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Moulding an emancipatory discourse: How mothers recovering from addiction build their own discourse†

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In this study, we investigated how mothers in different stages of recovery from addiction negotiate their identities along this process. We mapped the discursive fields in which those mothers act and the subject-positions available to them. The first discourse in this field was the popular discourse that according to it addicted mothers are compared to 'monsters'. Another discourse was the institutional discourse that stems from the milieu in which the women were treated. The discourse analysis demonstrated that the participants did not automatically accept the institutional discourse, but rather constructed a new identity based on several different discourses, borrowed from other treatment models demonstrating resilience, creativity and adaption to their unique experience. This reconstruction of identity served as an alternative to the 'monstrous mother' identity imposed on them by the popular discourse. The findings support the view that while social forces shape individual identity, individuals also create their own agency through language, relationships and cultural attributes.

Keywords: *Addiction, discourse, women, therapeutic community, narcotics anonymous, self-medication*

INTRODUCTION

In the course of the last few decades, the research corpus that deals with the recovery process[1] of drug-addicted women has undergone many changes (Grella, 2008). During this period, the recognition of the importance of gender-sensitive treatment has become established, calling attention to the unique identity formation among women under the influence of cultural constructions of womanhood and motherhood.

Identity transformation had been widely acknowledged as a process that is vital to the recovery of addicts (Baker, 2000; Biernacki, 1986; Koski-Jannes, 2002; McIntosh & McKeganey, 2002). This transformation embodies special difficulties and requires salient changes in the addict's knowledge and skills in order to develop new social positions (Harre, 1983). The process is complex particularly because of the discourse addicts employ to explain their experiences is unintelligible to most people outside the world of drugs (White, 1996). Therefore, recovering people need new discourses that will function as building blocks of their identity (Zemore & Kaskutas, 2004). Institutions that offer addiction therapy to encourage identity transformation by providing role models, narrative patterns and a stage on which the addicts can tell their story and thus construct their identity (Burns & Peyrot, 2003; Koski-Jannes, 2002). As a result, a match has been found between the recovery narrative of addicts and that of the institutions in which they are treated (McIntosh & McKeganey, 2002).

Although the essential role of identity construction as a component of the recovery process is well documented (Baker, 2000; Biernacki, 1986; McIntosh & McKeganey, 2002), the research has focused on the interaction between the institutional discourse and personal identity formation, and not on broad political and cultural aspects (Etherington, 2007; Koski-Jannes, 2002). In this study, we examined both the narrow and the broad social context of the recovery process of

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drug-addicted mothers. Accordingly, the goal of this research was to describe how drug-addicted mothers in Israel produce, negotiate and contest their identity in different stages of recovery.

For this purpose, we examined identity from the perspective of social constructionism, according to which people construct their identity in situations of interaction, focusing on multiple realities (Gergen, 2001). This approach sees the individual as a knowledge agent that generates change by challenging knowledge conventions and creating new worlds of meaning. From this perspective, we studied the dynamic process by which the recovering mothers interpreted their experiences, based on the assumption that individuals are capable of influencing the identity construction process and creating agency. In the spirit of social constructionism, identity is viewed here as the result of an ongoing process in which individuals collect building blocks from different discourses that are ingrained in their broad social and cultural environment, as well as the immediate setting, of which the therapeutic milieu is a part.

According to social constructionism, discourse can be likened to a workshop (Edwards, 1997), during which the participants create common local, context-dependent versions of meaning that they give their intrapersonal and interpersonal world (Lucius-Hoene & Depperman, 2000). Identity is constructed from competing discourses that are offered to the individual in a given situation, which he or she may adopt or reject, indicating the potential of agency. Thus there is general consensus that any given situation involves multiple discourses, or as Foucault put it, *discursive fields*, which 'consist of competing ways of giving meaning to the world and of organising social institutions and processes' (Weedon, 1997, p. 34).

