or beliefs about the self, others, and the world, typically formed in early life. (Young et al., 2003)	Internalised scripts, core beliefs

1.4 Co-dependency

Co-dependency remains a contested concept in both research and clinical practice (Pagano-Stalzer, 2021). Codependency is commonly defined as a phenomenon involving emotional reliance on others at the expense of personal well-being, particularly in the context of living with an alcoholic family member (Wright & Wright, 1991). However, this study adopts Weiss's Prodependence perspective (2022), viewing co-dependency as an adaptive response to challenging relational circumstances.

Co-dependency lacks a universally accepted definition, and critiques argue the term is grounded in popular culture rather than in empirical research (Bacon et al., 2020; Weiss, 2019). Co-dependency overlaps with the concept of symbiosis, which includes both adaptive and maladaptive traits (Schiff, 1974). While symbiosis is developmentally appropriate in childhood and within some caregiving or romantic contexts, unresolved symbiosis may result in relational difficulties resembling co-dependency.

Without formal diagnostic criteria, estimating prevalence is challenging. Nevertheless, studies suggest that 10% to 20% of the general population exhibit co-dependent traits, with figures rising to 36% among depressed women (Noriega et al., 2008; Hughes-Hammer et al., 1998). Co-dependency is particularly common among individuals exposed to relational trauma, including those involved with addicts (Beattie, 2009), adult children of alcoholics (ACOA - Cermak, 1984), and survivors of abuse (Evgin & Sümen, 2022).

The term "co-dependent" is often viewed as stigmatising, due to its historical association with women and the pathologisation of caregiving traits (Dear, 1996; Westermeyer, 2005). While some find self-labelling helpful (Bacon, 2015), its value remains debated. Given these ambiguities, it is worth considering whether co-dependency should be formally defined within the scientific literature. This study takes the position that, despite its contested nature, co-dependency represents a clinically and socially meaningful phenomenon that warrants further conceptual refinement. Rather than advocating for a rigid diagnostic framework which risks pathologising adaptive relational behaviours,

this thesis supports a more integrative approach. Clarifying the construct through trauma-informed, attachment-based, and culturally sensitive models may enhance both empirical investigation and therapeutic relevance.

Co-dependency is typically measured using self-report questionnaires. These vary in their focus, with some assessing relational behaviours and others capturing emotional dependency or boundary issues. In clinical contexts, measurement is often informal and based on therapist judgment or intake interviews rather than standardised tools. However, these instruments have faced criticism regarding their conceptual consistency and gendered assumptions (Marks et al., 2012). The lack of consensus on what constitutes co-dependency complicates both diagnosis and treatment planning, further contributing to its contested status in the field.

Additionally, divergent views have created gaps in the literature, hindering the establishment of clear treatment pathways (Abadi et al., 2015). Many individuals seek support through private therapy, self-help literature, or 12-step programmes, though these options may not be accessible or suitable for everyone. In response to these gaps, this study explores how attachment patterns and cultural orientation influence co-dependent behaviours, and how co-dependency affects mental wellbeing.

1.5 The Historical Evolution of Co-dependency

1.5.1 *Family Systems and Addiction Models*

The concept of co-dependency first appeared in the substance abuse treatment literature (Al-Anon Family Group Headquarters, 1965). The co-addiction movement depicted spouses of alcoholics as enablers, whose overinvolvement perpetuated family dysfunction (Griner & Griner, 1987). Eventually, co-dependency came to be viewed as more detrimental than alcoholism itself, with co-dependents characterised as 'volunteer-victims' who, while suffering due to their partner's addiction, also maintained the relationship to fulfil their own unmet needs (Troise, 1994).

Family systems theory played a significant role in shaping the understanding of co-dependency, particularly through the concepts of differentiation of self and enmeshment (Scaturo et al., 2000). Differentiation refers to the maintain autonomous thinking and feelings while remaining connected within relationships (Kerr & Bowen,1988). Low differentiation often results in emotional fusion, where family members' emotional experiences becoming intertwined (Bowen, 1978). This helps explain the relational patterns seen in co-dependent individuals, who might struggle to form a clear sense of self (Wells et al., 1999).

Undifferentiated individuals might cope through triangulation, redirecting stress onto another person or substance. For example, a co-dependent partner might focus on supporting the addicted individual with while avoiding direct confrontation, or the individual with addiction may use substances as an emotional outlet. While triangulation temporarily stabilise the relationship, it often reduces differentiation further, increasing dysfunction (Fagan-Pryor & Harber, 1992).

Within structural family therapy, Minuchin (1974) proposed enmeshment as a related concept, describing families with blurred emotional boundaries and an over-responsibility for others' feelings (Barber, & Buehler, 1996). This becomes particularly problematic when substances' dependency fosters reliance among other members to maintain stability (Minuchin, 1974). As a result, co-dependent behaviours may emerge as individuals assume responsibility for 'fixing' others in the system.

In summary, family systems and addiction models laid the foundation for early understandings of co-dependency. These continue to influence contemporary interpretations of co-dependency, even as the concept has evolved beyond its original clinical roots.

1.5.2 *From Relational Struggles to Personality Disorder*

In the 1980s, co-dependency gained prominence through the self-help literature (Hands & Dear, 1994). Here, co-dependency was framed as a relational issue in which individuals become overly affected by others' dysfunction (Beattie, 1986). Traits such as dysfunctional caregiving,

rigidity, and control (Case, 1987) were thought to stem from family dysfunctions and persist beyond its resolution (Larsen, 1985, as cited in Troise, 1994).

Self-help literature aimed to help individuals identify and manage co-dependent behaviours (Beattie, 2008). However, critics like Messner (1996) argued that the broad definition made the concept overly inclusive. Through its discourse, self-help literature has contributed to the creation and reinforcement of a co-dependent identity, offering a framework that shape how individuals interpret their relational experiences, often encouraging readers to self-identify with co-dependent traits (Gemin, 1997).

Despite its relational framing, this understanding remained rooted in the addiction model (Haaken, 1993). In this sense, co-dependency is framed as a compulsive attachment to others, akin to addiction, where the "substance" is the relationship itself. This may foster a sense of fear around relational dependency, leading individuals to rely more heavily on self-help narratives. Nonetheless, some authors have highlighted the empowering potential of co-dependent identification. For instance, Irvine (1995) argues that adopting this label can promote resilience and allow individuals to renegotiate relational boundaries on their own terms.

By the late 1980s, the personality model emerged, describing co-dependency as a set of traits resembling those found in Personality Disorders (PDs). O'Brien and Gaborit (1992) noted that co-dependency existed independently of direct exposure to chemical dependency, expanding the concept beyond its initial focus on spouses to include ACOA (Cermak, 1986), Adult Cousins of Alcoholics (Miller, 1987), and outside addiction altogether (Cermak et al., 1989).

Co-dependency began to be seen more widely as a disease (Whitfield, 1991) and Cermak (1986) advocated for its inclusion as an Axis II disorder in the Diagnostic and Statistical Manual of Mental Disorders. Symptoms cited by Cermak were low self-esteem, dysfunctional relationships, and compulsive control. However, questions were raised about diagnostic clarity, as discussed in later chapter.

In summary, the late 20th century saw co-dependency increasingly medicalised, shifting from a relational issue popularised by self-help literature to a proposed diagnostic category. This marked a conceptual tension between co-dependency as an adaptive interpersonal response and as a disorder, a debate that continues to influence both clinical and cultural discourse.

1.5.3 *Critical and Feminist Perspectives*

As the understanding of co-dependency evolved, critical perspectives emerged. Hands & Dear (1994) and Weinhold (1992) highlighted definitional inconsistencies and the lack of scientific rigour supporting its broad application. Morgan (1991), and Wells et al. (1998) argued that the personality-based model overlapped significantly with existing diagnostic categories, undermining its distinctiveness and clinical validity. Rice (1992) suggested that co-dependency functions as a discursive construct, reinforcing power dynamics and gendered relational expectations.

Feminist scholars raised concerns that the term pathologised behaviours traditionally associated with women's caregiving roles, ignoring the structural inequalities that often produce such dynamics. Morgan (1990) critiqued the label for stigmatising relational care, particularly among women, while Cowan et al. (1995) found empirical links between co-dependency, power imbalances and a loss of self. These critiques particularly resonate with me, as I have observed women in caring roles (either in my family or in the workplace) labelled as ‘’co-dependents’’ , carrying negative connotations.

Collins (1993) argued that women's sense of identity often derives from close relationships, and that viewing connection as dysfunction fails to account for relational strength. This argument is relevant to this study, as it encourages a shift in the understanding of co-dependency as a potentially adaptive response rather than inherently pathological. In support of this, Malloy & Berkery (1993) advocated for a reframing of the concept towards a more empowering perspective.

Nonetheless, some researchers continue to support the concept's clinical relevance. Harkness and Cotrell (1997) found that counsellors widely agree on the meaning of co-dependency, suggesting it retains practical utility despite theoretical controversy. This study also highlighted that, although

gender bias was initially associated with co-dependency, structured assessments showed its application to both genders, reinforcing its ongoing utility in treatment settings.

1.5.4 *The Relevance and Application of Co-dependency*

The concept of co-dependency has continued to evolve beyond its original link to alcoholism. Crothers & Warren (1996) found no significant association between parental chemical dependency and co-dependency in students. Other factors, such as having a co-dependent parent and coercive parenting styles, were predictive. Similarly, Fuller and Warner (2000) identified other family stressors, including mental or physical illness within the family, as contributing to co-dependency.

Studies on ACOAs have produced mixed findings. George et al. (1999) reported higher self-identified co-dependency among ACOAs, though actual behaviours did not differ significantly from non-ACOAs. Conversely, Lyon & Greenberg (1991) reported that women raised by alcoholic parents were more likely to exhibit co-dependent traits. These findings suggest that while exposure to parental substance dependency is not a necessary precursor, significant relational stress can influence later interpersonal patterns.

The co-dependency model has been applied in various contexts, including nursing and healthcare (Armstrong, 1992; Harrison, 2000), gambling addiction (Mazzoleni et al., 2009), domestic violence (Bornstein, 2002) and caregivers (Aşkan,& Ceylan, 2024). This highlight the enduring relevance of co-dependency as a framework for understanding relational dysfunction.

1.5.5 Contemporary Perspectives

In recent years, contemporary perspectives began to emerge, reinterpreting co-dependent behaviours as adaptive responses to trauma (Lancer, 2015) and attachment-related issues (Weiss, 2022). This marked a significant shift, moving away from pathologising co-dependency and toward a more compassionate view that considers how past relationships shape adult behaviours.

More recently, the concept of co-dependency has been discussed alongside or replaced by terms such as “affective dependence” (Sirvent-Ruiz et al., 2022) and “relationship or love addiction”

(Diotaiuti et al., 2022). While these constructs highlight the broader relevance of relational dependency beyond substance-related contexts, they also contribute to definitional ambiguity within the field.

While this chapter has focused on the historical evolution of co-dependency, upcoming chapters will delve into recent attachment and mental health perspectives. A systematic literature review will further examine how co-dependency research has evolved over the past decade, offering a comprehensive view of modern perspectives.

1.6. Attachment

1.6.1 Co-dependency and Attachment

Attachment refers to the innate human need for psychological connectedness that persists throughout life (Bowlby, 1969). In childhood, secure attachments with caregivers support emotional regulation, identity development, and later relational competence (Gelso et al., 2013), while inconsistent or disrupted bonds can lead to insecure attachment strategies associated with difficulties with self-esteem and relationships (Vivona, 2000). Attachment styles were initially classified as secure, avoidant, and anxious (Ainsworth et al., 1978) and later expanded to include disorganised (Main & Solomon, 1986) or fearful (Bartholomew & Horowitz, 1991). These early frameworks have shaped how adult relational patterns and psychological vulnerabilities are understood.

Given its relational nature, attachment theory offers a valuable lens for understanding co-dependency (Weegman, 2006). While early co-dependency research did not explicitly engage with attachment theory, indirect links emerged, particularly in studies associating paternal alcoholism with co-dependency. Family dysfunctions, including addiction, may compromise attachment quality (Kornaszewska-Polak, 2019), increasing the likelihood of insecure attachment (Fals-Stewart et al., 2004).

Recent research has further explored this. Several studies associate co-dependency predominantly with anxious attachment (Ançel & Kabakçı, 2009), with mechanisms including actual–ought self-discrepancy (Malakçıoğlu, 2019) and hunger for self-object provision (Alpsoy, 2023).

However, avoidant attachment has also been associated with co-dependency (Wells et al., 2006; Guzmán González et al., 2020; Collins, 2023), suggesting that some co-dependent behaviours might also serve to avoid vulnerability, resulting in dynamics that are both enmeshed and emotionally distant (Watt, 2002). This suggests both anxious and avoidant pathways may underlie co-dependent behaviours through distinct relational strategies.

To advance understanding, recent attachment-informed models have emerged. The Emotional Stocks and Bonds model (Daire et al., 2012), for example, integrates Bowenian theory with attachment concepts to explain emotional over-investment. However, traditional attachment theory offers limited scope for understanding how individuals adapt to adversity beyond early caregiving relationships. Co-dependency may arise not only from early attachment disruptions but also from later relational experiences. The following section introduces the Dynamic Maturational Model of Attachment (DMM; Crittenden, 2006), which might offer a more adaptive framework for understanding co-dependency across the lifespan.

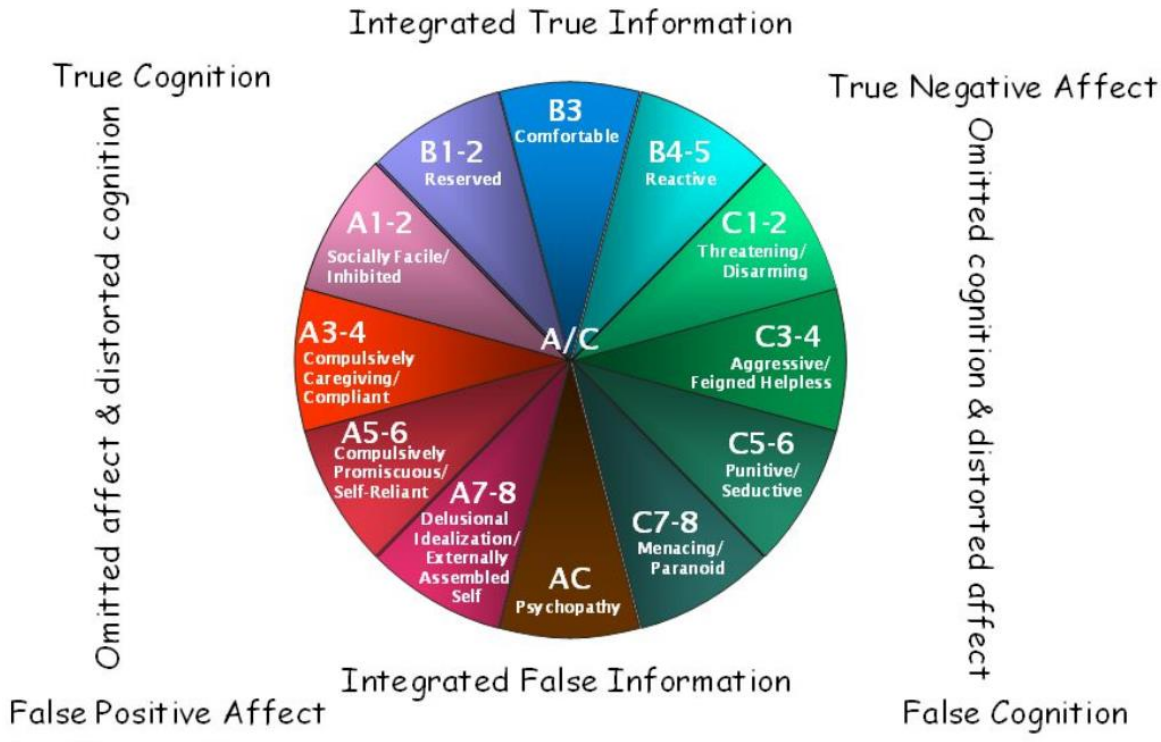
1.6.2. The Dynamic Maturational Model of Attachment and Adaptation

The DMM proposes that humans adapt to threats in the environment, considering the social context that drives these changes. Viewing co-dependency through the DMM lens frames it as an adaptive defense mechanism against relational threats, aligning with research showing that individuals with a history of childhood adversity are more likely to develop co-dependency (Evglın & Sümen, 2022).

The DMM conceptualises attachment not as a set of fixed traits, but as self-protective strategies developed in response to perceived danger. While the original A, B, and C categories align with the traditional styles of avoidant, secure, and anxious attachment, the DMM presents 13 subcategories. These (Figure 1) reflect adaptive strategies individuals use to process danger and manage relational threats.

Figure 1

The Dynamic-Maturational Model of Attachment and Adaptation



Notes: This diagram illustrates the DMM framework, categorising protective strategies into cognitive (Type A), balanced (Type B), and affective (Type C) approaches, with additional subcategories. The outer labels describe corresponding distortions in affect and cognition at each level, reflecting how individuals process danger and relational threats.

Type B represents balanced (secure) strategies, where both cognitive and affective information are integrated effectively. Type A (cognitive strategies) are primarily associated with avoidant relational patterns, characterised by a reliance on logic, suppression of emotional expression, and a tendency to determine safety through external cues such as rules, expectations, or others' reactions. Subcategories like compulsive caregiving (A3) or compulsive compliance (A4) represent ways individuals manage attachment-related stress by prioritising others' needs and minimising their own affective signals.

In contrast, Type C (affective strategies) reflect anxious relational strategies and involve heightened sensitivity to internal emotional states. Type C rely on internal cues, such as physiological arousal or feelings of distress, to assess danger and safety. Subcategories such as exaggerated helplessness (C4), where vulnerability is exaggerated to maintain closeness, or punitive control (C5), where emotional manipulation is used to prevent abandonment, illustrate affect-driven attempts to preserve relational bonds.

The DMM highlights that attachment strategies are dynamic, shaped by life events such as trauma, romantic relationships, or caregiving roles. Although not previously applied to co-dependency, the model offers a relevant framework for conceptualising co-dependent behaviours as adaptive responses to relational threat. This supports a view of co-dependency as a defensive relational strategy.

1.7 Cultural Variations in Co-dependency

Co-dependency is often considered an Anglo-Saxon concept, primarily reflecting Western values of independence (Irvine, 1997). Inclan and Hernandez (1992) argued that the construct is embedded in individualism, which may not translate well to collectivist societies, where relational interdependence is central. This raises questions about the universality of co-dependency and the extent to which it is culturally constructed.

1.7.1 Individualism and Collectivism

In collectivist societies, interdependence is not only normative but valued. African traditional cultures emphasise communal reliance for survival (Aigbodioh, 2011), while Latin American cultures display ‘’familism’’, prioritising family loyalty and relationship harmony (Falicov, 1998). Here, behaviours resembling co-dependency can be adaptive and functional (Milushyna, 2015).

In contrast, Western individualistic societies prioritise autonomy and self-sufficiency, often pathologising caregiving that involves self-sacrifice (Ng & Indran, 2021). As Young-Bruehl and Bethelard (2000) note, Western views often fail to distinguish healthy from unhealthy reliance, contributing to the stigmatisation of co-dependency.

1.7.2 Vertical and Horizontal Cultural Orientations

Cultural orientation also varies along vertical and horizontal dimensions (Triandis, 2001). Horizontal collectivist cultures (e.g., parts of East Asia) value equality and mutual caregiving, aligning with non-pathological interdependence (Milushyna, 2015). Horizontal individualism (e.g.,

Western Europe) also values equality, but emphasises autonomy and self-direction (Shavitt et al., 2010).

Vertical collectivism, (e.g Asian and Latin American), reinforces co-dependent behaviours through hierarchical family loyalty. In Japan, ‘’amae’’, the need to depend on others, is seen as a normal relational dynamic (Doi, 2005). Conversely, vertical individualist cultures like the U.S., emphasise competition and personal success, fostering a negative view of emotional dependence (Triandis, 1995).

1.7.3 Co-dependency and Well-being across Cultural Contexts

Cultural orientation influences both the perception and psychological impact of co-dependency. In individualistic cultures, well-being is associated with autonomy and control, while in collectivist settings, it is linked to relational harmony (Kitayama et al., 2010; Gutierrez, 2012). In Taiwan, for instance, individuals report guilt when prioritising the self over family obligations (Chang, 2010).

Collectivism is often associated with better mental health, as interdependence may act as a protective factor. Conversely, individualistic societies may experience lower emotional competence and reluctance to seek help, contributing to isolation (Bhullar et al., 2012; Scott et al., 2004). Attitudes toward mental health also differ: in Chinese collectivist contexts, mild psychological distress is often seen as a normal life experience, whereas Western contexts may be more inclined to pathologise it (Kolstad & Gjesvik, 2014).

In sum, cultural context shapes how co-dependency is understood and experienced. Behaviours seen as dysfunctional in one society may be adaptive in another. A culturally sensitive approach is therefore essential to avoid over-pathologising interdependence, recognising instead the diversity of values that shape well-being.

1.8 Co-dependency and Mental Health

Since its inception, co-dependency has often been linked to psychopathology (Worth, 1996; Karaşar, 2020). Psychological traits like low self-esteem, shame, and attachment insecurities often contribute to co-dependency (Wells et al., 1999, Knapek et al., 2021), and early experiences like parental neglect reinforce these tendencies (Noriega et al., 2008; Bacon et al., 2020;). However, some researchers argue that the dysfunctional caregiving roles, rather than co-dependency itself, cause psychological harm (Kaplan, 2023). Stigma around co-dependency also contributes to lowered psychological well-being (Sobol-Goldberg et al., 2023).

In this context, the concept of ‘’double causality’’ emerges: co-dependency may both originate from underlying vulnerabilities and simultaneously exacerbate these over time. Thus, co-dependency and mental health challenges become mutually reinforcing, creating a difficult cycle to break. Regardless of the direction of this relationship, co-dependency is associated with low psychological well-being manifested as low relationship satisfaction (Mazzoleni et al., 2009; Zaidi, 2015) and reduced life satisfaction (Happ et al., 2023).

Despite extensive research in Western contexts, co-dependency’s impact on mental health in collectivist societies is less defined. Although interdependence may support well-being in these cultures (Milushyna, 2015), stigma around co-dependency persists globally, potentially affecting mental health even in collectivist settings (Sobol-Goldberg et al., 2023). Considering this, further exploration is needed to clarify how co-dependency interacts with cultural values in shaping mental health outcomes.

1.9 Peer Support for Co-dependency

The lack of official recognition of co-dependency means that there is no standardised treatment pathway, with peer support networks currently representing the most accessible resource. These groups, based on Twelve-Step programs, are designed to help individuals develop healthier relationships and coping mechanisms (Lancer, 2015).

Despite the expanding reach of peer support networks, their effectiveness remains inconclusive (Bacon, 2015; Bacon et al., 2020). While some participants report meaningful changes through engagement, not all individuals resonate with peer-driven recovery methods (Greene, 2021). Barriers to engagement include concerns about spiritual beliefs, feelings of powerlessness, and, in some cases, experiences of stereotyping and victim-blaming (Young & Timko, 2014; Day et al., 2015). These challenges underscore the need for alternative support strategies and therapeutic interventions tailored to the diverse needs of co-dependent individuals.

1.10 Conclusion

In conclusion, this chapter has provided an overview of the phenomenon of co-dependency, highlighting its historical evolution, theoretical perspectives, and mental health impact. By examining the researcher's personal and epistemological position, alongside cultural and attachment-based frameworks, it has laid a foundation for the understanding of co-dependency. This highlights the need to move beyond stigmatising or reductive views, towards approaches that recognise both psychological and cultural dimensions.

Given the diverse and often conflicting conceptualisations identified, a systematic literature review is needed to synthesise existing research, clarify dominant frameworks, and examine how co-dependency is linked to mental health outcomes. The review will serve as a foundation for the empirical investigation that follows, helping to bridge theoretical gaps and inform therapeutic approaches.

2. INTEGRATIVE SYSTEMATIC LITERATURE REVIEW

2.1 Introduction

As discussed in the introduction, much research has explored co-dependency, yet the term remains ambiguous due to varying definitions (Pagano-Stalzer, 2021). This has resulted in conflicting conceptualisations, posing challenges in understanding its characteristics and implications for mental health (Abadi et al., 2015).

To address these gaps and establish greater clarity, this Integrative Systematic Literature Review (ISLR) seeks to answer the following Research Questions (RQs):

- *How has co-dependency been conceptualised in the past 10 years?*
- *What mental health outcomes are associated with co-dependency?*

The first question explores the conceptual evolution of co-dependency, essential for establishing a consistent foundation for research and clinical practice. The second question summarises its mental health outcomes, providing a comprehensive overview that can guide future therapeutic interventions.

An ISLR follows a systematic process to synthesise research and draw conclusions from diverse sources on a topic, such as empirical research, methodological and theoretical literature (Toronto & Remington, 2020). While SLRs are considered the gold standard in literature reviews (Lame, 2019), ISLRs provide a broader, more comprehensive approach to fully understand complex phenomenon like co-dependency (Souza et al., 2010). By incorporating multiple types of evidence, ISLRs are particularly well-suited for exploring multidisciplinary topics.

The findings from this ISLR will inform subsequent sections of this thesis, guiding the development of RQs and providing a foundation for the theoretical analysis (Andreasen et al., 2022). The review was pre-registered with PROSPERO (ID: CRD42024575573). A deviation from the original protocol was made during the screening stage; this is described and justified in the relevant sections below.

2.2 Methods

2.2.1 Search Strategy

A scoping search was conducted in August 2024 to identify all studies relevant to the RQs. The following databases were searched: Scopus, PubMed, ProQuest, EBSCO, PsycINFO, ResearchGate and PsycARTICLES accessed through ProQuest. The SPIDER framework (Table 2) was used to delineate and break down the various elements within the review questions, producing more targeted search results (Dhollande et al., 2021). Unlike frameworks such as PICO, SPIDER focuses on qualitative dimensions and phenomenon exploration, making it particularly suited for an ISLR using narrative synthesis (Cooke et al., 2012).

Table 2

SPIDER Framework

SPIDER	Inclusion Criteria	Exclusion Criteria
Sample	Published studies involving individuals, groups, or societies from any settings discussing or experiencing co-dependency and reporting on the conceptualisation of co-dependency and associated mental health outcomes	Studies not focusing on co-dependency conceptualisation, studies focusing on children and adolescents.
Phenomenon of **I**nterest	Conceptualisation of co-dependency over time and associated mental health outcomes	Related terms with no mentions of co-dependency (e.g. love addiction, enmeshment, relational dependency)
Design	Published papers (empirical and non) which reports on the conceptualisation of co-dependency or related mental health outcomes. Initially, no time restriction was applied to capture the historical development of co-dependency. However, during the full-text screening phase, a time criterion was introduced, restricting inclusion to studies published from January 2013 to today.	Single or multiple case studies Non-peer reviewed studies Grey literature with no significant theoretical contributions Studies published before January 2013.
Evaluation	Key Outcomes: conceptualisation of co-dependency, changes in conceptual frameworks, theoretical discussions, mental health outcomes (e.g., anxiety, depression, stress, well-being)	Studies that look primarily at substance abuse
Research Type	Integrative: Quantitative, Qualitative, mixed methods, theoretical papers/commentaries	Non-English papers and where a full text is not available.

SPIDER enabled us to determine inclusion criteria; however, exclusion criteria were also listed to produce a more focused search. Given that co-dependency symptoms have traditionally been observed in adults (Cermak, 1986), only studies on adults were included. Although co-dependency has been significantly discussed within the self-help literature (Hazleden, 2014), books were not included to allow for a more theoretically grounded exploration. Case studies were excluded due to their limited generalisability. Grey literature was included only when it provided significant theoretical contributions, ensuring the review was enriched by diverse perspectives without compromising the rigor needed to establish reliable conclusions (Mahood et al., 2014). Conceptual and theoretical papers were also included if they offered substantial contributions to the framing or interpretation of co-dependency, particularly where empirical research was limited or where theoretical clarity was needed to interpret constructs across studies. Their inclusion aligns with the goals of integrative reviews, which aim to synthesise both empirical findings and theoretical perspectives to advance conceptual understanding (Whittemore & Knafl, 2005).

Initially, the protocol did not set a time restriction, as the original aim was to explore the historical evolution of co-dependency. However, during full-text screening, it became evident that earlier studies frequently repeated foundational ideas already represented in more recent work. To reduce redundancy and ensure analytical clarity, the inclusion criteria were refined to focus on studies published within the last ten years (2013–2023). This represents a deviation from the PROSPERO protocol. Rather than tracing the full historical development of the concept, the review was reframed to capture recent conceptual developments and contemporary understandings of co-dependency. This period was considered particularly relevant, as the past decade has seen a shift towards trauma-informed, attachment-based, and culturally sensitive models of co-dependency. This allowed the review to explore how the construct is currently being defined, measured, and linked to mental health outcomes.

The SPIDER framework guided the finalisation of search terms (Table 3).

Table 3

Search Terms

Phenomenon of Interest	Conceptualisation	MH outcomes
"co-dependen*" OR "codependen*" OR "love addiction" OR "enmeshment" OR "relationship addiction" OR "affective dependenc**" OR "relational dependenc*	‘’conceptualization" OR "definition" OR "understanding" OR "interpretation" OR "theoretical model" OR "theoretical framework" OR "conceptual framework" OR "theoretical perspective" OR "psychological theory" OR "model of co-dependenc*" OR "theoretical construct"	"mental health outcomes" OR "anxiety" OR "depression" OR "stress" OR "well-being" OR "psychological impact"

To ensure comprehensive coverage of relevant studies, the following databases were searched (Table 4):

Table 4

Dataset Selection

Database	Rationale
PuBMeD	Due to its focus on medical and psychological phenomena.
Scopus	Due to its collection on a wide range of disciplines, to ensure access to diverse studies related to co-dependency.
ProQuest	Due to its collection of multidisciplinary research, including dissertations and theses.
PsychARTICLES	Due to its collection of peer-reviewed psychology journals.
PsychINFO	Due to its focus on psychology and mental health.
Ebsco	Due to its psychology, sociology, and health databases. Its use allows for a broader understanding of the socio-cultural aspects of co-dependency.

Each database was last searched on 25th September 2024. Appendix A shows an example of the search activity template. The terms were searched for in the titles and abstracts of journal articles in all databases. Additionally, reference screening was performed to identify further relevant studies that might have been missed in the initial search.

2.2.2 Selection Process

Covidence (Covidence systematic review software, 2024) was used to keep track of references and for screening, with assistance from Zotero (Zotero, 2024). Duplicates were removed by the software.

Two independent reviewers (E.M= the main researcher; S.D =fellow trainee clinical psychologist) conducted abstract and full-text screenings, guided by the inclusion and exclusion criteria. Some conflicts emerged during screening, primarily around the theoretical contributions of the studies. Conflicts were resolved by discussion and consensus.

Inter-rater reliability was assessed, yielding Cohen Kappa's scores of 0.69 for title and abstract screening, and 0.65 for full-text screening. These indicated substantial agreement at both stage (Park et al., 2015).

2.2.3 Data Extraction

A data extraction table (Table 5) was completed by the main reviewer, including the following information:

Table 5

Data Extraction Plan

Author, Year and Location	
Study Type	
Study Aims	
Population	Including: • Sample size • Gender • Mean age or age range • Context
Method	Including: 1. Study design 2. Sampling strategy 3. Data collection method 4. Data analysis
Theoretical Conceptualisation	Including: • Co-dependency as defined in the paper • Theoretical framework
Key Findings	Including: • Conceptualisation • MH outcomes
Strengths & Limitations	

2.2.4 Quality Appraisal

Due to the integrative nature of the review, different tools were employed to appraise the studies' quality. To appraise the empirical research, the Mixed Methods Appraisal Tool (MMAT - Hong et al., 2018) was selected because of its applicability to mixed designs. This was considered more appropriate than using different tools which might introduce bias (Pati & Lorusso, 2018). To appraise non empirical studies, the JBI Critical Appraisal Checklist for textual evidence (McArthur et al., 2020) was employed. This was selected due to its rigorous peer-review process and recent updates, which enhance its credibility and reliability (McArthur et al., 2015). The MMAT assessed study characteristics, such as adequateness of data collection and coherence of data analysis, while the JBI checklist assessed the credibility, relevance, and logical consistency of the theoretical arguments of a paper (Appendix B).

2.2.5 Data Synthesis Method

Narrative synthesis was selected to accommodate the heterogeneity of studies, providing a newer perspective on the conceptualisation of co-dependency and associated mental health outcomes (Toronto & Remington, 2020). This approach allows for a descriptive and interpretative approach, leading to an in-depth exploration of various frameworks (Popay et al., 2006) and aligning with the aim to provide a comprehensive understanding of a complex phenomenon (Centre for Reviews and Dissemination, 2009).

Conceptual information was extracted from all studies, aiming to build an integrative understanding of how co-dependency has evolved and its mental health implications. Quantitative studies provided insights on statistical relationships, qualitative research offered contextual and experiential insights, and conceptual studies provided theoretical and definitional contributions.

Whittemore & Knafl (2005) framework (Table 6) was used to guide the synthesis. It provided the flexibility needed to effectively synthesise diverse data types, aligning with the aim of the ISLR.

Table 6

Narrative Synthesis Plan

Step	Aim	Technique
1.Data Reduction	To organise findings into manageable pieces of data	Extract and categorise key information
2.Data Display	To present the data in an organised manner to facilitate pattern recognition	Create visual display that highlight themes, concepts, and findings (e.g. extraction table, conceptualisation and MH outcome tables)
3.Data comparison	To identify similarities, differences, and patterns in the findings.	Constant comparison
4.Data integration	To develop an overall narrative synthesis	Narrative synthesis of themes

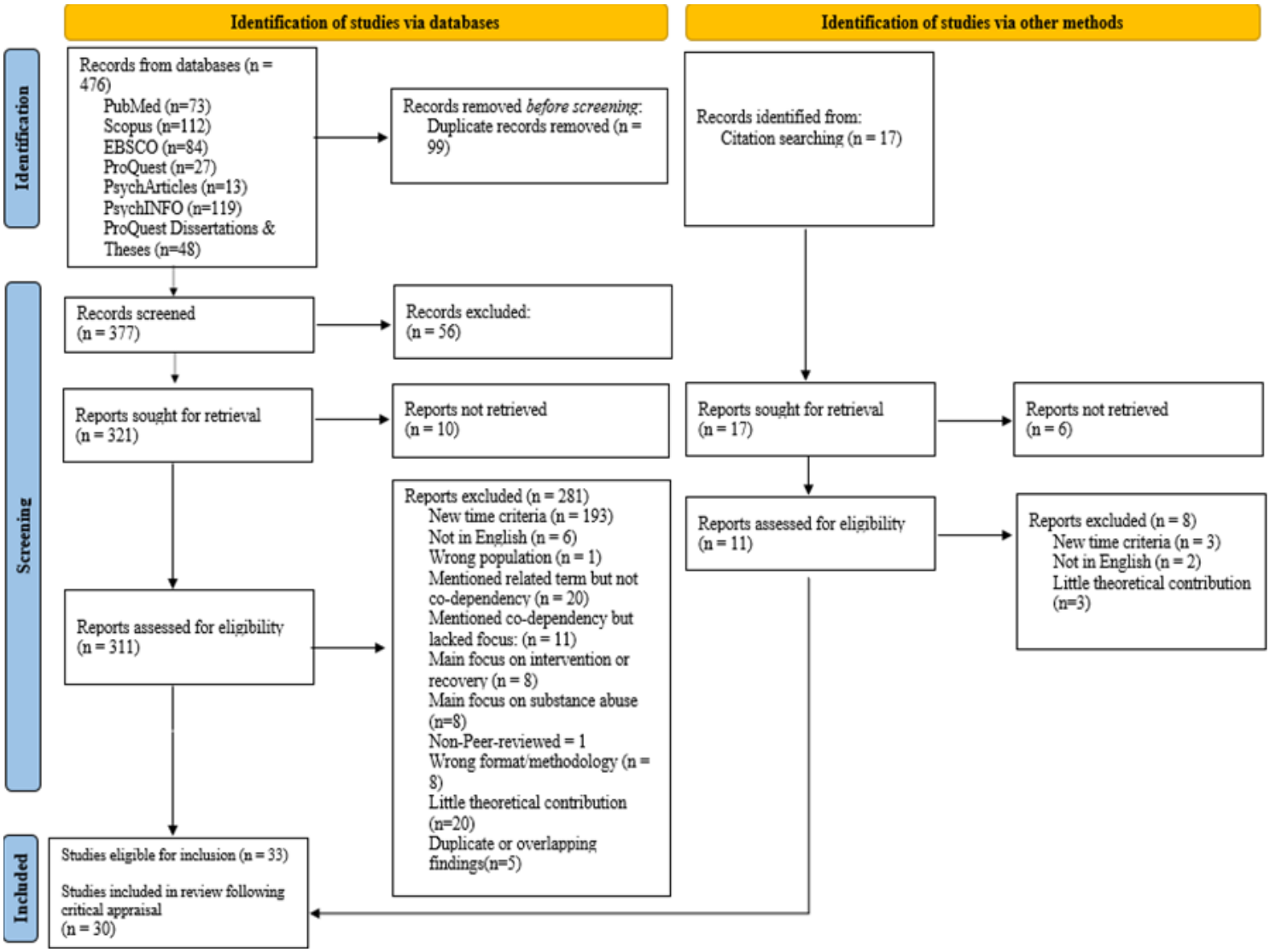
2.3 Results

2.3.1 Study Selection

The search process was conducted between August and September 2024. The systematic process is outlined in the PRISMA flowchart (Figure 2), illustrating each stage of identification, screening, and inclusion.

Figure 2

PRISMA Flowchart



The initial search yielded 476 records from the databases, along with 17 records identified via citation searching. After duplicate removal, 377 records were screened, resulting in the exclusion of 56 studies. Of the 321 reports sought for retrieval, 311 were assessed for eligibility. At this stage, we narrowed the inclusion criteria to studies published within the past 10 years, resulting in 125 studies being eligible for further review. Ultimately, 33 studies were deemed eligible for inclusion, and following appraisal, 30 studies were included in the final review. This process aimed to ensure that the most relevant and high-quality studies were selected for synthesis, reflecting the systematic rigor required.

2.3.2 Study Characteristics

Of the 30 studies, 17 used quantitative method, 5 used qualitative method, 8 were conceptual papers. Among the conceptual papers, 1 was theoretical with qualitative elements, 1 was an analytical review, and 6 were theoretical or expert opinion papers. Table 7 presents an overview of the studies' characteristics.

Studies were conducted across: Turkey (n=6), the USA (n=4), Hungary (n=3), Russia (n=3), Sweden (n=2), Italy (n=2), UK (n=2), Taiwan (n=1), Israel (n=1), Norway (n=1), Canada (n=1), Colombia (n=1), Poland (n=1), Pakistan (n=1), Ukraine (n=1).

Sample sizes ranged from 38 to 664 participants for quantitative studies and 8 to 32 participants for qualitative studies. Among the quantitative studies, the majority (n=11) used convenience sampling, 4 employed purposive sampling, and 1 used snowballing sampling. All qualitative studies used purposive sampling.

Quantitative data collection methods were predominantly surveys (n=16), with 3 studies also using clinical interviews and one using brain imaging. Qualitative studies primarily used interviews, with some incorporating focus groups, visual methods, and line drawing techniques.

Statistical analyses varied, including regression analysis (n=7), correlation analysis (n=8), structural equation modelling (SEM; n=4), analysis of variance and other group difference tests: (n=10), and factor analysis (n=2). Among the qualitative studies, one study employed IPA, one employed discourse analysis, one employed narrative and thematic content analysis, one used content analysis and one employed thematic analysis. The theoretical paper with qualitative elements employed content thematic analysis. Of the conceptual papers, three introduced new models to conceptualise co-dependency, two critiqued co-dependency, one explored co-dependency through the lens of public knowledge production, one examined co-dependency through attachment theory, and one synthesised literature on the psychological markers of co-dependency.

Participants age in empirical studies ranged between 18–81 years (Mean = 35.46), with 76.07% identifying as female (N = 2,607), from a total sample of 3,427 participants. Studies explored co-dependency in heterogeneous settings: significant others of individuals with substance abuse issue

(n=8), romantic relationships (n=5), people recovering from co-dependency (n=5), caregivers (n=4), significant others of people with non-chemical addictions (n=3), students in caring-related field (n=2), general population (n=2), public engagement and knowledge production (n=1).

Studies draw from various theories and models, often integrating different perspectives: Co-addiction and Family systems (n=14), social psychology/socio-psychological perspective (n=8), attachment (n=9), Personality/Cognitive psychology (n=6), critical perspectives (n =5), stress-coping/burn out model (n=5), psychodynamic approaches (n=6), childhood trauma and resilience frameworks (n=3), biological and biopsychosocial perspective (n=3), Disease model and disturbed personality (n=2). Although not the focus, 4 studies included cultural considerations.

Eleven studies reported mental health outcomes:, mental health/psychological functioning (n= 8), self-concept challenges (n=5), quality of life/life satisfaction (n=3), guilt/shame related to stigma (n=2), emotional dysregulation (n= 2) family/relationship functioning and satisfaction (n=5).

Table 7
Extraction Table

Author (Year) & Location	Study Type	Study Aim	Population	Method	Theoretical Framework	Key Findings	Strengths & Limitations
Aristizábal 2020 Colombia	Qualitative	To explore co-dependency in the relationships of imprisoned women. To investigate the relationship between co-dependency and violent crimes.	Sample size: 27 Gender: F Age: N/A Context: Imprisoned women reporting a romantic bond pre or during imprisonment.	Sampling strategy: purposive Data collection: in-depth interviews, focus groups and the ICOD (Emotional Co-dependency Inventory) Data analysis: Descriptive analysis and discourse analysis	**Co-dependency defined**: emotional dependency characterised by a cycle of control and enabling behaviours. **Theoretical framework:** Psycho-social and gender-based perspective Socio-constructionist perspective.	**Conceptualisation:** Co-dependency is influenced by gender roles, leading to behaviours such as denial, incomplete identity, repression, and rescuing. **MH outcomes:** Co-dependency contributed to crime involvement, emotional distress and relationship challenges as reflected in themes: 1) I did it for him 2) Although he doesn't love me and 3) I preferred to remain silent.	+ strategies on possible ways out of violent relationships. Helped in making the concept of co-dependency visible for the participants. - subjective limitations in trying to objectify knowledge
Bacon et al. (2020) UK	Qualitative	To explore the lived experiences of co-dependency. To inform clinical practice.	Sample size: 8 Gender: 5 F, 3 M Age: mid 30s to mid 60s Context: individuals who identify as co-dependents and engage with CoDA.	Sampling strategy: purposive Data collection: in depth semi structured interviews and a visual method. Data analysis: IPA	**Co-dependency defined:** a complex, multi-dimensional psychosocial problem, seen as both an adaptive coping strategy and a socially accepted form of addiction. **Theoretical framework:** Bowen's family system theory (1978)	**Conceptualisation:** Participant conceptualised co-dependency as manifesting through emotional instability and an unclear sense of self and resulting from difficult childhood experiences.	+ multiple interviews to gain deep insights on experiences. +employed measures to ensure rigour, and credibility. - narratives might be influenced by previous exposure to theories of co-dependency in CoDA - small sample size limits generalisation

					Winnicott's false self concept (1965) Trauma perspective		
Klimczak& Kiejna (2018) Poland	Qualitative	To explore the biographies of co-dependent women and to understand the relationship between their significant life events and the process of creating beliefs about themselves, interpreting and giving their own lives a meaning, and how they shape relationships with others.	Sample size: 32 Gender: F Age: age range 28-68 years; Mean age 47 (SD not reported) Context: Polish women who were receiving psychological support and had been diagnosed with co-dependency	Sampling strategy: purposive Data collection: semi-structured narrative autobiographical interviews , with time line drawing method Data analysis: Narrative and thematic content analysis applying the Big five.	**Co-dependency defined:** an adaptive response to prolonged stress and relational trauma, particularly in dysfunctional family settings **Theoretical framework:** Personality Psychology Trauma perspective (Bernstein et al., 1994) Stress perspective (Jackson, 1954 as cited in Troise, 1994)	**Conceptualisation:** Childhood trauma emerges in adult close relationships in the form of co-dependent behaviours. Co-dependent women manifested high levels of neuroticism and conscientiousness and a moderate level of agreeableness, as well as low levels of openness to experiences and extroversion.	+ provides recommendations for therapy -Limited generalisability due to purposive sampling -The big five analysis was exploratory and informal
Sobol-Goldberg et al. (2023) Israel	Qualitative	To explore the perceptions, lived experiences, and coping approaches of women who live with spouses who have alcohol use disorder in response to implicit and explicit messages from professionals and others in their environment	Sample size: 12 Gender: F Age: age range 30-69 years; Mean age 46 (SD not reported) Context: Women whose spouses had a diagnosis of lifetime alcohol use disorder and were treated in out to five outpatient treatment centres in Israel	Sampling strategy: purposive Data collection: semi-structured interviews Data analysis: Content analysis	**Co-dependency defined:** a relational phenomenon that has negative connotations and may affect the way people and society relate to family members of individuals with addiction. **Theoretical Framework:** Critical & social constructionist lens (Collins, 1993)	**MH outcomes:** Women experienced and internalised three types of social messages which impacted on their wellbeing 1)Messages leading to guilt, shame, and self-stigma. 2)Messages contributing to exclusion and isolation. 3)Messages supporting their caregiving role, which sometimes strengthened their sense of value.	+first study looking at social messages received by women whose spouse has an alcohol use disorder +implications for clinical practice -specific population limits generalisability of the findings -small sample size and no examination of mental health professionals' attitudes

					Attachment and Prodependence model (Weiss, 2019) Object relations (Winnicott's false self theory, 1965; Kohut's mirroring theory, 1977) Family System theory (Thombs & Osborn, 2019) Self-stigma model (Corrigan et al., 2006)		
Nordgren et al. (2020) Sweden	Qualitative	To analyse how parents of adult children with drug problems talked about and understood co-dependency.	Sample size: 32 Gender: 24 F, 8 M Age: age range 46-70 years Context: Swedish parents of adult children with drug problems	Sampling strategy: purposive Data collection: semi-structured interviews Data analysis: Thematic analysis	**Co-dependency defined**: a range of behaviours shaped by societal expectations among individuals who are affected by the drug use of family members **Theoretical Framework:** Social constructionist lens & Sociology of trouble model (Gemin, 1997; Emerson & Messinger, 1977)	**Conceptualisation:** The concept of co-dependency was often introduced by outsiders rather than by participants themselves. This suggests that co-dependency may be more of an externally attributed label than an internally recognized identity, at least initially. **MH outcomes:** Participants faced distress due to co-dependency, experiencing guilt and ambivalence between supporting their children and setting boundaries, as a response to reconcile societal expectations.	+ valuable insights into family disruptions related to drug problems -limited generalisability of the findings to parents who did not seek support for their difficulties
Winter (2019)	Theoretical with	To explore how co-dependency knowledge is	Sample size: N/A	Sampling strategy: N/A	**Co-dependency defined**: A construct shaped by repeated	**Conceptualisation:** The understanding of co-dependency was shaped	Not reported

Sweden	qualitative elements	produced and communicated within a semi-scientific collaboration involving experts and the public.	Gender: N/A Age: N/A Context: Participants in the Forum for Research on Drug Dependence network events in Sweden	Data collection: Observations, website materials, and field notes from a public meeting on codependency. Data analysis: Content thematic analysis focusing on claim repetition, claim coupling, and enthusiasm.	narratives of victimised children of parents with SUD, lived expertise, and the brain disease model. **Theoretical framework:** Social constructionism(e.g. Rice, 1992) Foucauldian theory (1980)	by repeated narratives about victimised children, the emphasis on sharing personal experiences, and the biological model of addiction. This focus led to the exclusion of alternative perspectives. Additionally, professionals may have had an agenda to promote the biological model of codependency to ensure that it aligns with scientific authority and provides a sense of legitimacy.	
Bacon & Conway (2023) UK	Commentary	To explore the conceptual overlap between co-dependency and enmeshment and to introduce the CODEM model for practical application.	N/A	Literature Review & Case Illustration	**Co-dependency defined:** a complex condition involving maladaptive schemas. It is seen as an outward manifestation of enmeshment, rooted in early family dynamics and unmet emotional needs **Theoretical framework:** Schema Therapy (Young et al., 2003) Family system theory (Minuchin, 1974)	**Conceptualisation:** Co-dependency was shown to be an outward manifestation of enmeshment, characterised by impaired autonomy and self-sacrifice.	N/A
Weiss (2019) USA	Expert opinion with theoretical and	To introduce and evaluate the Prodependence model as an	Sample size: 64 Gender: not reported	Sampling strategy: purposive Data collection:	**Co-dependency defined:** a deficit-based, trauma-informed model, where caring for others is seen as	**Conceptualisation:** Co-dependency is conceptualised as a deficit-based, trauma-informed model,	+provides a more compassionate way for treating loved ones of sex addicts

	quantitative elements	alternative to co-dependency. To explore whether sex addiction clinicians view prodependence as a more welcoming and potentially more effective paradigm for treatment of people close to sex addicts	Age:, not reported Context: clinicians treating love ones of sex addict.	A survey administered pre and post a presentation on Prodependence, assessing familiarity and opinions on the codependency and Prodependence model. Data analysis: descriptive survey analysis	dysfunctional behaviour. **Theoretical framework:** Attachment theory (Bowlby, 1988) Crisis model (Caplan, 1964) Critical perspective	suggesting that caring for others is inherently dysfunctional. In contrast, Prodependence is introduced as an alternative strength-based, attachment-focused model. This model frames the behavior of loved ones who continue to support addicts as normative and rational responses to a relational crisis, challenging the deficit-oriented view of co-dependency.	Limitations not reported
Calderwood & Rajesparam (2014) Canada	Commentary	To critique the co-dependency concept while highlighting possible differences between problem gambling and substance abuse, To identify important considerations when working with CSOs of problem gamblers;	Sample size: N/A Gender: N/A Age: N/A Context: concerned significant others of problem gamblers	Sampling Strategy: N/A Data Collection: N/A Data Analysis: N/A	**Co-dependency defined**: A stigmatising term that describes concerned significant others as having dysfunctional traits. The stress-coping model is proposed as a more empowering perspective, framing these behaviours as adaptive strategies to cope with significant stress. **Theoretical framework:** stress-coping model (Hurcom, Copello, & Orford, 2000).	**Conceptualisation:** There is no evidence that the co-dependency concept can be successfully applied to problem gambling. Using co-dependency in the context of problem gambling is problematic due to the stigma associated with the label, and it may not be relatable to significant others of problem gamblers. Significant others of gamblers tend to use more active coping strategies, and a shift towards the stress-coping model is recommended to reduce stigma and empower.	Not reported
Coffman & Swank (2020)	Theoretical paper	To explain the association between	Sample size:	Sampling strategy: N/A	**Co-dependency defined:** dysfunctional learned behaviour	**Conceptualisation:** Insecure attachment styles are predictors of	Not reported

USA		attachment styles and substance abuse within family systems	N/A Gender: N/A Age: N/A Context: individuals from families affected by substance abuse.	Data collection: N/A Data analysis: N/A	pattern influenced by insecure attachment styles. **Theoretical framework:** Attachment theory (Bowlby, 1969; Main, 2000) Family system theory	poor emotion regulation and interpersonal communication problems, which in turn may lead to codependent behaviours . Substance use in families significantly impacts attachment systems, leading to increased codependency.	
Kolenova et al. (2023) Russia	Theoretical review	To analytically review scientific approaches to the study of the features of psychological markers of co-dependent behaviour.	Sample size: N/A Gender: N/A Age: N/A Context: Co-dependent behaviours in the context of dysfunctional or caring relationships	Sampling strategy: N/A Data collection: N/A Data analysis: N/A	**Co-dependency defined:** a non-chemical addiction manifested in dependent behaviour caused by a change in value-semantic constructs and a lack of necessary competencies, formed under the influence of negative experience of dysfunctional relationships with significant others. **Theoretical framework:** Biopsychosocial perspective (Engel, 1977) Cognitive and personality psychology	**Conceptualisation:** Various psychological markers of codependent behaviour can be identified which are manifested through a learned set of behavioural patterns, adaptation disorders, and associations with various personality disorders. Co-dependency is associated to anxiety, depression and stress and has high comorbidity with PDs.	+enriches psychological approaches on co-dependent behaviours Limitation not reported
Liverano et al. (2023)	Theoretical paper	To describe the etiopathogenetic	Sample size: N/A	Sampling strategy: N/A	**Co-dependency defined**: a type of love addiction.	**Conceptualisation:** Codependency, the most common type of love addiction, is	+provides a practical method to work with love addictions, including codependency.

