Advances in Nursing Science
Vol. 34, No. 3, pp. E1–E13

Cocreating a Communicative Space to Develop a Mindfulness Meditation Manual for Women in Recovery From Substance Abuse Disorders

Bernadette Lange, PhD, DNS, AHN-BC

Mindfulness-Based Stress Reduction (MBSR) programs are becoming more integrated into the treatment of persons with substance use disorders (SUDs). A focus of MBSR is to increase awareness of sensations in the body and accept them in the moment without judgment. Little is known about the readiness of women, with posttraumatic stress disorder (PTSD), and their level of comfort to participate in MBSR programs. Habermas' ideal speech situation guided a cooperative inquiry with 45 women at 3 treatment centers. Women engaged in activities of MBSR and shared opinions on how to develop a manual that would address the readiness of women with SUDs-PTSD to participate in MBSR. **Key words:** *Habermas*, *ideal speech situation*, *mindfulness-based stress reduction*, *Participatory Action Research*, *therapeutic communities*, *women with post traumatic stress disorder*, *women with substance use disorders*

MENTAL HEALTH and addiction nurses have a significant role in helping women to heal from the complex psychological and physiological issues associated with the process of recovery from substance use disorders (SUDs). Holistic nurses with expertise in alternative healing modalities such as mindfulness meditation (MM) may also be able to help these women heal. Alternative healing modalities such as cognitive behavioral therapies and meditation are recognized as effective treatments for SUDs; yet, more research is needed to understand the potential benefits.[1–8] Effective treatment for women with SUDs is a divisive issue as the literature does not provide conclusive evidence to support or refute the long-term benefits. There is also a pressing need to better understand the role of gender in the treatment of the comorbid conditions of SUDs and posttraumatic stress disorder (PTSD) as their incidence and prevalence continue to escalate.[9–14] This article represents a project to develop a teaching manual for mindfulness-based stress reduction (MBSR) for women with SUDs.

Author Affiliation: *Florida Atlantic University, Boca Raton.*

The author has disclosed that she has no significant relationships with, or financial interest in, any commercial companies pertaining to this article.

Correspondence: *Bernadette Lange, PhD, DNS, AHN-BC, Florida Atlantic University 777 Glades Rd, Boca Raton, FL 33431 (blange@fau.edu).*

DOI: 10.1097/ANS.0b013e3182272405

BACKGROUND AND SIGNIFICANCE

The burgeoning problems of SUDs is evidenced by the more than 9 million women who abuse illegal drugs, 3.7 million who abuse prescription drugs, 6 million affected by alcohol, and one-half million who are undergoing treatment of SUDs.[8] Less than 8%

of women who need treatment enter a program as they have complex issues related to treatment: child care responsibilities; physical health issues; interpersonal violence; low self-efficacy; stigmatization; and co-occurring morbidities such as depression and PTSD.[15,16] There is limited access to conduct research with women in recovery due to their vulnerability; high attrition rates in treatment programs, which contribute to lack of control and comparison groups in studies; and transient lifestyles of women who have SUDs.[17,18] Specific biological factors in women such as metabolic variations of alcohol and drugs, higher concentration of body fat, lower concentration of total body water, reproductive hormones that may increase susceptibility of relapse, the function of the amygdala in the control of cravings,[19] and issues associated with reproductive health[20] contribute to the intricacies of effective treatment for women. In addition, an estimated 30% to 60% of women with SUDs who seek treatment have histories of abuse, violence, and maltreatment and meet the criteria for the diagnosis of PTSD.[21,22] These women have less success in treatment and are at more risk for relapse than men because the failure to diagnose and treat PTSD increases relapse probability.[10-12,23]

Mindfulness meditation and MBSR are programs used in the treatment of SUDs. The MM can be combined with other cognitive behavioral therapies for the treatment of SUDs and relapse prevention, depression, or other mental health disorders. The MBSR is attributed to the seminal work of Jon Kabat-Zinn at the University of Massachusetts Medical School, where he developed MBSR as an effective complementary treatment for stress reduction and chronic pain and symptom relief for various chronic health conditions. The MBSR method is grounded in the Buddhist philosophy of being present in the moment to increase self-awareness. The intent of the method is to develop a practice of meditation to cultivate a nonjudgmental attitude toward life experiences to reduce stress. A systematic review of MM and MBSR as a treatment for SUDs found "the preliminary evidence suggest MM efficacy, appears safe when performed in a clinical research setting" and cited a need for a manual to address "specific needs of a targeted population."[6(p291)] Developing a manual is a critical component of designing effective treatment programs as manualization improves fidelity of the treatment (eg, dose, target population, and setting).[24] The standardization and consistent delivery of treatment contributes to evidence-based practice.[25]

Aims

The primary aim of this study was to develop a MBSR teaching manual for a target population of women in therapeutic communities (TCs) based on the work of Marcus et al,[1-3] who developed and tested *Mindfulness-Based Therapeutic Community* manual. Marcus's manual was used for a target population of male and female participants in the TC setting. To advance the work of Marcus et al[1-3] to a gender-specific population, the protocol of the National Institute of Drug Abuse Stage Model of Behavioral Therapies[26] was utilized as a blueprint. The Stage Model of Behavioral Therapies is a 3-step process to evaluate behavioral changes and to promote scientific rigor of an intervention. The second step of the process focuses on the modification of the intervention and manual development to promote scientific rigor.[27] The secondary aim of the study was to contribute knowledge of holistic-healing modalities to the canon of nursing knowledge.

