



A house of cards: The long-term recovery experience of former drug-dependent Israeli women ☆☆☆



Keren Gueta*, Moshe Addad¹

Bar-Ilan University, Ramat-Gan, Israel

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SYNOPSIS

While previous studies on recovery from drug addiction have tended to focus on recovery initiation and treatment issues among men, the primary purpose of this study is to shed light on the experience of long-term recovery among women. For this purpose, we employed qualitative methods and interviewed nine long-term (two to seven years) recovering women. Additionally, we monitored five women for two years of the recovery process in a dual research track (a total of 24 interviews). The research findings indicate that developing recovery capital, including self-awareness, stress-coping strategies, and various social resources (Granfield & Cloud, 1999), can be part of an effective strategy for overcoming long-term recovery challenges while financial difficulties, intrusive memories, motherhood and inability to find leisure activities may hinder it. These results indicate the need to reconsider gender-sensitive therapies in order to help women to not only initiate, but also maintain recovery.

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Introduction

In groundbreaking articles, Leshner (1997) constructed addiction as a brain disease and McLellan, Lewis, O'Brien, and Kleber (2000) showed that drug addiction is similar to other chronic illnesses, such as type 2 diabetes and asthma, in terms of vulnerability, onset, and course of the disease White & Kelly, 2011. More recently, a fair amount of existing research has reconfirmed the chronic nature of addiction, indicating that the mechanisms required to maintain recovery differ from those that initiate it (Scott, Foss, & Dennis, 2005; Volkow, Fowler, Wang, Baler, & Telang, 2009; White & Kelly, 2011). Based on this evidence, high relapse rates, and the reported experience of drug-dependent individuals, the focus of research in the field of addiction has shifted from models of acute stabilization to a

model of sustained recovery management (Dennis & Scott, 2007; Hser, Longshore, & Anglin, 2007; McKay, 2009; White & Kelly, 2011). However, despite this paradigmatic shift, robust conceptual models or practices that adhere to the conceptualization of addiction as a chronic disorder are still rather limited (Hser & Anglin, 2011). Furthermore, although previous studies have documented women's special needs, establishing the impressive body of research known as gender-sensitive treatment and contributing significantly to the understanding of women's recovery (Grella, 2008; Tuchman, 2010), little research has focused on women's experience and needs for long-term recovery (LTR) after they depart from treatment services and need to maintain their achievements (White & Kelly, 2011). We undertook the present study as a first step in filling these lacunae, by learning about the LTR experience of recovering Israeli women and taking into account social and cultural contexts of drug addiction and recovery.

Long-term recovery from addiction

One of the models regarding long-term recovery is the model of recovery capital (Granfield & Cloud, 1999). In their research

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* Corresponding author.

¹ Postal address: Criminology Department, Bar-Ilan University, Ramat-Gan 52900, Israel.

on the natural recovery of middle-class, well-educated, and employed research participants (30 males and 16 females), Granfield and Cloud (1999) coined the concept “recovery capital” in reference to the intrapersonal, interpersonal, and environmental resources that can be drawn on to initiate and sustain recovery from addiction. Cloud and Granfield (2008) discussed four forms of recovery capital that usually interact with each other. The first is human capital, which includes one's strengths for facing the challenges of the recovery effort, such as handling stress and self-awareness. The second form is social capital, which includes various intimate relationships, especially family and social relationships that are supportive of recovery efforts. In addition, it also includes access to informal self-help groups and formal treatment institutions. The third is physical capital, including financial assets and status, especially housing and shelter, clothing, and food. Finally, the fourth form of recovery capital is cultural capital, which refers to an individual's beliefs and behavior codes that result from membership in a particular cultural group.

Even though recovery capital is not equally distributed across individuals and social groups (Granfield & Cloud, 2001), research based on this theoretical framework and conducted with a various populations has suggested that it is possible to accumulate recovery capital in the course of several years and multiple episodes of professional treatment (Dennis, Foss, & Scott, 2007). Furthermore, it has been shown that recovery capital fosters sobriety and sobriety generates more recovery capital (Cloud & Granfield, 2004; Laudet, Morgen, & White, 2006).

The present research

This research was based on data collected as part of a wider study that explored how women recover from substance addiction, from the perspective of gender issues, such as preference of single-gender over mixed-gender therapy (Gueta & Addad, 2014). In this paper we examined the challenges and processes involved in sustaining LTR among women, in contrast to other studies that have been limited to recovery initiation and treatment issues of men, probably since so little is known about the LTR experience of women (White & Kelly, 2011). The general body of knowledge on drug addiction therapy has undergone a notable shift with regard to women, from neglect of this population to the development of gender-sensitive therapies (Grella, 2008). These therapies are rooted in the seminal work of Gilligan (1982), which disputed the previous models of identity and focused on women's different voice and commitment to relationships. Therefore, women's self has been defined as a “relational self,” a concept that expresses the centrality of relationships for women's selfhood (Surrey, 1991) and indicates the rehabilitation of women's relationships as an important aspect of recovery from addiction. Accordingly, and based on the understanding that motherhood is as an important mental resource for women's recovery (Grella, 2008; Hiersteiner, 2004), an aim of the process is to establish meaningful relationships between the woman and her children.