Italy		origins of love addiction. To consider the connection between attachment and love addiction. To introduce a protocol for working with love addiction using transactional analysis.	Gender: N/A Age: N/A Context: Different types of love addiction	Data collection: N/A Data analysis: N/A	**Theoretical framework:** Attachment theory(E.g Fonagy and Target.1997) Psychodynamic theory (e.g. Winnicott's false self theory, 1965; Freud's repetition compulsion theory, 1938) Transactional analysis model (e.g. Clarkson & Gilbert, 1988)	characterised by low self-esteem, insecurity, and a desperate need to hold onto a partner to fulfil unmet emotional needs. Co-dependents tolerate mistreatment and assume a caregiver role, driven by the belief "I'm OK, you're not OK."	Limitations not stated
Shishkova & Bocharov (2022) Russia	Theoretical paper (theoretical literature review)	To identify the barriers and benefits of applying the burnout concept in the context of the relationships between addicts and their relatives.	Sample size: no of studies included not reported Gender: N/A Age: N/A Context: Publications on the caregiving impact on relatives of patients with addictive disorders indexed in Cochrane, EMBASE, Web of Science, Scopus, and PsycINFO	Sampling strategy: N/A Data collection: N/A Data analysis: N/A	**Co-dependency defined**: a phenomenon rooted in the stigma associated with traditional female roles in families dealing with addiction. The behaviours traditionally associated with co-dependency are instead conceptualised as a result of stress and burnout **Theoretical framework:** Burnout model (Bocharov & Shishkova, 2021; Jackson, 1954 as cited in Troise, 1994)	**Conceptualisation:** The behaviors typically associated with co-dependency can be conceptualised in multiple ways. While the co-dependency label frames these behaviours as dysfunctional they can also be understood through the stress-coping model, where these actions are seen as adaptive strategies to cope with significant stress and support loved ones. This perspective recognises the positive and resilient aspects of these behaviors.	+contributes to a deeper understanding of the problems and needs being experienced by family members taking care of addicts. -Limitations not reported

Chang (2018) Taiwan	Quantitative (cross sectional correlational study)	To test a model of co-dependency based on Bowen's concept of differentiation for college students	Sample size: 576 Gender: 372 F, 195 M Age: Mean age 20.44(SD=1.86) Context: college students in Taiwan	Sampling strategy: convenience Data collection: survey including Co-dependency Assessment tool(CODAT),Chinese Version of the Differentiation of the self Inventory (C-DSI), Family Assessment Device-General Functioning Scale (FAD-GF), Experiences in Close Relationships Scale-Chinese version (ECRS-C), Rosenberg's Self-Esteem Scale (RSE), General Health Questionnaire (GHQ). Data analysis: Statistical analysis (Pearson correlation and SEM)	**Co-dependency defined**: a multidimensional construct characterized by low self-differentiation, other-focused behaviors, and relationship anxiety, emerging from family-of-origin dysfunction. **Theoretical framework:** Attachment theory (Bowlby, 1969) Bowen (1978) Cultural perspective	**Conceptualisation:** Co-dependency is linked to social dysfunctions (insecure attachment styles and low self-differentiation) and impaired psychological adjustment. Lower levels of self-differentiation partially mediate the effect of family-of-origin dysfunction on co-dependency, highlighting the role of family dynamics.	+ Provides initial support for the Bowen-based model of co-dependency +Provides practical suggestions for clinical practice -exploratory nature of the study limits the ability to draw causal inferences -risk of bias associated with self-report measures -potential measurement error due to employment of measures based on a western cultural background
Eshan & Suneel (2020) Pakistan	Quantitative (cross-sectional, correlational)	To investigate the relationship between co-dependency and mental health functioning with relation to gender of parents with intellectually disabled children.	Sample size: 41 Gender: 20 F, 21 M Age: Mean age 35.98(SD=7.19) Context: parents with intellectually disabled children	Sampling strategy: random-based convenience Data collection: Survey Depression-Stress-Anxiety Scale-21 (DASS-21), Spann-Fischer co-dependency scale. Data analysis: Statistical analysis (Pearson correlation and ANCOVA)	**Co-dependency defined:** dysfunctional ways of relating with others, can develop in response to caregiving burden. **Theoretical framework:** Not reported. However aligns with Stress Theory (Jackson, 1954 as cited in Troise, 1994) and System Theory (Bowen, 1978; Minuchin, 1974)	**Conceptualisation:** No significant theoretical contributions. **MH outcomes:** Co-dependency negatively correlated with mental health functioning. Gender did not significantly predict mental health functioning when co-dependency was controlled for.	+ Helps raise awareness about the phenomenon of parents experiencing co-dependency. Limitations not reported.

Happ et al. (2023) Hungary	Quantitative (Cross-sectional, correlational)	To examine how co-dependency influences negative dyadic coping, perceptions of relationship problems, and ultimately affects life satisfaction through these factors.	Sample size: 246 Gender: 167 F, 79 M Age: Mean age 35.03(SD=11.6), range 18-72 years Context: Hungarian adults in an intimate relationship	Sampling strategy: convenience. Data collection: Online survey including the Spann-Fischer Codependency Scale (SF-CDS), the Dyadic Coping Inventory (DCI), the Shortened Marital Stress Scale (MSS-R), the Satisfaction With Life Scale (SWLS) Data analysis: Statistical analysis (Pearson correlation and SEM).	**Co-dependency defined:** a stable attitude that determine a person's perception and behaviour, manifesting in dysfunctional pattern of relating to others. **Theoretical framework:** Personality model (Spann & Fischer, 1990), Systemic Transactional Model (Bodenmann, 1995) Family Systems Theory (Kerr & Bowen, 1988)	**Conceptualisation**: Codependency is associated with negative dyadic coping and perception of relationship problems. **MH outcomes:** Co-dependent attitudes, negative dyadic coping and relationship problems perception predicted lower life satisfaction.	-higher number of females limited generalisability of the findings -potential response bias due to employment of self-report measures +findings support initial hypothesis and conceptualisation of co-dependency +relevant implications for clinical practice.
Kaplan (2023) Turkey	Quantitative (Descriptive, correlational & Cross-sectional)	To examine the mental health states of housewives within the framework of co-dependence and self-perceptions	Sample size: 371 Gender: F Age: Mean age 35.19(SD= 9.85) Context: housewives in Turkey	Sampling strategy: snowballing Data collection: A survey including: Codependency Assessment Tool (CODAT), social comparison scale (SCS), the Symptom Checklist-90-Revised (SCL-90-R) Data analysis: Statistical analysis (observed variable path analysis, SEM)	**Co-dependency defined:** a characteristic that develops in dysfunctional families, associated with neglecting oneself, focusing excessively on others, inability to express feelings. **Theoretical framework:** socio-psychological gender perspective (Morgan, 1990). Kohut's self-perception theory (1986)	**Conceptualisation:** No significant theoretical contributions. **MH outcomes:** There was strong correlation between the mental status of housewives and both their codependency levels and their self-perceptions. Increased levels of codependency and negative self-perception of housewives increase the psychological symptoms experienced.	+provides practical implications for government, research and clinical practice. - limited generalisability due to sample consisting exclusively of married women.

Evgin & Sümen (2022) Turkey	Quantitative (descriptive and correlational, cross-sectional)	To determine the relationship of neglect and abuse behaviours experienced by nursing and child development students during their childhood with co-dependency, and the factors affecting co-dependency	Sample size: 292 Gender: 207 F, 85 M Age: mean age 20.25 (SD=1.27) Context: nursing and child development students	Sampling strategy: random based convenience Data collection: Survey including the Codependency Assessment Tool, the Childhood Trauma Questionnaire, the Rosenberg Self-Esteem Scale, the Beck Depression Inventory, the Styles of Coping with Stress Scale. Data analysis: Statistical analysis (Mann–Whitney U test, Kruskal–Wallis H test, Spearman's correlation)	**Co-dependency defined**: a psychosocial issue involving maladaptive coping mechanisms and a distorted sense of self-worth, largely shaped by early relational experiences and continued through adult relationships, particularly in caregiving contexts. **Theoretical framework:** Trauma lens Stress-strain theory (Hurcom et al., 2020) Sociocultural perspective	**Conceptualisation:** Co-dependency is understood as being influenced by childhood trauma, with a positive relationship identified between childhood neglect and abuse and higher levels of co-dependency. **MH outcomes**: A negative relationship was found between co-dependency and levels of self-esteem, depression, and coping with stress.	+implication for nursing practice -limited generalisability due to convenience sampling from a single university
Karaşar (2020) Turkey	Quantitative (cross-sectional and correlational)	To test the mediator role of the need for social approval in the relationship between perfectionism and co-dependency.	Sample size: 188 Gender: 144 F and 44 M Age: not reported Context: pre-teachers in Turkey	Sampling strategy: random based convenience Data collection: Survey including: Spann-Fischer Codependency Scale, Need for Social Approval Scale and Frost Multidimensional Perfectionism Scale Data analysis: Statistical analysis (SEM)	**Co-dependency defined**: a complex pattern of self-neglect, driven by social approval need, perfectionism, and cultural expectations of self-sacrifice, all of which lead individuals to prioritise others' needs over their own well-being. **Theoretical framework:** Schema Therapy (Young et al., 2003)	**Conceptualisation:** Social approval plays a partial mediating role in the relationship between perfectionism and co-dependency, suggesting that the need for social validation is a key factor linking perfectionistic tendencies to co-dependent behaviours.	+ tested model had a good fit +provides cultural considerations -limited generalisability due to sample consisting of pre-teachers from one single university

					Theory of self-presentation (Goffman, 1959) Cultural perspective		
Kaya et al. (2024) Turkey	Quantitative (cross-sectional and correlational)	To investigate the mediating role of resilience in the relationship between childhood emotional abuse and emotional neglect and co-dependency in young adults.	Sample size: 401 Gender: 305 F and 96 M Age: mean age 35.6 (SD not reported) Context: young Turkish adults at different stages in life	Sampling strategy: convenience Data collection: Survey including: the Spann-Fischer Codependency Scale, the Emotional Abuse and Emotional Neglect subscales of the Childhood Trauma Questionnaire, and the Adult Resilience Measure Data analysis: Statistical analysis (Multiple regression analysis)	**Co-dependency defined:** relationship addiction: pathological condition characterised by overreliance on interpersonal relationships. **Theoretical framework:** Childhood trauma & Attachment perspective (Bernstein et al., 1994; Drapeau & Perry, 2004) Levinson's theory of the individual life structure (1986) Resilience perspective (Kobasa, 1979).	**Conceptualisation:** Childhood emotional abuse and neglect contribute to co-dependency, with resilience partially mediating the relationship between abuse and co-dependency. However, resilience does not mediate the impact of emotional neglect, indicating different effects of childhood adversity.	+ helps understand the impact of emotional abuse on codependency and resilience in young adults. -potential bias due to self-report measures, particularly retrospective scales - exploratory nature of the study limits the ability to draw causal inferences
Knapek et al. (2021) Hungary	Quantitative (correlational, cross-sectional)	To identify the factors best able to predict co-dependency while controlling for BPD and DPD traits.	Sample size: 192 Gender: 143 F and 49 M Age: range 18-45 years Context: young Hungarian adults engaging with psychiatry, self-help groups or from the general population.	Sampling strategy: convenience Data collection: The Structured Clinical Interview for DSM-IV Axis 11 Personality Disorders -SCID-II and a survey including: the Co-dependent Questionnaire (CdQ), the Traumatic Antecedents Questionnaire (TAQ), the Young Schema Questionnaire (YSQ-	**Co-dependency defined**: a behavioural addiction which can play a role in maintaining others' addictive behaviours. **Theoretical framework:** Schema Therapy (Young et al., 2003) Family System Theory (Minuchin, 1974) Behavioural Addiction	**Conceptualisation:** Co-dependency is predicted by several factors, including subjugation and self-sacrifice schemas, mental disorder diagnosis, female gender, borderline traits, early maladaptive schemas, and parentification.	+heterogeneous samples +first study to control for BPD and DPD traits +explores a broad range of predictors +provides clinical implications -retrospective design limits the ability to draw causal inferences

				S), the Parentification Questionnaire - Adult (PQA). Data analysis: Statistical analysis (Linear multiple regression)	Framework (Schaef, 1986) and the Disease model and disturbed personality theory (Whitfield, 1991).		-does not control for narcissistic traits
Knapek et al. (2017) Hungary	Quantitative (cross-sectional, comparative)	To identify whether 'pure' codependent individuals exist. Pure co-dependency refers to the condition of codependent individuals without BPD and/or DPD	Sample size: 407 Gender: 335 F and 72 M Age: range 18- 70 years Context: young Hungarian adults engaging with self-help groups or from the general population.	Sampling strategy: convenience Data collection: The Structured Clinical Interview for DSM-IV Axis 11 Personality Disorders -SCID-II), the Co-dependent Questionnaire (CdQ). Data analysis: Statistical analysis (Chi-square tests)	**Co-dependency defined**: a mental problem characterised by extreme caretaking, enabling behaviour, and responsibility for others. **Theoretical framework:** Disease model (Griner & Griner, 1987) & PD Perspective (Cermark, 1986).	**Conceptualisation:** Borderline and dependent traits are common among co-dependent individuals, with 31% exhibiting these traits. However, 16% of co-dependents do not display these traits, suggesting that co-dependency can exist as a distinct concept separate from PD.	+provided implications for a better-informed approach on co-dependency -sample is not perfectly representative due to convenience sampling
Lampis et al. (2017) Italy	Quantitative (Cross-sectional, correlational)	To assess the validity of a model in which codependent behaviours were predicted by two relational variables: differentiation of self and dyadic adjustment in couple relationships.	Sample size: 318 Gender: 160 F, 158 M Age: range 19- 81 years, mean age 47.32 (SD=15.7) Context: students and professionals living in Italy who were in a relationship.	Sampling strategy: convenience Data collection: A survey including the Differentiation of Self Inventory (DSI-R), the Dyadic Adjustment Scale (DAS), the Co-dependency Self-Inventory Scale. Data analysis: Statistical analysis (Pearson's correlation, independent t-test, multiple linear regression).	**Co-dependency defined:** an affective disorder developing from the internalisation of experiences within the family of origin. It manifests as a relationship addiction, characterised by emotional, social, and dependence on others. **Theoretical framework:** Bowen's Family Systems Theory (1978) Cultural perspective	**Conceptualisation:** The dimensions of differentiation of self were more important in explaining the codependent behaviour compared to the dimensions of dyadic adjustment. The most important variables in predicting codependent behaviours that emerged from the analysis were emotional reactivity and emotional cutoff.	+provides support for the role of self-differentiation in co-dependency - limited generalisation to clinical sample -single method bias due to relying exclusively on self-report measures

Rozhnova et al. (2020) Russia	Quantitative (Cross-sectional, case-control study)	To study the psychological and genetic components of co-dependency	Sample size: 256 Gender: F Age:, mean age 46.4 (SD=11.8) Context: three groups of Russian women (1) those with co-dependency, 2) phenotypically healthy women; 3) a population sample)	Sampling strategy: purposive Data collection: 1) IC10 Clinical interview. 2) Psycho-diagnostic typing including the Codependency Scale, questions for self-diagnosis, The «hand test» by Wagner 3)Clinical and genealogical testing Data analysis: Statistical analysis (ANOVA, Student's t-test, Chi-square).	**Co-dependency defined**: an addictive behaviour disorder which can be influenced by early family dynamics, unmet needs, and dysfunctional relationships. **Theoretical framework:** Biopsychosocial perspective (Engel, 1977) Behavioural addiction (Schaef, 1986)	**Conceptualisation**: Codependency has psychological and genetic components. Codependent women showed auto aggressive behaviours and a family history of alcoholism. **MH outcomes:** auto-aggressive behaviours, risk of both mental and physical health issues, psycho-emotional overstrain, somatoform disorders.	+the use of genetic method provides insights in genetic component of co-dependency Limitations not reported
Vederhus et al. (2019) Norway	Quantitative (Cross-sectional, validation study)	To validate the SCCS and to investigate the relationship between co-dependency and family functioning and co-dependency and quality of life.	Sample size: 664 Gender: 479 F, 185 M Age:, mean age 44.5 (SD not reported) Context: Close relatives of patients in treatment for SUD and a control group from the general population.	Sampling strategy: convenience Data collection Composite Codependency Scale (CCS), the general family functioning subscale from the McMaster Family Assessment Device, the Quality of Life Scale (QoL). Data analysis: Statistical analysis (CFA, latent regression model).	**Co-dependency defined**: A phenomenon comprising psychological characteristics such as self-sacrifice, interpersonal control, and emotional suppression. **Theoretical framework:** Addiction and family system theories	**Conceptualisation:** Family members of individuals with SUD exhibit higher co-dependency, characterised by greater emotional suppression and interpersonal control. **MH outcomes:** Higher co-dependency scores were associated with greater family dysfunction and worse quality of life.	+ successfully validated the SCCS. -limits to generalisation due to convenience sampling +risk for social desirability bias due to reliance on self-report measures

Zielinski et al. (2019) USA	Quantitative (quasi-experimental cross-sectional study with correlational and comparative elements)	To examine specific associations between co-dependency and brain functioning.	Sample size: 38 Gender: 30 F,8 M Age: mean age 37.41 (SD= 14.19) Context: individuals close with a person with SUD and a control group.	Sampling strategy: purposive Data collection: functional near-infrared spectroscopy while participants viewed images of a loved-one with SUD or of a "target family member". Spann-Fischer Codependency Scale Data analysis: FnIR processing and statistical analysis (t-test and bivariate correlations)	**Co-dependency defined**: a learned dysfunctional condition, manifesting as excessive focus on a loved-one struggling with SUD despite negative consequences. **Theoretical framework:** Co-addiction model & Family system theory (Bowen, 1974) Biological and Bio-psychosocial perspective (Mechtcheriakov et al., 2007)	**Conceptualisation**: Co-dependency is negatively associated with left dorsomedial PFC activation in response to images of a loved one with SUD, indicating potential differences in neural processing linked to co-dependent behaviour. **MH outcomes:** Reduced left dorsomedial PFC activation suggests that co-dependency may impair the ability to effectively regulate emotions in response to relationship stress.	+ findings match preliminary findings -lack of ethnic diversity limits generalisation -groups were not ideally matched and some had a small sample size -Procedure does not look at global brain functioning -Cross-sectional design limits inferences on the development of the association
Tunca et al. (2024) Turkey	Quantitative (Cross-sectional, descriptive, and comparative study)	To compare the codependency characteristics of individuals with (clinical group) and without (non-clinical group) dependent relatives, focusing on personal (defense mechanisms), domestic (family functionality), and relational (attachment styles) contexts.	Sample size: 115 Gender: 71.3% F, 28.7% M Age: mean age 40.88 years (SD=12.56), age range 19-69 Context: Clinical group consisted of individuals with dependent relatives, recruited from an alcohol and drug treatment centre in Turkey. Non-clinical group	Sampling strategy: purposive Data collection: A survey including Codependency Assessment Tool (CODAT), Defense Styles Questionnaire (DSQ-40), Family Assessment Device (FAD), Relationship Scales Questionnaire (RSQ). Data analysis: Descriptive and Statistical analysis (Independent t-tests, Pearson correlations,	**Co-dependency defined**: involves psychopathology, dysfunctional family systems, and maladaptive relational patterns. It manifests as self-neglect, low self-worth, and preoccupied attachment styles, with an overemphasis on others. **Theoretical framework:** Psychoanalytic theory Attachment theory - Bartholomew and	**Conceptualisation:** Codependency is influenced by personal context (defence mechanisms), domestic context (family dysfunction), relational context (preoccupied attachment style)	+ offers valuable insights into codependency across different relational contexts. - The clinical group is recruited from one alcohol and drug treatment centre, reducing generalisability. -between group design poses challenges in identifying confounding factors

			recruited via social media.	Hierarchical multiple linear regression)	Horowitz's model (1991) Family Systems Theory (Epstein et al., 1978).		
Hawkins& Hawkins (2014) USA	Quantitative (Cross-sectional, correlational)	To explore the relationship between co-dependency assessment scales, gender, positive and negative gender-stereotyped traits, and other measures of personality and problem drinking	Sample size: 208 Gender: 167 F, 41 M, 2 unspecified Age: mean age 23.6 years (SD=5.6) Context: American social work undergraduates	Sampling strategy: convenience Data collection: Beck's Codependent Assessment Scale (CODAS), the ACOA Tool (ACAT), the Internalized Shame Scale (ISS), The Drinking Restraint Scale (DRS), the Personal Style Inventory (PSI), the Sensation Seeking Scale (SSS), Self-Administered Short Michigan Alcoholism Screening Test (SMAST), the Extended Personal Attributes Scale (EPAQ). Data analysis: Statistical analysis (MANOVA, ANOVA, regression)	**Co-dependency defined:** a dimension of personality, varying by degree from normality to deviance, as operationalised by gender-stereotyped attributes, which may be expressed by both women and men. **Theoretical framework:** Personality psychology Codependence and contradependence model (Hogg and Frank, 1992) Agency and Communion (Bakan, 1966) and Masculinity and Femininity model (Spence et al., 1979)	**Conceptualisation**: Co-dependence does not differ by gender and is more prevalent among students with a positive family history of alcohol problems. It is negatively correlated with socially desirable masculinity and femininity traits and is linked to Adult Children of Alcoholics (ACOA) traits, shame, and vulnerability to depression. In contrast, contradependence is associated with sensation seeking, negative masculinity, and problem drinking tendencies.	+ provides preliminary evidence in support of the construct validity of the distinction between codependence and contradependence +provides clinical implications for treating codependence and contradependence -limitated generalisability of the findings due to convenience sampling from a single university -small males sample size might have limited the statistical power of the study

Atintaş &Tutarel-Kışlak (2019) Turkey	Quantitative (Cross-sectional, correlational and comparative)	To compare marital adjustment, co-dependency, marital power, depression, anxiety, and stress in wives of both alcoholics and non-alcoholics.	Sample size: 100 Gender: F Age: mean age 41.17 years (SD=9.47) Context: Wives of alcoholics whose partner was undergoing treatment in 3 different centres in Turkey and a comparison group	Sampling strategy: purposive for the experimental group, convenience for the comparison group Data collection: A survey including the Marital Adjustment Test, Codependency Assessment Tool, Depression-Anxiety-Stress Scale, Couple Power Scale Data analysis: Statistical analysis (independent samples t-test and regression)	**Co-dependency defined**: a phenomenon characterised by focus on the other/self-neglect with four sub-concepts (low self-worth, hiding self, psychosomatic problems, and family of origin issues) **Theoretical framework:** Relational/socio-cultural view (Hughes-Hammer et al., 1998) Interdependence theory (Kelley, 1959)	**Conceptualisation:** Co-dependency is higher in wives of alcoholics **MH outcomes:** Co-dependency negatively correlated with marital adjustment, power, and life satisfaction, and positively correlated with depression, anxiety, stress.	+important contributions to research and clinical practice - Limited generalisability due to recruiting wives of alcoholics from a single city -limited ability to make casual inferences due to correlational nature of the study
Bespalov et al. (2024) Ukraine	Quantitative (Cross-sectional, correlational and comparative)	To determine the individual psycho-logical characteristics of men and women in codependent marital relationships.	Sample size: 85 Gender: 46 F, 39 M Age: mean age 32.75 years (SD not reported) Context: couples who sought psychological counselling regarding codependent family relationships	Sampling strategy: random purposive Data collection: A survey including The Co-dependency Self-Inventory Scale (CSIS); Scale for measuring the level of co-dependency, Interpersonal Dependency Inventory (IDI); Test-questionnaire for determining self-esteem ; Diagnosis of emotional intelligence; Coping test Data analysis: Statistical analysis (student t-test, ANOVA, correlation analysis)	**Co-dependency defined:** a socio-psychological phenomenon involving emotional interdependence, low self-worth and autonomy, particularly in the context of marital relationships. **Theoretical framework:** Sociopsychological perspective Attachment theory (Main, 2000) Family system theory (Bowen, 1978) Emotional regulation (e.g. Gross, 1998)	**Conceptualisation**: the formation of codependent relationships is influenced by low self-esteem. Both men and women with co-dependency showed low self-esteem and emotional intelligence. Women tend to adapt to codependent relationships due to low emotional management and higher empathy, while men cope through confrontation and distancing.	+focuses on both men and women -small sample size

2.3.3 Quality Appraisal

Quality appraisal was carried out during extraction. Three studies did not meet quality standards due to selective reporting and insufficient methodological details, resulting in 30 eligible studies. All included studies were deemed of sufficient quality (see Appendix B)

While most studies identified clear RQs, two studies (Rozhnova et al., 2020; Eshan & Suneel, 2020) only presented the aims. As these were clearly defined, it was considered satisfactory. Most studies used appropriate methodologies, providing coherent interpretations of findings. However, one qualitative study (Klimczak & Kiejna, 2018) lacked details on derivations of findings, reducing transparency.

Several studies had limitations in participant representation, with 7 recruiting from single bases or specific geographic areas (e.g. Happ et al., 2023; Kaplan, 2023). Some studies had small sample sizes (Zielinski et al., 2019; Eshan & Suneel, 2020), though these issues were typically acknowledged. Given common constraints in correlational research, non-representative samples were deemed acceptable. Outcome measures were generally appropriate, with validated scales used across all studies.

Most qualitative studies employed interviews, though some incorporated additional methods like object-based elicitation (e.g. Bacon et al., 2020), adding depth to participants' narratives. Reflexivity was underexplored in several studies as some lacked sufficient reflection on researcher-participant dynamics (e.g. Klimczak & Kiejna, 2018). Conversely, Bacon et al. (2020) enhanced credibility through peer debriefing and reflective journaling. Despite limitations in reflexivity, the contributions of these studies remain valuable.

In conceptual papers, all demonstrated logical arguments, though one (Weiss, 2019) lacked sufficient references. Some conceptual studies (e.g. Winter, 2019) did not adequately address limitations, such as conflicting views, which limited the strength of the argument. Nevertheless, all conceptual papers were written by experienced authors, contributing important theoretical insights.

All studies articulated their findings in line with their aims and effectively situated these within existing literature. Despite their limitations, all studies were deemed sufficiently rigorous for inclusion.

Their findings contribute valuable insights into co-dependency, with implications for clinical practice, policy, and theory.

2.3.4. Narrative Synthesis

Whittemore & Knafl (2005) framework was used to synthesise the findings. Overarching themes and subthemes were created as part of the data reduction stage (Table 8).

Table 8

Narrative Themes and Subthemes

Themes	Subthemes
Theme 1: The evolving debate of Co-dependency	- Sociocultural and Gender Perspectives - Relational Perspectives - Addiction & Pathology Perspectives - Developmental Perspectives - Psychoanalytic Perspectives - Psychological Perspectives
Theme 2: The Impact of Co-Dependency on Wellbeing	-Emotional & Psychological Wellbeing -Self-concept & Identity -Relational & Social Functioning

2.3.4.1 The Evolving Debate of Co-dependency. To answer RQ1, 6 key subthemes emerged in the recent literature, contributing to the understanding of co-dependency. As conceptualisations did not always follow a clear temporal progression, findings are thematically organised to reflect the diversity and complexity of the topic. Several studies contributed to multiple conceptual categories. In this review, studies are discussed in each category to which they contribute, with a focus on their specific relevance to that category. This approach ensures that the complexity is fully represented, highlighting the interplay between theoretical frameworks and empirical findings. Table 9 provides an overview of the included studies and their alignment with the conceptual categories.

Table 9

Studies Contributing to Theme 1

Study	Relational	Developmental	Psychoanalytic	Sociocultural & Gender	Addiction & Pathology	Psychological
Calderwood & Rajesparam (2014)	✓					
Hawkins& Hawkins (2014)	✓			✓		✓
Knapek et al. (2017)	✓				✓	
Lampis et al. (2017)	✓			✓		
Chang (2018)	✓	✓		✓		
Klimczak & Kiejna (2018)	✓	✓				✓
Atintaş & Tutarel-Kışlak (2019)	✓			✓	✓	✓
Vederhus et al. (2019)	✓				✓	
Weiss (2019)	✓	✓				
Winter (2019)				✓		
Zielinski et al. (2019)	✓				✓	
Aristizábal 2020	✓			✓		
Bacon et al. (2020)	✓	✓	✓			
Eshan & Suneel (2020)	✓					

Karaşar (2020)	✓					✓
Nordgren et al. (2020)	✓					
Rozhnova et al. (2020)	✓				✓	✓
Coffman & Swank (2021)	✓	✓			✓	
Knapek et al. (2021)	✓	✓			✓	✓
Evgin & Sümen (2022)	✓	✓		✓		
Shishkova & Bocharov (2022)	✓					
Bacon & Conway (2023)	✓					✓
Happ et al. (2023)	✓					✓
Kaplan (2023)	✓		✓	✓		
Kaya et al. (2024)	✓	✓			✓	✓
Kolenova et al. (2023)	✓	✓			✓	✓
Liverano et al. (2023)	✓	✓	✓		✓	
Sobol-Goldberg et al. (2023)	✓		✓	✓		
Bespalov et al. (2024)	✓	✓		✓		✓
Tunca et al. (2024)	✓	✓	✓			

Notes: A bold tick (✓) represents the study's main contribution to a particular category, while a thin tick (✓) indicates a secondary or supporting contribu

2.3.4.1.1 Sociocultural and Gender perspectives. This subtheme explores the conceptualisation of co-dependency through cultural and societal lenses.

Hawkins & Hawkins (2014) broadened early feminist theories by focusing on gender traits rather than categorical gender differences. Using constructs of agency and communion (Bakan, 1966), they modelled masculinity as high agency (independence) and femininity as high communion (nurturance). Co-dependency was associated with exaggerated communion, while contradependence reflected exaggerated agency. They emphasised the role of socialisation rather than biological sex in shaping these traits. In contrast, Bespalov et al. (2024) explored gender differences in the manifestation of co-dependency and found that men and women navigate co-dependent relationships differently, shaped by distinct emotional and relational patterns. However, this study did not address the role of socialisation, limiting its insights into how gender norms influence these patterns.

Recent research increasingly links patriarchal norms to co-dependency. Aristizábal (2020) revealed that imprisoned women felt obligated to "rescue" abusive partners, reflecting caregiving expectations. Kaplan (2023) highlighted societal pressures on housewives to derive self-worth from caretaking, echoing findings by Atintaş & Tutarel-Kışlak (2019) on power imbalances in relationships. Sobol-Goldberg et al. (2023) showed how women internalise societal stigma despite cultural ideals of selflessness, reflecting the emotional cost of patriarchal norms.

Cultural contexts also play a critical role in shaping co-dependency. Karaşar (2020) and Evgin & Sümen (2022) highlighted how Turkish culture, which promotes self-sacrifice, fosters co-dependency. In contrast, Lampis et al. (2017) discussed how Italian culture integrates both collectivist and individualistic traits, leading to tensions between relational closeness and autonomy. Chang (2018) found that emotional fusion tendencies vary by societal context.

Social constructionist research provides a critical perspective. Winter (2019) critiqued public discourses for framing co-dependency within a victimisation framework that marginalise critical perspectives. Nordgren et al. (2020) highlighted that the concept of co-dependency is not inherent but emerges through interactions with third parties, such as social services, who label concerned

significant others as "codependent." Sobol-Goldberg et al. (2023) demonstrated how societal messages influence co-dependent behaviours in women, framing co-dependency as a construct shaped by broader norms.

In sum, co-dependency is conceptualised as a rooted in societal dynamics, where gender roles, cultural expectations, and relational norms intersect with psychological mechanisms.

2.3.4.1.2 Relational Perspectives. This subtheme explores relational perspectives, including family systems theory, social psychology, and couple/family dynamics.

Systemic theory was central, with co-dependency primarily examined through self-differentiation (Bowen, 1978) and enmeshment (Minuchin, 1974). Lampis et al. (2017) and Chang (2018) identified low differentiation as a key predictor, with Chang further demonstrating its mediating role between family dysfunction and co-dependency. These studies highlight how family dynamics influence co-dependency, offering an alternative to substance-focused views (Griner & Griner, 1987). Bacon et al. (2020) described co-dependents ‘chameleon-like’ identity, offering a behavioural perspective on low differentiation.

Bacon & Conway (2023) linked co-dependency to enmeshment, framing it as impaired autonomy and self-sacrifice. Tunca et al. (2024) and Happ et al. (2023) reinforced this focus using family functioning models to reveal dysfunctions across both addicted and non-addicted families. Atintaş & Tutarel-Kışlak (2019) further linked co-dependency to reduced marital power through interdependence theory.

Liverano et al. (2023) extended relational perspectives by linking co-dependency to love addiction, describing it as a Parent-Child dynamic within transactional analysis. In this model, the codependent individual assumes a rescuing role tied to a belief of “I will save you,” driven by a compulsion to manage the relationship. However, inconsistencies remain: studies like Lampis et al. (2017) imply a relationship addiction focus without explicitly referencing love addiction theories, leaving gaps in the literature.

Two studies critiqued co-dependency's pathological framing. Calderwood & Rajesparam (2014) argued for a stress-coping model, viewing co-dependent behaviours as responses to abnormal relational stress. Shishkova & Bocharov (2022) advocated replacing co-dependency with caregiver burnout terminology, noting parallels in symptoms. Eshan & Suneel (2020) indirectly supported this perspective, finding co-dependency prevalent in parents of disabled children.

In summary, this subtheme highlights how interpersonal dynamics define co-dependency. Systemic theories remain crucial, though alternative frameworks challenge its pathologisation.

2.3.4.1.3 Addiction and Pathology Perspectives. This subtheme explores the conceptualisation of co-dependency as a disorder, either through addiction or pathological frameworks.

Addiction-focused perspectives remain dominant, conceptualising co-dependency as phenomenon intertwined with substance use. Vederhus et al. (2019) described co-dependency as a maladaptive response to addiction-related stress, marked by emotional suppression. Zielinski et al. (2019) found reduced activation in the dorsomedial prefrontal cortex when co-dependents viewed images of addicted loved ones, pointing to a neurological basis for relational stress responses. Similarly, Rozhnova et al. (2020) defined co-dependency as a non-chemical addiction, identifying higher rates of alcoholism among co-dependents' relatives, pointing to hereditary factors.

Pathological perspectives beyond addiction also persist. The PD framework (Cermak, 1986) continues to influence contemporary research, though its validity remains debated. Knapek et al. (2017) found that co-dependency can exist distinctly from PDs and later explored predictors of co-dependency while controlling for PD traits (Knapek et al., 2023). However, their work often describes co-dependents as "substance abuse partners," retaining a substance-focused lens. Liverano et al. (2023) also positioned co-dependency within a behavioural addiction framework but framed it as a relational addiction. This perspective challenges the narrow focus on addiction, highlighting broader debates about whether co-dependency is a disorder or a relational phenomenon..

In summary, co-dependency is primarily situated within addiction-related dynamics, supported by neurological and genetic evidence. However, alternative perspectives, such as PDs and behavioural addiction frameworks, provide a broader understanding.

2.3.4.1.4 Developmental Perspectives. This subtheme examines co-dependency through the lens of developmental frameworks, particularly attachment theory and trauma-based models.

Weiss (2019) conceptualised co-dependency as a natural response to attachment needs and proposed a new model, ‘’Prodependence’’, to reflect this understanding. However, he provided limited exploration of attachment mechanisms, leaving significant gaps. Coffman & Swank (2021) expanded on this, highlighting how inconsistent caregiving in families with substance use fosters insecure attachment. Co-dependency might function as a relational strategy to meet unmet emotional needs. Liverano et al. (2023) further broadened this perspective, framing co-dependency as a form of love addiction linked to disorganised and anxious attachment. They linked disrupted attachment to impaired emotional regulation, self-concept, and relational stability, leading individuals to over-focus on others to avoid abandonment.

Although limited, empirical research offered further insights. Chang (2018) described insecure attachment as a defining characteristic of co-dependency. Findings linked co-dependency to attachment anxiety and avoidance, with anxiety showing a stronger association. Conversely, Tunca et al. (2024) found anxious attachment predicted co-dependency in clinical groups, while secure attachment predicted it in non-clinical groups. These contrasting findings suggest co-dependency may manifest differently in less distressed populations, where caregiving lacks the relational dysfunction seen in clinical settings.

Trauma models also underscore co-dependency’s developmental origins. Klimczak & Kiejna (2018) and Bacon et al. (2020) explored co-dependency qualitatively, highlighting themes of childhood neglect in its development. Klimczak & Kiejna (2018) showed that unresolved trauma manifests in co-dependent behaviours, particularly in relationships with alcohol-dependent partners while participants in Bacon et al. (2020) linked their co-dependency to early experiences of

abandonment and lack of control. In his model, Weiss (2019) critiqued trauma-based models for pathologising caregiving, but these findings suggest recognising trauma fosters agency and self-awareness.

Quantitative studies corroborated these findings. Evgin & Sümen (2022) and Kaya et al. (2024) found an association between emotional abuse and neglect and co-dependency. Kaya et al. further showed that resilience mitigates the effects of emotional abuse but not neglect while Happ et al. (2024) found co-dependents exhibited low emotional resilience, exacerbating stress and trauma's impact.

These findings suggest that co-dependency emerges from a complex interplay of attachment disruptions and relational trauma. While both frameworks highlight the role of early experiences, attachment theory emphasises relational strategies to manage emotional needs, whereas trauma-based models focus on coping mechanisms shaped by harm or neglect. Together, they underscore the developmental origins of co-dependency.

2.3.4.1.5 Psychoanalytic Perspectives. This subtheme outlines how psychoanalytic approaches conceptualise co-dependency as a defence shaped by early relational dynamics.

Bacon et al. (2020) applied Winnicott’s false self theory (1965), describing co-dependency as emerging from childhood invalidation, where individuals suppress their needs to meet external demands. This dynamic results in identity struggles and an excessive focus on others. Liverano et al. (2023) extended this by incorporating Freud’s repetition compulsion, explaining how co-dependents unconsciously recreate early relational dynamics to resolve unmet needs. While both perspectives emphasise the formative influence of childhood relationships, the false self concept offers an explanation of identity struggles, whereas repetition compulsion highlights recurring behavioural patterns in relationships, emphasising complementary but distinct challenges of co-dependency.

Sobol-Goldberg et al. (2023) used Kohut’s mirroring theory to argue that disrupted early relationships impair self-cohesion, fostering dependency. Kaplan (2023) applied Kohut’s self-perception theory to discuss how caregiving roles reinforced "saviour" identities tied to external

validation. This dynamic often perpetuates a negative self-image, reinforcing self-neglect. In contrast to Liverano et al.'s focus on unconscious dynamics, Kaplan highlights the interaction between individual vulnerabilities and societal expectations, adding a sociocultural layer to psychoanalytic insights.

Tunca et al. (2024) and Aristizábal (2020). highlighted immature defense mechanisms as central to co-dependency, serving to manage anxiety triggered by relational stress. Tunca et al. (2024) further integrated psychoanalytic concepts with empirically supported models, including family and attachment theories, offering an evidence-based lens to psychoanalytic concepts.

Together, these perspectives illustrate how psychoanalytic theories, particularly in integrative contexts, advance the conceptualisation of co-dependency as a relational and developmental construct.

2.3.4.1.6 Psychological Perspectives. This subtheme explores co-dependency through personality and cognitive psychology. This perspective bridges the gap between developmental and pathological conceptualisations, highlighting processes that may begin as adaptive responses to relational challenges but can contribute to maladaptive co-dependent behaviours.

Hawkins and Hawkins (2014) conceptualised co-dependency as part of a continuum, with contradependence representing the opposite extreme. Both reflect maladaptive interpersonal patterns, highlighting the need for balance between autonomy and connection. Building on this dimensional perspective, Kolenova et al. (2023) framed co-dependency as a stable personality attitude, shaped by diverse cognitive and emotional patterns (Andronnikova, 2017). This view emphasises the heterogeneity of co-dependent traits but risks diluting the construct's coherence, reinforcing critiques of its conceptual vagueness (e.g., Wells et al., 1998).In contrast, Klimczak & Kiejna (2018) used the Big Five framework to identify a common personality profile among co-dependent individuals, revealing high neuroticism, conscientiousness, and moderate agreeableness. This suggests that while co-dependency may involve diverse expressions of personality traits, it converges around shared characteristics.

Schema Therapy provided further insights into co-dependency. Bacon & Conway (2023) identified maladaptive schemas, such as impaired autonomy and other-directedness while Knapek et al. (2021) identified self-subjugation and self-sacrifice. Karaşar (2020) found co-dependency to be positively associated with perfectionism, driven by a need for social approval, further underscoring the interplay between cognitive distortions and relational dynamics. Perfectionism appears tied to schemas such as "defectiveness/shame", where individuals strive for perfection to compensate for feelings of inadequacy (Bacon & Conway, 2023)

Emotional dysregulation also emerged as a central feature. Rozhnova et al. (2020) emphasised emotional overload and suppression, and identified "auto-aggressive" behaviours, such as self-neglect and tolerating harmful relationships, which contributes to internalised distress. Bespalov et al. (2024) added on this, identifying emotional dysregulation and intelligence deficits.

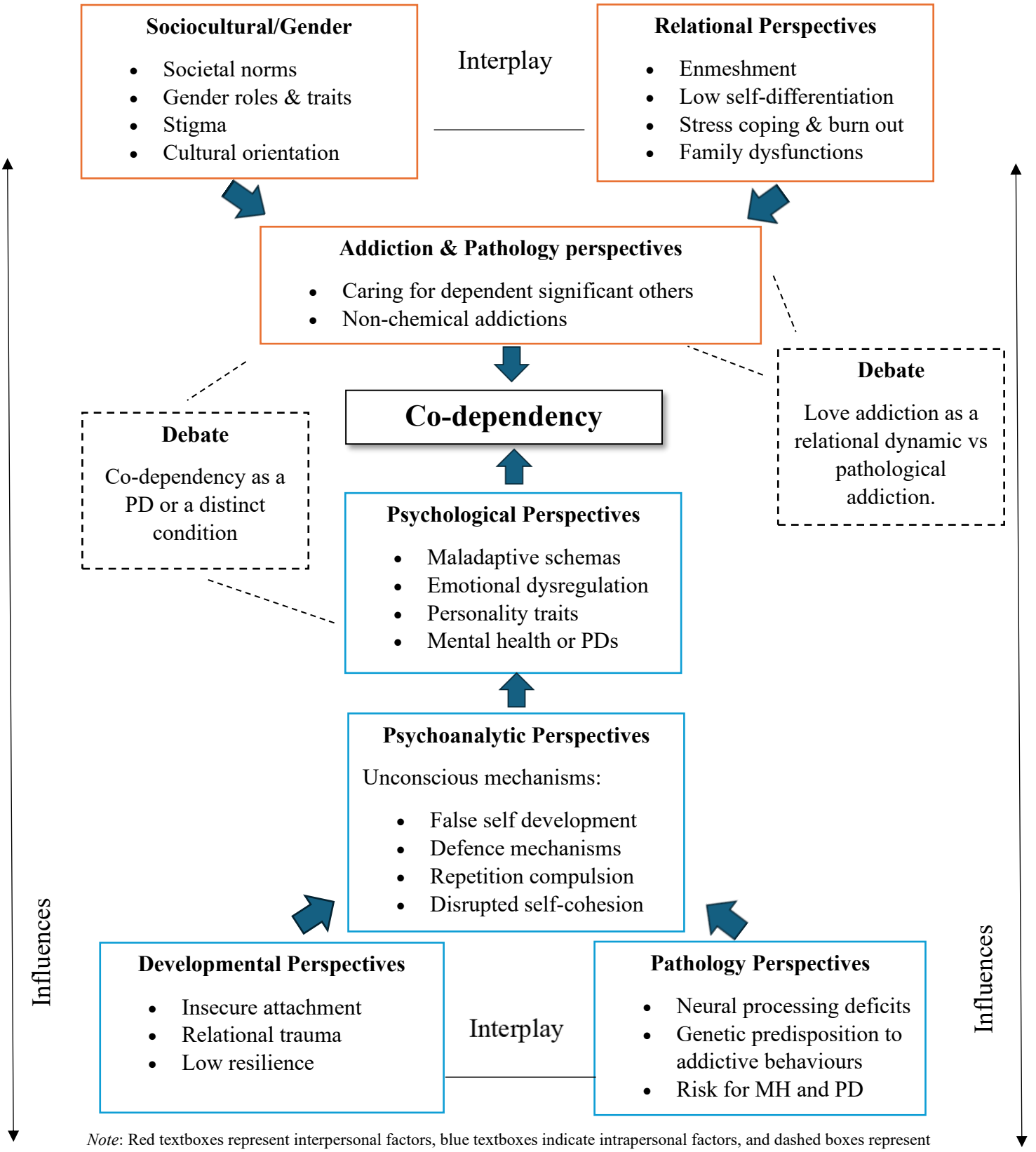
In summary, co-dependency is conceptualised as being rooted in maladaptive schemas, emotional dysregulation, and personality traits, all closely tied to relational patterns.

