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Recovering Drug-Dependent Mothers' Perspective on Gender-Sensitive Therapy: An Israeli Case

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Abstract

This study examined issues of gender-sensitive therapy, such as relational self, motherhood, and single-gender treatments from the perspective of recovering drug-dependent mothers. Using a social constructionism framework, 25 recovering drug-dependent mothers in different stages of recovery were interviewed and 5 of them were followed for another 2 years. The results challenge the argument presented by advocates of gender-sensitive therapy in the addiction field and underscore the importance of context, especially the therapeutic narrative that elicited an alternative construction of gender, motherhood, and gender-sensitive therapy. The findings suggest possible new directions for addressing therapeutic issues and the need for additional research.

Keywords

gender/identity, mothering, qualitative, recovery, substance abuse

Introduction

With an estimated 9% of the population in the United States having a substance use disorder, it seems that recovery from addiction is an important issue for social workers (Ashenberg Straussner, 2012). In recent decades, the body of knowledge on recovery from drug addiction has undergone a notable shift with regard to women, from neglect of this population to the development of gender-sensitive therapies. The dominant approach in this field is guided by the self-in-relation model (Grella, 2008). This model is rooted in the seminal work of Chodorow (1974) and Gilligan (1982), which disputed the previous models of identity and suggested that women and men have developed identity in different ways. Chodorow (1974) claimed that parents cultivate an identity of independence and separation among boys, compared with association and attachment among girls. Continuing Chodorow's work, Gilligan (1982) focused on women's different voice and

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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).

The Application of the Self-in-Relation Model in the Field of Addiction

Covington (1998) and Byington (1997) applied the self-in-relation model to explain drug addiction and recovery among women. According to Covington (1998), the relatively greater importance that women, compared with men, ascribe to relationships in their lives and to their identity make them particularly vulnerable to drug addiction in the absence of a meaningful, healthy relationship. In such cases, women develop a relationship with the substance, which is more rewarding and compensating compared with their human relationships (Byington, 1997). According to the same reasoning, if bad relationships influence drug addiction, good relationships can be used for recovery.

The self-in-relation model has been applied to the field of women's recovery in three main aspects of the practice, creating the gender-sensitive therapies employed in individual sessions and groups. The first application of this model in the addiction field is the rehabilitation of women's relationships as a central aspect of their identity. Accordingly, the aim during the recovery process is to discontinue the relationship with the drug and establish meaningful relationships between the woman and her children, therapist, and peers (Byington, 1997). The corpus of knowledge based on this perspective has focused mainly on the relationships of women with their children, documented the good therapeutic outcomes of joint treatment of mothers and children (Tracy & Martin, 2007), and emphasized motherhood as an important mental resource for women's recovery (Grella, 2008).

The second application of the self-in-relation model that created the gender-sensitive therapies is the preference of single-gender over mixed-gender therapy, in response to the concern that women's issues, such as sexual trauma, might be neglected in mixed-gender groups that consist predominantly of men (Reed, 1985). Furthermore, single-gender environments are designed to provide security for women and protect them from sexual harassment (Hodgins, El-Guebaly, & Addington, 1997; Nol, 1991).

The third focus of practice based on the self-in-relation model that created the gender-sensitive therapies concerns the inappropriate use of the confrontation technique, also known as the peer encounter group, among women. During employment of this technique, interpersonal observation is followed by one member of the therapeutic milieu providing another with aggressive feedback about a behavior pattern that he or she should change. This practice, which is aimed at changing the identity of the drug-dependent clients, has been described as one of the most effective therapy techniques in drug recovery (De Leon, 2000). Nevertheless, in light of the importance of relationships to women and the intense feelings of guilt and shame among drug-dependent women, compared with men, this technique was found to be counterproductive in the recovery process of women (Bloom, Owen, & Covington, 2003). In contrast, Polcin (2003) indicated several important contextual factors that may affect women's ability to recognize the therapeutic value of confrontation and hence affect its clinical impact, such as clients' acceptance of the underlying philosophy of the program and perceived motives of confrontation.