Based on this approach, treatment for women should be comprehensive and delivered in one place that includes provision of childcare, parenting training, transportation, housing, and medical care, especially for drug-dependent pregnant

women (Covington, 2002). Training of mothers is crucial to treatment, since the motherhood of drug-dependent women is affected by numerous stressors, such as deficient parental response to the child's needs due to drug abuse; instability of parenting skills and family life; and intergenerational maltreatment of children (Carlson, 2006). This woman-centered approach validates the mother–child bond by focusing on the health of the women as well as their fetuses/children (Greaves & Poole, 2005), unlike their portrayal in the media and public health reports as cultural icons of social decline due to their violation of the good motherhood mythos (Boyd, 2004).

Helping mothers recover by supporting their maternal role is especially important because motherhood serves as “seeds for recovery,” in contrast to losing custody of a child, which may increase women's risk of relapse in an effort to numb the pain of the loss (Hardesty & Black, 1999, p. 607). Moreover, due to the alarming rates of drug-dependent women's victimization during childhood (Tuchman, 2010), re-victimization related to being a prostitute, and women's strong preference for treatment that addresses both their history of trauma and their addiction issues (Najavits, Sullivan, Schmitz, Weiss, & Lee, 2004), it is crucial to work through these issues during recovery (Uhler & Parker, 2002). This process can alleviate emotions such as guilt and shame and prevent relapse (Van Wormer & Davis, 2008). Furthermore, throughout history, women's addiction has been characterized by its association with their dependence on men and stigmatization by society (Straussner & Attia, 2002). Thus it is important that the treatment design places high value on healthy interpersonal relationships (Uhler & Parker, 2002).

However, although gender-sensitive therapies address women's special needs during therapy and the therapeutic experience, only a few studies have focused on drug-dependent women's experience and LTR needs after they depart from the treatment service and maintain their recovery. Transition to the re-entry (aftercare) phase after residential treatment has been acknowledged as a stressful event (Soyez & Broekaert, 2003). Research has indicated that women, in particular, need intensive and long-term treatment, as well as aftercare support services (Sun, 2009). Another important need of women is community-based social support, which may be an effective alternative to AA and NA, which many women have found unhelpful because these programs represent prescribed rather than co-constructed approaches (Kruk & Sandberg, 2013). Furthermore, employment and economic self-sufficiency have been found to be key elements in women's LTR (Gregoire & Snively, 2001).

In Israel, research and prevalence details regarding female substance use are scant, but it is estimated that women account for 10% to 30% of the population of about 25,000–30,000 drug-dependent individuals (Israelowitz, Reznik, Spear, Brecht, & Rawson, 2007). The majority of drug-dependent women are drawn from the most disadvantaged and marginalized sectors of Israeli society; most are survivors of multiple forms of abuse and suffer from acute physical and mental health conditions (Israelowitz et al., 2007). This population is highly stigmatized by society and therapeutic institutions, alike (Salan, 2005). Moreover, Israeli society sanctifies motherhood (Remennick, 2001), and it is strongly influenced by the good motherhood myth of women's instinctive ability and desire to care for others and sacrifice their own needs for those of their children

(Hacker, 2005). Mothers who are not raising their children are unfairly judged as maternal failures (Finzi-Dottan, Goldblatt, & Cohen-Masica, 2012); as a result, drug-dependent mothers are especially prone to stigmatization (Gueta & Addad, 2013).

Research regarding LTR is limited in Israel; the concept of LTR is not incorporated into the Israeli recovery system, and consequently, the average duration of treatment is only one and a half years (Segev, Mordoqviz, & Altos, 2002). Furthermore, the system of treatment and rehabilitation of drug-dependent persons in Israel is comprised of a wide range of programs and lacks a comprehensive national social policy of treatment. This system suffers from financial difficulties since the Israeli National Health Law does not refer specifically to substance abuse, and does not cover the cost of the addiction treatment (Peleg-Oren, Rahav, & Teichman, 2002). Understanding the long-term experience of recovery is therefore imperative for the development of treatment and intervention efforts in Israel.

One of the therapeutic institutions that women are referred to in Israel is the therapeutic community (TC). The TC is a drug-addiction treatment method involving a prolonged stay in an institution that is designed to provide 24/7 supervision and treatment guided by self-help and mutual-help principles, holding the residents responsible for their own and each other's recovery (De Leon, 2000). The TC was originally designed for men. However, in light of criticism that the traditional TC model failed to attend to women's needs, and especially of its implementation of confrontation groups, which may be counterproductive for women (Kandall, 1996), the model was modified to empower women and undermine various patriarchal norms (De Leon, 2000). The first TC in Israel was founded in 1987, as an addition to other models for drug addiction treatment for women, such as methadone maintenance and Narcotics Anonymous. It also offered special gender-sensitive groups for women to work through painful issues related to being prostitutes and abuse victims. In addition, the TC offered support groups in which mothers could work on parenting skills and address issues related to motherhood, as well as individual sessions with a social worker (Sela, 2002). However, despite the emergence of the "woman-friendly" TC, further research is required to examine its potential to address the special characteristics and needs of women or, alternatively, to harm them (Straussner & Attia, 2002).