2.3.4.1.7 Theme 1 Conclusion. The perspectives explored in this theme underscore the multidimensional nature of co-dependency, including attachment disruptions, unconscious patterns, sociocultural influences, intrapersonal mechanisms. Despite this richness, there remains no unified conceptualisation of co-dependency. Existing studies often isolate specific factors, limiting understanding on their interaction.

This fragmentation highlights the need for an integrative framework. This review proposes the Inter-Intrapersonal Framework (Figure 3), which provides a comprehensive lens for understanding co-dependency, capturing the interplay between various interpersonal and intrapersonal factors.

Figure 3

Co-dependency Inter-Intrapersonal Framework



Note: Red textboxes represent interpersonal factors, blue textboxes indicate intrapersonal factors, and dashed boxes represent ongoing debates bridging different perspectives. One-directional arrows illustrate how each factor influences co-dependency, while bi-directional arrows highlight dynamic feedback loops between interpersonal and intrapersonal mechanisms, illustrating the complexity and interactions central to understanding co-dependency

At the foundation, Developmental Perspectives highlight the role of early experiences, including attachment disruptions and relational trauma, in shaping co-dependency. Complementing this, Pathology Perspectives emphasises how neurobiological factors, and genetic predispositions contribute to psychological vulnerabilities, including risk for addictive behaviours and mental health conditions. These foundational mechanisms form the basis for the maladaptive patterns seen in co-dependency.

Building on these vulnerabilities, Psychodynamic Perspectives focus on unconscious processes, such as defence mechanisms and unresolved conflicts, that influence relational patterns and dependency behaviours. These mechanisms reflect deeper psychological structures that often operate outside conscious awareness. Psychological Perspectives, within the intrapersonal domain, examines cognitive, emotional, and behavioural mechanisms, including maladaptive schemas, emotional dysregulation, and personality traits. These processes interact dynamically with external relational stressors, illustrating how internal vulnerabilities both shape and are shaped by interpersonal dynamics.

At the interpersonal level, Addiction and Pathology Perspectives highlights compulsive behaviours rooted in intrapersonal vulnerabilities and shaped by relational and sociocultural factors. Relational Perspectives address how dysfunctional dynamics, including enmeshment and low differentiation, contribute to co-dependent behaviours, creating external relational stressors that reinforce internal mechanisms. Sociocultural and Gender Perspectives consider broader external influences, including societal norms, caregiving expectations, and stigma, which provides the structural context within which relational and psychological patterns are sustained.

The framework illustrates the bidirectional feedback loops between intrapersonal mechanisms and interpersonal processes. Foundational vulnerabilities influence relational behaviours, while external stressors reinforce internal mechanisms. By bridging these processes. it provides a comprehensive framework for understanding co-dependency as a product of interconnected psychological, relational, and sociocultural influences. However, key debates remain unresolved. For

instance, the question of whether love addiction represents a relational dynamic or a pathological behavioural addiction continues to divide researchers. Similarly, the classification of co-dependency as a distinct condition versus its alignment with personality disorders remains contentious. These debates highlight the complexity of co-dependency and the need for further empirical exploration.

Overall, this model offers a comprehensive basis for future research, providing a lens to explore how interpersonal dynamics and intrapersonal vulnerabilities interact in the development of co-dependency.

2.3.4.2. The Impact of Co-Dependency on Well-being. To address our second RQ, this section synthesises and analyses literature on the mental health impacts of co-dependency. Only empirical studies are included in this theme to focus on observed impacts rather than theoretical discussions. While many studies discussed potential consequences of co-dependency, only 11 studies included measured outcomes. During extraction, it was noted that several studies reported outcomes related to social functioning and self-perception. While these are not traditional psychological symptoms, they were deemed highly relevant to understanding the broader mental health implications of co-dependency. Including these constructs aligns with contemporary perspectives viewing relational functioning and self-perception as integral to mental health (Keyes, 2002). Three subthemes were identified (Table 10) emphasising the diverse ways in which co-dependency affects individuals.

Table 10

Studies Contributing to Theme 2

Subthemes	Included Studies
Self-concept and Identity	Aristizábal (2020), Evgin & Sümen (2022), Kaplan (2023), Sobol-Goldberg et al. (2023).
Emotional and Psychological Wellbeing	Atintaş &Tutarel-Kışlak (2019), Vederhus et al. (2019), Zielinski et al. (2019), Aristizábal (2020), Eshan & Suneel (2020), Nordgren et al. (2020), Rozhnova et al. (2020), Happ et al. (2023), Kaplan (2023), Sobol-Goldberg et al. (2023), Evgin & Sümen (2022)
Relational and Social Functioning	Atintaş &Tutarel-Kışlak (2019), Vederhus et al. (2019), Zielinski et al. (2019), Aristizábal (2020),

2.3.4.2.1.Self-concept and Identity. Several studies discussed self-concept and identity difficulties in the context of co-dependency. As discussed in the introduction, these can be understood as both a cause and an outcome. Co-dependency may arise from early disruptions in self-concept or identity (Bacon et al., 2020), and in turn, might reinforce and exacerbate these difficulties.

Chang (2018) highlighted low self-esteem as a key feature of co-dependency, contributing to psychological difficulties. However, other research has identified it as an outcome of co-dependency. Evgin & Sümen (2022) reported that co-dependency erodes self-esteem through identity loss, fostering feelings of worthlessness. Similarly, Kaplan (2023) found that housewives developed negative self-perception through making others the focus of life and denying personal needs.

Sobol-Goldberg et al. (2023) highlighted self-stigma mechanisms in co-dependents, discussing how women internalise conflicting societal messages, such as expectations of selflessness, while simultaneously stigmatising co-dependency. This contributes to the development of negative self-perception and identity conflicts, reinforcing co-dependency.

This subtheme emphasis co-dependency negative impact on self-concept and identity, with significant implications for mental health.

2.3.4.2.2.Relational and Social Functioning. Reviewing Theme 1, it becomes clear that co-dependency relational features are central to understanding the construct. While co-dependency may serve as a compensatory response to unmet needs (Coffman & Swank, 2021), it often undermines relational and social functioning. Rather than fostering healthy connections, co-dependent behaviours tend to sustain unbalanced or harmful dynamics, impairing autonomy (Chang, 2018).

Whilst acknowledging the role of historic family dysfunction, Vederhus et al. (2019) found that co-dependent behaviours further impair family functioning in the long term. Atintaş & Tutarel-Kışlak (2019) further emphasised the impact on marital relationships, reporting that co-dependency leads to a perception of reduced power, diminishing marital adjustment.

Aristizábal (2020) observed that co-dependency often sets the stage for the engagement in and maintenance of violent relationships, strongly linked to low self-esteem, social isolation and a decline

in autonomy. Co-dependents may remain in such relationships due to a fear of abandonment and overreliance on their partners. This reduces individuals' emotional well-being, limiting opportunities for healthier relationships. Zielinski et al. (2019) highlight biological underpinnings to these difficulties. Co-dependents were found to suffer from executive dysfunctions and heightened relational stress, impairing their ability to process and regulate social responses, thereby hindering their capacity to cope with relational challenges.

In sum, co-dependency is shown to impact on relational dynamics, hindering relational and social functioning.

2.3.4.2.3 Emotional and Psychological Wellbeing. The emotional toll of co-dependency extends beyond relationships and self-concept, manifesting in broader psychological symptoms.

Chang (2018) tested a model of co-dependency where psychological adjustment problems were shown to be a core feature of co-dependency. Similarly, Rozhnova et al. (2020) found that somatoform disorders are common in co-dependency and reported that co-dependency poses a risk for the development of mental and emotional difficulties. However, studies like Chang (2018) blur the boundary between conceptualisation and outcome, framing psychological difficulties as intrinsic to co-dependency rather than as consequences.

Eshan & Suneel (2020) reported that parents in co-dependent relationships with their children experienced stress, depression, and anxiety. Similar results were observed in wives of alcoholics (Atintaş &Tutarel-Kışlak, 2019). Kaplan (2023) found that co-dependency in housewives was associated with various psychological symptoms, potentially exacerbated by their negative self-perception.

Aristizábal (2020) and Evgin & Sümen (2022) found depression to be associated with co-dependency, with Aristizábal (2020) additionally reporting anxiety, trauma symptoms, and emotional dysregulation. Emotional dysregulation, linked to biological mechanisms, was also reported by Zielinski et al. (2019). Nordgren et al. (2020) and Sobol-Goldberg et al. (2023) highlighted guilt and

shame due to societal expectations, both in relation to societal expectations and the stigma of co-dependency.

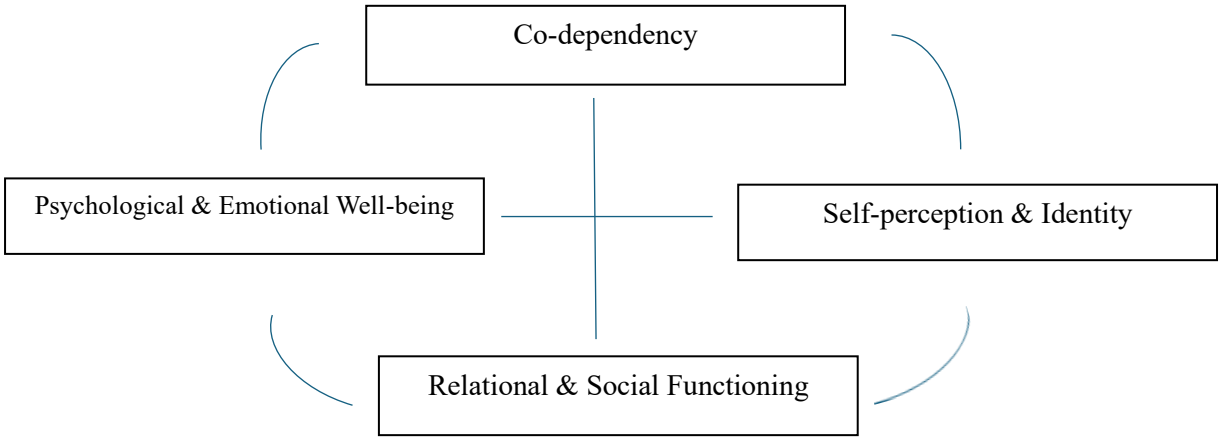
Reviewing this, it is perhaps unsurprising that co-dependency significantly impacts overall well-being. Happ et al. (2023) reported lower life satisfaction, while Vederhus et al. (2019) found lower quality of life. This might contribute to unhelpful coping mechanisms, such as passivity, learned helplessness, reliance on smoking (Evgin & Sümen, 2022) or other substances (Rozhnova et al., 2020) and crime involvement (Aristizábal, 2020). These behaviours might again also serve to reinforce and perpetuate the psychological and emotional outcomes of co-dependency.

In sum, the evidence strongly links co-dependency to emotional and psychological challenges, encompassing both internalised struggles and broader mental health difficulties.

2.3.4.2.4 Theme 2 Conclusion. This theme reveals negative outcomes of co-dependency, encompassing psychological and emotional well-being, self-perception and identity, relational and social functioning. These domains are interconnected, with challenges in one area often reinforcing difficulties in the others, creating a self-perpetuating cycle that sustains co-dependency. For example, disrupted self-perception can hinder relational functioning, while relational stress exacerbates emotional struggles, all of which feedback into the core features of co-dependency. To represent this, a framework (Figure 4) has been proposed with a central axis linking these domains, illustrating how they interact and collectively reinforce co-dependency. This framework offers a cohesive understanding of co-dependency as a unified phenomenon, integrating its core characteristics and observed outcomes.

Figure 4

Interconnected Mental Health Outcomes of Co-dependency.



Note: This framework illustrates how co-dependency is associated with psychological well-being, self-perception, and relational functioning. These domains are interconnected, with challenges in one area reinforcing difficulties in the others, contributing to the perpetuation of co-dependent patterns.

2.4 Discussion

This review synthesised diverse perspectives to provide a comprehensive understanding of co-dependency and its mental health outcomes. The conceptualisation of co-dependency drew on diverse frameworks, including family systems, attachment theory, sociocultural, addiction, and psychological models, highlighting its complex origins in relational, developmental, and intrapersonal processes. Across studies, co-dependency was associated with a range of negative mental health outcomes, including emotional distress, identity disturbances, and relational dysfunctions.

To bring coherence to these fragmented perspectives, this review introduces two conceptual frameworks (Figure 3 and 4). The first integrate existing conceptualisations on co-dependency, illustrating the interaction between intrapersonal vulnerabilities and interpersonal dynamics in shaping co-dependent behaviours. The second highlights how disrupted self-concept, emotional difficulties, and relational strain interconnect and reinforce co-dependent patterns. Together, these models offer a cohesive foundation for advancing theoretical understanding and guiding future empirical and clinical work on co-dependency.

A key strength of this review lies in its integrative approach, bridging conceptual and empirical gaps. While some conceptual papers overlapped with empirical findings, their inclusion

enriched the analysis by providing theoretical clarity and framing recent shifts in how co-dependency is understood, particularly in relation to trauma and attachment. Investigator triangulation enhanced the rigour and reliability of the findings. The use of Whittemore and Knafl's (2005) framework provided a structured synthesis process, supporting transparency and coherence in theme development. Additionally, the development of two novel frameworks (Figures 3 and 4) offers a meaningful theoretical contribution, helping to organise fragmented literature into clinically and empirically relevant models.

However, integrating such a wide body of literature posed challenges. Limiting the scope to studies published within the past 10 years ensured a focus on contemporary findings but excluded foundational works. Additionally, the screening process faced inefficiencies, with overlapping reasons for exclusion at the abstract and full-text stages. Although iterative refinements improved the rigour of study selection (Higgins & Thomas, 2020), future reviews would benefit from more stringent abstract screening criteria. Reflections on this are detailed in Appendix C.

Inconsistent terminology complicated full-text screening. While conceptually adjacent terms were included in the search terms, studies were only retained where co-dependency was explicitly referenced, as detailed in the Methods section. This may have limited insight into overlapping constructs, suggesting future research should examine related terms in parallel to enhance theoretical clarity.

The potential influence of positionality on study selection also warrants consideration. As the primary reviewer, my background may have influenced the interpretation and prioritisation of studies. While a second independent reviewer was employed, researcher subjectivity remains an inherent factor in any review process (Pascoe, 2022).

The empirical studies differ greatly in focus and sample, limiting the ability to generalise conclusions. Geographic concentration of the studies, predominantly in Turkey, the USA, and Europe further limits generalisability. Whilst some studies explored culture (e.g Lampis et al., 2017), cultural orientation remains underexamined despite its critical impact on relational dynamics. Future research

should focus on the role of cultural norms and values in shaping co-dependent behaviours, moving beyond broad geographic contexts.

Attachment theory has offered valuable conceptual insights, however, empirical research in this area remains limited and inconsistent. This underlines the need for research integrating attachment theory with cultural orientation, providing a more holistic understanding of co-dependency. Moreover, the research on co-dependency outcomes is extensive but lacks systematic exploration, particularly regarding adaptive elements such as resilience. Future research should explore the potential for post-traumatic growth, particularly in individuals engaged with recovery groups to provide a more balanced and clinically useful understanding of co-dependency.

These findings have important implications. Clinicians should adopt and integrative, strengths-based approach, addressing both the adaptive and maladaptive aspects of co-dependency. By building on existing coping mechanisms, such as empathy, and relational commitment, therapists can help reframe behaviours that may have once been pathologised. Attachment or trauma-informed care are critical for targeting co-dependency's psychological and relational dimensions. Integrating positive well-being measures into clinical assessment would support a more holistic understanding of clients' experiences, beyond deficit-based models.

The review highlights a lack of conceptual clarity and consistency in co-dependency research, particularly regarding its definition, measurement, and relationship to broader mental health outcomes. For policymakers, this underscores the importance of integrating co-dependency awareness into national mental health strategies and commissioning research that examines its relevance across diverse populations. Public health campaigns can help reduce stigma and raise awareness of relational struggles often obscured by diagnostic boundaries. Finally, dedicated funding for training clinicians in relationally-informed approaches is essential to ensure co-dependency is identified and addressed early in a range of service contexts.

For researchers, the need to move beyond addiction-focused frameworks is critical. Future SLRs should work to distinguish co-dependency from overlapping constructs, and empirical studies

should explore how cultural values and attachment patterns shape its development and expression. Mixed methods designs may offer a more comprehensive understanding of how co-dependency operates across interpersonal and cultural contexts, capturing both subjective narratives and measurable outcomes.

2.5 Conclusion

This review synthesises recent evidence on co-dependency, presenting two integrative frameworks that capture its diverse conceptualisation and mental health outcomes. The findings highlight co-dependency as a complex construct with significant implications for mental well-being. The review critiques the field's tendency to over-pathologise co-dependency and advocates for integrative, strengths-based perspectives.

The review identified key limitations in the literature, including conceptual ambiguity, limited cultural contextualisation, and inconsistencies in attachment-related findings. Future research should prioritise clarifying distinctions between co-dependency and overlapping constructs, examining cultural influences, and exploring developmental pathways.

Clinically, the findings underscore the importance of trauma- and attachment-informed interventions that are culturally sensitive and promote relational well-being. This review offers a foundation for advancing theory, improving practice, and shaping policy to better address the experiences of individuals affected by co-dependency.

2.6 Rationale for the Current Study

Research has highlighted co-dependency mental health outcomes, yet specific public healthcare support remains lacking. This reflects an urgent need for further empirical exploration. Drawing on the findings of the review, contemporary research primarily adopts addiction-focused and pathological frameworks (e.g., Vederhus et al., 2019), which oversimplify co-dependency.

The underrepresentation of non-Western contexts further restricts an understanding of how cultural dimensions influence co-dependent behaviours. While recruiting participants from

underrepresented cultural contexts can be challenging, investigating cultural orientation offers an alternative way to examine individuals' cultural values and relational norms. This allows for deeper insights into how cultural dynamics moderate the relationship between co-dependency and mental well-being.

Similarly, there is a strong conceptual link between co-dependency and insecure attachment (Coffman & Swank, 2020), yet empirical evidence remains limited and inconsistent. By investigating attachment patterns, this study will contribute to clarifying their role in co-dependency. Additionally, the study will employ the DMM, a novel approach in co-dependency research, to explore how individuals adapt to relational threats and environmental stressors. This attachment-informed lens offers critical insights into the relational and psychological mechanisms underlying co-dependent behaviours.

Previous studies have predominantly focused on females, limiting the generalisability of findings across genders. By including male and female participants who self-identify as co-dependent, this research aims to provide a more inclusive perspective on the experiences of co-dependency. Additionally, co-dependency remains heavily stigmatised, which exacerbates its negative effects on mental well-being (Nordgren et al., 2020; Sobol-Goldberg et al., 2023). A broader aim of this research is to destigmatise co-dependency by offering alternative perspectives that recognise its adaptive aspects.

Co-dependency research has predominantly employed quantitative methods (e.g. Knapek et al, 2017; 2021), leaving accounts of individuals' accounts unexplored. By adopting a mixed method design, this study aims to capture the narrative and emotional dimensions of co-dependency, that quantitative data alone may overlook.

This study holds significant relevance for clinical psychology by advancing the conceptualisation and understanding of co-dependency. It addresses gaps in the literature regarding cultural and attachment dimensions, providing evidence that can inform interventions tailored to diverse populations. Importantly, this research aligns with the HCPC's standards (2015) of cultural

competence, evidence-based practice, and stigma reduction, as well as the BPS's values (2018) of diversity, inclusion, and advancing psychological knowledge.

2.7Aims and Research Questions

This research aims to address critical gaps in the current understanding of co-dependency by adopting a mixed-methods approach to explore its attachment and cultural dimensions. Quantitatively, the study investigates the extent to which insecure attachment and cultural orientation independently explain co-dependency, as well as how cultural orientation moderates the relationship between co-dependency and mental well-being. Qualitatively, the study explores the personal accounts of co-dependent individuals, aiming to provide richer insights into their relational and psychological patterns. The RQs are presented in table 11.

Table 11

Research Questions

Research Question	Type
RQ1: Do attachment and cultural orientation independently explain co-dependency?	Quantitative
RQ2: How does cultural orientation interact with co-dependency to impact mental well-being?	Quantitative
RQ3: What attachment strategies are observed among individuals from SGFC with moderate-high co-dependency?	Qualitative
RQ4: What are the common themes in how individuals with moderate-high co-dependency scores who engage with SGFC describe their experiences of co-dependency and attachment?	Qualitative

3. METHODOLOGY

3.1 Chapter Overview

This chapter describes the study's design and its rationale. The quantitative phase identified key relationships between attachment, cultural orientation, co-dependency, and mental well-being, while the qualitative phase used in-depth interviews to explore participants' narratives and attachment strategies in greater depth. This chapter also outlines the triangulation strategy. Ethical implications, involvement of Experts by Experience (EBEs), and efforts to decolonise the research are also considered.

3.2 Design

The study employs an explanatory sequential mixed-methods design, beginning with a quantitative phase followed by a qualitative phase. In the quantitative part, the role of attachment and cultural orientation, including the potentially moderating role of cultural orientations on the relationship between co-dependency and mental well-being was explored. Following this, the qualitative phase employed interviews to provide a deeper understanding of how attachment strategies manifest in co-dependent behaviours, and the contextual factors that influence participants' accounts of co-dependency. Triangulation was used to integrate findings from both phases, enhancing the depth and rigour of interpretation (Fielding, 2012).

Table 12 outlines the RQs and the corresponding methods used to address them.

Table 12

Methodology Overview

Research Question	Phase	Measures	Analysis
How do attachment and cultural orientation contribute to co-dependency?	Quantitative	RAAS, COS and FCAI	Multiple regression
How does cultural orientation moderate the relationship between co-dependency and mental well-being?	Quantitative	SWEMWBS, FCAI, COS and RAAS	Moderation analysis

What attachment strategies are observed among individuals with moderate-high co-dependency?	Qualitative	Adapted DMM-AAI	DMM coding
What are the common themes in how individuals with moderate-high co-dependency scores describe their experiences of co-dependency and attachment?	Qualitative	Adapted DMM-AAI	Abductive Attachment-informed TA

Notes: RAAS = Revised Adult Attachment Scale, FCAI = Friel Co-Dependency Assessment Inventory, SWEMWBS = Short Warwick–Edinburgh Mental Wellbeing Scale, COS = Cultural Orientation Scale, DMM-AAI= Dynamic Maturational Model-Adult Attachment Interview

3.2.1 Epistemology and Positionality

This research employed a pragmatist epistemological stance. Pragmatism is often described as ‘’the mixed methods paradigm’’ due to its focus on solving real-world problems without adhering strictly to a single worldview (Feilzer, 2010). However, pragmatism extends beyond merely “doing what works” (Hall, 2013). Pragmatism bridges the gap between objectivity and subjectivity, recognising knowledge as both constructed and real (Biesta, 2021) and reality as dynamic, shaped by actions and consequences (DeForge & Shaw, 2012). Through this lens, the study integrates constructivist and social constructionist perspectives: individuals mentally construct their experiences (attachment theory), while meaning is co-constructed through cultural and social processes (cultural orientation).

It is important to acknowledge how my positionality shaped this study’s methodology, acting both as a potential source of bias and as a valuable interpretative resource (Braun & Clarke, 2022). Growing up in a family labelled as co-dependent (albeit without dependent relatives), gave me personal insights into co-dependency, which influenced the constructs I was drawn to explore. My background created a sense of connection with participants, deepening my understanding of their experiences; however, my researcher role introduced a level of separation that may have influenced what they felt comfortable sharing (Berger, 2015). To mitigate potential biases and draw from my personal resources, I engaged in self-reflexivity and bracketing (Fischer, 2009), maintaining a journal to critically analyse my assumptions, decisions, and interpretations. This enhanced the rigour and

transparency of the research (Milne & Oberle, 2005), supporting a sensitive and open approach to participants' narratives. Excerpts from this journal (Appendix C) document some of these reflections.

3.2.2 Rationale for Mixed Methods

As discussed, co-dependency research has been predominantly quantitative. To our knowledge, this is the first mixed methods study on co-dependency. While quantitative research is essential for identifying measurable characteristics and patterns, it is limited in capturing the complexities of co-dependency, which remains heavily debated (Pagano-Stalzer, 2021).

A mixed methods approach aligns with the study's aims by offering a robust framework to generate context-specific and actionable insights that can inform clinical practice (Biesta, 2021). Our design enabled the quantitative phase to identify relationships, while the qualitative phase explored the mechanisms underlying these relationships in greater depth (Toyon, 2021).

This allowed for integration and triangulation, which increases the validity of the findings (Alele & Malau-Aduli, 2023). This ensured that numerical findings were contextualised through participants' narratives, offering a more comprehensive understanding of co-dependency. While mixed methods designs are time-consuming, they enable a richer exploration of complex constructs, leading to findings that single-method approaches cannot achieve (Sharma et al., 2023).

3.2.3 EBE's Consultation

Consultation with co-dependent fellows has been sought at different stages, to promote research that is meaningful while still respectful of the community. The lead researcher contacted the admin of a support group, who provided a channel to recruit candidates. Two fellows volunteered and attended a total of 4 meetings.

In the first meeting (11/04/25) fellows were consulted regarding recruitment and measures. They recommended sensitivity and transparency, as some of their group principles might seem to discourage fellows from liaising with external agencies. The questionnaire was reviewed, highlighting the need for more accessible language. In the second meeting (12/09/24) fellows were consulted on

the interview's schedule and additional questions were co-produced. The third meeting (03/04/25) focused on feedback on the qualitative analysis, ensuring interpretation was aligned with participant's experiences. In final meeting (09/05/25) outlets for dissemination were discussed, considering strategies for accessible communication.

This approach enhanced the study's rigour and trustworthiness. By involving fellows, the study remained grounded in the lived experiences of those most connected to co-dependency, aligning with the pragmatist stance to generate context-specific and actionable insights. Fellows were thanked for their time and provided with a 10-pound e-voucher for each hour of consultation.

3.2.4 Research Decolonisation

Efforts were made to contribute meaningfully to decolonising research. Decolonisation challenges the dominance of Western paradigm of knowledge production, which often marginalise alternative perspectives (Barnes, 2018). Decolonising methodologies are crucial to ensures research benefits and empower all stakeholders, including the studied population.

In the context of co-dependency, marginalised voices are those from a collectivist cultural orientation, males, and those from the general population who might be unfamiliar with the label. Efforts were made to facilitate inclusive recruitment. While the qualitative part of this study recruited specifically from a UK support group, the quantitative part recruited from various sources to obtain a more diverse sample. By using cultural orientation as a variable rather than ethnicity, the study considered culture beyond geographical or ethnic boundaries.

Additional efforts were made to balance the sample, with attention to gender. Recruitment flyers were shared with a LGBTQ+ support group. To reach those who might not be on social media, flyers were posted in the support group forum. Interviews were offered in-person or online, increasing accessibility.

Employing reflexivity, this research intended to critically analyse the process of knowledge production, increasing awareness of how the researcher's positionality, within a Western academic context, influenced the research. Lastly, the study's general aim to destigmatise co-dependency aligns

with a decolonising methodology, as evidence shows that co-dependency is a western construct (Irvine, 1997). By exploring cultural orientation, the study critiques the Western-centric understanding of co-dependency and highlight its potential cultural variations. By adopting a relational perspective of distress (Grey, 2025) the research challenges pathological framings of co-dependency, offering a more contextualised and socially informed understanding.

3.3 Quantitative Phase

3.3.1 Design

The quantitative phase employed a cross-sectional design. While a longitudinal study could have provided stronger evidence for causality between co-dependency and mental wellbeing, practical constraints, including time and available resources, necessitated the use of a cross-sectional approach. This design allowed for the recruitment of a large and diverse sample, facilitating the examination of multiple predictors within a limited timeframe and ensuring the feasibility of data collection (Wang & Cheng, 2020).

3.3.2 Participants

Participants were recruited from both the general population and a UK Support Group For Co-dependents (SGFC).

3.3.3 Inclusion and Exclusion Criteria

Inclusion and exclusion criteria are presented in Table 13.

Table 13

Quantitative Phase Inclusion and Exclusion Criteria

Inclusion Criteria	Exclusion Criteria
Adults (over 18 years old)	Children (under 18 years old)
Identify as a co-dependent/resonates with common co-dependent behaviours (based on screening questionnaire)	Does not resonate with common co-dependent behaviour

No severe cognitive impairment or acute mental health conditions	Severe cognitive impairment or acute mental health conditions
Fluent in English	Non fluent in English

3.3.4 Recruitment

Participants from the general population were recruited using opportunity sampling, through social media platforms, psychology forums and university emails and flyers. For SGFC participants, purposive sampling was employed, with recruitment conducted through forums and WhatsApp groups recommended by the group's administrators. This ensured a diverse participant sample, including individuals familiar with co-dependency and those from broader contexts. The recruitment flyers can be seen in Appendix D.

We aimed for a sample of at least 100 participants justified by a priori power analyses. G*Power 3.1.9.4 (Faul et al., 2009) indicated that a sample of 60 would be sufficient to achieve 80% power to detect a moderate effect size ($f^2 = 0.15$) in a multiple regression model with 7 predictors at a significance level of $p < 0.05$. For the moderation analysis, power analysis indicated that a sample size of 99 was required to detect a moderate effect size ($f^2 = 0.15$) in a model with 11 predictors, including 4 interaction terms.

A medium effect size ($f^2 = 0.15$) was chosen based on Cohen's (1988) conventional thresholds. Previous research on co-dependency and its psychosocial predictors varies in whether effect sizes are reported, and where reported, the strength of associations differs considerably across studies and analyses (e.g. Chang, 2010). In light of this inconsistency and to ensure sufficient power to detect effects of practical relevance, a moderate effect size was selected.

A total of 405 participants was eligible to complete the study however only 328 completed the questionnaire. Participant attrition is common in survey-based research, particularly for online survey, and may be due to a variety of factors such as lack of time, loss of interest, or internet connection

issues (Hochheimer et al., 2019). Only completed responses were used in the analysis and this sample was considered adequate to provide sufficient power.

3.3.5 Ethical Considerations

Ethical procedures (Table 14) were guided by principles of respect, confidentiality, and safeguarding. While some procedures were shared across both phases of the study, others were tailored to the specific demands of the quantitative and qualitative components. Full documentation (e.g., consent forms, information sheets) can be found in Appendices E–K.

Table 14

Ethical Procedures

Ethical Domains	Procedure
Ethical Approval	Approved by University of Hertfordshire HSET Ethics Committee (Protocol: LMS/PGR/UH/05577). Amendment approved (0202 2024 Oct HSET). See Appendix E.
Consent	Participants received detailed consent form and information sheet (Appendices F & G). During the qualitative phase, an updated information sheet was sent (Appendix H), and consent was reconfirmed verbally before interviews.
Confidentiality and Anonymity	Data were stored on a password-protected university drive. Only non-identifiable data and pseudonyms included in transcripts.
Data Protection	All data were handled in line with GDPR and institutional policies. For the qualitative phase, contact details were stored separately. Video recordings were stored securely and deleted after transcription.
Right to Withdraw	Participants were informed of their right to withdraw at any point during the survey or up to 15 days post-interview. Interview participants were given the opportunity to retract any shared information at the end.
Managing Distress	A risk assessment (Appendix I) indicated low overall risk. Participants were advised of the sensitive nature of the topics. Distress was monitored during interviews and breaks were offered when needed. Debrief sheets included signposting to support services (Appendices J & K).
Appreciation	Survey participants entered into a prize draw (£50 Amazon voucher); interview participants received £10 voucher.

In discussion with SGFC consultants, it was noted that consent procedures required careful consideration. Recruiting through support group platforms risked participants assuming the research

was conducted internally, potentially influencing their participation. Hence, participants were explicitly informed during initial contact that the research was conducted independently from SGFC and the participation was voluntary. Psychology jargon was minimised throughout the research to ensure accessibility and facilitate understanding.

3.3.6 Data Collection and Measures

Following expression of interest, participants were emailed with a link to a Qualtrics questionnaire. Participants were invited to sign the consent form and complete a brief screening (Appendix L) to confirm eligibility before accessing the main survey. Twenty-four participants were screened out for not meeting the inclusion criteria. They were thanked for their time and effort and provided with signposting information. The questionnaire included demographic questions, including SGFC engagement and willingness to attend an interview, along with four psychological scales. Only validated measures with established reliability were used, helping to mitigate response bias (Elston, 2021). The questionnaire took 20-30 minutes to complete. The scales and their instructions can be seen in Appendix M and are below described.

3.3.6.1 Friel Co-Dependency Assessment Inventory (FCAI – Friel, 1985). The FCAI is a 60-items dichotomous checklist assessing co-dependency. It categorises participants into different co-dependency levels, with higher scores indicating greater severity. The FCAI takes approximately 5-8 minutes to complete. The FCAI has good internal consistency, test-retest reliability (West-Willette,1990) and validity criterions (Calleros, 1991) with a Cronbach's alpha of 0.91 (Besomo, 1996).

3.3.6.2 Revised Adult Attachment Scale (RAAS - Collins, 1996). The RAAS measures individual differences in attachment. It consists of three subscales (close, depend and anxiety) with a total of 18 items. Respondents rate items on a 5-point scale ranging from 1 (not at all characteristic of me) to 5 (very characteristic of me). The RAAS was selected because it allows for the computation of two attachment dimensions (anxiety and avoidance) which are believed to be relevant to co-dependency (Chang, 2018). The RAAS produces good reliability, with Cronbach's alpha scores

ranging from .77 to .86 across subscales (Graham, & Unterschute, 2015) and good validity (Teixeira et al., 2018). The scale takes 5-10 minutes to complete.

3.3.6.3 16-Item Culture Orientation Scale (COS - Triandis and Gelfand, 1998). The COS is a 16-item scale assessing individual cultural orientation across four dimensions: Vertical collectivism (VC), Vertical Individualism (VI), Horizontal Collectivism (HC) and Horizontal Individualism (HI). This scale was chosen for its comprehensive categorisation of cultural orientation. Respondents rate these items on a 9-point scale, ranging from 1 (never/definitely no) to 9 (always/definitely yes). It takes 5-10 minutes to complete. The scale has good reliability (Hui, 1984), a Cronbach's alpha of 0.91 (Hui & Yee, 1994) and acceptable validity (Li & Aksoy, 2007).

3.3.6.4 The Short Warwick-Edinburgh Mental Well-being Scale (SWEMWBS – Stewart-Brown et al., 2009). The SWEMWBS is a measure of Mental Wellbeing (MW) consisting of 7 items formulated with positive statements in a Likert-style format (from 0: not at all to 5: all the time). It conceptualises mental wellbeing as being made up of both hedonic and eudemonic aspects. Higher scores indicate higher mental wellbeing. This scale was chosen for its emphasis on positive aspects of wellbeing rather than dysfunctions, aligning with a strengths-based approach. The scales take approximately 5 minutes to complete. The scale has a good content validity, internal consistency (Cronbach's alpha = 0.89), high test-re-test reliability (Haver et al., 2015) and was validated in diverse cultural context (Sun et al, 2019) .

3.3.7 Data Analysis

Statistical analysis was performed using SPSS 29.01. The hypotheses and their directions are presented in Table 15 (See Table 11 for the RQs**).**

Table 15

Research Hypotheses

Hypothesis 1	Hypothesis 2
Attachment dimensions (Avoidance and Anxiety) and cultural orientations (VI, VC, HI, HC) will significantly and independently contribute to explain	Co-dependency will predict low mental well-being, with cultural orientation moderating this relationship. Specifically:

the variance observed in the participants' co-dependency scores. Specifically: 1) Attachment dimensions and collectivistic cultural orientations (VC and HC) are hypothesised to predict higher co-dependency 2) Individualistic cultural orientations (VI and HI) are hypothesised to predict lower co-dependency.	1) Collectivistic cultural orientations (VC and HC) are expected to buffer the negative impact of co-dependency on wellbeing, making the effects less pronounced. 2) Individualistic cultural orientations (VI and HI) will amplify the negative impact of co-dependency on wellbeing, making the effects more pronounced.

A multiple regression was conducted to explore whether attachment and cultural orientation independently explained the variance in participants' co-dependency scores. A moderation analysis was performed to examine whether co-dependency predicted lower mental wellbeing and whether cultural orientations moderated this relationship.

The directionality for the collectivist and individualistic dimensions was justified by research, suggesting that co-dependency might be considered healthy in collectivist orientations (Milushyna, 2015). Given the limited research on the impact of co-dependency in collectivist cultures, this study hypothesises that collectivism might buffer the negative impact of co-dependency on well-being, while individualism might amplify it. No specific directionality was proposed for the horizontal and vertical dimensions, as no prior research has investigated these, resulting in insufficient evidence to support a directional prediction (Field, 2018).

3.4 Qualitative Phase

3.4.1 Design and Methods

The qualitative phase employed a cross-sectional design using a mixed analytical approach, combining attachment-informed Thematic Analysis (TA) and DMM analysis. Grey & Dallos (2025) advocate for combining attachment-informed approaches with other qualitative methods to capture both implicit and explicit dimensions of meaning-making. These methods facilitated an in-depth exploration of co-dependency and attachment dynamics, aligning with the study's pragmatic focus on achieving useful explanations of phenomena. Triangulation was conducted within the qualitative phase before integrating findings across both phases.

3.4.1.1 Attachment-informed Thematic Analysis. An abductive attachment-informed TA was conducted, guided by Thompson's (2022) eight-step framework. This approach allows iterative movement between participants' narratives and existing theory (Proudfoot, 2023), making it well-suited for exploring relational processes like co-dependency. Rather than focusing solely on surface-level patterns, abductive TA supports the development of latent themes and causal explanations (Maxwell, 2022). Attention is paid to both within- and across-case patterns, enabling a comprehensive, theory-building analysis (Grey & Dallos, 2025).

Thompson's framework was selected for its rigour and flexibility, aligning with the study's pragmatist stance. This ensured deeper integration between participants' accounts and attachment concepts, while remaining open to novel, data-driven insights. The aims of this model are summarised in Table 16. The practical application of these steps is described in Table 20.

Table 16

Abductive Thematic Analysis Plan

Step	Aim
1.Transcription & Familiarisation	To ensure authentic representation of participants' narratives. To begin identifying meanings, patterns, and the context of participants' experiences.
2.Coding	To systematically organise and categorise data into meaningful segments facilitating the identification of patterns and themes within the dataset.
3.Codebook (adapted from Guest et al., 2012).	To provide clarity, consistency, and structure to the final round of coding by standardising the application of codes. To aid with reflection on coding choices.
4.Development of themes	To develop latent themes that comprehensively explain the phenomenon under study and answer the research question.
5.Theorising	To explain the relationships between themes and the entire dataset, offering a theoretical narrative that connects the data to existing knowledge while remaining open to novel insights.
6.Comparative analysis	As all participants were from the same group, formal group comparison is not possible. Instead, variation in theme expression can be explored across individuals, drawing on attachment strategies and cultural orientation scores to support interpretation.
7.Data Display	To visually synthesise the theoretical interpretation of key themes developed through coding and analysis. To enhance rigour and transparency of the coding process.

Several qualitative methods were reviewed before selecting attachment-informed TA, summarised below in Table 17.

Table 17

Summary of Qualitative Methods Considered

Method	Rationale for Consideration	Rationale for Exclusion
Reflexive Thematic Analysis (Braun & Clarke, 2019)	Well-established, flexible approach for identifying patterns in qualitative data.	Prioritises meaning making and co-construction over explanatory depth. Less suited to identifying self-protective functions and causal mechanisms. Clashes with DMM's epistemological stance.
Narrative analysis (Earthy & Cronin, 2008)	Useful for exploring personal identity and life stories.	Focuses on narrative structure and storytelling rather than theory-driven theme development. Misaligned with the study's aims to explore relational and attachment mechanisms.

Ultimately, abductive TA was selected for its capacity to support iterative engagement between theory and data. It enabled theoretical insights to be meaningfully integrated with findings from the DMM and quantitative phases, offering a structure for exploring co-dependency and attachment dynamics. This method offered a rigorous framework for exploring co-dependency and attachment dimensions, as demonstrated in similar studies by Bond et al. (2020), Coe et al. (2021), and Voellmy et al. (2024).

3.4.1.2 The Dynamic Maturational Model of Attachment (DMM). The DMM (Crittenden, 2006) served a dual role in this study: first, as a theoretical framework guiding the attachment-informed TA and second, as a coding system for categorising participants' attachment strategies. Rather than simply classifying attachment styles, the DMM employs discourse analysis to interpret how individuals narrate their experiences in ways that serve self-protective functions (Grey, 2025). While novel in co-dependency research, this model was selected to build on findings from the quantitative phase. The questionnaire provided insecure attachment scores, while the DMM allowed for a deeper exploration of the mechanisms underlying attachment strategies.

The DMM examined participants' accounts through the activation and transformation of information across memory systems, revealing unconscious patterns of processing attachment-related experiences. Congruence across systems may signal secure attachment, while transformations suggest defensive strategies. These interpretations are grounded in how individuals perceive and respond to danger within relationships, with the narrative itself understood as serving a protective function (Grey, 2025).

Participants' strategies were categorised using the DMM's typology (see Section 1.6.3.1), which helped exploring the relational dynamics underlying co-dependency. However, the analysis moved beyond classifications. Annotated transcripts were used to examine how participants constructed meaning, regulated affect and managed danger within their discourse. These insights were then integrated into the attachment-informed TA to support within-method triangulation.

Other frameworks and models were reviewed before selecting the DMM, as presented in Table 18.

Table 18

Frameworks Considered to Complement TA

Method	Rationale for Consideration	Rationale for Exclusion
The Power Threat Meaning Framework (PTMF- Johnston & Boyle, 2018)	Helpful to explore the power dynamics involved in co-dependency, which are discussed in the literature (Atintaş & Tutarel-Kışlak, 2019).	Lacks a direct focus on attachment. Including it could dilute the attachment-based lens.
The Berkeley Model of the Adult Attachment Interview (AAI; Main et al., 1985)	Foundational in attachment research; classifies attachment states based on coherence and narrative consistency.	Relies heavily on rating scales and fixed categories, making it less suitable for idiographic, qualitative analysis. DMM offers more developmental and functional depth. (Crittenden & Spieker, 2018).

Ultimately, the DMM was selected as the most appropriate framework due to its emphasis on how individuals adapt attachment strategies in response to perceived danger. Unlike the PTMF, which focuses on social narratives of distress, the DMM embeds these dynamics within attachment theory, offering a more targeted understanding of self-protective strategies. It also extends the Berkeley AAI

by adding a developmental and functional perspective, allowing for a richer exploration of how attachment strategies evolve over time in response to relational danger (Crittenden et al., 2021). This made it an ideal complement to the abductive TA, enabling a more nuanced, theory-driven analysis.

3.4.2 Participants

SGFC fellows who completed the questionnaire and expressed an interest to be contacted for the qualitative phase were invited to participate in the interview.

3.4.3 Inclusion and Exclusion Criteria

Table 19 presents the inclusion and exclusion criteria.

Table 19

Qualitative Phase Inclusion And Exclusion Criteria

Inclusion Criteria	Exclusion Criteria
Adults (over 18 years old)	Children (under 18 years old)
Currently engages with a UK SGFC	Does not engage with a UK SGFC
No severe cognitive impairment or acute mental health conditions	Severe cognitive impairment or acute mental health conditions
Fluent in English	Non fluent in English
Consented to be contacted for an interview Moderate-to-severe co-dependency scores	Did not consent to be contacted for an interview Low or mild co-dependency scores

The threshold of moderate-to-severe co-dependency scores was chosen based on suggestion for clinical relevance (Friel, 1985). This is consistent with the study's aims, as individuals with lower scores might not display the depth of relational dynamics required for meaningful analysis.

3.4.4 Recruitment

Recruitment strategy is described in paragraph 3.2.5.3. Participants were emailed a link to the interview. We aimed to recruit 5-6 participants, consistent with previous studies using a similar design (Coe et al., 2021; Voellmy et al, 2024). Eleven participants volunteered, however two did not meet the clinical threshold**.** Of the remaining participants**,** one was experiencing acute mental health issues and

was admitted to hospital, and another chose not to participate after receiving the information sheet. This resulted in six participants being successfully recruited.

While other qualitative designs traditionally recruit a larger sample size (Braun & Clarke, 2013), our chosen methods focused on in-depth analysis of complex phenomena which can be successfully achieved with a small sample (Boddy, 2016). This sample size enabled a detailed exploration of each participant's narrative. The aim was not to generalise to a wider population, but to interpret the self-protective function of discourse and the relational meaning-making embedded in individual accounts (Grey, 2025).

3.4.5 Ethical Considerations

Ethical considerations specific to the qualitative phase extended those outlined in Table 14, with additional safeguards tailored to the interview setting.

As the researcher, I was mindful that my presence and the interview format could create a power imbalance, potentially influencing participants to over-disclose or shape their responses to align with perceived expectations. To mitigate this, I adopted a conversational and participant-led approach, helping the interviews feel collaborative and non-directive.

My positionality as a researcher with lived experiences of co-dependency also required careful self-reflexivity. By documenting interactions and potential biases, I facilitated transparency and maintained sensitivity in the process. These strategies aimed to create a safe and respectful space for participants.

3.4.6 Data collection and Measures

Interviews were conducted remotely via Microsoft Teams, using the DMM-Adult Attachment and Adaption Interview (DMM-AAI, Crittenden & Landini, 2011). While the DMM-AAI is traditionally conducted in-person to facilitate the observation of non-verbal cues and emotional responses (Baldoni et al., 2017), the online format was chosen based on participants' preferences due to logistic constraints, as participants were located across the UK. The mode of attendance was

determined through a majority vote, maintaining reliability and consistency across interviews. Although the validity of online DMM-AAI has not yet been examined, it ensured accessibility. Consistent with the broader adoption of online interviews in social research, this was considered effective for data collection. Strategies like ensuring participants had their camera on and framing their bust within view, allowed for the collection of a satisfactory amount of non-verbal communication (Brown, 2022).

3.4.6.1 DMM-AAI (Crittenden & Landini, 2011). The DMM-AAI is a semi-structured interview designed to operationalise the DMM framework. It builds on the Berkley model (Main et al., 1985) and incorporates a broader range of attachment strategies (Figure 1).

Participants are asked to reflect on their childhood experiences, relationships with caregivers, and how these have influenced their current attachment patterns. The DMM-AAI focuses on eliciting unconscious processes and feelings by activating participants' attachment systems (Grey & Dallos, 2025). Interviews typically last 1 to 1½ hours. The DMM-AAI has been extensively used in research, and it has been validated for normative adults and various mental health conditions (Crittenden et al, 2021; Spieker et al.,2021).

Interviews were coded by trained researchers with advanced experience, focusing on producing clinically meaningful and theoretically grounded interpretations. To align with the study's focus, minor adaptations were made to the protocol. Additional prompts were incorporated to explore themes of co-dependency in relation to participants' attachment experiences. These were co-produced with SGFC fellows following consultation. For example, the question, "How have your childhood experiences affected your adult personality?" was expanded to "including your co-dependency''.

The Lead Researcher received training to conduct the DMM-AAI and piloted the updated protocol with two external individuals to evaluate its effectiveness and feasibility. Piloting revealed that the interviews exceeded the standard time, prompting discussions with a DMM-AAI-trained supervisor. Non-essential questions were excluded, and some were shortened. For the study's aims,

questions about participants' children were deemed non-essential and omitted. Appendix N shows the final protocol.

3.4.6.2 Interview Procedure. Interviews were conducted by the Lead Researcher from 3rd to 25th October 2024. These ranged from 1 hour and 30 minutes to 1 hour and 50 minutes. This variation was due to the depth of the participants' responses, particularly when discussing emotionally significant experiences. Although exceeding the anticipated length posed some time management challenges, it enriched the data by allowing participants to fully articulate their experiences. Participants were asked if they were comfortable to continue and breaks were offered as needed. On one occasion, the interview was split into two sessions to accommodate the participant. No signs of distress or fatigue were observed because of the length. Reflections on this are presented in Appendix C.

The interview began with the Lead Researcher introducing themselves and reiterating the points outlined in the information sheet. Participants provided verbal consent for the interview to commence, including permission to record and transcribe. The interview followed the updated protocol, and flexibility was maintained to accommodate the natural flow of the conversation (Karatsareas, 2022). Probes and additional questions were used as needed to explore relevant areas.