The Current Study

Research and clinical experience indicate that gender-sensitive treatment that focuses on these three aspects in addressing women's needs is more effective compared with traditional therapy (Ashley, Marsden, & Brady, 2003; Messina, Grella, Cartier, & Torres, 2010). Despite the recognition of practitioners and theoretical evidence of the importance of gender-sensitive therapy, its relative effectiveness, as perceived by clients of therapy centers for women, remains unclear. Therefore, the goal of this study was to gain an understanding of how mothers in different stages of drug-addiction recovery perceive the gender-sensitive mechanisms.

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Moreover, in recent decades, a broad range of new feminist and social constructionism theories have criticized the self-in-relation model and its essentialist features (e.g., Butler, 1990; Collins, 1994). First, labeling particular ways of being as "women's" bears a strong resemblance to gender stereotypes and may prevent women from experiencing other modes of being (Bohan, 1993). Along the same lines, Butler (1990) challenged the construction of gender as a dichotomous category suggesting that femininity and masculinity are not necessarily mutually exclusive. Rather, Butler noted that the lived experiences of women go beyond those traditionally associated with femininity indicating on multiplicity in gender identity construction. Specifically, the application of gender-sensitive principles in the justice system and addiction treatment has been criticized for not questioning gender stereotypes (Anderson, 2008; Goodkind, 2005).

Second, the self-in-relation model has been criticized for constructing mother's love for her child and the practice of mothering as natural and instinctive, thus objectifying mothers and ignoring their own subjective needs. These constructions created the "good mother" myth, based on a one-dimensional concept of motherhood that focuses solely on the harmonic and positive aspect of the maternal role (Hays, 1996; Maushart, 1997; Ruddick, 1994). Finally, the essentialist perspective fails to consider the complex ways in which gender operates in social interactions (Bohan, 1993), leading to foundation of gender-sensitive therapeutic approaches on a decontextualized understanding of women (Goodkind, 2005). Similarly, proponents of social constructionism have presented identity largely as a function of the social contexts in which individuals operate in the course of their lives, with different aspects of identity evolving, in part, as adaptations to diverse social contexts, and constructed from the available cultural stock of narratives (Gergen, 1991). Furthermore, this approach does not see therapy as a process of exposing essential truths (Gergen & Warhus, 2001), but instead considers therapeutic issues as construction as well, indicating the broad and local cultural contexts in which the individual operates. Accordingly, every therapeutic institution is seen to offer a framework to narrate therapy. Indeed, research based on this approach has presented socialization within addiction-treatment programs as enabling clients to reconstruct identity and revealed the close parallels between their participants' accounts and the content of their recovery programs (Baker, 2000; McIntosh & McKeganey, 2000).

Despite this progress of feminist conceptions of gender, which have become more complex and interaction-oriented, and the new insights into therapy and identity based on social constructionism, researchers of gender-sensitive therapy for addiction have continued to treat gender as a dichotomous categorization and an inherent characteristic of individuals. Hence, in this article, we address gender-sensitive therapy from a new feminist and constructive framework, in order to create a more sophisticated method of bridging the social context, and not simply characterize women as victimized or vulnerable, because this characterization denies the transformative potential of agency (Hannah-Moffat, 2010).

In order to elucidate the recovering drug-dependent Israeli mothers' perspective on gender-sensitive therapy and due to the importance of the social context in which the research participants act, we first describe the broad context (Israeli society) and then the local one (the therapeutic community [TC]).

The Broad Social Context: Israeli Society's Perception of Motherhood and Addicted Mothers. Ajzenstadt (2009) indicated the dynamic and hybrid nature of Israeli society with regard to women's status and social role, focusing mainly on nonreligious Israeli society. On one hand, Israel has adopted a modern western lifestyle, whereby women formally enjoy equality and freedom in education and the workplace, enabling them agency. On the other hand, Israeli society is governed by a strong patriarchy and has been defined as a pronatalistic society, due to religious tradition and the encouragement of demographic growth in the Jewish population. Thus, the motherhood role has been defined as crucial to the identity and morality of Israeli women (Remennick, 2001). In Israel, this role is

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strongly influenced by the good mother myth of women's instinctive ability and desire to care for and to sacrifice their own needs for those of their children (Hacker, 2005). Hence, it is not surprising that Israeli pathological women gamblers emphasized the role of motherhood in their life, indicating their desire to fulfill the ideal of the good mother (Gavriel-Fried & Ajzenstadt, 2012) and drug-addicted Israeli women are subjected to harsh stigmatization by institutions and the general society (Salan, 2005). Although little is known regarding their prevalence, it is estimated that women account for 10% to 30% of the population of about 25,000–30,000 heroin addicts in Israel (Isralowitz, Reznik, Spear, Brecht, & Rawson, 2007).