Cloud and Granfield (2008) argued that since women face significant challenges when attempting to terminate addiction compared with their male counterparts, gender might be conceptualized as negative recovery capital, because of its capacity to actually impede one's ability to successfully terminate addiction. However, they also indicated that socio-cultural taboos and stigma associated with women's substance misuse, along with facing the loss of custody of their children, may serve as major incentives for some women to stop addiction. Hence, paradoxically, although women may face enormous challenges for terminating addiction, many can be seen as having strong incentives to do so, which could translate into more recovery capital than for men. Better understanding of this paradox may be a possible benefit of investigating women's LTR experience.

Furthermore, most of the existing studies regarding LTR are based on quantitative methods, overlooking the experience of drug-dependent individuals. Based on our assumption that recovering drug-dependents are experts regarding the recovery

experience (Orford, 2008), we chose to employ qualitative methods to shed light on this subject.

Method

Participants and procedure

The data consisted of verbatim transcribed and translated semi-structured in-depth interviews with 9 women in LTR (2 to 7 years) from drug addiction. We drew upon Covington's (2002) women-centered definition of addiction as "a chronic neglect of self in favor of something or someone else. This neglect of self includes patterns of repetition and compulsion that reinforce self-destructive behavior, cognition, and affect" (p. 4). All the participants were associated with the same TC, as past residents who had completed the stay in the TC and halfway houses, lived in different cities across Israel, and maintained recovery. In addition to this research track, we also conducted a complementary longitudinal study that monitored 5 women in order to enable systematic examination of intra-individual change regarding LTR issues over time. Each of these participants was interviewed at treatment entry (early recovery; during the first 3 months) and at 8 (advanced recovery) and 24 months post-baseline (long-term recovery), after they had left the TC and were living in halfway houses (a total of 24 interviews in both tracks). Qualitative data collection reached the point of saturation at 24 interviews, when we noted the repetition of central findings with little new information arising. The departmental ethics committee approved this study.

All of the research participants were Jewish Israeli women; 8 of them were born in Israel and 6 were born in the former Soviet Union. Their ages ranged from 22 to 46. Seven participants were employed full-time; five worked part-time, and two did not work outside the home. On average, the research participants had completed 11.14 years of education. All were mothers; the ages of their children ranged from 3 months to 16 years and all but two were married. Most of the participants (12) had previously been poly-drug abusers; their main drug of choice was heroin and the majority had abused drugs during pregnancy. All, but one reported the onset of drug use at the age of about 15. While some women were self-referred to programs, most were court-referred as a result of poor parental functioning due to drug abuse, and all but one had a long history of failure in treatment in various modalities (e.g., day care centers, "cold turkey" withdrawal, NA). We recruited the participants by two means: most of them (9) were recruited through the TC, and the others (5) were recruited by means of a snowball sample, because we wanted to interview women who had completed the therapy program but were no longer in touch with the TC, as part of the maximum variation approach aimed at including a wide range of perspectives throughout the recovery process (Kuzel, 1999).

Data collection and analysis

During the interviews, the participants were asked a series of open-ended questions based on the research question and review of the literature on LTR. We asked them to use their own words to describe this period, including the associated difficulties, and how they managed or did not manage to overcome them. The interviews in the longitudinal research group were

conducted according to the method recommended for longitudinal qualitative research (Saldana, 2003). In this track, direct and open-ended questions regarding LTR were asked in the second and third interviews with regard to the first interview data, for example: “In the first interview, you talked about your aspirations for the future such as moving to a nice neighborhood; how do you feel about that now?”

The first author conducted in-person interviews with the participants who resided in the TC in an isolated, private room on the premises. The location was chosen to ensure them anonymity and a relaxed and familiar environment. The first author interviewed the participants who were in LTR in their homes, except in the case of one participant, who preferred to speak with us at a coffee shop, because she couldn't assure privacy in her house. The interviews lasted between 2 and 6 h.

The concept of “recovery” has become central in research on addiction, but there is no consensus regarding its definition, since it is associated with some of the most controversial issues in the study of addiction (White, 2007). In this study, we adopted White's definition of recovery, which is consistent with the recovery capital model and is not restricted to any single treatment model:

Recovery is the experience (a process and a sustained status) through which individuals, families, and communities impacted by severe alcohol and other drug (AOD) problems utilize internal and external resources to voluntarily resolve these problems, heal the wounds inflicted by AOD-related problems, actively manage their continued vulnerability to such problems, and develop a healthy, productive, and meaningful life.

[White (2007, p. 236).]

However, in light of our aim to learn about the LTR recovery of mothers from their own point of view, we did not define “recovery” for our participants. Furthermore, in keeping with the tradition of qualitative research, we did not ask them direct questions stemming from the recovery capital model or use the term “recovery capital” in the interview. Rather, we encouraged our participants to use the word “recovery” in any manner they chose to. Often the participants used the Hebrew word for “cleaning up” to refer to recovery and in order to establish rapport with them, we used it as well.

We employed theoretical thematic analysis (Braun & Clarke, 2006) using Narralyzer 1.1 qualitative data analysis software (Shkedi & Shkedi, 2005) to analyze the data at two levels. Each level of analysis was initially conducted by the first author, and then carefully reviewed by the second author. The analytic process followed the steps outlined by Braun and Clarke (2006). At the first level, we read and re-read the transcribed interviews and identified initial themes of the participant's experience of LTR. This open coding began as the data were collected and it was guided by concepts gathered implicitly from the original words of the participants. These themes were then coded into emergent descriptive categories, such as attempts to deal with the craving for drugs, building social networks, and financial difficulties. At the second level of the analysis, we read and re-read the transcribed interviews in a manner that was mindful of the framework of recovery capital developed by Granfield and Cloud (1999). The participants' discussions of LTR directly indicated three forms of recovery capital: human capital, social capital, and physical

capital. The fourth form of recovery capital, cultural capital, appeared indirectly in the participants' discussions of LTR.

