Mindfulness-Based Relapse Prevention for Substance Abusers:

Therapist Training and Therapeutic Relationships

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Introduction

Struggling with the addicted mind is not unique to individuals with substance abuse disorders. The need to "self medicate" is common to all human beings, whether manifested in drug and alcohol use, overeating, sexual practices, work habits or a pervasive need to stay occupied in service of avoiding discomfort. Mindfulness practice presents a radically different approach to working with discomfort, cultivating a curiosity and willingness to "lean in" to the experience, rather than to "fix" or avoid it. Modeling of such a stance is critical for individuals beginning to adopt a more mindful and accepting attitude. In Mindfulness-Based Relapse Prevention (MBRP; Witkiewitz, Marlatt & Walker, 2005), as in many of the mindfulness or acceptance-based therapies, one of the key roles of MBRP therapists is an embodiment of this stance, both in their own personal practice and approach to experience, and in the style in which they interact with clients. The therapeutic relationship developed in the environment of an MBRP course can serve as a model of a nonjudgmental and compassionate approach for working with the craving, attachment and discomfort so often experienced by clients in recovery. The therapists' personal mindfulness practice, which fosters a deeper understanding of these principles, is paramount to the formation of such a relationship.

The current chapter will begin by discussing the roots and foundations of MBRP, a new behavioral treatment which integrates traditional cognitive behavioral Relapse Prevention techniques (RP; Marlatt & Gordon, 1985) with mindfulness meditation for treatment of substance use disorders. The chapter will describe development, training and implementation of the MBRP protocol, and the role of both therapists' and clients' mindfulness practice in enhancing group cohesion and alliance. Particular focus will be given to factors that enhance the therapeutic relationship. Further, aspects of the relationship that are unique to this intervention will be highlighted, as well as differences between fundamental approaches of MBRP and more traditional approaches to substance use treatment.

At the root of MBRP is the practice of mindfulness meditation, based on the traditional Buddhist practice of Vipassana, which literally translates as "seeing things as they really are." The practice begins with observation of the breath, and expands to include awareness of bodily sensations, thoughts, emotional states, and all aspects of current experience. Mindfulness practitioners are taught to approach their experience in a nonjudgmental fashion, while observing the pulls of attachment and aversion (Hart, 1987). While traditional courses in Vipassana meditation require up to ten days of highly intensive training in a residential setting, with students meditating for up to ten hours a day, several recently developed therapies integrate the core practices and principles of Vipassana into cognitive behavioral structures more familiar to Western clinicians and clientele.

MBRP is largely based on the practices and structure of Mindfulness-Based Stress Reduction for chronic pain (MBSR; Kabat-Zinn, 1982; 1990) and Mindfulness-Based Cognitive Therapy for depression (MBCT; Teasdale, Segal, & Williams, 1995; Segal, Teasdale, & Williams, 2002), similarly using a secularized approach to mindfulness practice in combination with CBT-based techniques. Corresponding in structure, MBRP consists of eight two-hour sessions delivered in group format over the course of eight weeks. It has been proposed that in order for mindfulness techniques to be most effective, certain components should be tailored to the particular needs of the population (Teasdale, Segal & Williams, 2003). MBRP incorporates exercises, meditations and homework activities specifically tailored to recognition of and coping with craving, triggers and high-risk situations for substance use.

The research literature on treatment of substance dependence includes numerous studies that have described the clinical and cost effectiveness of CBT in the promotion of abstinence rates, reduction of drug and alcohol use (Kadden, 2001), and prevention of relapse (Carroll,

1996; Irvin et al., 1999). Based on the premise that maladaptive substance use is the result of learning, CBT for substance dependence attempts to identify contextual, social, affective, and cognitive precipitants of substance use. Additionally, the treatment aims to improve interpersonal skills and substitute positive life activities for drug use (Marlatt & Donovan, 2005; Marlatt & Gordon, 1985). Relapse prevention, in particular, relies on the initial assessment of potentially high-risk situations for relapse (e.g., environmental stressors, personality characteristics; see Witkiewitz & Marlatt, 2007), monitoring of behavior in high-risk situations, and assessment of lifestyle factors (e.g., lifestyle imbalance) that may increase the probability of encountering high-risk situations (Larimer, Palmer & Marlatt, 1999).

