UNIVERSITI PUTRA MALAYSIA

PROCESS OF RECOVERY FROM CO-DEPENDENCY AMONG WIVES OF DRUG ADDICTS IN NAR-ANON SELF-HELP GROUPS IN IRAN

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PROCESS OF RECOVERY FROM CO-DEPENDENCY AMONG WIVES OF DRUG ADDICTS IN NAR-ANON SELF-HELP GROUPS IN IRAN

By

PARASTOO ASKIAN

Thesis Submitted to the School of Graduate Studies, Universiti Putra Malaysia, in Fulfillment of the Requirements for the Degree of Doctor of Philosophy

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Drug addiction adversely affects the addict and his/her entire family. Spouses of drug addicts are seriously affected by their partners’ addiction. Co-dependency is usually attributed to family members of addicts, especially spouses. It is often described as a condition whereby a person/s related to the drug addict is extremely focused on the addict and his/her behavior such that the family member eventually becomes dysfunctional.

In Iran, the majority of drug addicts are married men. Hence, this study focused on wives of drug addicts in Iran who were actively involved in Nar-Anon self-help groups. However, their experience in the journey to recovery from co-dependency is unclear. There is also a lack of consensual definition about the concept of co-dependency and its recovery process despite the vast use of this term in addiction counseling.

This qualitative study explored the characteristics of co-dependency among wives of drug addicts in Iran before their involvement in Nar-Anon self-help groups and provided insight into the process of their recovery through participation in Nar-Anon. This study was guided by two research questions: 1) What are the characteristics of co-dependency among wives of drug addicts before their involvement in Nar-Anon self-help groups in Iran? 2) How do the wives of drug addicts recover from co-dependency based on their experiences in Nar-Anon self-help groups in Iran?

Specifically, this study employed qualitative case study design. Based on purposive snowball sampling technique, 11 Iranian wives of drug addicts voluntarily participated. The respondents had been actively participating in Nar-Anon self-help groups and had completed working on the 12 steps of the Nar-Anon program. The data were
collected through face to face interviews, non-participation observation, and documents. The data derived from transcripts of the interviews were analyzed through constant comparative method. Field notes, and documents were used to triangulate the data.

The analyses of data derived from the first research question yielded five major themes for the characteristics of co-dependency among wives of Iranian drug addicts, namely: denial, enabling behaviors, low self-worth, enmeshed self, and weak relationship with God. The findings showed that the characteristics of co-dependency among wives of Iranian drug addicts were mostly similar to the characteristics of co-dependents in previous studies conducted outside Iran. However, the finding that "Weak relationship with God" as one of the characteristics of co-dependent wives in Iran, had rarely been reported in previous studies.

Seven interconnected themes emerged from analyses based on the second research question including: social network of Nar-Anon, raised awareness, acceptance of the reality, spiritual growth, detachment from unhealthy dependence on others, taking the responsibility of herself, and transferring the message of Nar-Anon to others. The findings indicated that recovery from co-dependency was an ongoing process which takes place gradually through regular participation in the Nar-Anon self-help program and step work. The findings of this study demonstrated the importance of a supportive and empathetic group environment in the process of recovery from co-dependency. Furthermore, the present study highlighted the importance of integrating spirituality in the process of recovery from co-dependency.

These findings of this study mainly support Whitefield's Recovery Model of Co-dependency. In terms of practical implications, this study would help addiction counselors and other mental health professionals in Iran to gain a better understanding of the characteristics of co-dependency among wives of drug addicts and to provide more effective services to family members of drug addicts.
Abstrak tesis yang dikemukakan kepada Senat Universiti Putra Malaysia sebagai memenuhi keperluan untuk ijazah Doktor Falsafah

PENGALAMAN PERGANTUNGAN-BERSAMADAN PROSES PEMULIHAN DALAM KALANGAN ISTERI PENAGIH DADAH TERLIBAT DENGAN KELOMPOK BANTU-DIRINAR-ANON DI IRAN

Oleh

PARASTOO ASKIAN

Januari 2015

Pengerusi: Maznah Bt Baba, PhD.
Fakulti: Pengajian Pendidikan

Penagihan dadah memberi kesan buruk kepada penagih dan seluruh keluarganya. Pasangan hidup penagih dadah dipengaruhi secara serius oleh penagihan pasangan mereka. Pergantungan-bersama lazimnya merujuk kepada keadaan ahli keluarga penagih, terutamanya pasangan hidup. Ia kerap diperihalkan sebagai satu keadaan di mana individu yang ada hubungan rapat dengan penagih dadah terlalu tertumpu kepada penagih tersebut dan tingkah lakunya sehingga ahli keluarga tersebut akhirnya tidak dapat berfungsi.