Participatory action research

The process of participatory action research (PAR) should produce an outcome of social or political action to improve or benefit the members of the group. An assumption of this study was that the political, democratic process of group participation would encourage women in recovery to contribute their tacit knowledge and expert opinions to determine how an MBSR manual should be developed for women in the TC environment.

Another assumption was that women in the TC environment could experience a therapeutic value from a "double objective" of PAR: increase knowledge and promote action and experience empowerment "at a deeper level through the process of constructing and using their own knowledge."[28(p6)] The commonality of the processes of PAR and structure of the TC are the intentions to create a collaborative milieu to reflect on change, take action, and evaluate the outcomes of the action.

Conceptual framework supporting therapeutic community and participatory action research

The concept of TC as a treatment for promoting behavior changes for persons with SUDs has a 40-year history and is contingent on the concept of "right living" and the therapeutic utilization of "community as treatment."[8,29] The principle of behavior change to promote increased self- awareness for "right living" is a commonality of MBSR and TC program philosophies. In this project, PAR as a collaborative inquiry was used to access the tacit knowledge and wisdom of women in 3 TC centers. Through reflective subjective experiences of the experiential activities of MBSR, the participants identified issues related to how a manual could be developed for women. The process of reflection was repeated to identify actions to address changes. The coparticipatory action of the group is the end result of the PAR method. This cyclical process is very similar to the behavioral change expectations in the TC as women are expected to recognize the need to change behavior, reflect on peer input, and take action to change behavior. The process is repeated as a cycle of action to promote permanent behavior changes and subsequently avoid risky behaviors.

The TC treatment is intended to modify behaviors based on the theories associated with self-change and readiness for change,[30-32] employing the therapeutic method of community as treatment.[29] The TC model relies on peer confrontation to create a therapeutic speech situation to inspire behavior changes and identify denial issues. However, this confrontational technique may create a less-than-ideal speech situation. Thus, it may be inappropriate for women with SUDs, and PTSD as the hierarchal structure of power created by the confrontation may exacerbate the feelings of oppression and further contribute to low self-esteem and hinder successful recovery.[33,34]

Habermas's[28] ideal speech situation guides the framework for the study to encourage an equal opportunity in discourse, foster an egalitarian distribution of power, and promote truthful exchange among participants to equalize power within discourse. To enhance the ideal speech situation in PAR, the researcher assumes the role of participant and relinquishes the power relationship of researcher. Although the equalization of power was important in the TC environment, the most essential aspect was to recognize, value, and honor the women for their personal knowledge. Many women in a TC environment represent a culture of silence as they are oppressed by the dominance created by the TC structure and are detached from family and friends. They may feel a moral disenfranchisement due to abandonment of their assigned social roles of mother, wife, daughter, or sister. Freire[35] suggested that a dialogical encounter with others can provide the oppressed with a means to critically examine their world. In this study, women were invited to engage in a cocreated communicative space and transcend the less-than-ideal speech situation that is created by the hierarchal structure of the TC.

DESIGN

Participants

The sample consisted of voluntary participants (n = 45) who were purposively recruited from 3 TCs. The ethnic diversity of the women in the sample was self-reported: 33 white; 9 African American; 2 Hispanic; and 2 Native American. Ages ranged from 18 to 59

Table 1. Participant Characteristics

Centers	Center 1	Center 2	Center 3
Participants, n	6	19	20
Highest level of education (HS = high school), n	>HS = 2 Some college = 3 College degree = 1	HS diploma = 5 Some college = 7 College degree = 7	>HS = 9 HS diploma = 7 Some college = 2 College degree = 1 Missing data = 1
Primary drug of choice (Rx = prescription), n	Cocaine/crack = 3 Rx drugs/ alcohol = 3	Cocaine/crack = 4 Rx drugs/alcohol = 9 Alcohol = 5 Heroin = 1	Cocaine/crack = 13 Rx drugs/alcohol = 5 Meth/alcohol = 1 Missing data = 1
Women incarcerated for drug-related crimes, %	83	42	60
Average length of incarceration, days	16	6.7	331

years, with an average of 35 years. The average number of years of substance abuse was reported as 13 years, and the women had previously attended an average of 2 treatment programs. The diversity of the sample is reflected in the level of education and types of substance abuse and arrests related to drug crimes or drug related for secondary to substance use (Table 1).

