



Mindfulness-Based Relapse Prevention *for Addictive Behaviors*

A CLINICIAN'S GUIDE

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G. Alan Marlatt, PhD, is Director of the Addictive Behaviors Research Center, Professor of Psychology, and Adjunct Professor in the School of Public Health at the University of Washington. His major focus in both research and clinical work is the field of addictive behaviors. In addition to over 250 journal articles and book chapters, he has published several books in the addictions field, including *Relapse*

Prevention (1985, 2005), *Assessment of Addictive Behaviors* (1988, 2005), *Harm Reduction* (1998), and *Brief Alcohol Screening and Intervention for College Students (BASICS): A Harm Reduction Approach* (1999). Over the course of the past 30 years, Dr. Marlatt has received continuous funding for his research from a variety of agencies, including the National Institute on Alcohol Abuse and Alcoholism, the National Institute on Drug Abuse, ABMRF/The Foundation for Alcohol Research, and the Robert Wood Johnson Foundation. He is a recipient of the Jellinek Memorial Award for outstanding contributions to knowledge in the field of alcohol studies (1990), the Robert Wood Johnson Foundation's Innovators in Combating Substance Abuse Award (2001), and the Research Society on Alcoholism's Distinguished Researcher Award (2004). In 2010, he received the Association of Behavioral and Cognitive Therapy's Career/Lifetime Achievement Award.

Preface

Mindfulness-based relapse prevention (MBRP) is a program integrating mindfulness meditation practices with traditional relapse prevention (RP). Traditional RP is a cognitive-behavioral intervention designed to help prevent or manage relapse for clients following treatment for addictive behavior problems. Similarly, MBRP is designed as an outpatient aftercare program to support maintenance of treatment gains and to foster a sustainable lifestyle for individuals in recovery. In this book we present clinical strategies in the treatment of alcohol and other substance use problems. We also discuss methods for coping with urges and cravings that might be triggers for relapse across a variety of addictive behaviors. This Preface sets the stage for the material presented in this book by providing an account of how previous research and experience led to the emergence of MBRP.

Much of the present research has been informed by a quest for what has been termed the “middle way,” or a balance between harmful indulgence and strict renunciation as well as between self-discipline and self-compassion. I began my career with a study evaluating electrical aversion therapy in the treatment of alcohol dependence. Aversion therapy is a punishment procedure designed to transform craving into an aversive response, marked by a desire to avoid or escape pain to prevent the urge to drink or take drugs. As we discovered, although this treatment approach may be effective in the short run, individuals in aversion therapy often have a higher relapse potential in the long run.

As our research developed, my colleagues and I found ourselves moving toward a more balanced approach. We have come a long way since, and realized that incorporating mindful skills, based on principles of self-compassion and acceptance of all experiences, including craving and urges, may be more success-

ful than aversion approaches in lowering relapse risk. Mindfulness practice provides effective and skillful means for diligent, intentional behavior change, while emphasizing kindness and flexibility.

Addiction is considered by many individuals (including those who self-identify as “addicts”) to be a moral problem deserving of punishment. In the “war on drugs,” illegal drug users are put in jail to punish them for their immoral and illegal behavior, another extension of the aversion approach. Addicts are often viewed as responsible for their “bad habit” of continuing to abuse substances. They often experience considerable guilt and shame about their abuse of alcohol and other drugs, and are not likely to voluntarily seek out treatment for fear of rejection and punishment. Many of these individuals will eventually end up either forced into treatment, often as a result of a confrontational “intervention” by family members and peers, or incarcerated following a substance-related offense. These consequences only add to their stigma and shame.

