**Mindfulness Interventions for Alcohol Use Disorder**

Alcohol Medical Scholars Program

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I. Introduction

A. US Alcohol Use Disorders (AUDs) common (SLIDE 2)

1. Lifetime AUD = 30% [1]

2. By sex:

a. ♂ = 35%, ♀ = 25%

3. By race:

a. White = 35%, Black = 20%

4. Largest ↑ in age 65+ [2]

B. AUD costly (SLIDE 3)

1. #3 cause of disability & early death (with other drugs) [3]

2. Age-adjusted mortality rate ↑ ~20% 1990 to 2016

3. Excessive drinking costs ¼ trillion $/year ($2.05/drink) [4]

4. After completing Rx, ~50% success in Pts

5. AUD Rx can do better

D. This lecture will: (SLIDE 4)

1. Define AUD & its Rx

2. Describe mindfulness-based interventions (MBIs – meditation-like)

3. Describe MB Relapse Prevention

4. Discuss MB Relapse Prevention evidence

5. Caveats & conclusions

II. Definitions (SLIDE 5)

A. AUD Criteria (SLIDE 6)

1. Defined by Diagnostic & Statistical Manual – 5 (DSM5)[5]

a. Using longer or ↑ than intended

b. Unable to quit or ↓ drinking

c. Excess time using/recovering

d. Strong cravings

e. Failure to fulfill obligations – e.g., at home or work

f. Social problem – e.g., arguing

g. Giving up important activities

h. Hazardous use – i.e., in dangerous situations

i. Continued use despite awareness of problems

j. Tolerance – i.e., needing to drink more for same effect

k. Withdrawal – i.e., physical symptoms if drinking stops

B. Available AUD Rx (SLIDE 7)

1. Motivational Interviewing [6]

a. ↑ readiness for change by discussing:

1’. Pros/cons of use

2’. Address conflicted feelings of drinking

b. Get patient to enter Rx

2. Cognitive Behavioral Therapy [7]

a. Focus on problematic thoughts of use

b. How to change behaviors

3. Mindfulness Therapy (aka MB Relapse Prevention) [8]

4. Acamprosate (Campral) ↓alcohol withdrawal

5. Naltrexone (ReVia/Vivitrol) ↓ reward from alcohol

III. MBIs (SLIDE 8)

A. Mindfulness is not [8] (SLIDE 9)

1. A passive “time out”

2. A way to clear your mind

3. Facilitation for specific emotions/trance – e.g., serenity

4. Requiring a set time – e.g., 20 min

5. A religion

B. Mindfulness is (SLIDE 10)

1. Focused attention on an object – e.g., the breath

2. ↑ing awareness (can ↓ stress)

3. Open to any practice time

4. Relevant to any belief set

5. Definition – paying attention[9]

a. On purpose

b. In present moment

c. Nonjudgmentally

C. Why discuss mindfulness? (SLIDE 11)

1. Pt outcomes can be better

2. You might:

a. Integrate mindfulness in Rx

b. Refer Pts to mindfulness clinicians

3. Address public misperceptions of mindfulness

a. MBIs for AUD are structured

b. MBIs are a data-backed Rx

E. How might mindfulness work?

1. MBIs help stress recovery (SLIDE 12)

a. First published study in 1976 [10]

b. Recruited meditators & non-meditators

c. Participants saw woodworking safety video: “It didn’t have to happen”

d. Compared group reaction (sweating) after accidents

1’. Groups had = reactions to accidents

2’. Meditators recovered faster

3’. Mindfulness may not affect immediate reaction

4’. Mindfulness may speed up stress recovery

3. MBIs Help Pain [11] (SLIDE 13)

a. Early studies showed ↓ pain

b. 10-week mindfulness program for chronic pain

c. First formalized MBI Rx

d. Examined changes from pre- to post-Rx

1’. Pain ↓ 60%

2’. Mood ↑ 55%

3’. Improvements remain 15 months later

e. Might work by ↑ awareness ↑ relaxation

4. How mindfulness may help AUD? (SLIDE 14)

a. Focus on craving sensations mindfully (instead of stress/pain):

1’. ↑ awareness of craving in moment

2’. ↓ mental chatter (e.g., judging or worrying about craving)

3’. ↓ craving duration & intensity

b. ↑ awareness of drinking consequences may also help

c. Cravings happen, but break link to use

IV. MB Relapse Prevention [8] (SLIDE 15)

A. Overview (SLIDE 16)

1. Designed as aftercare following inpatient Rx

2. Integrated other Rx:

a. MB Stress Reduction

b. MB Cognitive Therapy

c. Relapse Prevention

B. Components (SLIDE 17)

1. Sessions start w/ mindfulness practice:

a. Group: 20 min

b. Individual: 5-10 min

2. Check in w/ Pts:

a. Mindfulness practice last week

b. Drinking & challenges last week

3. Discuss session topics

a. Introduce mindfulness concepts/skills

b. How to apply skills to Pt use?