Social constructionism adopts the metaphor of the narrative to describe identity; narratives are approached here as stories in which the subjects make sense of their life and identity (Gergen, 2001). Accordingly, Shotter and Gergen (1989) see human identity as a story in which the 'narrator' occasionally makes structural changes in order to justify his or her world and personal role in it. Given that the story is told in interaction with others, it is not surprising that individuals invest effort in preserving their positive self-image, especially if they belong to a stigmatised group (Goffman, 1959). In order to ensure that this identity meets with the approval of others, individuals use linguistic tools, such as conventional and legitimate forms of discourse, to strengthen their arguments and help them construct positive identities (Gergen, 2001). This 'life story' framework shifts the focus from a factual retrospective report of personal life occurrences to the meanings the person ascribes to these facts, so that the narrative becomes an agency process (Maruna, 2001; McAdams, 1985).

In order to place the recovery process in the social context in which the mothers act, we mapped the discursive fields in which the recovery process is described and the positions available to the narrators. The first discourse is the popular discourse that arises from the literature on drug-addicted mothers. In this discourse, motherhood and womanhood are constructed as synonymous identities (Chodorow, 1978; McMahon, 1995); this is true even in the modern age (Lawler, 1996), and especially in reference to low-income women (Bedimo, Bessinger, & Kissinger, 1998). Israeli society has been described as pro-natalistic, because of its religious tradition and an ideological commitment to increasing the Jewish population. Accordingly, the motherhood role is defined as crucial for Israeli women, in terms of both identity and morality (Remennick, 2001).

The popular discourse also incorporates the 'good mother mythos' (Chodorow, 1978; McMahon, 1995), a set of ideas and images that construct the widespread conceptualisation of motherhood by which women are judged (Kline, 1993). According to this mythos, motherhood is conceptualised as natural and instinctive. Every women is expected to adopt this model; those who do not are constructed as bad mothers and morally deficient (Becker, 1992; McMahon, 1995).

Drug-addicted mothers represent a clear violation of the 'good mother mythos': they are considered as unreliable, childish, irresponsible, egoistic and focused on their own gratification (Baker & Carson, 1997; Boyd, 2004; Murphy & Rosenbaum, 1999; Taylor, 1993). As a result, every drug-addicted mother is stigmatised twice, both as a failed woman and as a bad mother (Klee, Jackson, & Lewis, 2002). In research conducted in Israel, Salan (2005) found that drug-addicted women are badly stigmatised and criticised both by society and by therapeutic institutions.

In this discourse, drug-addicted mothers are likened to 'monsters'. For example, Western media frequently describes addicted mothers as transmitting biological–social inferiority to their children. The image depicts drug-addicted mothers as contaminated and polluted (Ettorre, 2007), and as a deadly 'foetal containers' (Purdy, 1996). It was popularised in the American media in the late 1980s, after the outbreak of 'the cocaine epidemic' (Gubrium, 2008).

Addicted mothers accept the popular motherhood ideal embodied in this discourse and adopt the image of themselves as 'monster moms'. Consequently, they tend to conceal and deny negative aspects of their conduct as mothers, such as neglect and abuse (Baker & Carson, 1997) and develop depression and alienation (Finkelstein, 1994). These feelings pose an actual threat to their moral identity and instil them with a need to repair their identity (Brown, 2006).

Another salient discourse stems from the milieu in which the women were treated, namely, the therapeutic community. The therapeutic community is an addiction treatment method that involves an all-encompassing institutional framework where the clients stay continuously, receiving therapy and 24/7 surveillance

(Kooyman, 1992). The community is based on an overall perspective composed of values, norms and philosophy, which is intended to guide recovery and is expressed in an argot that the participants learn. According to this therapeutic perspective, addiction is understood as a mere symptom of an incorrect learned lifestyle and the aim of recovery is gradual identity transformation by means of re-socialisation based on the principles of self- and mutual-help (De Leon, 2000).