The census of a TC may fluctuate considerably as some women may be legally remanded or may voluntarily enter or exit. The TC may also be the second point of entry for women who initially undergo detoxification in another facility. It is critical that the researcher acknowledges the potential variability of the sample before conducting the research. For these reasons, women were invited to voluntarily participate at any time during the 3-week period of the MBSR program and were required to attend at least 1 of the 6 meetings to qualify for a 20-dollar gift card from a local retail store. A sign-in sheet was used to identify the women who did qualify for the gift card. It was not expected that all participants would be able to attend each meeting due to the rigorous schedule of therapeutic activities at each TC. The method of a rolling group allows for the members to enter and exit at different points of a group program and can promote attendance and a shared learning experience as participants can inform each other.[4] Although there is a need for more on the use of this method in group therapy, it is apparent that the rolling method can create some problems with data analysis and the inference of findings.[36]

Setting

The setting included 3 TC sites in the southeastern United States (Table 2). The initial point of entry was center 1, located in a mid-sized city near several social service agencies and a residential neighborhood. The TC philosophy was grounded in a Christian and traditional 12-step approach. A cooperative work ethic of the women and staff supported the daily operations of housekeeping, food preparation, and laundry services. The women were eager to share their pride about the meticulous order and home-like atmosphere. Treatment site of center 2 occupied several large office suites in a commercial building in a busy area of a large city. The site was decorated with an Eastern motif to create a Zen-like atmosphere. The program at center 2 was grounded in a holistic philosophy and offered complementary and alternative approaches

Table 2. Therapeutic Community Center Characteristics

Centers	Center 1	Center 2	Center 3
Participants, n	6	20	19
Treatment approach	12-step, with focus on Christian values	Relational growth model for women supported by traditional and twelve step focus and holistic modalities	Traditional TC with focus on community as method and 12-step focus
Fees	Sliding scale/work program	Private pay, insurance accepted, financing plans	Medicaid, state financed, vouchers, military insurance
Program length	Short and long term (usually no longer than 1 year)	Short and long term (usually 30-45 days)	Long term (usually 3-9 months)
Location	Urban city population 38 000	Urban city population 100 000	Rural city population 16 000
Other	Founded and administrated by women in recovery, self-contained facility as residents assume most operational activities such as food service, housekeeping, etc.	Residential facility is separate from treatment facility. Women are transported for activities. Holistic Adjunct providers of acupuncture, yoga, etc.	Criminal Justice situations, women with AIDS, postpartum and pregnant women, newborn and infant children may reside with mother during treatment.

such as yoga, massage, and acupuncture. The residential site for center 2 was located in another area of the city; the women were transported daily to the treatment site. Center was located in a rural area and was based in a 12-step philosophy but was unique as it accepted pregnant women and had facilities for newborns. Women were referred to the center from a nearby crisis unit, the county jail system, or other referring social service agencies. The facility had limited recreational areas, but there was a strong spirit of community created by the presence of 2 newborn babies.

Ethical considerations

The institutional review board consent was obtained from the researcher's institution, which required an outside community member to represent the rights of female prisoners, as some prospective participants could be remanded to the TCs by court order. Because of the sensitivity of the privacy of women in the treatment of SUDS, great care was used to ensure that this vulnerable population was afforded a just and respectful experience. The consent contained an explicit statement that participation in the study was not part of the TC program and would occur during a free activity period. Caution was exercised by the researcher to avoid any hostility-provoking discourses that could erode the sense of community during the meetings. Women who experienced any discomfort about their participation were advised that they would be referred to their counselor in the TC and could drop out of the study at any time without consequences. The women were informed in the consent document that audiotapes and other records from the research could be subpoenaed by a court if they were needed as supporting evidence for a legal action related to substance use.

Procedures

The MBSR programs usually follow an 8-week program of weekly 2- to 3-hour meetings. To accommodate the rigorous schedule of the TC, the program was offered in 6 group meetings that met twice weekly for about 60 to 90 minutes. The following activities were introduced in the meetings: introduction to mindfulness; raisin eating exercise; automatic pilot; wandering mind; body scan; yoga stretches; seeing and hearing awareness; focus on the breath; and sitting and walking mediations. At the beginning of each meeting, a description of the experiential activities was given by the researcher. At the end of the activities, women were invited to share their experiences in a cooperative group process. An audiotape recorder and poster boards were utilized to capture the responses. Transcriptions of the audiotapes were available at the subsequent meetings for the women to verify the data from the previous meetings. Participants were supplied with a personal journal and were asked to record their reflections about MBSR between the meetings. The researcher recorded audiotaped field notes before and after each meeting at each center.

ANALYSIS

Analysis was a cooperative group process that occurred during each meeting and relied on the democratic process of group consensus. The analysis began with the women by using the poster boards as a group workspace to list descriptors of their experiences with the activities. Consensus was reached to combine words with similar meanings and to delete duplications, resulting in the formation of codes. Saturation was reached when the group agreed that the word list was correct and complete. Comments that did not fit into a code were written in the margins of the poster board. Near the end of the meeting, a vote was taken to either move the comment into a code or to delete it from the results of the analysis. Simple tree diagrams were drawn on the poster boards to combine key words and codes into 2 themes. The diagrams were used as a method of member checking and provided opportunities for women to visualize what was being verbally confirmed. Because of the rigorous schedule of the TC environment, none of the 45 women expressed an interest in reading the transcripts that were available at each meeting. Preferences were voiced as "Let's not waste time on that" and "It is too much to read" or "I like the parts where we can just speak our minds," "Let's do more of the practices," and "We really like those big boards to read and write on instead."