4. Assign homework/practice

a. Anticipated challenges

b. Opportunities for using skills

C. Principles

1. Focus on Pt's direct experience (SLIDE 18)

a. Immediate experience (sensations/feeling), before thinking

1'. Physical reaction – e.g., near-miss car accident → muscles tense

2'. Sensations in the body – e.g., tightness in chest, heart racing

b. Thoughts following immediate reaction

1'. Judgments – e.g., blame careless driver

2'. Stories – e.g., driver disregarded others

3'. Thoughts about hypotheticals – e.g., what if I was in accident

c. Thoughts ↑ emotional intensity

d. Focus on direct experience, ↓ thoughts & emotions

2. Example – discuss direct experience of craving (SLIDE 19)

a. Pt: We had a fight, and I just wanted to drink.

b. Dr: What did 'wanting to drink' feel like?

c. Pt: I don't know, I just wanted to drink.

d. Dr: How do you know you wanted a drink?

e. Pt: I was just thinking 'I want to drink'.

f. Dr: So, you didn't feel anything?

g. Pt: I guess I was angry and I wanted to stop feeling that.

h. Dr: Where do you feel anger? (OK to focus on anger)

D. Structures (SLIDE 20)

a. 8 sessions cover three broad topics

1’. Sessions 1 – 3: Introduce Mindfulness

2’. Sessions 4 – 6: Mindfulness for Addiction

3’. Sessions 7 – 8: Lifestyle Balance

E. Session 1: Auto-pilot & mindfulness

1. Autopilot: acting w/out awareness (SLIDE 21)

a. Unaware of:

1’. Experience/sensations

2’. Actions

3’. Consequences

b. e.g., mindfulness eating vs. mindful eating

c. Autopilot in AUD (SLIDE 30)

1’. craving → drinking

2’. Get home → drink

d. Mindfulness in AUD:

1’. Crave → pause → awareness → (maybe drink)

2’. Get home → awareness → “Do I want to drink?”

2. Practice: mindful eating – i.e., w/ full awareness (SLIDE 22)

a. Bodily reactions – e.g., salivate before eating

b. Sensations of eating – e.g., taste, texture

c. Thoughts pop up? – e.g., like/dislike for food

d. After practice, focus on Pt’s direct experience

3. Practice: mindful eating – i.e., w/ full awareness (SLIDE 23)

a. Dr: What did you notice during mindful eating?

b. Pt: I didn't like how it tasted.

c. Dr: How did you experience 'not liking'?

d. Pt: It just tasted bitter.

1'. Dr: Where was bitterness the strongest?

2'. Dr: Where in your body did you notice feelings of 'not liking'?

F. Session 2: Awareness of triggers/craving

1. Triggers (SLIDE 24)

a. Triggers ↑ risk of use

b. Mindfulness helps:

1'. Notice triggers & reactions

2'. Disrupt autopilot

2. Practice: Urge Surfing – i.e., aware of craving sensations (SLIDE 25)

a. Premise: craving/emotion is temporary (vs. emotions never stop)

1'. Intensity comes in waves

2'. Physical location changes

3'. Characteristics change (e.g., tightness, warmth)

4'. Eventually fades

b. Initially, cravings last longer w/out use

c. Learn craving ≠ use → ↓ duration & ↓ intensity

d. Practice in-session – imagine triggering situation (SLIDE 26)

1'. Where is craving first noticed?

2’. What sensations come w/craving?

a’. Tightness

b’. Pulse/palpitations

c’. Numbness

d’. Warmth/coolness

3’. How do sensations change?