My search for a middle way led me to wonder if there was another, perhaps more positive, perspective on the nature and origins of addiction. Buddhist psychology provides a promising route to recovery that offers an alternative and perhaps complementary means to overcome addictive behavior. According to the “Four Noble Truths” outlined by the Buddha, life is fraught with suffering (first Truth), and this suffering is caused by attachment or craving. This can take several forms, such as craving for sense pleasures, wanting to be someone different, or reaching for what comes next. It can also take the form of aversion or struggling against “what is” (second Truth). The good news is that there is a way out of this suffering (third Truth) provided by the “eight-fold path” (fourth Truth).

The eight-fold path provides a list of the eight desirable behaviors (or what are termed in Buddhism “right” behaviors) and associated mental states, including “right mindfulness” based on the practice of meditation. (The other steps on this path are consistent with many cognitive-behavioral treatment goals, including “right view, intention, speech, action, livelihood, effort, and concentration.”) The eight-fold path and Buddhist psychology in general deal with the very issues that so often arise in the treatment of addictions and thus provide not only a foundation for our understanding of addictive behaviors, but specific interventions that address the problems that often keep recovery at bay.

But what does mindfulness specifically offer to the addictive behaviors field? As defined by Jon Kabat-Zinn (1994), mindfulness is “a way of paying attention: on purpose, in the present moment, and nonjudgmentally” (p. 4). Our focus in applying mindfulness clinically is on helping individuals with addictive behaviors “see things the way they really are” instead of focusing on the future and finding their “next fix.” Buddhist psychology emphasizes acknowledging, feeling, and accepting discomfort when it arises, and understanding the experience intimately, rather than endlessly attempting to run away from it. This is a compassionate approach,

emphasizing acceptance and openness rather than guilt, blame, and shame about one's behavior. Mindfulness also promotes awareness of the changing nature of things; our minds, bodies, and environments are in a constant state of change. For example, consider the smoker who cannot imagine going 45 minutes without a cigarette, but who doesn't realize that his or her seemingly overwhelming desires may attenuate if he or she can just ride them out. Mindfulness can provide a "skillful means" of coping with urges and craving that involves observing them, without being wiped out or consumed by them. Even though the smoker may feel that the urge to smoke will increase unless he or she gives in and lights up a cigarette, the smoker's urges and craving will change on their own if he or she gives them time to pass.

Additionally, mindfulness provides a state of metacognitive awareness in which one can see more of the "big picture" instead of giving into one's usual conditioned, habitual behavior. This awareness provides a greater sense of freedom and choice. As stated by Viktor Frankl (1946), "Between stimulus and response, there is a space. In that space is our power to choose our response. In our response lies our growth and freedom." Mindfulness practices increase awareness of this space and create the opportunity to respond skillfully rather than react automatically and habitually. Thus, when faced with a trigger for substance use, one can make a mindful choice that decreases the likelihood of relapse. Finally, a mindful approach can help reduce the tendency of the mind to exacerbate negative emotional states, lowering the stigma, shame, blame, and guilt commonly experienced by people who struggle with addictive behaviors.

In considering my personal journey from practicing aversion therapy to mindfulness, many paths have led me to this juncture. The first of these was my effort to discover what led people to relapse. One of my first clinical patients was a middle-aged man who was diagnosed with alcohol dependence. My clinical supervisor at Napa State Hospital, where I was doing a predoctoral internship, recommended an insight-development approach ostensibly designed to help my patient understand why he had become a problem drinker, why he should make a lifelong goal of abstinence, why he should attend Alcoholics Anonymous, and why he needed to be in an inpatient treatment program. Having worked with him to facilitate his understanding of why he should give up drinking for the rest of his life, I felt confident that his level of motivation for recovery was well established when he completed the program. On the day of his discharge, I saw him off on the Greyhound Bus headed for San Francisco, his hometown.