Mindfulness-Based Relapse Prevention: An Overview

In the original publication of RP (Marlatt & Gordon, 1985), mindfulness meditation was proposed as a means of helping clients achieve lifestyle balance. Today, MBRP has expanded the use of meditation as a means to achieve balance by thoroughly integrating specific RP strategies (Larimer, Palmer & Marlatt, 1999; Marlatt & Donovan, 2005) into a mindfulness-based treatment. As suggested by Breslin, Zack and McMain (2002), helping clients recognize the emotional and cognitive responses to triggers for substance use interrupts the previously automatic response of using substances. Indeed, neurobiological findings support the hypothesis that meditation enhances awareness and may help individuals generate alternatives to mindless, compulsive behavior. As described by Groves and Farmer (1994), "In the context of addictions, mindfulness might mean becoming aware of triggers for craving…and choosing to do something else which might ameliorate or prevent craving, so weakening the habitual response" (p. 189). Mindfulness meditation may disrupt habitual craving responses by providing heightened awareness and even acceptance of the initial craving response, without judgment or reactance.

The goal of MBRP is to develop awareness and acceptance of thoughts, feelings, and sensations through practicing mindfulness, to observe both pleasant and unpleasant experience, and to accept whatever is present without judgment. These practices are combined with traditional relapse prevention techniques for developing effective coping skills, enhancing self-efficacy, and learning to recognize common antecedents of substance use and relapse (e.g., outcome expectancies, the abstinence violation effect, drinking motives, social norms and risk perception). Observation and acceptance are both forms of coping strategies (Marlatt, 2002), in which the focus is on acceptance of the present moment and observation of cognitive, sensory, physical, and intuitive experiences, without analyzing, judging, or emotional responding. The focus is not on "doing what's right" or making "good decisions," but rather on a state of "just being" (Segal, et al, 2002). Identification of one's individual high-risk situations for relapse remains a central component of the treatment. Clients are trained to recognize early warning signs for relapse and to increase awareness of substance-related cues, such as people and places that have previously been associated with substance use. Mindfulness practice provides clients with a new way of processing situational cues and monitoring reactions to environmental contingencies.

One example of a coping strategy taught in MBRP is a technique called "urge surfing" (Marlatt & Kristeller, 1999). Urge surfing uses the imagery of a wave to help a client gain control over impulses to use drugs or alcohol. The client is first taught to label internal sensations and cognitive preoccupations as an urge, and then to foster an attitude of unattached, curious observation of the experience. The technique focuses on identifying and accepting the urge, rather than acting on or attempting to fight it using suppression or avoidance strategies. The curious and accepting attitude taken by facilitators and trainers towards the experiences of participants models this stance. The thoughts, feelings and sensations experienced by participants are identified simply as arising events,

without judgment, evaluation or attempts to alter and control them. This includes aversive states such as cravings and urges, as well as physical and emotional discomfort. Accepting the occurrence of thoughts and experiences rather than attempting to avoid or suppress them has been shown to be an effective component of mindfulness practice in relation to decreased substance use (Bowen, Witkiewitz, Dillworth & Marlatt, in press). In a recent study (Bowen et al., 2006; Marlatt et al., 2004) on the effectiveness of Vipassana meditation in reducing substance use, clients reported that "staying in the moment" and being mindful of urges were the most helpful coping strategies.

MBRP may be particularly effective for individuals who are inclined to use substances to ameliorate negative affective states (sometimes in response to craving or other internal or external stimuli). Negative affect has been identified as one of the primary predictors of relapse (Marlatt, 1978; Marlatt & Gordon, 1985; Cummings, Gordon & Marlatt, 1980), and numerous studies suggest a strong relationship between negative affect and substance use (Shiffman et al., 1996; Witkiewitz & Marlatt, 2004). After repeated experiences of the immediate alleviation of negative affective states through the use of substances, the experience of negative affect can elicit a conditioned response of craving. Meditation provides an opportunity to practice new responses to cues, such as observation and acceptance of experiences, thus replacing the habitual self-medication of negative emotional states with substances.