Using a qualitative research method, which encourages drawing information from the research setting (Lincoln & Guba, 1985), we were able to detect two additional discourses in the participant research narratives oriented in distinct addiction therapy models. The first of these is the self-medication discourse, which conceptualises addiction as a tragic, recurrent attempt to self-medicate in order to regulate inner tensions and promote self-esteem (Khantzian, 1985; Kohut, 1977). Thus addicts are perceived as lacking the inner ability to regulate tensions (due to neglecting parents or sexual abuse), and as a result, as victims doomed to seek external means (such as drugs) to regulate their feelings.

Another discourse found in the participant narratives was drawn from the self-help organisation, Narcotics Anonymous (NA). This discourse, which is based on the personal experience of addicts and not on medical research (Shaffer, 1991), conceives of addiction as a disease that impairs the self-control and reasoning of the addict. According to this discourse, recovery requires a spiritual process in which the addict acknowledges a 'higher power' and accepts its help and guidance (Denzin, 1987). It should be clarified, however, that although many therapeutic communities encourage members to join NA groups when they leave the community, the therapeutic community model rejects the perception of addiction as a disease (De Leon, 2000).

METHOD

Participants

The data consisted of verbatim transcribed and translated semi-structured interviews with 25 mothers in different stages of recovery from drug addiction. All the participants were associated with the same therapeutic community, either as current residents in the course of recovery or as past residents who had completed and maintained recovery. We divided the research participants into three groups, according to their place on the recovery continuum: mothers at the beginning of the recovery process who had just entered the therapeutic community (1–3 months; $n = 10$); mothers in the advanced stage of recovery who were still in the therapy program (6–12 months; $n = 6$); and mothers who had completed the therapy program in the community and were in the long-term recovery process (2–7 years; $n = 9$). In addition to this research, we also conducted a complementary longitudinal study that monitored five mothers from the beginners' group. Each of these participants was interviewed at the beginning of the recovery process, again when she reached the advanced stage of the recovery process and once more about 2 years later, when she was in the process of long-term recovery (a total of 35 interviews). This dual-track research design enabled a comparative-developmental examination of the recovery process.

All of the research participants were Israeli women; 14 of them were born in Israel and 11 were born in the former Soviet Union. Their ages ranged from 22 to 46, with a median age of 31. All were mothers; the ages of their children ranged from 3 months to 16 years.

Adopting Rosenthal's (1993) method for conducting life story interviews, we created a four-stage interview: In the first stage, the interviewer asked the participant to tell her life story in a spontaneous and continuous manner, without any interference. In the next stage, the participant was asked to clarify aspects of the life story as necessary, and in the third stage she was asked a series of open-ended questions based on the research question and review of the literature. The fourth stage was completion of a demographic questionnaire. The interviews in the longitudinal research group were conducted according to the method recommended for longitudinal qualitative research (Saldana, 2003).

Interviewing process, transcription and analysis

We conducted in-person interviews with the participants who resided at the therapeutic community in an isolated, private room on the premises. The location was chosen to ensure them anonymity and a relaxed and familiar environment. We interviewed the participants who were in long-term recovery in their homes, except in the case of one participant, who preferred to speak with us at a coffee shop, because she could not assure privacy in her house. The interviews lasted between 2 to 6 h.

We used Narralizer 1.1 qualitative data analysis software (Shkedi. A & Shkedi. Y, 2005) to analyse data using Willig's (2008) recommendations for Foucauldian discourse analysis. The transcripts were read and re-read in a manner that was mindful of the associated discourses as well as the rhetorical devices and metaphors employed by the interviewees to construct and negotiate their identity. We were interested specifically in adopting or rejecting the subject-positions offered by the various discourses and in examination of how these subject-positions locate the participant in the general moral order and how this influenced the participant's inner world experience.

RESULTS

The research analysis indicated that the participants in the advanced stage and those in long-term recovery constructed a recovering-addict identity by means of a

recovery discourse composed of the institutional, self-medication and NA discourses. This identity served as an alternative to the construct imposed by the popular discourse. In contrast, the participants who were at the beginning of the recovery process constructed their identity under the influence of the popular discourse, leading to a 'monstrous mother' identity.