G. Session 3: Introduce formal & informal practice (SLIDE 27)

1. Practice: SOBER Breathing Space in triggering situations

a. **S**top: step back from situation (e.g., leave to restroom/step out)

b. **O**bserve: objectively notice situation

1’. Who

2’. What

3’. When

4’. Where

c. **B**reath: narrow focus on breathing (30-60 sec.)

d. **E**xpand: ↑ awareness of context & consequences

e. **R**espond: decide what to do

H. Session 4: ↑ awareness of high-risk situations (SLIDE 28)

1. Practices: ↑ awareness of experience

2. Start with sound, then incorporate new sensations each week

a. Sound

b. Breath

c. Sensation

d. Thoughts

e. Emotion

3. ↑ awareness of high-risk situations

a. Discuss most common triggers in AUD

1'. Social pressure

2'. Social conflict

3'. Negative emotion

b. Discuss triggers for Pt

I. Session 5: Acceptance & Action (SLIDE 29)

1. Accepting emotions & thoughts – e.g., cravings, "I want to drink"

2. Notice & accept, but don't react

3. Discuss: how to balance acceptance with making change?

a. Accepting that there are problems can help make change

b. Does not mean accepting you won't change

c. Instead, accept that change is happening

J. Session 6: Seeing thoughts as thoughts (SLIDE 30)

1. Thoughts are best viewed as:

a. Not part "you"

b. Don't need to identify/agree with them

c. Words/images in mind (e.g., I want to use)

d. Don't need to act

2. Awareness of thoughts ↓ relapse risk

3. Diagram: Triggers, Reactions, & Autopilot/Mindful Reactions (SLIDE 31)

a. High-risk situations start with trigger

b. Triggers initiate emotional reaction

c. In autopilot (bottom diagram)

1'. Get caught up in thoughts (I want to drink)

2'. React on impulse (e.g., drink)

3'. Leads to more thoughts (e.g., guilt)

4'. Increased risk of future drinking

d. In mindfulness (top diagram)

1'. Stop

2'. Observe physical reaction/sensations

3'. Breathe

4'. Choose response with intention

K. Session 7: Balance & self-care

1. Where does relapse begin? (SLIDE 32)

a. Prior focus on acute risk (e.g., triggers, high-risk situations)

b. Here, focus on broad/lifestyle risk (e.g., self-care)

c. Identify energizing & exhausting activities

1'. Imbalance of these ↑ risk

2'. Discuss: when is imbalance highest?

d. HALT: ↑ impulsivity when:

1'. **H**ungry

2'. **A**ngry

3'. **L**onely

4’. **T**ired

4. Practice: Lovingkindness Meditation (SLIDE 33)

1’. Focus on loved one

2’. Wish good things for them

3’. Realize they wish good things for you

4’. Wish good things for yourself (or your future self)

5’. Opens discussion: What does Pt want for him/herself?

L. Session 8: Support networks in recovery (SLIDE 34)

1. Support networks are important in recovery

a. Identify Pt’s social supports

b. Who knows when you’re at-risk?

c. Who provides support, feedback, & encouragement?

2. Reflect on the Rx

a. Challenges during Rx?

b. Changes during Rx?

c. How change was made?

d. What changes are next?

e. Obstacles ahead?

f. How will you know if you’re struggling?

g. What to do if struggling?

V. Evidence about MB Relapse Prevention (SLIDE 35)

A. MB Relapse Prevention Evidence: Clinical Trials [12] (SLIDE 36)

1. Randomized Clinical Trial: 286 Pts assigned to:

a. MB Relapse Prevention

b. Standard Relapse Prevention (RP)

c. 12-Steps + Education

2. MB / RP > 12-Steps: ↓ relapse & heavy drinking

3. MB > RP: ↓ heavy drinking 12-months after Rx

B. MB Relapse Prevention Evidence: Meta-Analyses [13] (SLIDE 37)

1. 700 Pts across studies (↑ reliability)

2. Examined effects of MBIs for SUDs

3. ↓ heavy use & problems

4. ↓ stress & other symptoms

V. Conclusions (SLIDE 38)

A. Contraindications of mindfulness? (SLIDE 39)

1. Some warn against MBIs for Pts w/:

a. Trauma Hx

b. Psychotic Sx

2. Evidence does not currently support contraindication

3. Best to allow Pts to choose how to practice

a. Can practice with eyes open/closed

b. Provide additional resources if relevant (e.g., trauma-sensitive mindfulness)

B. Conclusions (SLIDE 40)

1. AUD is common, costly, & needs more effective Rx

2. Mindfulness may help ↓ AUD

a. MB Relapse Prevention is a manualized Rx

b. ↓ Auto-pilot

c. ↑ Awareness of triggers & consequences

3. Evidence supports MBIs for AUD and related conditions

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