The Local context: The TC and Its Recovery Narrative. 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 without the use of drugs. Charles E. Dederich, a former alcoholic, introduced the TC method in the United States in 1958, using eclectic therapeutic tools to help addicts recover and develop a sense of responsibility for their lives. Since then, various TC models have been developed around the world. Although the details vary, all are based on a perception of drug addiction as general problem of the individual, requiring a total lifestyle change and identity transformation. To this end, they employ various therapeutic techniques, guided by principle of self-help and mutual-help principles, holding the residents responsible for their own and the others' recovery (hence "residents" and not "patients"). The staff, which is usually comprised of social workers and former residents, uses these tools mainly in group work. In addition, based on the self-help principle, the TC is self-managed: The residents perform all the regular maintenance, such as cleaning, in order to encourage their work ethic. During their stay in the TC, for about a year and a half, each resident progresses through five phases, contingent upon demonstration of improvement in emotional and social functioning. The first stage is dedicated to integration of the new resident and learning the TC narrative regarding addiction and recovery. The next phase is devoted to developing self-awareness and identifying individual behavior patterns that led to addiction, using techniques such as confrontation. In the third phase, the residents embrace leadership positions in managing the TC. During the phase of preparation for exit, the residents live in the TC but work or study outside it. In the final phase, aftercare, they live in a hostel outside the TC and rejoin the general society (De Leone, 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, the model was modified. The aim was to maintain some characteristics of the classic TC model and create a mixed gender-sensitive milieu. According to the modified TC narrative of recovery, the mobility in various TC leadership positions helps women develop agency and undermines various patriarchal norms. Furthermore, the mixed-gender milieu provides women an opportunity to practice abandoning common behavior patterns of drug-dependent women, such as sexual seduction, and to embrace new perceptions about men by stressing the shared experience of addiction and recovery. The TC recovery narrative focuses on transformation from an addict identity to a recovering addict identity as a crucial factor in the recovery process. This identity construction, for all the TC residents, regardless of gender, includes close personal relationships, but simultaneously stresses personal agency (De Leon, 2000).

The first TC in Israel was founded in 1987, as an addition to other models for drug addiction treatment, such as methadone maintenance and Narcotics Anonymous (Sela, 2002). The residential TC from which our sample was drawn was a mixed gender-sensitive milieu, located in a rural area. There was a 1- to 2-year specialized track for women and their children, followed by residence in a hostel. This track offered special gender-sensitive groups for women and 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. While some women were self-referred to programs, most were court-referred as a result of poor parental functioning due to drug abuse. In addition, this track was embedded within the larger residential program that treated men and women together and included

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employment of the confrontation technique, in contradiction to the argument presented by advocates of gender-sensitive therapy in the addiction field. Thus, the mixed gender-sensitive milieu in which the research was conducted constituted a good setting for studying the experience of women regarding gender-sensitive therapy.

Method

Participants, Materials, and Procedure

The research sample consisted of 25 Israeli mothers in different stages of recovery from drug addiction. This maximum variation approach (Kuzel, 1999) was selected in order to include a wide range of perspectives along the recovery process. All participants were associated with the same TC, 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 (BRP) who had just entered the TC (BRP; 1–3 months; $n = 10$); mothers in an advanced stage of the recovery process who were still in the therapy program (advanced recovery process [ARP] ; 6–12 months; $n = 6$); and mothers who had completed the therapy program in the community and were in the long-term recovery process (LTRP; 2–7 years; $n = 9$). In addition to this research, we conducted a complementary longitudinal study that monitored five mothers from the BRP group. Each of these participants was interviewed at the beginning of the recovery process, again when she reached the ARP and once more about 2 years later, when she was in the process of long-term recovery (a total of 35 interviews). This research design enabled a comparative developmental examination of gender-sensitive therapies. We recruited participants by two means: Most of them (20) were recruited through the TC, and the others (5) were recruited by means of a snowball sample because we wanted to interview subjects who had completed the therapy program but were no longer in touch with the TC, as part of the maximum variation approach (Kuzel, 1999).

