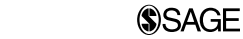
Journal of Drug Issues
43(4) 450–467

DOI: 10.1177/0022042613491097
jod.sagepub.com



Self-Forgiveness in the Recovery of Israeli Drug-Addicted Mothers: A Qualitative Exploration

Keren Gueta[1]

Abstract

It has been suggested that self-forgiveness plays an important role in the process of recovery from addiction, especially for women, but this issue has been largely overlooked in the research. This study explored self-forgiveness from the perspective of 25 recovering drug-addicted mothers associated with the same therapeutic community, either as current residents in the course of recovery or as past residents who maintained recovery. The participants were interviewed in a dual-research design (35 interviews) that enabled comparative-longitudinal examination of the self-forgiveness process. Qualitative methods were used to identify the emotional, cognitive, and offense-related factors associated with self-forgiveness regarding mothering patterns during addiction. The results indicated that self-forgiveness involves cognitive flexibility by using the disease model, creating new constructions of motherhood, and changing mothering patterns. Furthermore, self-forgiveness is accompanied by diminishment of guilt and enables construction of a new shame-free identity. The findings may inform self-forgiveness interventions in the addiction field.

Keywords

addiction, self-forgiveness, women, motherhood

Researchers have argued that forgiveness intervention is highly relevant to drug-addiction therapy because of its ability to target emotional states that can lead to destructive coping skills such as substance abuse (Enright & Fitzgibbons, 2000; Schibik, 2006). Studies have shown that participants who had completed forgiveness therapy had greater decrease in depression, anger, anxiety, and vulnerability to drug use than patients who had undergone treatment based on conventional drug and alcohol therapy (Lin, Mack, Enright, Krahn, & Baskin, 2004; Worthington, 2005). Furthermore, Scherer, Worthington, Hook, and Campana (2011), who tested the efficacy of intervention to promote self-forgiveness, found that participants who had undergone intervention reported more positive gains on measures of drinking refusal efficacy, and experienced more guilt and shame over alcohol-related offenses than participants who had not undergone intervention.

[1]Interdisciplinary Department for Social Sciences, Bar-Ilan University, Ramat-Gan, Israel

Corresponding Author:
Keren Gueta, Interdisciplinary Department for Social Sciences, Bar-Ilan University, Ramat-Gan, 52900, Israel.
Email: keren@gueta.com

Nevertheless, scientific study of forgiveness in addiction and recovery is relatively new and the specific, distinct effect of forgiveness has not yet been established (Webb, Hirsch, & Toussaint, 2011). One aspect of this issue that is particularly lacking in the research is self-forgiveness, which has been found to be the most difficult type of forgiveness to develop, compared with forgiveness of others and feelings of forgiveness by God (Webb, Robinson, Brower, & Zucker, 2006).

The purpose of the present research was to explore the experience of self-forgiveness, from the perspective of Israeli mothers in various stages of recovery from drug addiction, with the aim of helping guide the development of more adequate and effective treatment strategies for recovering addicts.

Self-Forgiveness

Hall and Fincham (2008) defined self-forgiveness as a system of motivational changes that decreases the individual's motivation to ignore stimuli associated with the offense, punish oneself, and act self-destructively, and increases actions intended to benefit oneself. According to Hall and Fincham (2005), self-forgiveness involves different psychological processes and qualities than those of forgiveness of others. First, self-forgiveness is related to being an offender rather than a victim of injustice. Second, in contrast to interpersonal forgiveness that does not require reconciliation with the offender, self-forgiveness requires reconciliation with oneself and, in turn, may further promote self-reconciliation because of its ability to reduce the emotional distress that results from the transgression. Thus, the absence of self-forgiveness may have more severe consequences than lack of interpersonal forgiveness does (Hall & Fincham, 2005).

Several studies have suggested that the ability for self-forgiveness is related positively with self-esteem and life satisfaction, and negatively with neuroticism, depression, and aggression (Leach & Lark, 2004; Maltby, Macaskill, & Day, 2001; Mauger et al., 1992). Failure to self-forgive has been found to correlate with a relatively low quality of life (Friedman et al., 2007). It has also been shown to be more strongly associated, relative to difficulty in forgiving others, with mental health problems among combat veterans suffering from posttraumatic stress disorder (PTSD; Witvliet, Phipps, Feldman, & Beckham, 2004).

Hall and Fincham (2005) proposed a theoretical model of self-forgiveness that is based on two prerequired conditions that in this article will be referred to as the model's features: The first feature requires that the self-forgiveness process be initiated following an interpersonal transgression and not a case of self-inflicted harm. The second feature requires that the perpetrator take responsibility and acknowledge the wrongful behavior. The model does not refer to pseudo self-forgiveness that lacks the feature of acknowledging the wrongfulness of the act and taking responsibility and hence may lead to excusing, minimizing, or neutralizing the transgressions. According to Hall and Fincham, once the two features of the model exist, self-forgiveness is appropriate.

The model divides the process of self-forgiveness into three separate components: cognitive, offense-related factors, and emotional. The first component in Hall and Fincham's (2005) model of self-forgiveness is the cognitive one. According to the model, external, unstable, and specific attributions for one's own behavior may facilitate self-forgiveness, while internal, stable, and global attributions may make it more difficult. Similarly, according to model of forgiveness developed by Enright and the Human Development Study Group (1996), offenders need to utilize cognitive reframing techniques to better understand themselves and achieve the self-acceptance that leads to self-forgiveness. This process has also been described as reconstruction of a new narrative about the transgression and the transgressor (Ingersoll-Dayton & Krause, 2005; Thompson et al., 2005).

The second component of Hall and Fincham's (2005) model is that of offense-related factors. According to this model, compensatory behavior, such as apology, may help reduce feelings of

guilt and increase self-forgiveness. In addition, receiving forgiveness from the victim is also conducive to self-forgiveness. However, according to Hall and Fincham, the relationship between forgiveness by the victim and the offender's self-forgiveness requires further clarification in light of contradictory findings (Zechmeister & Romero, 2002). They also predicted that more severe transgressions would be associated with lower levels of self-forgiveness.

Last, the emotional component of Hall and Fincham's (2005) model consists of two main emotions that have been associated with psychopathology: shame and guilt (Abe, 2004). Lewis (1971) and Tangney (1995) suggested that the difference between these two emotions lies in the way people attribute the negative events to themselves and how this affects future interactions. Shame is defined as an emotion experienced when adverse events are attributed to the global self and lead to a sense of inadequacy and self-loathing and, in turn, avoidance of interaction with the victim (Lewis, 1971; Lindsay-Hartz, de Rivera, & Mascolo, 1995). In comparison, guilt is seen as the result of attributing bad behavior to a particular situation and thus, in contrast to shame, does not refer to the individual's basic identity. In addition, guilt leads to the desire to repair the relationship with the victim, empathy, and atoning by means of apology or asking forgiveness. According to Hall and Fincham (2005), there is likely to be a negative relationship between guilt and self-forgiveness, and an even stronger negative relationship between shame and self-forgiveness. Furthermore, the other-oriented compassion and empathy fostered by guilt may actually inhibit self-forgiveness. Indeed, Zechmeister and Romero (2002) found lower levels of guilt among prisoners who had forgiven themselves compared with those who had not, and those that forgave themselves reported feelings of relief and well-being, whereas those who didn't felt confusion and chronic guilt (Ingersoll-Dayton & Krause, 2005).