Constructing drug addiction: The victim identity

The first step in constructing the recovering-addict identity was narrating the past. The participants in the advanced stage and those in long-term recovery did not merely describe their past, but created a new conceptualisation, incorporating new meanings of the experience by using the recovery discourse. These participants constructed an empathic story (Omer, 1997), which expressed an internal and emotional logic that interpreted their past behaviour not only as reasonable, but as the only possible choice under their life circumstance, while constructing themselves as victims. In contrast, the participants who were at the beginning of the recovery process presented descriptions that were characterised by factual retrospective records, influenced by the popular discourse.

The focal topic of the participants' descriptions of the past was how they constructed their pathways into the world of drugs. According to most of the participants in the advanced stage or in long-term recovery, drug use was a functional reaction to life circumstances, of which they were victims. In comparison, the descriptions of the past by the participants at the beginning of the recovery process were characterised by a general experience of victimisation and their entry into the world of drugs. This implied, albeit vaguely and associatively, a possible connection between them. For example, one participant told the interviewer:

> When I was nineteen I was raped. I came home late, and there was a group of six guys and they said that the first girl that passed, they would all 'do' her. I didn't tell anybody, I didn't want to tell my parents and even if I had it wouldn't have helped – they didn't care. Afterwards I started to use.

In contrast, a long-term participant described her sexual victimisation and drug use:

> When I was fifteen I started to drink. We went to parties – I would drink and it gave me self-confidence. When I was 5 years old, I was sexually molested by my brother-in-law and that was the straw that broke the camel's back, meaning I wasn't confident and I had low self-esteem and it just broke me because nobody protected me, no one contained me, I had no one to tell.

Despite the similar themes in the two stories, which both refer to sexual abuse and pathways into the drug world, this participant's description is causal and explains the addiction based on the self-medication discourse (Khantzian, 1985) in a more direct manner, thus constructing herself as a victim. The participant indicated the emotional profits she gained from drugs and constructed them as a panacea that gave her self-confidence. Moreover, she used a professional language in referring to the absence of protective figures that could have reduced the detrimental effects of the sexual abuse and compared their absence with her perception of the norm.

A minority of the research participants attributed their entry into the world of drugs to curiosity and fun. However, their description varied. The participants who were at the beginning of the recovery process described their drug use as a means to satisfy curiosity and experience diverse life options, presenting themselves as autonomous hedonists. This is consistent with the popular discourse (Baker & Carson, 1997), but contradicts the institutional discourse, which refers to addiction denial as characteristic of the early phases of treatment (De Leon, 2000). For example, one of them described her introduction to the drug world:

> Many people begin to use drugs because of social pressure or whatever. I don't know how to explain this, but I am one that loves it, you know. See, I am very curious. I told myself I had to taste everything in life.

This participant began her narrative by describing a possible pathway to the drug world that suggests a lack of free will, but she did not perceive this as her path to drug use. Furthermore, her account of the inner dialogue that preceded her decision to use drugs indicates that this was a conscious act, and is used to position herself as an autonomous agent, and not a victim that was driven to drugs.

In contrast to this description, when the participants who were in the advanced stage or in long-term recovery described their curiosity, they associated it with the self-medication and institutional discourses, which link addiction to the family environment. For example, one participant described her pathway:

> We grew up with a drug-addicted father. We were ten siblings, with a house full of people coming by all day and going out to parties and drinking. I was an introverted girl, and it was difficult financially. There was no warmth, and we got no attention; they were more interested in people and parties than in the children. I was curious; I wanted to know how they were having fun; I started to drink and to eat my mother's grass cookies.

By opening her narrative with 'we', she positioned herself as a one of many children of an addict, implying that the intergenerational nature of addiction and the influence of her early family experiences had led her to addiction. To further support this construction, she referred to how it would have been like in a normal family, depicting an abnormal childhood that inevitably led to drug use, and thereby adopting a victim identity.

Another construction of the pathway into the world of drugs is associated with pleasure. In the case of participants at the beginning of the recovery process,

this construction helped them position themselves as autonomous, consistent with the popular discourse:

> I enjoy it [laughing; silence]. I love grass, I love *homer* [heroin], why should I lie?