However, as part of the qualitative paradigm, as well as our feminist research approaches, we aimed to develop practical knowledge that would lead to effective social change regarding women's status and were especially mindful of issues related to interpretation, translation, and representation of women and mothers' experiences as a group (Harding & Norberg, 2005). Accordingly, we looked for other themes that could capture women's LTR such as motherhood, victimization due to sexual abuse, the importance of family relationships in their lives, and economic problems. We then grouped together the themes and checked for emerging patterns. Then we interpreted these themes by a process of reading and re-reading, as well as reference to relevant literature of gender and recovery capital. While reading the interviews, we looked for points of similarity and differences according to which personal features of the participant, such as age and birth country, are drawn from the interviews to create different categories. We did not find a difference in this regard. In addition, we employed qualitative peer debriefing. In this process, we presented our preliminary findings to four specialists in the addiction field – two academic researchers and two practitioners in the field of addiction – and asked each one separately for feedback. Based on their comments, we further modified our interpretation of the findings.

Results

The descriptions provided by the research participants indicated that they preserved their recovery by means of accumulating different types of recovery capital, activism, and a daily renewed process of choosing to maintain recovery and implement practices to that end (White & Kelly, 2011). For the research participants, recovery was more than refraining from drug use. Abstinence was only the first necessary step in rebuilding a meaningful life in the aftermath of addiction, most notably healing from past victimization, improvement in mothering and family and social ties, and financial stability. According to the research participants, the primary type of recovery capital they needed to accumulate was human capital.

Accumulating human capital: acknowledging the chronic nature of addiction

Craving for drugs, even after prolonged abstinence and intensive treatment, was one of the challenges of LTR that the research participants mentioned. The main mechanism that they described for dealing with this challenge was self-awareness, a form of human capital. For example, Sima (all the names used here are fictitious), a 38-year-old in LTR acknowledged the chronic nature of addiction and described her ways of dealing with the craving:

Sometimes I want to drink, [but] we are not the kind of people that can be satisfied with having a drink and then drinking again in another year – no, we use till the end. It is “you touch, you drive” – which means that we can't touch at all.

This account identified this participant as a member of a recovery culture (Ronel, 1998; White, 1996); she used the

plural “us” and the phrase “you touch, you drive,” which is taken from the Israeli NA discourse on the danger of relapse even with single use and the advice to avoid the risk by means of total abstinence (Kurtz, 1982). It seems that acknowledging that she was a recovering addict² and identifying herself as part of a community of recovering addicts served as cultural capital, which provided her with reassurance and guidance about dealing with the danger of relapse, demonstrating the interaction between human and cultural capitals.

Another form of self-awareness and human capital (Granfield & Cloud, 1999) that appeared in the participants' narratives was the ability to work through painful and shameful issues from the past, which they recognized as a strategy to maintain recovery. For example, 33-year-old Ola at the beginning of recovery described working through painful issues related to being a prostitute: “I was working and also getting money that way. It's very hard for me to admit this But ... if I don't put it out there and discard of it—I'll get back to that place.” This description indicated the conflict between fear about working through painful issues and the need to do so as a way to start to maintain recovery. A few months later, Ola described the therapeutic value of dealing with those painful issues in therapeutic groups:

Many of them were doing the same thing, so they could understand me and didn't judge me. This gave me a sense of safety ... a sort of cleaner place inside me, as if I am that type, and I tell you and that helps me do something new and not go there.

It seems that in the homogeneous group of women, Ola felt a sense of identification and normalization, which created a safe space for her to enter a process of working through difficult and traumatic experiences such as that of prostitution. Furthermore, the exposure of a painful subject as a means of asking for help was constructed as an experience of efficacy (Wolf, 1988), derived from the ability to enlist others to help her maintain the recovery process. However, despite this process of working through, Ola described how past memories and traumatic experiences that originated in prostitution invaded her life and threatened her LTR:

Every Friday he [a customer] comes in and it reminds me of when I worked as a prostitute—the client would pay and you had to work and give him what he wanted. When I caught myself thinking about that, I could not sell to this customer. ... It was such a sudden shock and I told myself: oh my god ... I still remember. You can't forget something that was so difficult for many years.

This description supports previous research that conceptualized prostitution as a complex trauma (Herman, 1992). Similar to the symptoms of post-traumatic stress disorder, such as intrusive flashbacks and avoidance behavior, in this story, automatic thoughts invaded the participant's consciousness, aroused a sense of shock, and deprived her of achieving optimal performance at work.

In the area of human capital, some participants, such as Natasha, a 25-year-old single mother of one child, mentioned the challenge posed by leisure time, including related gender issues:

It's hard to get used to this routine of returning home every day and being the woman of the house. I'm not used to it. I used to be one who never sat at home—I was always out and always with people and many times this got me into trouble Lots of times I really miss this freedom. I often long for – I don't know – laughing and being free. And I talk about it and I try to find ways I can enjoy these things in a more normal way To tell you the truth, I haven't found anything I can enjoy.