Mindfulness-Based Relapse Prevention: Implementation

The current trial assessing the feasibility of MBRP is composed of three phases: initial development of the MBRP protocol and therapist training, a pilot study, and a main implementation trial. To date, only the pilot phase has been completed. This phase consisted of conducting four gender-segregated groups in conjunction with a private treatment agency. There was no control condition for this phase; the purpose was to provide an opportunity for therapists

to practice leading groups, and to incorporate feedback from clients about the content and process of the MBRP groups. The second phase of the study, currently in progress, involves conducting MBRP groups as part of an aftercare program in a community treatment agency. Study participants who are randomly assigned to the control condition continue with their usual aftercare. Groups are mixed-gender and consist of six to eleven participants. In all phases of the trial, groups meet weekly for two hours and are co-led by two therapists. Throughout the first two phases of the study, trainers and therapists learned to acknowledge, with compassion, the therapists' own struggles in maintaining a personal mindfulness practice. It is important for fellow therapists, therapist supervisors and the research team to uphold the same accepting, non-judgmental, and compassionate stance toward the clients and therapists alike.

The role of the therapist's personal practice in therapeutic alliance

The elemental principles and practices of MBRP are rooted in the basic tenets of Buddhism. Although the treatment does not explicitly reference Buddhism, it remains faithful to the core Buddhist principles regarding the nature of the mind and human suffering. Inherent in these principles is the assumption that human beings universally experience discontent or dissatisfaction, attributable to the nature of the mind itself, which is conditioned to become attached to a world that is impermanent. According to Buddhist philosophy, relief from suffering lies in direct observation of the nature of the mind and the experience of thoughts, sensations and emotions as impermanent phenomena, rather than fixed or permanent states. This allows individuals to respond with awareness rather than react automatically. MBRP is an extension of this theory and practice, tailored to meet the needs of individuals struggling with addiction.

In any therapeutic relationship (see also Lambert & Witold, chapter one, this volume), the alliance between clients and therapists is a critical component of the change process, providing a

necessary foundation for creating an atmosphere of safety, confidence and trust. In MBRP, the alliance between the therapists and clients is particularly crucial, as the nonjudgmental curiosity and openness of the therapists toward group members provide a model for clients to develop a mindful, accepting and compassionate approach to their own experience. The therapists' embodiment of these qualities, and the therapeutic relationship that begins to develop as a result of this approach, is one of the most powerful teaching tools in MBRP.

This nonjudgmental, egalitarian stance may be particularly important for clients who have a history of "tough love" or Higher-Power-focused substance abuse treatments (e.g., twelve-step programs such as Alcoholics Anonymous) and who may have struggled with the evaluative or judgmental nature of these treatments. The MBRP therapist in contrast, is not only working to develop the alliance with clients, but must also take the extra steps of socializing clients to a nonhierarchical, nonstigmatizing and compassion-focused approach to treatment. For example, throughout the course of the groups, clients often make comments such as, "that's because I am an addict," or will ask if they will be able to successfully engage in mindfulness meditation exercises because they hold the belief that their brain is different, and lesser, than a "non addict's." The therapists repeatedly enforce the equalizing approach of MBRP, wherein the struggles they are encountering are more about being human than being an "addict." Therapists reiterate that the experience of craving and the pull to reach for something to ameliorate discomfort is just how the mind works, and that craving and addiction is present in all humans in some form; it is just part of the human experience. Clients are encouraged to treat evaluative and self-judgmental thoughts as "just thoughts" that arise and pass away, rather than as factual truths to be identified with. They are asked to bring the same curiosity and gentleness towards these thoughts and the emotions they may trigger as towards all other experience.

This nonjudgmental therapeutic stance was cultivated from the initial phases of manual development and therapist training. Therapist training began with an intensive two-and-a-half day program, beginning with a basic overview of the theory, history and design of MBRP. The remainder of the training consisted of meditation and RP skills-based exercises designed to give therapists an experience similar to that of the future clients. The trainers alternated between leading exercises and metateaching about the process and style of leading the groups.