This participant positioned herself as an active agent fulfilling her desire for pleasure. She asked a rhetorical question, a discursive measure implying that one should be quite and lie about enjoying drugs. In contrast, when the participants in the advanced stage or in long-term recovery constructed drug use as enjoyable, they did so in short descriptions, immediately followed by reference to the negative aspects of drug use:

> You enjoy your high, but after two or three days – okay, you're stoned, but then it becomes an existential need, [necessary for you] to wake up in the morning, to work, or to clean. You become a slave [to it]. It is so frustrating but . . . it is stronger than you are.

According to Bell (1985), the 'slavery concept' positions the drug as the problematic agent in addiction, endowing it with diabolical features that invade the individual. This image of the drug as a tyrant and the user as slave supports the victim identity. This is reminiscent of the NA discourse that addicts have no control (Denzin, 1987). It seems that the use of 'you' when the speaker actually means 'I' functions as an instrument to involve the audience and arousing empathy (O'Connor, 1994).

The most common feature identified in this study regarding past construction by the participants as a whole was the description of their motherhood patterns during addiction. These descriptions indicated agreement with the popular discourse, which constructs them as unfit mothers. However, the participants at the beginning of the recovery process described their motherhood in terms of the popular discourse only, constructing a monster identity; their descriptions were full of self-hate, guilt and shame. For example, after losing custody of her child, one participant described herself:

> I don't believe I am a mother. It's very hard for me because I knew from the beginning that even animals don't leave their puppies.

This description indicates an adoption of stigma, that is a psychological process of accepting negative stereotypes and incorporating them into the self-concept (Crocker, 1999). This internalisation of stigma led to a denial of their identity as mothers and self-dehumanisation: the reference to animals hints at the instinctive nature of motherhood, in keeping with the popular discourse. In comparison, the participants in the advanced stage and those in long-term recovery also used the recovery discourse to construct a victim identity, moderating the threat to their identity that arose from the descriptions:

> I moved to a rented apartment with two little girls and the disease appeared once again. It is very devious, constantly appearing. It was an evening that I felt very lonely; I had no one – a young mother with two girls and without strength to raise them. The *doda* [craving] worked; I wanted to lose my sanity, to flee from reality. I left my twins with a seven-year-old boy, in order to look for a fix.

In describing the events that led to her parental neglect, this participant used concepts from the NA discourse, which likens addiction to a disease and personifies it (Denzin, 1987). The image here refers to control by devious forces – the *doda* ('worm' in Arabic), a term commonly used by Israeli addicts in reference to the craving for drugs, which relieves them of responsibility for using (Ronel, 1999). It seems that this discursive component alleviated the feelings of guilt about neglecting her children and constructs a victim identity.

Identity construction during treatment: The recovering-addict identity

In keeping with the institutional discourse, the research participants described their time in the therapeutic community as an opportunity to create a new identity – the recovering addict identity. One of the main aspects of the recovering-addict identity was a change in body experience. This change was well demonstrated in the course of recovery of one of the participants in the longitudinal study. As a beginner in the recovery process, she described her physical condition before entering the therapeutic community in terms drawn from popular discourse, which constructs drug-addicted women as contaminated (Ettorre, 2007), and the popular image of addicts as abject, dirty, and sick (Douglas, 1966):

> I had infected sores on my bottom and abscesses all over my legs and other places. One day I looked at myself and I was thoroughly disgusted. I injected and hurt myself, causing myself pain, so that it would hurt not only in my soul but also in my body.

This narrative is characterised by a sense of loathing, detailed descriptions of the body, and conceptualisation of the body as tool for self-punishment. In the advanced stage of recovery, this participant described a change that had taken place in her body experience:

> I did not respect myself, I used to hate myself. I damaged myself physically. I injected myself as punishment for creating abscesses in my hands. Here, actually, they restored my belief in myself. Even though I have destroyed a lot, I try a lot to love myself, to respect myself, to accept myself – it's hard but it's possible. I have gone forty per cent of the way. Starting not at zero but at minus fifty, I have reached forty.