Natasha's description indicates a dichotomy between the private sphere, associated with women and characterized by performing household chores, and the public sphere, which is characterized by freedom, fun, and laughter, but involves the risk of getting into “bad places.” This participant was still looking for “more normal” ways of finding pleasure.

Accumulating social capital

The complex experience of motherhood in LTR

The descriptions by the participants reveal a conceptualization of motherhood as a complex experience that not only made a vital contribution to LTR, but also had the potential to undermine this process. The contribution of motherhood to their LTR was twofold. First and foremost, being a mother served as a recovery resource by serving as a major motive for overcoming the craving for drugs. For example, Sima, a mother of four children, said that she refrained from using drugs because she thought about the sacrifice her son was forced to make during her stay in the TC and the future price he might pay if she would use again:

When [my partner and I] first moved in together, I wanted to use almost every day! And I wanted to die ... You cannot, because if you do, you will kill your son—[This is] what kept me going at first and slowly our relationship got better and then the girls were born and other things fell into place.

Sima's account shows that she measured her recovery not only in terms of her efforts and its impact on her sense of self, but also in terms of the mental price that her son would pay for a relapse. In this way, she bound her return to drug use with a fatal impact on her son, thus again associating her recovery and its preservation with moral aspects of her commitment as a mother. In addition, her story reflects the gradual nature of recovery maintenance, which strengthened as she accumulated social capital.

Moreover, motherhood serves as social capital in LTR because it allows the woman to establish a foothold in conventional life (Waldorf, Reinerman, & Murphy, 1991). For example, Sima described the risk of relapse due to boredom and the recovery capital provided by routine tasks, such as cleaning the house and feeding her family:

I sit like this in front of the TV, bored. Suddenly I see people drinking or something like that on TV, and then I want to drink. ... But it goes away ... because the children are coming, so there's no time. Your husband comes home—you have to give him something to eat; the girls arrive.... This is what replaces [the drug]—daily life.

Along with the conceptualization of motherhood as social capital, research participants also described the potential of

motherhood to hinder the recovery effort. For example, Pnina, a 40-year-old divorcee and a mother of four children, described the pain of her children's disengagement from her due to her past neglect of them, even after the fundamental change in her lifestyle. This demonstrates that the struggle for approval and acceptance in recovery is a difficult one that includes losses and disappointments.

It's hard for me that every time I call my child, she tells [me]: "whore, drug addict, why are you calling me?".... [I say]: "I'm clean; come to my house ... see the change I have made in my life, give me a chance!" ... She tells me: "Anyone who believes in you is just stupid. They do not know who you are and what you are."

According to this description, Pnina experienced her daughter's refusal to recognize the change in her lifestyle and identity as threatening to dissolve the fragile fabric of life she had built. However, despite her pain, Pnina demonstrated human capital that indicated the self-efficacy that helped her combat this emerging threat. This recovery capital arose from her hypothetical consideration of the option of using drugs as a way to deal with this rejection:

If I use, it won't give me anything. The opposite is true: what I built over seven years—all that will collapse. Look, it was very hard for me to build, but all this time I said, it's like a house of cards: each day that ends, I say thank God I finished another day without drugs and then I add another card to the house—before I felt I had nothing to lose, now I do have something, and it's fragile.

This use of the image of a house of cards fits White's (1996) term, "recovery metaphor," referring to a metaphor that catalyzes recovery, captures the meaning of recovery and encourages the recovering addict to carry on with it. Here Pnina used it to demonstrate the day-to-day maintenance of her recovery work and express gratitude for each and every drug-free day, acknowledging the good that was now present in her life.

Building a social network to support recovery

According to the TC, building a social network and continuing to attend informal therapeutic groups are major strategies in maintaining the recovery process (De Leon, 2000). However, the ability to acknowledge this kind of recovery capital was a process that developed as the recovery progressed. Research participants who had recently begun the recovery process recognized this resource, but expressed doubt in its contribution to maintaining recovery. In the course of the recovery process, the focus of the doubt changed. For example, at the beginning of the recovery process, Margarita, a 33-year-old and a single mother of one child, indicated difficulties in creating a social network that would support her recovery: *"I have problems sharing ... I'm a closed person, and here you have to tell everyone what you think, what's in your mind ... I don't have many friends."* A few months later, Margarita described the change in her feelings toward peers and their role in her recovery: *"In difficult times when it was hard for me and I didn't know what to do, I came to the group and shared and the members gave me a lot of help, support, and solidarity."* This indicates the value of the peer group as a whole in providing her needs for calming down, guidance, and social

acceptance. When Margarita was interviewed in LTR, she cited relationships with peers as an essential resource for maintaining recovery:

I'm going to NA groups. At least once a week I go and it does help. Even if I don't feel like going, if I don't want to leave the house, I make a switch and I do go, because I know that's where I get the strength. There are problems more severe than mine, and people live and deal with them. I talk and share with friends and that's actually the solution.

This description shows that the meetings with members of self-help groups, in other words, getting informal help, allowed the participant the cathartic relief that accompanies the person's exposure of charged and painful issues. In addition, hearing about other members' difficulties, which were sometimes more severe than her own, and their ability to cope, gave her a sense of power.