Less than 3 days later, he returned to Napa State, severely intoxicated, and was readmitted to the detox unit. When I asked him what had happened after his discharge, he told me that his bus made its first stop in the Tenderloin district of San Francisco, right in front of a bar that he had regularly frequented. He said he thought one of his close friends might be inside, so he walked straight from the

bus into the bar. His friend was not there, but the bartender recognized him and poured him a free double-shot of whiskey as a way of welcoming him back. He described a "loss of control" over the next hour, during which he continued to drink until he passed out. A friend had him readmitted the next day. After telling me this story, he said, "Dr. Marlatt, you were very persuasive in helping me understand *why* I had become an alcoholic, and *why* I should give up drinking, and *why* abstinence was my only pathway to recovery. But you never said a damn thing about *how* I was supposed to achieve this goal!"

After this interview, I approached the Director of the Alcoholism Treatment Center at Napa and asked why, given the high relapse rates of patients treated in the program, we didn't give patients any information about how to cope with relapse. He looked at me askance and replied, "We're definitely not going to talk about relapse, because if we did that, we would be giving them permission to do so." I countered by asking why we need to have fire drills; these procedures are not designed to give people permission to set fires but to keep them safe and alive in the event of one. He replied that relapse was a sensitive issue and not to be encouraged in any way. It was at this point that I saw the moral model in action and realized it wasn't working. But what alternative could we offer? I was inspired to look more closely at what caused relapse. In addition, given that my doctoral training focused on behavior therapy, I became interested in examining a variety of behavioral interventions that might help in the development for a cognitive-behavioral program for relapse prevention.

After my internship at Napa State Hospital and a brief sojourn at the University of British Columbia, I accepted a new assistant professorship at the University of Wisconsin. I began doing clinical work with patients in the alcoholism treatment ward at Mendota State Hospital. In the late 1960s, the literature on behavior therapy approaches to treating alcoholism advocated aversion therapy more highly than most other interventions. As noted earlier, its purpose is to transform craving and urges to drink into an aversive response that deters further consumption. This is based on classical conditioning principles and is designed to elicit a conditioned response when the patient is presented with alcoholic beverages and associated drinking cues.

To further explore aversion therapy for use with addictions treatment, I received a grant to construct a small bar in the basement of the hospital in which patients from the regular month-long treatment program volunteered to be randomly assigned either to receive aversion therapy or to be in the treatment-as-usual control group. All of the patients in the study were male, most of them with long histories of alcohol dependence. For the electrical aversion procedure, each patient selected a shock level that was painful but not physically harmful. During the twice-weekly sessions in the bar (which hospital staff nicknamed "Marlatt's Bar

and GRILL”), patients were presented with their favorite alcoholic beverage and asked to pick up the glass and look at and smell the drink, but not to consume any of it. At that point, a brief shock was administered to create a conditioned aversion to the alcoholic beverage (Okulitch & Marlatt, 1972).

After the patients were released, we conducted follow-up assessments at 3 months posttreatment and again a year later (15 months posttreatment). At the 3-month follow-up, patients who completed aversion treatment had higher abstinence rates and significantly lower drinking rates than those who had been in the treatment-as-usual control group. Despite these promising initial results, a year later patients in the aversion condition showed a strong rebound effect and were drinking significantly more than patients in the control condition. Not only had the aversion effects worn off over time, but the participants ended up drinking even more than patients who had been in the regular hospital program.

The literature on the short-term and long-term effects of punishment and aversive conditioning confirmed these results. Research suggested that punishment tended to result in the temporary suppression of target behaviors, but over time, in the absence of learning an alternative behavioral response, the suppressed behaviors tended to reappear. We realized we needed to teach alternative coping responses. As I thought about this process, it seemed important to assess the situation that precipitated the patient’s first lapse after an initial period of abstinence. What were the triggers associated with taking the first drink? What happened on the day the patient first “fell off the wagon”? If we had more information on the precipitating circumstances, perhaps we could train the patient to acquire new and effective coping skills that might help prevent relapse.