Two themes, the "wandering mind" and "too many things are going on" and the "body scan" and "just not ready to go there yet" were specific about how to develop a teaching manual that would meet the needs of women. Determination of the themes was supported by the content of the transcripts from the audiotaped sessions at each center, review of the tree diagrams on the poster boards to confirm codes and categories, and examination of the field notes for contextual meanings. The following field note represents the reflexive process of self-inquiry of the researcher as a participant, observer, and collaborator.

> Collecting data from three sites has been chaotic. Today is the last day of data collection. Rolling that cart around with the yoga mats and poster boards has been tedious and cut into my allotted time with the women. Setting up the rooms with the rolling out and rolling up of the yoga mats became a participatory action! The women were eager to help me load up that cart. Packing up the cart and rolling it out the door extended our mindfulness. We were focused in the moment on that action of participation.

Patience was required by the researcher to hear the voices of all women. Because of the chaotic milieu shaped by the contextual reality of the TC environment, the veracity of the ideal speech situation created in PAR, and the time constraints of the meetings, some of the cooperative analysis process may have been hampered. However, it was important to recognize the side-effects of various stages of

recovery that some women experienced, such as agitation, impatience, sleepiness, and frequent interruptions in the meetings for trips to the bathroom and counseling.

The term *working the program* is frequently heard in the TC environment and is used as a measure of the level of engagement that women have in their commitment to realize their recovery goals. At the beginning of the second meeting at each center, less than 10% of the women had written in the journals that had been provided. Women said that they were unable to reflect and write because of the time constraints and their obligations of "working the program." They were eager to discuss their reflections about MBSR during the meetings. Several women were apologetic about the blank journals and offered to return them. The women were encouraged to keep the journals and to reconsider using them, as journaling is an important aspect of MBSR.

In this study, rigor was achieved through the numerous notations, deletions, corrections, and modifications to the content of the poster board to achieve a consensus from the women. The ongoing process of member checking during the meetings at each site resulted in a "more thorough probing of the situations and practices under investigation."[37(p371)] Rigor was evaluated by the expressions of empowerment in the voices of some women: "It gave me a sense of purpose by contributing in the study that will hopefully help future women with the struggle of addiction," "The after effects of the activities were powerful," and "Women should have their own manual!" Testing of transferability of the findings is planned in a subsequent study with women in treatment to evaluate the usefulness of MBSR for women in TC environments.[31]

RESULTS

Two themes specific to developing the manual for women were identified: the "wandering mind" and "too many things are going on" and the "body scan" and "just not ready to go there yet." The "wandering mind" is a concept within MBSR protocol to encourage acceptance of being in the present moment by bringing attention to the breath as a focus and to accept a nonstriving attitude to just be in the present moment. The inclination to suppress thoughts or expect things to be a certain way is also influenced by the automatic pilot response, a habitual reaction to a stressor, rather than an increased awareness of the likely results. Reactive automatic pilot responses to triggers can lead to relapse. The "body scan" focuses awareness on all the aspects of the body and progresses from the toes throughout the body to the top of the head, using the breath as a guide. It is a 20- to 30-minute practice that can be done seated or lying, with the eyes closed or open. For women with SUDs and PTSD, the practice may be intimidating but must not evoke a sense of threat or pain, as the practice is intended cultivate "observe our experiences—particularly those that are painful—with curiosity, presence, and gentleness, so as to practice a different way of relating to them."[4(p19)] Women were especially interested to discuss their experiences with the "wandering mind" and "body scan."

The "wandering mind" and "too many things are going on"

At the first session, women were asked if they had specific needs in recovery. The resounding response was "yes," and they cited the obligation that women have as caregivers. A good number of women felt beleaguered by the decision to enter the TC because of their responsibilities. The "wandering mind" was described by 1 woman as a cycle of guilt and thoughts about family and "what did I have to leave to come here?" Although most women entered the TCs voluntarily, many expressed their feelings of "guilt" and "homesickness" and anxiety about "isolation" from home and family. One woman was overwhelmed as a mother and thought that it would be very hard to be mindful when she was focused on

returning to her children. She said: "Too many things are going on. Making sure I am focused on my program, making sure I am striving for my future for my reunification with my family. Making sure I am true to myself and that I get out of denial."

Women with children were in agreement that the initial stress of admission is greatly compounded by guilt associated with leaving children at home in the care of others. One woman expressed disappointment with her inadequate commitment to her family: "I am very upset with myself, for being away from family, I felt very displeased with myself, I made the decision in two days to commit myself to this program and no time to take care of things before I came in with my family."

Women who did not have children also felt the guilt of stress related to being "needed by other family members, not only children, and I think that definitely adds to the stress," or as another woman said, "I don't have any children but I felt a lot of guilt when I got here." The voice of a mother described her release from feeling guilty:

I have been thinking about it for the past few days about that. When I first came here, my son was a very big part of my thought process. I have noticed in the past couple of weeks that I am not thinking about him as much. It is a conflict but I am learning that it is OK for me to not be thinking about him all of the time. It is a good thing for me and for him, I am sure. But it has been hard for me to acknowledge that. It is ok Laura; the mom in you is cool. If you are helping yourself you're helping your kids. You do not have to be there 24/7. I am working on that.