Another form of social capital was formal therapeutic interventions, underscoring the need for continuity of care to deal with the challenges of LTR. For example, Sima described how her father, who would bring alcohol to her house, posed a threat to her recovery:

I was ashamed to tell him it bothers me and he left [the bottle] under the sink. And sometimes I would say, oh my God, how I want to drink ... I told my social worker: "It messes with my head. I cannot!" She replied: "First of all, pour it out." "Well, okay, I'll pour it out but my dad will come again ..." Just tell him: "Dad, alcohol is not coming into our house."

This story shows that acknowledging the risk of exposure to alcohol (human capital) may not be enough to generate effective action. This participant had difficulty rallying the necessary assertiveness to face her father and prevent him from bringing alcohol into her house. As a result, she turned to another source of help – the social worker, representing the social capital of formal care assistance – who offered concrete guidance in dealing with the exposure.

Another example that demonstrates the importance of formal care assistance was provided by Sofia, a 26-year-old and a mother of one child, who at the beginning and in advanced recovery said that she was afraid to leave the TC, but that friends she could trust and therapeutic tools she would acquire would help her maintain recovery: *"I am afraid to leave ... (but) I believe that the tools I got here will help me."* However, when Sofia moved to LTR, she relapsed. She described the early re-intervention employed by the TC: *"I came back to the community for several months; I realized all the difficulties—mistakes I made ... now I feel more confident that I can manage outside [the community]."*

Accumulating physical capital: the wish for financial independence

The participants' descriptions of their economic circumstances after leaving the TC and the halfway houses revealed that they returned to economic marginality, forcing them to face the consequences of the past, such as poor housing and no professions or jobs, as Pnina described:

I was full of debts and unable to function! I didn't have money to pay electricity. My mother helped me, and [government] support was not enough for me. I had to pay debts to other people, to settle past issues.

This story reveals that one of the central difficulties in the recovery process is the ability to build financial independence. In light of their financial situation, many women regressed to creating ties in which they were economically dependent on men: “[The relationship] was based on my own interests, of course—I was with him so that he'd help me pay electricity and so forth.”

In the arena of financial capital, housing was one of the most salient issues. The participants perceived ownership of their own homes as essential to their recovery and as reflecting their role as good mothers, as Miriam, a 40-year-old and a mother of three children described:

[The public housing authorities] wanted to take it. My therapist helped me with letters; she told them that I was in rehabilitation and seeing her regularly. In the end they didn't take it I have loans but I fulfilled my dream; I have rehabilitated and I have a house, my corner. Little by little, I'll bring [my older son] back home. I want to correct what I missed; I have my “warm nest,” with my kids.

However, the wish for a house also created difficulties. Most of the research participants had trouble paying rent and some of those who lived in public housing had to return to their old neighborhoods. As a result, they had to give up their jobs in their halfway houses, as by law, residents of public housing cannot receive alternative public housing in another city:

I wanted to move [permanently] to that city because of the job. So they said to me, “Give up your [public housing] and we will help you with the rent.” I said, “What am I, stupid?” [They told me] I'd get help [with rent] but I'd be losing my home.

Returning to the old neighborhood jeopardized the well-known recovery practice of “the geographic cure,” that is, relocation in order to stop drug exposure (Biernacki, 1986). Miriam, LTR described this:

There are many addicts there, I don't mix with them, I don't even say hello. Today it's hello, tomorrow it's five bucks and then it's: let's use together. I'm afraid of not staying clean. We recovering addicts need to take care of ourselves.

According to this description, upon returning to her old neighborhood, this participant applied practices aimed at preserving her recovery and being an active agent in shaping her social world. In addition, this description reveals the fourth type of recovery capital – cultural capital – in the form of affiliation with a culture of recovery (Ronel, 1998; White, 1996). This is indicated by the participant's use of “we” in reference to recovering addicts, emphasizing an affiliation that supported her effort to implement the conservation practice of avoiding interaction with drug-using individuals. Thus, her identification as a recovering addict, one that suffers long-term “disease,” did

not legitimize relapse but rather served to further encourage recovery, in contrast to Aston's (2009) finding that addicted women learned to “hail” themselves as addicts. This example further demonstrates how the different forms of recovery capital are intertwined.

Discussion

The findings of this research indicate that accumulating recovery capital that includes self-awareness, stress-coping strategies, and diverse social resources is part of an effective strategy for maintaining LTR among women (Granfield & Cloud, 1999; Laudet & White, 2008). During this period of recovery, the research participants used recovery capital in order to deal with the aspects of their lives that had not changed since they enrolled in the TC. Throughout this process, the participants demonstrated resilience in facing their problematic situations and expanded their ability to deal with them using recovery capital, thus somewhat reducing the potential for crisis presented by the events and circumstances of their lives. Hence their position as recovering addicts in LTR was one of “subjects in process” (Kristeva, 1998), a term that implies the need to make daily choices during recovery, based on an activist stance and personal commitment to the process. This situation requires constant repetition of activities that generate identity; it enables complex negotiations with the environment, including symbolic struggles against limiting reality, as well as concrete actions. These findings are consistent with the findings of other research that have indicated that identity transformation processes, such as returning to a former identity or developing an identity of an ex-addict, is vital to the recovery of drug-dependent people (Baker, 2000; Biernacki, 1986). However, our findings expand the literature regarding the issue of identity by elucidating the importance of identity transformation in LTR, particularly in light of the preservation aspect of identity transformation. Furthermore, despite the participants' recovery achievements, past residues in many areas of their lives, such as finances, still accompanied them, creating multifaceted marginality even after they completed their stay in the TC and after many years of abstinence from drugs.