Di Iran, majoriti penagih dadah adalah para suami. Oleh itu, kajian ini memfokus kepada isteri penagih dadah di Iran yang terlibat secara aktif dalam kelompok bantu-diri Nar-Anon. Bagaimanapun, pengalaman mereka dalam perjalanan ke arah pemulihan dari pergantungan-bersama adalah samar. Walaupun istilah ini digunakan secara meluas dalam bidang kaunseling penagihan, terdapat kekurangan persetujuan mengenai definisi konsep pergantungan-bersamadand proses pemulihan.


Khususnya, kajian ini mengaplikasi rekabentuk kajian kes kualitatif. Berdasarkan teknik pensampelan bertujuan bola salji, 11 isteri penagih dadah Iran telah melibatkan diri secara sukarela. Para responden adalah
mereka yang aktif melibatkan diri dalam kelompok bantu-diri Nar-Anon dan telah tamat mengaplikasi 12 Langkah program Nar-Anon.

Data kajian telah diperolehi melalui temubual bersemuka, pemerhatian tanpa-penglibatan, dan dokumen. Data dari transkripsi temubual telah dianalisis menggunakan kaedah perbandingan. Nota lapangan dan dokumen digunakan untuk triangulasi.

Data yang dianalisis berdasarkan soalan kajian pertama menghasilkan lima tema utama bagi ciri-ciri pergantungan-bersama dalam kalangan isteri penagih dadah Iran, iaitu: penafian, tingkah laku membantu, rendah harga diri, peranan diri bertindih, dan hubungan yang lemah dengan Tuhan. Hasil kajian menunjukkan bahawa ciri-ciri pergantungan-bersama dalam kalangan isteri penagih dadah Iran kebanyakkan serupa dengan ciri mereka yang dianggap bergantung-bersama melalui kajian lepas di luar Iran. Bagaimanapun, dapatan bahawa “hubungan yang lemah dengan Tuhan” adalah salah satu ciri isteri yang bergantung-bersama di Iran jarang dilaporkan dalam kajian lepas.

Tujuh tema yang berangkaian didapati terhasil berdasarkan analisis soalan kajian kedua iaitu: rangkaian sosial Nar-Anon, peningkatan kesedaran, penerimaan realiti, perkembangan spiritual, pemisahan dari kebergantungan yang tidak sihat kepada orang lain, menjadi bertanggungjawab, dan menyampaikan mesej Nar-Anon kepada orang lain. Hasil kajian menunjukkan bahawa pemulihan dari pergantungan-bersama adalah suatu proses berterusan yang berlaku secara perlahan sepanjang penglibatan yang konsisten dalam kelompok bantu-diri Nar-Anon dan pengaplikasan program 12 Langkah. Hasil kajian menunjukkan kepentingan persekitaran kelompok yang menyokong dan berempati dalam proses pemulihan dari kebergantungan bersama. Tambahan pula, kajian ini menonjolkan kepentingan mengintegrasispiritualiti dalam proses pemulihan dari kebergantungan.

Kajian ini utamanya menyokong Model Pemulihan dari Pergantungan-bersama yang dikemukakan oleh Whitefield. Dari segi implikasi praktis, kajian ini akan dapat membantu kaunselor penagihan dan professional kesihatan mental yang lain untuk lebih memahami ciri pergantungan-bersama dalam kalangan isteri penagih dan menyediakan perkhidmatan yang lebih berkesan kepada ahli keluarga penagih dadah di Iran.
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I certify that a Thesis Examination Committee has met on 7 January 2015 to conduct the final examination of Parastoo Askian on her thesis entitled "Process of Recovery from Co-Dependency among Wives of Drug Addicts in Nar-Anon Self-Help Groups in Iran" in accordance with the Universities and University Colleges Act 1971 and the Constitution of the Universiti Putra Malaysia [P.U.(A) 106] 15 March 1998. The Committee recommends that the student be awarded the Doctor of Philosophy.

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CHAPTER 1
INTRODUCTION

1.1 Introduction

This chapter begins with an introduction to the background of the study including describing the drug addiction problem in general and particularly in Iran, the impact of drug addiction on families, the model of co-dependency, Family Systems Theory and recovery from co-dependency in Nar-Anon self-help groups. The problem statement, significance of study, research questions, objectives, definition of important terms and limitations of the study are also presented in this chapter.