The MBSR approach to the "wandering mind" and the need to be present in the moment were considered by 1 woman as very "doable" as she said, "I came here to rehab to clear my mind." Yet, the majority of women were not convinced that controlling a "wandering mind" was a priority, as evidenced in the truthful expression of 1 participant: "I wouldn't even take the time to think that way to focus on the breath."

The mantra of "working the program" was expressed as a key ingredient for success in the TC, and the women did not want to be "burdened" by learning yet another program. Women also wanted time to sort out their guilt on admission to the TC. The consensus was that the initiation of an MBSR program should be after an adequate orientation to the TC as, "It is just too stressful in the beginning to focus. It is pretty upsetting."

The "body scan" and "just not ready to go there yet"

The "body scan" garnered the most attention. Its aim was to get in touch with the body as a whole by bringing an awareness of the breath to each part of the body. The body scan was explained in detail before beginning the exercise, and the women were reminded that participation in any experiential activity was optional. At each center, at least 1 woman elected to not participate. One woman said she preferred to "just sit this one out."

After completing the "body scan," the dialogue focused on the topic of women and abuse as a few women at each center volunteered comments about their personal experiences. Abuse was listed as physical, emotional, or sexual. At each center, a few women described the graphic details of their experiences, emphasizing a particular body part that suffered an injury. Some women commented that the body scan could increase stress for women who had memories associated with abuse. The following comments indicate how the experience of trauma influenced the perception of the anticipated body scan exercise:

For me, I wouldn't be able to relax. That happened with me and my dad. I would have to deal with that before I could just relax. It is going to be painful and you will be all stressed out.

I have never looked at focusing on parts of my body that have been hurt because of my addiction. I would rather discuss that just with my counselor to get that off your shoulders.

I think it would keep people away from doing it. To just go back and feel that pain.

Some people are at different stages of your healings it might help and know how special each parts of your body are. To take more care of your body parts.

Talking to a counselor does not get rid of that pain but looking at yourself and understanding the pain.

Some women who did participate in the "body scan" felt a sense of safety and comfort in doing so and said, "I can talk about it now but not when I first got here," and "Some women may feel uncomfortable if they have a history like me. I have let go of that and I feel better." Another woman added, "I got stuck in one part of my body and then brought myself back."

But some women felt that the "body scan" was not appropriate to be introduced in the initial stages of the MBSR program as some women "were just not ready to go there yet." Women also suggested that yoga props such as pillows and blocks be used as supports to relieve the symptoms of detoxification that some women might experience. A dialogue ensued at both centers 2 and 3 about the respect for women's bodies as several women had prostituted their bodies to support their SUDs. A few women offered comments about pregnant women in treatment and the need to respect them, although their pregnancies might have been negatively impacted by substance abuse.

The experiential activity of the "body scan" created a communicative space for women to discuss their intimate thoughts and personal needs in recovery, as they described the importance to cultivate a trustful environment in an MBSR program. Somatic complaints that were experienced by many of the women on admission or in the entry phase to the program were listed as symptoms related to untreated sexually transmitted infections; side-effects from prescribed medications for depression and anxiety; discomfort related to pregnancy, menstruation, and menopause; and acne and dental issues caused by crack abuse. Several of the women felt that the health services at the TCs were inadequate, as their complaints were not considered by staff to be serious enough to warrant treatment. For women with symptoms that caused pain, medication usually was limited to over-the-counter analgesics dispensed within the TC, perceived by most women to be inadequate. Other unmet unique needs of women were a lack of access to personal hygiene products; inadequate personal space for clothing, toiletries, makeup, and hair care items; and lack of privacy. The dialogues included intimate details of how women felt about body image. To meet the unique needs of women, a unanimous basic requirement for a MBSR program for women was to have a teacher who "must be a woman," "have experience with women in recovery," "recognizes the sensitive needs of women," and "respects our sense of pride" to cocreate a healing environment.

DISCUSSION

Although the benign nature of MBSR, to cultivate awareness and accept pain in a safe environment, is an inviting option or adjunct to the treatment programs, more needs to be known about the readiness of women to participate in a MBSR program. The results of this research reveal critical elements to be incorporated into a manual-based program for women. Foremost, the readiness of women to voluntarily participate must be honored. Although MBSR programs intend to do no harm, participation may conversely exacerbate the symptoms of PTSD and inclusion criteria for participation should adhere to a screening-and-assessment protocol. The sensitive needs of women may be suppressed by the treatment programs that emphasize a hierarchy of power or encourage women to surrender to a greater power, which may increase feelings of low self-esteem, intimidation, and oppression and may increase vulnerability for relapse.[33,38]

The manual for such a program should apprise MBSR teachers of the fact that there is no standardized screening tool for SUD-PTSD,[13] state that concurrent treatment is the best practice even though many programs are not able to provide this,[21] and clearly list the inclusion criteria protocol. Further development of a manual for women is warranted to understand the readiness of women

to participate in a MBSR program and how to implement the "body scan" to safely accommodate women who have experienced trauma. While there is no evidence to support whether specific changes in a manual influences outcomes,[6] the results of this study indicate a need for more focus on changes that are specific to the target population of women.