Throughout the training, exercises and concepts behind MBRP were illustrated through experiential exercises wherever possible instead of through didactics, moving through as much of the material in "real time" as possible. The trainees' personal experience and feedback were encouraged. Early in the training, it became clear that the desired dynamic was that of a facilitated group process, rather than a psycho-educational or process group. Within the MBRP groups, therapists are referred to as facilitators, and clients as group participants.

Throughout the next phase of training, involving weekly group training and practice sessions, therapists were asked to play mock group clients, while other therapists took turns leading the sessions. It quickly became apparent that the experiences in these training groups were likely to bear significant similarity to the experiences of the future clients. Training groups were thus run with trainees portraying their "real" selves, asking questions about practice, discussing issues in their own practice, and using that material to allow them to practice facilitation skills.

The tenor and format of MBRP therapist training were inspired largely by the structure of MBCT intensive trainings and reflective of the core practices of mindfulness meditation. Embodied in traditional mindfulness practice is a sense of interconnectedness and compassion, both for one's own and for others' experiences. The experience of attachment and suffering is

seen as common to all beings, despite evident distinctions in their stories and in the objects of attachment. The trainers hoped to engender, from the very beginnings of development and training, this stance of shared process, cooperation, nonjudgmental openness and respect. Throughout the training process, which continued for several months, a mindful, nonjudgmental approach was taken towards all experience.

From the beginning phases of therapist recruitment and training, the importance of maintaining a personal practice was emphasized. Similar to MBCT and MBSR, it was a primary requisite for working on the project that therapists commit to daily personal practice. The practice itself may be viewed at the "true" teacher or guide, and the role of the therapist is one of supporting and encouraging clients while drawing upon their own experience with the practice. Rather than view therapists as "experts" teaching others what to do, they are seen as participants in a common human experience alongside the group members, acting as guides. Although the therapists often differ from clients in manifestations of desire or problematic behaviors, therapists' self-observations and experiences in mindfulness practice are viewed as no different from those of the clients. The sense of shared experience and the importance of therapist engagement in the process are reflected in the feedback received by clients in comments such as, "the teachers felt like family."

As the trial began and several teams of therapists began to facilitate MBRP groups, it became apparent that therapists with a strong personal practice were better able to respond to issues and questions that arose both in the training groups and with clients regarding practice. Maintaining a consistent practice allowed them to draw upon their personal experiences in responding to questions and concerns raised by clients, regarding challenges such as staying awake during meditations, scheduling time to practice, expecting to attain calm or peaceful

states, and working with difficult mind states such as anger and self-criticism. Direct experience with these challenges allowed therapists to respond with a gentleness and honesty that modeled the same attitudes of acceptance and self-compassion that clients were being asked to take towards themselves. They could sincerely acknowledge that setting forty-five minutes aside for meditation practice could seem overwhelming at first, or the challenges of sitting through discomfort, boredom or restlessness. Their responses reflected an authenticity that seemed to add to the strength of the alliance with clients. For instance, hearing the therapists disclose that they too struggled with judgmental or distracting thoughts or with challenging emotional states appeared to reassure clients and foster a sense of group cohesion. This is reflected in several comments from clients (i.e., "The explanation that almost everyone has distracting thoughts was very helpful," and "It was good to be able to listen to the struggles of others.")

Many of the practices as well as the style and language used in MBRP are based upon Kabat-Zinn's MBSR protocol (Kabat-Zinn, 1990). Careful use of language during meditations and group discussions further supports a sense of shared experience. Therapists are encouraged to use the word "we" rather than the word "you" to refer to the common group experience and to minimize the distinction between themselves and other members of the group. Therapists are also invited to use the present participle when guiding meditations, to reflect an ongoing and present-centered process of exploration, rather than commands or directives that could potentially create disparity between the experience of the therapist and that of the clients ("allowing" your attention to rest upon the breath vs. "allow" your attention to rest upon the breath).