1.2 Background of the Study

Today, drug addiction is one of the most destructive problems in many countries. Drug addiction is a serious social problem which causes devastating effects on health, criminal behavior, work productivity and economies. Furthermore, it also brings about many negative impacts on the families in terms of damaging relationships, responsibilities, or everyday performance, thus making it a problem with serious implications (Thomas & Corcoran, 2001).

This problem is also serious in Iran and is considered as the first social threat in this country (Narenjiha, Raiey, & Baghestani, 2005). Every day, around 2000 kilograms of substances are used illegally in Iran and each year approximately 120 tons of these substances are discovered by the police in this country (Hejazizade Z., 2013). Official statistics stated the rate of addiction has risen from 2 million in 1998 to 3700000 in 2005 (Razzaghi, Rahimi, Hosseini, Madani, & Chatterjee, 2008). The majority of Iranian drug addicts are men, married and employed (Narenjiha et al., 2005). So, with such a high number of addicts in the Iran community, there are many families affected by drug addiction and its related problems (Ajri, 2010).

1.2.1 The Impact of Drug Addiction on Families

Addiction is not merely an individual problem and whoever lives with an addict person or have a close relationship with him or her is seriously affected by the addiction (Rotunda, Scherer, & Imm, 1995; Rotunda, & Doman, 2001). As the family is a system consisted of members in dynamic and continuous interaction with each other, any change in the behavior of one of its members influences not only each of the other family members but
the whole family as a system. According to Gruber and Taylor (2006), Kumpfer and Johnson (2011), Moore, Biegel, and McMahon (2011), Rao and Kuruvilia (1992), Wormer (2008), and Roth and Tan (2007, 2008) addiction is a family disease, and have pervasive effects on the family functioning, marital relationship and children.

Previous studies indicated that the spouses of drug addicts are vulnerable to many physical and psychological problems such as poorer health (Homish, Leonard, & Kearns-Bodkin, 2006), more physical illnesses, such as high blood pressure, gastrointestinal problems, ulcers, and cancer (Whitfield, 1991), mood and anxiety disorders, and also victimization and injury (Dawson, Grant, Chou, & Stinson, 2007). Moreover, substance abuse is a risk factor in spousal violence (Klostermann, Kelley, Mignone, Pusateri, & Fals-Stewart, 2010; Schafer & Fals-Stewart, 1997).

In Iran also some studies have been conducted focused on the problems of wives of drug addicts and the negative effects of addiction on them. Drug addiction is one of the social harms in Iran that not only causes psychological and social problems for the addict, but also many problems for their families (Pourmovahed, Yassini, Dehghani, & Askari, 2013).

Mohammadkhani’s study (2009) revealed that social avoidance and labelling by society were the problems experienced by most of the wives of drug addicts. Likewise, the wives had to participate lonely in family gatherings and ceremonies, and most of their communications were limited to those people that their husbands approved such as other drug addicts’ families. The researcher also asserted that in most of the cases, the substance abuser husbands were unaware of their wives’ obstacles, and even if they were aware, they paid no attention to them. The author concluded that the wives of drug addicts in Iran are one of the vulnerable groups in the society.

The results of another study (Salehyan, Bigdeli, & Hashemian, 2011) indicated that there was a significant difference between psychological disorders in women with husbands affected by substance dependency disorder and that of normal population. The undesirable level of mental health among wives of substance abuser husbands was due to interrelation of biological, psychological and social factors. Furthermore, findings of demographic information showed that, women with husbands affected by substance dependency disorder suffer from low vocational and educational level, premature marriage, unemployment, living in insecure rental houses, low income and family history of substance abuse.

On the other hand, the previous studies demonstrated that family members especially the spouses have a powerful positive or negative effect on treatment, behaviors and reactions of the substance abuser (Rotunda, West, & O’Farrell, 2004; Rotunda& Doman, 2001). Therefore, the family members probably need as much as attention as the drug addicts.
1.2.2 Co-dependency

The concept of co-dependency has been extensively utilized in the field of chemical dependency and mental health (Hawkins & Hawkins, 2012). Most of the services for families of substance abuse problems apply the co-dependency model as one of their main theoretical frameworks (Dear & Roberts, 2002). The term co-dependency was originally used to point out the emotional, psychological, and behavioral difficulties showed by the partners of alcoholics who unintentionally enabled perpetuation of the drinking problem (Schaef, 1992).

