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

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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.

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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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 (Isralowitz, 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 (Isralowitz 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