In my study of aversion therapy, I wanted to know whether relapsed patients took their first drink in a situation that differed from that of the treatment environment (our simulated bar). Aversion treatment would have limited application if the effects were confined to the specific beverage and environment used in the initial treatment. As a result, we obtained detailed accounts of relapse episodes from patients in the follow-up interviews. Patients who relapsed were interviewed within a few days to obtain information about the initial lapse, including the physical location, presence or absence of others, any external or internal events that occurred prior to the lapse, and any emotions or feelings that occurred. Descriptions of the relapse episodes were coded and assigned to operationally defined categories.

Most of the relapse episodes could be assigned to surprisingly few categories. The first two areas, accounting for more than half of the cases, involved an interpersonal encounter. Almost one-third of the situations involved an episode in which the patient was frustrated in some goal-directed activity and reported feelings of anger. Rather than expressing their anger constructively, patients ended up having

a drink. The second category involved social influences, with patients reporting an inability to resist direct or indirect social pressure to engage in drinking. The other categories could be described as intrapersonal, including giving in to urges or cravings often elicited by environmental stimuli (as was the case with my patient from Napa State Hospital who gave in to the urge to drink once he entered a bar setting). In subsequent studies, we found similar patterns of high-risk situations associated with relapse episodes for other addictive behaviors, including cigarette smoking and heroin use. In all, there seemed to be a common thread running through these situations that made them potential triggers for relapse: the need to “self-medicate” when the individual experienced strong negative emotional states, including anger, anxiety, depression, and interpersonal conflict.

In efforts to identify high-risk situations, we learned that although there may be a variety of underlying mediating factors involved, it is the individual’s own subjective perception of “risk” that is most important. As such, a high-risk situation is defined broadly as any situation that poses a threat to one’s sense of perceived control (self-efficacy) and increases the risk of potential relapse. To the extent that heavy drinking, smoking, or other substance use occurred (prior to one’s commitment to abstinence) in similar situations, most users will have developed strong positive expectancies (craving) about using the drug as a coping strategy. Users come to believe they cannot cope with certain stressful situations, such as feeling angry, socializing with substance-using peers, or facing the threat of negative evaluation, unless they are able to lean on the addictive behavior as a crutch.

The most salient factor that serves to decrease the risk of relapse in an otherwise high-risk situation, and which is at the core of the RP model, is access to an alternative coping response. If the individual has acquired new ways of coping with stressful situations, we hypothesized that self-efficacy would be strengthened and the probability of relapse would decrease. RP focuses on identifying high-risk situations and teaching coping skills so as to increase self-efficacy and decrease the likelihood of relapse. After the publication of *Relapse Prevention* (Marlatt & Gordon, 1985), a variety of treatment outcome studies were completed evaluating the clinical effectiveness of RP, many of which have been summarized in the second edition (Marlatt & Donovan, 2005). The results overall show that although RP does not result in higher abstinence rates following treatment, it does significantly reduce the frequency and intensity of relapse episodes, helping people get “back on track” more quickly if they do fall off the wagon.

Over the past quarter century, we have attempted to include strong and easily adopted coping skills in our RP program. Of course, one of the most potent and readily accessible coping mechanisms we had at our disposal is mindfulness meditation. In the first edition of *Relapse Prevention*, the chapter on “Lifestyle Modification” included meditation as a cognitive coping strategy that might help provide balance for individuals at risk for relapse related to a stressful lifestyle:

One of the most significant effects of regular meditation practice is the development of mindfulness—the capacity to observe the ongoing process of experience without at the same time becoming “attached” or identifying with the content of each thought, feeling, or image. Mindfulness is a particularly effective cognitive skill for the practice of RP. If clients can acquire this ability through the regular practice of meditation, they may be able to “detach” themselves from the lure of urges, cravings, or cognitive rationalizations that may otherwise lead to a lapse. (Marlatt & Gordon, 1985, p. 319)