According to this perspective, although it was the co-dependent’s partner who struggled with substance abuse, the co-dependent was believed to develop an addiction to his or her partner’s substance abuse and the attempts to control it (Peled & Sacks, 2008). Afterwards, the term co-dependent or enabler expanded to include individuals considerably affected by any stressful and dysfunctional family of origin experience such as addictions which predispose them to forming dysfunctional care-taking relationships with addictive, exploitative or obsessive individuals in their later lives (Schaef, 1992).

Although the precise origin of the term co-dependency is unclear, many earlier opinions about the spouses of alcoholics can be recognized as affecting its development (Miller, 1994). Summarising the history of co-dependency concept, Whitfield (1991) remarked the theories and ideas which contributed in the emergent of this concept. Some of the sources mentioned by him are: ancient legends and myths, Freud’s and others’ trauma theory, Jung’s and others’ expanded psychology, object relations and self psychology, family therapy dynamics, addiction dynamics and recovery experiences, and 12-step self-help groups. The writings of other psychologists such as Karen Horney and Erich Fromm also were utilized to generate the concept of co-dependency (Melody, Miller, & Miller, 1989).

Adams (2008) believed that the co-dependency movement has rooted in the twelve-step approaches; but, it relies on a broader base which includes knowledge of psychotherapy, modern self-help psychology, and feminism. In fact, the concept of “co-dependency” takes the notion of “enabling” mentioned by Al-Anon (12 step self-help group for families and friends of Alcoholics) one step further and discusses that an individual can establish an emotional dependence to other persons in ways which imitates an addictive relationship.

The concept of co-dependency emerged in clinical practice and literature in the 1980s by practitioners and clinicians as an effort to portray the caretaking activities of family members especially spouses of alcoholics (Beattie, 1987; Melody et al., 1989; Wells, Glickauf-hughes, & Jones, 1999). First attempts in
treatment of the family focused all of its energies on the alcoholic. The pioneers of the psychological treatments for alcoholism that appeared in the 1930s usually saw the family members of the alcoholic as a threat that sabotaged the treatment efforts for the alcoholic person with their “childish resentments” (Schaef, 1992). Clinicians observed that the controls and caretaking behaviors of family members and spouses of alcoholics mostly made them so preoccupied that they ignored their own needs and on the other hand, those behaviors let the alcoholic to continue his or her pathological behaviors (Dodge-Reyome & Ward, 2007). So, basically the purpose of clinicians to engage the family in the treatment programs was not working on the family members, rather they intended to obtain an agreement from the spouse and other family members not to interfere in the alcoholic’s treatment (White & Savage, 2005).

In 1954, Jackson described the responses of the family members to the alcoholism as a chain of adaptational stages which progressed according to the progression of alcoholism (Jackson, 1954). In 1973, Vernon Johnson introduced the term co-alcoholism and the process of family intervention to help the alcoholic get into treatment and recovery (Whitfield, 1991). As Virginia Satir developed her ideas of family therapy, Vernon Johnson, Sharon Wegscheider-Cruse, and others started to view alcoholism as a family disease, and the whole field of chemical dependence opened itself to the consciousness that the alcoholic was not the only individual influenced by the disease. As a matter of fact, it became clear that the whole family was involved and each member played a role in externalizing the disease (Schaef, 1992). This change was a prominent shift in the way that the family members of the alcoholic were viewed. Through this shift, the family members were not seen merely as the source of support in the recovery of alcoholic; rather, they were viewed as patients in their own right that damaged from a condition which needed recovery and support services (White & Savage, 2005).

Following these attempts, the National Institute for Alcoholism and Alcohol Abuse (NIAAA) took an interest in the impact of alcoholism on children (Irvine, 1999). Initially, the term “adult child” coined to describe adult children of alcoholics; then, this concept expanded to the children of any parent who was not able to meet their physical or emotional needs (Washton & Boundy, 1989). At the latest 70’s, Brown and colleagues began the first therapy group for the adult children of alcoholics (Whitfield, 1991). The expansion of these efforts for the children and adult children of any dysfunctional family stained a shift between the notion of co-alcoholism and recently rising concept of co-dependency (White & Savage, 2005). From this time on, the clinical term of co-dependency began to be used with progressively more frequency (Whitfield, 1991).