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. Most of the participants (23) had previously been polydrug abusers and their main drug of choice was heroin. One participant used cocaine and another used tranquilizers. On average, the research participants had completed 10.72 years of education. Most of the research participants ($n = 23$) were single or divorced; the others ($n = 2$) were married.

In light of the research aim of examining the gender-sensitive therapies from the point of view of drug-dependent mothers, we adopted a qualitative approach to data collection and analysis. This interpretive framework allows drug-dependent mothers to be experts regarding their experiences and identification of appropriate and effective therapeutic models (Orford, 2008).

The first author conducted in-person interviews with the participants who resided at the TC in an isolated, private room on the premises. The location was chosen to ensure them anonymity. 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 couldn't assure privacy in her house. The interviews ranged in length from 2 to 6 hr. We obtained the university ethical board's approval and to comply with the principle of anonymity, we asked staff at the TC or friends to make the initial appeal to prospective participants. The candidates were assured that the interview would have no influence—good or bad—on their treatment and asked to sign a written statement of informed consent. We also advised the participants that they could stop the interview at any point they chose. Only one participant terminated an interview after it had started; this interview was not included in the study.

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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 questions regarding the gender-sensitive mechanisms: identity, motherhood, mixed-gender milieu, and confrontation technique. 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. This method focuses on temporality along the research designs and implementation. It involves recurrent waves of data collection over period of time, aimed at capturing change over time regarding the research question (Saldana, 2003). For this purpose, we asked the participants in the longitudinal research questions such as "in our last meeting, you told me that you were afraid of the confrontation technique; please tell me how you feel about it now." All interviews were audiotaped, transcribed verbatim in Hebrew, and then translated into English in a way that captured their meaning and context.

We used Narralizer 1.1 qualitative data analysis software (Shkedi & Shkedi, 2005) to process and organize the extensive data into themes and subthemes. The method was based on the constructive paradigm, which was designed to investigate how the individual constructs and gives meaning to the world (Gergen, 1991). In the first stage of the data analysis, the entire body of interviews was read to get a general impression of them as a whole. Next, we read each interview separately, as though it was a case study (Stake, 1995), recording notes and looking for themes and subthemes that focused on identity features and the participants' construction of motherhood, mixed-gender milieu, and confrontation techniques. At this point, we avoided speculations and did not attribute the differences among participants to their position on the recovery continuum alone. Thus, while reading the interviews, we looked for points of similarity and differences using the constant comparative method (Glaser & Strauss, 1967), according to which personal features of the participant such as age, birth country, and recovery stage are drawn from the interviews to create different categories (Patton, 2002). In terms of most of the themes and subthemes, the differences among participants corresponded to their respective stages of recovery, indicating a developmental process. It was based on this finding that we decided to conduct a longitudinal examination of recovery and to trace how the constructs changed in the course of the recovery process. The research findings refer intermittently to each of these two research tracks.

The assessment of research quality was based on the accepted criteria for qualitative research studies, such as transferability and credibility of the findings (Lincoln & Guba, 1985). For this purpose, we encouraged participants' free and open expression, presented a full and detailed description of the research population and analysis processes, and supplied detailed descriptions of the participants' points of view. In addition, we paid special attention to the impact of various researcher attributes on the study throughout its stages, by evoking reflective and critical discussions among the researchers and employing qualitative peer debriefing. In this process, we presented our preliminary findings to four specialists in the addiction field—two academic researchers of addiction and two practitioners in the addiction field—and asked each one separately for feedback. Based on their comments, we further modified our interpretation of the findings.

Results

The analysis revealed an identity transformation along the recovery process, from addict identity to a recovering addict identity.[1] This identity transformation was parallel to the model offered by the TC (De Leon, 2000), but its characteristics diverged from the self-in-relation model and its treatment applications and revealed the complexity of recovery.