At the end of the interviews, participants were given the opportunity to ask questions or provide feedback on the experience. The debrief sheet and an online voucher were sent by email. A participant became emotional when revisiting their childhood experiences. A follow up appointment was offered to provide additional support, however the participant declined, expressing they felt safe and were able to get support through other means.

3.4.7 Data Analysis

All interviews were transcribed by the Lead Researcher and were uploaded on NVivo 14 (QSR International, 2023) for analysis.

3.4.7.1 Attachment-Informed TA. Transcripts were analysed following the steps outlined by Thompson's (2022). Each step and the associated procedures are presented in Table 20.

Table 20

Abductive Thematic Analysis Steps

Step	Procedures
1.Transcription & Familiarisation	-Transcribed using MS teams, ensuring accuracy by re-checking against the recording. -Preserved participants' mode of speech to maintain authenticity in their narratives. -Actively engaged with the data by re-reading transcripts, making notes or highlights to document impressions and emerging ideas.
2.Coding	-Performed coding on NVivo. Undertook 2-3 rounds of coding to ensure precision. • First round: Conducted exploratory coding to capture all points of significance, focusing on inclusivity rather than selectivity. • Second round: Refined and consolidated codes, combining overlapping categories and eliminating irrelevant or redundant codes. • Third round: See column 4
3.Codebook (adapted from Guest et al., 2012).	-Produced a label and definition for each code to succinctly represent its meaning. -Applied a ‘’when to use’’ and ‘’when not use’’ criteria to each code. -Included an example quotation for each code.
4.Development of themes	-Identified relationships between codes to determine how they collectively contribute to explaining the data's underlying story. -Sorted and grouped codes based on their theoretical relevance, incorporating the informing theoretical perspective where applicable. -Named themes using clear language that captures their essence. - Categorised themes as overarching, primary, secondary, or sub-themes to organise their importance and relationships.
5.Theorising	-Determined the extent to which existing theories account for the relationships between themes, identifying areas where they fail or need refinement. -Engaged with both theory and data iteratively to produce theoretical conclusions, considering possibilities for adapting, consolidating, or extending existing theoretical perspectives.
6.Comparative analysis (adapted from Guest et al., 2012).	While Guest et al.'s (2012) comparative analysis was considered, the qualitative sample comprised a single participant group (SGFC members), meaning cross-group comparisons were not applicable. However, variation in how themes were expressed across individuals was explored through participant-level coding and individualised formulations.
7.Data Display	-A conceptual diagram (Figure 8) that mapped latent themes and theoretical constructs was developed and presented in the Discussion to visually synthesise key findings.

3.4.7.2 DMM Coding. The DMM analysis examined participants' narratives across multiple dimensions to identify attachment strategies. Table 21 summarises these dimensions, their descriptions, and their relevance.

Table 21

Dimensions of DMM Analysis

Dimension	Description	Relevance
Affect	Emotional expression and regulation. Includes the intensity, appropriateness, and coherence of emotions in narratives.	Overemphasis on affect and the use of arousal to control and make other predictable is linked to Type C strategies. Suppression or minimisation indicates Type A strategies.
Cognition	Logical reasoning and abstract thinking. Reflects the individual's ability to organise and process information logically. Cognition is about predicting the responses of others through temporal order.	Over-reliance on cognition at the expense of emotional expression is typical of Type A strategies, while balanced use reflects Type B attachment.
Behavioural Patterns	Observable, nonverbal actions or reflexive responses (e.g., avoidance of eye contact, body language, restlessness).	Reflect implicit defensive processes often tied to attachment strategies. Type A individuals may suppress emotional expression and display physical distancing behaviours, while Type C may exhibit hyper-vigilant or exaggerated behaviours to elicit care or reassurance.
Memory Systems	Six systems (procedural, imaged, semantic, episodic, connotative language and reflective integration) that process and store relational experiences	Congruence across systems indicates secure attachment, while transformations (e.g., omissions, distortions) signal defensive strategies.

	While two additional systems (body talk and physiological arousal) have been identified, they are not yet formally integrated into the AAI coding system. (Crittenden et al.,2021)	
Narrative Coherence	Logical and emotional consistency in participants' accounts.	Coherent narratives indicate Type B, while contradictions, unresolved stories, or fragmentation suggest insecure strategies.
Transformations of Information	Alteration, suppression, or distortion of information to manage relational threats or emotional discomfort.	Omissions and distortions are defensive strategies often observed in Type A or Type C attachment styles.
Defensiveness	Strategies to manage relational or emotional discomfort (e.g., suppression, hyper-vigilance).	Avoidance reflects Type A, hyper-vigilance reflects Type C, and mixed defenses (e.g., conflict between the two) indicate Type AC strategies.
Dysfluencies	Irregularities in speech, such as pauses, interruptions, or repetitions, often tied to emotionally significant topics.	Suggest unresolved emotional content or internal conflict, often reflecting insecure attachment strategies.
Meta-Communication	Underlying relational messages conveyed through tone, body language, and emotional intensity.	Inconsistent or incongruent meta-communication can reveal suppressed affect or internal conflict related to insecure strategies.
Power and Control Dynamics	Patterns in the narrative reflecting struggles for autonomy or dominance within relationships.	Often observed in avoidant or anxious strategies, reflecting relational imbalances or dependency.

The analysis was carried out by four trained independent coders who followed Crittenden & Landini (2011) steps, detailed in Table 22.

Table 22

DMM Analysis Steps

Step	Procedure
Familiarisation	Each transcript was reviewed twice: • First reading: focused on learning key facts about the participant's history, discourse style, and organisation of information. • Second reading: aimed to identify discrepancies, transformations and defensive patterns.
Identification & analysis of memory systems	Coders evaluated patterns in the four memory systems to examine how information was processed and represented: • Procedural Memory: Nonverbal cues (e.g., pauses, hesitations) were examined for signs of suppressed affect. • Imaged Memory: Sensory-based details (e.g., vivid descriptions of sights or sounds) were noted for their emotional intensity. • Semantic Memory: Logical but detached accounts were flagged as potential indicators of avoidance or suppressed emotions. • Episodic Memory: Emotional recollections of significant events were analysed for coherence and emotional expression. • Connotative Language: Metaphors, symbolic phrases, and emotionally loaded word choices were identified to uncover implicit emotional meaning or defensive strategies not explicitly stated. • Reflective integration: Efforts to link past experiences with present functioning were analysed for coherence, depth, and emotional attunement.
Annotations of discourse markers	Discourse markers were annotated to capture observable indicators of transformations (e.g., omissions, contradictions) or congruence across memory systems: • Transformations: Suppressed, distorted, or exaggerated information reflected defensive strategies. • Defensiveness: Speech irregularities (e.g., hesitations, repeated phrases) indicated hyper-vigilance or avoidance. • Narrative Coherence: fragmented or contradictory narratives were flagged for further analysis
Classification of attachment strategies	Attachment strategies were classified into Types A (Avoidant), B (Balanced), or C (Anxious) based on observed patterns: • Type A: Over-reliance on cognition, suppression of affect, and logical but detached narratives. • Type C: Overemphasis on affect, fragmented narratives, and hyper-vigilance to relational threats. • Type B: Integration of affect and cognition, with coherent and congruent narratives.
Documenting results	Final classifications were recorded, along with evidence from discourse features and memory system patterns that supported each classification. Annotated transcripts were further used to examine narrative function and self-protective strategies, which informed the triangulation with thematic analysis findings.

3.5 Methodological Triangulation

This study employed a multi-stage triangulation process to synthesise and cross-validate quantitative and qualitative findings. A Convergence Coding Matrix (O'Cathain et al., 2010; see Table 23) was used across both within- and between-method triangulation, offering a transparent and systematic structure for integration.

Within-method triangulation involved synthesising TA findings with DMM classifications and annotated transcripts to enhance the robustness of the qualitative results. This narrative approach (Creswell & Plano Clark, 2017) explored how themes emerging from participants' accounts aligned with or diverged from attachment strategies, highlighting areas of complementarity and contradiction. This approach facilitated the development of a more comprehensive understanding of co-dependency, moving beyond identifying patterns to building explanatory insights.

Between-method triangulation integrated quantitative and qualitative results, with the matrix facilitating comparison across datasets. To support this integration, each participant's dominant cultural orientation was determined based on their highest score across the subscales. This approach allowed for the identification of participants' most strongly endorsed cultural orientation, enabling contextual interpretation of their qualitative narratives (Maxwell, 2022).

Table 23

Convergence Coding Matrix

Integration Type	Description
Convergence	Qualitative and quantitative findings confirm and reinforce each other.
Divergence	Qualitative and quantitative findings reveal conflicting insights, highlighting complexities or limitations.
Complementarity	Qualitative data explain the mechanisms underlying quantitative trends.

3.6 Quality, Validity, and Reflexivity

Various strategies were used to ensure methodological rigour, validity, and reflexivity.

3.6.1 Assessing Quality and Validity

The quality and validity of this study were evaluated using a combination of established frameworks tailored to its mixed-methods design. The MMAT (Hong et al., 2018) was employed for its ability to assess mixed methodologies, ensuring coherence, rigor, and transparency. Post-hoc reliability of the psychological scales was conducted to confirm accuracy and consistency within the study's context (Taherdoost, 2016).

Braun & Clarke's (2019) Tool for Evaluating Thematic Analysis, containing 20 questions to appraise the quality of the analysis, was used to ensure the systematic development and justification of codes and themes. Unlike other qualitative appraisal tools focusing on general criteria, this tool is designed to assess the unique aspects of TA. The reliability and validity of the DMM coding process were ensured through employing trained coder and adhering to established frameworks. The qualitative findings were reviewed with another research member and SGFC consultants, providing an additional layer of peer triangulation. Feedback from these consultations helped refine the analysis and validate the credibility of the results.

Triangulation was conducted using the Convergence Coding Matrix (O'Cathain et al., 2010), facilitating a systematic evaluation of alignment and divergence between quantitative and qualitative findings. In addition, theoretical triangulation was employed by integrating multiple frameworks. This allowed the study to examine co-dependency from complementary conceptual angles, reducing interpretive bias and enriching the depth of analysis (Yeasmin & Rahman, 2012). Together, these strategies ensured methodological rigor and enhanced the comprehensiveness of the study's understanding of co-dependency.

3.6.2 Self-Reflexivity

Bracketing and reflexivity are essential in research as they increase the rigour of the methods and the validity and reliability of the findings (Fischer, 2009; Darawsheh, 2014). In mixed methods research, reflexivity plays a particularly important role in facilitating the integration, transparency, and flexibility required to combine different methods and paradigms effectively (Popa and Guillermin,

2017). For instance, during triangulation, reflexivity was essential in examining how quantitative findings aligned with qualitative results, ensuring that constructs were applied sensitively and without overshadowing participants' voices.

I attempted to integrate self-reflexivity within the study's methodology with the aid of a reflexive diary (Appendix C). As mentioned in the introduction, my positionality inevitably impacted this study. My own experiences with co-dependency, along with my personal beliefs, shaped how I approached the topic and how I related to the participants.

While I have observed traits of co-dependency in myself and my family, I do not formally identify with the label. Early in the process, I noticed a tendency to position myself as an "outsider," which initially led me to avoid attending a SGFC meeting. This reluctance reflected a subconscious desire to maintain distance from the participants and the phenomenon under study. However, as I became more immersed in the research, I recognised the importance of understanding participants' experiences within their context, which required attending a meeting. This act of stepping outside my comfort zone deepened my understanding of the participants' experiences and allowed me to engage more authentically with the research.

During the analysis phase, reflexivity was vital in ensuring that my interpretations were grounded in participants' narratives rather than shaped by my assumptions or theoretical leanings. Maintaining a reflexive diary allowed me to document moments where my personal experiences with co-dependency might have influenced coding choices, particularly when identifying themes related to relational dynamics and attachment.

By incorporating self-reflexivity into this study, I was able to critically reflect on how my positionality and assumptions informed my methodological decisions and interpretations, thereby enhancing the transparency and credibility of the research process.

4. RESULTS

4.1 Overview of Results

This chapter presents the results of the quantitative and qualitative analyses. It begins sample demographics, followed by findings addressing the two quantitative RQs (see Table 11).

Firstly, a multiple regression examined whether attachment (RAAS) and cultural orientation (COS) predicted co-dependency (FCAI). Insecure attachment and HI emerged as significant predictors of co-dependency.

Secondly, a moderation analysis explored whether cultural orientation moderated the relationship between co-dependency and mental well-being (SWEMWBS). Co-dependency negatively predicted MW, and HC moderated this relationship. While HC was associated with better well-being at low and average levels of co-dependency, its protective role weakened at high co-dependency levels, where individuals reported lower well-being.

To address the qualitative RQs, this chapter then presents integrated attachment-informed TA and DMM analysis from 6 semi-structured interviews. The qualitative findings expand upon the quantitative results by exploring participants' attachment strategies and their accounts of co-dependency in the context of early relational experiences. DMM analysis revealed the use of insecure strategies among participants. Six overarching themes were developed: *Insecure and Unsafe Beginnings, Living Through Adversity, The Co-dependency Backstage, Navigating Connection and Self-protection, Co-dependency in Action, and Empowering vs Performative Self-growth.*

Finally, the qualitative and quantitative findings were triangulated to enhance theoretical integration and identify convergences and divergences.

4.2. Demographics of the Quantitative Sample

Three hundred twenty-eight participants completed the questionnaire. Table 24 shows the demographics.

Table 24

Demographic Characteristics of the Quantitative Sample

		N	Percentage %	M (SD)
CoDA engagement	No	191	58.23%	
	Yes	137	41.77%	
Gender	Female	194	59.15%	
	Male	129	39.33%	
	Non-binary / third gender	4	1.22%	
	Prefer not to say	1	0.30%	
Age				34.98 (6.45)
Ethnicity	White English	150	45.73%	
	White Others	147	44.82%	
	Asian/Asian British	16	4.88%	
	Black/Black British	6	1.83%	
	Others	5	1.52%	
	Multiple Ethnic Groups	4	1.22%	
	Prefer not to say	0	0.00%	
Education	Bachelor's Degree	266	81.10%	
	Masters degree	36	10.99%	
	Doctoral degree	9	2.74%	
	Mandatory education	7	2.13%	
	Vocational training	6	1.83%	
	Others	4	1.22%	

Notes: CoDA = Co-dependents Anonymous, M= Mean, SD= Standard Deviation.

4.3 Demographics of the Qualitative Sample

The qualitative sample (Table 25) included six UK-based SGFC participants, all of whom scored in the moderate to severe range on the FCAI. Cultural orientation is included here for context and will be explored further in the triangulation section. To protect participant confidentiality, all names presented in Table 25 are pseudonyms.

Table 25

Demographic Characteristics of the Qualitative Sample

Name	Gender	Age	Ethnicity	Cultural Orientation
Sarah	F	55	British Hungarian	HC
Evan	M	41	British Arab	HI
Lydia	F	47	White British	HI
Martha	F	39	White British	HI
Ruth	F	55	White British	HC
Jennifer	F	30	Black British	VI

4.4 Quantitative Results

4.4.1 Descriptive Statistics

Table 26 presents the descriptive statistics for the key variables in the study. Due to deviations from normality, both the median and the mean are presented for each variable.

Table 26

Descriptive Statistics for Key Variables

Variable	M	SD	Mdn	IQR	Interpretation / Scale Info
CO-DEPENDENCY	32.20	6.82	31.00	7.00	FCAI; Range: 0–50; 31–40 = Moderately Severe
AVOIDANCE	3.05	.51	3.00	.58	RAAS; Range: 1–5; Moderate
ANXIETY	3.11	.78	3.17	.83	RAAS; Range: 1–5; Moderate
HI	21.99	6.11	22.00	7.50	COS; Range: 4–36; Slightly Above Midpoint
VI	20.38	6.06	21.00	8.00	COS; Range: 4–36; Near Midpoint
HC	22.23	5.93	22.00	8.00	COS; Range: 4–36; Slightly Above Midpoint
VC	20.76	5.76	20.00	8.00	COS; Range: 4–36; Near Midpoint
MW	19.88	3.41	19.25	4.11	SWEMWBS; Range: 7–35; Cut-off = 19

Note. M = Mean; SD = Standard Deviation; Mdn = Median; IQR = Interquartile Range. HI = Horizontal Individualism, VI = Vertical Individualism, HC = Horizontal Collectivism, VC = Vertical Collectivism, MW = Mental Wellbeing; RAAS = Revised Adult Attachment Scale; COS = Cultural Orientation Scale; FCAI = Friel Co-dependency Assessment Inventory; SWEMWBS = Short Warwick–Edinburgh Mental Well-being Scale.

Co-dependency scores were elevated, and mental well-being was slightly above the clinical cut-off, suggesting mild psychological strain across the sample. Attachment anxiety and avoidance showed moderate mean levels, with anxiety slightly higher. Cultural orientation scores were relatively balanced, with a modest tendency toward horizontal individualism and collectivism.

4.4.2 Preliminary Statistical Analysis

Analysis was performed using SPSS 29.01. Data were checked for missing values and none were found. Outliers and influential points were checked using Cook's Distance and leverage values. As all values fell within acceptable ranges, no cases were excluded from the analysis.

Preliminary reliability analyses (Appendix O) were conducted, revealing low internal consistency for some subscales. The implications are discussed in the limitations section.

A Pearson correlation analysis was conducted to examine associations between key variables and to guide variable selection for regression. Co-dependency was positively associated with attachment insecurity and negatively associated with MW, while horizontal cultural orientations showed positive links with MW. The full analysis is provided in Appendix P.

4.4.3 RQ1 results

The analysis revealed a significant positive association between insecure attachment (anxiety, avoidance) and co-dependency. HI was also found to be a significant positive predictor of co-dependency.

4.4.3.1 Predictors of Co-dependency. A multiple regression (Table 27) was performed to determine how much of the variation in co-dependency scores was explained by insecure attachment and cultural orientation.

Table 27

Regression Results using Co-dependency as the criterion

Predictor	b	SE	β	t	sig	r	Fit
Intercept	14.20	3.00		4.74	<.001		
AVOIDANCE	3.54	.72	.27	4.95	<.001	.33**	
ANXIETY	1.48	.48	.17	3.07	.002	.27**	
HI	.20	.06	.18	3.25	.001	.24**	F = 12.18, df(6,321)
VI	-.10	.06	-.09	-1.67	.09	-.06	R^2 = .185**
HC	.04	.06	.04	.70	.48	.05	Adjusted R^2= .170
VC	-.04	.06	-.03	-.56	.57	.13	

Note. *b* = unstandardised regression coefficient; SE = standard error; *β* = standardised coefficient; *r* = zero-order correlation; R^2 = coefficient of determination; Adj. R^2 = adjusted R^2. **$p < .001$, $p < .05$.

All assumptions for multiple regression were met, as indicated by diagnostic plots (Gareth et al., 2013; Appendix Q). Attachment (anxiety and avoidance) and cultural orientation (HI, VI, HC, VC) were inserted as significant predictors of Co-dependency. Gender was considered as a potential control variable; while the correlation matrix revealed a small but statistically significant association between Gender and Co-dependency, the effect size was modest. Given that Gender was not a variable of theoretical interest and its inclusion would not meaningfully enhance model interpretability (Field, 2018), it was not included in the regression analysis.

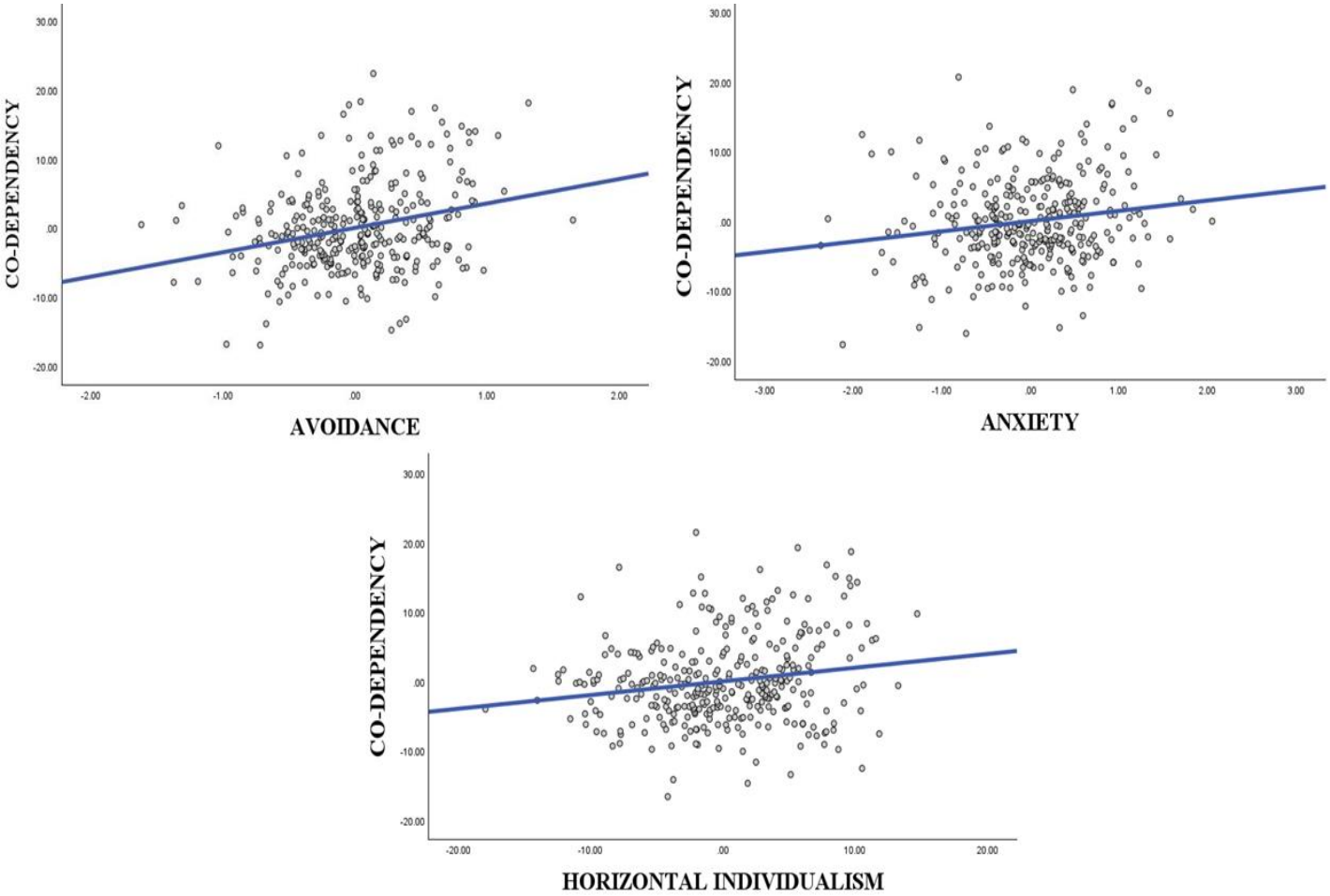
The overall model was significant, explaining approximately 17% of the variance in co-dependency traits: $F(6, 321) = 12.18$, $p < .001$, $R^2 = .185$. Attachment avoidance emerged as the strongest predictor, followed by attachment anxiety. Among cultural orientation variables, only horizontal individualism (HI) significantly predicted co-dependency, while the other dimensions (VI, HC, VC) were non-significant.

These results partially supported the hypothesis, which stated that attachment styles and cultural orientation would independently predict co-dependency. As hypothesised, insecure attachment significantly predicted higher co-dependency scores. However, contrary to expectations,

collectivistic orientations (HC and VC) were not significant predictors. Instead, HI was associated with higher co-dependency traits (Figure 5).

Figure 5

Regression Scatterplots Illustrating Predictors of Co-dependency



Note: Scatterplots showing the significant main effects of Avoidance, Anxiety, and Horizontal Individualism on Co-dependency. The red regression lines represent the linear relationship between each predictor and co-dependency ($p < .05$).

4.4.4 RQ2 Results

Statistical analysis showed a significant negative association between co-dependency and MW. Horizontal Collectivism was found to moderate the association between co-dependency and MW, providing a protective effect only at low and moderate co-dependency levels.

4.4.4.1. Co-dependency as a Predictor of Mental Well-being and the Moderating Role of Cultural Orientation. A two-step hierarchical multiple regression was conducted to test Hypothesis

2, which proposed that co-dependency would negatively predict MW, and that this relationship would be moderated by cultural orientation. Specifically, it was hypothesised that the negative association between co-dependency and MW would be less pronounced among individuals with collectivistic orientations.

All predictors were mean-centred to reduce multicollinearity and enable meaningful interpretation of interaction effects. In the first model, most assumptions were met, as indicated by diagnostic plots (Appendix R). However, heteroscedasticity was observed in the residuals scatterplot and confirmed by a significant Breusch-Pagan test ($p < .001$). Robust standard errors were therefore used. In the second model, all assumptions were met, so standard errors from ordinary least squares regression were considered valid.

In Model 1, co-dependency, cultural orientation (HI, VI, HC, VC), and attachment (anxiety and avoidance) were entered as predictors of MW. Education was considered as a control variable; however, the sample was predominantly composed of participants with an undergraduate degree (N = 266, 81.1%), limiting variability across educational levels. Including it could introduce bias and offer limited interpretive value, so it was excluded to preserve clarity. In Model 2, interaction terms between co-dependency, and each cultural orientation subscale were added to examine potential moderation associations. Attachment anxiety and avoidance were retained as predictors but were not included in interaction terms. Table 28 presents the results.

Table 28

Regression Results Using Mental Wellbeing as the Criterion

Predictor	b	Robust SE	β	t	sig	r	Fit
Intercept	19.86	.16		121.19	<.001		
CO-DEPENDENCY	-.15	.02	-.29	-5.16	<.001	-.24**	
AVOIDANCE	-.22	.33	-.03	-.65	.51	-.14	F = 8.916, df(7, 320)
ANXIETY	.39	.27	.09	1.45	.15	.10	R^2 = .285**
HI	.05	.03	.09	1.53	.13	.16	Adjusted R^2 = .270
VI	.08	.03	.13	2.14	.03	.20*	
HC	.18	.03	.31	5.20	<.001	.37**	
VC	.09	.03	.16	2.95	.00	.29*	

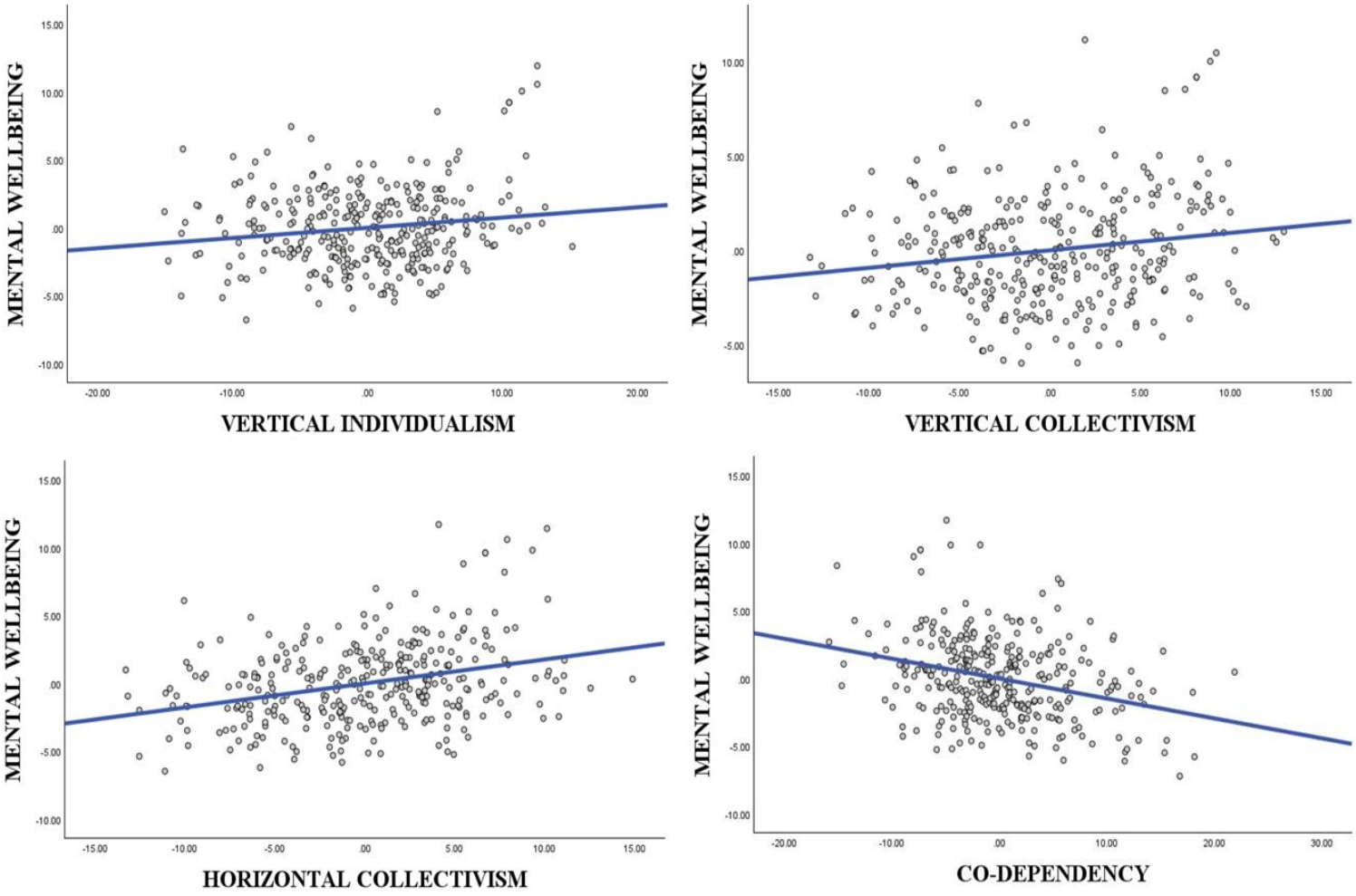
Note. Model = "Enter" in SPSS. b = unstandardised regression coefficient; SE = standard error of the coefficient; β = standardised coefficient; r = zero-order correlation; R^2 = coefficient of determination; Adj. R^2 = adjusted R^2. p < .05. p < .001.

The overall model was significant, explaining 27% of the variance in mental well-being, F(7, 320) = 8.92, $p < .001$, $R^2 = .285$. Co-dependency significantly predicted lower mental well-being. Among cultural orientation dimensions, HC, VC and VI were associated with higher well-being. Attachment anxiety and avoidance did not significantly contribute to the model. These associations are illustrated in Figure 6.

A post hoc power analysis conducted using G*Power 3.1.9.4 (Faul et al., 2009) indicated that the sample size of 328 was sufficient to detect large effects ($f^2 = 0.40$), with achieved power (1 - β) = 1.00.

Figure 6

Regression Scatterplots illustrating Predictors of Mental Wellbeing



Note: Scatterplots showing the significant main effects of Vertical Individualism, Vertical Collectivism, Horizontal Collectivism, and Co-dependency on Mental Well-being. The red regression lines represent significant linear relationships between each predictor and mental well-being ($p < .05$).

Table 29 presents Model 2 results. The conceptual diagram of this analysis can be seen in appendix S.

Table 29

Moderation Results using Mental Wellbeing as the Criterion and Cultural Orientation as the Moderator

Predictor	B	SE	β	t	sig	r	Fit
Intercept	19.96	.17		120.18	<.001		
CO-DEPENDENCY	-.12	.03	-.23	-4.02	<.001	-.25**	
AVOIDANCE	-.18	.35	-.03	-.50	.62	-.15	
ANXIETY	.43	.23	.10	1.89	.06	.11	
HI	.05	.03	.08	1.63	.10	.16	F = 12.96, df(11, 316)
VI	.09	.03	.15	3.10	.002	.20**	R^2 = .311**
HC	.17	.03	.30	5.68	<.001	.37**	Adjusted R^2 = .287
VC	.09	.03	.15	3.05	.002	.29**	
CO-DEPENDENCY*HI	-.01	.00	-.07	-1.23	.22	-.20	
CO-DEPENDENCY*HC	-.01	.00	-.14	-2.56	.01	-.21**	
CO-DEPENDENCY*VI	-.01	.00	-.02	-.37	.71	.04	
CO-DEPENDENCY*VC	.01	.00	.01	.21	.83	-.10	

Note. *b* = unstandardised regression coefficient; SE = standard error of the coefficient; *β* = standardised coefficient; *r* = zero order correlation; R^2 = coefficient of determination; Adj. R^2 = adjusted R^2.Model 1 included only main effects; Model 2 was the full model including main effects and interaction terms. *p < .05. **p < .001.

The overall model was significant, $F(11, 316) = 12.96$, $p < .001$, $R^2 = .311$, Co-dependency remained a significant negative predictor of mental well-being, while HC, VI and VC were significant positive predictors. In contrast, attachment variables (anxiety and avoidance) and HI were not significant.

Among the interaction terms, only the interaction between co-dependency and HC reached statistical significance, indicating that the effect of co-dependency on mental well-being varied depending on levels of HC. Table 30 presents the mean and standard deviation of mental well-being scores across different levels of co-dependency and HC.

Table 30

Descriptive Statistics for MW by HC Levels and Co-dependency Levels

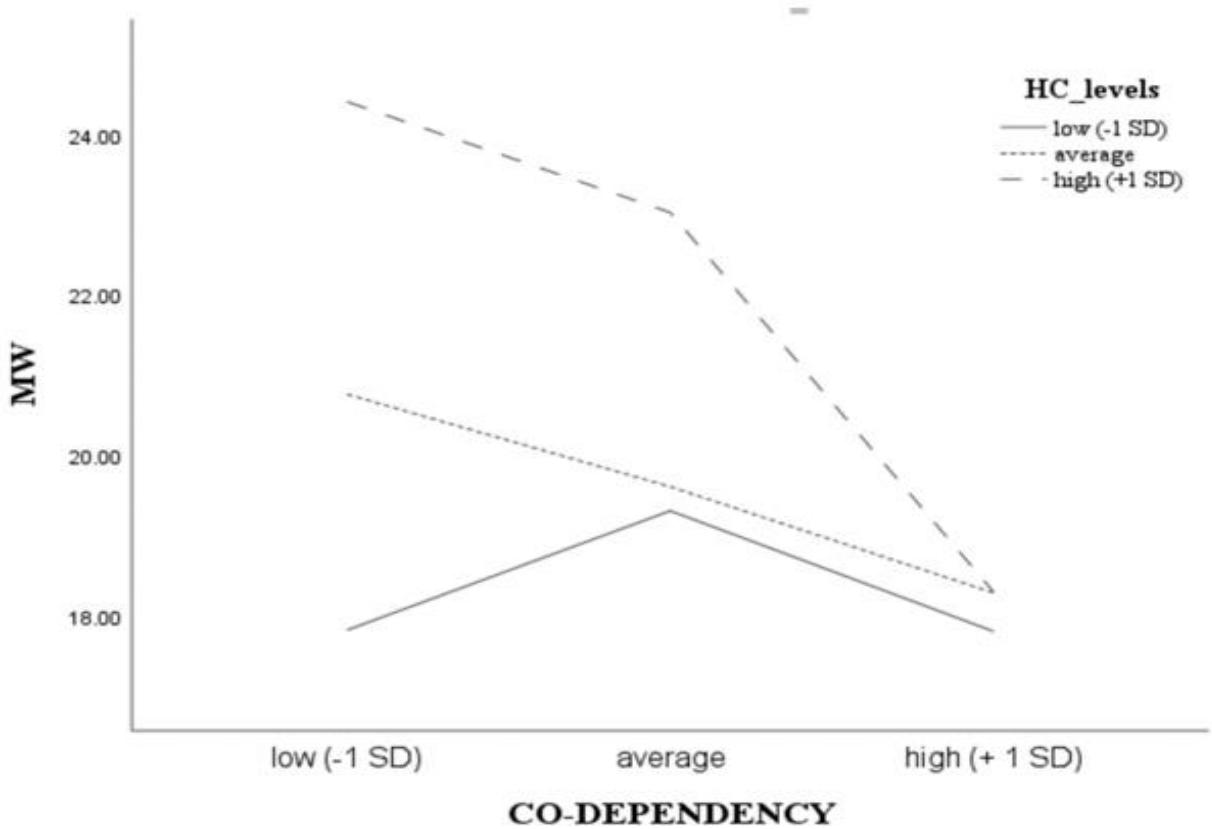
	Mental Wellbeing - M-SD		
HC Levels	**Low Co-dependency**	**Average Co-dependency**	**High Co-dependency**
Low	17.81 (2.11)	19.3 (2.48)	17.8 (2.86)
Average	20.76 (2.71)	19.6 (2.59)	18.28 (2.65)
High	24.41 (2.57)	23.03 (5.96)	18.29 (1.95)

Note. HC = Horizontal Collectivism; M = Mean; SD = Standard Deviation.

Individuals with high HC reported higher MW at all levels of co-dependency. However, the gap in wellbeing between HC groups narrowed as co-dependency increased, suggesting that HC may offer diminishing protection at higher co-dependency levels. This is also illustrated in Figure 7.

Figure 7

The Moderating Role of Horizontal Collectivism



Note: Interaction between co-dependency and horizontal collectivism on mental well-being. Individuals high in horizontal collectivism (HC) reported greater mental well-being at low and average levels of co-dependency, suggesting a protective effect. However, as co-dependency increased, this benefit diminished, with well-being scores converging across all HC levels. The steep decline among individuals high in HC indicates that while HC is linked to better well-being under lower co-dependency, its positive influence weakens at higher co-dependency levels.

The model explained approximately 28.7% of the variance in MW (Adjusted $R^2 = .287$). This reflects an increase in explained variance from model 1 ($R^2 = .285$; Adjusted $R^2 = .270$), with $\Delta R^2 = .026$, suggesting that the interaction terms contributed an additional 2.6% of explained variance. A post-hoc power analysis was conducted using G*Power 3.1.9.4 (Faul et al., 2009) using an effect size of $f^2 = 0.45$, an alpha level of .05, and a sample size of 328. This indicated that the achieved power ($1 - \beta$) for detecting a significant effect was 1.00, suggesting that the model had sufficient power to detect significant effects for the predictors and interaction terms.

Our hypothesis was partially confirmed. As predicted, co-dependency significantly predicted lower MW. However, only HC moderated this relationship: High HC appears to have a protective function only at low and average co-dependency levels. At high co-dependency level, this weakens, resulting in a steeper decline in MW.

4.5 Qualitative Results

While the quantitative findings highlighted associations between attachment insecurity and co-dependency, they could not fully explain how early experiences and protective strategies might contribute to co-dependency development. The qualitative phase therefore aimed to explore these relational processes in depth, answering RQs 3 and 4 (Table 11).

To address RQ3, interviews were coded using DMM-AAI coding system to identify adaptive relational strategies. To address RQ4, an attachment-informed TA was conducted. The DMM coding was not treated as separate; rather, it was integrated into the TA to support within-method triangulation. This enabled a deeper understanding of participants' narratives by examining not only what was said, but how it was said, and the relational function of language.

The next section presents an overview of the DMM coding, followed by the integrated TA themes, and concludes with a triangulation summary of findings across both analytic lenses..

4.5.1 RQ3 Results

Table 31 presents the DMM analysis identifying participants' attachment strategies. A more detailed explanation of the identified strategies is provided in Appendix T.

Table 31

DMM-AAI Results: Attachment Strategies and Associated Relational Dangers

Participant	Attachment strategy	Danger	Description of strategy
Sarah	A4-5/C6	-Emotionally unavailable caregiving -Unresolved loss (father) -CSA	Alternating between compulsive compliance/indiscriminate attachment (A4–5) and coercive rescue-seeking (C6).
Evan	A6 (history of A3–4, A5–6).	-Parental coercion and unpredictability -Enmeshment and role confusion -CSA	Compulsive self-reliance (A6) characterised by withdrawal from intimacy, shaped by earlier caregiving and compliance (A3–4) and indiscriminate attachment (A5).
Lydia	C4 touching on C6 (Pseudo-A)	- Emotionally unavailable and unpredictable caregiving -Family triangulation and role confusion	Exaggerated helplessness strategy (C4), with elements coercive rescue-seeking (C6) and pseudo-A presentation.
Martha	C4 (Pseudo-A)	- Emotionally unavailable and unpredictable caregiving -Role confusion	Exaggerated helplessness strategy (C4), with pseudo-A presentation.
Ruth	C5-6	-Lack of protection -Enmeshment and role confusion -CSA	Alternating between angry, blaming, and controlling behaviours (C5 – punitive), and rescue-seeking behaviours (C6). Stronger C6 elements.
Jennifer	C5-6	-Emotionally unavailable caregiving -Parental neglect	Alternating between angry, blaming, and controlling behaviours (C5 - punitive), and rescue-seeking behaviours (C6). Stronger C5 elements.

Notes: CSA = Childhood Sexual Abuse

All participants employed non-B strategies, reflecting adaptive attempts to survive and cope with relational danger, a pattern evident across their narratives. These were predominantly coercive (C) strategies, with two participants showing C4 patterns and two showing C5–6 patterns. One participant demonstrated a mixed strategy, alternating between compulsive (A5–6) and coercive (C6) patterns. One participant used a compulsive self-reliant strategy (A6). Notably, both participants

coded as C4 displayed pseudo-A presentations, presenting initially as self-reliant or compliant while underlying coercive dynamics were evident in the narrative.

All the participants disclosed dangers that appeared to shape their attachment trajectories. For example, Evan, coded with a history of A3–4 and current A6 strategy, described early caregiving roles in response to coercive parenting, followed by later emotional withdrawal and self-reliance. Lydia, coded with a C4 strategy and pseudo-A presentation, described family triangulation and emotionally unpredictable caregiving which appeared to contribute to a help-seeking stance, masked by self-reliance and over-functioning.

Although the DMM analysis is presented separately to address RQ3, it also informed the TA, particularly where attachment strategies shaped relational coping. DMM coding offered insight into how these strategies may have once served survival or relational safety. Table 32 presents an integrative formulation linking DMM codes and narrative context to illustrate how co-dependency may be expressed within each participant's attachment strategy.

Table 32

DMM-Informed Formulations of Co-dependency Across Participants

Participant	DMM Strategy	Relational Pattern	Co-dependency Features	Formulation
Sarah	A4-5/C6	Shifts between compliance and performance (A4–5) to maintain approval, and C6 rescue-seeking to elicit care through vulnerability or crisis. Engages in emotionally distant but sexually active relationships, using both compliance and protest to manage relational danger.	Emotional dependency, relational hypervigilance, idealisation of others, fear of abandonment, performative self-worth, unstable boundaries and identity, helpless stance, somatic distress, and difficulties with intimacy.	Co-dependency as a strategy to cope with unresolved loss, trauma, and neglect. Alternating use of compliance and vulnerability enable care-seeking while avoiding abandonment but also reinforces unstable relational dynamics. Sexuality and idealisation are used to gain closeness and control, while emotional intimacy remains threatening and is often avoided.
Evan	A6	Withdraws from emotional closeness and relies on compulsive self-sufficiency (A6), while engaging in emotionally detached sexual relationships. Uses caregiving, pseudo-objectivity, and flat affect to maintain distance. Minimises or detach from painful experiences.	Compulsive caregiving, emotional detachment, suppressed needs, self-neglect, self-worth through usefulness, avoidance of intimacy, sexual relationships used for control and validation, internalised shame.	Co-dependency characterised by compulsive caregiving and emotional withdrawal to maintain functional connection while avoiding vulnerability. Early enmeshment, coercion and CSA contributed to internalised shame and self-reliance. These dynamics are reinforced through co-dependent patterns that prioritise control and utility over intimacy.
Lydia	C4 touching on C6 (Pseudo-A)	Uses helplessness (C4) and heightened affect to elicit support. Drawn into family triangulation and caretaking roles (Pseudo-A), struggles to distinguish between abusive and nurturing dynamics. Relationships are marked by dependency, and volatility.	Emotional dependency, validation and rescue seeking, helpless stance, over-involvement/over-functioning, fear of abandonment, unstable boundaries, difficulty identifying relational risk, externalised blame, idealisation of care figures.	Co-dependency functions to maintain closeness while avoiding responsibility. Rooted in early emotional neglect and role confusion, these strategies blend protest and dependency, with caretaking narratives masking deeper unmet needs.

Martha	C4 (Pseudo-A)	Exaggerated displays of vulnerability to elicit care and diffuse anger. Avoids confrontation or expression of anger, using protests and intensity to maintain connection. Presents as compliant or helpless, while subtly resisting through withdrawal or non-cooperation. Claims of caretaking serve to uphold a coherent self-image, though rarely grounded in real caregiving behaviour.	Emotional dependency, fear of abandonment, chronic guilt, indirect control, unstable boundaries, low self-worth, difficulty asserting needs, tendency to suppress anger, and reliance on being needed to feel secure in relationships.	Co-dependency as a means of maintaining closeness and safety through learned helplessness and passive control. Early relational unpredictability and, emotional abuse and neglect, reinforced a pattern where vulnerability was rewarded, and autonomy felt risky. Her claimed caregiving role masks deep dependency needs and protects against shame and rejection.
Ruth	C5-6 (Stronger C6 elements)	Draws others in with emotional intensity and partial disclosures (C6), then pushes them away through sarcasm, blame, or overt hostility (C5). Maintains control and closeness through relational ambiguity.	Low self-worth, self-neglect, internalised shame, obsessive focus on other/caretaking. helpless identity, fluctuating openness and withdrawal, indirect control, need for validation without overt vulnerability, somatic distress, and difficulties with trust and intimacy.	Co-dependency as a defence against relational unpredictability and past trauma. Protest and rescue-seeking maintain proximity while shielding against rejection. Emotional control and caretaking serve to regulate a fragmented sense of self, shaped by enmeshed family dynamics and unresolved abuse.
Jennifer	C5-6 (Stronger C5 elements)	Shifts between angry protest and vulnerability to elicit care, creating relational dynamics marked by emotional intensity, unmet needs, and ambivalence.	Low self-worth, emotional dependency, validation seeking, helpless/rescue seeking stance, resentment as self-protection, indirect care-seeking (inviting sympathy), difficulties with trust.	Co-dependency is used to protest unmet emotional needs while preserving emotional safety. Anger and vulnerability serve as indirect routes to connection, protecting against rejection. Early neglect fostered mistrust and reinforced a cycle of protest-based intimacy and emotional distancing.

4.5.2 RQ4 Results

TA identified several patterns related to difficult early experiences and unmet emotional needs. These appeared to influence how participants navigated close relationships and made sense of their co-dependency. Across accounts, attachment-related protective strategies, unconscious defence mechanisms, and efforts toward self-growth were evident in participants' narratives. The DMM lens was integrated throughout the analysis, helping interpret not only the content but also the relational function of language. Themes and subthemes are presented in Table 33.

Table 33

Themes and Subthemes from Interviews

Themes	Subthemes
Theme 1: Insecure and Unsafe Beginnings '*'The erratic nature of my childhood was really hard because it made it much more difficult to work out what was going on. The ongoing nature of it was also very challenging. It was years and years, and it was relentless. Having lived in that context made my adult life, quite difficult.*" (Lydia)	Lack of emotional safety and stability Parental harm Unsafe environments Distress due to unmet emotional needs
Theme 2: Living Through Adversity '*'After the abuse, anything that felt really good was too dangerous… I had to bring this wall of consciousness down in order not to enjoy myself… It ruined it.*" (Sarah).	Moments that changed everything The body remembers Trying to survive
Theme 3: The Co-dependency Backstage '*'I could tell my mum was upset and my dad didn't really care. So, I kept trying to be nice to her to make her feel better. I felt quite safe, like I was doing my duties. And I felt proud of myself.*" (Evan)	Distorted blueprint for connection Becoming who they needed This is just what we do
Theme 4: Navigating Connection and Self-protection '*'I think my childhood actively walled me off from other people. I put a wall between me and everybody in the world and I find it very difficult to receive anything through that. I'm terrified of intimacy on every level"* (Ruth)	Grasping for comfort Escaping abandonment Escaping rejection and distress Pulled in opposite direction
Theme 5: Co-dependency in Action '*'I've gone through a couple of abusive relationships. I've been emotionally abusive myself too. I had very low expectations for how I'd let people treat me, and no boundaries"* (Martha)	Craving to be cared for Caretaking as identity When love hurts
Theme 6: Empowering vs Performative Self-Growth '*'I can't fully depend on someone. After going through counselling and stuff, I've come to tell myself, if I'm to be in a relationship, then I need a partner that will have a common understanding, who would be on the same page. If it's not that, then it's nothing. I don't want it.*" (Jennifer)	Healing through peer support Keeping a safe distance

4.5.2.1 **Theme 1: Insecure and Unsafe Beginnings.** This theme captures early experiences of emotional absence, instability, and harm, which shaped participants' self-concept and relational patterns. These caregiving dynamics can be understood as relational danger.