Numerous in-session exercises encourage clients to be present with painful or uncomfortable emotional experiences. Exercises and meditations are followed by discussion,

which often highlights the commonalties between clients' experiences. Therapists acknowledge and accept any observations and challenges that clients share in the group, while encouraging a similar attitude of openness and curiosity towards the thoughts, feelings and sensations that arise during meditation, without positive or negative valence placed upon any one experience, and without attempts to "fix" discomfort. For example, cravings sometimes arise for clients during the group. Clients are encouraged to stay present with the craving and to bring a gentle and curious awareness to any accompanying thoughts, emotions and sensations. The therapists might also encourage the other group members to pause and pay attention to any emotions, thoughts and sensations that may be arising for them in reaction to this. This stance fosters a parallel process between what occurs in the group, i.e., a curious and nonjudgmental stance towards clients' experiences, and the aims of personal practice, i.e. a compassionate and accepting stance towards one's own experience.

Within this framework, urges and cravings for substances are viewed as just another manifestation of the mind's tendency to cling to pleasant experience and to avoid unpleasant thoughts or sensations. Clients are encouraged to explore cravings as a conglomeration of physical sensations and thoughts, and to experiment with gentle and compassionate observation rather than avoidance or suppression. This may be viewed as novel, uniquely destigmatizing and empowering for individuals who have struggled with addiction and who may have been the subject of repeated judgment and criticism from family, friends and mental health professionals.

Mindfulness-Based Relapse Prevention in relation to other treatment approaches

As inferred throughout this chapter, techniques used in MBRP integrate several different treatment approaches. In client-centered therapy, developed by Carl Rogers (1959), the therapist adopts an accepting relationship marked by unconditional positive regard, attempting to help the

client achieve his or her goals, without setting an outside or "top-down" agenda. The style of discussion in MBRP relies heavily on Motivational Interviewing (MI) techniques, which adopt a similar set of principles, in which the therapist provides active support and collaboration with the client's agenda and treatment goals (Miller & Rollnick, 2002). Here the therapist expresses empathy and compassion toward the client, avoiding argumentation and "rolling with resistance" if it arises in the therapy session. Consistent with the "stages of change'" model (Prochaska & DiClemente, 1982) the MBRP therapist helps work through their clients' ambivalence about change, particularly for those who are in either the precontemplation or contemplation stage, and who need to work through the pros and cons of making a commitment to an "action plan" designed to achieve treatment goals. Therapists support any efforts made by the client to move toward goal-achievement, no matter how small the steps may seem, thereby facilitating self-efficacy.

MBRP therapists also work in congruence with the values incorporated within harm-reduction therapy (Marlatt, 1998; Denning, Little & Glickman, 2003; Tatarsky, 2002). Here the therapist attempts to "meet the clients where they're at" in terms of developing an empathic and nondirective relationship. Rather than setting down fixed rules and regulations, or insisting upon a single treatment goal (e.g., abstinence only), the therapist works on establishing an atmosphere of support and collaboration so as to serve as the client's ally in the process of change. Clients often change their minds, switching between "cutting back" or "giving it up altogether" when it comes to their plans for changing their addictive behavior. Many clients who are unsuccessful in pursuing a moderation or "controlled use" goal will be more motivated to try to give up their alcohol/drug use altogether. On the other hand, if the client is unable or unwilling to pursue total abstinence, or if the client experiences numerous episodes of relapse in abstinence-based

programs, a harm-reduction goal may be more successful. For clients who are prone to relapse despite their best efforts to maintain abstinence, MBRP therapists may draw upon "relapse management" strategies to help them get "back on track" rather than allow them to give up or drop out of treatment (Marlatt & Donovan, 2005). As such, the therapist continues to work with the client in developing a positive therapeutic relationship, one based on active partnership and collaboration, as opposed to a more confrontational approach. The relationship between therapist and client is of central importance when considering the various ups and downs experienced by clients in the process of the MBRP course. The therapist stays with the client through set-backs and even large relapses, with the recognition that change is difficult and many clients need positive, compassionate support to counteract a network of negative peer pressure and self-doubt.