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"I am Proud of Myself": Mixed-Gender Representation

The analysis revealed that the recovering addict identity was embodied in agency characteristics, such as taking responsibility, achievement, and self-control—features of autonomy that are typically associated with men—as well as relational features, such as ascribing importance to family and friends, which are typically associated with women (Gilligan, 1982). This mixed-gender representation in identity construction is consistent with the TC narrative of recovery (De Leon, 2000). A participant in the longitudinal research expressed this well: At the BRP, she said of herself, "I don't know anything, I'm nothing... I'm not a human being." This description, which characterizes self-dehumanization and self-hate, had changed a few months later, when she had progressed to the ARP stage. At that point, she referred to an ideal model, but noted that she had not yet fulfilled her aspiration, "I have a lot of work to do on myself, to become responsible, to learn to do everything I haven't done all my life .... I'm not alone any more, I can't give up. I have a child and responsibility." When she moved to LTRP stage, it seemed that this participant had completed her identity transformation.

> I am working hard but I walk with my head high .... I am proud of myself .... They respect me and trust me at work. There are a lot of good things going on in my life. If I look at the full half of the glass, as they taught us—I have a home, my daughter has everything, I have a job, I have friends.

This participant's description indicated that at that point in the recovery process her self-perceptions and abilities had changed dramatically, from an identity as inhuman to an identity characterized by features of autonomy, such as work, as well as relational features, such as her friends and daughter.

"Motherhood Is Difficult But It Is Fun": Motherhood as a Multidimensional Experience

Living with their children in the TC provided the research participants an opportunity for reflexive examination of the meaning of motherhood in their lives and varied according to stage of recovery. The BRP participants constructed their maternal identity as an object only and described motherhood in one-dimensional terms as a mental resource. In comparison, the descriptions of the ARP and LTRP participants revealed a dual position, in which they were striving for balance between their roles of subject and object, reflecting the TC narrative of recovery (De Leon, 1997). These participants constructed their motherhood during treatment as a multidimensional experience—a mental resource, but also as a mental burden.

The common denominator among all the research participants was the construction of motherhood as a facilitator and motivator of recovery, meaning a mental resource. For example, an LTRP participant described her motive for recovery: "I understood that I cannot be the center of the world anymore. My children need me and I have to provide them with values, honesty, frankness, and integrity." In addition, however, along the recovery process, the construction of motherhood as a mental burden also arose among ARP and LTRP participants. These participants cited various difficulties that arose from living together with their children, and also indicated their solutions. For example, at the beginning of the process, one of the participants in the longitudinal research described motherhood as a one-dimensional aspect, providing mental relief. She noted that her son's visits made her feel well and encouraged her to continue her treatment: "Ever since my child started visiting me here, it's been much easier for me. Now I have to do what I have to do so that he will visit again." After she had progressed to the ARP stage and her child had come to live with her in the TC, the same participant described motherhood as a mental burden, indicating the conflict between her needs as a subject undergoing painful treatment and her duties as an object, with responsibilities as a mother.

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> It is difficult, I am in the routine from 7 a.m., taking the child to kindergarten, and then the child comes home. I need to separate the two: in therapy I recall my past, my own childhood, and at 4 p.m. I have to go back to my child and be a completely different person.

Finally, in the LTRP stage, this participant demonstrated a more integrated position with respect to motherhood: "Motherhood is difficult but it is fun. All the responsibility, all the difficulties are hard . . . but it is fun. I pick him up from kindergarten and he is happy, he gives me a kiss". Members of the ARP and LTRP groups, as well as other participants in the longitudinal study, also expressed constructions of motherhood as a burden. For example, the description provided by an LTRP participant revealed a conflict between her needs as an object and as a subject.

> I didn't want my child here. I was scared before every visit. I made a lot of problems, because I knew that if she came I would not have much freedom. I wanted to spend time with the other community members, especially on weekends when we have music and we can dance. What did I need her for? . . . . You learn to ask for help; I have asked other members to watch her on occasion.

This description reveals the conflict between the mother's wishes, as a subject, to enjoy the community life as well as fulfill her duties as a mother. She acknowledged the problem and sought solutions. The construction of motherhood as a mental burden also arose in narratives about the obligation to stay in therapy because of the fear of losing custody, as in the description provided by another LTRP participant.