4.5.2.1.1. Lack of Emotional Safety and Stability. This subtheme explores participants' experiences of caregivers who were emotionally distant, alongside instability in their wider environment.

While all participants described early experiences of parental love, this was often expressed through material provision rather than emotional presence, resulting in feelings of emotional deprivation.

'' *My dad is a kind person, he provided everything for the house and to him, that was enough. But he wasn't present. To me, it felt like he was just doing his duty. Even kids in the orphanage get emotional support, I didn't. I felt worse than them*.'' (Jennifer).

Despite participants' efforts to connect, caregivers were often perceived as emotionally unavailable and lacked mirroring or attunement:

' *'Sometimes, I would attempt stuff. But he always used to say things like who rattled your cage or who threw you a biscuit? I remember showing some affection and he shoved me and went, soppy girl.*'' (Martha)

' *'I cried a lot and mum never seemed to notice''*.(Sarah)

Several participants also described environmental instability, including financial hardship and housing insecurity, often triggered by family breakdown.

' *'We had to sell our house when I was six. Later, my parents split up, and we were declared homeless. We got a council house, moved again when I was ten, and my mum met a new partner I didn't get along with. At fourteen, I went to live with my dad. He moved to the US, and I ended up moving in with a friend. My living situation felt erratic and unstable for a lot of that time. And that continued up into my adulthood''*.(Lydia)

In some cases, family structural changes, such as the birth of a sibling, or the introduction of a new partners, were linked to negative shifts in attachment security.

‘ *’Before my brother was born, I was the apple of his eye… as I grew up, our relationship became more and more combative and abusive*.”(Ruth)

Taken together, these accounts describe childhoods marked by emotional distance and unstable foundations.

***4.5.2.1.2 Parental Harm*.** This subtheme explores overt forms of harm that participants experienced within their caregiving relationships. While the previous subtheme focused on emotional unavailability, this section highlights instances where parents’ actions or prolonged inaction contributed to participants’ sense of unsafety.

Many participants described exposure to punitive or intimidating parenting, where fear, blame, or punishment were common responses to emotional expression.

‘’ *I remember wheezing from asthma, but I was scared to wake my parents. If I did, my dad would get angry, and I'd have to sit facing the door until I fell asleep”* (Evan)’’

‘ *’It was always my fault. Her response was: why did you do that? Why did that happen to you?*’’ (Lydia)

While emotional neglect was a shared experience, several participants also described emotional and physical abuse.

‘‘*It was guilt-tripping and manipulation. Scaring the **** out of me and belittling. Making fun of my physical appearance”*. (Martha).

‘ *’My mum was violent. One morning, she couldn’t find her tights. I’d put them on. When she realised, she went mad and started smacking me around the head and calling me every ****** under the sun. I was terrified, thinking, ‘She’s going to kill me”.”*(Sarah).

Although less visible, participants also described chronic neglect, experienced as deeply impactful and difficult to make sense of.

‘*’When I was ill…..we had books my dad was kind enough to get us. And first-aid kits. We’d just get by. I’d been in hospital a few times, and we’d just watch the nurses. That’s how we learned. Help yourself not to die yet.*’’ (Jennifer)

‘*Not having baths regularly, not being supported with my appearance, not knowing about periods and bodies and how they worked*.’’ (Lydia)

All participants also described practical parentification. Although some participants later internalised this responsibility, they recalled the experience as burdensome and developmentally inappropriate.

‘*Very young, I was working to pay off her debt. I felt a lot of responsibility; it was quite a burden. I've had to grow up quickly.*’’ (Martha)

‘’ *When my sister was born, I became responsible for looking after her. From six, that meant cooking dinner, and even talking about how we’d afford food or rent*.’’ (Lydia).

Together, these accounts describe caregiving relationships that were at times experienced as unsafe or overwhelming. Participants’ narratives suggest this not only undermined their sense of stability but also shaped how they navigated responsibility and care within their families.

4.5.2.1.3 Unsafe Environments. This subtheme illustrates participants’ accounts of growing up in unsafe environments, characterised by unpredictability and exposure to harm.

All participants recalled witnessing parental conflicts, many of which were endured for years. Participants described feeling responsible for siblings or their parents, though at times the conflict posed a direct threat to themselves.

‘*’I stood between them, so he couldn’t get to her. That just made him angrier*.’’ (Evan)

‘*’My dad was walking towards the door and a glass hit the wall next to my head and smashed. […] My mum had thrown it at my dad and nearly hit me in the face with*.’’ (Martha).

Parents’ mental health and substance use often contributed to these arguments. This had a direct impact on participants, as it led to unpredictable caregiving.

‘’ *My mum had mental health issues. She’d think something, assume she’d said it, and then react as if I should know. I’d say, ‘I don’t understand,’ and she’d explode, accuse me of ignoring her, say I was horrible. My childhood felt chaotic and hard to make sense of*.’’’ (Lydia)

Parental’s instability also facilitated exposure to harm, failure to protect, and inappropriate environments:

‘’ *My parents had relationships with a lot of other people. […]. There were lots of strangers and parties in the house and I didn’t feel safe.*’’ (Ruth)

‘*Mum and I stayed at her partner’s house when I was 11. Everyone was taking drugs, and they taught me how to roll joints. A guy had died in the bath from an overdose. […] There was constant drinking. […]. Nobody ever cooked anything*’’. (Sarah).

These excerpts clearly convey how participants grew up in erratic and often unsafe environments. The psychological impact of these experiences is explored further in the following sections on trauma.

4.5.2.1.4 Distress due to Unmet Emotional Needs. This subtheme explores participants’ emotional experiences in the context of childhood unmet needs.

Participants described a range of painful emotions when their need for connection and validation went unmet. Many interpreted caregiver unavailability as abandonment, while others shared feeling invisible and unwanted.

‘ *’When they split up, my dad took some of us to UK. I'm the youngest, my mum should’ve held on to me. But she let everyone go, like it was nothing. I wasn’t expecting that. I thought she’d at least pretend*.’’ (Jennifer)

‘’ *I remember asking if I was adopted, I couldn’t believe they were my real parents. I used to imagine there might be other parents who’d actually like me. I asked them once: ‘Who will take care of us when you split up?’ I couldn’t imagine either of them wanting us. My mum said, ‘obviously I’ll have you,’ but it wasn’t obvious*’’ (Lydia).

Despite or, perhaps, because of these feelings, participants craved warmth and closeness, However, physical affection was often absent. While some identified alternative attachment figures, others described profound isolation and exclusion within their family.

‘ *’I wanted to hug with my brother or parents, but we didn't really have hugging. […] I didn't have much physical contact*.’’ (Evan)

Over time, these unmet needs appeared to evolve into emotional responses that persisted into adulthood. Many described feeling helpless, while others described a sense of resentment that appeared to stem from feeling abandoned or neglected.

‘ *’I was eight and felt hopeless. I spoke to my mum and a teacher, but they said, ‘Everything’s OK.’ Noone listened. I decided to eat some poisonous plants. I didn’t die, and I woke up furious. I remember thinking, ‘What am I going to do now?*’ (Lydia)

‘ *’I feel resentment for them. They knew exactly what they were doing. How do you tell a six-year-old, ‘I’ve provided everything you need, grow up and fix your problems’? They were fully awar*e.’’ (Jennifer)

This subtheme highlights how unmet emotional needs during childhood contributed to emotional distress. Ongoing emotional absence, more than overt trauma, left many feeling helpless, resentful, or emotionally cut off

Overall, this theme reflects how a lack of emotional safety and stability, combined with parental harm and unsafe environments led to a range of unmet emotional needs.

4.5.2.2 Theme 2: Living Through Adversity. This theme explores early trauma. While the previous theme explored chronic relational dangers, this theme focuses on unresolved traumatic

events. In the DMM, these experiences are conceptualised as distinct from ongoing danger but often interact with it to intensify the development of self-protective strategies.

4.5.2.2.1 Moments that Changed Everything. This subtheme focuses on early trauma and its emotional impact.

Some participants reported the loss of a family members, whose death left a profound mark.

‘’ *My father suddenly died in a car accident when I was 7. [..] Everything was grey. The house became quiet. Everything almost died with him”*. (Sarah)

While bereavement often marked a sudden loss of emotional safety, other participants described experiences that blurred the boundaries of safety and harm over time. Sexual abuse or inappropriate were only understood through the lens of adult reflection.

‘ *’I used to stay around my sister's when I was 10. Me and her boyfriend used to stay up and watch TV. He sometimes asked if I would massage him and I would. [..] He would also massage me, touching places he shouldn't. I never grew up thinking I was abused. Only recently I've thought...that wasn't good.*’’ (Martha)

‘’ *He put music on, made me dance. He started kissing and touching me. […]. My mum walked out of the room. I managed to push him off me […] Went to my mum and asked her if she was okay, she said she was. I cried, wanting to go home. Neither of them seemed to understand why. To get into my bedroom, I had to go through theirs and they would often tell me to join them in bed. And he would ask me to touch him”*. (Sarah)

This subtheme shows ow disrupted attachment and trauma, where emotional neglect, lack of protection, and blurred boundaries created conditions in which abuse could occur and remain unacknowledged. For many, the absence of safety or support, both during and after these events, meant that distress remained unprocessed for years.

4.5.2.2.2 The Body Remembers. This subtheme captures a range of trauma symptoms described by participants, manifesting in emotional, cognitive and physical difficulties,

When telling their accounts, several participants struggled with memory gaps, while others described dissociation, mistrust, and hypervigilance. One participant discussed her experience with paranoia following sexual abuse:

‘*’My mum apparently was in hospital when I was 7 and my dad apparently looked after us for a week. I've got no recollection of that. And that would have been significant*.’’ (Lydia)

‘*’I've worried a lot with my children. I'm scared of male aggression and anger. It's not whether it's a real danger, it's hot wired in me*’’ (Ruth)

‘’ *After the rape, I went psychotic. I hadn't been eating and was seeing things. The TV was talking to me. The smoke alarms had a red light on which I thought was recording me”* (Sarah).

Internal distress was often somatised, leading to sleep difficulties and physical symptoms:

‘*When around my parents I would get ill and lose my voice. Couldn't talk for days afterwards*.’’ (Ruth)

‘*’I had nightmares, I remember waking up with asthma, sweating. There was a recurring nightmare of the wolf from Wiley coyote chasing me*.’’ (Evan)

Other times, trauma symptoms were less visible but appeared to shape how participants related to others, particularly in their ability to distinguish safety from danger. This impacted on participant’s life and increased vulnerability to future harm.

‘*’I went and lived with my dad. Even though he was still drinking, that felt safer than being with mum*.’’ (Lydia).

‘’ *The counsellor said: ‘There’s a connection between rape and incest. If you grow up around that, your life is dangerous from the start. So, you end up in dangerous situations*’’ (Sarah)

Together, this subtheme demonstrates the impact of trauma on participants’ wellbeing. Trauma was not experienced as a single event but as an ongoing state of threat and disconnection, underscoring the cumulative nature of early adversity.

4.5.2.2.3 Trying to Survive. This subtheme captures coping mechanisms participants described adopting to manage and make sense of trauma. While some of these were linked to acute events many also emerged in the context of ongoing relational disruptions described in Theme 1.

In the context of persistent fear and hypervigilance within the family, participants described the experience of walking on eggshells:

‘’ *I worried about when he's returning. Until then we can be ourselves, play. Once he’s home, we must be quiet and always being aware of that”*. (Evan)

‘’ *I couldn’t predict how my dad would respond, but I didn't want to find out. I never tested that button. My mum’s anger was a constant threat, always on eggshells”* (Lydia).

Many participants described strategies such as repetition compulsion and trauma suppression. Others described falling into learned helplessness, characterised by passivity and resignation:

‘ *’For years, I shut the abuse down and forgot about it. [..] I recreated it in my adulthood. Whenever I was down I’d find someone to abuse me, recreating the feeling that I wasn't loved*.” (Evan)

‘ *’I don't act or fight. I accept it. This is how it's supposed to be, how you're supposed to feel. I don't fight all that stuff anymore*” (Jennifer)

All participants described internalising blame for their experiences or feeling responsible for the harm and the behaviour of others.

‘ *’I was ashamed. I felt like I was in control, I was making it happen.”* (Evan)

This subtheme highlights how trauma shaped participants' coping strategies. These strategies reflect survival in unsafe environments where self-protection often meant self-disconnection.

4.5.2.3 Theme 3: The Co-dependency Backstage. This theme illustrates the mechanisms that appeared to contribute directly to the development of co-dependency. While most remain rooted in early relational experiences, this section examines the specific patterns that were internalised both through the family system and sociocultural influences. This theme was also supported by insights

drawn from the DMM-informed individual formulations (Table 32), which helped clarify how early relational dynamics functioned within participants' attachment strategies, contributing to co-dependency.

4.5.2.3.1 Distorted Blueprint for Connection. This subtheme explores the maladaptive family patterns participants described being exposed to, including dynamics within the parent–child dyad and among siblings. These interactions provided a blueprint for later relationships, shaping how participants understood roles, connection, and emotional safety.

All participants described enmeshment or emotional parentification, characterised by a lack of boundaries and a role reversal where they were made responsible for meeting the emotional needs of a caregiver.

‘’ *There are secrets in my family that my mother has made me keep. You don't tell no one else. That's between us”* (Ruth)

‘*’I remember her in the kitchen, not being happy, banging things while cooking. I felt guilty. [..] She often talked about dad with me, about her being unhappy*.’’ (Evan)

Enmeshment and parentification often overlapped, leaving participants with a burden that often separated them from other members of the family. Triangulation was also present, often placing participants in conflicted loyalties.

‘’ “*When picking us up, my dad started bringing along his partner. My mum went mad, told me what an ******* he was, saying that was his time with us. Her reaction pushed me to say I wouldn't go if she came. I didn't see him for a year*.” (Martha)

Some participants also described disrupted relationships with siblings, involving conflicts and rivalry. These were often instigated by parents' behaviour, such as favouritism and scapegoating.

"*I found that really hard, to see my mum being a mum, looking after my sister, while I wasn't receiving any of that.*” (Lydia)

‘ *’My relationship with my brother was difficult. My mum told him he could not hurt me but he could hate me*.’’ (Sarah)

These dynamics likely intensified unmet needs. Participants described repeating these patterns and reflected they had normalised these dysfunctions.

‘ *’I grew up without boundaries, so didn't think that I was important. That I taught people how to treat me, or that I could say no or yes appropriately”* (Ruth).

‘’ *My parents made fun of my physical appearance. We all used to do it, even I started doing it to my siblings”* (Martha)

‘ *’I was used to it, it started when I was five. I no longer feel bad about it. It's normal*.’’ (Jennifer)

These quotes illustrate how participants carried the burden of responsibility for their caregivers’ wellbeing, while simultaneously learning that their own needs were secondary. Though framed as inevitable, participants appeared to modify their behaviour or normalise the dysfunction, perhaps as a covert way to maintain proximity, while simultaneously externalising blame to their caregivers.

By internalising these patterns, participants developed a distorted blueprint for connection, including tolerating and normalising emotional neglect.

4.5.2.3.2 Becoming who They Needed. This subtheme captures family patterns that posed threats to participant’s identity and autonomy development. While enmeshment involves a loss of autonomy, it is discussed under the previous subtheme as participants described it as a systemic pattern rooted in broader family dysfunction.

Many participants defined at least one of their caregivers as controlling, describing power imbalances that threatened their autonomy and sense of self.

‘’ *My dad was God like. He had to control everything, what I can and can’t do. […] They both wanted to make me what they expected me to be*.’’ (Evan)

‘*’My mum is narcissistic. I couldn't choose not to play the violin. At nine, I had to practise for three hours a day. After practice, all my friends had already gone in for dinner. I wasn’t allowed friendships.*’’ (Sarah)

Whilst these patterns were often recognised as unfair, participants often described a lack of agency:

‘*I felt small, insignificant. When my dad was there, we had to turn to supporting and doing everything he said*.’’(Ruth)

‘*’I felt trapped, it was a long time until adulthood. When you're 8, you've got to wait 10 years before you can take control of your life*.’’ (Lydia)

In some cases, participants described a striking absence of parental accountability. When caregivers deflected blame, or denied past events, they left participants confused which likely made it hard for participants to recognise danger or know how to seek protection. This likely contributed to self-doubt and identity difficulties.

“*I told her I was angry. She went ‘Really? You’re going to be mad?’. She wasn’t remorseful. She said, ‘When you’re done, call me if you like.’ I thought, seriously*?.” (Jennifer)

“*She maintained she had no recollection of what had happened… she still denies it. I felt gaslighted*.” (Sarah)

These dynamics left little choice to participants but to conform – or at least appear to. While some narratives reflected compulsive compliance, others used more strategic or emotionally charged language, suggesting different functions.

‘’ *We learned to be good. I was constantly trying to please and keep the peac*e’’ (Martha)

‘*’Being good was my best defense, keep small, keep quiet. […] Today, if men are aggressive with me, I turn into people pleasing. Let me make myself acceptable for you.*’’(Ruth)

While Ruth spoke of "being good" her language also invited sympathy, subtly drawing others into her emotional world. Martha similarly described learning to "people please" but her formulation (Table 32) suggests passive protest, presenting as innocent to avoid blame. Though framed as appeasement, both accounts reflect covert strategies to maintain proximity and express distress without overt challenge.

Regardless, these strategies suggests participants often struggled to develop a sense of self that was distinct from or acceptable to their caregivers. In some cases, threats to identity and autonomy extended beyond the immediate family and were reinforced by cultural or familial scripts:

‘’*My mum took pride in us being different, alternative clothes and music. When I explored other styles, I felt judged. Eventually, I did go back to the way I was*." (Martha)

‘ *’My childhood was marked by compulsory heterosexuality. There were no queer role models around me, and it was actively spoken against*." (Ruth)

Gender roles were also discussed as influencing identity formation and relational roles:

‘ *’I had to be fine all the time, so I could support mum and be a strong man”* (Evan)

‘’ *On my dad's side of the family, boys are more important than girls*.’’ (Ruth)

Overall, this subtheme illustrates how these conditions posed threats to autonomy and identity development. Participants described shaping themselves around others' needs, becoming who they felt they had to be to maintain connection, or feel safe.

4.5.2.3.3 This is Just What we Do. This subtheme explores participants' reflections on the impact of parental modelling and cultural or intergenerational influences on their co-dependency.

Several participants described parents who displayed anxious or co-dependent traits, potentially modelling patterns of over-involvement or fusion in relationships:

‘’ *Mum was an enabler. I often told her ‘’You should split up” because, when dad came back, there was more arguments. She couldn't let him go and eventually, he left* ‘’ (Lydia)

‘*’My mum never showed anger openly. She would talk about dad with me, swearing and getting angry.*’’ (Evan)

These examples suggest that emotional dependence, indirect expression of needs, and lack of boundaries were part of the relational template participants internalised. Many caregivers were also described as emotionally immature which hindered participants' opportunities to build emotional literacy:

‘*’They didn’t give me opportunities to experience my emotions and understand myself. They didn't have that themselves, they still don't*’’. (Evan)

‘*’I don't think my parents were adults. I don't know whether they still are. […] My father never admits when he’s wrong”*. (Ruth)

Participants also identified receiving love only when meeting certain conditions. This taught them that their worth was dependent on performance or self-sacrifice:

‘*’I would only get love if I did well at school, or by what I'd read, what I knew”* (Ruth)

‘*’My mum would take stuff seriously sometimes, and it was almost like that was her nurture, if I wasn't well*.’’ (Lydia)

These narratives suggest early caregiving set up transactional models of love, reinforcing behaviours that prioritised others’ needs and neglected emotional authenticity. Some participants also connected this to societal influences:

‘*’I grew up in the 70s. Feminists were ugly lesbians. Comedians were sexist. […] With dad, I only get love if I look at my best. He’s only told me he loves me twice: when I graduated, and about my kids. His praise was always linked to how well I look after my partners”*. (Ruth)

Exposure to these narratives, where worth is linked to performance and gender roles, appeared to reinforce an identity tied to being needed, compliant or helpless.

When asked about the impact of their childhood on their co-dependency, participants spoke about trauma transmission, both in relation to how caregivers behave and behaviours they themselves had adopted:

‘*’I've been in abusive relationships and been abusive myself. I had low expectations on how people should treat me. I've witnessed my mum and my sisters in abusive relationships*’’ (Martha)

‘’ *My mum had the expectation that I should look after her. Codependence is a family disease, which has been passed on to my children*.’’ (Ruth)

These quotes reveal that not only did participants observe harmful patterns in their families, but many also described reproducing them, highlighting how roles and dysfunctions were learned, internalised, and passed on.

To conclude, this subtheme suggests that co-dependency was shaped not only by early attachment disruptions but also by behavioural modelling, implicit family expectations, and sociocultural narratives. Across these narratives, there was often a striking absence of agency. Participants tended to position themselves as inevitable products of their trauma histories, reinforcing a sense of helplessness and dependency on others for emotional regulation and meaning.

Overall, this theme illustrates how co-dependency appears to have developed through a combination of early dysfunctional dynamics, autonomy and identity threats, and family and cultural patterns.

4.5.2.4 Theme 4: Navigating Connection and Protection. This theme explores how participants navigated their need for connection while simultaneously trying to protect themselves from relational harm. These strategies were often fluid and shifted over time, influenced by past adversity and current fears.

4.5.2.4.1 Grasping for Comfort. This subtheme highlights participants’ effort to maintain their connections, often to soothe attachment fears and reduce distress.

In the context of emotional deprivation or unpredictability, participants described attempts to strengthen bonds with caregivers, often unsuccessfully.

‘*’I tried to build relationships with both. I worked to make things better, thinking that if I changed, we could connect. It never worked*.’’ (Lydia)

Over time, repeated disappointment led to a deep yearning for stability and a sense of normalcy.

‘’ *That’s the only time I felt I have a family. It felt different. It feels special having a family*.’’ (Jennifer).

‘’ *We went to my dad’s house, it was lovely. It felt like a glimpse into a normal life, where people sit down, share a meal, and someone else makes it*.’’ (Lydia).

Participants described clinging to people, memories, or objects that felt safe.

‘’*My granddad was my male role model. He never got angry. There was none of that threatening behaviour”* (Evan)

‘’ *I had a teddy bear, I still do. I remember crying holding it”* (Sarah).

Additionally, to compensate for the lack of secure caregiving, some participants described idealising other attachment figures.

‘’ *I met her when I was 10 but she lived far. She was an amazing woman, the opposite of anyone I knew. She looked like someone off the TV […] and had this incredible life.*’’ (Lydia)

‘’*I’ve always thought I was closer to dad, but reflecting, some memories are quite negative. I think I put him on a pedestal, especially after he died. My mum never spoke about her experience of living with an alcoholic, so I held onto that idealised image*.’’ (Sarah)

These idealised individuals, often distant or deceased, represented the care participants longed for. However, their limited presence heightened the contrast with emotionally unavailable caregivers, reinforcing a sense of loss.

Overall, these excerpts reflect participants' resilience in building connections in the face of adversity. Their deep yearning for love and recognition persisted into adulthood, contributing to patterns of overinvestment and unhealthy relationships, explored in later subthemes.

4.5.2.4.2 Escaping Abandonment. This subtheme explores patterns of emotional coping that emerged in the context of perceived abandonment, or relational inconsistency. In the DMM coding, these strategies often aligned with C patterns.

In response to inconsistent caregiving, many participants appeared to develop proximity-seeking behaviours and fears of abandonment. Relational hypervigilance and reassurance seeking were also commonly reported and will be discussed further in discussion of emotional dependency.

'I wanted to be with mum constantly. I worried that she was gonna die or abandon me. I used to check she was still breathing.'' (Martha)

' *'We have to say goodbye properly, you never know. Since my dad's death, I worry that if you don't say goodbye, they could die, and you'd never get the chance"* (Sarah).

Sarah's pattern can also be understood as the result of unresolved loss. These strategies, while initially shaped by acute fear, often became internalised and persisted into adolescence and adulthood. For instance:

'' *I used to sleep with my mum. Since when I was small until I was 13/14.*'' (Martha)

' *'I've been suffocating with my boyfriend. I need to be very physical and know that he's there*'' (Sarah)

Despite the deep need for connection, participants often reported conflicted emotions regarding their caregivers. This was often associated to push-pull dynamics, leading to confusion and ambivalence:

' *'The relationship with my father was enmeshed. And conditional. And weirdly, loving. But maybe loving isn't the right word. I've never thought of my relationship with my father as enmeshed, but it ******* is. I'd probably say destructive more than anything else.*'' (Ruth)

In the DMM, these patterns align with C5-6 strategies, where unresolved anger coexist with a need for connection.

Participants described re-experiencing emotional ambivalence in romantic relationships, which likely served to protect from emotional abandonment:

‘*’It's a battle trying to figure out what is reality. What is me? What's his reaction to my behaviour? Or is he a narcissist? He can be wonderful. And then unfeeling. But do I trigger that?*’’ (Sarah).

Overall, this subtheme illustrates how for many participants, fear of abandonment was managed through several strategies that served to maintain connections despite relational inconsistencies.

4.5.2.4.3 Escaping Rejection and Distress. This subtheme explores strategies that emerged in the context of experiencing parental blame, invalidation, and unsafety. In the DMM, these strategies aligned with A or Pseudo-A presentations, however they were sometimes described by participants in the context of traumatic experiences.

Many participants interpreted being blamed as parental rejection. Over time, repeated invalidation, taught them that expressing distress was unsafe, leading to emotional suppression and detachment.

‘*’I didn't want to talk to mum, I never felt I could be open. […] If I was upset I would hide it, suppress it, eat*.’’ (Evan)

Participants who felt shamed or judged by their caregivers described developing a secretive self-presentation to maintain the relationship while hiding aspects of themselves they feared would be rejected.

‘*’I wasn't sure if I was straight. If I wasn’t, I wouldn't be accepted. So, I was afraid of showing it or having any feelings about lot of things*.’’ (Evan)

‘*’I’ve learned not to show who I am. I am not a heterosexual person, but I had no way of expressing that part of me*.’’ (Ruth)

Similarly, participants who experienced their caregivers as controlling or over-involved often described a need to create distance. While some maintained surface-level contact, they recalled emotionally withdrawing to preserve autonomy.

"*I wanted to escape. I started not caring. My dad was suffocating, my mum over-involved so I joined the Navy to get out. I kept my distance, just occasional phone calls, and became independent*." (Evan).

In conclusion, this subtheme illustrates how participants adapted to early experiences of rejection, blame, and invalidation by retreating from emotional expression and closeness. For many, this meant hiding parts of themselves or suppressing emotional needs to avoid further rejection.

4.5.2.4.4 Pulled in Opposite Directions. This subtheme captures how participants drew on a range of relational strategies to manage conflicting needs for closeness, protection and autonomy.

Avoidance of emotional closeness, typically linked with self-reliance, was sometimes rooted in fear of abandonment and self-doubt:

‘’*I was avoidant, and didn't try to have healthy relationships. I wanted to but I didn't think I was good enough. I don't want to have a bad relationship, so I rather have none*.’’ (Evan)

‘’ *I avoid people. Anyone could be good to me one day, then suddenly control me or abandon me. So I don't want long-lasting relationships. I can't fully depend on anyone, the moment you trust, they disappear. I have poor judgment, so I don't want them getting close*’’ (Jennifer)

These quotes highlight a tension between seeking connection and withdrawing to protect oneself from harm. Evan's narrative suggests a pattern where self-reliance is prioritised even when the need for connection is present. While Jennifer's words may initially suggest avoidance, her emotionally charged language reflects a protest against unpredictability rather than true detachment, suggesting that closeness feels dangerous, yet remains central. While this dynamic wasn't always explicitly named by participants, it frequently surfaced in how they described navigating relationships:

‘*’I saw someone later who wanted to help, and I thought you don't have to be involved with my life. You don't have a business in whatever is happening to me”* (Jennifer).

Participants also described using protest behaviours, often observed in anxious coping, to elicit attention or have emotional needs met:

‘*’I did some self-harming behaviour when I was 9. That was a way of getting mum attention.”* (Lydia)

‘*’I acted out, forcing him to take me to the cinema. He got angry; told me I was selfish, and maybe he hit me. But I still got what I wanted*.” (Ruth)

In Lydia’s account, helplessness appears to be used to prompt caregiving responses. In contrast, in Ruth’s account anger and protest are used to secure attention and meet needs.

When protest went unacknowledged, it often turned inward. Some participants described despair and internalised protests that emerged in adulthood:

‘*’I’d never hurt myself because I’d be the only one who lost. Ending my life, would almost be doing them a favour, giving them the space they want. I’m not gonna give them that satisfaction*” (Jennifer)

Jennifer’s narrative reflects elements of fantasised revenge. Her decision to withhold self-harming behaviour appears not to stem from self-preservation, but from a desire to deny her parents the perceived satisfaction of her suffering.

Emotional intensity sometimes escalated into externalising behaviours or dysregulation, including self-harm, substance use, and impulsive coping:

‘*’I remember being very cross that my mum was working with disturbed adolescents, still she never noticed I was struggling. I started cutting my wrists.*” (Sarah)

‘*’As a teenager I would drink, use drugs or sex not to have those feelings*.’’ (Ruth).

These narratives reflect profound emotional conflict, where needs for closeness, recognition, and self-protection were often in tension. Although some responses overlapped with trauma coping, they also reflect attachment-related protest and dysregulation.

4.5.2.5 Theme 5: Co-dependency in Action. This subtheme captures relational strategies that participants described as part of their co-dependency. Co-dependent coping appears to show different manifestations across participants, likely to be influenced by attachment strategies.

***4.5.2.5.1 Craving to be Cared for*.** This subtheme explores accounts describing an intense need to be cared for, often described by participants displaying preoccupied or mixed strategies.

Many participants spoke about a deep need for reassurance and validation. This appeared to compensate for abandonment and self-esteem wounds.

‘*’I looked for validation and reassurance that I'm lovable. I've been relying on other people to rescue me and make me feel OK”*. (Martha)

‘’ *If someone is kind of present, I'll go there. [..] if I decide to depend on you, I do it to the extreme. If they abandon me, I will always find a way back to them”* (Jennifer)

While Martha's account reflects rescue-seeking, in Jennifer's narrative the need to be cared for becomes more intense, with obsessive or retaliatory elements in response to abandonment.

Participants recalled experiencing intense distress associated with difficult relationships and abandonment:

‘*’I had a physical reaction to him leaving me. I had this terrible diarrhoea and sickness, for days”* (Sarah)

‘*’I have had suicidal thoughts, when he abandoned me…It was too much, I couldn't bear it.*” (Martha)

Sarah's intense physical reaction to abandonment reflects somatisation of affect, alongside traits of overwhelming distress when attachment is threatened.

Participants described strategies they used to avoid this distress and maintain a sense of control in relationships, including relational hypervigilance:

‘*’I chose partners I thought would be unlikely to leave me, who were less cultured or intelligent”.[..] I am constantly fearful my partner's seeing other people. I tend to see it when it's not there”* (Sarah)

These quotes suggest that fear of abandonment and need for external validation might develop into emotional dependency. Overall, this subtheme reflects the entanglement between attachment-based fear and behavioural patterns seen in codependent coping.

4.5.2.5.2 Caring as Identity. This subtheme presents participants' reflections on caretaking behaviours. Rather than an external behaviour or a trait, caring is discussed as central to participants' sense of self and meaning making.

As discussed, participants were exposed to significant threats to their autonomy, leading to difficulties with self-differentiation.

'' *I didn't know what my needs and wants were. Autonomy meant having responsibilities for others*. '' (Ruth)

As a result, personal needs were likely minimised or suppressed, and participants described difficulties with self-care:

'' *I didn't really care about my own sexual gratification. It's always about others"* (Evan)

' *'I struggle prioritising self-care tasks; I must consciously work on to ensure I do it"* (Ruth)

These struggles might be understood in the context of prioritising other needs to secure love. Participants reflected feeling they had to earn love through caring, likely a result of conditional love described in earlier chapters:

' *'I've been trying to find someone to give me the love I lacked. I wanted to love them the most, do nice things. I'd find someone broken, and if I fixed her, then she'd love me. I had a hero complex*.'' (Evan)

While Evan's quote is consistent with compulsive caregiving, caretaking claims appeared to have various functions:

' *'I know exactly what you need and think, what's good for you. Because I'm caretaking. So that I can avoid my own feelings. I think that's what fuel my obsession with others. If I take responsibility for you, I will have power and shore up my self-esteem*,'' (Ruth)

‘ *’I was a bit of a rescuer. I remember mum being upset a lot, but not me because I was always trying to comfort her”* (Martha)

For Ruth, the caregiving identity appeared to function as a means of regulating distress through control and preoccupation with others. Martha framed herself as a caregiver, but her account subtly drew attention to her own unmet needs and her mother’s failures, positioning herself as both helpless and morally superior, indirectly eliciting care. While these accounts may appear compliant, the language suggests vulnerability was not avoided per se, but expressed through the performance of being a caregiver. This reflects distinct co-dependent patterns: some individuals may feel compelled to fix or rescue others to affirm their self-worth (as seen in A strategies), while others use caregiving discourse to make their own pain visible without overt dependency (C strategies). This interpretation was supported by individualised formulations (Table 32).

Overall, this subtheme illustrates how caring becomes internalised as identity, shaped by early attachment disruptions and reinforced by conditional relational dynamics. Participants’ caregiving was not simply about helping others, but about preserving a fragile sense of self-worth and avoiding the uncertainty of being cared for.

***4.5.2.5.3 When Love Hurts*.** This subtheme explores participant’s vulnerability to imbalanced relationships, which was frequently described as central to participants’ struggles and recovery journeys.

As discussed, participants had been exposed and normalised to various forms of harm and power imbalances. Through internalising blame and shame, participants often reflected having internalised self-worthlessness:

‘’ *I thought there’s something wrong with me. I wasn't good enough. I had very low self-esteem*.’’ (Evan)

‘’ *I think I am not important, not worthy of anyone's time or not good enough, I am nothing*.’’ (Martha)

Understandably, such beliefs often limited participants' relationships expectations, leading them to seek emotional security through dysfunctional relationships. This was also often reincorced by difficulties with recognising danger and the need for external validation previously discussed.

'' *I had no reason to be involved with the wrong crowd, but I needed comfort, something that looked like family. Since I wasn't getting it at home, I looked for it elsewhere*.'' (Jennifer)

' *'My childhood had a negative impact on the partners that I've chosen, the behaviour I've tolerated and how long I've stayed with them*.'' (Lydia)

Repetition compulsion, discussed under ''Trauma coping'' is relevant here. Both sexual abuse and attachment trauma often distorted the meaning of security, which became entangled with harm:

' *'I liked to be shamed, abused. For my partners to spit on me, hit me like I'm disgusting. It's still part of my sexuality.*'' (Evan)

''*After the incest, I started going out with older men. A guy I was seeing had porn magazines about mother and daughter, and my mum had had a relationship with him before*.'' (Sarah)

Both Evan and Sarah described relational patterns consistent with A5 strategies, where sexuality becomes a means of engaging with others while defensively avoiding vulnerability. For both, these strategies were reinforced by CSA.

Several described staying in relationships marked by volatility, control, or manipulation, reflecting patterns consistent with trauma bonding:

''*I stayed with someone abusive for years, even if I knew it wasn't good. I couldn't leave. I thought it's what I deserve, sometimes it's all I want*.'' (Jennifer)

'' *Living together was dreadful. I tried ending it, but he kept coming back, we're still together now. Back then, he'd give me the silent treatment for days*.'' (Sarah)

Overall, this subtheme illustrates how attachment trauma, internalised worthlessness, and unmet needs contributed to participants' vulnerability to harmful relationships. Participants described these dynamics appeared reinforced through repetition compulsion and trauma bonding.

To conclude, this subtheme reflects the dual nature of co-dependent coping, at times seeking closeness through emotional dependency, while simultaneously maintaining emotional distance through self-sufficiency or over-functioning. These shifting strategies suggest the fluid and adaptive ways participants attempted to navigate connection and safety.

4.5.2.6 Theme 6: Empowering vs Performative Growth. This theme highlights the efforts for self-growth participants showed through their recovery. Participants described post-traumatic growth and positive outcomes from attending peer support. However, emotional wounds were still obvious in participants' narratives and these sometimes manifested in their use of language which revealed unconscious defense mechanisms.

4.5.2.6.1 Healing through Peer Support. This subtheme explores how participants experienced healing through peer support, described as pivotal for their recovery.

Peer groups offered a sense of belonging through shared experiences, emotional safety, and, for many, spiritual connection:

"*It gave me a space where I finally felt safe to talk, without the fear of being judged or abandoned. When I share, others feel safe too. It's therapeutic, like making amends to the part of me that couldn't speak back then.*" (Evan)

' *'There is a fellowship of people around me who also are co-dependents. Codependency in therapy, it's I'm going to sort it out myself. Codependency in a fellowship is I'm going to get a power greater than myself.*" (Ruth)

Being in such a safe and reflective space allowed participants to understand and name their difficulties:

‘*’When I read co-dependency characteristics, I realised that every single part of that is me. I thought somebody's read about my life and put it together*.’’ (Lydia)

‘*’The bottom line of co-dependency is either chronic illness, suicide, or addiction. which have all been part of my story*.‘’ (Ruth)

While naming their struggles fostered clarity, some participants expressed a rigid identification with co-dependency, which may reflect residual emotional distancing:

‘*’I just know that being ill is a thing in my family. I don't have a memory. It's just a common thread in co-dependency that you were given attention when you were ill. […] I will always be a co-dependent*’’ (Ruth)

For some, overidentification may serve to reinforce their relational strategies, particularly those involving helplessness as a means of eliciting care. Despite these tensions, participants described positive outcomes from attending peer support, including improved self-awareness, self-compassion, and emotional regulation:

‘*’I'm improving, but it's literally learning from the ground up. It's learning new behaviours and new ways of being. […] Now I'm aware of my feelings and my responses”* (Lydia)

‘’*Positive learning is that you don't have to be perfect for people to accept you. Nobody is supposed to be perfect*.’’ (Jennifer)

Participants also described reframing negative experiences, increasing their autonomy, and setting boundaries:

‘’ *My resilience comes from my childhood. I wasn’t taught certain skills, but I’ve consciously learned them, which is beautiful*.’’ (Ruth)

‘’ *I don't do as much caretaking now. I've realised I don’t need to take my dad’s behaviour personally.*’’ (Martha)

These narratives reflect intentional post-traumatic growth and emotional maturation. However, in some cases, autonomy carried traces of avoidance or resignation:

‘*’I've learned to depend on myself. Because you can amount to something that even people with supportive parents cannot amount to. I'm doing fine for myself, even without love*.’’ (Jennifer)

While these stories reveal lingering wounds and relational contradictions, they also reflect participants’ strength, adaptability, and growing capacity to protect and prioritise themselves in ways that were previously unavailable to them.

***4.5.2.6.2 Keeping a Safe Distance*.** This subtheme captures protective language used by participants which might reflect unconscious defense mechanisms. In line with co-dependent and attachment-related coping, these responses are understood as adaptive strategies shaped by exposure to adversity.

Participants often acknowledged the impact of early experiences on their co-dependency. However, some used humour to deflect from painful emotions or maintain emotional distance:

‘*’I feel ready for a loving relationship. If a healthy partner exists (participants chuckles*)’’ (Evan)

‘*’What helped me? Drinking, drugs. (Participants laugh)”* (Ruth)

Some participants recognised their own patterns of denial, while others appeared to minimise past harm:

‘’ *I don't admit to myself when I've done wrong or when someone's done wrong to me*.’’ (Ruth)

‘*’I guess she wasn’t that bad, other parents do dreadful things. Children end up with blood and bruises and I don’t think that happened. She was just whacking me”* (Sarah)

These expressions may reflect a need to preserve connection to caregivers, or to protect the self from overwhelming feelings of abandonment or shame.

Some showed resistance to emotional reflection during the interview process itself, often through subtle undermining or intellectualisation. In some cases, this took the form of sarcasm or an overreliance on therapeutic language:

‘’ *That’s a big one to start with, well done. It’s a very broad question, lovely. What are you looking for? I’d say maybe start with something easier before diving straight in… but that’s just my opinion”* (Ruth)

‘ *’I think my parents were in fight or flight throughout my childhood, we can understand it through evolution and that”*. (Lydia)

This subtheme illustrates how participants employed protective language and defence mechanisms to manage vulnerability. Though these strategies may hinder deeper emotional connection, they offered a sense of safety when engaging with past experiences.

Taken together, this theme highlights the tension between healing and self-protection. Recovery and reflection offered space for growth, yet persistent distress remained, often managed through defensive strategies, revealing that progress and ongoing emotional regulation coexist

4.5.3 Qualitative Triangulation

While this study included distinct DMM and TA components, the analysis was not conducted in isolation. As the attachment-informed TA drew directly on the DMM coding insights, integration began during the analytic process, with DMM informing the interpretation of themes. TA, in turn, enabled the synthesis of individual DMM-informed formulations into a cross-case understanding, supporting a more comprehensive response to the research questions. While the integrated TA has been presented earlier, a summary of results is presented in Table 34.

Table 34

Within-Method Triangulation (TA + DMM)

Research Findings	DMM-AAI	TA	Integration Type
Co-dependency was traced back to early adversity	Unresolved trauma and relational danger were coded across narratives.	Theme of Insecure and Unsafe beginnings and Living through adversity	***Convergent***
Co-dependency development appeared rooted in dysfunctional family dynamics, threats to autonomy and identity and intergenerational patterns.	Elements of family triangulation, emotional burden, and diffuse sources of danger were coded across narratives. Clear A3-style role reversal was only observed in Evan's narrative.	Theme of The Co-dependency Backstage: enmeshment, parentification, controlling parenting, power imbalances, and cultural/familial scripts	***Complementary*** - DMM identified implicit relational dangers, and the defensive strategies used to manage them (e.g., blame, role confusion, distancing). TA revealed how participants made meaning of these experiences through identity, control, and relational scripts, highlighting the psychological impact and long-term internalisation of those dangers.
Various types of insecure attachment strategies were observed in co-dependency narratives	Various A and C patterns, as well as combined types were identified. Developmental trajectory of strategies was identified, as well as False presentations.	Themes of Escaping abandonment and Escaping rejection and despair.	***Complementary*** - DMM identified emotional and relational strategies shaped by danger, offering an external view on how participants adapted to threat. TA provided insight into how these dynamics were subjectively experienced, emotionally narrated, and made sense of by participants.
Participants are still on their recovery journey	SGFC supported some reorganisation but also reinforced protective strategies in others; use of intellectualised therapeutic language observed.	Theme of Self-Empowering vs performative growth theme captured positive change alongside persistent defences	***Complementary*** - DMM highlighted structural variation in reorganisation; TA revealed subjective growth alongside emotional distancing

Most findings were either convergent or complementary. In several cases, DMM coding offered a complementary lens to participants' explicit narratives, revealing the relational function of language and clarifying complex strategies (e.g. caregiving discourse in pseudo-A) that were less visible through TA alone.

Conversely, the TA illuminated cultural and power-related dynamics, including familial scripts and gendered expectations, that extended beyond the scope of DMM coding. Together, these lenses offered a more comprehensive understanding of co-dependency, highlighting both structural attachment patterns and participants' lived narratives.

4.6 Between-Method Triangulation

Table 35 presents the integrated findings from the quantitative and qualitative phase. All findings were complementary, with qualitative data elaborating on the patterns observed in the quantitative phase.

Table 35

Between-Method Triangulation

Research Findings	Quant Data	Qual Data (DMM + TA)	Integration Type
Co-dependency is associated with insecure attachment strategies	Both attachment avoidance and anxiety positively predict Co-dependency, with avoidance showing a greater contribution to the model.	All participants used insecure attachment strategies identified through DMM coding (C+ and A+ patterns) and themes (Navigating connection and self-protection, Co-dependency in action) with coercive (C) strategies being most common.	***Complementary*** -Quantitative data highlighted associations; qualitative findings added depth by illustrating specific patterns, trajectories, and the role of early adversity in shaping attachment strategies linked to co-dependency.
Co-dependency is linked to mental health difficulties	Co-dependency predicts lower mental wellbeing	All participants described psychological distress. Flat affect was observed in A+ patterns, and heightened emotional expression (e.g., anger) in C+ patterns. TA subthemes included 'Unmet emotional needs', 'Trauma symptoms', 'Escaping abandonment-rejection', 'When love hurts', 'Keeping a safe distance'.	***Complementary*** - Quantitative data highlighted general associations, while qualitative analysis enriched understanding by revealing the nature, context, and emotional texture of participants' distress and its links to co-dependent coping.
Cultural orientation is associated to co-dependency	HI positively predicts co-dependency	HI was the most common orientation among participants, followed by HC and VI.	***Complimentary*** – quantitative data partially aligned with qualitative results, where HI was the most common orientation. However, diverse cultural orientations were present. Co-dependency may be shaped by different cultural pathways (e.g. self-reliance in HI, emotional fusion in HC).
Cultural orientation (HC) moderates the relationship between MW and co-dependency	HC moderated the relationship between co-dependency and MW, with a protective effect only at low/moderate co-dependency levels.	Participants with HC orientation reported emotional dependency and enmeshed dynamics, suggesting that at higher co-dependency levels, HC traits may not buffer distress.	***Complementary*** – Quantitative results showed HC buffered distress only at low/moderate co-dependency levels. Narratives from HC participants reflected emotional dependency and enmeshment, supporting the idea that HC values may not protect against distress at higher co-dependency levels.

Although both attachment anxiety and avoidance predicted co-dependency quantitatively, C patterns were more prevalent in the qualitative sample. C+ patterns appeared commonly linked to emotional dependency, especially in narratives marked by fear of abandonment and coercive care-seeking. Both C and A strategies were associated with the development of caregiving as an identity, although in C presentation the caregiving identity appeared performative. Mixed and C5–6 patterns revealed inner conflict and ambivalence, especially between control and connection.

While cultural orientation was not explicitly explored in interviews, participants' dominant orientations (from questionnaires) were used to inform interpretation. HI was most common, aligning with quantitative results, though diverse orientations were observed. HC, found to buffer distress only at lower co-dependency levels, did not appear protective in narratives of participants with high co-dependency, supporting the quantitative findings.

5. DISCUSSION

5.1 Overview

This chapter begins by discussing the findings in relation to existing literature. A critical appraisal of the study follows, including its strengths and limitations. Finally, implications and directions for future research are presented.

5.2 Summary of Findings

Quantitatively, this study explored the relationship between attachment, cultural orientation, co-dependency, and MW. Insecure attachment and HI significantly predicted co-dependency. Co-dependency, in turn, significantly predicted lower MW. HC moderated this relationship, buffering distress at low to moderate levels of co-dependency but offering little protection at higher levels.

Qualitatively, this study explored the attachment narratives and personal accounts of co-dependent individuals. DMM analysis revealed that all participants used a range of insecure strategies (including C, A and mixed patterns). Individualised formulations (Table 32) were developed by integrating DMM classifications with participants' accounts of their developmental histories and co-dependency patterns. These provided a clinically meaningful interpretative layer, illustrating how attachment strategies functioned within specific relational contexts and offering insight into the varied ways co-dependency was expressed across individuals.

TA then identified six themes: Insecure and Unsafe Beginnings, Living through adversity, The Co-dependency Backstage, Navigating Connection and Self-Protection, Co-dependency in Action, Empowering vs Performative Self-Growth.

As summarised in Table 35, triangulated findings were largely complementary; however subtle divergences were noted. Quantitative associations among insecure attachment, co-dependency, well-being, and cultural orientation were enriched by qualitative themes highlighting early adversity, self-protective patterns, and culturally shaped expectations around care. DMM classifications mapped

onto participants' co-dependency, reinforcing a developmental and relational understanding of co-dependency as an adaptive response to relational threat.

5.3. Integration with Existing Literature

This study found that insecure attachment predicted co-dependency, with avoidance contributing more variance in the model. This supports previous studies linking insecure attachment to co-dependency (e.g. Chang, 2018), but it contrasts with research reporting only anxious attachment as a significant predictor (e.g. Ançel & Kabakçı, 2009). Qualitative findings, however, revealed predominantly C strategies, including protest-based and controlling, suggesting that anxious-type dynamics may be more visible among help-seeking individuals. This apparent contradiction reflects what the introduction and ISLR also observed: both avoidant and anxious attachment contribute to co-dependency, though their prominence may vary by method or sample characteristics.

HI significantly predicted co-dependency scores. While this finding diverges from research linking co-dependency to collectivism (e.g., Chang, 2010), it may reflect the way co-dependency manifest within individualist frameworks. Individuals who value self-reliance and equality (as in HI) may, under certain conditions, (e.g. relational trauma, dysfunctional dynamics) prioritise others' needs over their own or struggle with boundaries. These patterns, while seemingly incongruent with individualistic values, may reflect how early adversity interacts with cultural orientation to shape co-dependency.