Self-Forgiveness Among Drug-Addicted Mothers

Guilt and shame have been identified as important factors in addiction (Dearing, Stuewig, & Tangney, 2005; Potter-Efron, 2002). In particular, women have been shown to experience higher levels of shame and guilt, compared with men, regarding drug abuse (O'Connor, Berry, Inaba, Weiss, & Morrison, 1994) as well as their mothering patterns during addiction (De Leon, 2000). A central aspect of the stigmatization of mothers with drug addiction focuses on their mothering patterns (Ettorre, 1992) since maternal substance abuse has been associated with dysfunctional lifestyle, emotional neglect, and abuse of children (Locke & Newcomb, 2004). Accordingly, the popular discourse constructs them as monstrous moms (Gubrium, 2008). This construction has a direct effect on the feeling of shame; as Brown (2006) put it, shame is a "psycho-social-cultural construct that is supported by a 'web' of expectations defined by self, family, partners, friends, community, and the media" (p. 45).

Given the importance of cultural and social expectations in shame enhancement, it is important to note that Israeli society has been defined as a pronatalistic society, due to religions tradition and the call for demographic growth of the Jewish population. Thus, the role of the mother is defined as crucial for Israeli women's sense of identity and morality (Remennick, 2001), and it is not surprising that Israeli drug-dependent women are stigmatized and rejected by society and therapeutic institutions, alike (Salan, 2005).

It is important to address feelings of shame and guilt, because they have a direct impact on women's recovery process (Ehrmin, 2001; Roberts & Nishimoto, 2006). Furthermore, Van DeMark (2007) reported that drug-addicted mothers in rehabilitation identified self-forgiveness for neglecting their children as one of the hardest tasks in the recovery process. Even for women who have completed 5 years of treatment and recovery from drugs, self-forgiveness is a long-term necessity for acquiring new coping skills and new life meaning (Weaver, Turner, & O'Dell, 2000).

Self-forgiveness has been argued as one way to reduce shame and guilt (Ianni, Hart, Hibbard, & Carroll, 2010), and as a salient component for women in the recovery from addiction (Gomberg,

1988). However, this subject has been largely overlooked in research as well as practice. In particular, there is a dearth of studies on facilitating self-forgiveness among women offenders regarding their mothering patterns, compared with the role of forgiveness for women victims (e.g., M. E. Baker, 2007; Freedman & Enright, 1996). Based on White and Chaney (1993), it is extremely important to investigate this issue, as the introduction of guilt and shame intervention in addiction treatment requires willingness to consider the perpetrations of women as well as the victimization of men.

The lack of attention to the issue of women's self-forgiveness is compounded by the relative neglect of the issue of forgiveness in general in addiction research (Webb & Trautman, 2010), even though its importance has been recognized in Twelve-Step therapy and other therapeutic models used in the field of addiction. An example of an addiction treatment model that includes guilt and shame intervention is the therapeutic community model. According to the therapeutic community model, working on issues such as guilt and shame is crucial to recovery, as expressed in a common phrase of the community argot, "guilt kills" (referring to their role in addiction and relapse). The therapeutic process regarding guilt and shame begins by introducing residents to the different types of guilt: guilt regarding injuries to the self and to significant others, including physical and psychological neglect of children. It then focuses on creating an understanding of the self in the past, to cope with the feelings of guilt and shame and establish a new identity (De Leon, 2000).

The Present Research

In this research, the process of self-forgiveness from the individual's point of view was explored in an effort to shed light on our understanding of self-forgiveness among drug-addicted mothers based on four important aspects. First, the research focus was on self-forgiveness within the process of recovery from drug addiction in a therapeutic community that conducted guilt and shame interventions and recognized identity transformation as a crucial component in this process (De Leon, 2000). In the framework of such a program, self-forgiveness is viewed as a vehicle that contributes to identity transformation and thus to the recovery process. However, to the best of our knowledge, this is the first empirical study to compare the consequences of self-forgiveness and lack of self-forgiveness on identity in the course of the recovery process. Second, Hall and Fincham's (2005) model was embraced to examine self-forgiveness as a multidimensional construct that includes emotional, cognitive, and offenses-related factors. This model was based on the theoretical work on interpersonal forgiveness (Bauer et al., 1992; Enright & the Human Development Study Group, 1996), which is adapted to self-forgiveness. This model was chosen because of its suitability for the process of self-forgiveness and for its focus on forgiving oneself for hurting someone else and not for hurting oneself. To date, this model has been tested almost exclusively on students or in nonclinical samples (e.g., Rangganadhan & Todorov, 2010), but not in the field of addiction. Third, the recommendations of Ingersoll-Dayton and Krause (2005) and Webb et al. (2011) for future research with longer follow-up periods were addressed to examine the development of self-forgiveness over time. Finally, following Bauer et al. (1992) and Ingersoll-Dayton and Krause (2005), qualitative methods were used to explore the self-forgiveness process, as this approach is particularly effective for illuminating new research domains (Miles & Huberman, 1994), creating adequate therapeutic tools (Orford, 2008; Stahler & Cohen, 2000), and addressing the lived experience and cultural variations that are still lacking in the field of forgiveness research (McCullough et al., 2000).

Based on the above aims, four research questions were formulated: First, is there a connection between the recovery stage or personal features of the participants such as age and country of birth to the self-forgiveness process? Second, what differentiates between women who forgave

themselves and those who did not regarding accepting responsibility for past motherhood patterns? Third, what differentiates between women who forgave themselves and those who did not regarding the three components (emotional, cognitive, and offense-related components) of the self-forgiveness process? Last regarding the acceptance of responsibility for past motherhood patterns and regarding each of the three components in the self-forgiving process, does it enhance or hinder self-forgiveness according to the research participants?

Method

The following section describes the sampling procedure, the interview procedure, and its ethical aspects, and the analysis stages of the findings.

Participants, Materials, and Procedure

The research sample consisted of 25 Israeli mothers in different stages of recovery from drug addiction. This maximum variation approach (Patton, 2002) was adopted to include a wide range of perspectives in different stages of the recovery process. 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.

The research participants ($n = 25$) were divided 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 an advanced stage of the recovery process, 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, a complementary longitudinal study ($n = 5$) that monitored five mothers from the beginners group was conducted. Each of these participants was interviewed at the beginning of the recovery process, again when she reached the advanced 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 self-forgiveness process. The report of the findings here refers intermittently to each of these two research tracks. The participants were recruited by two means: Most of them (20) were recruited through the therapeutic community and the others (5) were recruited by means of a snowball sample, to enable us to interview participants who had completed the therapy program but were no longer in touch with the therapeutic community, in keeping with the maximum variation approach.

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 poly-drug abusers and their main drug of choice was heroin. One participant had 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.