> In the beginning it seems like a prison: the mentors seem like your wardens, you feel suffocated, they are grabbing you by the balls because you are a mother . . . . Only later do you understand that this is intended to help you.

In her description, this participant compared the community to a prison, ironically using the phallocentric slang phrase "grabbing you by the balls" to demonstrate the sense of threat and incarceration during the therapy. However, in the course of the recovery, she expressed agreement and acceptance of the TC narrative of recovery (De Leon, 1997).

One of the most effective resources for dealing with this contradiction between the participants' needs as subjects and as objects was the special group for mothers. For example, the construction of the experience in the mothers' group by one of the LTRP participants attests to this:

> I was not ashamed to say that I felt nothing [toward my daughter] and I also don't know what to do with her. It was very important to me that nobody judged me . . . . To the contrary, they gave me tools and ideas and it was very helpful.

This narrative undermines the assumption that a mother's love for her child and the practice of mothering are natural and instinctive; this participant knew she was expected to be ashamed of her inability to function as a mother, but she felt that the special group for mothers was a safe milieu where she would not be judged. Consequently, she was able to share these unspeakable elements and get help.

"It Was Hard, but I Took It to a Good Place": Constructing Confrontation Techniques

The constructions of the confrontation techniques varied according to stage of recovery. Among the BRP participants, this issue generally evoked expressions of fear. For example, one BRP participant explained how she felt about the peer encounter group.

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> I'm afraid because sometimes they say very difficult things .... If they tell me I'm using my eyes to manipulate them into giving me things, I fear that they'll reveal this in the confrontation and prevent me from using it to get what I want in the future.

In general, this participant focused mainly on disadvantages of the confrontation: The pain she felt when bad and unacceptable behaviors were exposed. In comparison, the LTRP and ARP participants emphasized the transformative value of this technique, along similar lines to those of the TC narrative of recovery (De Leon, 1997). They described a process that began with difficulty to accept feedback regarding their behavior but culminated in their understanding and appreciation of the purpose and effectiveness of the confrontation in achieving their goal:

> They confront you and say "you're such and such" ... it's hard, but I took it to a good place because I understood that they loved me, they were seeing me and not giving up on me because if they wouldn't [confront me], I wouldn't change.

In this description, the participant recalled the criticism that had been directed at her during the confrontation, and her "taking it to a good place," concluding that it was for the best. The confrontation did not lead to a collapse in her self-esteem; instead, she understood it as an act of mirroring and empathy intended to help her change her behavior.

"They Can All Be Like Brothers to You": Constructing the Mixed-Gender Milieu

In the TC, the only relationships permitted between men and women are those of a sibling-like nature (De Leon, 2000). Most of the research participants, regardless of group, agreed with this rule and referred to the male residents as their alternative family. For example, one of the ARP participants described her relationships with male residents at the TC, "They can all be like brothers ... I don't know if I could take care of myself with somebody else on my mind, or discuss my pain with someone I was sleeping with."

Despite this consensus, many participants from all the research groups described various situations in which they were emotionally involved with men in the therapeutic milieu. The constructions of this relationship varied according to stage of recovery. BRP participants described such emotional involvement with fear.

> I was afraid to take the leap [run away from the TC with him], I am confused .... I told a friend of mine that I was afraid and didn't want to start using again, to start something and not finish it, to disappoint myself again. I know that if I screw up again I won't have any more chances.

The participant focused on the confusing and threatening consequences of her friend's offer to leave the TC. This description underscores the disadvantage of a mixed-gender milieu. In contrast, the narratives of ARP and LTRP participants regarding involvement with men in the therapeutic milieu indicate the advantages of therapy in a mixed-gender group, as does the TC narrative of recovery (De Leon, 1997).

> I think that for a woman, especially coming from the drug world, it is important not to be separated [from men] .... It's especially important during treatment to be involved with a man as a different type of woman—not a submissive or criminal woman .... This helped me a lot, because through them I did [therapeutic] work on my relationship with my brothers, my husbands. Through them I learned a lot.

