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# Mindfulness-Based Interventions to Reduce Relapse in Clients with Alcohol Use Disorders

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MINDFULNESS-BASED INTERVENTIONS TO REDUCE RELAPSE IN CLIENTS WITH  
ALCOHOL USE DISORDERS

By

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A Research Paper  
Submitted in Partial Fulfillment of the Requirements for the  
Master of Science Degree

Rehabilitation Counseling Training Program  
In the Graduate School  
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RESEARCH PAPER APPROVAL

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For the Master of Science Degree

In the field of Rehabilitation Counseling

Approved by: Dr. D. Shane Koch

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## TABLE OF CONTENTS

<u>CHAPTER</u>	<u>PAGE</u>
CHAPTER 1 – Introduction.....	1
Background.....	1
Purpose.....	1
Definitions.....	2
CHAPTER 2 – Survey of Literature.....	3
Prevalence .....	3
Psychosocial Implications.....	4
Assessment.....	5
Theory.....	5
Treatment.....	7
CHAPTER 3 – .....	11
Discussion.....	11
REFERENCES .....	13
VITA .....	15

## CHAPTER ONE

### INTRODUCTION

#### **Background**

##### *Population*

Alcohol use disorders remain a major public health problem (Savage, 2013). Current estimates suggest that 30% of adults in the United States will meet criteria for a substance use disorder (SUD) during their lifetime (Murphy & MacKillop, 2014).

##### *Problem*

For many individuals struggling with SUD, craving, or a constant desire for alcohol, is a common occurrence (Segal, 2013). Cravings are theorized to maintain problematic drinking and this has been supported by many empirical studies (Segal, 2013). One treatment method thought to help individuals endure craving and other intense experiential states is the use of mindfulness (Witkiewitz & Bowen, 2010). Mindfulness is described as a “non-judgmental observation of the ongoing stream of internal and external stimuli as they arise” (Murphy & MacKillop, 2014). Use of this intervention for individuals with substance use disorders shows promise. The impact of this method of treatment should be more widely disseminated among counseling professionals.

#### **Purpose**

Cravings have been identified as one of leading causes for relapse. Mindfulness based interventions are focused on reduction in thoughts that lead to cravings and have been used successfully with this population. Many counselors may be unfamiliar with MT or may be unaware of the methods that would be useful for their clientele. This research will explore how mindfulness works, who it works with, what it entails, when it should be offered and why it is better than other interventions. A literature review was conducted and the results will be

reported in the following chapter. A discussion section follows which summarizes the implication of mindfulness based interventions for use in reduction of cravings in treatment settings. This will be followed by recommendations for counselor use and future research recommendations.

### **Definitions**

Substance Use Disorder- Substance use disorders are chronic relapsing conditions that lead to significant morbidity and impairment in psychosocial functioning.

Craving- a powerful desire for something.

Mindfulness- Mindfulness involves attending to experiences on a moment-to-moment basis.

For ease in reading, the term mindfulness based treatment will be abbreviated to MBT throughout the remainder of this paper.

## CHAPTER TWO

### LITERATURE REVIEW

#### **Prevalence**

Substance abuse is a growing dilemma and has been the subject of many research articles, journals, and books over the years. The lifetime occurrence of addictive disorders among US adults is about 12.5% for alcohol dependence, 17.8% for alcohol abuse, 2.6% for drug dependence, and 7.7% for drug abuse (Savage, 2013). Similar numbers are reported by the 2012 National Survey on Drug Use and Health (NSDUH) conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA), who reported that roughly 17 million Americans experienced alcohol use disorders.

Although treatments designed to reduce substance use show promise, up to 50% of patients relapse within 6 months of treatment and up to 40% cycle through periods of relapse, treatment reentry, and recovery (Moore et al., 2014). Cravings have been identified as one of leading causes for relapse.