Evidence-based practice supports MBSR as an effective modality for stress reduction, but little is known about the adverse effects of MBSR for SUDs.[7] Women may be influenced by the this empirical knowledge and rely less on their personal knowledge of body awareness due to PTSD.[39] While there are no reports concerning negative effects for women with SUDs, it has been reported that some persons with obsessive compulsive disorder or traumatic memories of the body can be overwhelmed by the experience of MBSR rather than relieved of stress through its practice.[40] One recently published manual for mindfulness-based relapse prevention addresses trauma, suggesting that participants could practice with eyes open or in a seated position but emphasizes that "these practices should never feel threatening and are thus best fostered in a safe, supported context. Individualizing practices to support this is fine."[4(p19-20)]

Limitations

Limitations of PAR include length of time to conduct the participatory groups, access to the community, and the spiraling nature of the PAR process that requires an expert leader to facilitate the process.[41] Time spent in the field is a critical element for all successful qualitative research. Because of the limitations of physical space in the TCs, a portion of each meeting was spent in gathering of the women and creating the environment for the experiential activities. Some meetings had frequent interruptions, as women were called out for counseling meetings or other obligations. At times I was unable to decide if my level of engagement was that of a facilitator or participant, as I was more focused on the action needed to set up the room in a timely manner and to create a healing environment. The twice-weekly meetings for only three weeks did not allow enough time for me to fully experience the role of being a participant. Although I have considerable experience with women in the TC setting, I felt constrained as a participant due to the time schedule of the meetings. The philosophical framework of each TC is a critical factor in how the researcher will be able to assume the role of participant. The researcher must also carefully consider the potential for a philosophical misfit with a particular TC.

Although the consent was obtained from each woman in the study, the possibility of participant coercion was indicated in the following comment by a woman at center 2, who had voluntarily signed an informed consent document: "I don't know why we are doing research when I am paying twelve thousand dollars a month to be here for treatment. But this is interesting and I like it." This raises concerns about the freedom of women in TCs to decline consent and how this may ultimately affect research results.

Reflections

Feminist researcher Shulamit Reinharz claims that the individual researcher should "honestly assess what she has learned about herself."[41(p196)] The highly structured environment of the TCs gave me an appreciation of the desperate effort expressed by some of the women to succeed in the program. Initially the study was to be conducted at Center One where I had gained access after several visits with the director who was very clear that the TC program was based in a Christian philosophy. The women had commitments to attend church services as part of "working the program." She reviewed the manual's template and determined that the MBSR program would not be in conflict with the Christian values of the TC. However, when the research assistant (RA) and I arrived for the third meeting we were informed by a counselor who had attended the previous meetings, "The women

won't be here today. They are at a prayer meeting at church. They are not interested to continue with the research." I thanked her for their interest in the research project and asked her to inform the women who participated that they would receive their gift cards. I was very surprised as there was no indication of the cancellation of the research project. I later spoke by phone with the Director who repeated the same reason for the abrupt termination and extended no invitation to explore the decision, so I thanked her for the initial enthusiasm and support and sent the gift cards with a letter of appreciation.

The abrupt termination of the research at Center One highlighted my inability as a researcher and participant to establish an *ideal speech situation*. The RA and I spent several days carefully reviewing the audiotaped transcripts and poster boards of the two meetings and we were unable to identify a probable cause for the abrupt cessation of the research. The RA, who relied on her tacit knowledge and wisdom as a nurse in recovery from substance abuse, felt that the director was committed to help the women in "working the program" as a structured approach to success. This unexpected occurrence of not being able to continue the project at the center was an impetus to the research team to seek alternative sites. Gaining access to conduct research in a TC environment is a difficult process due to the rigorous structure of the TC program, and some administrators of TC programs are reluctant to introduce MBSR as an alternative method of "working the program" of the TC. This is a significant view that deserves more attention from researchers and MBSR practitioners, as it raises concern about the liberty of TC participants to make choices about which program to work. The TC philosophy is grounded in community participation and self-help, and the level of engagement of the participants is expected to be full immersion. More research is needed to understand whether the level of engagement of "working the program" is compromised by participation in an adjunct program such as MBSR. After care programs such as Mindfulness Meditation Relapse that are specific to relapse, prevention may be a more appropriate fit for conducting research as participants would be able to exercise the freedom to choose a program.

Implications for nursing

The relational nature of the discipline of nursing requires an ideal speech situation to promote mutual moral caring actions of participating in a communicative space between the nurse researcher and women in recovery.[42] The ideal speech situation created by PAR is a practical method for nurses to hear the tacit knowledge of the group and demonstrate respect for the wisdom of women in recovery to affect changes in the development of programs for others in the same situation. Some women have benefited from psychotherapeutic and pharmacologic advances in the treatment of PTSD-SUDs; yet, more effort is needed to improve mental and physical outcomes as well as to facilitate integrated community care.[44] Nurses in all practice settings should offer a sensitive and holistic approach to encourage women to utilize treatment options that "work for them."[9(p223)] Nurses have been described as being "invisible"[45] in addiction treatment teams; yet, many nurses in a variety of health care settings are in fact the initial contact for women with SUDs who seek health care. Advocates nurses should strive to encourage the use of a self-assessment tool for PTSD, which would be beneficial to promote early diagnosis, leading to earlier treatment. The use of self-administered instruments may encourage women to gain confidence in being able to discuss sexual issues with the nurse.[14] The specialized patient population of SUDs (eg, adolescent, gender specific, incarcerated, and outpatient) and the variation in program delivery (eg, TC, 12-step, harm reduction, and abstinence) significantly decrease the likelihood of comparison studies[41]; however, further research for the development of a manual specific for women is necessary to provide

optimal healing environments for women in all stages of recovery.