From the perspective of this participant, being in a TC with men offered her an opportunity to experience and explore an egalitarian relationship and discover various characteristics of

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womanhood. Moreover, for her, treatment in a mixed-gender group enabled reflexive examination of her past relationships with men and provided a raw material for her therapy. Similarly, one of the LTRP participants also described a process of change in her perceptions of men, indicating the ability of mixed-gender therapy to undermine stereotypes by focusing on the common denominator of drug addiction, "At first I saw the men as devils, but in time, I understood that they were addicts just like me and couldn't judge me. So I revealed everything, and I saw a different world."

In comparison with these examples, and unlike the TC narrative of recovery (De Leon, 1997), the narrative of one of the women in the LTRP group revealed a disadvantage of the mixed-gender setting, when she described how she "used her sexuality" as a survival technique in the harsh therapeutic milieu.

> I used my sexuality in the community, I wasn't the most beautiful but, you know, the boys were [sexually] frustrated so every little thing they gave me—cigarettes, letting me eat whenever I want without reporting me . . . —that's how I managed to survive there.

This description exposes the "benefit" of being a woman among a majority of men, namely, attaining power and protection by means of her sexuality. In this respect, it supports the criticism of mixed-gender therapy as providing a setting for repeating past relationships where women are objects whose strength is limited to seductive behavior.

Discussion

The results of this research challenge the self-in-relation model and its applications in the addiction field (Byington, 1997), while indicating the importance of context, especially the local context in the therapeutic narrative that elicited an alternative construction of gender, motherhood, and gender-sensitive therapy. In particular, the narrative of the ARPs and LTRPs, in contrast to that of the BRPs, indicated autonomous as well as relational features of identity, both positive and negative aspects of motherhood, and the advantages of the confrontation technique and mixed-gender milieu. The dominance of the local context in the recovery narrative is consistent with the findings of some of the research literature (Baker, 2000; McIntosh & McKeganey, 2000) and contradicts other (Gueta & Addad, 2013). This might be a result of the TC context, which is able to serve as an alternative to the stigmatizing narrative of drug-addicted women in Israel (Salan, 2005). However, it could also be specific to the hybrid nature of Israeli society with respect to women's social role, which stresses agency as well as relationship features (Ajzenstadt, 2009).

In particular, the results indicate an identity transformation during the recovery process: A dehumanized and stigmatized identity was replaced by one of resilience, which embodied representations of both male and female identities. This counters common assumptions about the relational self commonly associated with women (Surrey, 1991). The mixed-gender representation indicates a social construction of gender (Butler, 1990) and challenges the view of gender as an intrinsic entity that is expressed through behavior. Butler argued that if an individual who has been forced to take part in the gender binary delineation does not repeat the binary gender norm but refutes it by means of mixed-gender representation, that individual can establish an alternative gender identity. This way, for example, the participants' identity construction that embodied the importance of work to their life and recovery, which is a traditionally masculinity feature, enabled them to resist gender coercion and empower their individual agency, thus representing a less oppressive conceptualization of women's subjectivity.

The research findings shed light on the monolithic concept of motherhood by suggesting an alternative multidimensional construction. In the recovery process described here, motherhood was, among other things, a priceless mental resource of success and satisfaction in the lives of the research

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participants. Thus, similar to other research on recovery (Baker, 2000; Tracy & Martin, 2007), our findings indicate that maternal identity can have optimal influence on the recovery process. In addition to this construction of motherhood as a mental resource, these women in the process of recovery constructed motherhood as a mental burden, contradicting the common unilateral focus on motherhood as a mental resource for the recovery process. These findings are surprising, considering the participants' broad context of a pronatalistic society that glorifies motherhood commitments (Remennick, 2001). However, they are in line with the local context, the TC narrative of recovery, as manifested in the mothers' support group (De Leon, 1997). This construction challenges the good mother myth based on a one-dimensional concept of motherhood that focuses solely on the harmonic and positive aspect of the maternal role and ignores the subjective needs of the mother herself (Hays, 1996; Ruddick, 1994). In fact, the ability to expose those unspeakable aspects of motherhood (Maushart, 1997) contributed substantially to the recovery process, because it made the participants seek solutions and strive for balance between their identity as a separate subject and as an object.