The MBRP program differs significantly from other major approaches to changing addictive behavior problems, including both the "moral model" and the "disease model" of addiction (Brickman, Rabinowitz, Karuza, Coates, Cohn, & Kidder, 1982). In the moral model, the client is assumed to be responsible both for the development of the addiction problem ("It's your fault that you became an alcoholic") and for its eradication. The "War on Drugs" is a prime example of this pejorative approach, in which the drug user is punished via severe prison sentences for their using or selling illicit substances. Given the recidivism rates (as high as 52.5% of men and 29.7% of women), and relapse rates (as high as 58.5% of men and 42.6% of women) in the 36 months following discharge from prison (Pelissier, et. al, 2000), it is clear that this approach is an abject failure. It is important to note that prison inmates are rarely offered treatment for their addiction problems (Bender, 2007). Interestingly, several research studies in India and a recent study conducted by our research group (Bowen et al., 2006; Marlatt et al.,

2005) have shown mindfulness training is well-received by inmates and is related to reductions in drinking and drug use following release from prison.

In the disease model of addiction, clients are told that their problem is due to factors beyond their control, namely biological factors such as genetic predisposition or biological vulnerability to the reinforcing effects of drugs on brain functioning (e.g., Jellinek, 1960). In the traditional model, it is assumed that addiction is a progressive disease, with no known cure, except that the course of the disease can be "arrested" if the patient commits to a life-long goal of total abstinence. Clients who are reluctant to accept this premise are accused of being in total denial as to the true nature of their problem. Those who are unwilling to pursue abstinence-based treatment (ranging from pharmacotherapy to participation in 12-step groups) are often denied any treatment assistance. Therapists from this tradition often adopt a confrontational treatment approach designed to break down the patient's resistance to accepting the true biological nature of their illness. This approach is widely used, and includes the high incidence of therapeutic "interventions" in which the client is suddenly confronted by family and friends who have teamed up with a treatment program requiring immediate and total abstinence. Other confrontational treatment approaches include the use of "therapeutic communities" in which the client participates in an "encounter group" characterized by the use of direct and often negative feedback from other group members.

In contrast to the moral and disease models of addiction treatment, MBRP adopts the position that addiction has multiple causes and that it is a biopsychosocial problem, unique in its manifestation with each client. Just as there are several causes that determine the development of addictive problems that need to be explored with each client, there are also multiple pathways to resolution of the problem. This shift in underlying attitude is helpful if MBRP therapists are to

facilitate a mindful attitude in their clientele, one characterized by nonjudgmental awareness and acceptance. It stands in sharp distinction to the moral model, with its emphasis on increasing self-blame, shame, guilt and other aspects of stigma as the primary means of motivating change. The MBRP approach also differs strongly from the strict disease model, which focuses on breaking through denial, confronting clients and convincing them that they are caught up in a progressive disease.

Although there are no official "therapists" in the 12-step programs such as Alcoholics Anonymous, clients are also told that they suffer from a chronic disease and must follow the 12 steps to recovery, with a reliance on belief in a "Higher Power" and participation in a spiritual self-help group. Clients are told that they each must follow the 12 steps in strict progression until they are firmly on the path to recovery. This path is the same for all, with little room for individual differences in the process of change. Total abstinence is the ultimate goal, and lifelong attendance at meetings is strongly advised. Recently, there has been some discussion about the parallel assumptions adopted by the 12-step community and the mindfulness-based approaches, given that both have been described as spiritual pathways to recovery (e.g., Griffin, 2004). Although the spiritual foundations are incorporated in both AA and MBRP approaches, MBRP therapists focus on *empowering* the client through personal practice, whereas AA encourages clients to give up their own power to some "Higher Power." In addition, MBRP therapists are more individual-oriented in their approach to working with clients, and allow clients a choice of treatment goals other than total lifelong abstinence.

The quality of the therapeutic alliance in the treatment of addictive behavior problems is perhaps the most critical factor in determining treatment outcome. There is evidence in the literature that the nature of the alliance between therapist and client may carry more impact as a

mediator of outcome than the theoretical orientation or intervention approach applied by the treatment provider. In an investigation comparing three different treatment modalities for alcohol dependence (cognitive-behavioral therapy, 12-step facilitation, and motivational interviewing), the research team conducting Project Match (Project MATCH Research Group, 1998) tried to investigate the role of various potential mediators of treatment outcome, including client personality factors, demographics, motivation for change, and drinking patterns. The only factor that was predictive of treatment success was the quality of the therapeutic alliance (determined by objective ratings of therapy sessions and the self-report evaluations made by both clients and therapists). Clients who had positive alliance with their therapists did better overall in terms of changes in drinking behavior, regardless of the specific therapeutic model being applied. This is an important finding and has strong implications for developing a positive therapeutic relationship that is fundamental to the successful implementation of MBRP.