Whitefield (1991) defined co-dependency as “a multidimensional (physical, mental, emotional and spiritual) condition presented by any dysfunction and distress that is related to or due to concentrating on others’ behaviors and needs. Indeed, co-dependency happens when the people turn the responsibility of their lives and their happiness over to their false self or ego
and to other people. Some of the characteristics of co-dependent individuals are consisted of: denial, low self-worth, caretaking, obsession, controlling, poor communication, weak boundaries, dependency, repression, lack of trust, anger, and sex problems (Beattie, 1987).

Whitfield (1991) asserted that co-dependency is often primary that means it occurs from childhood, and because of growing up in a dysfunctional family environment. Many of studies approved that co-dependency significantly related to impaired interpersonal relations and any kind of neglect and dysfunctional environment in the family of origin (Cullen & Carr, 1999; Dodge-Reyome & Ward, 2007; Fischer, Spann, & Crawford, 1991; Harkness, 2003; Hawkins & Hawkins, 2014; Knudson & Terrell, 2012). Secondary co-dependency that is a less severe form of co-dependency happens when a person grows up in a healthy family, but she or he enters into a close or important relationship with an actively addicted, disordered or otherwise dysfunctional person. The secondary co-dependency is often milder and easier to treat and to recover from (Whitfield, 1991).

Based on the existing literature, wives of alcoholics and drug addicts are one of the most vulnerable people to be co-dependent. The results of Sabater’s (2006) study found that regardless of ethnic affiliation, wives of alcoholics were more co-dependent and were reared in the most dysfunctional families, and held the most negative attitudes toward alcohol and alcoholism when compared to women not married to alcoholics. There were not significant differences between any indicator of socioeconomic background, including educational background, and co-dependency. This finding suggests that co-dependency can be found relatively equally throughout the socio-economic strata (Sabater, 2006).

1.2.3 Family Systems Theory

Family systems theory is one of the theoretical models which offers a framework for comprehending how chemical dependency affect the family (Lander, Howsare, & Byrne, 2013). Previous studies demonstrated that codependency is theoretically linked to the concepts of family systems theory (Prest & Protinsky, 1993; Pryor & Haber, 1992; Scaturo, Hayes, Sagula, & Walter, 2000).

The appearance of family therapy caused a fundamental shift from concentrating on an internal, individual dysfunction to considering psychological problems as emergent and being maintained in the social context of the family (Lander et al., 2013). Some of the co-dependency theorist such as Black, Cermak, Subby, and Wegscheider-Cruse employed the principles of family systems theory as a way of understanding the mutual nature of interpersonal relations within the alcoholic family. They asserted that adult children and wives of alcoholics usually belong to dysfunctional families of origin where family relationships and parent-child communication were damaged. These theorists hypothesized that these individuals choose partners who enable them to repeat the familiar and dysfunctional patterns of behavior that they have experienced in their families of origin. These
maladaptive behaviors are portrayed by difficulty in experiencing intimacy and in establishing healthy fluid boundaries in interpersonal relationships, a lack of clear expression of emotion, and poor self esteem (Sabater, 2006).

The family systems theory conceptualized the family as an emotional unit, a network of interlocking relationships, which can be best understood when analyzed within a multigenerational or historical framework. This theory explains how the family, as a multigenerational network of communications, forms the interaction of individuality and togetherness using eight interlocking concepts including: differentiation of self, triangles, nuclear family emotional process, family projection process, multigenerational transmission process, sibling position, emotional cut-off and societal emotional process. Bowen asserted that individuals tend to repeat in their marital choices and other significant relationships the patterns of relating learned in their family of origin, and to pass along similar patterns to their children (Bowen, 1978; Kerr & Bowen, 1988).

According to Family systems Theory developed by Murray Bowen, people in the family system are driven by two counterbalancing life forces, that is, togetherness and individuality. The ideal goal is to balance these two forces and achieve emotional maturity and differentiation of self in the system. Differentiation of self includes both an intrapersonal and an interpersonal aspect, and individuals who are differentiated are able to think logically and not respond automatically to emotional pressures (Goldenberg & Goldenberg, 2008; Prest & Protinsky, 1993). They are able to connect with other people but at the same time maintain their own autonomy even in the face of anxiety. The opposite pole of differentiation of self is fusion. Individuals who are undifferentiated tend to be emotionally reactive and fused with other people around them. They may have little sense of self and spend much energy seeking others’ approval, particularly from authority figures or significant others (Kerr & Bowen, 1998). The characteristics associated with an undifferentiated self correspond to the characteristics of co-dependency, and are likely to be heightened in individuals facing developmental and situational stressors (Prest & Protinsky, 1993).