The research findings regarding confrontation techniques indicate that according to the experience of the research participants, it was only at the end of the process that they could conceive of this technique as an empathetic act that enabled their individual transformation. These findings challenge the objection to its employment among women (Bloom et al., 2003), but underscore the importance of the context factor regarding this technique, such as timing and acceptance of the TC philosophy in determining its effect (Polcin, 2003).

The combined model offered in the TC studied here, where the central milieu is heterogeneous but there are also special groups designed to address gender-specific issues such as motherhood, has advantages and disadvantages. One of the advantages is the mixed-gender therapeutic milieu can be used as a platform for training in unromantic relationships and expanding "masculine" characteristics among women (Burrowes & Day, 2011). One of the disadvantages is the potential of mixed-gender milieu to jeopardize creation of a safe therapeutic environment, especially during the first period of recovery, when in the absence of drugs, women might regress to stereotypical sexual behavior, such as seduction, which is liable to hinder treatment (Nol, 1991).

We began this article with a discussion of the welcome trend in the field of drug recovery, which is increasingly addressing the specific needs and characteristics of drug-dependent women. The main finding of the research, however, challenges the self-in-relation model, giving rise (once again) to the question "what do women want?" Therefore, based on these findings, we propose a series of practical recommendations for social workers, as well as other therapy professionals, regarding treatment. First, the research findings revealed the adoption of autonomy as well as relational features in identity construction, suggesting that therapy should encourage them both. For this purpose, therapy should encourage financial independence and occupational training and not focus on motherhood as a dominant motive for recovery. Furthermore, the complexity of including children in the therapeutic milieu was revealed, indicating that therapists should pay special attention to related issues. Specifically, the participants emphasized the burden of taking care of children after intense therapeutic sessions, indicating the importance of identifying patients in distress and supplying various therapeutic resources to help mothers in this respect. In addition, the therapists need to address the unique implications of being in treatment under the threat of losing custody by, inter alia, stressing the therapeutic value of this act.

Second, the research participants' indicated that employing peer encounter groups among women is effective under certain conditions, as reported by Polcin (2003). Accordingly, in order to employ effective confrontation among women, it is recommended that practitioners (a) draw a direct line between past behaviors or lifestyle and a deleterious state during the confrontation; (b) address women's fear about being subjected to this technique; (c) employ it only after the aim of confrontation as an act of empathy intended to facilitate lifestyle change and recovery has been established; and (d) employ this technique only after a sense of a community and support among the male and female residents has been established.

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Third, the advantages of the mixed-gender therapeutic milieu were stressed, but should be adapted only along aside special groups that meet the women's needs. This way women can benefit 2-fold: On one hand, therapy with men may be the women's first opportunity to experience an egalitarian relationship, embracing leadership positions, and developing relationships with men, which can provide a raw material for their therapy. On the other hand, the special groups for women and mothers alone can address their unique gender issues such as involvement in prostitution. In any case, it is important that therapists employ several means aimed at protecting women from sexual harassment and involvement in romantic relationships during treatment in the mixed-gender milieu.

Despite the contributions of this study, several limitations should be noted. First, even though our sample included drug-dependent recovering mothers in various stages of recovery, this study relies on a small nonrepresentative convenience sample of participants that were treated in one kind of drug addiction therapeutic intervention and from a unique social–cultural background. Therefore, conclusions should be made with caution until they can be replicated in a more generalizable sample.

Despite these limitations, the present research findings contribute to the knowledge regarding treatment for women with addictions by presenting the voice of recovering drug-dependents and revealing their experiences. Furthermore, our research findings highlight the potential of mixed gender-sensitive therapy to enable alternative constructions, which may help challenge and change gendered norms, rather than perpetuate them. Like Goodkind (2005), our goal was not to reject the role that gender should play in designing recovery programs for women in addiction therapy. Instead, the objective was to shed light on the development of alternative gender-sensitive therapy and to go beyond essentialist assumptions in order to create adequate therapeutic tools. The research findings indicated that new theoretical perspectives and additional research and conceptualizations of gender-sensitive therapy may be needed, perhaps requiring new measures and research approaches.

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Note

1. 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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