Future of MBRP

Several empirical investigations of MBRP are currently underway, including randomized controlled trials assessing the effectiveness of MBRP in comparison to other empirically-supported treatments. Because MBRP is still in its early stages of development, the protocol will continue to evolve and strengthen. The egalitarian, compassionate relationships between clients and therapists, however, are a core element of creating an environment that supports venturing into new territory and making fundamental changes in relating to and experiencing one's internal and external world. Respecting each individual's unique experience, goals and readiness for change is fundamental to creating such an environment and will remain at the center of the MBRP stance and treatment protocol.

References

Bender, E. (2007) Most substance-abusing inmates fail to get treatment. *Psychiatric News, 42*, 36.

Bowen, S. Witkiewitz, K., Dillworth, T.M., Chawla, N., Simpson, T.L., Ostafin, B., Larimer, M.E., Blume, A.W., Parks, G.A., and Marlatt, G.A. (2006). Mindfulness meditation and substance use in an incarcerated population. *Psychology of Addictive Behaviors*, *20, 343-347.*

Bowen, S. Witkiewitz, K., Dillworth, T.M., & Marlatt, G. A. (in press). The role of thought suppression in the relationship between mindfulness meditation and substance use. *Addictive Behaviors.*

Breslin, F. C., Zack M., & McMain, S. (2002). An information-processing analysis of mindfulness: implications for relapse prevention in the treatment of substance abuse. Clinical Psychology: *Science and Practice, 9(3)*, 275-299.

Brickman, P. Rabinowitz, V. C., Karuza, J., Coates, D., Cohn, E., & Kidder, L. (1982). Models of helping and coping. *American Psychologist, 37*, 368-384.

Carroll, K.M. (1996). Relapse prevention as a psychosocial treatment: A review of controlled clinical trials. *Experimental and Clinical Psychopharmacology. 4(1),* 46-54.

Cummings, C., Gordon, J. R., & Marlatt, G. A. (1980). Relapse: Strategies of prevention and prediction. In W. R. Miller (Ed.), *The addictive behaviors: Treatment of alcoholism, drug abuse, smoking, and obesity* (pp. 291-321). Oxford, UK: Pergamon Press.

Denning, P.; Little, J. and Glickman, A. (2003). *Over the Influence, The Harm Reduction Guide for Managing Alcohol and Drugs.* New York: Guilford Press.

Griffin, K. (2004). *One Breath at a Time: Buddhism and the Twelve Steps to Recovery*. New York: Rodale Press.

Groves, P. & Farmer, R. (1994). Buddhism and Addictions. *Addiction Research,* 2, 183-94.

Hart, W. (1987). *The art of living: Vipassana meditation as taught by S. N. Goenka.* San Francisco: HarperCollins.

Irvin, J. E., Bowers, C. A., Dunn, M. E., & Wang, M. C. (1999). Efficacy of relapse prevention: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 67 (4),* 563-570.

Jellinek, E.M. *The Disease Concept in Alcoholism*. New Brunswick, NJ: Hill House Press, 1960.

Kabat-Zinn, J. (1982). An outpatient program in behavioral medicine for chronic pain patients based on the practice of mindfulness meditation: Theoretical considerations and preliminary results. *General Hospital Psychiatry, 4*, 33-42.

Kabat-Zinn, J. (1990). *Full catastrophe living.* New York, NY: Delacorte.

Kadden, R. M. (2001). Behavioral and cognitive-behavioral treatment for alcoholism research opportunities. *Addictive Behaviors, 26*, 489-507.

Larimer, M., Palmer, R. S., & Marlatt, G. A. (1999). Relapse prevention: An overview of Marlatt's cognitive behavioral model. *Alcohol Research and Health, 23*, 151-169.

Marlatt, G. A. (1998). *Harm Reduction: Pragmatic strategies for managing high-risk behaviors.* New York: Guilford Press.