CONCLUSION

Nurses can engage in an ideal speech situation with women and encourage an opening of communicative space to cocreate "an arena for the expression of interpersonal needs and the development of social contexts in which these needs are met."[46(p248)] This space provides a naturalistic setting to give primacy to relationships with women and to conduct research and adds to evidence-based practices to help women heal. Nurses have a moral obligation to offer women with SUDs-PTSD an opportunity to feel safe and to engage with them in an ideal speech situation that advances an understanding of their sensitive and unique needs.

The primary aim of this study was to develop a manual for women to determine the need for the modification of the intervention. These preliminary findings suggest a need for a reflexive consideration of the appropriateness of introducing MBSR as an adjunct treatment in the TC. The findings require more investigation of the right patient, right dose, and right time for the MBSR intervention. The secondary aim of the study was to contribute knowledge of holistic healing modalities to the canon of nursing knowledge. The results highlight the possibilities for holistic nurses to cocreate communicative space as a healing environment for women. Future research that relies on the moral obligation of the nurse would be supported by a critical or feminist view to advance the strategy of using an ideal speech situation to develop a practice theory for holistic nursing.

REFERENCES

1. Marcus MT, Fine M, Kouzekanani K. Mindfulness-based meditation in a therapeutic community. *J Subst Use*. 2001;5:305-311.
2. Marcus MT, Fine M, Moeller FG, et al. Changes in stress levels following mindfulness-based stress reduction in a therapeutic community. *Addict Disord Treat*. 2003;2:63-68.
3. Marcus MT, Liehr P, Schmitz J, et al. Behavioral therapies trials: a case example. *Nurs Res*. 2007;56(3):210-216.
4. Bowen S, Chawla N, Marlatt A. *Mindfulness-Based Relapse Prevention for Addictive Behaviors: A Clinician's Guide.* New York, NY: The Guilford Press;2011:1-24.
5. Marcus MT, Schmitz J, Moeller G, et al. Mindfulness-based stress reduction in therapeutic community treatment: a stage 1 trial. *Am J Drug Alcohol Abuse*. 2009;35(2):103-108.
6. Ziegierska A, Rabago D, Chawla N, Kushner K, Koehler R, Marlatt A. Mindfulness meditation for substance use disorders: a systematic review. *Subst Abuse*. 2009;30:266-294.
7. Bowen S, Chawla N, Collins SE, et al. Mindfulness-based relapse prevention for substance use disorders: a pilot efficacy trial. *Subst Abuse*. 2009;30:205-305.
8. NIDA archives. http://archives.drugabuse.gov/womendrugs/Women-DrugAbuse.html. Accessed September 1, 2010.
9. Brady TM, Ashley OS. *Women in Substance Abuse Treatment: Results From the Alcohol and Drug Services Study (ADSS) (DHHS publication no. SMA 04-3968, Analytic Series A-26)*. Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies; 2005.
10. Hien DA, Cohen LR, Miele GM, Litt LC, Caspstick C. Promising treatments for women with comorbid PTSD and substance use disorders. *Am J Psychiatry*. 2004;161:1426-1432.
11. Smith CS. Coping strategies of female victims of child abuse in treatment for substance abuse relapse: their advice to other women and healthcare professionals. *J of Addict. Nurs*. 2007;18:75-80.
12. Gatz M, Russel L, Grady J, Kram-Fernandez D, Clark C, Marshall B. Womens's recollections of victimization, psychological problems, and substance abuse. *J Comm Psychology*. 2005;33(4):479-493.
13. Harrington T, Newman E. The psychometric utility of two self-report measures of PTSD among women substance abusers. *Behaviors*. 2007;32:2788-2798. NIDA Research Report Series: Therapeutic Communities http://www.drugabuse.gov/ResearchReports/Therapeutic/Therapeutic2.html. Published 2008. Accessed Decemeber 15, 2009.
14. Sobczak JA. Struggling to reconnect: women's perspectives on alcohol dependence, violence, and sexual function. *J Am Psychiatr Nurse Assoc*. 2009;14(6):421-428.
15. Brewer NK. The contextual factors that foster and hinder the process of recovery for alcohol dependent women. *J Addict Nurs*. 2006;17:175-180.