In this description, the participant evaluated the process of change in her body experience in terms of numbers, suggesting a process that was not yet complete. In addition, compared with the earlier description, this one contains less hateful body descriptions and more descriptions that associate self-love

with a better body experience. Nevertheless, at this point she did not attribute the change to herself as an active agent, but used a passive voice, attributing the process to the community. When this participant moved to a long-term recovery process, she described a further change in her body experience:

> We had a lot of workshops on [body experience]. I was very ashamed. Now I have been on a diet. I take care of myself and I don't allow myself what I did in the past. You see, nobody can touch me and do whatever he wants with me for money, and that makes me feel better. I know that I respect myself; I respect my body.

In this construction, the participant did not include any loathing or abject body descriptions. Instead, she described her practice of body maintenance. The description, directly guided by the institutional discourse, associated a favourable mental state with a good body experience, in contrast to her earlier references to the body as an instrument of punishment. Furthermore, in this description, the participant used an active voice, consistent with the self-help principle incorporated in the institutional discourse, and she constructed an identity of agency and action.

In the institutional discourse, peers are constructed as an alternative family, and mutual help is one of the most salient principles of recovery: every resident in the therapeutic community is meant to contribute to the recovery of the others. Ideally, this mutual help is expressed in a demonstration of caring and responsibility for others without any self-interest, based exclusively on recognition of a common fate, which creates social cohesion. At the beginning of the recovery process, one of the participants in the longitudinal study had difficulty with this kind of relationship:

> They help me a lot here . . . I feel that I have people . . . I am not alone. I know that, but it is hard for me to get used to somebody being interested in me without any reason, without any self-interest.

In this description, this participant examined her relationship with her peers from a perspective she had developed in the course of many years of addiction and prostitution, in which her relationships were based by personal interests. She had difficulty experiencing herself has likeable. A few months later, when she had progressed to the advanced stage of recovery, she adopted the institutional discourse:

> I know that I have friends that care for me selflessly . . . there is a lot of identification and a lot in common, I think I get more here than I got at home from my parents.

However, when she moved to the stage of long-term recovery, this participant looked back at the change that had taken place in her peer relationships:

> At the beginning, I acted as if I believed people cared about me without any self-interest, but from that point to my actually believing took a lot of time and work.

This description reveals adoption of the therapeutic technique of 'acting as if' that is used in order to achieve change (De Leon, 2000), and also demonstrates the gradual nature of such change.

Another discursive tool that allowed most of the participants to describe change or the aspiration for change in their identity during recovery was the powerful image of rebirth. This image is drawn from the institutional discourse, which, as in other therapeutic communities, referred to the mythos of the phoenix, the mythological bird that symbolises the strength of the human spirit to overcome life circumstances and create a new life. Participants at the beginning of the recovery process described the rebirth image as an aspiration for the future. One said:

> Like a little girl, I want to learn how to live, step by step, like a newborn just learning to move.

For the participants in the advanced stage and those in long-term recovery, it seems that the change was present and powerful, enabling them to construct an identity endowed with agency and responsibility:

> Q: If you compare the Margaret[2] who entered [the community] and the Margaret who left it, what would you say about her?
>
> A: I would say 'well done!' Seven years ago Margaret was a member of the living dead, a wreck, using drugs and working as a prostitute. Now I have a house, I work, thank God. I'm paying my debts; I'm not a burden.
>
> The old Margaret is dead – she died the moment I entered the community. She is dead and buried. A new Margaret was born.
>
> You know, I celebrate my birthday on the date I entered the community; that is the day I was reborn.

This participant constructed her new identity by distancing herself from her former identity, which she condemned, and she described her major transformation with the powerful image of rebirth. She emphasised this dichotomy by consistently using the third person in reference to her past identity and the first person when describing her present identity. It seems that her stigmatised identity as an addict required an overwhelming rhetorical measure, such as death, to enable the emergence of the new identity.

