



Enactment of home practice following mindfulness-based relapse prevention and its association with substance-use outcomes



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ABSTRACT

Introduction: Mindfulness-based treatments have received increasing interest and empirical support in the clinical psychology literature. There are, however, no studies to date that have systematically examined treatment enactment, which is the amount and type of home practice participants incorporate into their daily lives. Because treatment enactment has been cited as a key aspect of treatment fidelity, this study examined the relationships between treatment enactment (i.e., home mindfulness practice) and alcohol and other drug (AOD) use and craving in the context of a larger study of mindfulness-based relapse prevention (MBRP).

Methods: Participants ($N = 93$) in this secondary analysis had been randomized in the parent study to receive MBRP. AOD use, craving, and home mindfulness practice were assessed at baseline, post-treatment, 2-month and 4-month follow-up time points.

Results: MBRP participants significantly increased the amount of time spent in home mindfulness practice over the course of the study. Further, greater time spent in home practice was associated with less AOD use and craving at the 2- and 4-month follow-ups. Of note, the significant treatment gains in home practice faded somewhat at the 2- and 4-month follow-ups as participants returned to standard aftercare, which did not involve mindfulness-based practice.

Conclusions: Participation in MBRP was associated with a significant increase in home mindfulness practice, and increased involvement in home practice was associated with significantly lower AOD use and craving over the course of the study. This suggests that treatment enactment, which entails building mindfulness practice into one's daily life, plays a key role in ongoing recovery following MBRP treatment. Teaching mindfulness skills for daily use versus for only in high-risk situations has the potential to boost the longevity of MBRP treatment effects. These findings also suggest that MBRP clinicians should target the post-intervention decline in home practice (e.g., with ongoing mindfulness practice groups) to maximize the benefits of mindfulness meditation in decreasing AOD use and craving.

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1. Introduction

Recent decades have seen an explosion of interest in clinical treatment programs based on mindfulness meditation, particularly those modeled after the mindfulness-based stress reduction (MBSR) program of Jon Kabat-Zinn (1990). As taught in these programs, mindfulness refers to the development of a mental state characterized by nonjudgmental awareness of present moment experience. This awareness includes physical sensations, thoughts, emotions, and the environment, and is characterized by an attitude of openness and curiosity. Recent

meta-analyses (Hofmann et al., 2010; Grossman, 2004) found that MBSR was being successfully applied to a broad range of chronic disorders, and there are now hundreds of such programs around the world. Evidence-based adaptations of MBSR include mindfulness-based cognitive therapy (MBCT) for depression (Segal, Williams, and Teasdale, 2002), MBSR-T for stress reduction for adolescents (Biegel, Brown, Shapiro, & Schubert, 2009), and MB-EAT for eating disorders (Kristeller, Baer, & Quillian-Wolever, 2006).

Recently, Bowen, Chawla, and Marlatt (2010) developed mindfulness-based relapse prevention (MBRP) as a manualized, structured aftercare program for individuals who have completed intensive inpatient or outpatient treatment for substance use disorders. MBRP integrates mindfulness practices with cognitive-behavioral relapse prevention (Marlatt & Gordon, 1985) therapy and aims to help participants increase awareness and acceptance of difficult thoughts, feelings, and sensations to create changes in patterns of reactive behavior that

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commonly lead to relapse. Mindfulness training in MBRP provides clients with a new way of processing situational cues and monitoring internal reactions to contingencies, and this awareness supports proactive behavioral choices in the face of high-risk relapse situations (Witkiewitz, Marlatt, & Walker, 2005). In a recent, randomized pilot study of MBRP, Bowen et al. (2009) found that MBRP participants experienced fewer and shorter relapses compared to control participants.

1.1. Treatment enactment

Despite the growing body of research supporting the use of mindfulness techniques in the treatment of various physical and psychological disorders, Ospina et al. (2007) noted that research on mindfulness practices and their therapeutic applications is still in an early stage of development. One important aspect of treatment development research in this stage is the evaluation of treatment integrity, also known as treatment fidelity. Studies have shown that strengthening treatment integrity can improve treatment outcomes (e.g., Henggeler, Melton, Brondino, Scherer, & Hanley, 1997). The establishment and assessment of treatment integrity have been grouped into three broad areas (Bellg et al., 2004): treatment delivery (i.e., whether the treatment was delivered as intended), treatment receipt (i.e., whether the client comprehended and used the treatment skills during the session), and treatment enactment (i.e., whether the client applied skills learned in treatment to his or her daily life).