My own interest in meditation began in the early 1970s, after I moved to the University of Washington in Seattle. I was experiencing the typical stress associated with the “publish or perish” demands of academic life, and my blood pressure became elevated. My physician suggested meditation as a way to relax. I became defensive, explaining that as a behavior therapist, I had no interest in participating in “Eastern” practices associated with Hinduism or Buddhism. He handed me an article showing that the regular practice of transcendental meditation (TM) lowered the diastolic blood pressure of patients being treated for hypertension. “Since you’re a researcher,” he said, “I thought you would be impressed with these results.” He advised me to sign up for TM and give it a try for 3 months, telling me that if it did not bring my blood pressure down, he would recommend medication. “You can measure your blood pressure on a daily basis and make a graph of the results—either it will work or not, so that’s the purpose of your personal research study.” I agreed and signed up for TM training.

TM is known as a “concentrative meditation” technique in which the meditator focuses on a single word (a unique mantra given to each new student by the TM instructor). The instructions were to sit quietly with eyes closed for two 20-minute periods each day, repeating the mantra with each inbreath and outbreath. When distracted by other thoughts or images, I was told to gently return the attention to the mantra and to continue to sit quietly.

After considerable initial skepticism, once I began the practice, I found it to be very relaxing. I sat in the morning before going to work and again after work in the late afternoon. To my delight, my diastolic blood pressure showed a significant drop after the first 2 weeks of daily practice. My physician was also pleased and encouraged me to continue practicing TM on a long-term basis. He also recommended the book *The Relaxation Response* by physician Herbert Benson (1975). Benson included a basic meditation practice to enhance muscle relaxation and reduce tension. Clearly there was medical evidence supporting the benefits of meditation as a tension-reduction practice. Given that both ongoing addictive behavior and risk for relapse go up as tension and stress increase, both at the physiological and psychological levels, it seemed clear that meditation could be a helpful coping skill in addiction treatment.

As a result of personal and professional experience in the meditation field, my colleagues and I decided to do some outcome research to see how the practice of meditation, relaxation training, and exercise might affect the drinking behavior of male heavy social drinkers. We selected heavy drinkers rather than alcohol-dependent patients as our subjects because we wanted to determine if their daily practice (of meditation, muscle relaxation, or exercise, depending on their random assignment to condition) would affect the amount of alcohol they consumed. We did not include alcohol-dependent drinkers because treatment usually requires abstinence as the only acceptable goal. The results showed that all three of the daily practices had a significant impact on reducing drinking rates compared to the control group during the 16-week intervention period. On average, consumption rates dropped 50% from the preintervention drinking rates (Marlatt & Marques, 1977; Marlatt, Pagano, Rose, & Marques, 1984). In addition, participants continued to practice on their own volition during the follow-up period: 62% of the aerobic exercise group (running practice) and 57% of the subjects in the meditation group continued practicing their techniques regularly.

My interest in TM was limited to the extent that there was little theoretical literature showing how TM worked in terms of changing cognitive functioning and personal stress levels. Starting in the early 1980s, my interest in meditation evolved to include the study of Buddhist psychology (Marlatt, 2002). The Buddhist literature seemed parallel in many ways to cognitive-behavioral therapy, and I began doing meditation retreats with a variety of Buddhist teachers, including S. N. Goenka, the renowned teacher of *vipassana* (a Sanskrit term meaning “seeing things as they really are”). At the end of one 10-day retreat, I asked him about the Buddhist definition of addiction. After explaining that most experts in the United States defined addiction as a “disease of the brain,” I posed the question “How does Buddhism define addiction?” He replied, “Yes, addiction is a disease—it’s a disease of the *mind*.” At that point, I realized that mindfulness meditation could be helpful for people with addictive behavior in terms of coping with urges and craving, whether they are pursuing a goal of moderation or abstinence.

Several years later, I received a call from a psychologist at a minimum-security jail in Seattle, regarding a 10-day meditation retreat based on Goenka’s teachings for inmates at the facility who were willing to participate. Starting with the first course in 1997, the jail continued to offer 10-day *vipassana* courses for inmates who volunteered to participate. As is traditional in these courses, they were held in silence, except for meditation instructions from the teachers, questions from the participants, and a daily “dharma talk” to explain the Buddhist principles of mindfulness meditation.