With specific regard to the model of recovery capital (Granfield & Cloud, 1999), our research findings indicate that the ability to develop awareness of the chronic nature of one's addiction encourages vigilance over oneself, as well as other strategies and stress-coping techniques for confronting a range of difficulties related to LTR as part of one's human capital. This vigilance and maintenance of the daily work of recovery are strategies used to meet the challenge of the fragility of their lives as recovering addicts, as encapsulated in the metaphor of a “house of cards.” This metaphor has also been used by parents who provided long-term home care for a technology-dependent child (O'Brien, 2001), in order to describe the potential for frequent and unexpected change inherent in all dimensions of their family, which encouraged them to use vigilance in the effort to increase stability in their life. Hence the research findings refute the criticism that the conceptualization of addiction as a chronic disease legitimizes relapse (Davis & Jansen, 1998). Rather, for our research participants, acknowledging that they suffered from the long-term addiction “disease” did not lead to despair and passivity, but to daily action aimed at maintaining LTR. However, within this form of capital, leisure time presented

a challenge. Our findings support Hood's (2003) findings that women in recovery from drug addiction consider leisure activities to be critical to their recovery, but many of our participants had difficulty finding such activities. The need for relaxation, enjoyment, and even escape from traditional gender roles, which addiction had previously fulfilled, was not satisfied during the recovery process, and this could jeopardize their LTR (Ettorre, 2008).

Regarding social capital, our findings support Granfield and Cloud's (2001) claim that recovery does not occur in a vacuum, but is situated within a larger social context that can either impede or facilitate it. The need of family recovery capital was especially salient, highlighting the limited effect of individual-focused addiction treatment (Moos & Moos, 2007). First and foremost, the participants constructed motherhood and its role in providing meaning, motivation, routine, and alternative activities as a major form of social capital, supporting Granfield and Cloud's (2001, p. 1557) result that "individuals with obligations to others possess increased motivation to act in particular ways." Similar to Collins (1991) findings with regard to the significance of household for women, our results indicated that for some of our research participants, the hard work of housecleaning and feeding the family was a valuable resource in creating routine and generating satisfaction in life. Motherhood serves as social capital in LTR because it allows the woman to establish a foothold in conventional life (Waldorf et al., 1991). The research literature does not offer sufficient documentation of commitment in daily life as a recovery resource. However, in the present research, the role that commitment in daily life played in maintaining their recovery was a prominent aspect of the participants' stories. Hence, in line with other findings regarding drug-dependent mothers, motherhood served as a survival strategy (Hardesty & Black, 1999, p. 609), by promoting the woman's positive good-mother identity based on her caring for her children. This positive identity is essential in the Israeli society, where motherhood is a core element in women's identity and a way to enter the social mainstream (Remennick, 2001).

However, as a rule, motherhood and family ties also potentially threatened the recovery process, especially in light of the meaning of family and motherhood to women in general (Covington, 1998), and in the Israeli context, in particular, where being childless may be considered deviant (Remennick, 2001). For recovering drug-dependent mothers, the centrality of motherhood in Israeli society can act as a double-edged sword: the children's estrangement from their mothers may pose an additional negative social judgment and a potential threat to their identity as women (Finzi-Dottan et al., 2012). Furthermore, for the research participants, their children's refusal to maintain contact with them was especially difficult. They could not find comfort by blaming the loss of the child on the social services, as other drug-dependent mothers have done (Hardesty & Black, 1999), or on the father's manipulation of the children in a divorce battle (Finzi-Dottan et al., 2012). They could only find themselves responsible, thereby intensifying their self-blame, which could further escalate addiction. Hence, the stories told by the participants fit the term coined by Brown and Lewis (1999), "recovery trauma," referring to the stress and effort involved in changing mechanisms that are designed to maintain family balance during addiction and the disruption that occurs in the lives of family after the drug-dependent member completes the

recovery process. These recovering women's narratives are subversive in challenging the motherhood myth regarding the one-dimensional harmonic aspect of maternal caregiving (Hays, 1996). Thus, by presenting the experiences of marginalized mothers, the present study contributes to a growing body of literature that reconstructs motherhood as a diverse and social concept.

Taken together, our research findings indicate that traditional gender role socialization has the potential to actually impede women's ability to maintain recovery due to inability to find leisure time. On the other hand, traditional gender role socialization can serve as major incentives for some women to maintain recovery. This mixed finding counters common assumptions about the "relational self" commonly associated with women (Surrey, 1991), and may be due to the social and cultural background of the participants living in a culture that is influenced by both Western individualist culture and Middle-Eastern collectivist and familial heritage (Levitzi, 2009). These findings may also indicate women's need to challenge binary gender coercion by incorporating both traditionally masculine and feminine features in order to establish less oppressive conceptualization of women's subjectivity (Butler, 1990).