This was echoed in the qualitative findings, where HI was the most prevalent cultural orientation in the sample. In Theme 4, participants described conflicting needs for closeness and self-protection. This may reflect a pattern of over-functioning, where individuals strive to maintain self-reliance while simultaneously seeking connection, preserving autonomy externally while suppressing their own needs.

However, other orientations were also present, suggesting that co-dependency may arise through multiple cultural pathways. The western framing of co-dependency as a disorder may shape the expression and recognition of these traits in individualist contexts (Irvine, 1997). HI individuals

may report co-dependency as distressing due to conflict with autonomy values, whereas collectivist individuals may normalise similar dynamics through cultural norms, potentially influencing how they respond to standardised measures.

Co-dependency negatively predicted MW, consistent with prior research (e.g. Eshan & Suneel, 2020) and supported by the qualitative findings (Table 34), which highlighted unresolved trauma and emotional distress, including identity disturbances. These findings align, in part, with the pathology-oriented perspective that frames co-dependency as a disorder linked to psychological distress. However, the qualitative data suggest that these difficulties may instead emerge as adaptive responses to early relational trauma, supporting trauma- and attachment-informed interpretations.

Previous research has consistently found a direct association between insecure attachment and poorer MW (e.g., Mikulincer & Shaver, 2012). While this assumption informed this study's design, our findings revealed a different pathway: attachment insecurity predicted co-dependency, which in turn predicted MW, whereas attachment alone did not directly predict well-being. This suggests that co-dependency may mediate the relationship between attachment and well-being. Although mediation was not formally tested, this offers a promising direction for future research into the mechanisms through which attachment history influences psychological outcomes.

Finally, while collectivist orientations are often associated with enhanced well-being due to their emphasis on mutual support (Bhullar et al., 2012), our findings suggest HC’s protective effect weakens as co-dependency intensifies. However, HC still appeared to offer some relative protection, as high-HC individuals maintained slightly better well-being than their low-HC counterparts, even at high co-dependency levels. These results suggest that while HC may buffer distress in less intense cases, its emphasis on self-sacrifice may become less adaptive when co-dependency is severe. This was supported by theme 5 findings, where high-HC participants described prioritising others' needs at their own expense. These internalised obligations, though culturally reinforced, appeared to create psychological strain when combined with high co-dependency, offering insight into the diminishing well-being seen in the quantitative data.

The qualitative findings enriched the quantitative results by illuminating the developmental trajectory that may lead to insecure attachment and, subsequently, co-dependency. Theme 1 findings align with studies emphasising the role of insufficient early mirroring and attunement (Sobol-Goldberg et al., 2023), childhood abuse/neglect (Evgin & Sümen, 2022), and unmet needs (Bacon & Conway, 2023) as key precursors to co-dependency. These early disruptions help explain the quantitative finding that higher co-dependency scores were associated with insecure attachment styles. Taken together, these findings suggest that the absence of a secure base (Bowlby, 1969) plays a central role in the developmental pathway toward co-dependency.

Theme 2 findings support existing research indicating that co-dependency is associated with relational trauma (e.g., Evgin & Sümen, 2022). Participants described a range of adversities, diverging from earlier conceptualisations that linked co-dependency primarily to growing up with an alcoholic parent or framed it as an individual pathology (e.g., Cermak, 1984). While the quantitative data do not capture trauma exposure directly, these findings complement the quantitative result that co-dependency is associated with poorer MW, reinforcing the view that co-dependency is linked to broader psychological distress.

Participants described how trauma heightened vulnerability to further adversity, with cumulative effects compounding over time. The symptom profile reported by participants (internalization, difficulties distinguishing safety from danger, nightmares and somatic symptoms) mirrors features of Complex Post-Traumatic Stress Disorder (CPTSD), where unresolved relational trauma disrupts self-concept, affect regulation, and interpersonal functioning (Cloitre et al., 2013), and aligns with findings by Rozhnova et al. (2021) identifying somatisation as common in co-dependency.

Overall, Themes 1 and 2 support contemporary views of co-dependency as an adaptive response to early trauma and attachment disruption (Lancer, 2015; Weiss, 2019). These findings refine the Prodependence model (Weiss, 2019), showing that co-dependent behaviours often reflect both caregiving intentions and unresolved trauma. While Weiss (2019) critiqued trauma models for pathologising care and positioned Prodependence as an attachment-focused alternative, our findings

suggest that in co-dependency attachment disruption and trauma responses are deeply intertwined. This highlights the need for integrative frameworks that honour the relational function of care while acknowledging its developmental traumatic origins.

Theme 3 findings align with research highlighting the role of impaired autonomy and identity confusion (Bacon et al., 2020), coercive parenting style (Crothers & Warren, 1996) and enmeshment (Bacon & Conway, 2023) in the development of co-dependency. They also add to the literature by emphasising parental modelling and intergenerational transmission, where emotionally dependent or anxious caregivers modelled relational patterns rooted in compliance and blurred boundaries. These dynamics appeared to contribute to enduring identity disturbances in participants, consistent with findings from the ISLR.

These dynamics were frequently normalised and reinforced by cultural and gendered expectations (e.g. the strong, self-reliant man; the nurturing, self-sacrificing woman) consistent with the social constructionist perspective discussed in the ISLR (Sobol-Goldberg et al., 2023). These early learning shaped identity and appeared to contribute to maladaptive schemas, such as subjugation and self-sacrifice (Young et al., 2003). Although based on limited data, some patterns appeared to complement quantitative findings related to cultural orientation. For example, individuals with higher HI scores often described internalised messages about being self-reliant while simultaneously feeling responsible for others, a tension that contributed to over-functioning and emotional suppression. In contrast, participants with HC described family scripts grounded in relational obligation or fusion, which appeared to foster preoccupation with others and an internalised belief that closeness required enmeshment. This tentatively suggests that cultural values may interact with early relational modelling in shaping co-dependent roles. This theme lays the foundation for Theme 5, where these roles manifest in adult co-dependent behaviours.

Theme 4 illustrates the complex and often conflicting strategies participants employed to balance emotional closeness and self-protection. These findings align with studies linking co-dependency to attachment insecurity (Chang, 2010) and emotional dysregulation (Rozhnova et al.,

2020). They also reflect DMM-informed interpretations of attachment as adaptive responses to perceived relational danger (Crittenden, 2006).

Participants' narratives reflected a range of strategies related to fear of abandonment and rejection. While some patterns reflected clear C strategies, others appeared mixed or involved pseudo-A presentations, illustrating the complex adaptations individuals developed to preserve connection and manage distress. This complements our quantitative findings, showing that both anxiety and avoidant attachment are associated with co-dependency. Theme 4, therefore, bridges the early vulnerabilities explored in Themes 1–3 and the behavioural expressions of co-dependency detailed in Theme 5, highlighting the internal conflicts that arise when attachment needs coexist with fear.

Theme 5 aligns with research conceptualising co-dependency as characterised by low self-esteem (e.g. Chang, 2018), self-sacrifice schemas (e.g. Knapek et al., 2021) and emotional dependency (e.g. Aristizábal, 2020). This aligns with modern conceptualisation of co-dependency as a form of relationship addiction (e.g. Liverano et al., 2023), where repetition compulsion bridges the gap between early trauma and adult relational difficulties.

Difficulties distinguishing safety from danger and a deep need for validation played a key role in maintaining harmful relationships, consistent with Aristizábal's (2020) findings. Two distinct but overlapping relational strategies emerged in participants' narratives: emotional dependency, involving protest behaviours and reassurance-seeking (more common in C strategies), and caretaking, marked by over-functioning and emotional suppression (more common in A or pseudo-A strategies). Though functionally different, both were underpinned by a need for external validation and served to preserve conditional attachment, one by demanding care, the other by providing it.

These strategies also reflected two roles: the "rescuer" expressed either through actual caregiving behaviour or the adoption of a caregiving identity, and the "helpless" associated with rescue-seeking. Importantly, these were not fixed; participants often described shifting between them depending on the relational context or developmental stage. While only one participant described consistent caretaking behaviours, others claimed the identity of caregiver without corresponding

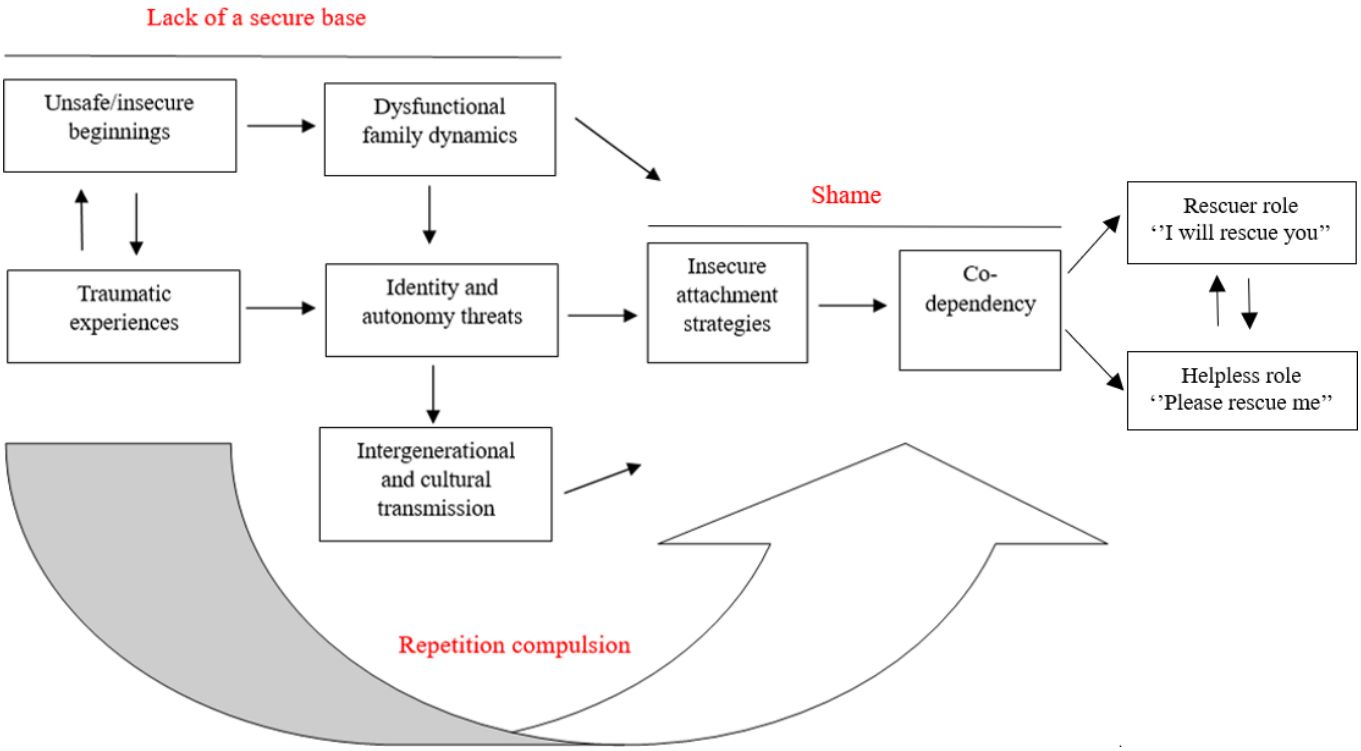
behavioural examples. This identity, however, still functioned relationally, positioning them as self-sacrificing or burdened in ways that could invite care, sympathy, or validation. This partially contrasts with literature that frames co-dependency more narrowly as a "saviour" identity (e.g., Kaplan, 2023) and aligns with Liverano's (2023) conceptualisation of love addiction through the Drama Triangle, where individuals oscillate between Victim and Rescuer roles to manage attachment needs and low self-worth.

This fluidity was reflected in the individualised formulations (Table 32), which offered insight into how specific strategies functioned differently across individuals. For example, some participants identified strongly with the role of caregiver; however, DMM analysis revealed discrepancies between this caregiving identity and their narrative content. In several cases, this identity did not necessarily reflect consistent caregiving behaviours but instead functioned as a discursive strategy, used to elicit sympathy or deflect blame. This suggests that for some, being a caregiver was less about action and more about how they saw themselves or wanted to be seen. These profiles enriched the understanding of how individuals navigate shifting roles in response to relational threat, validating the interpretative complexity of Theme 5.

Our analysis adds to this literature by illustrating a trajectory from unsafe childhoods, through exposure to dysfunctional family dynamics, to increased vulnerability to adversity. These experiences contributed to the development of insecure attachment strategies and co-dependent behaviours. Figure 8 presents a conceptual model, highlighting how the themes interrelate to form a developmental pathway from early adversity to enduring relational difficulties.

Figure 8

Conceptual Model of Co-dependency Development: From Early Adversity to Relational Repetition.



Theme 6 explores what happens beyond this trajectory, during participants' recovery journey. Many described positive outcomes of attending SGFC, aligning with research documenting its benefits (Bacon et al., 2015). SGFC appeared to provide participants with the secure base they lacked, offering opportunities for self-disclosure and attunement. However, despite group engagement, participants continued to rely on subconscious defences, consistent with literature identifying such strategies as a feature of co-dependency (Tunca et al. 2024). Some appeared to overidentify with co-dependency or use therapeutic language in ways that suggested emotional distancing. While therapeutic language helped participants make sense of their histories, overreliance on it sometimes seemed to inhibit genuine emotional processing. These findings echo critical perspectives arguing that rigid self-labelling may inadvertently reinforce relational difficulties (Gemin, 1997).

Shame, linked to past experiences or continued struggles, appeared to underlie many of these defences, consistent with its recognised role in co-dependency (Wells et al., 1999). Subtle undermining or sarcasm may have served to rebalance power or assert control. Humour was also

frequently used to deflect distress, with participants often laughing at incongruent moments, potentially a form of gallows humour employed to manage emotional discomfort (Galloway, 2010). Together, these patterns suggest that for some individuals, co-dependency may persist despite long-term support, which may reflect the elevated co-dependency scores among interviewees. This aligns with Kaya et al.'s (2021) findings, which suggest that resilience may buffer the effects of emotional abuse but not emotional neglect, highlighting the enduring impact of unmet needs in early caregiving relationships. These findings contrast with Happ et al. (2024), who reported low resilience among co-dependents. While participants in this study showed functional resilience through help-seeking and reflection, deeper relational wounds may remain unresolved despite long-term support.

5.4. Critical Evaluation

The quality of the study was evaluated using the MMAT (Hong et al., 2018), as described in Section 2.2.4, with the rationale for its selection provided in Section 3.2.6.5.6. The completed MMAT appraisal is presented in Appendix U**.** The study met the majority of criteria in the relevant domains, supporting its methodological soundness. While MMAT criteria recommend accounting for confounders, gender and education were explored as potential confounding variables and were either unrelated or showed only modest associations with the outcomes. As such, they were excluded from the final analysis. Future studies could benefit from a more comprehensive strategy for identifying and controlling for confounders.

Additionally, the TA was evaluated using Braun & Clarke's (2019) Tool for Evaluating TA (Appendix V) as introduced in paragraph 3.2.6.5.6. The TA was deemed to be of good quality. While some themes naturally overlapped (e.g. Theme 1 and 2), they were considered conceptually distinct enough to warrant separation, reflecting different layers of participants' experiences. The analysis demonstrated coherence, depth, and alignment with the study's abductive and critical realist approach.

5.5. Strengths and Limitations

A key strength of this study is its novel application of the DMM, marking the first known attempt to use this framework to understand co-dependent behaviours. This was supported by an

abductive, pragmatist approach that integrated participant meaning-making with theoretically informed interpretation, offering both empirical and conceptual depth. While applying a theoretical lens risks overshadowing participants' voices, this was mitigated through ongoing reflexivity (Galdas, 2017). By integrating DMM-informed analysis with quantitative analysis the study offers a rich exploration of co-dependency as both a relational and developmental construct, challenging pathologising narratives and generating clinically relevant insights.

Another strength lies in the identification of a developmental trajectory, visually represented in figure 8. This may provide a valuable framework for understanding how early relational adversity may lead to co-dependent behaviours through disrupted attachment and internalised schemas. However, as this was developed from a small qualitative sample, it should be interpreted as exploratory rather than generalisable. Future research is needed to validate and expand this framework in larger and more diverse populations.

Additionally, several limitations must be acknowledged. The study aimed to explore cultural orientation; however, most participants identified as White. While cultural orientation is not limited to ethnicity, the lack of ethnic diversity may have constrained the range of cultural values represented. This potentially limited the depth of insight into how cultural orientation intersects with co-dependency across different backgrounds. Future research should aim to recruit more diverse participants.

While the quantitative sample showed a good gender balance, the qualitative sample was predominantly female. Non-binary individuals were either absent (qualitative) or minimally represented (quantitative), which may reduce the relevance of findings for gender-diverse populations. Nevertheless, the qualitative sample did include participants with diverse sexual orientations, contributing some variation. Future studies should aim for greater gender diversity to better explore how co-dependency is experienced across a broader range of identities.

As qualitative participants were drawn from SGFC and selected based on high co-dependency scores, their narratives may reflect more enduring experiences of co-dependency. This limits the transferability of qualitative findings to the general population with lower co-dependency.

SGFC membership was not included as a covariate in the quantitative analysis, as group status was not our focus and there is currently no empirical evidence that SGFC participation results in meaningful change in attachment or cultural orientation. Including group membership would have added complexity to an already multivariable model and may have reduced statistical power without clear theoretical justification. Including both population aligned with our goal to explore shared predictors and enhanced the ecological validity of the study. Future research could explore whether group engagement meaningfully shapes how co-dependency is experienced or expressed, or control for it in multivariable models.

An important consideration relates to the measures used in the quantitative phase. Although all scales were previously validated, post-hoc reliability analyses revealed poor internal consistency in some subscales (COS and RAAS), possibly due to the sample's demographic homogeneity. Limited variability can reduce response range and compromise a scale's sensitivity to underlying constructs. Moreover, measures may fail to reflect the full spectrum of experiences when samples lack diversity (DeVellis, 2017). These factors likely influenced the scales' psychometric performance and the interpretation of findings. Future research should prioritise more diverse sampling to improve measurement robustness.

In addition, relying on self-report questionnaires increases the risk of bias (Rosenman et al., 2011). While the mixed-method design aimed to mitigate this by incorporating in-depth interviews, there remains a theoretical tension between the RAAS and the DMM-AAI, as they are grounded in different conceptualisations of attachment strategies. Therefore, triangulated findings should be interpreted with caution.

Quantitative findings indicated that avoidant attachment accounted for more variance in co-dependency than anxious attachment, while DMM coding revealed predominantly preoccupied

strategies. This may reflect selection bias, with individuals using preoccupied strategies more likely to engage in support groups or qualitative interviews. It may also reflect methodological differences: self-report tools capture conscious perceptions, while the DMM identifies underlying, often unconscious, attachment strategies. Although DMM-aligned measures such as the Adult Attachment Questionnaire (Crittenden & Landini, 2011) were considered, they are not yet widely established. Future research should support the development of such tools.

While not a limitation per se, it is notable that HC significantly moderated the relationship between co-dependency and MW, yet this aspect was not deeply explored qualitatively. This was partly due to the study's primary focus on attachment processes within the DMM framework, and partly due to challenges in recruiting a culturally diverse UK-based SGFC sample. As such, the integration of cultural values into the qualitative phase was limited, though participants' cultural orientation scores were considered during triangulation with the interview data.

Similarly, the impact of trauma on co-dependency and well-being is well established in the literature. As such, trauma was not included as a variable in the quantitative phase to avoid an overly lengthy questionnaire and reduce participant burden. Instead, the qualitative phase was designed to explore participants' early relational experiences, which often revealed trauma-related themes. While this provided a in-depth perspective, it may still have been beneficial to include a measure of trauma in the regression model to assess its influence alongside attachment and co-dependency. Future studies should consider incorporating trauma-related variables to capture a more comprehensive picture of these interrelated factors.

Finally, while the DMM provides a rich framework for understanding individual attachment strategies, it focuses primarily on intra-personal processes. It would have been valuable to explore co-dependency within couples or relational dyads to better understand how attachment strategies interact in close relationships and how co-dependent patterns are maintained or challenged within relational dynamics. Future research could incorporate dyadic methods or partner perspectives to extend the analysis beyond the individual and gain deeper insight into the relational nature of co-dependency.

Regardless of these limitations, this study represents the first known mixed-methods investigation exploring the interplay between co-dependency, attachment, cultural orientation, and mental well-being. The integration of quantitative and qualitative data provided a nuanced understanding of the mechanisms underpinning co-dependent behaviours, including how early relational experiences, cultural values, and attachment strategies contribute to their development and maintenance.

As the study employed a cross-sectional design, causal inferences cannot be drawn. While this design allowed for the exploration of associations, future longitudinal research would be better suited to capture the developmental trajectory of co-dependency and its outcomes over time.

5.6. Implications and Recommendations

Our findings have implications for clinical practice, policy development, and research. Clinically, these findings underscore the importance of recognising co-dependency in its diverse presentations. The data revealed a range of attachment-based strategies underlying co-dependency, not limited to preoccupied patterns. As such, assessments should explore not only the presence of co-dependent patterns, but also their functional impact, even in individuals who appear self-reliant or emotionally distant.

While this study underscores the need to recognise co-dependency, it is important to acknowledge that no standardised or clinically validated screening tools currently exist. Existing measures are primarily research-focused and vary in their conceptual foundations. The development of brief, psychometrically sound screening tools, grounded in attachment and trauma theory, represents an important next step for facilitating early identification and appropriate intervention in clinical settings.

The study also revealed the use of defences through protective language such as minimisation and intellectualisation. Clinicians should be alert to these presentations as they may mask the impact of early trauma and relational insecurity. Clinicians should be aware that co-dependency and CPTSD might co-occur, and symptoms may be masked by protective strategies. Screening for one should

prompt consideration of the other, particularly in the context of trauma histories and attachment disruptions. Professionals should also be mindful of somatic presentations as, as discussed in Themes 3 findings, some individuals may express emotional distress through physical symptoms. Future studies should explore the prevalence of co-dependency within CPTSD populations.

Quantitative findings also highlighted the role of cultural orientation. Clinicians should consider this during assessment, particularly in relation to individuals' attitudes toward interdependence. Professionals need to be aware of the increased likelihood of co-dependent traits in individuals with high HI, as well as the limited protective effect of HC. Clinicians could support the integration of values typically associated with HC, such as mutual support and emotional openness, particularly in less severe presentations. These may help buffer distress, although such strategies may be less effective when co-dependency is severe.

The study highlighted an association between co-dependency and lower well-being, even among those accessing peer support. While SGFC engagement showed benefits, particularly in fostering resilience, clinicians should offer multiple treatment options and view peer support as one possible pathway. Interventions should attend to the distinct identity patterns that sustain co-dependency, including both over-functioning "rescuer" and more passive care-eliciting "helpless" identities. Transactional analysis, particularly the use of the Drama Triangle (Karpman, 1968), may offer a helpful framework for recognising and interrupting these relational roles. Support should help individuals explore alternative ways of relating that do not rely on conditional worth.

As resilience alone may be insufficient to mitigate the effects of childhood neglect (Kaya et al., 2021), there is a need for interventions that directly address the developmental impact of emotional neglect, shame, and unmet needs. Attachment-based interventions tailored to co-dependent individuals are needed to provide corrective emotional experiences, helping individuals develop more secure patterns. Cognitive Analytic Therapy (Ryle & Kerr, 2020) may support individuals in recognising unhealthy reciprocal roles and developing exits. Early access to family therapy may be beneficial in families marked by dysfunctions, parental mental health difficulties, or substance misuse.

Safeguarding teams should also be encouraged to screen for co-dependent dynamics and refer individuals to appropriate support. Schema therapy (Young et al., 2003) may help targeting maladaptive schemas, while psychodynamic or trauma-focused approaches, such as Narrative Exposure Therapy (Schauer et al., 2020) can support processing of repetition compulsion.

Co-dependency should be recognised within national mental health strategies and trauma-informed care pathways. Educational campaigns are needed to raise awareness and reduce stigma, and healthy relationship courses should be made available to individuals with co-dependent traits to support the development of healthier coping strategies and reduce vulnerability to harmful relationships. Funding should be allocated to train frontline professionals in recognising co-dependency.

Targeted interventions should be available across both statutory and third-sector services. Schools also have a preventative role to play: curricula should include emotional literacy, boundary-setting, and education on healthy relational dynamics to prevent normalisation of dysfunctional patterns. Finally, co-dependency should be considered within domestic abuse policy, as supported by the theme 3 and 5 findings, which highlighted emotional dependency, fear of abandonment, and relational trauma, factors that appeared to heighten vulnerability to trauma bonding within the sample.

The findings highlight several areas for further research. Longitudinal studies are needed to explore how co-dependency develops and evolves over time, including key life events, relational patterns, and shifts in attachment strategies. Recruiting couples or family units could help explore relational dynamics contributing to and sustaining co-dependency.

Qualitative studies that directly integrate cultural orientation could provide deeper insight into why HI may predict poorer mental well-being, how HC buffers the impact of co-dependency at lower levels, and what barriers prevent this protective effect at higher levels of co-dependency. Additionally, research is needed to evaluate the effectiveness of different therapeutic approaches for individuals with co-dependency, particularly across varying attachment strategies and cultural backgrounds.

Further studies should investigate barriers to recognising and seeking help for co-dependency, especially among individuals who may not identify with the label due to stigma, cultural norms, or the lack of formal diagnosis. Research into digital interventions could offer accessible support options. Finally, future work should consider the role of protective factors, such as later-life secure attachments or positive role models, which may buffer the impact of early trauma and reduce vulnerability to co-dependency.

5.7 Reflections

This research has deeply impacted me in several ways. Although I approached it with a personal understanding of co-dependency and a desire to destigmatise it, I often felt pulled in different directions. I was drawn to the view of co-dependency as socially constructed, yet I could not ignore the individual lived experiences and the very real consequences participants described. Taking a truly pragmatic stance, I now believe there is truth in each conceptualisation presented in this study, and yet, I am still far from being able to offer a single, comprehensive definition of the term.

When writing, I also became increasingly aware of the language used to describe participants' strategies. Terms such as "punitive" or "rescue-seeking" can carry negative connotations, and I was mindful of how they might be perceived. Where terms were part of established theoretical frameworks, such as the DMM, I retained them for consistency and clarity. However, in other cases, particularly where terminology was not formally tied to a specific model, I deliberately chose alternative wording. For example, I used "rescuer" and "helpless" rather than "saviour" and "victim" to avoid overly pathologising labels and to better reflect the adaptive and shifting nature of these roles within participants' narratives.

Hearing participants' stories was the most transformational part of the research. While common themes emerged, each participant brought a unique perspective. This process challenged some of my own clinical assumptions, particularly around resistance in therapy. I noticed moments of resistance during the interviews, and it led me to reflect on how, in clinical settings, this is sometimes interpreted as "clients not being ready for therapy." I now question that. Perhaps resistance is not a

barrier but a form of self-protection, the very thing that allows someone to show up at all. It is my responsibility as a clinician to foster the trust that enables them to stay and grow.

I hope that this research, however imperfect, helps other professionals better support individuals struggling with co-dependency and that, at the very least, it offers the co-dependent community a sense of being heard.

5.8 Conclusion

This study added to the literature on the co-dependency, showing that insecure attachment and HI positively predict co-dependency. Our findings confirmed that co-dependency is associated with low MW and this association is partially moderated by HC. While HC appeared protective at lower levels of co-dependency, its buffering effect diminished at higher levels, resulting in poorer well-being.

Qualitative findings provided a developmental account of co-dependency, beginning with unsafe and insecure childhoods, followed by trauma exposure and relational mechanisms that contributed to co-dependent patterns. Participants described the tension between seeking closeness and self-protection, the use of coping strategies rooted in co-dependency, and recovery attempts that were sometimes empowering, sometimes performative. All participants employed insecure attachment strategies to manage relational threat and distress.

Clinical implications include the importance of recognising co-dependency in its varied forms, screening for CPTSD where relevant, incorporating cultural orientation into formulation, and offering tailored psychological support alongside peer-led groups. Safeguarding considerations are also crucial, especially in the context of harmful attachments.

Future research should include more diverse samples, individuals with different levels of co-dependency and support engagement, and adopt longitudinal or family-based designs. Finally, policy recommendations include early preventive measures in schools, public education campaigns, and increased funding for training professionals in recognising and supporting co-dependency.

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Zaidi, U. (2015). Co-dependency and relationship satisfaction among spouses of alcohol abusers. *Journal Of Humanities And Social Science (IOSR-JHSS)*, *20*(1), 86-91.

Zielinski, M., Bradshaw, S., Mullet, N., Hawkins, L., Shumway, S., & Story Chavez, M. (2019). Codependency and prefrontal cortex functioning: preliminary examination of substance use disorder impacted family members. *The American journal on addictions*, *28*(5), 367-375

APPENDICES

Appendix A

Search Activity Template

List of sources searched:	Date of search	Search strategy used, including any limits	Total number of results found	Comments
PsychINFO through ProQuest	15/08/24	**Initial Search** ("co-dependen*" OR "codependen*" OR "love addiction" OR "relationship addiction" OR "affective dependenc*" OR "relational dependenc*") AND ("conceptualization" OR "definition" OR "understanding" OR "interpretation" OR "theoretical model" OR "theoretical framework" OR "conceptual framework" OR "theoretical perspective" OR "psychological theory" OR "model of co-dependency" OR "theoretical construct") **Articles found:** 573 **Relevant articles:** 50 **Adjusted Search** Breakdown: The main search was broken down into two focused searches: one focusing on conceptualisation and one focusing on MH. **Search 1: Focus on Conceptualisation** Search Query: ("co-dependen*" OR "codependen*" OR "love addiction" OR "relationship addiction" OR "affective dependenc**" OR "relational dependenc*") AND ("conceptualization" OR "definition" OR "understanding" OR "interpretation" OR "theoretical model" OR "theoretical framework" OR "conceptual framework" OR "theoretical perspective" OR "psychological theory" OR "model of co-dependency" OR "theoretical construct") **Results**: 412 **Relevant Articles:** 53 **Search Focus on Mental Health Outcomes** • Search Query: ("co-dependency" OR "codependency" OR "love addiction" OR "relationship addiction" OR "relational dependency") AND ("mental health outcomes" OR "anxiety" OR "depression" OR "stress" OR "well-being" OR "psychological impact") NOT ("book review") **Results**: 358 articles **Relevant Articles**: 16	119	

Appendix B

Quality appraisal

Table B1

JBI - Textual Evidence

Table B2:

MMAT – Qualitative evidence

Author (year)	Source identified	Source has standing experience	Population Focused	Logical Argument	Literature Reference	Incongruence Defended
Bacon & Conway (2023)	Yes	Yes	Yes	Yes	Yes	Yes
Weiss (2019)	Yes	Yes	Yes	Yes	No	No
Coffman & Swank (2021)	Yes	Yes	Yes	Yes	Yes	No
Liverano et al. (2023)	Yes	Yes	Yes	Yes	Yes	Yes
Kolenova et al. (2023)	Yes	Yes	Yes	Yes	Yes	Yes
Shishkova & Bocharov (2022)	Yes	Yes	Yes	Yes	Yes	Yes
Calderwood & Rajesparam (2014)	Yes	Yes	Yes	Yes	Yes	Yes

Author (year)	Clear RQs	Data addresses RQs	Appropriateness of qualitative approach	Adequate data collection	Adequately derived findings	Interpretation of results is substantiated by data	Coherence of data & analysis
Aristizábal 2020	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Bacon et al. (2020)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Klimczak& Kiejna (2018)	Yes	Yes	Yes	Yes	Unclear	Yes	Yes
Sobol-Goldberg et al. (2023)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Nordgren et al. (2020)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Winter (2019)	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Table B3:

MMAT – Quantitative evidence

Author (year)	Clear RQs	Data addresses RQ?	Relevant sampling strategy	Representative sampling	Appropriate measurements	Low risk of non-response bias	Appropriate statistical analysis
Chang (2018)	Yes	Yes	Yes	Yes	Yes	No	Yes
Eshan & Suneel (2020)	No	Yes	Yes	Yes	Yes	No	Yes
Happ et al. (2023)	Yes	Yes	Yes	No	Yes	No	Yes
Kaplan (2023)	Yes	Yes	Yes	No	Yes	Unclear	Yes
Evgin & Sümen (2022)	Yes	Yes	Yes	No	Yes	Unclear	Yes
Karaşar (2020)	Yes	Yes	Yes	Yes	Yes	Unclear	Yes
Kaya et al. (2024)	Yes	Yes	Yes	No	Yes	Unclear	Yes
Knapek et al. (2021)	Yes	Yes	Yes	Yes	Yes	Unclear	Yes
Knapek et al. (2017)	Yes	Yes	Yes	Yes	Yes	Unclear	Yes
Lampis et al. (2017)	Yes	Yes	Yes	No	Yes	Unclear	Yes
Rozhnova et al. (2020)	No	Yes	Yes	Unclear	Yes	Unclear	Yes
Vederhus et al. (2019)	Yes	Yes	Yes	No	Yes	Unclear	Yes
Zielinski et al. (2019)	Yes	Yes	Yes	No	Yes	Unclear	Yes
Tunca et al. (2024)	Yes	Yes	Yes	Yes	Yes	Unclear	Yes
Hawkins& Hawkins (2014)	Yes	Yes	Yes	Yes	Yes	No	Yes
Atintaş & Tutarel-Kışlak (2019)	Yes	Yes	Yes	Yes	Yes	Unclear	Yes
Bespalov et al. (2024)	Yes	Yes	Yes	Yes	Yes	Unclear	Yes

Appendix C

Reflective Diary Excerpts

Reflections during SLR & planning stage

20/10/24

As I engaged with the literature on co-dependency, I became increasingly aware of its definitional ambiguity. Initially, I found this disorienting, but over time, it affirmed my commitment to a pragmatist stance: accepting that multiple, sometimes conflicting, definitions can coexist if they serve different purposes. This led me to value both behavioural descriptions and relational understandings of co-dependency, shaping my choice of a mixed methods design to explore both patterns and meaning. I think co-dependency cannot be understood in isolation but must be considered in relation to the contexts in which it manifests. I aim to read about the different perspectives currently used to make sense of it.

09/11/25

At the start of the systematic review, I found it difficult to exclude papers. I had a strong urge to keep everything that seemed even slightly relevant, perhaps out of fear of missing something valuable or overlooking complexities in how co-dependency is conceptualised. I initially wanted to keep overlapping terms, broader timeframes, and studies that loosely aligned with my focus, but this quickly became unmanageable.

Through this process, I've realised that trying to be too inclusive led to inefficiencies and diluted the focus of the review. Reflecting on this helped me keeping to my pragmatic approach, recognising that clarity and usefulness are more important than exhaustive coverage. I refined my inclusion criteria, especially around conceptual overlaps and publication timeframe, and now see the value of iterative decision-making rather than rigidly sticking to an idealised protocol. I plan to bring this up in supervision to make sure the final parameters are both defensible and methodologically sound.

This experience has reinforced the importance of balancing rigour with feasibility.

Reflections during interview and qualitative analysis stage

05/12/25

Feedback from SGFC consultants highlighted areas for improvement in the interview schedule. However, due to the structure required for DMM coding, not all suggestions could be implemented. I have been struggling from this, conflicted between keeping necessary rigour and integrating relevant feedback. From a pragmatic perspective, I recognised that while full flexibility wasn't possible, the process of consultation itself added validity and grounded the protocol in the lived experience of participants. This tension shaped how I reflected on co-production within structured methods. I will spend some time thinking about how to balance both needs.

16/12/25

During the last interview, the participant began sharing deeply traumatic experiences shortly after the session began. Although I intended to follow the semi structured protocol, the conversation quickly deviated, evolving into an emotional and cathartic experience for the participant. As a researcher, I found myself trying to balance empathy with the need to maintain the focus of the interview. Interrupting a participant sharing deeply personal stories felt ethically inappropriate, but at the same time I was conscious of the need to address all planned questions and also consider the potential impact on the participant.

This interview lasted nearly two hours, well exceeding the anticipated length, prompting reflections on maintaining boundaries and managing time while prioritising participant well-being. Ethically, I ensured breaks were offered and regularly checked in with the participant, who expressed feeling supported throughout. However, this experience highlighted the unpredictable nature of qualitative research, particularly on sensitive topics like trauma.

While I did not address every planned question, the depth of the participant’s narrative provided invaluable insight, reinforcing the importance of flexibility in qualitative research. This experience is making me reflect on the blurred boundaries between researcher and participant. It also served as a reminder that qualitative research is as much about listening and understanding as it is about data collection, and that unexpected moments often lead to the richest data.

18/01/25

Today, I attended my first SGFC group meeting, and the experience was both enlightening and challenging. Initially, I felt a strong sense of discomfort joining the group, as I had avoided this step for some time. I realised that this hesitation was the result of my subconscious need to maintain a sense of distance, perhaps to avoid confronting the parts of myself that resonate with co-dependency. This avoidance was something I had not fully acknowledged before, and it revealed how my own biases might have subtly influenced my approach to this research.

As the meeting began, I noticed how structured the SGFC process is, with clear guidelines around sharing and listening. This structure provided a sense of safety, but I also observed how it created space for deep vulnerability among members. Listening to their stories, I felt a mix of emotions: empathy, curiosity, and a slight discomfort, as their accounts mirrored elements of my own family experiences. It struck me that while I have never formally identified as co-dependent, the themes of care-taking, self-sacrifice, and seeking validation were familiar.

Participating as an observer allowed me to understand the shared language and norms within the SGFC community, which I had previously only read about. These insights have reshaped how I approach my interview questions, as I now recognise the importance of incorporating the terminology and frameworks that participants find meaningful.

Reflecting on this experience, I feel that attending the meeting was a necessary step to deepen my understanding of the participants' context. It not only challenged my preconceptions but also helped me engage more authentically with the phenomenon of co-dependency. While I initially felt uncomfortable, I left with a sense of gratitude for the opportunity to witness the resilience and honesty of the group members. This experience reinforced the importance of balancing theoretical knowledge with genuine human connection in my research.

23/01/25

I've been avoiding going back to the interview transcripts for analysis. The last one, in particular, has been weighing heavily on my mind. The participant shared painful stories, and while I felt honoured

to hold space for them, revisiting those words feels daunting. I'm anxious about reliving the intensity of their experiences and how it might affect me emotionally.

I've been wondering if my reluctance is a form of self-protection. It's not just the heaviness of the stories, it's also the fear of not doing justice to their narrative in the analysis. There's a responsibility I feel to accurately and sensitively represent their experiences, and that pressure amplifies my anxiety.

Action Points:

- Take small steps: Start with shorter sessions to ease into the analysis rather than tackling it all at once.
- Build in self-care: Plan something grounding after each session, like a walk or journaling, to help process any emotions that arise.
- Seek support: Reach out to my supervisor or a colleague to discuss strategies for managing the emotional load of the analysis.

15/03/25

As I continue working through the qualitative data, I've been struck by how often participants speak of boundaries, detachment, or emotional distance as signs of "growth." Statements like "I don't let people in anymore," "I've learned to put up walls," or "I just don't think about it now" are often delivered with clarity and even pride. Yet, at times, the emotional tone feels incongruent when compared to the depth of pain described elsewhere in the interviews.

This has raised interpretive questions: are these expressions of growth, or are they protective strategies, subtle forms of defensiveness or emotional suppression developed to manage relational threat? As someone working with both TA and the DMM, I initially found it challenging to decide how best to bring these two interpretive frameworks together. For a time, I considered keeping the DMM coding and thematic interpretation separate, concerned that applying the DMM lens too early might distort participant meaning.

However, reflecting on my pragmatic approach, I began to see the value of allowing these frameworks to speak to each other. Rather than treating behavioural strategies as "maladaptive," the DMM helped me focus on the function of language and behaviour, asking what these defences protect and how they serve the individual in the absence of secure relational experiences. This shift aligns with TA's flexibility and the pragmatic aim of producing useful insights, not abstract theory for its own sake, but interpretations that honour both lived experience and psychological complexity.

Now, I'm less focused on whether participants' narratives of "growth" are objectively accurate, and more concerned with what these stories do for them, how they provide safety, meaning, or a sense of coherence. I'm learning that growth and avoidance can coexist, that what is framed as strength may be rooted in unresolved grief or fear, and that defences, while protective, may also come at a cost.

My task as a researcher is to hold space for both interpretations: the surface narrative of empowerment, and the deeper, less articulated undercurrents of pain and protection. I don't seek to challenge participants' versions of healing, but to sensitively trace the psychological texture of their stories, honouring their meaning while acknowledging the complexity beneath. This integrated lens, grounded in both TA and DMM, supports a richer understanding of co-dependency and attachment not as fixed traits, but as dynamic, context-sensitive strategies shaped by survival and adaptation.

Reflections during the triangulation stage

24/02/25

Feeling both overwhelmed by the breadth of my topic and frustrated by its limits prompted me to clarify the purposeful boundaries of the study. Pragmatism helped me accept that research does not have to be exhaustive to be useful. I returned to my core aims and reminded myself that partial insights, when grounded and well-integrated, can still offer meaningful contributions.

11/04/25

As I moved into analysis, I became increasingly aware of the tension between using established theoretical frameworks and representing participants' experiences in a way that does not reproduce

clinical or pathologising language. While the DMM has been invaluable in helping me understand relational strategies as adaptations to perceived danger, I found some of its terminology (e.g. sexualised strategies, punitive, contradictory) difficult to apply without feeling like it risked misrepresenting or oversimplifying participants' meaning.

This led me to critically reflect on the language I used in coding and write-up, and to adopt a more careful, contextualised approach. For example, where the DMM might classify a pattern as sexualised, I considered describing it as "indiscriminate" or "boundary-blurring", depending on the function it served in the participant's narrative. I wasn't trying to dilute the theory, but to use it in a way that aligned with both its developmental intent and my pragmatic, trauma-informed stance.

Throughout the process, I've tried to honour the voices of participants by approaching their stories with empathy and respect, resisting reductive interpretation even when applying structured coding systems. This has underscored my commitment to producing research that doesn't just examine co-dependency through a psychological lens, but humanises it, showing how adaptive strategies are shaped by histories of pain, protection, and resilience.

Appendix D

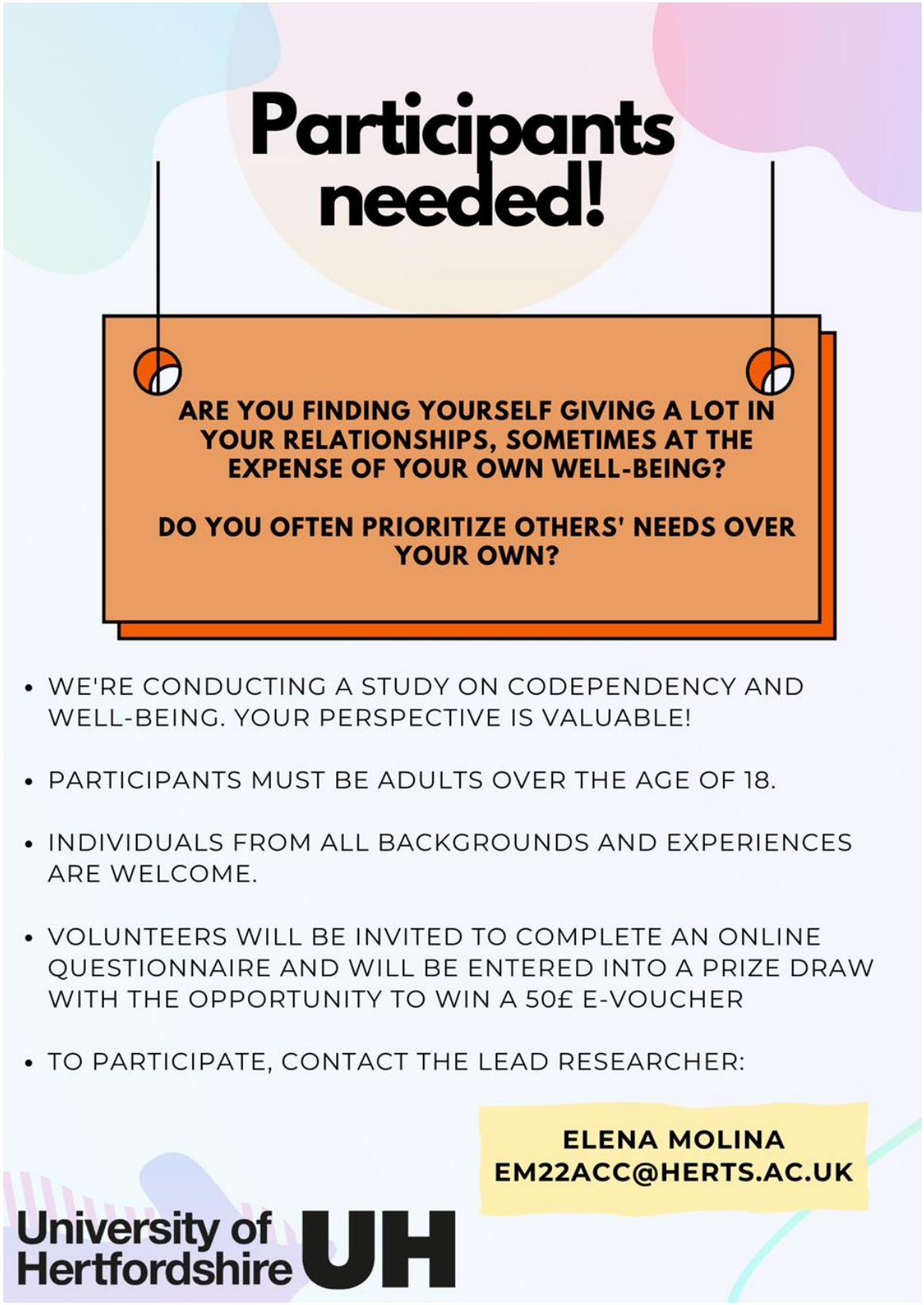
Recruitment Flyer

Figure D1:

SGFC recruitment flyer

Figure D2:

General Population Recruitment Flyer



Appendix E

Ethical approval and amendment

iversity of
rtfordshire UH

HEALTH, SCIENCE, ENGINEERING AND TECHNOLOGY ECDA

ETHICS APPROVAL NOTIFICATION

TO	**Elena Molina**
CC	**Dr Abigail O Taiwo**
FROM	**Dr Rosemary Godbold, Health, Science, Engineering and Technology ECDA Vice Chair**
DATE	**27/03/2024**

Protocol number:	LMS/PGR/UH/05577
Title of study:	Beyond Labels: A Mixed-Methods Exploration of Attachment and Cultural Dynamics in Co-dependency

Your application for ethics approval has been accepted and approved with the following conditions by the ECDA for your School and includes work undertaken for this study by the named additional workers below:

Ben Gray (secondary supervisor)

General conditions of approval:

Ethics approval has been granted subject to the standard conditions below:

Permissions: Any necessary permissions for the use of premises/location and accessing participants for your study must be obtained in writing prior to any data collection commencing. Failure to obtain adequate permissions may be considered a breach of this protocol.

External communications: Ensure you quote the UH protocol number and the name of the approving Committee on all paperwork, including recruitment advertisements/online requests, for this study.

Invasive procedures: If your research involves invasive procedures you are required to complete and submit an EC7 Protocol Monitoring Form, and copies of your completed consent paperwork to this ECDA once your study is complete.

Submission: Students must include this Approval Notification with their submission.

Validity:

This approval is valid:

From: 27/03/2024

To: 31/01/2025

To: Ms Elena Molina

Your application for an amendment of the existing protocol listed below has been approved by the Health, Science, Engineering and Technology Ethics Committee with Delegated Authority. **Please read this letter carefully.**

Study Title: Beyond Labels: A Mixed-Methods Exploration of Attachment and Cultural Dynamics in Co-dependency

Your UH protocol number is: **0202 2024 Oct HSET**
The Protocol Number issued from the online system replaces any previously issued protocol numbers and should be quoted on all paperwork, including advertisements for participants.

If you wish to use the UH Ethics Committee logo disclaimer in your communications with participants, please find it in our UH Ethics Canvas site under 'Units - Application Forms': UH Ethics Approval (instructure.com.

This ethics approval expires on 31/01/2025

Amending your protocol

Individual protocols will normally be approved for the limited period of time noted above. Application for minor amendments (including time extensions) of a protocol, may be made for a maximum of 4 working weeks after the end date of that protocol.

It is expected that any amendments proposed via the online system will be minor. Should substantial modification be required, it would be necessary to make a fresh application for ethical approval.