The author conducted personal interviews with the participants, who resided in the therapeutic community. To ensure confidentiality, the interviews were conducted in an isolated, private room on the premises. Hence, no one (aside from the stuff) would know who was participating in the research. In addition, the participants' names, their therapeutic community name, and all other identifying details were omitted. In addition, the author personally transcribed the audiotaped interviews and used security measures for data storage. The interviews were not conducted during the women's spare time or therapeutic activity, but when they were involved in other types of chores or activities. The participants who were in long-term recovery were interviewed in their

homes, except in the case of one participant, who preferred to be interviewed speak at a coffee shop, because she couldn't assure privacy in her house. The length of the interviews ranged from 2 to 6 hr. In light of the stigma attached to the research topic, the research was classified as a socially sensitive research (Johnson & Clarke, 2003), and special attention to ethical issues was paid. First, the approval of the university's ethics board was obtained. Second, to comply with the principle of confidentiality, the staff at the therapeutic community was asked 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. The participants were asked to sign a written statement of informed consent and were also assured 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.

Adopting Rosenthal's (1993) method for conducting life story interviews, a four-stage interview was created: 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 second stage, the participant was asked to clarify aspects of her life story as necessary. In the third stage, the participant was asked a series of open-ended questions based on the research questions and the review of the literature. For that purpose, two types of questions were created. The first type of questions was meant to encourage the participants to talk about the presence or absence of self-forgiveness in their own words. The first question, "do you think your children were hurt during your addiction," was devised to raise this issue. However, as the research progressed, that question proved redundant because participants raised the issue on their own volition when describing their life story. Other questions in this group of questions were, "Did you forgive yourself for your conduct as a mother during your addiction? If not, why not? If yes, please tell me how you forgave yourself. What helped and what made it difficult for you to forgive yourself?" The second type of questions was devised in accordance with Hall and Fincham's self-forgiveness model. The questions asked were, "Who is responsible for the pain that your children suffered at the time of your active addiction? What did you feel when you forgave/did not forgive yourself? How do you feel about your children's pain and what have you done to forgive yourself?"

The fourth stage of the interview 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). All interviews were audio-recorded, transcribed verbatim in Hebrew, and then translated into English in a way that captured their meaning and context.

As mentioned above, the participants spontaneously raised the issue of hurting their children and the issue of self-forgiveness as part of their life story. Raising those issues spontaneously as part of their life story may be due to several reasons. First, as mentioned previously in this article, the issues of guilt and shame regarding transgression during addiction is given extra emphasis in the therapeutic community where the women were being treated, as are interventions that promote forgiveness, especially among mothers. Second, the fact that guilt and shame regarding past motherhood patterns and the need for self-forgiveness is documented in several research papers shows how important they are for women (Ehrmin, 2001; Gomberg, 1988). Last, as Israeli society is a pronatalist society in which mothering is a crucial component of a woman's personal identity, when the women in the study were asked to tell their life story, they spontaneously raised the issue of hurting their children, indicating its importance in their lives and their sense of identity.

The research participants described various offenses toward their children, especially neglect. Some described beating their children or mentally abusing them, such as telling them that they regret having them. As the women described all their offenses as severe and either totally forgave themselves or not at all, I named all the offenses as "past motherhood patterns." Discussing past motherhood patterns evoked intense feelings and many of the participants needed a break at that

point of the interview. During the break, the participants smoked cigarettes, drank water, or sat and rested for a few minutes, after which they returned to the room to continue with the interview. In the longitudinal study, direct and open-ended questions regarding self-forgiveness were asked in the second and third interviews, such as, "In the first interview you talked about hard feelings regarding your parenting in the past; how do you feel about it now?" to encourage them to describe the process and meaning of self-forgiveness in their own words.

Analysis

Narralizer 1.1 qualitative data analysis software (Shkedi & Shkedi, 2005) was used to process and organize the extensive data into themes and subthemes. The method was based on the phenomenological-hermeneutic paradigm, which was designed to investigate how the individual organizes and gives meaning to the world (Patton, 2002). 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, each interview was read separately, as though it were a case study (Stake, 1995), in regard for themes and subthemes that focused on identity features and the participants' construction of self-forgiveness. At this point, the author avoided speculations and did not attribute the differences among participants to their position on the recovery continuum alone. Thus, while reading the interviews, points of similarity and differences using the constant comparative method were examined (Glaser & Strauss, 1967), according to which personal features of the participant such as age, country of birth, and recovery stage are drawn from the interviews to create different categories (Patton, 2002). Next, the interviews were analyzed in accordance with Hall and Fincham's (2005) self-forgiveness model as the model's features and components were found to be general enough to encompass most of the participants' descriptions. The narratives of those who forgave themselves and those who did not were first compared with regard to the two features of Hall and Fincham's model: self-forgiveness regarding hurting someone other than self and accepting responsibility. Then, the narratives of those who forgave themselves and those who did not were compared with regard to the three components of Hall and Fincham's model: emotional, cognitive, and offense-related.

Results

The results revealed that most of the participants who were at the advanced and long-term recovery stage (13 out of 15) had forgiven themselves for their parenting patterns during addiction while participants at the beginning of the recovery process (10 out of 10) experienced difficulty with self-forgiveness. The results also revealed distinct and common themes among the two groups regarding the model's feature of acknowledging responsibility and regarding to the components of self-forgiveness (emotional, cognitive, and offense-related factors).

The main common theme among participants who forgave themselves and those who did not was that of acknowledging responsibility for bad parenting during addiction, one of the features in the self-forgiving model. Other common themes were expressing the severity of bad parenting during addiction from the participants' perspective (an element of the offense-related component), and demonstrating an empathetic attitude toward their children (an element of the emotional component). The testimony of one long-term participant captures all three aspects of this theme:

> I relapsed, like a lion that had been in a cage for 5 years that was suddenly opened. The whole world fell apart on me, everything was black and the only thing I wanted was to die. I finally established a good relationship with my children and they trusted me, and then I shattered their world, just when they were adolescents.

Such examples express a sense of responsibility, the perceived severity of the transgression ("I shattered their world"), and empathy, by describing the situation from the teenage children's perspective. A participant from the beginners group also referred to all three aspects of this theme:

> She didn't deserve a mother like this . . . I hated myself that I was an addict and raising a child. She was growing and understood why I was feeling bad all the time. I hated that it was hard for me to take care of her.

These three themes of accepting responsibility, perceiving the transgression as severe, and expressing empathy have mixed implications regarding self-forgiveness. On one hand, they express the acceptance of responsibility for committing a wrongful act, hence may encourage self-forgiveness, but on the other hand, feeling empathy toward the victim and expressing the severity of this offense may inhibit self-forgiveness according to Hall and Fincham's (2005) model.