Another form of social capital demonstrated in this research was the need for continuity of care in order to maintain recovery. Our findings support other research results that have shown that informal treatment, such as engagement in a 12-step program, contributes significantly to maintaining recovery (Laudet, Savage, & Mahmood, 2002). They contradict other studies on women that have found NA participation unhelpful (Kruk & Sandberg, 2013). The appeal of the 12-step program and NA groups for our participants may be associated with the beneficial uses of the disease model of addiction for people recovering from drug-dependency (Ronel, 2000), and especially for mothers. In their case, this conceptualization may help them shake off stigmatized identities that develop as a result of their motherhood patterns during addiction (Gueta & Addad, 2013). Moreover, the present findings reveal that the affiliation with the recovery culture (Ronel, 1998; White, 1996) was an important informal social and cultural resource, which also provided participants with concrete tools to manage daily life against the "disease" of addiction. Our research findings also indicate the need for formal intervention, such as that of the welfare system, and the importance of early re-intervention in order to maintain recovery.

The most challenging aspect of recovery, according to the research participants, was related to physical capital. Similar to other research findings regarding the economic hardship of women in LTR (Gregoire & Snively, 2001), economic self-sufficiency was also evident in the current study. In particular, the descriptions of the research participants revealed that the subject of housing after leaving the TC and halfway house was a prominent issue in their recovery. This issue has been associated with numerous symbolic meanings. Home ownership is conceptualized as ontological security (Giddens, 1990), a sense of well-being and of "being at home" that arises from the feeling of a stable social and physical environment, which in turn provides a safe platform for the development of identity (Shaw, 2004).

The present study has some limitations. First, since we used a small, non-randomly selected sample of drug-dependent women, our findings cannot be generalized. They represent the

views and experiences of a small sample of women who were served by one particular program, the TC, and later participated in NA groups, both of them part of a plan based on total abstinence. Thus the LTR experience presented in the current study may not capture the full spectrum of women's LTR experiences. This spectrum is very important in light of the importance of variety and choice of therapeutic approaches as part of the gender-sensitive therapy (Covington, 2002). Moreover, TCs and NA have been both criticized for their inability to address the specific needs of women (Kandall, 1996; Kasl, 1992). Furthermore, linking recovery to abstinence and personal choice may further marginalize other women; according to researchers who have defined recovery as part of a harm-reduction approach, this focus of personal choice may lend itself to a personal responsibility discourse that blames individuals for their own addiction (Greaves et al., 2004). In addition, the research participants were members of a particular cultural group that has unique features, such as the pivotal role of motherhood, and thus the findings cannot be generalized. Second, despite the support of LTR management provided by these findings, it is important to stress that people with drug-dependency do not constitute a homogenous population and not all cases of drug addiction require chronic care. Many individuals are able to terminate their addictions and maintain LTR without treatment (Sobell, Ellingstad, & Sobell, 2000).

In conclusion, the research findings support the model of recovery maintenance and refute a linear model that focuses on achieving cure (White & Kelly, 2011). As such, the research findings have implications for policy as well as practice. First, they indicate the need of continuity of care by means of formal intervention, such as the welfare system, in order to maintain recovery. This need is not addressed by the official policy of the welfare system in Israel, according to which the duration of treatment is only one and a half years, since patients should be cured by the end of this period (Segev et al., 2002). It might be possible to respond to this by means of outreach programs that include various techniques to improve the continuity of care, such as therapist-initiated telephone calls (McKay et al., 2004), assertive monitoring, or early re-intervention (Dennis & Scott, 2007; McKay, 2009). Moreover, it is especially important to expand a social support alternative for women that is not based on NA, which is not always suitable for women (Kruk & Sandberg, 2013) and does not accept clients of methadone maintenance treatment, leaving these recovering addicts especially vulnerable to lack of social support and hence prone to relapse (Ronel, Gueta, Abramsohn, Caspi, & Adelson, 2011). Second, gender-sensitive therapies should not only include issues of drug abstinence but also help women deal with daily life, by means of, for instance, acquiring a profession, managing finances, and housing. Future interventions should also address the use of leisure time by introducing women to challenging activity that provides pleasure and does not impose gender roles, as well as a way to discover new aspects of themselves through a variety of hobbies and activities. In keeping with gender-sensitive treatment regarding motherhood, special programs should be developed to work through the issue of separation from children, due to loss of custody or the inability to reunite with a child, particularly in light of their potential contribution to the risk of relapse (Hiersteiner, 2004). Last, in light of the unrealistic expectations regarding the duration and

achievement of recovery among drug-dependent people, care professionals, policy makers, and the public, it is necessary to promote models of sustained recovery management and to create a discourse that legitimates a long-term vision of recovery (Granfield & Cloud, 2001; White & Kelly, 2011). Furthermore, despite the unique cultural and social affiliation of the research participants, the current research was also informed by a cross-cultural model of LTR (Granfield & Cloud, 1999); thus the implications for policy and practice may be relevant to other countries as well.

In summary, these findings contribute to the growing body of literature that supports a model of LTR from addiction by giving voice to the women's experience. Our findings indicate that instead of viewing the high relapse rate as a failure of interventions or lack of women's motivation, we can consider it as the result of low recovery capital, which can be increased in time by acquiring self-awareness, techniques for coping with stress, a combination of formal and informal social support, various solutions to financial difficulties, and cultural affiliation.

Endnotes

¹ Postal address: Criminology Department, Bar-Ilan University, Ramat-Gan 52900, Israel.

² The research participants presented themselves as "recovering addicts" as part of their group affiliation. We chose to adhere to their self-presentation despite the negative and demeaning associations of the word "addicts."

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