So what are cravings? A craving is essentially unpleasant and so naturally drives individuals to act, whether to smoke, drink, or use other drugs (Brewer et al., 2013). The longer this craving goes unsatisfied, the more it may intensify as it becomes fueled by further reactions to the unpleasantness of the wanting itself (Brewer et. al). For example, in a study of treatment-seeking smokers, for each standard deviation increase in craving scores on the target quit date, the threat of lapsing rose by 43% on that day and 65% on the following day (Brewer et. al, 2013).

Cravings tend to be triggered by external or internal cues associated with rewarding use (pleasure or relief), such as the sight of bottle of gin, a bout of anxiety, or any symptom of

withdrawal (Segal, 2013). Often, when a relapse occurs, it begins with a craving to use. The mode pattern is that they gradually decrease over a period of months, and eventually disappear. But other patterns occur. At times abstinence is almost free of cravings. Other times people are overwhelmed by cravings to use drugs or alcohol every day. Cravings are powerful and often cause problem drinkers to act against what they would consider to be their own best interests (Segal, 2013). If the person with the substance use disorder continues to think about the craving to use it can continue to the point of fixation. This in turn can turn into the person relapsing.

### **Psychosocial Implications**

Although the amount of substance used is important, it is more important to evaluate the consequences of the drug and alcohol use on life domains, such as family, work or school, and involvement with the criminal justice system. Substance use is a major public health concern that affects every level of society. Individuals, families, communities, and overall government spending is impacted by the use of licit and illicit substances.

In 2004, 22.5 million Americans (9.4% of the population) aged 12 and older were classified with a SUD (Morgan, Crane, Moore, & Eggett, 2013). Recent reports estimated that annual costs in the United States are approximately USD \$193 billion for illicit drug use, USD \$223 billion for excessive alcohol use, and USD \$193 billion for tobacco use. These costs include lost wages and productivity, criminal activity, and healthcare expenses. The financial impact of alcohol abuse on society in the USA includes increased use of health care, crime and accident costs, which rose from \$148 billion in 1992 to \$185 billion in 2000 (Morgan, Crane, Moore, & Eggett, 2013). In addition, the costs of drug abuse to society have risen annually by 5.9 per cent since 1992, and in 2002, reached an estimated \$180.8 billion (Morgan, Crane, Moore, & Eggett, 2013).



Treatment cost is important to think about in light of what is called the cost-ramping profile of addiction (Morgan, Crane, Moore, & Eggett, 2013). This phenomenon accounts for the growing cost of healthcare that accumulates over time as a person continues to abuse substances (Morgan, Crane, Moore, & Eggett, 2013).

### **Assessment**

Clinicians should try to determine patients' recovery status, which is vital in developing a treatment plan (Substance Abuse and Mental Health Services Administration, 2011). Many clients will be cooperative about the past substance abuse during a comprehensive assessment. Sometimes when the client does not have good insight on their past use and histories, family members can frequently provide this information.

Most tools are short, can be self-administered, and can be incorporated into the health-screening forms the patient completes prior to seeing the clinician (Substance Abuse and Mental Health Services Administration, 2011). Although no tool is a replacement for a good clinical interview, screening is necessary to care. Normally, mindfulness is assessed in psychological research using proxy measures such as the Mindful Attention and Awareness Scale or the Five Facet Mindfulness Questionnaire (Day, 2014). We conduct an assessment to answer three questions. What is their current level of functioning, what goal or goals might be most appropriate for the client, and what services are required for the client to achieve the goal or goals.

### **Theory**

Mindfulness means maintaining a moment-by-moment awareness of our thoughts, feelings, bodily sensations, and surrounding environment. Though it has its roots in Buddhist meditation, a secular practice of mindfulness has entered the American mainstream in recent

years (Kabat-Zin, 2011). Mindfulness involves acceptance of our thoughts and feelings without judging them so that our thoughts tune into what happening, what is being sensed, in the present moment rather than rehashing the past or imagining the future (Witkiewitz, Bowen, Douglas, & Hsu, 2013). Two significant insights can be learned from this process. According to (Brewer, Elwafi, & Davis, 2013) individuals learn that cravings are physical feelings in their bodies rather than moral imperatives that have to be acted upon. Second, they gain first-hand knowledge with the temporary nature of these physical sensations. In time they ride out a craving—experiencing its physicality without acting on it—this reinforces their insight that cravings will resolve on their own, even if not satisfied. Cravings may continue to occur, but learning to sit with urges, to pause and not immediately react, may disturb the associative learning process and the automaticity of the action normally taken.