Note that you must obtain approval from the relevant UH Ethics Committee with Delegated Authority **prior to implementing any changes**. Failure to do so constitutes a breach of ethics regulations (UPR RE01).

Adverse circumstances
Any adverse circumstances that may arise because of your study/activity must be reported to ethicsadmin@herts.ac.uk as soon as possible.

Permissions
Any necessary permissions for the use of premises/location and accessing participants for your study/activity must be obtained in writing prior to any data collection commencing. Failure to obtain adequate permissions may be considered a breach of this protocol.

Ethics Administration Team

ethicsadmin@herts.ac.uk

Appendix F

Consent Form

3. CONSENT FORM

UNIVERSITY OF HERTFORDSHIRE

ETHICS COMMITTEE FOR STUDIES INVOLVING THE USE OF HUMAN PARTICIPANTS ('ETHICS COMMITTEE')

FORM EC3

CONSENT FORM FOR STUDIES INVOLVING HUMAN PARTICIPANTS SURVEY

I, the undersigned *[please give your name here, in BLOCK CAPITALS]*

of *[please give contact details here, sufficient to enable the investigator to get in touch with you, such as a postal or email address]*

hereby freely agree to take part in the study entitled ''Beyond Labels: A Mixed-Methods Exploration of Attachment and Cultural Orientation in Co-dependency''

(UH Protocol number LMS/PGR/UH/05577)

1 I confirm that I have been given a Participant Information Sheet (a copy of which is attached to this form) giving particulars of the study, including its aim(s), methods and design, the names and contact details of key people and, as appropriate, the risks and potential benefits, how the information collected will be stored and for how long, and any plans for follow-up studies that might involve further approaches to participants. I have also been informed of how my personal information on this form will be stored and for how long. I have been given details of my involvement in the study. I have been told that in the event of any significant change to the aim(s) or design of the study I will be informed and asked to renew my consent to participate in it.

2 I have been assured that I may withdraw from the study at any time without disadvantage or having to give a reason. However, it might be difficult to identify my survey/interview and delete it after completion as I will be assigned a code/pseudonym to ensure confidentiality.

3 In giving my consent to participate in this study, I understand that voice, video or photo-recording will take place if I volunteer and I am eligible for the second phase and I have been informed of how/whether this recording will be transmitted/displayed.

4 I have been given information about the risks of my suffering harm or adverse effects and I agree to complete any required health screening questionnaire in advance of the study. I have been told about the aftercare and support that will be offered to me in the event of this happening.

5 I have been told how information relating to me (data obtained in the course of the study, and data provided by me about myself) will be handled: how it will be kept secure, who will have access to it, and how it will or may be used.

6 I understand that if there is any revelation of unlawful activity or any indication of non-medical circumstances that would or has put others at risk, the University may refer the matter to the appropriate authorities.

Signature of participant……..…Date……

Signature of (principal) investigator  ……Date……

Name of (principal) investigator *[in BLOCK CAPITALS please]* ELENA MOLINA

Appendix G

Questionnaire Information Sheet

4. PARTICIPANTS INFORMATION SHEET SURVEY

UNIVERSITY OF HERTFORDSHIRE

ETHICS COMMITTEE FOR STUDIES INVOLVING THE USE OF HUMAN PARTICIPANTS

('ETHICS COMMITTEE')

FORM EC6: PARTICIPANT INFORMATION SHEET SURVEY

1 **Title of study**

Beyond Labels: A Mixed-Methods Exploration of Attachment and Cultural Orientation in Co-dependency

2 **Introduction**

You are being invited to take part in a study. Before you decide whether to do so, it is important that you understand the study that is being undertaken and what your involvement will include. Please take the time to read the following information carefully and discuss it with others if you wish. Do not hesitate to ask us anything that is not clear or for any further information you would like to help you make your decision. Please do take your time to decide whether or not you wish to take part. The University's regulation, UPR RE01, 'Studies Involving the Use of Human Participants' can be accessed via this link:

https://www.herts.ac.uk/about-us/governance/university-policies-and-regulations-uprs/uprs

(after accessing this website, scroll down to Letter S where you will find the regulation)

Thank you for reading this.

3 **What is the purpose of this study?**

The purpose of this study is to comprehensively investigate co-dependency, a psychological phenomenon often associated with challenging interpersonal relationships. Individuals experiencing co-dependency may display emotional or psychological reliance on others, often to the detriment of their own well-being. This research seeks to broaden our understanding by exploring co-dependency across genders, considering cultural orientation and attachment patterns. By employing both quantitative and qualitative methods, we aim to capture the nuanced emotional and narrative dimensions of co-dependency that may be overlooked in quantitative studies alone. The research also aims to contribute to destigmatize co-dependency and foster a more inclusive and culturally sensitive understanding. The overarching goal is to inform preventive and therapeutic interventions, enhance clinical practice, hopefully contributing to improve the well-being of individuals who identify as co-dependents.

4 **Do I have to take part?**

It is completely up to you whether or not you decide to take part in this study. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a consent form. Agreeing to join the study does not mean that you have to complete it. You are free to withdraw at any stage without giving a reason. A decision to withdraw at any time, or a decision not to take part at all, will not affect any treatment/care that you may receive (should this be relevant). However, keep in mind that following completion of the survey, it won't be possible to identify it and delete it as you will be assigned a code for confidentiality reasons.

5 **Are there any age or other restrictions that may prevent me from participating?**

You are eligible to participate if you are an individual over 18 years old, identify with the label ''co-dependency'', you are fluent in English and don't have acute mental health difficulties or cognitive impairments which might make it difficult to engage with the study. If you are willing to participate, you will be invited to complete a brief online screening to assess your suitability for this study.

6 **How long will my part in the study take?**

If you decide to take part in this study, you will be invited to the first phase which involve completing an online survey, lasting approximately 30 minutes. Following this, if you are invited to the second phase, you will attend an interview with the Lead Researcher, lasting 1-1:30 h approximately.

7 **What will happen to me if I take part?**

If you decide to take part, you can continue with the survey, and you will be invited to sign a consent form. Before you can access to the main survey, you will be asked to complete a short screening. If you are eligible for the study, you will be directed to the main survey which will contain items about co-dependency, mental wellbeing, attachment and cultural orientations. Your responses will be kept anonymous and confidential. Participants will be entered into a prize draw, where one participant will be randomly selected to win a 50-pound Amazon voucher

8 **What are the possible disadvantages, risks or side effects of taking part?**

This research does not intend to cause intentional harm, although it is recognised that reflecting on or discussing your experiences could feel difficult at times. Co-dependency and childhood experiences in particular can be triggering topics. You are under no obligation to answer any questions that you do not feel comfortable answering. You can complete the survey at your own pace and at any time suits you and you can withdraw at any time within the questionnaires. Following the questionnaire, you will receive a debrief sheet with information on how to seek further support should you need it.

I am feeling distressed - what if I need some help or support?

There are external organisations which can provide information or support:

1. Your **GP**

2. **The Samaritans (telephone: 116 123)** is a helpline available 24 hours a day, 365 days a year. The service offers listening and support to anyone who is struggling to cope or is experiencing difficulties. https://www.samaritans.org/

3. **SANE** is a UK mental health charity offering a range of services including **SANEline (telephone: 0300 304 7000)**, a national out-of-hours mental health helpline every day of the year (4pm-10pm). https://www.sane.org.uk/
4. You can **text "SHOUT" to 85258** for free from all UK mobile networks. You'll then be connected to a volunteer for an anonymous conversation by text. https://giveusashout.org/
5. **NHS urgent mental health helplines** – you can find your local NHS urgent mental health helpline at the following web address: https://www.nhs.uk/service-search/mental-health/find-an-urgent-mental-health-helpline
6. **CoDA UK** aims to support individuals who identify as Co-dependents. You can find information and links to support at their website: Home – Co-Dependents Anonymous UK (codauk.org)

- **SupportLine** – this service provides a confidential telephone helpline offering emotional support to any individual on any issue, as well as email support. Accessed via: https://www.supportline.org.uk/ or by calling their helpline on 01708 765200

9 **What are the possible benefits of taking part?**

By participating in this study, you may gain insights into your own behaviors and relational patterns related to co-dependency, fostering self-awareness. The completion of the survey contributes to the advancement of psychological knowledge about co-dependency and might inform therapeutic practices and policy decisions. Your involvement could also play a role in destigmatizing co-dependency, shaping more supportive societal perspectives. Your participation is entirely voluntary, and you can withdraw in the given time limit without

facing any negative consequences. Confidentiality measures are in place to protect your privacy throughout the research process.

10 **How will my taking part in this study be kept confidential?**

Your confidentiality is a top priority in this study. Your personal data will be held and processed in the strictest confidence, and in accordance with current data protection regulations. Confidentiality will be maintained for personal identifiable information in accordance with the Data Protection Act (2018), the British Psychological Society's Code of Human Research Ethics (2021), and the General Data Protection Regulation 2016/679. Personal data including special category data obtained for the purposes of this research project is processed lawfully in the necessary performance of scientific or historical research or for statistical purposes carried out in the public interest. Processing of personal data including special category data is proportionate to the aims pursued, respects the essence of data protection, and provides suitable and specific measures to safeguard the rights and interests of the data subject in full compliance with the General Data Protection Regulation and the Data Protection Act 2018.

To ensure the security of your information, data will be stored in a secured and encrypted drive within the Lead Researcher's university account. Only the Lead Researcher and authorised researchers involved in analysis will have access to this data. Anonymity will be maintained by replacing any personally identifiable details with codes. Your consent form, linking you to the study, will be stored separately from your data using a unique identifier. Data retention will be limited to the minimum period necessary for the research, and identifiable information will be securely deleted thereafter. Any information disclosed during the study will be used exclusively for research purposes and will not be shared with third parties.

11 **What will happen to the data collected within this study?**

- The data collected will be stored electronically, in a password-protected environment, until Summer 2025, after which time it will be destroyed under secure conditions;

    - The data will be anonymized prior to storage.
- The data will be analysed for research purposes, focusing on the study's objectives and research questions. Findings or conclusions drawn from the data will be presented in an aggregated, non-identifiable format to ensure anonymity.
- Personal data will be retained for the minimum period necessary for the research, and after this period, all identifiable information will be securely deleted. The results of the study may be disseminated through academic publications, presentations, or reports, with a commitment to maintaining the confidentiality of participants.
- If you choose to withdraw from the study, any data collected from you will be treated with the same level of confidentiality and included in the overall data analysis up to the point of withdrawal. You have the right to request the deletion of your data.

12 **Will the data be required for use in further studies?**

The data will not be used in any further studies.

13 **Who has reviewed this study?**

This study has been reviewed by:

- The University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee with Delegated Authority

The UH protocol number is LMS/PGR/UH/05577.

14 **Factors that might put others at risk:**

Please note that if, during the study, any medical conditions or non-medical circumstances such as unlawful activity become apparent that might or had put others at risk, the University may refer the matter to the appropriate authorities and, under such circumstances, you will be withdrawn from the study.

15 **Who can I contact if I have any questions?**

If you would like further information or would like to discuss any details personally, please get in touch with the Lead Researcher, by phone or by email: Elena Molina, 07842726941, em22acc@herts.ac.uk.

Although we hope it is not the case, if you have any complaints or concerns about any aspect of the way you have been approached or treated during the course of this study, please write to the University's Secretary and Registrar at the following address:

Secretary and Registrar

University of Hertfordshire

College Lane

Hatfield

Herts

AL10 9AB

Thank you very much for reading this information and giving consideration to taking part in this study.

Appendix H

Interview Information Sheet

5. PARTICIPANTS INFORMATION SHEET INTERVIEW

UNIVERSITY OF HERTFORDSHIRE

ETHICS COMMITTEE FOR STUDIES INVOLVING THE USE OF HUMAN PARTICIPANTS

('ETHICS COMMITTEE')

FORM EC6: PARTICIPANT INFORMATION SHEET INTERVIEWS

1 **Title of study**

Beyond Labels: A Mixed-Methods Exploration of Attachment and Cultural Orientation in Co-dependency

2 **Introduction**

You are being invited to take part in a study. Before you decide whether to do so, it is important that you understand the study that is being undertaken and what your involvement will include. Please take the time to read the following information carefully and discuss it with others if you wish. Do not hesitate to ask us anything that is not clear or for any further information you would like to help you make your decision. Please do take your time to decide whether or not you wish to take part. The University's regulation, UPR RE01, 'Studies Involving the Use of Human Participants' can be accessed via this link: https://www.herts.ac.uk/about-us/governance/university-policies-and-regulations-uprs/uprs (after accessing this website, scroll down to Letter S where you will find the regulation)

Thank you for reading this.

3 **What is the purpose of this study?**

The purpose of this study is to comprehensively investigate co-dependency, a psychological phenomenon often associated with challenging interpersonal relationships. Individuals experiencing co-dependency may display emotional or psychological reliance on others, often to the detriment of

their own well-being. This research seeks to broaden our understanding by exploring co-dependency across genders, considering cultural orientation and attachment patterns. By employing both quantitative and qualitative methods, we aim to capture the nuanced emotional and narrative dimensions of co-dependency that may be overlooked in quantitative studies alone. The research also aims to contribute to destigmatize co-dependency and foster a more inclusive and culturally sensitive understanding. The overarching goal is to inform preventive and therapeutic interventions, enhance clinical practice, hopefully contributing to improve the well-being of individuals who identify as co-dependents.

4 **Do I have to take part?**

It is completely up to you whether or not you decide to take part in this study. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. Agreeing to join the study does not mean that you have to complete it. You are free to withdraw up to two weeks following the interview without giving a reason. Unfortunately, it will not be possible to withdraw after that time because your transcript will be anonymized to protect confidentiality. A decision to withdraw, or a decision not to take part at all, will not affect any treatment/care that you may receive (should this be relevant).

5 **Are there any age or other restrictions that may prevent me from participating?**

You are eligible to participate if you are a member of CoDA UK who has completed the first phase of the study and has expressed interest in attending a semi-structured interview. In order to attend the second phase, your survey's scores on the co-dependency scale should show a moderate to severe level of co-dependency.

6 **How long will my part in the study take?**

If you are interested and meet the suitability criteria, you will be invited to attend an interview with the Lead Researcher, lasting 1-1:30 h approximately.

7 **What will happen to me if I take part?**

You are being invited to attend a semi-structured online interview. If you wish to go ahead with the interview, the lead researcher will contact you to arrange a suitable time and will send you a Microsoft Team link, During the interview, the lead researcher will ask you questions about your childhood experiences, relationships with caregivers, and how those experiences have influenced your current attachment patterns. Additionally, the lead researcher will ask you questions about your relationship with co-dependency and your experiences. The interview will be recorded using the in-built function on Microsoft Teams to enable verbatim transcription. The recordings and transcripts will be held securely at the University of Hertfordshire and stored on a secure university server. Only the Lead researcher will have access to the recordings, and these will be deleted as soon as the Lead researcher has completed their study and attended their research exam, in July 2025. Few authorized researchers will have access to the transcripts for analysis purposes. Verbatim extracts and quotes from your interview may appear in the results of the research or in an article to be published in an academic journal. Quotes will be sensitively selected to minimize any possibility of participant identification and will be anonymised, using a pseudonym. All participants who complete the interview will receive a 10-pound shopping voucher for their time and contribution.

8 **What are the possible disadvantages, risks or side effects of taking part?**

This research does not intend to cause intentional harm, although it is recognised that reflecting on or discussing your experiences could feel difficult at times. Co-dependency and childhood experiences in particular can be triggering topics. You are under no obligation to answer any questions that you do not feel comfortable answering. You can request to take a break from the interview or withdraw within two weeks following the interview. At the end of the interview, you will receive a debrief sheet with information on how to seek further support should you need it.

I am feeling distressed - what if I need some help or support?

There are external organisations which can provide information or support:

7. Your **GP**

8. **The Samaritans (telephone: 116 123)** is a helpline available 24 hours a day, 365 days a year. The service offers listening and support to anyone who is struggling to cope or is experiencing difficulties. https://www.samaritans.org/
9. **SANE** is a UK mental health charity offering a range of services including **SANEline (telephone: 0300 304 7000)**, a national out-of-hours mental health helpline every day of the year (4pm-10pm). https://www.sane.org.uk/
10. You can **text "SHOUT" to 85258** for free from all UK mobile networks. You'll then be connected to a volunteer for an anonymous conversation by text. https://giveusashout.org/
11. **NHS urgent mental health helplines** – you can find your local NHS urgent mental health helpline at the following web address: https://www.nhs.uk/service-search/mental-health/find-an-urgent-mental-health-helpline

- **SupportLine** – this service provides a confidential telephone helpline offering emotional support to any individual on any issue, as well as email support. Accessed via: https://www.supportline.org.uk/ or by calling their helpline on 01708 765200

9 **What are the possible benefits of taking part?**

By participating in this study, you may gain insights into your own behaviors and relational patterns related to co-dependency, fostering self-awareness. Your experiences and perspectives contribute to the advancement of psychological knowledge about co-dependency and might inform therapeutic practices and policy decisions. Your involvement also plays a role in destigmatizing co-dependency, shaping more supportive societal perspectives. Your participation is entirely voluntary, and you can withdraw without facing negative consequences. Confidentiality measures are in place to protect your privacy throughout the research process.

10 **How will my taking part in this study be kept confidential?**

Your confidentiality is a top priority in this study. Your personal data will be held and processed in the strictest confidence, and in accordance with current data protection regulations. Confidentiality will be maintained for personal identifiable information in accordance with the Data Protection Act (2018), the British Psychological Society's Code of Human Research Ethics (2021),

and the General Data Protection Regulation 2016/679. Personal data including special category data obtained for the purposes of this research project is processed lawfully in the necessary performance of scientific or historical research or for statistical purposes carried out in the public interest. Processing of personal data including special category data is proportionate to the aims pursued, respects the essence of data protection, and provides suitable and specific measures to safeguard the rights and interests of the data subject in full compliance with the General Data Protection Regulation and the Data Protection Act 2018.

To ensure the security of your information, data will be stored in a secured and encrypted drive within the Lead Researcher's university account. Only the Lead Researcher and authorised researchers involved in analysis will have access to this data. Anonymity will be maintained by replacing any personally identifiable details with pseudonyms. Your consent form, linking you to the study, will be stored separately from your data using a unique identifier. Data retention will be limited to the minimum period necessary for the research, and identifiable information will be securely deleted thereafter. Any information disclosed during the study will be used exclusively for research purposes and will not be shared with third parties.

11 **Audio-visual material** Interviews recordings will be stored within the Lead Researcher's university account. Any personally identifiable information in the audio-visual materials will be carefully pseudonymized to ensure that individuals cannot be directly identified. If any electronic transfers of audio-visual materials are necessary, encryption methods will be employed to prevent unauthorized access during transmission. Only the Lead Researcher and authorized members of the research team will have access to analyze transcripts of the audio-visual materials, and any dissemination of findings will be done in a non-identifiable manner. The retention period for audio-visual materials will be limited to the minimum necessary for the research, and after this period, all identifiable information will be securely deleted.

12 **What will happen to the data collected within this study?**

- The data collected will be stored electronically, in a password-protected environment, until Summer 2025, after which time it will be destroyed under secure conditions;
- The data will be anonymized prior to storage.
- Data won't be moved from the secure drive, except for interviews recorded using a Dictaphone if the participants' mode of preference is face-to-face. These will be securely moved from the Dictaphone to the drive immediately after the interview. Encryption methods will be employed to prevent unauthorized access during transmission. Interviews will be transcribed by the Lead Researcher and analyzed by authorized researchers.
- The data will be analysed for research purposes, focusing on the study's objectives and research questions. Findings or conclusions drawn from the data will be presented in an aggregated, non-identifiable format to ensure anonymity.
- Personal data will be retained for the minimum period necessary for the research, and after this period, all identifiable information will be securely deleted. The results of the study may be disseminated through academic publications, presentations, or reports, with a commitment to maintaining the confidentiality of participants.
- If you choose to withdraw from the study, any data collected from you will be treated with the same level of confidentiality and included in the overall data analysis up to the point of withdrawal. You have the right to request the deletion of your data.

13 **Will the data be required for use in further studies?**

The data will not be used in any further studies.

14 **Who has reviewed this study?**

This study has been reviewed by:

- The University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee with Delegated Authority

The UH protocol number is LMS/PGR/UH/05577.

15 **Factors that might put others at risk:**

Please note that if, during the study, any medical conditions or non-medical circumstances such as unlawful activity become apparent that might or had put others at risk, the University may refer the matter to the appropriate authorities and, under such circumstances, you will be withdrawn from the study.

16 **Who can I contact if I have any questions?**

If you would like further information or would like to discuss any details personally, please get in touch with me by phone or by email: Elena Molina, 07842726941, em22acc@herts.ac.uk.

Although we hope it is not the case, if you have any complaints or concerns about any aspect of the way you have been approached or treated during the course of this study, please write to the University's Secretary and Registrar at the following address:

Secretary and Registrar

University of Hertfordshire

College Lane

Hatfield

Herts

AL10 9AB

Thank you very much for reading this information and giving consideration to taking part in this study.

Appendix I

Risk Management Form

UNIVERSITY OF HERTFORDSHIRE

ETHICS COMMITTEE FOR STUDIES INVOLVING THE USE OF HUMAN PARTICIPANTS ('ETHICS COMMITTEE')

FORM EC5 – HARMS, HAZARDS AND RISKS:

ASSESSMENT AND MITIGATION

Name of applicant: Elena Molina Date of assessment: 15/02/24

Title of Study/Activity: MRP: Beyond Labels: A Mixed-Methods Exploration of Attachment, Adversity, Gender Scripts, and Cultural Dynamics in Co-dependency

UNIVERSITY OF HERTFORDSHIRE

ETHICS COMMITTEE FOR STUDIES INVOLVING THE USE OF HUMAN PARTICIPANTS ('ETHICS COMMITTEE')

FORM EC5 – HARMS, HAZARDS AND RISKS:

ASSESSMENT AND MITIGATION

Name of applicant: Elena Molina Date of assessment: 15/02/24

Title of Study/Activity: MRP: Beyond Labels: A Mixed-Methods Exploration of Attachment, Adversity, Gender Scripts, and Cultural Dynamics in Co-dependency

Activity Description					
1 IDENTIFY RISKS/HAZARDS	2 WHO COULD BE HARMED & HOW?		3 EVALUATE THE RISKS		4 ACTION NEEDED
Activities/tasks and associated hazards Describe the activities involved in the study and any associated risks/ hazards, both physical and emotional, resulting from the study. Consider the risks to participants/the research team/members of the public. In respect of any equipment to be used read manufacturer's instructions and note any	Who is at risk? e.g. participants, investigators, other people at the location, the owner / manager / workers at the location etc.	How could they be harmed? What sort of accident could occur, eg trips, slips, falls, lifting equipment etc, handling chemical substances, use of invasive procedures and correct disposal of equipment etc. What type of injury is likely?	Are there any precautions currently in place to prevent the hazard or minimise adverse effects? Are there standard operating procedures or rules for the premises? Have there been	Are there any risks that are not controlled or not adequately controlled?	List the action that needs to be taken to reduce/manage the risks arising from your study for example, provision of medical support/aftercare, precautions to be put in place to avoid or minimise risk or adverse effects NOTE: medical or other aftercare and/or support **must** be made available for participants and/or investigator(s) who require it.

hazards that arise, particularly from incorrect use.)		Could the study cause discomfort or distress of a mental or emotional character to participants and/or investigators? What is the nature of any discomfort or distress of a mental or emotional character that you might anticipate?	agreed levels of supervision of the study? Will trained medical staff be present? Etc/			
Psychological distress	Participants	Both questionnaires and interviews revolve around sensitive topics which might trigger psychological distress.	Participants will be provided with an information sheet so that they are informed of the content of the questionnaires and aims of the interviews. Participation is voluntary and participants will be informed they are able to withdraw at any time. The lead researcher will receive training on conducting the interview and will scan for signs of distress and stop the interview and provide support if necessary	no	We will provide signposting information and helpline numbers following completion of the questionnaires and interviews and participants will have the chance to contact researchers to ask information.	
Stress	Participants	Questionnaires and interviews can be intense and time consuming, there is a risk this might stress the participants. Online participation can be stressful for participants who are not versatile with technology.	Participants will be provided with an information sheet so that they are informed of the content of the questionnaires and aims of the interviews. Participation is voluntary and participants will be informed they are able to withdraw at any time. Participants can complete the questionnaire at their own	Low	We will provide signposting information and helpline number following completion of questionnaires and interviews and participants will have the chance to contact researchers to ask information. The lead researcher will be scanning for signs of stress during the interview and pause if necessary. In case of intense stress, it will be possible to stop and reschedule the interview.	

			pace and in a comfortable environment. Interviews will be scheduled at a convenient and information on how to use Teams will be provided to participants. We will specifically select scales and interview questions that are not too time consuming.			
Computers and other display screens	Participants	Prolonged use of computers or phone screens can lead to eye strain, headaches, and fatigue among participants when completing questionnaires or virtual interviews.	The survey will last approx. 30 minutes and has achieved a ‘’fair’’ scores on Qualtrics, suggesting it should not induce fatigue on participants. However, participants will be advised they are welcome to take as many breaks as needed. The interview will last between 1 hour and 1:30 minutes.	Low	During the interview, the lead researcher will scan for signs of fatigue and introduce breaks if needed. In some cases, it will be possible to divide the interviews in two parts if this is convenient to participants.	

Signed by applicant:	Dated:
EH	15/02/24

Appendix J

Questionnaire Debrief Sheet

I would like to thank you for the time and effort taken to participate in the study. The study aims to investigate whether attachment and cultural orientation can explain co-dependency and whether their interaction affects mental wellbeing. The results of this research could contribute to expanding existing knowledge on co-dependency and fostering a more compassionate understanding of the phenomenon. It is our hope that the findings will support the development of effective preventive interventions and more targeted therapeutic treatments.

Your invaluable input has been crucial to the research. Your performance on the survey has allowed us to measure levels of co-dependency and mental wellbeing, as well as identify cultural orientation and attachment style. We will analyse these variables to determine potential associations.

If you need any emotional support, please contact any of the organisations listed below.

The list is not exhaustive, but designed to provide helpful avenues in case of need:

Co-Dependents Anonymous (CoDA UK):

CoDA is a program of recovery from co-dependence, offering online resources and group support.

Email: communications@codauk.org

For more information visit:

Home – Co-Dependents Anonymous UK (codauk.org)

Mind :

Mind is a mental health charity which provides emotional support for those experiencing mental health difficulties and their families.

Tel: 0300 123 3393 (9am- 6pm, Monday to Friday; except for bank holidays).

For more information visit: www.mind.org.uk

Samaritans:

The Samaritans provide a confidential listening service to emotionally support anyone feeling down or in distress (whether related to mental health difficulties or not). Support can be accessed via telephone, email, post, or face to face at a local branch.

Tel: 116 123 (Free phone, 24 hours)

Email: jo@samaritans.org

Freepost RSRB-KKBY-CYJK, PO Box 9090, Stirling, FK8 2SA

For more information and to find your local Samaritans branch, visit: www.samaritans.org

Relate:

Relate provide a talking space for anyone who is struggling with relationships, marriage, parenting, family, sex life, separation or divorce. Counselling can be accessed via livechat, webcam or telephone

Tel: 03000030396 (booking line opening times 8am-10pm, Monday to Thursday; 8am-6pm, Friday and 9am-5pm, Saturday)

For more information visit: www.relate.org.uk

Beatstress UK:

Beatstress UK, provide an online (webchat) service to emotionally support anyone who is struggling with stress. Webchat is open on Wednesdays 7pm-10pm

For more information visit: www.beatstress.uk

HealthTalk:

An online platform providing information and exchange for a wide range of mental health issues.

For more information visit: www.healthtalk.org

Once again, thank you for your participation and contribution to this study.

If you have any questions about the research and wish to discuss them with the researchers, please use the following contacts:

Researchers' contact:

Principal Researcher

Elena Molina

Trainee Clinical Psychologist

AL10 9AB

Email: em22acc@herts.ac.uk

Tel: 07842726941

Professional Doctorate in Clinical Psychology

University of Hertfordshire

School of Life and Medical Sciences

College Lane Campus

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Project Supervisor

Dr. Abigail Taiwo

Email: a.o.taiwo@herts.ac.uk

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School of Life and Medical Sciences

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Second Supervisor

Dr. Ben Grey

Email: b.grey@herts.ac.uk

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School of Life and Medical Sciences

College Lane Campus

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Appendix K

Interview Debrief Sheet

I would like to thank you for the time and effort taken to participate in the study. The study aimed to investigate whether attachment and cultural orientation can explain co-dependency and whether their interaction affects mental wellbeing. The implications of this research could contribute to expanding existing knowledge on co-dependency. It is our hope that the findings will support the development of effective preventive interventions and more targeted therapeutic treatments.

Your invaluable input has been crucial to the research. Your performance on the survey has allowed us to measure levels of co-dependency and mental wellbeing, as well as identify cultural orientation and attachment style. We will analyse these variables to determine potential associations. Data gathered through the interviews will allow us to explore in depth the attachment patterns and the narratives of individuals who identify as co-dependents.

Below is a list of organizations that offer emotional support, should you need it. The list is not exhaustive, but designed to provide helpful avenues in case of need:

Mind :

Mind is a mental health charity which provides emotional support for those experiencing mental health difficulties and their families.

Tel: 0300 123 3393 (9am- 6pm, Monday to Friday; except for bank holidays).For more information visit: www.mind.org.uk

Samaritans:

The Samaritans provide a confidential listening service to emotionally support anyone feeling down or in distress (whether related to mental health difficulties or not). Support can be accessed via telephone, email, post, or face to face at a local branch.

Tel: 116 123 (Free phone, 24 hours)

Email: jo@samaritans.org

Freepost RSRB-KKBY-CYJK, PO Box 9090, Stirling, FK8 2SA

For more information and to find your local Samaritans branch, visit: www.samaritans.org

Relate:

Relate provide a talking space for anyone who is struggling with relationships, marriage, parenting, family, sex life, separation or divorce. Counselling can be accessed via livechat, webcam or telephone

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For more information visit: www.relate.org.uk

Beatstress UK:

Beatstress UK, provide an online (webchat) service to emotionally support anyone who is struggling with stress. Webchat is open on Wednesdays 7pm-10pm

For more information visit: www.beatstress.uk

HealthTalk:

An online platform providing information and exchange for a wide range of mental health issues

For more information visit: www.healthtalk.org

Once again, thank you for your participation and contribution to this important study.

NHS Talking Therapies:

Talking therapies is a free service that support individuals with anxiety and depression. You can self-refer visiting the website:

NHS talking therapies for anxiety and depression - NHS (www.nhs.uk)

If you have any questions about the research and wish to discuss them with the researchers, please use:

Principal Researcher

Elena Molina

Trainee Clinical Psychologist

AL10 9AB

Email: em22acc@herts.ac.uk

Tel: 07842726941

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Dr. Abigail Taiwo

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Second Supervisor

Dr. Ben Grey

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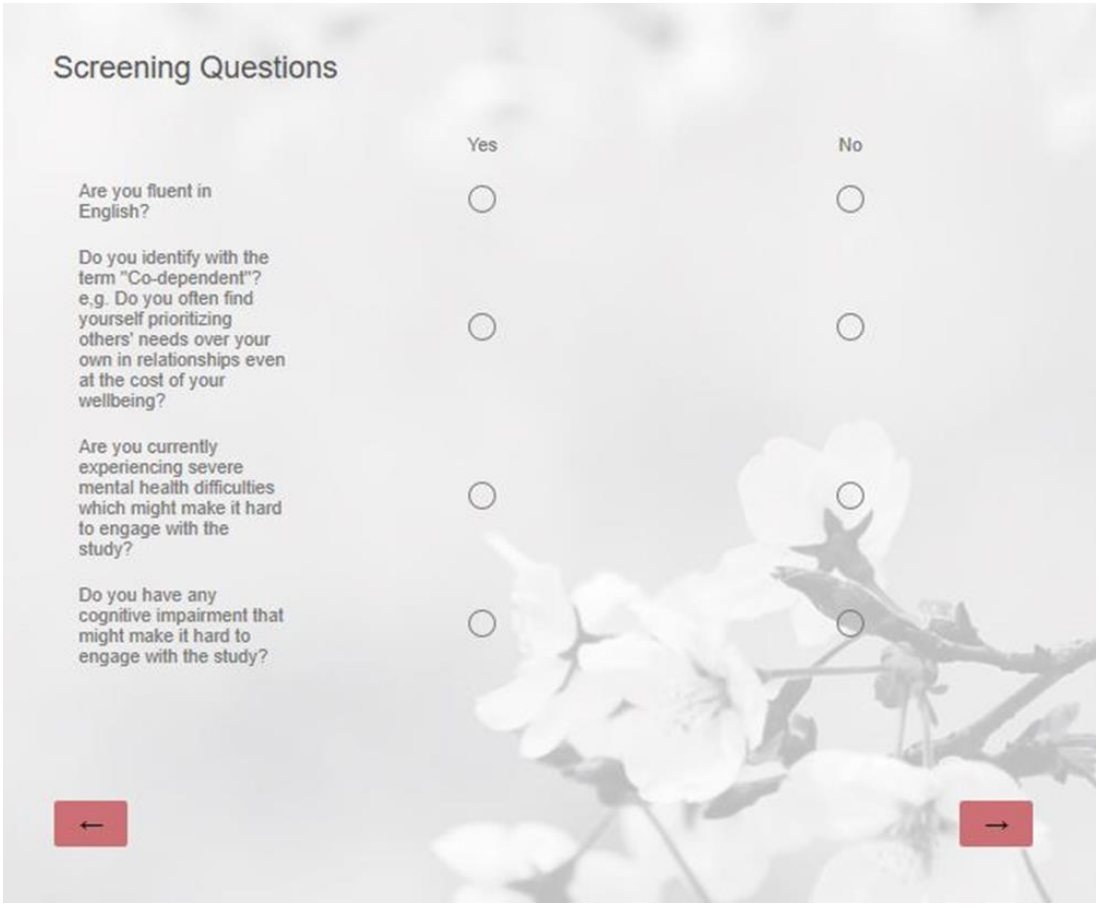
Appendix L

Online Screening



Appendix M

Psychological Scales

Friel Co-Dependency Assessment Inventory (Friel, 1985)

Below are a number of True / False statements dealing with how you feel about yourself, your life and those around you. As your mark True or False for each question, be sure to answer honestly, but do not spend too much time dwelling on any one question. There are no right or wrong answers. Take each question as it comes and answer as you usually feel.

1. I make enough time to do things for myself every week.
2. I spend lots of time criticizing myself after an interaction with someone.
3. I would not be embarrassed if people knew certain things about me.
4. Sometimes I feel like I just waste a lot of time and don't get anywhere.
5. I take good enough care of myself.
6. It is usually best not to tell someone they bother you; it only causes fights and gets everyone upset.
7. I am happy about the way my family communicated when I was growing up.
8. Sometimes I don’t know how I really feel.
9. I am very satisfied with my intimate love life.
10. I’ve been feeling tired lately.
11. When I was growing up, my family liked to talk openly about problems.
12. I often look happy when I am sad or angry.
13. I am satisfied with the number and kind of relationships I have in my life.
14. Even if I had the time and money to do it, I would feel uncomfortable taking a vacation by myself.
15. I have enough help with everything that I must do every day.
16. I with that I could accomplish a lot more than I do now.
17. My family taught me to express feelings and affection openly when I was growing up.
18. It is hard for me to talk to someone in authority (boss, teachers, etc.).
19. When I am in a relationship that becomes too confusing and complicated, I have no trouble getting out of it.
20. I sometimes feel pretty confused about who I am and where I want to go with my life.
21. I am satisfied with the way I take care of my own needs.

22. I am not satisfied with my career.

23. I usually handle my problems calmly and directly.

24. I hold back my feelings much of the time because I don't want to hurt other people or have them think less of me.

25. I don't feel like I'm "in a rut" very often.

26. I am not satisfied with my friendships.

27. When someone hurts my feelings or does something I don't like, I have little difficulty telling them about it.

28. When a close friend or relative asks for my help more than I'd like, I usually say "yes" anyway.

29. I love to face new problems and am good at finding solutions for them.

30. I do not feel good about my childhood.

31. I am not concerned about my health a lot.

32. I often feel like no one really knows me.

33. I feel calm and peaceful most of the time.

34. I find it difficult to ask for what I want.

35. I don't let people take advantage of me.

36. I am dissatisfied with at least one of my close relationships.

37. I make major decisions quite easily.

38. I don't trust myself in new situations as much as I'd like.

39. I am very good at knowing when to speak up and when to go along with others' wishes.

40. I wish I had more time away from my work.

41. I am as spontaneous as I'd like to be.

42. Being alone is a problem for me.

43. When someone I love is bothering me, I have no problem telling them so.

44. I often have so many things going on at once that I'm really not doing justice to any one of them.

45. I am very comfortable letting others into my life and letting them see the "real me".

46. I apologize to others too much for what I say or do.

47. I have no problem telling people when I am angry with them.

48. There's so much to do and not enough time.

49. I have few regrets about what I have done with my life.

50. I tend to think of others more than I do of myself.

51. More often than not, my life has gone the way I wanted it to.

52. People admire me because I'm so understanding of others, even when they do something that annoys me.

53. I am comfortable with my own sexuality.

54. I sometimes feel embarrassed by the behavior of those close to me.

55. The important people in my life know the "real me" and I am okay with them knowing.

56. I do my share of work and often do a bit more.

57. I do not feel that everything would fall apart without my efforts and attention.

58. I do too much for other people and then later wonder why I did so.

59. I am happy about the way my family coped with problems when I was growing up.

60. I wish that I had more people to do things with.

Give yourself one point for the number of "False" answers to the odd-numbered questions and one point for the number of "True" answers to the even-numbered questions to get your score.

Scoring Thresholds:

0–9: Little or no concern

10–20: Mild co-dependency

21–30: Mild-to-moderate co-dependency

31–45: Moderate-to-severe co-dependency

46+: Severe co-dependency

16-Item Individualism and Collectivism Scale (Triandis and Gelfand, 1998)

The items should be mixed up prior to administering the questionnaire.All items are answered on a 9-point scale, ranging from 1= never or definitely no and 9 = always or definitely yes.

Horizontal individualism items:

1. I'd rather depend on myself than others.

2. I rely on myself most of the time; I rarely rely on others.

3. I often do "my own thing."

4. My personal identity, independent of others, is very important to me.

Vertical individualism items:

1. It is important that I do my job better than others.

2. Winning is everything.

3. Competition is the law of nature.

4. When another person does better than I do, I get tense and aroused.

Horizontal collectivism items:

1. If a coworker gets a prize, I would feel proud.

2. The well-being of my coworkers is important to me.

3. To me, pleasure is spending time with others.

4. I feel good when I cooperate with others.

Vertical collectivism items:

1. Parents and children must stay together as much as possible.

2. It is my duty to take care of my family, even when 1 have to sacrifice what I want.

3. Family members should stick together, no matter what sacrifices are required.

4. It is important to me that I respect the decisions made by my groups.

Scoring:

Each dimension's items are summed up separately to create a VC, VI, HC, and HI score.

The Short Warwick–Edinburgh Mental Well-being Scale (Stewart-Brown et al., 2009)

Below are some statements about feelings and thoughts. Please tick the box that best describes your experience of each over the last 2 weeks

1 = None of the time / 2 = Rarely / 3= Some of the time/ 4 = Often / 5= All of the time

1. I've been feeling optimistic about the future

2. I've been feeling useful

3. I've been feeling relaxed

4. I've been dealing with problems well

5. I've been thinking clearly

6. I've been feeling close to other people

7. I've been able to make up my own mind about things

The total scores need to be added then converted using a conversion table.

Revised Adult Attachment Scale (Collins, 1996)

Please read each of the following statements and rate the extent to which it describes your feelings about romantic relationships. Please think about all your relationships (past and present) and respond in terms of how you generally feel in these relationships. If you have never been involved in a romantic relationship, answer in terms of how you think you would feel. Please use the scale below by placing a number between 1 and 5 in the space provided to the right of each statement.

1----------2----------3----------4----------5

Not at all characteristic of me — Very characteristic of me

1) I find it relatively easy to get close to people.

2) I find it difficult to allow myself to depend on others.

3) I often worry that romantic partners don't really love me.

4) I find that others are reluctant to get as close as I would like.

5) I am comfortable depending on others.

6) I don't worry about people getting too close to me.

7) I find that people are never there when you need them.

8) I am somewhat uncomfortable being close to others.

9) I often worry that romantic partners won't want to stay with me.

10) When I show my feelings for others, I'm afraid they will not feel the same about me

11) I often wonder whether romantic partners really care about me.

12) I am comfortable developing close relationships with others.

13) I am uncomfortable when anyone gets too emotionally close to me.

14) I know that people will be there when I need them.

15) I want to get close to people, but I worry about being hurt.

16) I find it difficult to trust others completely.

17) Romantic partners often want me to be emotionally closer than I feel comfortable being.

18) I am not sure that I can always depend on people to be there when I need them.

If you would like to compute only two attachment dimensions – attachment anxiety (model of self) and attachment avoidance (model of other) – you can use the following scoring procedure:

Scale	Items
ANXIETY	2* 4 5 10 11 12
AVOID	1* 3 6* 7* 8 9 13* 14* 15 16 17 18

* Items with an asterisk should be reverse scored before computing the subscale mean.

Appendix N

Interview Protocol

Modified Adult Attachment Interview

I = Imaged memory probe

S = Semantic memory probe

E = Episodic memory probe

R = Reflective probe

H = Request for history of other attachment figures

Part I - Orientation to the speaker's childhood family

R Before we begin, could you orient me to your childhood family? For example, where you were born, who was in your family, where you lived, what your parents did for a living, and whether you moved around much - things like that. I just want to know something about your family before we start.

H Did you know your grandparents when you were a child?

a. *Ask a bit about the relationship with each and frequency of contact. Assess specifically whether any were attachment figures for the speaker (and should, therefore, be included in the questions about 3 descriptive words and corresponding episodes.)*

b*. If they were not known personally, ask what the parents said about their parents.*

H Were there any other people to whom you were close when you were young?

(Explore whether there were any other attachment figures - about whom the three descriptive words and corresponding episodes should be obtained.)

What is the earliest memory that you have as a child? Tell me as much as you can remember about it.

Follow-up with questions about:

a*. the sensory aspects of the memory;*

b. *whether anything "happens", i.e., whether it is an image or an episode;*

c. *how old the speaker was at the time;*

d. *why the speaker thinks he/she has this memory.*

Part II: The relationships with attachment figures

R I'd like you to describe your relationship with your mother (or attachment figure #1), as far back as you can remember.

S Now, I'd like you to choose three words or phrases to describe your relationship with your mother when you were young. This may take a bit of time, so go ahead and think for a moment. I'll write them down as you're talking.

If adolescence or the present is the speaker's frame of reference, encourage them to think about early childhood. Assure them that adolescence and the present will be discussed later.

Okay, let me check, I wrote down [list the words or phrases], is that correct?

E *For each word or descriptive phrase, in the exact order in which they were given, the interviewer asks*:

You said that relationship with your mother was _____. Can you tell me about a specific occasion when your relationship was _____? Try to think back as far as you can.

If the speaker does not provide an episode, clarify and ask again. If the do not conclude the episode, especially if protection or comfort were needed, ask how it ended (without specific reference to protection or comfort). If they have drifted from the topic, take them back to the moment when the story broke off and ask what happened after that.

R Could you now describe your relationship with your father (or attachment figure **#2),** going as far back as you can remember.

S Now, I'd like you to choose three words or phrases that describe your relationship with your father when you were young.

E You said that relationship with your father was _____. Can you give me a memory of a specific occasion when your relationship was _____? Try to think back as far as you can.

If the speaker does not provide an episode, clarify and ask again. If the do not conclude the episode, especially if protection or comfort were needed, ask how it ended (without specific reference to protection or comfort). If they have drifted from the topic, take them back to the moment when the story broke off and ask what happened after that.

R To which parent did you feel closest as a child?

Ask these as separate questions.

Why do you think you felt closer to _____?

Why isn't there this feeling with _____ (the other parent)?

Part III: Direct probes of normative events in which children often feel unsafe

The next set of questions is about some common experiences that children have. For these questions, be sure that the examples include both parents, but it is not necessary to have an example for each parent for each answer. So if one parent is consistently omitted, e.g., the father, ask specifically about him two or three times.

Always ask the general (semantic) question first and then the episodic question. Ask about the speaker's age at the time, but only after the episode is complete and only if it is unclear.

E What happened when you went to bed as a child?

Can you remember any specific time when you were in bed?

Be sure to explore any memories of fear, nightmares, sleeping with parents, etc. that the speaker introduces.

S For example, what happened when you were ill as a child?

E *Can you remember a specific instance?*

S What about when you were hurt physically, what would you do?

E *Can you remember a specific instance?*

S When you were upset emotionally, what would you do?

E *Can you remember a specific instance?*

S If you needed comfort, what would you do?

E *Can you remember an instance?*

S Can you recall how your parents would touch you, either gently as in a caress or harder as in punishment?

E *Can you remember a specific time and how that felt?*

Probe for specific images of tactile, physical touch.

E Can you tell me about the first time you remember being separated from your parents?

Some speakers ask what constitutes a separation. Tell them that it is whenever they felt separated.

E How did you respond? *Probe if the response does not include both feelings and actions.*

E How do you think your parents felt? *Ask what they did as well.*

S When you were young, did you ever feel rejected by your parents - even though they might not have meant it or have been aware of it?

E Can you remember an instance? *Be sure to get the age.*

R Why do you think your parents did this (or these things)?

R Do you think they realized that you felt rejected?

E Can you think of a time when your parents were angry with you? What happened?

Seek both temporal order (initiating events and consequences) and also feelings.

E Can you think of a time when you were angry with your parents? What happened?

Seek both temporal order (initiating events and consequences) and also feelings.

S What happened when your parents were angry with each other?

E Can you tell me about a time when your parents were angry with each other?

Part IV: Direct probes of potentially dangerous experiences

In the next set of questions, I'll ask about some very difficult experiences that you might have had as a child. First, I'll just ask about the list and you can answer yes or no. Then, if some of these happened, I'll ask you to tell me about them.

U Did your parents ever threaten you, for example, for discipline or even jokingly?

Be certain to include actions and not mere threats that resulted in no action.

Did they ever threaten to leave you?

Do you have any memories of frightening punishment or abuse?

What about periods of silence when people in your family wouldn't speak to each other for a long time?

Did you ever feel very frightened or not sure that you were safe?

Do you think that you may have been abused physically?, sexually?, or neglected?

For example, was there ever a time when there was nobody to take care of you?

Follow-up questions: Choose which incidents to query specifically about. Choose those that 1) reflect serious danger, 2) have not been addressed earlier, and 3) fit within the time constraints of the interview.

EU Tell me what happened.

If it is not mentioned spontaneously, probe for temporal order, imaged context, and the speaker's feelings during the event.

The following questions refer only to threats that could be considered serious enough to elicit traumatic psychological responses. If they are used, they should be handled cautiously such that an unwilling speaker is not pushed too far or a too-willing speaker is not encouraged to lose emotional control. Omit these questions if there were no substantial threats.

Do you worry about something like this occurring again? Under what sort of conditions?

Explore whether the speaker thinks this could happen again:

a. following certain events

b. in certain contexts (places, images, feeling states)

c. is limited to anniversaries.

How likely do you think it is that this could happen again?

What would you do to try to recover if it happened again?

U Has this event changed your relationships with other family members?

Ask these questions one at a time.

In what way?

R Why do you think this has happened?

R Can you think of anything good that has come from this experience?

Part V: Loss

The next section is about people who might have died during your lifetime. Can you tell me of anyone who died when you were a child?

Get the names (relationship, e.g., grandmother) and age of the speaker.

What about as an adult?

Again, get names and age of the speaker at the time of the death.

When you have the full list, select the ones to ask about, keeping in mind the importance of the person as an attachment figure in mind, the relation of the death to other disruptions in the history, and the time constraints of the interview. Always include the parents, siblings, and the speaker's spouse or children.

U *For the deaths that you select to query about, ask the questions one at a time, in the clusters below. Don't ask questions that are answered spontaneously.*

a. Can you tell me the circumstances and how old you were?

If the person was present at the death or funeral, ask for a description of what happened and how they felt.

Were you present during the death? What happened?

If not, how did you find out about it?

Did you go to the funeral? What was that like for you?

b. How did you respond at the time?

c. Did you have any warning the death would occur?

If yes, ask for details.

d. Were there any long-term consequences for you? Have your feelings regarding this death changed much over time? *If yes, ask how.*

e. How did it affect other members of your family?

g. Has this event changed your relationships with other family members?