The psychologist who called me said that a review of the prison records showed that inmates who took the *vipassana* retreat showed a significant reduc-

tion in recidivism, compared to inmates who did not take the course. She asked if I would be interested in conducting a clinical outcome study to evaluate the effects of the vipassana course, with a focus on alcohol and drug use and associated risk of recidivism. We obtained a research grant from the Robert Wood Johnson Foundation to follow up with inmates who participated in the retreat and compared their outcomes with those who chose not to take the course. Results obtained 3 months following participants' release from jail showed statistically significant reductions in alcohol (and alcohol-related harm), cocaine, and marijuana use, and improved psychiatric symptoms and enhanced optimism, compared to the control group (Bowen et al., 2006).

How could we extend this experience to a broader treatment approach? Although attending a 10-day vipassana retreat can have beneficial effects for people with both mental health and addictive behavior problems, we knew that many individuals would find attending a silent retreat of this length to be too challenging. Also we knew some might object to participating in a course based on Buddhist teachings. These issues have been addressed in the development of mindfulness treatment programs for other disorders, including chronic pain and distress (mindfulness-based stress reduction [MBSR], originally developed over 30 years ago by Jon Kabat-Zinn at the University of Massachusetts Medical School; Kabat-Zinn, 1990) and depressive relapse (mindfulness-based cognitive therapy [MBCT], developed by Zindel Segal at the University of Toronto; Segal, Williams, & Teasdale, 2002). Both the MBSR and MBCT programs are conducted in a group therapy format and consist of eight weekly outpatient sessions. Both programs train patients in secular mindfulness meditation practices and metacognitive coping skills that help them manage painful physical sensations and associated anxiety (MBSR) or triggers that might precipitate a relapse into depression following initial treatment (MBCT). Both MBSR and MBCT have been found to be effective in a series of treatment outcome studies (e.g., Kabat-Zinn et al., 1992; Roth & Creaser, 1997; Teasdale et al., 2000).

Based on the structure and format of both MBSR and MBCT, we decided to develop a parallel program for the treatment of addictive behavior, MBRP, originally described by Witkiewitz, Marlatt, and Walker (2005). As outlined in this treatment guide, MBRP consists of eight weekly sessions conducted in a group therapy format integrating cognitive-behavioral RP skills with mindfulness practices. The purpose of these practices is to increase awareness of triggers and habitual reactions, to develop a new relationship with these experiences, and to learn concrete skills to use in high-risk situations.

In stark contrast to aversion therapy, which is designed to punish one's craving responses, mindfulness practice can foster exploration and acceptance of craving and urges. Instead of giving in to the desire for immediate gratification, mind-

fulness practice provides an opportunity to observe the cresting of the craving wave without getting “wiped out” by it. As one of my clients observed, the words *addiction* and *dictation* have the same Latin stem: *dicere* (“to impose or give orders with or as with authority”). She observed, “I still think I want to drink a lot when I get depressed, but since I finished the meditation course, I no longer have to be dictated to by my thoughts. I accept them and let them pass.” By moving from aversion to acceptance as a means of coping with craving, recovery is facilitated on the basis of a new compassionate approach, which is what we hope to offer in the MBRP program.

G. ALAN MARLATT

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The structure and content of MBRP are largely inspired by and based on the work of Jon Kabat-Zinn and colleagues at the Center for Mindfulness in Medicine, Health Care, and Society at the University of Massachusetts Medical School and the seminal work of Kabat-Zinn's mindfulness-based stress reduction program, as described in his book *Full Catastrophe Living* (1990). Additionally, several exercises are derived or adapted from the work of Zindel Segal, Mark Williams, and John Teasdale in *Mindfulness-Based Cognitive Therapy for Depression* (2002).

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