1.2.4 Recovery from Co-dependency in 12 Step Program

Co-dependency is treatable. Whitfield (1991) believes that to heal and treat the pain and dysfunction of co-dependency, co-dependents firstly understand that they are powerless over others. But they discover that they are powerful over themselves. They began to reclaim their personal power by working on a process of boosting their awareness, and by taking responsibility for their well-being and functioning. He gives this formula: Power = Awareness + Responsibility. The stages of recovery from co-dependency proposed by Whitfield (1991) involves: awakening, core issues, transformation, integration, and spirituality. He asserted that regular and long attendance at
12 step self-help groups like Al-Anon, and CoDA (Codependent Anonymous) is one of the main beneficial vehicles of recovery from co-dependency.

Cermak (1986) identified four stages in the process of recovery from co-dependency: (1) survival/denial, (2) re-identification, (3) working on core issues, and (4) reintegration. According to Cermak, group therapy is most often best for treating codependence, due to its capacity of interpersonal interactions. He suggested that 12-step participation is appropriate and recommended at any stage of therapy, providing support and a structured program for recovery from co-dependency. Cermak (1989) believed that 12 step program of Al-Anon is a unique resource for nurturing long-term, in-depth healing for codependents.

12 step programs refer to any self-help group which utilizes the original 12 steps and 12 traditions of Alcoholics Anonymous (AA). These programs are nonprofessional, voluntary, and self-directed group meetings that employ peer support to improve recovery for addicts and their families (Pickard, Laudet, & Grahovac, 2013). The 12 step programs for families and friends of alcoholics and drug addicts, named respectively Al-Anon and Nar-Anon, would be regarded as one the most pervasive and successful self-help programs for recovery from co-dependency (Ajri, 2010; Cermak, 1989; Timko, Young, & Moos, 2012).

By far, the most important and most influential resource for people in addictive relationships and their families has been the twelve-step movement in the United States (Adams, 2008). The Narcotic Anonymous (NA) program which is the 12 step program for drug addicts has been distributed among 137 countries all over the world. The NA in Iran started in 1990 by an Iranian man who had joined NA in California earlier. Now, NA is very pervasive in Iran and has around 400,000 members all over the country that include approximately one fifth of the whole population of NA in the world (Iran Region of Narcotics Anonymous, 2014). Nar-Anon also is widespread in Iran and these groups hold in many cities of this country. Generally, the focus of Al-Anon or Nar-Anon members is accepting powerless over addict individual, detaching themselves in a loving way from the unnecessary pain and suffering of addiction, taking the responsibility of their own recovery process, and seeking help from other members of that program (Timko et al., 2012).

As the 12 step programs is associated with better psychosocial outcomes for drug addicts and their families, and also reduced health care costs (Donovan, Ingalsbe, Benbow, & Daley, 2013; Zemore & Kaskutas, 2009), the clinicians and professionals usually are encouraged to become more familiar with 12 step program to get a better understanding about the psychological mechanisms of change in these self-help groups to make effective referrals or integrate this program in their treatment plans (Donovan et al., 2013; Holleran & Macmaster, 2005; Katz, 1986; Kingree, 2005; Matusow et al., 2012; Timko et al., 2012; Zemore, 2008).
All in all, regarding the need of family members especially the wives of drug addicts to work on their recovery from co-dependency, and also their probable enabling role, it is needed that the wives’ experience of recovery from co-dependency be examined and researched to add on the knowledge in this field. As the 12 step fellowship of Al-Anon and Nar-Anon are considered as an effective and unique source for long-term and in-depth recovery from co-dependency, exploring the wives’ experience of recovery in such groups adds another dimension into existing notion of recovery from co-dependency.

1.3 Statement of Problem

Previous studies have shown that drug addiction is not simply an individual problem, and impacts on the entire family (Kumpfer & Johnson, 2011; Lander et al., 2013; Roth & Tan, 2008). Each addict person is in a close relationship with significant others around him or her who are too severely influenced by the addicted person’s addiction (Gruber & Taylor, 2006; Rotunda & Doman, 2001). Conservative estimates proposed that each person with drug addiction problem or any other kind of addiction influences negatively on at least six to ten individuals around him or her directly (Thomas, Santa, Bronson, & Oyseerman, 1987).