DISCUSSION

The research findings indicate that the participants in the advanced stage or in a long-term recovery process – but not the beginners – employed the institutional discourse, but also elaborated and broadened it by adopting the self-medication discourse. These participants also integrated certain themes into their discourse that contradict the institutional discourse. For example, they adopted the conceptualisation of addiction as a disease from the NA discourse, but not the spiritual aspect that is central to NA. In this way, they created a new recovery discourse, which enabled them to negotiate and challenge the popular discourse.

According to the findings, the main mechanism of change in the recovery process was the adoption of aspects of several different discourses to describe reality (Gergen, 2001), or moulding discourse, drawing on a new core of consciousness that we refer to here as a recovery discourse. This core of consciousness is a well-rooted system of beliefs regarding the optimal conditions for individual development, composed of vocabulary and concepts for interpreting the past and the ability to construct their own identities (Rotenberg, 1987). This process of change in the worldview among recovering drug addicts is well documented in the research literature (O'Reilly, 1997; Ronel & Humphreys, 1999–2000), but in the present research findings this change did not result in a single definitive discourse, as described in the literature, but rather involved several discourses, indicating agency. Furthermore, the main stigmatised identity imposed on the research participants was associated with their being drug-addicted mothers, but the identity transformation that occurred in the course of their recovery, revealed aspects of identity related to womanhood and recovery from addiction in general. This suggests that the process of moulding discourses transcends motherhood issues, although they continued to play a significant role in the women's identity.

The findings reveal that a significant component of the recovery process was the transformation of the 'monstrous mother' identity into a victim identity indicating on negotiating the popular discourse. These findings are consistent with other research (Baker & Carson, 1997; Hardesty & Black, 1999; Virokannas, 2011) on strategies for negotiating the damaged mother identity. However, unlike those previous studies, focus on the deconstruction of motherhood conceptualisations, our participants negotiated and challenged the dominant discourse regarding their identity as recovering women in general.

Examination of the victim identity in the broad context of cultural power relations and cultural conventions suggests the necessity and benefits of this construction (Gergen, 2001). First, constructing a victim identity is essential in light of the widespread construction that condemns deviant hedonist acts by women on the basis that they are manly, and thus undermines the gender order (Klee et al., 2002). In this sense, the replacement of the popular discourse with a recovery discourse reinforces female representation and eliminates the male aspect of their identity construction, thereby moderating the threat to gender norms inherent in the deviant behaviour. From this point of view, as long as the woman addict is the victim of a disease, she is not a real threat to the gender order. In this sense, the recovery discourse is a 'reverse discourse' by which a marginal group employs a basic assumption of the popular discourse in order to challenge it (Foucault, 1980).

The necessity of constructing a victim identity is further increased by the alternative identity that was available to the research participants, namely that of 'monstrous mothers' who abandoned their natural role. In this respect, the victim identity is clearly preferable, even though it embodies concession of one of the most central features of Western culture – autonomous free will and rationality. Apparently, these women are willing to be constructed as lacking free will because it is better than being monstrous mothers, especially in an environment that sanctifies motherhood like Israeli society (Remennick, 2001). Moreover, acknowledgement and legitimating victimisation in childhood is constructed as crucial to recovery, since it anchors the life story in a broad social context that overpowered individual control, thus alleviating emotions such as guilt and shame (Van Wormer & Davis, 2008).

One might argue that the victim identity is actually an attempt to escape from the prevailing negative status of a defective woman and a bad mother, and as a discursive measure for avoiding responsibility (Cloward & Ohlin, 1960). Such acts, associated with neutralisation of deviation, are characteristic of a criminal personality (Beech & Mann, 2002; Scott & Lyman, 1968; Sykes & Matza, 1957), and not a recovering identity. Other researchers who have documented this contradiction (Farrall & Calverley, 2006; Maruna, 2001) echo the criticism of constructionist psychotherapy for attributing ethical problems to past constructions in order to relieve the client of responsibility for wrongdoing (Minuchin, 1998). Nevertheless, the victim identity construction is culturally compatible and has therapeutic value, as shown above. Furthermore, since it is based on the good behaviour in the present, it can be seen as part of a conscious change and recognition that encourages recovery (Rotenberg, 1987). Therefore, it seems that the neutralisation technique is actually beneficial, because those who employ it convince themselves and those around them that their past behaviours were not based on an intrinsic aspect of their identity. In so doing, they lessen the damage to self-esteem and negative feelings, such as guilt and shame for this past behaviour (Schlenker, Pontari, & Christopher, 2001), which in turn enhances their chances for recovery (Maruna, 2001) as independent individuals and not only as mothers.