Despite the relative newness of MBRP in the treatment literature, steps have already been taken to establish its integrity. For example, the treatment has been manualized (Bowen et al., 2010), and studies have begun to establish protocols in assessing both therapist competence and adherence in delivering MBRP (Chawla et al., 2010). Thus far, however, the establishment of MBRP treatment integrity has been focused on *therapist* behavior, not *participant* behavior. To address this research gap, the present study therefore explores treatment enactment within a recent randomized controlled trial of MBRP.

1.2. Treatment enactment in MBRP: the role of home practice

Many mindfulness-based programs clearly state the importance of regular home practice of mindfulness meditation. For example, the manual for MBCT (Segal, Williams, & Teasdale, 2002) recommends 45 min of daily home practice in order to obtain its therapeutic benefits. Although this expectation of daily home practice is well-established in the Buddhist meditation traditions on which these programs are based, there is mixed empirical evidence for the effects of home practice in clinical research studies (Carmody & Baer, 2008). Whereas several studies have shown an association between home practice and improved treatment outcomes for MBSR (Carlson, Ursuliak, Goodey, Angen, & Speca, 2001; Gross, 2004; Shapiro, Bootzin, Figueredo, Lopez, & Schwartz, 2003; Speca, Carlson, Goodey, & Angen, 2000) and MB-EAT (Kristeller & Hallett, 1999), other researchers failed to find these significant associations (Astin, 1997; Davidson, 2003). No research to date has examined the relationship between home practice and treatment outcomes for MBRP.

1.3. Current study aims and hypotheses

The current study builds on previous MBRP research by examining treatment enactment (i.e., time spent in home practice of mindfulness meditation) during and following treatment delivery. A further aim of this study was to examine the association between home practice and key treatment outcomes: AOD use and craving. Since a goal of MBRP is to integrate mindfulness concepts into daily living, treatment enactment is believed to be critical to improved treatment outcomes. Thus, we hypothesized that participating in the MBRP program would lead to a pre- to posttest significant increase in home practice of mindfulness

meditation. We also hypothesized that greater home practice would be associated with lower AOD use and craving following the intervention.

2. Methods

2.1. Participants

Participants in this secondary analysis ($n = 93$; 55.4% of the full 168 participants) were adults with substance-use disorders who were recruited from a community treatment agency to participate in the larger, parent MBRP efficacy trial (Bowen et al., 2009). Clients at the agency complete 28-day inpatient (60.3%) or 90-day intensive outpatient (39.7%) treatment, and then attend approximately one year of aftercare. Eligible study participants were between the ages of 18 and 70; had completed the inpatient or intensive outpatient phase of treatment in the previous two weeks; demonstrated English fluency; and were medically cleared for participation. Exclusion criteria included presence of psychosis or dementia, imminent suicide risk, or significant withdrawal risk.

2.2. MBRP treatment

In the parent study, MBRP was delivered as an aftercare program (i.e., a relapse prevention program delivered after clients had successfully completed either inpatient or intensive outpatient treatment). MBRP comprised eight, weekly, two-hour, closed-group sessions that were delivered in a small group format. There were a total of 12 MBRP groups, ranging from 6 to 11 participants (average size was 8.1). Therapists facilitating MBRP groups held master's degrees in psychology or social work and were experienced in delivery of cognitive-behavioral interventions. Therapists participated in intensive training and received weekly supervision throughout the trial. In addition, sessions were coded for therapist adherence and competence (Chawla et al., 2010). Participants learned, practiced, and discussed relapse prevention and mindfulness meditation techniques. In addition to in-group instruction, participants received standardized meditation CDs and were expected to institute a regular mindfulness practice outside the group. They were also assigned mindfulness exercises for home practice (e.g., body scan, walking meditation, mindfulness of breath).

2.3. Measures

2.3.1. Demographic questionnaire

This questionnaire assessed basic sociodemographics, such as gender, age, and racial/ethnic background. These data were used to describe the baseline sample.

2.3.2. Substance use

The Timeline Followback (TLFB; Sobell & Sobell, 1992) assessed daily use of alcohol (using a standard drink conversion chart) and drugs. At baseline, participants were asked to report for the 60 days prior to initial inpatient or outpatient treatment admission. For all other assessments, they reported on the 60 days immediately prior to assessment. The TLFB has demonstrated good reliability and validity with both online administration and in-person administration (Sobell, Brown, Gloria, & Sobell, 1996). Because quantity measures are not equivalent across substances, days of any AOD use were summed and the resulting frequency score was used as one of the primary outcome variables in the current analyses.

2.3.3. Alcohol and drug craving

The Penn Alcohol Craving Scale (PACS; Flannery, Volpicelli, & Pettinati, 1999) was adapted to include both alcohol and drug cravings. The PACS is a 5-item, self-report measure assessing frequency, intensity, and duration of craving, and overall rating of craving for the previous week. It has shown excellent internal consistency and predictive

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