In contrast to the various strategies commonly employed in substance-abuse interventions (e.g., cognitive-behavioral interventions and 12-step groups), such as thought-stopping, avoidance of negative or challenging experiences and emotions, or reliance on will power, mindfulness-based practices emphasize intentional awareness and acceptance of all experiences, including those that are uncomfortable or unwanted, and teach skills to better relate to these experiences (Witkiewitz, Lustyk, & Bowen, 2013).

Mindfulness-based interventions are more short term usually 8-12 sessions spread over the course of less than 6 months. Psychoanalytic is a long term therapy that focuses unconscious issues by using, dream analysis, free association, transference, and other methods.

Psychoanalytic therapy can last from 6 months to 2 years. People who have substance use disorders can need results sooner. There can be a change in thinking for the client in just a few

sessions with mindfulness saving time and money compared to the slow paced therapy of psychoanalytical.

## **Treatment**

Mindfulness training teaches individuals to instead step back and take a minute to discover what cravings essentially feel like in their bodies, however uncomfortable or unpleasant they may be (Brewer et. al). Craving is essentially unpleasant and so as you would expect it drives individuals to act, whether to drink, or use other drugs. The longer this craving goes unfulfilled, the more it may strengthen as it becomes fueled by further reactions to the unpleasantness of the wanting itself (Brewer et al., 2013).

So what does the research say about mindfulness-based interventions and their ability to reduce cravings in the substance use disorder population? How do mindfulness-based interventions work and when can they be used and what are the outcomes? How will counselors use it in their practice?

After reviewing the research on how mindfulness-based interventions can help people with substance use disorders to reduce cravings I found that the research in the area of cravings is fairly new. Most of the research that will be covered has to do with mindfulness-based relapse prevention (MBRP).

Marlatt (2002) acknowledged that craving and addiction could be targeted by mindfulness meditation, but that many individuals might need further cognitive and behavioral skills for coping with high risk situations for relapse (Witkiewitz et al, 2013). In reaction to the need for integrating mindfulness meditation with cognitive-behavioral skills training for addiction, Mindfulness-Based Relapse Prevention was developed as an aftercare treatment program that was designed to decrease the risk and severity of relapse following intensive

substance abuse treatment (Witkiewitz et al, 2013). Mindfulness-based relapse prevention (MBRP) was intended to target experiences of craving and negative affect and their roles in the relapse process (Witkiewitz & Bowen, 2010). MBRP offers skills in cognitive behavioral relapse prevention incorporated with mindfulness meditation. Clients typically meditate for 30-45 minutes in sitting and assigned approximately 45 minutes of daily meditation with audio-recording instructions (Witkiewitz & Bowen, 2010). According to this 2010 research publication, MBRP appeared to influence cognitive and behavioral responses and provided verification for incorporating mindfulness practice into substance abuse treatment, and recognized a potential mechanism for change following MBRP (Witkiewitz & Bowen, 2010).

In a first efficacy trial, (Bowen et al., 2009), participants in MBRP, as compared to those in a treatment-as-usual control group, reported, lower rates of substance use, greater decreases in craving, and greater increases in acceptance and mindful awareness (Bowen & Kurz, 2012). Other studies have also examined mindfulness-based treatments for addictive behaviors with hopeful results.