In what way?

h. Why do you think it has turned out that way?

U Do you worry about people dying? Do you worry or think about your own death?

Under what sort of conditions?

Some people think of taking their own lives. Have you ever thought of that? *(If yes, ask follow up questions.)*

Part VI: Integrative questions regarding childhood in general

These integrative questions are very important. Be sure to probe if the answers are very narrow or superficial.

R Looking back on it now, do you think your parents loved you? Can you tell me how you know this?

R Taken as a whole, how do you think your childhood experiences have affected your adult personality? How have they affected your co-dependency?

R Are there any aspects of your childhood that you think were a setback or hindered your development?

R Why do you think that your parents acted as they did, during your childhood?

S Has your relationship with your parents changed since you have gotten older? In what way?

Was it any different in adolescence?

This question is especially important for some mixed and compulsive or obsessive classifications.

E Can you give me an example?

S How is your relationship with your parents now?

R How do you think your childhood experiences prepared you for romantic love relationships? For example, did they affect whether you chose to marry, how you chose your wife (husband/partner), or how you manage your adult love relationships? Again, we might be thinking about co-dependency here.

Be prepared to break this question into smaller components.

H *Thinking about your life now, do you have a partner? Children?*

Part VII: Closing integrative questions

R Thinking over all that you have told me, what do you think you have learned from your experience as a child?

R. I've been asking about your relationships with your parents, as a child and up to now. Is there something more that you wish to add that is important to understand the adult you have become?

Sometimes, after this sort of interview, you might find that you continue to think about these issues after the interview. If you find yourself feeling uncomfortable or thinking about them too much, please don't hesitate to contact me. In any case, thank you very much.

Appendix O

Reliability Analysis

To assess the reliability of the scales used in this study, Cronbach's Alpha values were calculated for each scale and subscale.

The Cronbach's alpha for the Co-dependency scale was 0.70, suggesting that the scale's reliability was acceptable.

The reliability analysis for the Cultural Orientation subscales indicated potential concerns with internal consistency, as Cronbach's Alpha values were below the recommended threshold of 0.70. Specifically, Cronbach's Alpha for the Horizontal Individualism Subscale was 0.40, and 0.35 for the Vertical Individualism Subscale. Similarly, the Horizontal Collectivism Subscale had a Cronbach's Alpha of 0.38, and the Vertical Collectivism Subscale had an alpha of 0.31. Given these lower values, the Mean Inter-Item Correlation (MIIC) was calculated as a complementary measure. The MIIC for the Horizontal Individualism Subscale was 0.36, for the Vertical Individualism Subscale was 0.34, for the Horizontal Collectivism Subscale was 0.35, and for the Vertical Collectivism Subscale was 0.32. These MIIC values fall within the optimal range of 0.2 to 0.4, as recommended by Briggs and Cheek (1986), suggesting moderate internal consistency among the items within each subscale. Although the Cronbach's Alpha values indicate potential limitations in reliability, the MIIC results provide some evidence of coherence among the items. The implications of these findings and their potential impact on the study's conclusions will be further addressed in the limitations section.

The Mental Wellbeing scale had a Cronbach's Alpha of 0.51. While a Cronbach's Alpha value higher than 0.70 is generally considered satisfactory, it is important to note that the Mental Wellbeing questionnaire contains fewer than 20 items. In such cases, a Cronbach's Alpha value of 0.50 can be deemed satisfactory (Dall'Oglio et al., 2010). Furthermore, Field (2009) suggested that an Alpha level of 0.5 can be accepted, especially in

psychological research. Therefore, despite the lower Alpha value, the reliability of this scale is considered acceptable within the context of this study.

The Anxiety subscale had a Cronbach's Alpha of 0.53, indicating moderate internal consistency. However, the Cronbach's Alpha for the Avoidance subscale was lower at 0.41, suggesting less reliable internal consistency. The Mean Inter-Item Correlation (MIIC) for the Avoidance subscale was found to be 0.06, indicating weak correlations between items. The relatively low Cronbach's Alpha and MIIC for the Avoidance subscale suggest potential issues with the internal consistency and reliability of the subscale. These issues will be further explored in the discussion section.

APPENDIX P

Correlation Matrix

Table P1

Correlation Matrix of Co-dependency and Related Variables

	1	2	3	4	5	6	7	8	9
1.AVOIDANCE	_								
2.ANXIETY	.27**	_							
3.CO-DEPENDENCY	.33**	.27**	_						
4.MW	-.15**	.11	-.24**	_					
5.HI	.10	.22**	.24**	.16**	_				
6.VI	-.01	.12*	-.06	.20**	.08	_			
7.HC	-.11*	.17*	.09	.37**	.32**	.01	_		
8.VC	-.08	.12*	-.02	.29**	.12*	.21**	.25**	_	
9. GENDER (Binary)	.01	-.01	.17**	-.05	.16**	-.09	.11*	-.04	_

Note. MW = Mental Wellbeing; HI = Horizontal Individualism; VI = Vertical Individualism; HC = Horizontal Collectivism; VC = Vertical Collectivism. $p < .001$ = **; $p < .05$. Gender was coded as 0 = Male, 1 = Female. N = 328 for all variables except Gender (N = 323).

The table illustrates the correlations among co-dependency and the other constructs. Co-dependency showed significant positive correlations with attachment avoidance ($r = .33$, $p < .001$) and anxiety ($r = .27$, $p < .001$), indicating that higher levels of avoidance and anxiety are associated with greater co-dependency. Co-dependency was also positively associated with HI ($r = .24$, $p < .001$), suggesting that individuals who value equality and independence may be more prone to co-dependent behaviours. A small negative correlation was observed between co-dependency and MW ($r = –.25$, $p < .001$), indicating that individuals with higher co-dependency tend to report poorer wellbeing.

Mental wellbeing was also negatively correlated with avoidance ($r = –.15$, $p = .008$), while showing significant positive correlations with HI ($r = .16$, $p = .004$), VI ($r = .20$, $p < .001$), HC ($r = .37$, $p < .001$), and VC ($r = .29$, $p < .001$). These findings suggest that both individualistic and collectivistic orientations are associated with better wellbeing, while avoidant attachment relates to poorer wellbeing.

HI was positively correlated with anxiety ($r = .23$, $p < .001$), HC ($r = .32$, $p < .001$), and VC ($r = .12$, $p = .031$), indicating modest overlaps between individualistic and collectivistic traits. Anxiety also correlated positively with VI ($r = .12$, $p = .031$), HC ($r = .17$, $p = .002$), and VC ($r = .12$, $p = .031$).

Small but significant correlations were observed between Gender and HI ($r = .16$, $p = .004$), HC ($r = .11$, $p = .050$), and co-dependency ($r = .17$, $p = .002$), suggesting subtle gender differences across these constructs. All other correlations were non-significan, indicating no meaningful associations among those variable pairs.

APPENDIX Q

Analysis 1 Assumptions Checks

Table Q1

Multicollinearity check

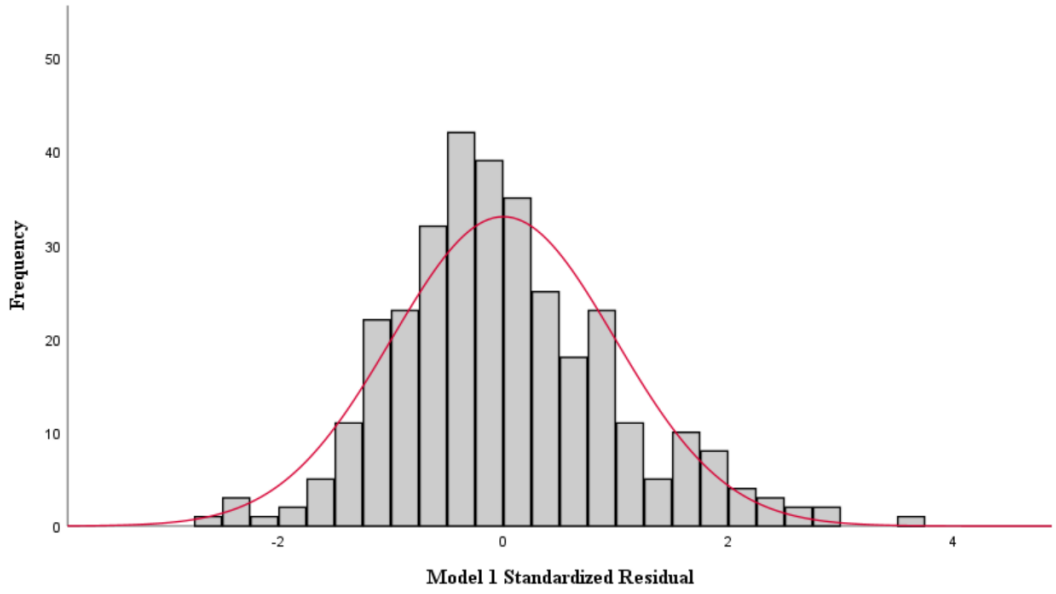
Multicollinearity Statistics for Predictors in the First Regression Model [a]

Model		Tolerance	VIF
1	AVOIDANCE	.88	1.13
	ANXIETY	.85	1.18
	HI	.86	1.17
	VI	.94	1.06
	HC	.82	1.22
	VC	.89	1.13

a. Note.VIF = Variance Inflation Factor.

Figure Q1

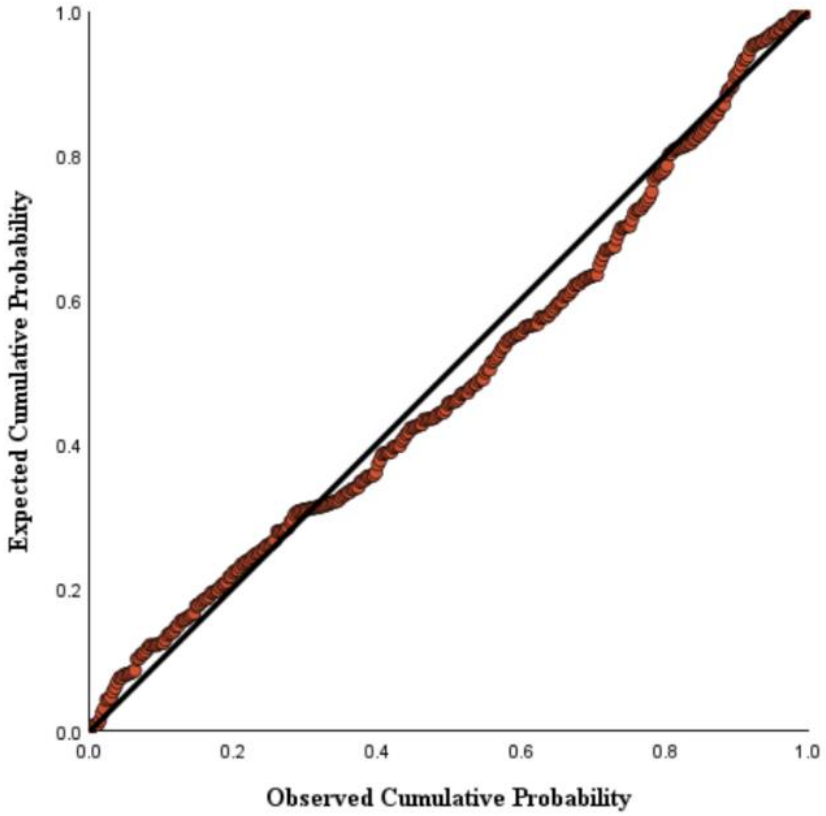
Histogram of Model 1 Standardized Residuals.



Note: The histogram shows the distribution of standardized residuals with a normal curve overlay, indicating that the assumption of normality of residuals is approximately met.

Figure Q2

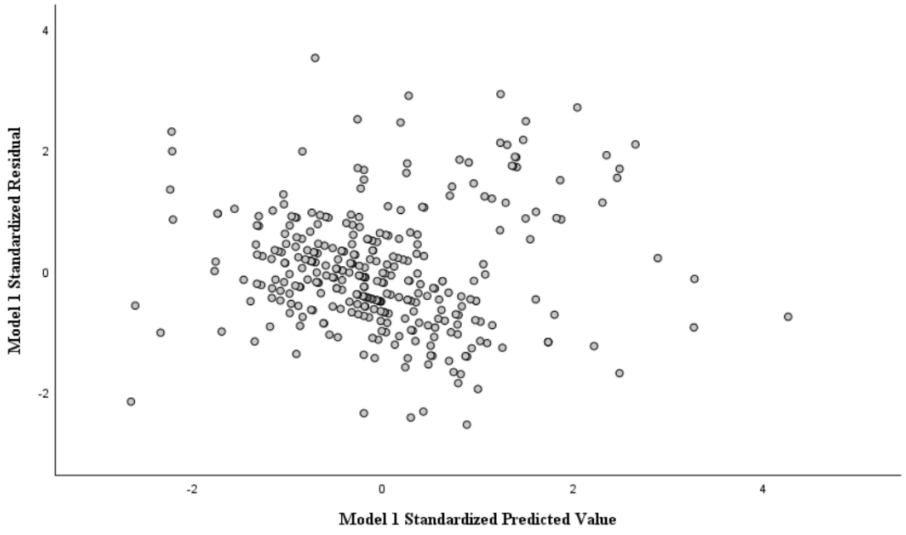
Model 1 Normal P-P Plot of Regression Standardized Residuals.



Note: The plot shows that the observed cumulative probabilities (red points) align closely with the expected cumulative probabilities (black diagonal line), suggesting that the residuals are approximately normally distributed.

Figure Q3

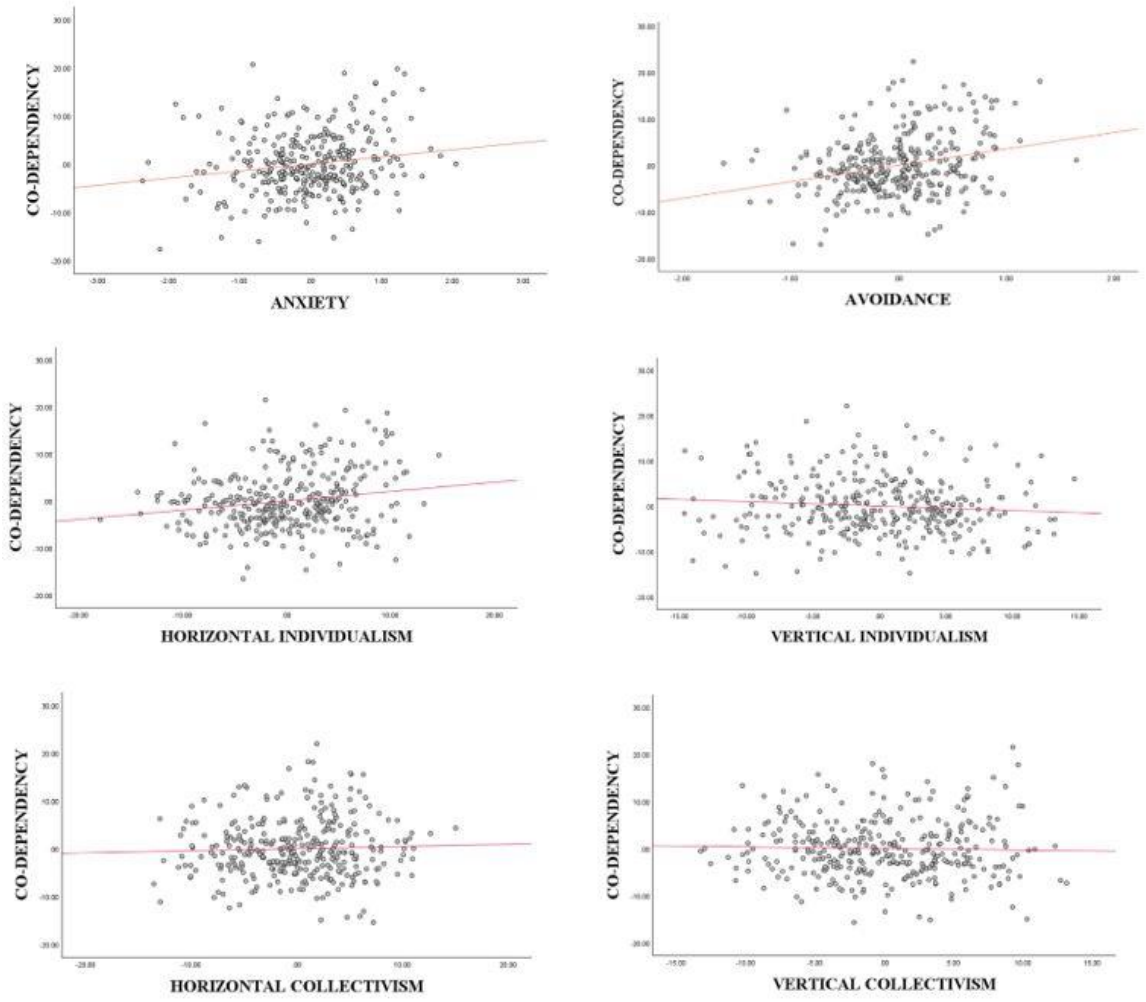
Model 1 Scatterplot of Regression Standardized Residuals vs. Predicted Values



Note: The scatterplot shows the distribution of residuals around the regression line, indicating that the assumption of homoscedasticity is met, as there is no clear pattern in the spread of residuals.

Figure Q4

Partial Regression Plots with Regression Lines for Predictors of Co-Dependency.



Note: Each plot displays the relationship between a predictor (e.g., Anxiety, Avoidance, Individualism, Collectivism) and Co-dependency, controlling for the effects of other predictors in the model. Regression lines indicate the linear trend for each predictor.

Appendix R

Analysis 2 Assumption Checks

MODEL 1

Table Q1

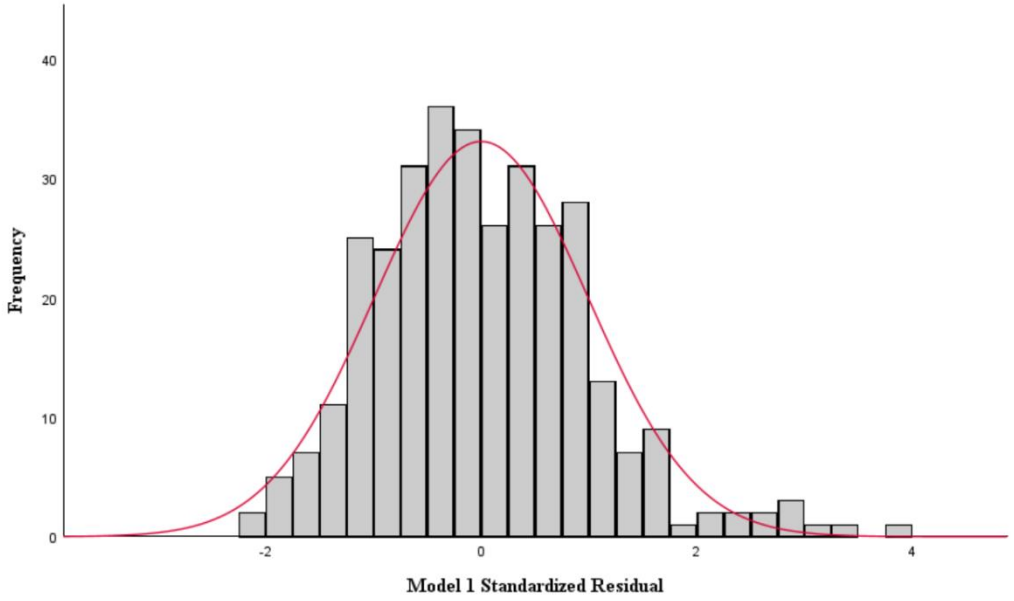
Multicollinearity Statistics for Predictors in the First Regression Model (Second Hypothesis) [b]

Model		Tolerance	VIF
1	Co-dependency	.815	1.228
	AVOIDANCE	.821	1.219
	ANXIETY	.824	1.213
	HI	.828	1.208
	VI	.931	1.074
	HC	.817	1.225
	VC	.886	1.128

[b]. *Note: VIF= Variance Inflation Factor.*

Figure R1

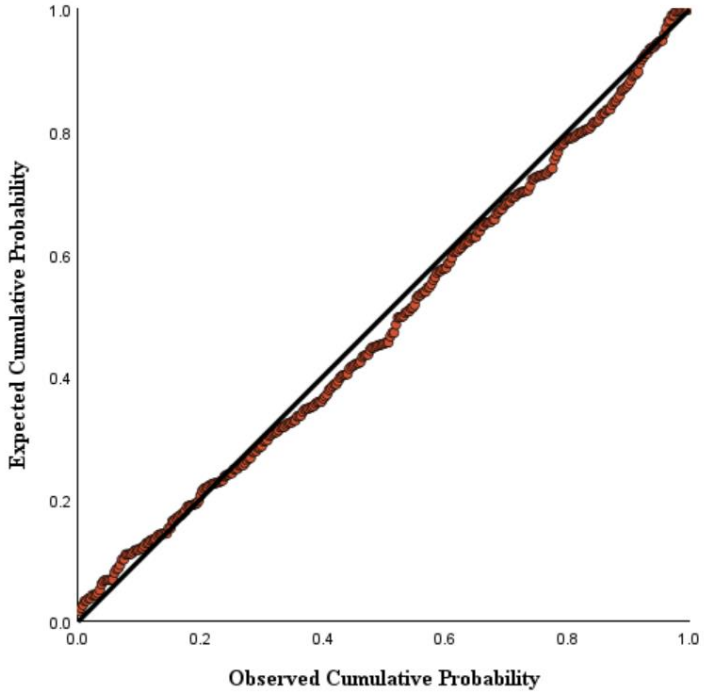
Second hypothesis - Histogram of Model 1 Standardized Residuals.



Note: The histogram shows the distribution of standardized residuals with a normal curve overlay, indicating that the assumption of normality of residuals is approximately met.

Figure R2

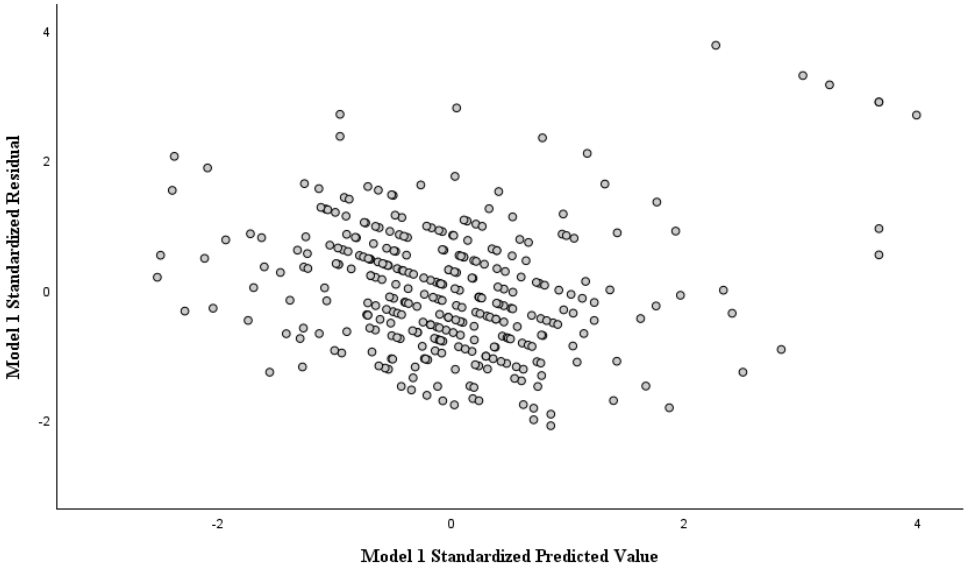
Model 1 Normal P-P Plot of Regression Standardized Residuals



Note: The plot shows that the observed cumulative probabilities (red points) align closely with the expected cumulative probabilities (black diagonal line), suggesting that the residuals are approximately normally distributed.

Figure R3

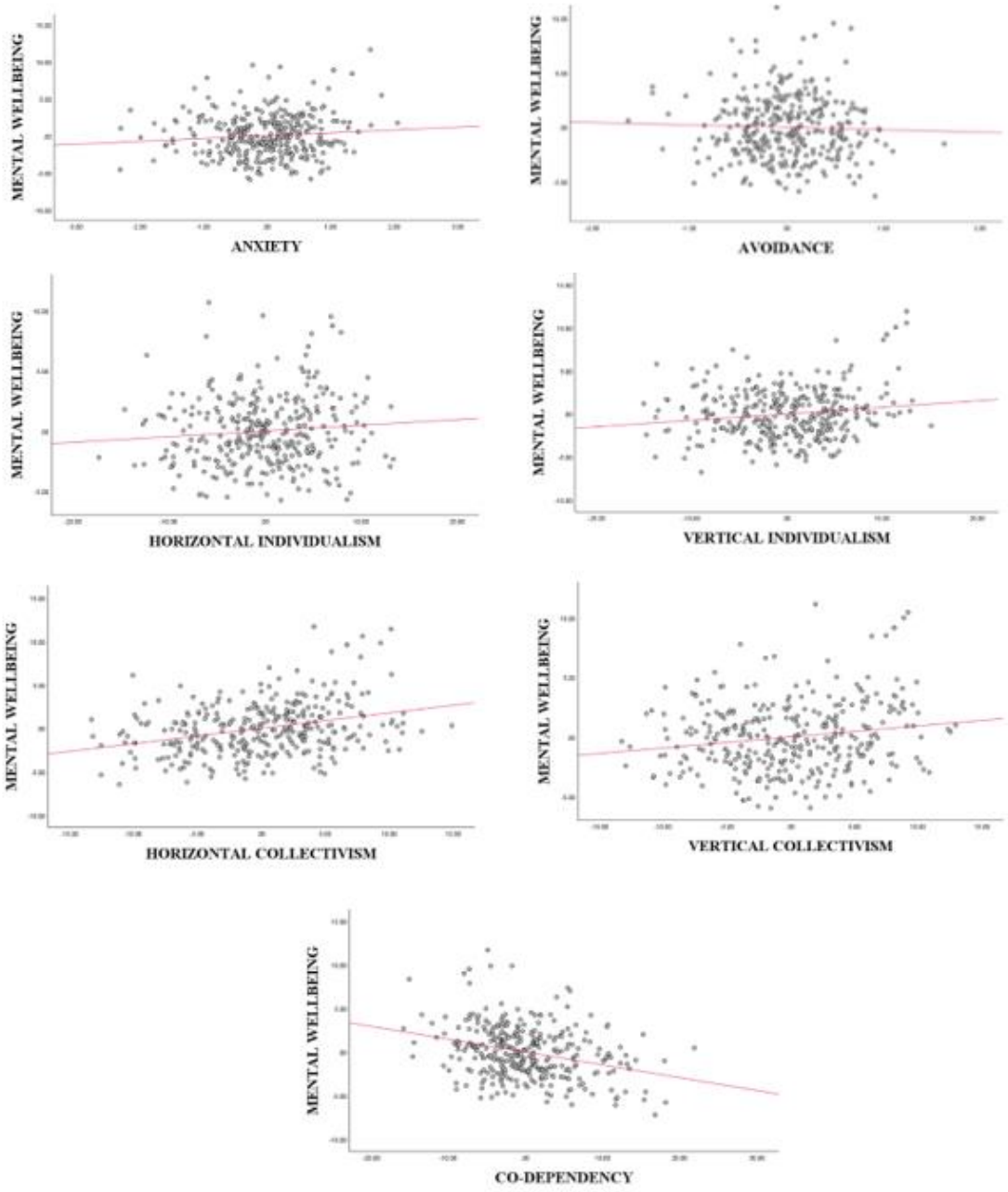
Scatterplot of Model 1 Standardized Residuals vs. Standardized Predicted Values.



Note:The scatterplot illustrates the relationship between the standardized residuals and standardized predicted values for Model 1. The random scatter around the horizontal axis suggests that the assumption of linearity is met. However, there is a slight funnel shape, indicating potential heteroscedasticity in the model residuals. This pattern suggests that the variance of the residuals may not be constant across all levels of predicted values.

Figure R4

Partial Regression Plots with Regression Lines for Predictors Of MW.



Note: Partial regression plots illustrating the relationship between each predictor (Anxiety, Avoidance, Individualism, Collectivism, Co-dependency) and Mental Well-being, controlling for other variables in the model.

MODEL 2

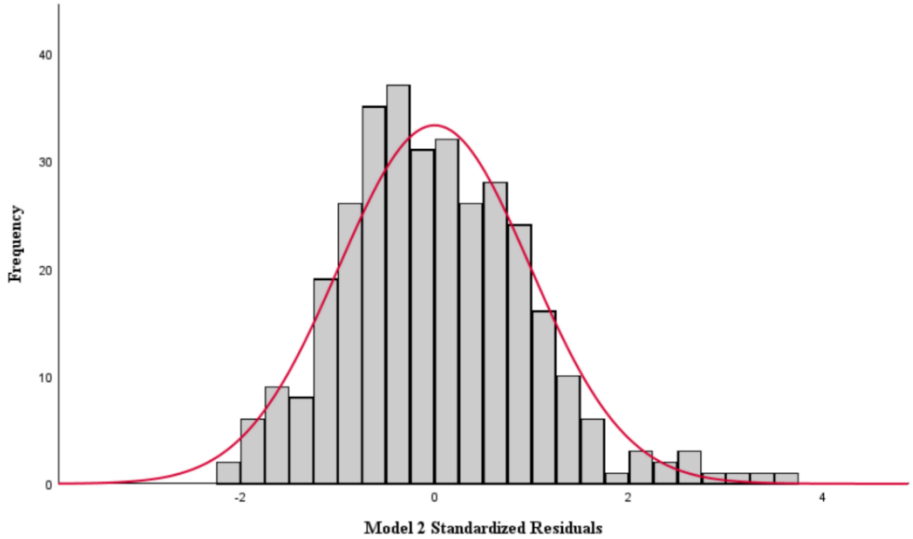
Table R2

Multicollinearity Statistics for Predictors in the Second Regression Model (Second Hypothesis)

Model		Tolerance	VIF
2	CO-DEPENDENCY	.64	1.57
	AVOIDANCE	.78	1.27
	ANXIETY	.81	1.24
	HI	.83	1.21
	VI	.91	1.10
	HC	.80	1.25
	VC	.88	1.13
	CO-DEPENDENCY*HI	.68	1.48
	CO-DEPENDENCY*HC	.72	1.39
	CO-DEPENDENCY*VI	.78	1.29
	CO-DEPENDENCY*VC	.80	1.26

Figure R5

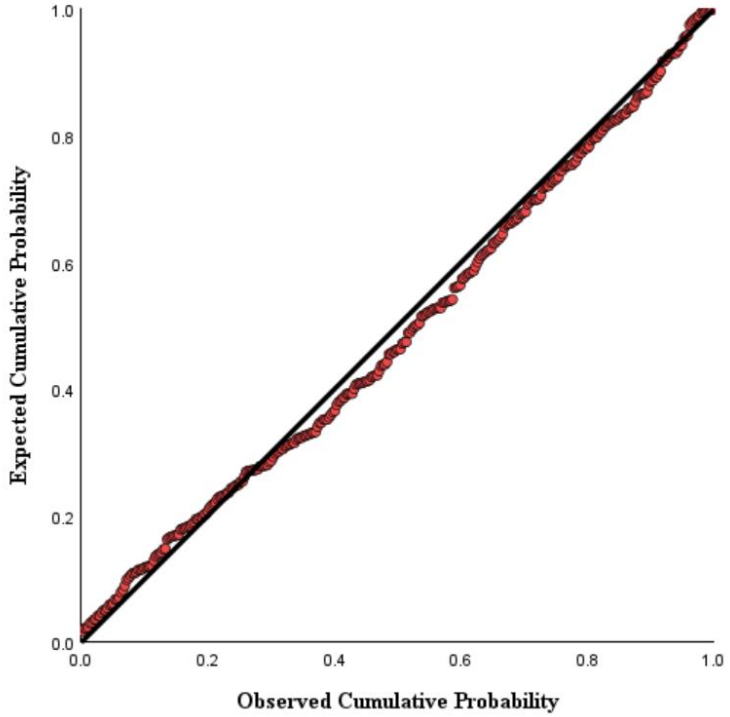
Second hypothesis - Histogram of Model 2 Standardized Residual



Note: The histogram shows the distribution of standardized residuals with a normal curve overlay, indicating that the assumption of normality of residuals is approximately met.

Figure R6

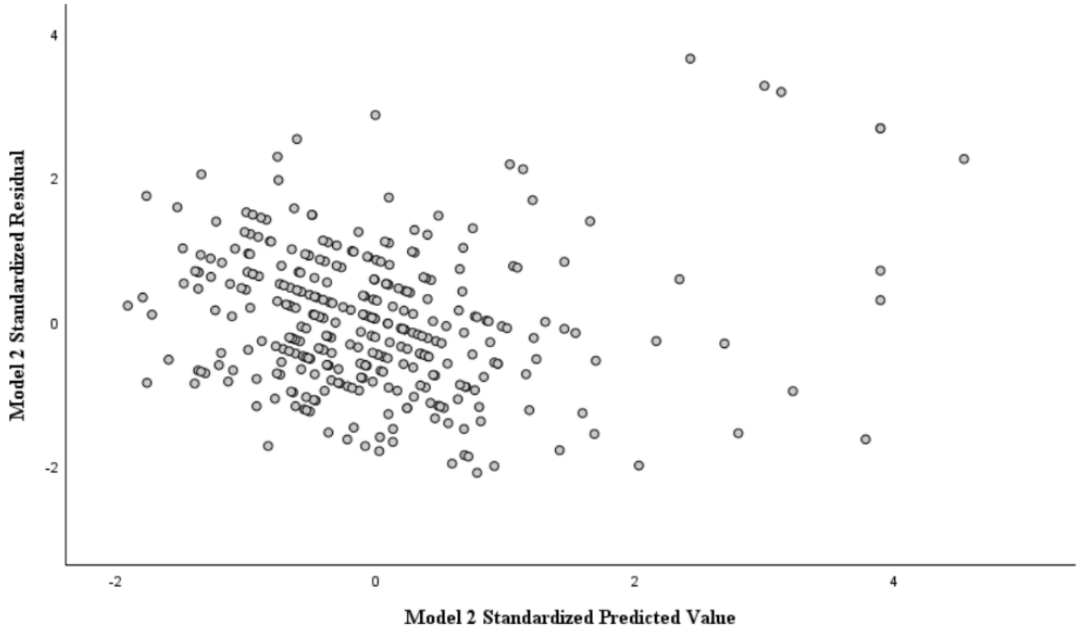
Scatterplot of Model 2 Standardized Residuals vs. Standardized Predicted Values.



Note: The scatterplot illustrates the relationship between the standardized residuals and standardized predicted values for Model 1. The random scatter around the horizontal axis suggests that the assumption of linearity is met. However, there is a slight funnel shape, indicating potential heteroscedasticity in the model residuals. This pattern suggests that the variance of the residuals may not be constant across all levels of predicted values.

Figure R7

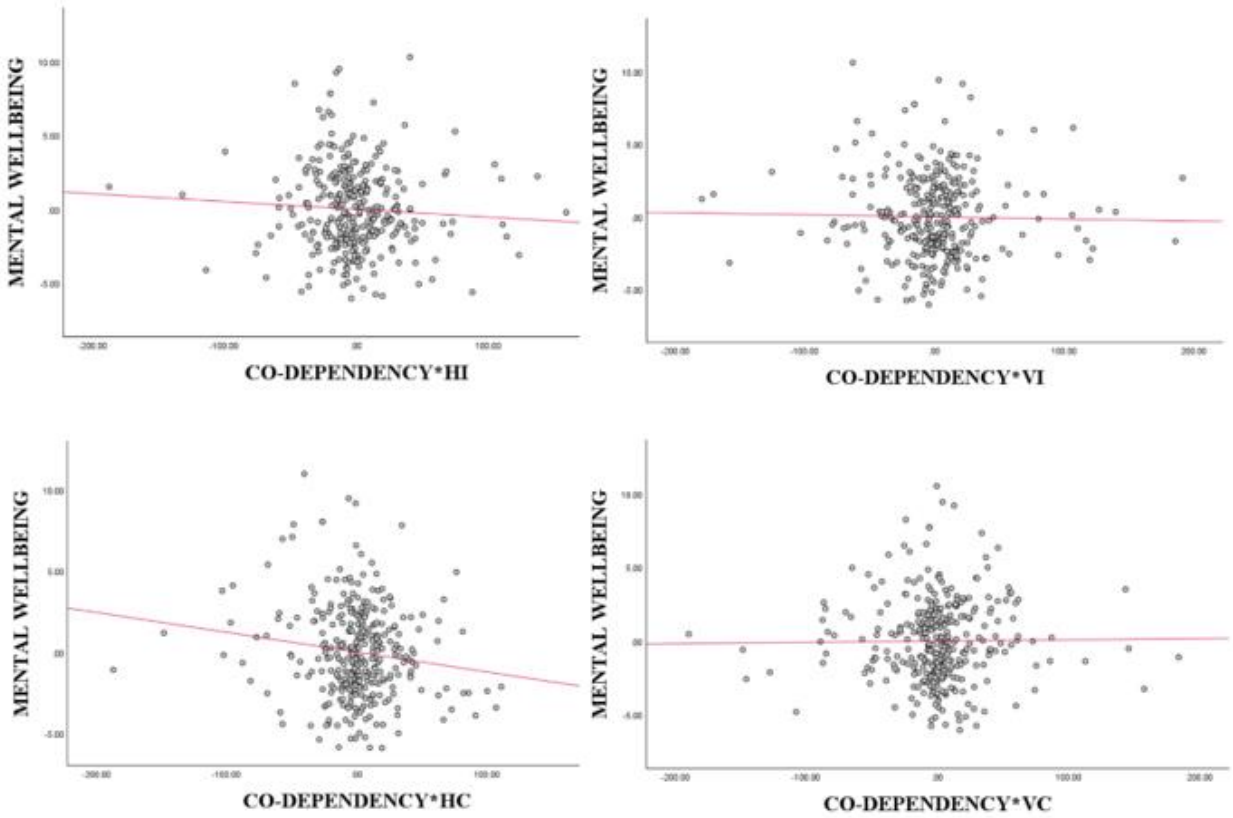
Scatterplot of Model 1 Standardized Residuals vs. Standardized Predicted Values



Note. The scatterplot illustrates the relationship between the standardized residuals and standardized predicted values for Model 1. The random scatter around the horizontal axis suggests that the assumption of linearity is met. However, there is a slight funnel shape, indicating potential heteroscedasticity in the model residuals.

Figure R8

Partial Regression Plots for Linearity Check of Interaction Terms between Co-dependency and Cultural Orientation Subscales



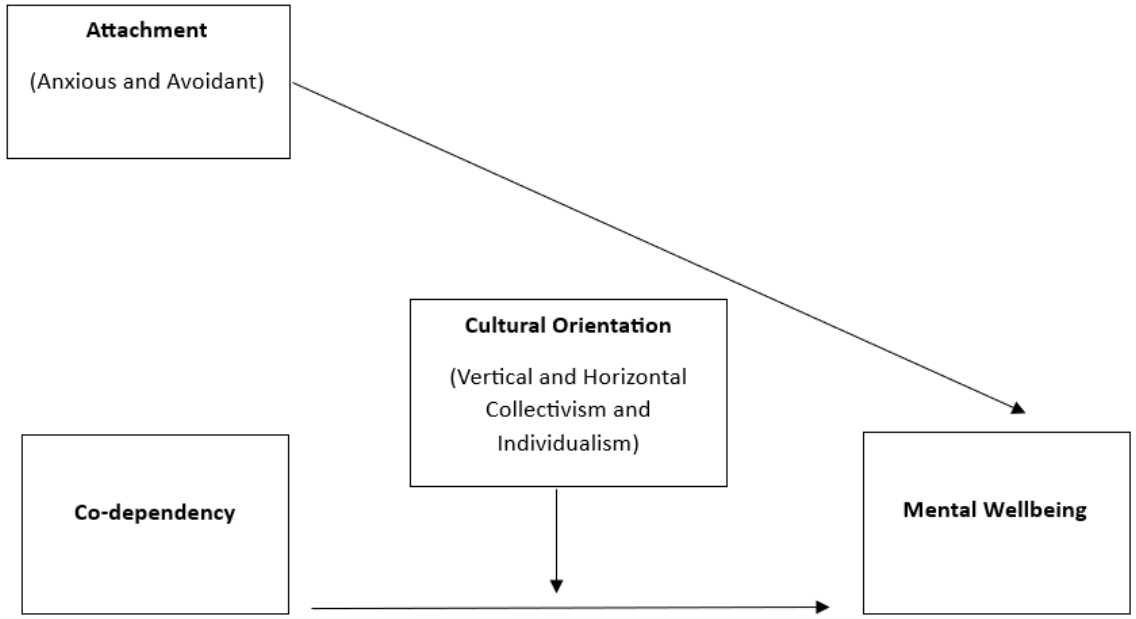
Note: These plots illustrate the linear relationship between each interaction term (Co-dependency × HI, VI, HC, VC) and mental well-being. The red regression lines indicate the slope of each interaction effect, confirming that the assumption of linearity is met for inclusion in moderation analysis.

APPENDIX S

Moderation model diagram

Figure S1

Moderation model conceptual diagram



Note: Moderation model illustrating the moderating role of Cultural Orientation (Vertical and Horizontal Collectivism and Individualism) on the relationship between Co-dependency and Mental Well-being. Attachment (Anxiety and Avoidance) has a direct impact on Mental Well-being.

Appendix T

DMM Strategies identified in the study

Table U1:

Identified DMM Strategies

DMM Classification Code	Label	Description
C4	Exaggerated helplessness	Individuals appear helpless to elicit caregiving, using passive or indirect strategies to gain attention or support.
C5	Punitive/Obsessed with revenge	Uses anger, blame, and punitive behaviours to elicit care or control others.
C6	Seductive/Obsessed with rescue	Seeks care through dramatic, often exaggerated displays of vulnerability or charm. May idealise others and use emotional intensity to secure rescue.
A4	Compulsive compliance	Focuses on being good, obedient, or pleasing to others to avoid rejection or conflict. Emotions are suppressed and the self is minimised to maintain perceived safety.
A5	Indiscriminate attachment	Uses charm, sociability, or sexual behaviour to engage others while avoiding intimacy. Relationships are superficial and used strategically to manage risk or gain validation.
A6	Compulsive self-reliance	Avoids closeness and depends only on the self. Emotions and needs are suppressed, and others are seen as unreliable or dangerous. Independence is used defensively to maintain control.
Not coded	Pseudo-A	Appears avoidant but driven by underlying emotional dependency and protest behaviours. Typically, a C strategy masked as an A, often emerging when open need expression is seen as unsafe or ineffective.

APPENDIX U

Critical Appraisal Using MMAT

Category of study designs	Methodological quality criteria	Response		
		Yes	No	Can't tell
Screening questions (for all types)	S1. Are there clear research questions?	x		
	S2. Do the collected data allow to address the research questions?	x		
	Further appraisal may not be feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.			
1. Qualitative	1.1. Is the qualitative approach appropriate to answer the research question?	x		
	1.2. Are the qualitative data collection methods adequate to address the research question?	x		
	1.3. Are the findings adequately derived from the data?	x		
	1.4. Is the interpretation of results sufficiently substantiated by data?	x		
	1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?	x		
2. Quantitative randomized controlled trials	2.1. Is randomization appropriately performed?			
	2.2. Are the groups comparable at baseline?			
	2.3. Are there complete outcome data?			
	2.4. Are outcome assessors blinded to the intervention provided?			
	2.5 Did the participants adhere to the assigned intervention?			
3. Quantitative non-randomized	3.1. Are the participants representative of the target population?	x		
	3.2. Are measurements appropriate regarding both the outcome and intervention (or exposure)?	x		
	3.3. Are there complete outcome data?	x		
	3.4. Are the confounders accounted for in the design and analysis?		x	
	3.5. During the study period, is the intervention administered (or exposure occurred) as intended?	x		
4. Quantitative descriptive	4.1. Is the sampling strategy relevant to address the research question?			
	4.2. Is the sample representative of the target population?			
	4.3. Are the measurements appropriate?			
	4.4. Is the risk of nonresponse bias low?			
	4.5. Is the statistical analysis appropriate to answer the research question?			
5. Mixed methods	5.1. Is there an adequate rationale for using a mixed methods design to address the research question?	x		
	5.2. Are the different components of the study effectively integrated to answer the research question?	x		
	5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?	x		
	5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?	x		
	5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?	x		

APPENDIX V

Tool for Evaluating Thematic Analysis Manuscripts for Publication

These questions are designed to be used either independently, or alongside our methodological writing on TA, and especially the current paper, if further clarification is needed.

Adequate choice and explanation of methods and methodology

1. Do the authors explain why they are using TA, even if only briefly?
2. Do the authors clearly specify and justify which *type* of TA they are using?
3. Is the use and justification of the specific type of TA consistent with the research questions or aims?
4. Is there a good 'fit' between the theoretical and conceptual underpinnings of the research and the specific type of TA (i.e. is there conceptual coherence)?
5. Is there a good 'fit' between the methods of data collection and the specific type of TA?
6. Is the specified type of TA consistently enacted throughout the paper?
7. Is there evidence of problematic assumptions about, and practices around, TA? These commonly include:
   - Treating TA as one, homogenous, entity, with one set of – widely agreed on – procedures.
   - Combining philosophically and procedurally incompatible approaches to TA without any acknowledgement or explanation.
   - Confusing summaries of data topics with thematic patterns of shared meaning, underpinned by a core concept.
   - Assuming grounded theory concepts and procedures (e.g. saturation, constant comparative analysis, line-by-line coding) apply to TA without any explanation or justification.
   - Assuming TA is essentialist or realist, or atheoretical.
   - Assuming TA is only a data reduction or descriptive approach and therefore must be supplemented with other methods and procedures to achieve other ends.
8. Are any supplementary procedures or methods justified, and necessary, or could the same results have been achieved simply by using TA more effectively?
9. Are the theoretical underpinnings of the use of TA clearly specified (e.g. ontological, epistemological assumptions, guiding theoretical framework(s)), even when using TA inductively (inductive TA does not equate to analysis in a theoretical vacuum)?
10. Do the researchers strive to 'own their perspectives' (even if only very briefly), their personal and social standpoint and positioning? (This is especially important when the researchers are engaged in social justice-oriented research and when representing the 'voices' of marginal and vulnerable groups, and groups to which the researcher does not belong.)
11. Are the analytic procedures used clearly outlined, and described in terms of what the authors actually did, rather than generic procedures?
12. Is there evidence of conceptual and procedural confusion? For example, reflexive TA (e.g. Braun and Clarke 2006) is the claimed approach but different procedures are outlined such as the use of a codebook or coding frame, multiple independent coders and consensus coding, inter-rater reliability measures, and/or themes are conceptualised as analytic inputs rather than outputs and therefore the analysis progresses from theme identification to coding (rather than coding to theme development).
13. Do the authors demonstrate full and coherent understanding of their claimed approach to TA?

A well-developed and justified analysis

14. Is it clear what and where the themes are in the report? Would the manuscript benefit from some kind of overview of the analysis: listing of themes, narrative overview, table of themes, thematic map?
15. Are the reported themes topic summaries, rather than 'fully realised themes' – patterns of shared meaning underpinned by a central organising concept?
    - If so, are topic summaries appropriate to the purpose of the research?
      - If the authors are using reflexive TA, is this modification in the conceptualisation of themes explained and justified?
    - Have the data collection questions been used as themes?
    - Would the manuscript benefit from further analysis being undertaken, with the reporting of fully realised themes?
    - Or, if the authors are claiming to use reflexive TA, would the manuscript benefit from claiming to use a different type of TA (e.g. coding reliability or codebook)?
16. Is non-thematic contextualising information presented as a theme? (e.g. the first 'theme' is a topic summary providing contextualising information, but the rest of the themes reported are fully realised themes). If so, would the manuscript benefit from this being presented as non-thematic contextualising information?
17. In applied research, do the reported themes have the potential to give rise to actionable outcomes?
18. Are there conceptual clashes and confusion in the paper? (e.g. claiming a social constructionist approach while also expressing concern for positivist notions of coding reliability, or claiming a constructionist approach while treating participants' language as a transparent reflection of their experiences and behaviours)
19. Is there evidence of weak or unconvincing analysis, such as:
    - Too many or two few themes?

    Too many theme levels?
    Confusion between codes and themes?
    Mismatch between data extracts and analytic claims?
    Too few or too many data extracts?
    Overlap between themes?
20. Do authors make problematic statements about the lack of generalisability of their results, and or implicitly conceptualise generalisability as statistical probabilistic generalisability (see Smith 2017)?