Today’s Presenter

Neha Chawla, PhD

- Founder & Director, Seattle Mindfulness Center
- Co-creator, MBRP
- Group facilitator and trainer
Mindfulness-Based Relapse Prevention for Addictive Behavior

Neha Chawla, PhD
Seattle Mindfulness Center
nchawla@uw.edu

www.SeattleMindfulnessCenter.com
www.MindfulRP.com
Road Map

✧ Why MBRP?
✧ What is Mindfulness?
✧ Why is it useful in treating addictive behavior?
✧ MBRP: Content, Structure & Research
Road Map

✧ Why MBRP?
“Chronic relapsing conditions”

- 65% to 90% have at least one drink in the first year following treatment, 50% in first 2 months

- Improved coping skills are related to less frequent drinking at first lapse and lighter drinking thereafter

(Maisto et al., 2003; Sutton, 1979; Witkiewitz & Masyn, 2008)
Relapse Prevention

✧ RP is an effective treatment for a range of substances (e.g., Alcohol, Cocaine, Marijuana, Smoking, Gambling, Eating)

✧ Does not always prevent a lapse better than other treatments, but more effective at delaying, and also reducing duration and intensity of lapse

(e.g., Irvin, et al., 1999; Carroll, 1996; Dimeff & Marlatt, 1998; Roffman, et al.1990; Schmitz, et al., 2001)
RP + Mindfulness?

✧ Would the addition of mindfulness enhance the efficacy of RP?

✧ Can we integrate the two in a way that is accessible/feasible?

✧ Are there individuals who would do better with an alternative approach?
Road Map

✧ Why MBRP?
✧ What is Mindfulness?
Mindfulness Journal Publications by Year, 1980-2017

American Mindfulness Research Association, 2018
Source: goAMRA.org
What is Mindfulness?
(Experiential Exercise)
Notice wandering, begin again. Attention wanders. Chosen object (e.g., breath). (Nonjudgmental) (Present Moment)
“Awareness that emerges through paying attention on purpose, in the present moment, and non-judgmentally to the unfolding of experience moment by moment”

(Kabat-Zinn, 2003)
“Awareness that emerges through paying attention on purpose, in the present moment, and non-judgmentally to the unfolding of experience moment by moment”

(Kabat-Zinn, 2003)
Road Map

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✧ What is Mindfulness?
✧ Why is it useful in treating addictive behavior?
Mindfulness & Addictive Behavior

✧ **PAYING ATTENTION**
   Greater awareness of triggers and reactions. Interrupting automatic behavior.

✧ **PRESENT MOMENT**
   Accepting present experience, rather than escaping or avoiding it.

✧ **NONJUDGMENTALLY**
   Detach from self-critical and automatic thoughts that often lead to addictive behavior and relapse.
Mindfulness & Transtheoretical Model
(Prochaska & DiClemente, 1983; Prochaska, DiClemente, & Norcross, 1992)

✧ CONTEMPLATION
Greater awareness of ambivalence/impact of changing vs. maintaining status quo; Greater ability to “be with” vs. “avoid” discomfort

✧ PREPARATION
Increased awareness of triggers/seeing more clearly what needs to change and how

✧ ACTION Greater ability to respond vs. react/interrupt habitual behaviors/take skillful action

✧ MAINTENANCE Support continued awareness and choice; minimize self-judgment
Mindfulness-Based Relapse Prevention
Structure and Format

✧ Patterned after MBSR (Kabat-Zinn) and MBCT (Segal et al.)

✧ 8 weekly 2-hour sessions; daily home practice

✧ Components
  ✧ Formal mindfulness practice
  ✧ Informal practice
  ✧ Coping strategies
Core Intentions

◦ **AWARENESS**
  Thoughts, feelings and sensations, including triggers. Interrupt previously automatic/habitual behaviors

◦ **RESPONDING VS. REACTING**
  Greater sense of freedom and choice

◦ **RELATIONSHIP TO DISCOMFORT**
  “Being with” rather than “fighting”, “avoiding” or “trying to fix”

◦ **SELF-ACCEPTANCE/COMPASSION**
  Recognizing self-judgment and criticism
  Relating to experience with greater compassion

◦ **LIFESTYLE BALANCE**
  Supporting a lifestyle that is aligned with recovery
Approach

✧ Experiential

✧ Present moment vs. story

✧ Importance of facilitator mindfulness practice: Nonjudgment, openness, curiosity

Similar to MI Spirit: collaborative, accepting, compassionate and evocative.

✧ Elicit vs. teach

‘Evoking’ in MI speak: The resources and motivation for change are presumed to lie within the person.
Inquiry

“I can’t do this”,
“What’s wrong with me?”
“I need a drink”

Pain in the knee,
feeling of sadness

➜ Relationship to Relapse
➜ Not personal; a human experience

Adapted from Segal et al., 2002
Session Themes

Session 1: Automatic Pilot and Relapse
Session 2: Awareness of Triggers and Craving
Session 3: Mindfulness in Daily Life
Session 4: Mindfulness in High-Risk Situations
Session 5: Acceptance and Skillful Action
Session 6: Seeing Thoughts as Thoughts
Session 7: Self-Care and Lifestyle Balance
Session 8: Social Support and Continuing Practice
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Increasing Awareness
Session Themes

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Formal Practices

✧ Body Scan
✧ Sitting Meditation
✧ Mountain Meditation
✧ Loving-kindness Meditation
Informal Practices

✧ Urge Surfing
✧ Mindfulness of Daily Activities
✧ SOBER Breathing Space
✧ Mindful Movement
Working with Urges & Craving

Riding the Wave

Urge Surfing: Staying with the urge (wave) as it grows, riding it to its peak, using the breath to stay steady, trusting it will naturally subside without any action.