There was research conducted to follow-up on the outcome of MBRP on post-treatment craving scores (Witkiewitz, Bowen, Douglas, & Hsu, 2013). They examined the levels of cravings and changes in cravings over time (Witkiewitz et al, 2013). They also examined whether changes in acting with awareness, acceptance, and nonjudgement, mediated the relationship between participation in MBRP and self-reported changes in cravings for the duration of and after MBRP (Witkiewitz et al, 2013).

In this study there were 168 participants recruited from a private, nonprofit agency providing continuum of care for alcohol and drug use disorders (Witkiewitz et al, 2013). MBRP was delivered by two therapists to groups of 6-10 participants (Witkiewitz et al, 2013). Sessions

included guided meditations, experimental exercises to practice in between sessions and were given CD's for daily meditation (Witkiewitz et al, 2013). Relapse prevention practices were integrated into the mindfulness-based skills (Witkiewitz et al, 2013). Participants continue to follow the regular aftercare as usual including work in the 12-step model, process-oriented groups, and psychoeducation (Witkiewitz et al, 2013). Relapse prevention skills, based on the disease model of addiction, were incorporated in some of the groups (Witkiewitz et al, 2013). All of the procedures used in this study were self-reported and were given using a web based program with staff accessible to help them use the program (Witkiewitz et al, 2013). This study supported that participating in the MBRP was associated with considerable reductions in self-reported craving during and following treatment (Witkiewitz et al, 2013). Treatment hours were also linked with a greater decrease in cravings in this study.

Results from another study concluded that participating in (MBRP) was associated with significant reductions in self-reported craving throughout and following treatment (Witkiewitz, Bowen, Douglas, & Hsu, 2013). Results indicated that an underlying factor representing scores on measures of acceptance, awareness, and nonjudgmental significantly mediated the relation between receiving MBRP and self-reported levels of cravings (Witkiewitz et al, 2013). The meditation findings are consistent with the goals of MBRP and emphasize the importance of interventions that increase acceptance and awareness, and help clients promote nonjudgmental toward their experience (Witkiewitz et al, 2013). This may help reduce the occurrence and response to cravings.

So how can counselors apply mindfulness-based interventions in their practice with people with substance use disorders? Counselors can use the practice of mindfulness techniques in sessions with their clients. They help their clients learn, practice, and discuss relapse

prevention techniques. Counselors can also help their clients by having their clients practice mindfulness techniques outside of the therapy sessions. Clients can be given meditation CD's to use at home and be assigned mindfulness practices including mindfulness of breath, and walking meditation. The more that the clients practice these mindfulness skills the better they will get at it and therefore reducing the cravings for using substances.

## CHAPTER III

### DISCUSSION OF IMPLICATIONS

#### **Discussion**

After reviewing the summary of the research that has been conducted in relation to the use of mindfulness-based interventions in helping to reduce relapse in clients with substance use disorders there has been various studies in the research about this topic. When looking at the research there are good outcomes regarding the use of mindfulness-based interventions to help reduce cravings and relapse in the substance use disorder population. There was only 1 study that found no significant differences between mindfulness-based interventions and other interventions.

Future research needs to go on to look at what components of mindfulness aid in the management of acute cravings for alcohol and other addictive drugs. There also needs to be research conducted about psychological measures of affect and craving. Studies of other addictive behaviors, such as pathological gambling, and binge eating could shed some light on a possible common role of the relation between the negative affective states and craving across a broader class of addictive behaviors (Witkiewitz et al. 2010).

Counselors can help by putting more emphasis on helping clients with coping skills. It will also be helpful to be aware of the populations that are at greatest risk of relapse. Clients with most risk are those experiencing an increase in cravings which include, women, older individuals, individuals with a family history of drug abuse, and individuals who used distraction and disengagement or seldom used acceptance as coping strategies (Moore et al., 2014).

Overall, when looking at the research on how mindfulness-based interventions help to reduce cravings in the substance use disorder population there is more research to be done on

effectiveness and how effective it is with certain substances and populations. The research is lacking in looking at the different drugs of choice for the client and if there is any difference in cravings and outcomes targeting various drugs of abuse when using mindfulness-based interventions.



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