In comparison with the relative similarity among participants who forgave themselves and those who did not regarding the three themes, major distinctions were found regarding the three components of self-forgiveness. Regarding the cognitive component, the results show that participants who forgave themselves, in comparison with those who did not used external, unstable, and special attributions to reconstruct their past mothering patterns and created alternative explanations for their behavior. Regarding the offense-related factors, participants who forgave themselves, in comparison with those who did not, described a change in their mothering patterns and improvement in their relationships with their children. Regarding the emotional component, participants who forgave themselves described a process in which guilt and shame decreased as the self-forgiveness process progressed. In comparison, participants who did not forgive themselves described the heavy weight of guilt and shame that they were feeling.

The Components of Self-Forgiveness

The cognitive component of self-forgiveness. One of the salient cognitive elements that were found among participants was their ability to identify the causes of their wrongful behavior: One of the main differences found between the narratives of those who forgave themselves and those who did not involved the factors that led to their mothering patterns during addiction. The narratives of the participants who forgave themselves were characterized by the attribution of external, unstable, and special causes to their past mothering patterns. For example, one participant in long-term recovery explained why she forgave herself:

> [I need to] forgive myself and [move] on . . .to understand that I'm just a good, generous, honest, and fair woman—that *it wasn't me* . . . It was the drug that took me to where I was.

In this description, the participant externalized her drug problem and blamed the drug as the active agent that had caused the problem. Moreover, as her deeds were due to the influence of the drug, they were special and unstable, and did not reflect her stable identity as a "good woman." This description corresponds to the Narcotics Anonymous discourse, which conceptualizes the drug as controlling (Denzin, 1987; Ronel, 2000).

In contrast, the participants from the beginners group who did not forgive themselves attributed their dysfunctional parenting patterns during addiction to the internal self: "Drugs become . . . In short, destroying everything, destroying a family . . . I lost my child, but it's my fault, me alone." This participant opened her narrative by accusing the drug that led her to lose her family but ended it with self-accusation.

Another salient cognitive element that was found among participants was the lack of malicious intent. For example, while describing her process of self-forgiveness, a participant in the advanced stage of recovery addressed her son (although he was not in the room):

> I didn't mean to hurt you; I just could not take care of you' I had no strength. I didn't know how to do it.

Another cognitive element that was found among the participants who forgave themselves was taking a new perspective on past actions and creating an alternative explanation for past parenting patterns by "zooming out." This process was well demonstrated by one participant in the longitudinal study. At the beginning of the recovery process, this participant presented a description saturated with criticism of her parental role and focused on simple explanations of her behavior. For example, she described her feelings after the birth of her child, whom she gave up for adoption: "I lost trust in myself, I don't care anymore." A few months later, when this participant moved to advanced stage of recovery, she considerably developed the narrative on her son's adoption:

> I thought even a dog would not leave his kids, but then I told myself, "Listen, in your position, to have a child and let him live the life you were living would be worse . . . " It's like I chose to give the child the chance of a different life, because I really couldn't give him a normal life.

At the later point in her recovery process, this participant created a new context-dependent definition of motherhood, by examining the broader context of her actions as a mother. As a result, she presented an alternative explanation of her past behavior, focusing on her good intentions and not only the bad consequences.

Another cognitive element that was found among participants and seemed to assist them in self-forgiveness was accepting past mistakes and acknowledging the inability to change things. Nevertheless, they emphasized that the experience had not been diminished. For example, one participant in the advanced stage noted her understanding that she could not change the past: "Today, in this phase, I'm no longer mad at myself. I just understand, and though it hurts me and it's hard to remember it, there's nothing I can do about it—it happened."

In contrast, for the participants who did not forgive themselves, past mothering patterns were remembered vividly and had a direct impact on their present. They described being occupied with their past mothering patterns. For example, one participant from the beginners group described her inability to accept help from the therapeutic community, because she had not forgiven herself:

> I [have] difficulty accepting and forgiving. [For instance], to this day I cannot forgive myself that with two children . . . I had the children, and a so-called family and home, and I still chose to go back to using.

The offense-related component of self-forgiveness. One offense-related element that was found among participants was the change in their behavior. The participants who forgave themselves described how changing mothering patterns and establishing good relationships with their children enhanced self-forgiveness. For instance, one participant described the change in her relationship with her daughter: "She loves me and trusts me. [She] has everything and is happy . . .Maybe seeing this flower blooming improves the feeling of . . . very heavy guilt." In contrast, the inability to change mothering patterns was described as hindering self-forgiveness. For example, one participant in the longitudinal research described at the beginning stage feelings of guilt about her mothering patterns:

> I have a guilty conscience about accepting [the mistake have made when I was in situations] that I didn't felt good, because of the withdrawal symptoms . . . I relapsed many times only because of my self-accusation; I couldn't deal with it.

This participant constructed the guilt as an agent of relapse, a maladaptive self-accusation that did not lead to self-improvement but to self-punishment, creating a repetitive cycle of blame (Potter-Efron, 2002). A few months later, when she had progressed to the advanced stage of recovery, she described the beginning of a process of self-forgiveness that was focused on changing her mothering patterns:

> Sometimes I have thoughts that she didn't get everything in life . . . but in everything I am doing today I know that I am a good mother, I am proud of myself . . . I am fixing it.

However, despite the evidence of this process, when this participant moved to the long-term recovery stage, she described a regression in her development of self-forgiveness, caused by renewed instability in her daughter's life when she relapsed and moved back to the therapeutic community:

> It's not so easy to forgive; it will take a lot of years to forgive. I cannot throw it away, you know . . . I cannot forgive all the transitions to and from the community—I cannot forgive myself, because she moved in with me.

This description indicates that a change in mothering patterns is important to self-forgiveness.

Interestingly, the participants who forgave themselves described a process in which improved parenting patterns contributed to self-forgiveness, and this contributed to normalization of their relationships with their children, and, in turn, to developing better parenting patterns. For instance, one participant at long-term stage described the benefits of her relationship with her children after self-forgiveness:

> They know now that I can be angry with them, that they can be angry at me, that I will place limits on them, and that I'm there for them. I'm strong and stable and it does not break me!

In contrast, the inability to forgive oneself was constructed as leading to bad parenting, such as trying to please the child and failing to set limits for them. For example, one participant in the longitudinal track said, in contrast to other participants in her phase, that she could not forgive herself, even after 2 years of therapy:

> I still feel guilty. Maybe that's why I allow him too much—as if I look at him and remember things and feel guilty, and although he doesn't remember, I feel it and I allow him to do things. [It] was like this in the community, and now it is that way again.

This description expresses the undesirable implications of failing to forgive oneself. If guilt is not resolved, the guilty party continues to try to please the victim, leading to bad parenting patterns.

Another offense-related element that was found among participants was the perceived forgiveness by the victim. Among the participants who forgave themselves, two forms of perceived forgiveness by the victim were identified. Some of the participants described self-forgiveness as an intrapsychic and unconditional process: "I forgive myself and automatically they [my children] forgive me; first of all, it starts with me." However, another form of self-forgiveness was based on the victim's approval, suggesting an interpersonal process. For instance, one participant

in long-term recovery talked about guilt based on a comparison of her mothering patterns with her older son, during addiction, with her patterns with her daughters, during recovery:

> Sometimes I feel guilty that with them I am okay and with him it was different. So I talked with him about it and explained it to him. So he says, "Mom—really—at least now you are doing something different; this isn't what you used to be like."