The findings of the present research indicate that the participants in the advanced stage or in long-term recovery constructed a hybrid identity of a 'recovering addict'. The ability to simultaneously construct an identity endowed with agency and a victim identity indicates a unique combination of rejecting responsibility for past behaviour but accepting responsibility for the present. This flexible combination, which is compatible with the compensation model for accepting responsibility (Brickman et al., 1982), has been documented in other research as a critical component in recovery (Maruna, 2001; Rotenberg, 1987). Moreover, this hybrid identity is a new way of cultural and social agency (Anzaldua, 1987) since rather the

acknowledgement of the addiction as a disease and the victimology in the past requires action in the present. These findings indicate that the addiction as a disease concept is not repressive for women (Aston, 2009) but rather one monolithic category of women that is not sensitive to women experience is repressive.

To summarise, the research findings support the post-modern constructionism perspective that emphasises the multiplicity and the flexibility of discourses during identity construction (Gergen, 2001). The participants did not automatically accept the institutional discourse, but rather developed a new identity based on the several different discourses, demonstrating resilience, creativity and adaption to their unique experience. These findings challenge the criticism of post-modern constructionism that it ignores the individual as a meaningful agent (Parker, 1992). Instead, the findings support the view that while social forces shape individual identity, individuals also create their own agency through language, relationships and cultural attributes (Gergen, 2009). This is a process of deconstruction and reconstruction of reality, by which recovering people create an alternative meaningful discourse that accurately depicts their experience and functions as a catalyst of personal change (Henry & Milovanovic, 1996). The recovery discourse is 'real' for its users, because it validates and gives meaning to experiences that otherwise cannot be explained, and provides them with building blocks to construct their identity (White, 1996). Since no discourse can claim hegemony or exclusivity, the construction of a beneficial narrative has the potential to contribute substantially to the recovery process of the individuals, making them the narrators of their respective life stories (Gergen, 2001). Thus the recovery discourse is an emancipatory one, one that contributes positively to a politics of resistance, hope and freedom (Denzin, 2005). Moulding an emancipatory discourse is hence an act of 'talking back', that is, of negotiating and creating a dialogue with dominant stigmatising discourses that evokes the possibility of alternative identities (Juhila, 2004).

However, it is important to point out some of the risks inherent in the recovery discourse, despite its cultural and therapeutic benefits. First, the concept of addiction as a disease could paradoxically serve as justification for the punishment of addicts (Reinarman, 2005). Furthermore, according to social constructionism, the recovery discourse presented here is one of many recovery narratives, and diverse narratives may be most effective in representing the complex heterogenic nature of the processes in question. Therefore further research should be conducted to explore other recovery narratives, perhaps contradictory to that presented here to further our understanding of recovery discourses. In addition, this study relies on a non-representative sample of participants from a unique social-cultural background. Therefore, it is important to examine the same issues with mothers from different social-cultural backgrounds, including those in which motherhood is a less crucial component in women's identity. Also, since the process identified here, moulding of discourse, has implications for recovery processes in general, and not only those involving women and motherhood, we recommend an examination of its applicability regarding the identity construction of men identity during recovery from addiction.

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NOTES

1. The research participants presented themselves as ''recovering-addicts'' as part of their group affiliation and as a way to acknowledge their recovery journey. We chose to adhere to their self-presentation despite the negative and demeaning associations of the word 'addicts'.
2. Pseudonym.

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