The existing literature on the spouses of drug addicts demonstrated that spouses of substance abuser individuals experience high levels of stress and marital stress (O’Farrell & Fals-stewart, 2001); they are more likely to experience spousal violence (Klostermann et al., 2010; Schafer & Fals-Stewart, 1997); and, they may even die sooner because of physical illnesses such as cancer, high blood pressure or ulcers (Schaefer, 1992; Whitfield, 1984) since they are more concentrated on others’ needs (Beattie, 1987) and not engaging in behaviors that are suppose to prevent diseases (Martsolf, Sedlak, & Doheny, 2000). Family members of alcoholics and drug addicts have been long-cursed by social stigma, public neglect, and professional misinterpretation (White & Savage, 2005). The studies conducted on the drug addicted families in Iran also demonstrated that the wives of drug addicts showed more psychiatric symptoms (Mohammadkhani, Asgari, Ameneh, Momeni, & Delavar, 2011) depression, anxiety, insomnia, dysfunctional relationships with others, psychological harms (Mohammadkhani, Forouzan, & Delavar, 2010), and less marital satisfaction (Golparvar & Molavi, 2002), and experience significantly higher domestic violence compared to wives of non-drug addicts (Jalali, Aghai, & Rahbarian, 2008).

In the field of addiction counselling and psychotherapy, one of the most commonly used models for families of drug addicts and alcoholics has been the co-dependency model (Granello & Beamish, 1998). The phenomena described as “co-dependency” is known to adversely affect a large number of spouses of addicts. However, in spite of the fact that wives of drug addicts are affected seriously by their husbands’ addiction, and suffer from co-dependency, there is limited research on the spouses of drug addicts and
their co-dependency (Dear & Roberts, 2005; Stafford, 2001) both in Iran and elsewhere. Indeed, most of the studies and treatment programs have mainly concentrated on the drug addicts (Schaef, 1992; White & Savage, 2005; Wright & Wright, 1991). The spouses of chemical dependent individuals are almost the forgotten population in the treatment programs for drug addiction (Zimer, 2012). Therefore, research needs to be conducted to understand the nature of co-dependency among families of addicts. There is also a dire need to understand the co-dependency phenomenon among wives of drug addicts in Iran where drug addiction is recognized as a number one social harm to the nation and most of the drug addicts are married men.

Among the existing literature on the concept of co-dependency, the majority of the studies focused on the definition of this concept or constructing and validating the instruments to measure co-dependency in clinical settings (Ançel & Kabakçı, 2009; Dear, Roberts, & Lange, 2004; Dear & Roberts, 2005; Dear, 2002; Marks, Blore, Hine, & Dear, 2012); however, the research on the process of recovery from co-dependency is limited and there is a need to understand how the family members of drug addicts recover from co-dependency. Ajri (2010) recommended researchers for employing qualitative research methodology to explore the process of recovery from co-dependency among family members of drug addicts.

Among different approaches of recovery from co-dependency, Nar-Anon and Al-Anon 12-step self-help groups for families and friends of alcoholics and drug addicts are one of the most popular, effective and recommended programs for recovery from co-dependency. Nevertheless, limited number of research has been conducted to explore the value of these 12 step programs (Csiernik, 2002). In fact, there is still approximately little known about the mechanisms of change or psychosocial effects of 12 step programs for families of drug addicts (Tonigan, Miller, & Connors, 2000; Zemore, Subbaraman, & Tonigan, 2013). Although the 12-step program is popular in Iran, research is scarce on how the program works. The majority of studies conducted on the 12-step programs have been done in the United States (Richter, Chatterji, & Pierce, 2000; Roth & Tan, 2007, 2008; Timko et al., 2012). Hence, there is a dire need to investigate those findings to other cultural contexts (Gaston, Best, Day, & White, 2010).

In short, the current literature on the concept of co-dependence and its process of recovery seems to be insufficient both in Iran and elsewhere; on the other hand, little is known about the process of change and transformation which take place in the 12 step program for families of drug addicts that is considered as one of the most successful approaches to recovery from co-dependency. Accordingly, this study addressed these gaps in the existing literature. By providing insight about the characteristics of co-dependency among wives of drug addicts and their process of recovery from co-dependency, this study may help the addiction counselors and other
mental health professionals to provide more effective services to the family members of drug addicts.