This participant's self-forgiveness seems to be related to and conditional on her son's implied forgiveness of her and making amends for her behavior, again indicating that changing mothering patterns is important to self-forgiveness.

The emotional component of self-forgiveness. The two emotional elements that were found among participants were in accordance with Hall and Fincham's (2005) model, that is, the research participants described guilt and shame as the two emotions most relevant to self-forgiveness. They described their guilt directly as the condemnation of a single act that emerged as a result of past mothering patterns, but indirectly, their descriptions suggested feelings of shame in the form of general self-condemnation (Tangney, 1995). However, like other addicts, they erroneously interchanged shame and guilt (Potter-Efron, 2002).

The participants who forgave themselves described a process in which guilt decreased as the self-forgiveness process progressed, supporting the model of Hall and Fincham (2005). For example, in the begging stage of recovery, one participant of the longitudinal study described a strong sense of guilt in response to her daughter's refusal to talk to her: "I deserve this, it is my fault." However, when the same participant moved to the long-term stage, her attitude had changed: "Maybe part of the therapy is to forgive myself and give myself a chance. It's like the ultimate goal. I couldn't say now that I have forgiven myself and everything is okay, but there is much less guilt." This description indicates that self-forgiveness is not dichotomous, but a continual process accompanied by a diminishing sense of guilt.

In contrast, participants who did not forgive themselves described the heavy weight of guilt, as in the example of this participant in the beginning stage:

> It is difficult to live with feelings of guilt and anger because the child was born with withdrawal syndrome and I didn't take care of her . . . I am angry with myself all the time, I blame myself, and sometimes I curse myself. For instance I say to myself: "may you be paralyzed for what you did." Like crime and punishment, that's how I see it, really. As if I have sinned in this life and this is my punishment.

This description indicates the burden of guilt and thoughts about past events that led to a desire to punish oneself.

The main difference between the participants who forgave themselves and those who did not involved their sense of shame. The participants who did not forgive themselves were ashamed of themselves, and their descriptions of themselves were full of self-loathing and dehumanization. For example, one participant at the beginning stage described the first meeting with her child after the child had been taken to a foster home:

> I cried and I asked for her forgiveness but I have already hurt her, like they hurt me when I was young. I already did this to my child . . . Maybe I am a monster.

This participant could not forgive herself because she saw her offense as a reflection of her self-worth. This led her to construct her identity as a monster, meaning she saw herself as deficient and unworthy of acceptance. In contrast to this identity construction, the participants who forgave themselves refused to see their offenses as a reflection of their self-worth and were thus released from feeling ashamed.

> All the time I realized that I was a sick person—That's not me, I'm a sensitive and caring human being, I'm not a bad woman, I wouldn't hurt my children . . . To constantly turn the blame on yourself is a kind of misery and self-pity and I am not like that! I'm a fighter!

This participant's description indicates resistance to the suggested representation—"it is not me" and constructs herself as a "sick person" by using the disease model of addiction (Denzin, 1987; Ronel, 2000). This participant even goes as far as to construct her identity as a sensitive and caring human being that is not preoccupied with self-interest and misery, but is fighting for her life. This indicates the role of self-forgiveness in constructing a positive identity.

Discussion

In the analysis of the self-forgiveness process, the participants' narratives were analyzed according to the features and components of Hall and Fincham's (2005) model. The two features of the model are that the transgression is interpersonal and not a case of self-inflicted harm and that the perpetrator takes responsibility and acknowledges the wrongful behavior. The three components of the model are the emotional component, the cognitive component and the offense-related component. The emotional component includes guilt, shame, and empathy toward the victim, the cognitive component includes the attributions and reconstruction of the transgression, and the offense-related component includes compensatory behavior, receiving forgiveness from the victim and the perpetrator's perceived severity of the offenses.

In accordance with Hall and Fincham's (2005) model features of the self-forgiveness process, taking responsibility about motherhood patterns during addiction was addressed to distinguish between a true self-forgiveness and simply excusing, minimizing, or neutralizing one's transgressions (Fisher & Exline, 2006; Murphy, 2002). Regarding this issue, the research participants were all at a similar starting point: They all took responsibility for their mothering patterns. This finding might be explained by the institutional model that guides the treatment community, which encourages the acceptance of responsibility (De Leon, 2000), as well as Israeli cultural expectations, which see mothers as the child's primary caregiver (Remennick, 2001).

Acceptance of responsibility among self-forgiving participants as well as among participants who did not forgive themselves may indicate that while acceptance of responsibility is a necessary first step, it is not a sufficient step toward true self-forgiveness as it generally initiates feelings of guilt and regret, which must be fully experienced before one can move toward true self-forgiveness (M. E. Baker, 2007; Fisher & Exline, 2006; Hall & Fincham, 2005). However, the main tasks confronting the participants in their recovery process was accepting responsibility for their mothering patterns during addiction, while also constructing a positive identity (De Leon, 2000). Achieving this task is especially difficult in the pronatalist Israeli society, in which mothering is a crucial component of the women's personal identity (Remennick, 2001). Furthermore, for all the research participants, this complex task included overcoming two additional elements that the model identifies as hindering self-forgiveness: acknowledging the severity of the transgression and adopting an empathetic attitude toward their victims, which are part of the offense-related and emotional components of self-forgiveness, respectively (Hall & Fincham, 2005). At this point, the participants were divided into two different paths, where most of the participants in advanced-stage and long-term recovery, in contrast to those in the beginning stage, were able to experience a process of self-forgiveness that included three components: cognitive, offense related, and emotional.

Regarding the cognitive component of self-forgiveness, the research findings indicate that the participants who forgave themselves used external, unstable attributes, exploring the context of their actions and their intentions at the time of their inadequate parenting, in accordance to the model (Hall & Fincham, 2005). Similar to other findings (Thompson et al., 2005), the

self-forgiving participants demonstrated cognitive flexibility and constructed new narratives about themselves and the transgression that allowed them to acknowledge and take responsibility for their past transgressions while also distancing their "true selves" from such actions. A distinction can be made between a wrong-doer and the act by decreasing the level of responsibility (because drug users are not fully responsible for their actions) and stressing the lack of intention. Condemning the act instead of the person who did the act enables and encourages future change in behavior (Fincham, 2000). Self-forgiveness is the first step in a path of moral growth in which the person is a responsible moral agent for all his unexcused actions, and at the same time, his intrinsic worth as person is grounded in his capacity for moral choice and change in the future (Holmgren, 1998). Hence, self-forgiveness is a way to break the vicious cycle in which many addicts find themselves when they attribute blame to their immoral character, thus throwing themselves deeper into addiction instead of encouraging themselves to change.