16. Armstrong M. Foundations for a gender based treatment model for women in recovery from chemical dependency. *J Addict Nurs.* 2008;19(2):77-82.
17. Campbell ND. *Using Women, Gender, Drug Policy, and Social Justice*. New York, NY: Routledge; 2000.
18. The National Center on Addiction and Substance Abuse at Columbia University. *Women Under the Influence.* Baltimore, MD: The Johns Hopkins University Press; 2006.
19. Back SE, Contini RC, Brady KT. Substance abuse in women: does gender matter? *Psychiatric Times*. 2007; 24(70). http://www.psychiatrictimes.com/display/article/10168/4696. Accessed November 1, 2009.
20. Jessup MA, Bridis CD, Issues in reproductive health and empowerment in perinatal women with substance use disorders. *J Addict. Nurs.* 2005;16:97-105.
21. Gupp K. Women with co-occurring substance abuse disorders and PTSD: how women understand their illness. *J of Addict. Nurs.* 2008;19:49-54.
22. Krejci J, Margolin J, Rowland M, Wetzell C. Integrated group treatment of women's substance abuse and trauma. *J Groups Addict Recovery*. 2008;3(3,4):263-283.
23. Cook LS, Epperson L, Gariti P. Determining the need for gender-specific chemical dependence treatment: assessment of treatment variables. *Am J on Addict*. 2005;14:328-338.
24. Herman-Smith R, Pearson B, Cordiano TS, Aquirre-McLaughlin A. Addressing individual client needs in manualized treatment. *Clin Case Stud* 2008;7(5):377-396.
25. Bellg AJ, Resnick B, Minicucci DS, et al. Enhancing treatment fidelity in health behavior change studies: best practices and recommendations from the NIH behavior change consortium. *Health Psych*. 2004;23(5):443-451.
26. Onken LS, Blaine JD, Battjes R. Behavioral therapy research: a conceptualization of a process. In: Hennegler SW, Amentos R, eds. *Innovative Approaches From Difficult to Treat Populations.* Washington, DC: American Psychaitric Press; 1997:477-485.
27. Rounsaville BJ, Carroll KM, Onken LS. A stage model of behavioral therapies: getting started and moving along. *Clin Psych: Sci Pract*. 2001;8(2):133-142.
28. Habermas J. *The Theory of Communicative Action: Reason and the Rationalization of Society.* (T. McCarthy, Trans). (vol 1). Boston, MA: Beacon; 1981.
29. De Leon G. *The Therapeutic Community: Theory, Model and Method*. New York City, NY: Springer Publishing Company; 2000.
30. Gossop M, Stewart D, Marsden J. Readiness for change and drug use outcomes after treatment. *Addiction*. 2006;102:301-308.
31. Marcus MT. Changing careers: becoming clean and sober in a therapeutic community. *Qual Health Res*. 1998;8(4):466-480.
32. Prochaska JO, DiClemente CC, Norcross J. In search of how people change. *Amer Psychol*. 1992;47:1102-1114.
33. Eliason MJ. Are therapeutic communities for women? *Subst Abuse Treat Prev Policy*. 2006;1:3. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1435997. Accessed August 1, 2009.
34. Hien D, Simpson T. *NIDA CTN Blending Conference.* Integrated treatment for addiction and trauma: seeking safety. http://www.seiservices.com/blendingseattle/monday_pdfs/Session5_Simpson_and_Hien.pdf. Published 2006. Accessed December 1, 2009.
35. Freire P. *Pedagogy of the Oppressed*. New York, NY: Continuum; 2000.
36. Morgan-Lopez A, Fals-Steward W. Analytic methods for modeling longitudinal data from rolling therapy groups with membership turnover. *J Consulting Clinical Psychology.* 2007;75(4):580-593.
37. Marshall J, Reason P. Quality in research as taking an attitude of inquiry. *Manage Res Rev.* 2007;30(5):368-380.
38. Blume SB. Women and alcohol: Issues in social policy. In: Wilsnack, Wilsnack SC, eds. *Gender and Alcohol: Individual and Social Perspectives*. New Brunswick, NJ: Rutgers Center for Alcohol Studies; 1997:462-489.
39. Whitman-Price RA, Bhattacharya A. Reexploring the subconcepts of the Wittmann-Price theory of emancipated decision making in women's healthcare. *Adv Nurs Sci*. 2008;31(3):225-236.
40. Shapiro SL, Carlson LE, Astin JA, Freedman B. Mechanisms of mindfulness. *J Clin Psychol*. 2006;62(3):373-386.
41. Melrose MJ. Maximizing the rigor of action research: why you want to? How could you? *Field Methods*. 2001;13(2):160-180.
42. Reinharz S. *Feminist Methods in Social Research.* New York, NY: Oxford University Press; 1992.
43. Lange B. Mutual moral caring actions: a framework for community nursing practice. *Adv Nurs Sci.* 2006;29(2):E44-55.
44. Hien DA, Jiang H, Campbell ANC, et al. Do treatment improvements in PTSD severity affect substance use outcomes? A secondary analysis from a randomized clinical trial in NIDAS's clinical trials Network. *Am J Psychiatry.* 2010;167:95-101.
45. Fornili K. Another quality chasm: the failure of nursing to clearly communicate its role within the addition treatment workforce. *J Addict. Nurs*. 2007;18:57-59.
46. Gaya Wicks P, Reason P. Initiating action research. Challenges and paradoxes of opening communicative space. *Action Res*. 2009;7(3):243-262.