1.4 Purpose of the Study

The purpose of current study was to explore the process of recovery from co-dependency among wives of drug addicts based on their experiences in Nar-Anon self-help groups in Iran. For understanding the process of change and recovery from co-dependency, this study also intended to explore the characteristics of co-dependency among wives of drug addicts before involvement in Nar-Anon. Qualitative case study methodology was employed as this study was concerned with a group of individual wives of drug addicts who had gone through their process of recovery in a particular setting, Nar-Anon 12 step self-help group.

1.5 Research Questions

This study is going to answer following questions:
1. What are the characteristics of co-dependency among wives of drug addicts before involvement in Nar-Anon self-help groups in Iran?
2. How do the wives of drug addicts recover from co-dependency based on their experiences in Nar-Anon self-help groups in Iran?

1.6 Research Objectives

Based on the research questions of this study, the objective of the study are:
1. To explore the characteristics of co-dependency among wives of drug addicts before involvement in Nar-Anon self-help groups in Iran.
2. To understand the process of recovery from co-dependency among wives of drug addicts based on their experiences in Nar-Anon self-help groups in Iran.

1.7 Significance of the Study

This research is thought to be important for providing both theoretical and practical implications. The present study provides a knowledge base on the co-dependency model by exploring characteristics of co-dependency among wives of drug addicts and also their process of recovery from co-dependency in Nar-Anon. As most of the studies regarding co-dependency have been conducted in western countries, this qualitative study certainly contributed to the body of knowledge in the field of co-dependency model and family members of drug addicts in Iran as an eastern country. Moreover, the current study expands the body of knowledge in the field of Nar-Anon self-help program that is one of the most successful programs for recovery from family disease of drug addiction by shedding light on the process of recovery and transformation which happens in such groups.
From the practical point of view, this study would help the Addiction counselors, psychologist and other helping professionals to get a better understanding about characteristics of co-dependency among wives of drug addicts and also the process of their recovery from co-dependency. This understanding may assist the professionals to develop or strengthen the recovery plans for co-dependent wives of drug addicts and accordingly, provide more effective services to them. Mental health professionals also may help to prevent many of the damages which may threaten co-dependents' physical and mental health by early recognition of co-dependency in them and guiding them to work on their recovery. Therefore, this study would be beneficial for the large number of co-dependent people who suffer from living with drug addicts.

Furthermore, by providing insight about the process of recovery in Nar-Anon 12 step groups, this study can help the helping professionals to make proper referrals to such groups. This current study also may help them to use and integrate the strengths points of 12 step program in their recovery plans.

1.8 Limitations of the Study

This study was a qualitative case study which aimed to understand the experience of co-dependency and the process of recovery among wives of drug addicts in 12-step self-help groups in Iran. The study relied heavily on the wives of drug addicts as the primary source of data. The data consisted of individuals’ experiences, thoughts and perceptions. The opinions of any individual are biased by the position from which they observe events. As another limitation of this study, the stage of husband’s drug addiction was not considered in selecting the respondents of this study.

Generalizability may consider as one of the limitations of this study. As the purpose of qualitative research is not generalizing data, the researcher of this study makes no claims that the data derived from this study will reflect the experience of all women in the Nar-Anon self-help groups. Based on the nature of qualitative research that the researcher considered as instrument (Ary, Jscobs, & Sorensen, 2008), the findings may be limited by researcher’s bias.

1.9 Definition of Terms

1.9.1 Co-dependency

According to Whitfield (1991), co-dependency is “a multidimensional (physical, mental, emotional and spiritual) condition manifested by any suffering and dysfunction that is associated with or due to focusing on the needs and behavior of others.
1.9.2 Wife of Drug Addict

A married woman who lives with an active or recovering drug addicted husband.

1.9.3 The Process of Recovery from Co-dependency

The process of recovery from co-dependency means the process of change and transformation which take place for the respondents and enable them to overcome and minimize their co-dependent characteristics and establish a more balanced life with healthy dependency.

1.9.4 Nar-Anon Self-Help Group

Nar-Anon Family Group is a worldwide fellowship for those affected by someone else's drug addiction. The members of this self-help group are relatives and friends who are concerned about the addiction and drug problem of another person. As a 12 Step Program, the members offer their help by sharing their experience, strength, and hope. The only requirement for membership is that there would be a problem of addiction in a relative or friend. Nar-Anon program of recovery is adapted from Narcotics Anonymous. The Nar-Anon members work on its Twelve Steps and Twelve Traditions (Appendix A)(Nar-Anon, n.d.).
REFERENCES


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