Although this cognitive flexibility resembles the strategies in other cases of self-forgiveness, the content of the process examined here was unique to the addiction field and to the position of the participants as mothers. First, they constructed the drug (rather than themselves) as the problem, using the disease model (Denzin, 1987; Ronel, 2000). This construction helped them shake off labeling and stigmatized identities (Gueta & Addad, 2013), facilitated the self-forgiveness process, and enabled them to construct new identity. Second, like other substance-abusing mothers, they created new constructions of motherhood (P. L. Baker & Carson, 1997), which focused on intention and not on consequences. These constructions become the main instrument for preserving new narratives of the self and creating unity in their lives, which they had experienced as fragmented and full of guilt and shame, threatening their sense of worth (Lofland, 1969).

Another cognitive element that was found in the research was that acceptance of past mistakes and the inability to change them facilitated self-forgiveness, while dwelling on thoughts about the transgressions hindered its development; this is consistent with other findings and theoretical assumptions (Ingersoll-Dayton & Krause, 2005; Worthington, 2005). The need to accept past wrongdoing to obtain recovery is well documented (Ehrmin, 2001; Potter-Efron, 2002), yet it is difficult to achieve as it requires going against people's usual perception of recovery. Recovery is usually thought of as requiring change and activism, but this task requires the opposite, to develop the ability to accept the unchangeable and thus accept that recovery has its limitations (Wallace, 1996). It seems that the participants who forgave themselves were able to accept their past wrongdoings due to their revised understanding and reconstruction of their past as well as their ability to focus on the things that they could change such as changing motherhood patterns in the present. The participants narrative about their inability to change the past and the acceptance of that past is reminiscent of the Serenity Prayer that is said in self-help groups such as the Narcotics Anonymous (NA): God grant us the serenity to accept the things we cannot change, the courage to change the things we can, and the wisdom to know the difference (Ferentzy, Skinner, & Antze, 2010). Hence, according to the research participant, the ability to distinguish between what can be changed and what cannot is a cognitive process that encourages self-forgiveness.

Regarding the offense-related component, and especially, conciliatory behaviors, the current study demonstrated the important role of adopting new parenting patterns that enhance self-forgiving in reducing guilt, corroborating previous research (Ingersoll-Dayton & Krause, 2005; Zechmeister & Romero, 2002), and the model developed by Hall and Fincham (2005). These findings are also consistent with Jewish tradition, with which most of the participants were associated, regarding offender's repentance (*teshuvah*, in Hebrew), which requires specific actions of the transgressor to attain forgiveness (Rotenberg, 1987; Rye et al., 2000). This finding suggests that forgiveness is embedded in cultural context (McCullough et al., 2000).

These findings counter other research results that highlight the possible deleterious consequences of self-forgiving among smokers, based on evidence of an association between increased self-forgiveness and a decreased likelihood of advancing through the stages of behavioral change

toward action (Wohl & Thompson, 2011), and among gamblers, where self-forgiveness was shown to deter readiness to change (Squires, Sztainert, Gillen, Caouette, & Woal, 2012). One explanation for this contradiction may lie in the timing of the self-forgiveness process. It may be that self-forgiveness at an early stage of recovery brings about an emotional relief that weakens the motivation of smokers and gamblers to change their problematic behavior and thus hinders the progress toward a stage of action (Squires et al., 2012; Wohl & Thompson, 2011). In contrast, in the present research, self-forgiveness intervention was used after rehabilitation, which means that participants had already entered the action stage (Prochaska & DiClemente, 1986). This may indicate that self-forgiving is appropriate only at the action stage. Otherwise, it may inhibit change.

Another element of the offense-related component is being forgiven by the victim. The participants who forgave themselves presented two different perspectives on gaining the victim's forgiveness. Some participants indicated that obtaining forgiveness from the victim was conducive to self-forgiveness, indicating an interpersonal process (Hall & Fincham, 2005), and others described an intrapsychic process, consistent with Zechmeister and Romero (2002), who found that forgiveness by the victims did not affect the offenders' self-forgiveness. This diversity of findings supports the theoretical claim that intrapsychic and interpersonal processes may both be legitimate pathways to forgiveness, depending on the context (Worthington, 2005).

Regarding the emotional component of self-forgiveness, the findings indicate that, contrary to the model proposed by Hall and Fincham (2005) and other findings (Zechmeister & Romero, 2002), empathy toward the victim did not hinder self-forgiveness. The explanation for this contradiction of the model regarding empathy may lie in implications of the special relationship between the offenders and the victims, a possibility noted by Hall and Fincham (2005). Concerning guilt, the present findings, similar to those of other researchers (Hall & Fincham, 2005; Ingersoll-Dayton & Krause, 2005), revealed that one of the advantages of self-forgiveness is the diminished guilt and relief that accompanies it. Regarding shame, the research showed that shame can be a functional emotion, as it may lead to new knowledge about one self (Barrtett, 1995), encourage commitment to change (Lindsay-Hartz et al., 1995), and, most importantly, lead to creating a new narrative about the self and constructing a new identity.

The present research contributes several important insights about the self-forgiveness process. Nevertheless, some limitations should be addressed in future research. First, future research should examine self-forgiving regarding self-injury, as Hall and Fincham (2005) argued that self-forgiveness may be especially relevant to substance abuse because the transgressors themselves are their own primary victims. In addition, this study relies on a qualitative methods and a nonrepresentative sample of participants who were treated in one form of therapeutic intervention for drug addiction, in a unique social-cultural context. Furthermore, this research included methodological strategies for demonstrating qualitative rigor (Lincoln & Guba, 1985). Within these are the thick description and triangulation of data (i.e., gathering information from multiple sources such as the dual-track research design). Yet, others methodological strategies such as peer debriefing (i.e., inviting peers who were not immersed in the research topic to provide feedback on the methods and analysis) were not used. Therefore, any inference of conclusions should be made with caution until they are replicated in a more generalizable sample, including male participants, participants in preliminary stages of recovery, and participants in other therapeutic models.

Despite these limitations, this study provides a useful evaluation of the process of self-forgiveness from the recovering addict's perspective and the findings may inform self-forgiveness interventions in the addiction field. First, the finding that assuming responsibility for one's actions during addiction was common among our entire group of participants, together with Scherer et al.'s (2011) findings of decreased self-forgiveness and increased guilt and shame due to taking responsibility among clients entering to standard alcohol treatment, indicates that subjects entering addiction intervention programs are at risk of relapse. On one hand, these people

accept responsibility for their actions, but on the other hand, they still lack the therapeutic coping mechanisms to deal with feelings of guilt and shame, and have already given up substance abuse, which they used for this purpose in the past (Potter-Efron, 2002). Hence, it is recommended that the issue of self-forgiveness be addressed a short time after people enter therapeutic programs.

Regarding the content of self-forgiveness interventions, the research findings advise therapists to assist their clients in reappraising past life experiences and creating an alternative narrative using discourses unique to addiction, such as the disease concept (Denzin, 1987; Ronel, 2000). Second, the finding that changing mothering patterns was a dominant element in recovery underscores the importance of including the children in the treatment and creating programs to improve mothering patterns (Grella, 2008). Last, the findings regarding the emotional component highlight the benefits of self-forgiveness in diminishing guilt and increasing the ability to construct a positive shame-free identity, which are crucial to the recovery process.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) declared the following financial support for the research, authorship, and/or publication of this article: The author received financial support from the Israeli Anti-Drug Authority.