Seems as though the craving will get BIGGER and BIGGER...

Unless you do something to “fix it”
urge

time
SOBER Breathing Space

S: Stop
O: Observe
B: Breath
E: Expand
R: Respond
Cognitive-Behavioral Exercises

✧ Noticing Triggers
✧ Relapse Chain
## Awareness of Triggers

<table>
<thead>
<tr>
<th>Situation/Trigger</th>
<th>What sensations did you experience?</th>
<th>What moods, feelings or emotions did you notice?</th>
<th>What thoughts arose?</th>
<th>What did you do?</th>
</tr>
</thead>
<tbody>
<tr>
<td>An argument with my girlfriend.</td>
<td>Tightness in chest, sweaty palms, heart beating fast, shaky all over</td>
<td>Anxiety, hurt, anger</td>
<td>“I can’t do this.” “I need a drink.” “Forget it. I don’t care anymore”</td>
<td>Yelled, slammed door, went for a walk</td>
</tr>
</tbody>
</table>
Relapse Chain

Trigger → Initial Reaction → Observe Reaction → Respond w/ Awareness

STOP

Automatic Pilot

Believe thoughts → React (e.g., lapse) → More thoughts/Reactions

Abstinence violation effect

Relapse
Research
MBRP Pilot Study

N = 168

Completed Inpatient or Intensive Outpatient

Baseline

MBRP

8 weeks

Post Course

TAU

2 months

4 months

Funded by National Institute on Drug Abuse Grant R21 DAO 10562-01A1; PI: G. Alan Marlatt
Participants

- Age 40.5 (10.3); 64% male

- Ethnicity
  - 50% Caucasian
  - 28% African American
  - 15% Multiracial
  - 7% Native American

- 72% completed high-school
- 41% unemployed
- 33% public assistance
- 62% less than $4,999 / year

- Homeless/unstably housed

(Bowen et al., 2009)
Results

✧ Increased awareness and acceptance \((p < .01)\)

✧ Reduction in craving \((p < .05)\)

✧ Decreased rates of substance use \((p < .05)\)

✧ Effect of treatment on substance use mediated by reduction in craving

✧ Weaker relationship between depressive symptoms and craving for MBRP group
Negative Affect

Outcomes

Substance use treatment outcomes
(e.g., Hodgins, el Guebaly, & Armstrong, 1995)

Re-initiation of use following abstinence
(e.g., Witkiewitz & Villarroel, 2009)

Comorbidity

~ 40% of Americans with depressive/anxiety disorders have co-occurring substance use disorders
(NCS; Kessler, Nelson, McGonagle, Liu, et al., 1996)

Depression has particularly strong relation with craving and relapse
(Gordon et al., 2006; Zilberman et al., 2007; Curran et al., 2000; Levy, 2008)
Depressive Symptoms

Awareness/acceptance of affective discomfort

Over time, craving response in the presence of negative affect weakens

Hypotheses:

“Staying with” vs. “escaping or ‘fixing’”

- Weaker relationship between depression and craving in MBRP group

- Thereby reducing Negative Reinforcement model (e.g., Cleveland & Harris, 2010; Cooney, et al., 1997; Perkins & Grobe, 1992; Shiffman & Waters, 2004; Sinha & Malley, 1999; Stewart, 2000; Wheeler et al., 2008)

Self-medication hypothesis (Khantzian, 1985)

Craving

Substance Use

(e.g., Hartz, et al., 2001; Hopper et al. 2006; Shiffman et al., 2002)
Depressive Symptoms

Craving

Substance Use

TAU

(Moderated mediation effect of treatment; $p = 0.04$)

MBRP
Results: Depression and Craving

![Graph showing the relationship between BDI postcourse and Penn Alcohol Craving Scale 2-months. The graph includes two lines, one for TAU and another for MBRP, with R-Square values of 0.28 and 0.01, respectively.](image-url)
Larger MBRP Trial

N = 286

8 weeks

Funded by National Institute on Drug Abuse Grant PI: Sarah Bowen
Results

3 Months: No differences

6 Months:

✦ MBRP and RP (vs. TAU)
  ✦ Higher probability of abstinence from drug use & not engaging in heavy drinking
  ✦ Among those who drank, 31% fewer days of heavy drinking

✦ RP (vs. MBRP)
  ✦ Longer time to first use
12 Months:

- **MBRP (vs. RP & TAU)**
  - Higher probability of not engaging in heavy drinking
  - 31% fewer drug use days
Conclusions

✧ All treatments are equally effective at 3 months.

✧ Both MBRP and RP (compared to TAU) blunt the probability and severity of relapse at 6 months, with RP delaying time to first drug use.

✧ MBRP may have a more enduring effect beyond 6 months.

Hypothesized mechanism
Over time, and with greater exposure, participants may be better able to recognize and tolerate craving and negative affect.
Resources

❖ MBRP website
   www.mindfulrp.com

❖ MBRP Trainings
   ❖ Vashon Island, Washington USA: June, 2019

THANK YOU!
Surveys

Look for our surveys in your inbox!

We’ll send two short surveys: one now, and one in a month.

We greatly appreciate your feedback! Every survey we receive helps us to improve and develop our programming.
Questions? Please type them in the chat box!
Upcoming Events

Thank you for coming!

Join us for our next webinar:

Addressing High-risk Sexual Behavior Among People in SUD Treatment

Mary Hatch-Maillette, PhD
December 19, 2018, 12-1pm