Marlatt, G. A. (2002). Buddhist philosophy and the treatment of addictive behavior. *Cognitive and Behavioral Practice, 9*, 44-50.

Marlatt, G. A. (1978). Craving for alcohol, loss of control, and relapse: A cognitive-behavioral analysis. In P. E. Nathan, G. A. Marlatt, & T. Loberg (Eds.), *Alcoholism: New directions in behavioral research and treatment* (pp. 271-314). New York, NY: Plenum.

Marlatt, G.A., & Donovan, D.M. (Eds.).(2005). *Relapse Prevention: Maintenance strategies in the treatment of addictive behaviors (2nd Ed)*. New York, NY, Guilford Press.

Marlatt, G. A., & Gordon, J. R. (Eds.) (1985). *Relapse prevention: Maintenance strategies in the treatment of addictive behaviors.* New York: The Guilford Press.

Marlatt, G. A., & Kristeller, J. (1999). Mindfulness and meditation. In W. R. Miller (Ed.). *Integrating spirituality in treatment: resources for practitioners* (pp. 67-84). Washington, D.C.: APA Books.

Marlatt, G.A., Parks, G.A., Witkiewitz, K., Dillworth, T., Bowen, S., & Lonzcak, H. (2004). Mindfulness, addictive behaviors, and Vipassana meditation. In Hayes, S. Linehan, M. and Follette, V. (eds) *The New Behavior Therapies: Expanding the Cognitive Behavioral Tradition.* New York: Guilford Press.

Miller, W. R., & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change* (2nd ed.) New York: Guilford Press.

Pellissier, B., Rhodes, W., Saylor, W., Gaes, G., Camp, S. D., Vanyur, S. D., et. al (2000). Triad drug treatment evaluation project: Final report of three-year outcomes: Part 1. *Federal Bureaus of Prisons Offoce of Research and Evaluation.*

Prochaska, J.O., & DiClemente, C.C. (1982). Transtheoretical therapy: Toward a More Integrative Model of Change. Psychotherapy: Theory, Research, and Practice, 19, 276-288.

Project MATCH Research Group. (1998). Matching alcoholism treatments to client heterogeneity: Project MATCH three-year drinking outcomes. *Alcoholism: Clinical and Experimental Research, 22*(6), 1300-1311.

Rogers, C.R. (1959). A theory of therapy, personality, and interpersonal relationshiops, as developed in the client-centered framework. In S. Koch (Ed.), *Psychology: A study of a science (Vol. 3).* NY: McGraw-Hill.

Segal, Z., Teasdale, J.D., & Williams, M. (2002). *Mindfulness-Based Cognitive Therapy for Depression.* New York: Guilford Press.

Shiffman, S., Hickcox, M., Paty, J. A., Gnys, M., Kassel, J. D., & Richards, T. J. (1996). Progression from a smoking lapse to relapse: Prediction from abstinence violation effects, nicotine dependence, and lapse characteristics. *Journal of Consulting and Clinical Psychology, 64,* 993–1002.

Tatarsky, A. (2002). *Harm Reduction Psychotherapy: A New Treatment for Drug and Alcohol Problems*. Northvale, NJ: Aronson.

Teasdale, J. D., Segal, Z., & Williams, J. M. G. (1995). How does cognitive therapy prevent depressive relapse and why should control (mindfulness) training help? *Behaviour Research and Therapy, 33,* 25–39.

Teasdale, J.D., Segal, Z.V., & Williams, J.M.G. (2003). Mindfulness training and problem formulation. *Clinical Psychology: Science and Practice, 10(2),* 157-160.

Witkiewitz, K., & Marlatt, G.A. (2004). Relapse prevention for alcohol and drug problems: That was Zen, this is Tao. *American Psychologist, 59(4)*, 224-235.

Witkiewitz, K., & Marlatt, G.A. (2007). *Therapist's Guide to Evidence-Based Relapse Prevention.* New York: Elsevier.

Witkiewitz, K., Marlatt, G. A., & Walker, D. D. (2005). Mindfulness-based relapse prevention for alcohol use disorders: The meditative tortoise wins the race. *Journal of Cognitive Psychotherapy, 19*, 221-228.