References

Abe, J. A. (2004). Shame, guilt, and personality judgment. *Journal of Research in Personality*, *38*, 85-104.

Baker, M. E. (2007). Self-forgiveness: An empowering tool for working with women in recovery. In W. M. Malcolm, N. DeCourville, & K. Belicki (Eds.), *Women's reflections on the complexities of forgiveness* (pp. 61-74). New York, NY: Brunner-Routledge.

Baker, P. L., & Carson, A. (1997). "I take care of my kids": Mothering practices of substance-abusing women. *Gender & Society*, *13*, 347-364.

Barrtett, K. C. (1995). A functionalist approach to shame and guilt. In J. P. Tangney & K. W. Fischer (Eds.), *Self-conscious emotions: The psychology of shame, guilt, embarrassment and pride* (pp. 25-63). New York, NY: Guilford.

Bauer, L., Duffy, J., Fountain, E., Halling, S., Holzer, M., Jones, L., & Rowe, J. (1992). Exploring self-forgiveness. *Journal of Religion and Health*, *31*, 149-160.

Brown, B. (2006). Shame resilience theory: A grounded theory study on women and shame. *Families in Society: The Journal of Contemporary Social Services*, *87*, 43-52.

Dearing, R. L., Stuewig, J., & Tangney, J. P. (2005). On the importance of distinguishing shame from guilt: Relations to problematic alcohol and drug use. *Addictive Behaviors*, *30*, 1392-1404.

De Leon, G. (2000). *The therapeutic community theory, model, and method*. New York, NY: Springer.

Denzin, N. K. (1987). *Treating alcoholism: An alcoholic anonymous approach*. Newbury Park, CA: SAGE.

Ehrmin, J. T. (2001). Unresolved feelings of guilt and shame in the maternal role with substance-dependent African American women. *Journal of Nursing Scholarship*, *1*, 47-52.

Enright, R. D., & Fitzgibbons, R. P. (2000). *Helping clients forgive: An empirical guide for resolving anger and restoring hope*. Washington, DC: American Psychological Association.

Enright, R. D., & the Human Development Study Group. (1996). Counseling within the forgiveness triad: On forgiving, receiving forgiveness, and self-forgiveness. *Counseling and Values*, *40*, 107-126.

Ettorre, E. (1992). *Women and substance use*. Basingstoke, UK: Macmillan.

Ferentzy, P., Skinner, W., & Antze, P. (2010). The serenity prayer: Secularism and spirituality in gamblers anonymous. *Journal of Groups in Addiction & Recovery*, *5*, 124-144.

Fincham, F. D. (2000). The kiss of the porcupines: From attributing responsibility to forgiving. *Personal Relationships*, *7*, 1-23.

Fisher, M. L., & Exline, J. J. (2006). Self-forgiveness versus excusing: The roles of remorse, effort and acceptance of responsibility. *Self and Identity*, *5*, 127-146.

Freedman, S. R., & Enright, R. D. (1996). Forgiveness as an intervention goal with incest survivors. *Journal of Consulting and Clinical Psychology*, *64*, 983-992.

Friedman, L. C., Romero, C., Elledge, R., Chang, J., Kalidas, M., Dulay, M. F., & Osborne, C. K. (2007). Attribution of blame, self-forgiving attitude and psychological adjustment in women with breast cancer. *Journal of Behavioral Medicine*, *30*, 351-357.

Glaser, B., & Strauss, A. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Chicago, IL: Aldine Publishing.

Gomberg, E. S. L. (1988). Alcoholic women in treatment: The question of stigma and age. *Alcohol and Alcoholism*, *23*, 507-514.

Grella, C. E. (2008). From generic to gender-responsive treatment: Changes in social policies, treatment services, and outcomes of women in substance abuse treatment. *Journal of Psychoactive Drugs*, *5*, 327-343.

Gubrium, A. (2008). Writing against the image of the monstrous crack mother. *Journal of Contemporary Ethnography*, *37*, 511-527.

Gueta, K., & Addad, M. (2013). Moulding an emancipatory discourse: How mothers recovering from addiction build their own discourse. *Addiction Research & Theory*, 21, 33-42.

Hall, J. H., & Fincham, F. (2005). Self-forgiveness: The stepchild of forgiveness research. *Journal of Social and Clinical Psychology*, *24*, 621-637.

Hall, J. H., & Fincham, F. (2008). The temporal course of self-forgiveness. *Journal of Social and Clinical Psychology*, *27*, 174-202.

Holmgren, M. (1998). Self-forgiveness and responsible moral agency. *Journal of Value Inquiry*, *32*, 75-91.

Ianni, P. A., Hart, K. E., Hibbard, S., & Carroll, M. (2010). The association between self-forgiveness and alcohol misuse depends on the severity of drinker's shame: Toward a buffering model. *Addictive Disorders & Their Treatment*, *9*, 106-111.

Ingersoll-Dayton, B., & Krause, N. (2005). Self-forgiveness: A component of mental health in later life. *Research on Aging*, *27*, 267-289.

Johnson, B., & Clarke, J. M. (2003). Collecting sensitive data: The impact on researchers. *Qualitative Health Research*, *133*, 421-434.

Leach, M. M., & Lark, R. (2004). Does spirituality add to personality in the study of trait forgiveness? *Personality and Individual Differences*, *37*, 147-156.

Lewis, H. B. (1971). *Shame and guilt in neurosis*. New York, NY: International Universities Press.

Lin, W., Mack, D., Enright, R. D., Krahn, D., & Baskin, T. W. (2004). Effects of forgiveness therapy on anger, mood, and vulnerability to substance use among inpatient substance-dependent clients. *Journal of Consulting and Clinical Psychology*, *72*, 1114-1121.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Beverly Hills, CA: SAGE.

Lindsay-Hartz, J., de Rivera, J., & Mascolo, M. (1995). Differentiating guilt and shame and their effects on motivation. In J. P. Tangney & K. W. Fischer (Eds.), *Self-conscious emotions: Shame, guilt, embarrassment, and pride* (pp. 274-300). New York, NY: Guilford.

Locke, T. F., & Newcomb, M. D. (2004). Child maltreatment, parent alcohol and drug-related problems, polydrug problems, and parenting practices: A test of gender differences and four theoretical perspectives. *Journal of Family Psychology*, *18*, 120-134.

Lofland, J. (1969). *Deviance and identity*. Englewood Cliffs, NJ: Prentice Hall.

Maltby, J., Macaskill, A., & Day, L. (2001). Failure to forgive self and others: A replication and extension of the relationship between forgiveness, personality, social desirability and general health. *Personality and Individual Differences*, *30*, 881-885.

Mauger, P. A., Perry, J. E., Freeman, T., Grove, D. C., McBride, A. G., & McKinney, K. E. (1992). The measurement of forgiveness: Preliminary research. *Journal of Psychology and Christianity*, *11*, 170-180.

McCullough, M. E., Pargament, K. I., & Thoresen, C. E. (Eds.). (2000). *Forgiveness: Theory, research, and practice*. New York, NY: Guilford.

Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded sourcebook*. Thousand Oaks, CA: SAGE.

Murphy, J. G. (2002). Forgiveness in counseling: A philosophical perspective. In S. Lamb & J. G. Murphy (Eds.), *Before forgiving: Cautionary views of forgiveness in psychotherapy* (pp. 41-53). New York, NY: Oxford University Press.

O'Connor, L. E., Berry, J., Inaba, D., Weiss, J., & Morrison, A. (1994). Shame, guilt, and depression in men and women in recovery from addiction. *Journal of Substance Abuse Treatment*, *11*, 503-510.

Orford, J. (2008). Asking the right questions in the right way: The need for a shift in research on psychological treatments for addiction. *Addiction*, *103*, 875-885.

Patton, M. Q. (2002). *Qualitative research and evaluation methods* (3rd ed.). Thousand Oaks, CA: SAGE.

Potter-Efron, R. (2002). *Shame, guilt, and alcoholism* (2nd ed.). New York, NY: Haworth Press.

Prochaska, J. Q., & DiClemente, C. C. (1986). Toward a comprehensive model of change. In W. R. Miller & N. Heather (Eds.), *Treating addictive behaviors: Processes of change* (pp. 3-27). New York, NY: Plenum.

Rangganadhan, A. R., & Todorov, N. (2010). Personality and self-forgiveness: The roles of shame, guilt, empathy and conciliatory behavior. *Journal of Social and Clinical Psychology*, *29*, 1-22.

Remennick, L. I. (2001). Childless in the land of imperative motherhood: Stigma and coping among infertile Israeli women. *Sex Roles*, *431*, 821-841.

Roberts, A. C., & Nishimoto, R. (2006). Barriers to engaging and retaining African-American post-partum women in drug treatment. *Journal of Drug Issues*, *36*, 53-76.

Ronel, N. (2000). Perception of addiction as a disease: A metaphoric approach to encourage recovery (Hebrew, English abstract). *Society and Welfare*, *20*, 83-98.

Rosenthal, G. (1993). Reconstruction of life stories: Principles of selection in generating stories for narrative biographical interviews. In R. Josselson & A. Lieblich (Eds.), *The narrative study of lives* (pp. 59-91). London, England: SAGE.

Rotenberg, M. (1987). *Re-biographing and deviance: Psychotherapeutic narrativism and the Midrash*. New York, NY: Prager.

Rye, M. S., Pargament, K. I., Ali, M. A., Beck, G. L., Dorff, E. N., Hallisey, C., & Williams, J. G. (2000). Religious perspectives on forgiveness. In M. E. McCullough, K. I. Pargament, & C. E. Thoresen (Eds.), *Forgiveness: Theory, research, and practice* (pp. 17-40). New York, NY: Guilford.

Salan, D. A. (2005). *Experiences of Israeli drug addicted women in treatment* (Unpublished doctoral dissertation). The Hebrew University, Jerusalem.

Saldana, J. (2003). *Longitudinal qualitative research*. New York, NY: Alta Mira Press.

Scherer, M., Worthington, E. L., Hook, J. N., & Campana, K. L. (2011). Forgiveness and the bottle: Promoting self-forgiveness in individuals who abuse alcohol. *Journal of Addictive Diseases*, *30*, 382-395.

Schibik, J. M. (2006). Forgiveness therapy in psychological trauma and chemical abuse treatment. *Journal of Chemical Dependency Treatment*, *8*, 227-253.

Shkedi, A., & Shkedi, Y. (2005). *Narralizer: A software for qualitative research analysis*. Yakum, Israel: Yazamut Yakum.

Squires, E. C., Sztainert, T., Gillen, N. R., Caouette, J., & Woal, M. (2012).The problem with self-forgiveness: Forgiving the self deters readiness to change among gamblers. *Journal of Gambling Studies*, *28*, 337-350.

Stahler, G. J., & Cohen, E. (2000). Using ethnographic methodology in substance abuse treatment outcome research. *Journal of Substance Abuse Treatment*, *18*, 1-8.

Stake, R. E. (1995). *The art of case study research*. London, England: SAGE.

Tangney, J. (1995). Recent advances in the empirical study of shame and guilt. *American Behavioral Scientist*, *38*, 1132-1145.

Thompson, L. Y., Snyder, C. R., Hoffman, L., Michael, S. T., Rasmussen, H. N., Billings, L. S., & Roberts, D. E. (2005). Dispositional forgiveness of self, others, and situations. *Journal of Personality*, *73*, 313-359.

Van DeMark, N. (2007). Policy on reintegration of women with histories of substance abuse: A mixed methods study of predictors of relapse and facilitators of recovery. *Substance Abuse Treatment Prevention and Policy*, *2*, 1-11.

Wallace, J. (1996). Theory of 12-step oriented treatment. In F. Rotgers, D. S. Keller, & J. Morgenstern (Eds.), *Treating substance abuse: Theory and technique* (pp. 13-37). New York, NY: Guilford.

Weaver, G. D., Turner, N. H., & O'Dell, K. J. (2000). Depressive symptoms, stress, and coping among women recovering from addiction. *Journal of Substance Abuse Treatment*, *18*, 161-167.

Webb, J. R., Hirsch, J. K., & Toussaint, L. (2011). Forgiveness and alcohol problems: A review of the literature and a call for intervention-based research. *Alcoholism Treatment Quarterly*, *29*, 245-273.

Webb, J. R., Robinson, E. A., Brower, K. J., & Zucker, R. A. (2006). Forgiveness and spirituality among people entering treatment for alcohol problems. *Journal of Addictive Diseases*, *25*, 55-67.

Webb, J. R., & Trautman, R. P. (2010). Forgiveness and alcohol use: Applying a specific spiritual principle to substance abuse problems. *Addictive Disorders & Their Treatment*, *9*, 8-17.

White, W., & Chaney, R. (1993). *Metaphors of transformation: Feminine and masculine*. Bloomington, IL: A Lighthouse Institute Monograph.

Witvliet, C. V. O., Phipps, K. A., Feldman, M. E., & Beckham, J. C. (2004). Posttraumatic mental and physical health correlates of forgiveness and religious coping in military veterans. *Journal of Traumatic Stress*, *17*, 269-273.

Wohl, M. J. A., & Thompson, A. (2011). A dark side to self-forgiveness: Forgiving the self and its association with chronic unhealthy behavior. *British Journal of Social Psychology*, *50*, 354-364.

Worthington, E. L., Jr. (Ed.). (2005). *Handbook of forgiveness*. New York, NY: Brunner-Routledge.

Zechmeister, J. S., & Romero, C. (2002). Victim and offender accounts of interpersonal conflict: Autobiographical narratives of forgiveness and unforgiveness. *Journal of Personality and Social Psychology*, *82*, 675-686.

Author Biography

Keren Gueta, PhD, is a faculty member in the Interdisciplinary Department for Social Science, Bar-Ilan University, Israel. Her research interests include the recovery process from addiction, and gender in addiction with a particular focus on mothering experience.