Shrink Rap Radio #183, November 21, 2008. Mindfulness, Harm Reduction and Relapse Prevention

Dr. David Van Nuys, aka "Dr. Dave" interviews Alan Marlatt
(transcribed from www.ShrinkRapRadio.com by Jo Kelly)

Excerpt: *"We had done a study here with college student binge drinkers, where we taught them TM and they practiced it for one academic quarter; and compared to muscle relaxation or just periods of quiet reading, the meditation group had significantly lower rates of drinking in the follow up. And most of them wanted to continue meditating because they liked it."*

Introduction: So says today's guest, **Dr Alan Marlatt,** who is Professor of Psychology at the University of Washington and Director of the Addictive Behaviors Research Center at that institution. He has conducted pioneering research on the role of meditation in three areas: harm reduction, brief interventions and relapse prevention.

He received his Ph.D. in clinical psychology from Indiana University in 1968. After serving on the faculties of the University of British Columbia and the University of Wisconsin-Madison, he joined the University of Washington faculty in the fall of 1972.

In 1996, Dr. Marlatt was appointed as a member of the National Advisory Council on Drug Abuse of the National Institute on Drug Abuse (NIH). He served as the President of the Society of Psychologists in Addictive Behaviors; President of the Section for the Development of Clinical Psychology as an Experimental-Behavioral Science of the Society of Clinical Psychology; and President of the Association for the Advancement of Behavior Therapy.

Dr. Marlatt's books include Alcoholism: New Directions in Behavioral Research and Treatment (1978), Relapse Prevention: Maintenance strategies in the treatment of addictive behaviors (1985, 2005), Assessment of Addictive Behaviors (1985; 2005), Addictive Behaviors Across the Lifespan (1993), Harm Reduction: Pragmatic Strategies for Managing High-Risk Behaviors (1998), Changing Addictive Behavior (1999), and Brief Alcohol Screening and Intervention for College Students (BASICS) Manual (1999), The Tao of Sobriety: Helping You to Recover from Alcohol and Drug Addiction (2002), and Therapist's Guide to Evidence-Based Relapse Prevention (2007). In addition, he has published over 200 book chapters and journal articles and served on the editorial boards of

numerous professional journals, including the Journal of Consulting and Clinical Psychology, Journal of Abnormal Psychology, Addictive Behaviors, and Journal of Studies on Alcohol.

In 1990, Dr. Marlatt was awarded The Jellinek Memorial Award for outstanding contributions to knowledge in the field of alcohol studies from the International Society for Biomedical Research on Alcoholism. In 2001, he was given the Innovators in Combating Substance Abuse Award by the Robert Wood Johnson Foundation, and in 2004 he received the Distinguished Researcher Award from the Research Society on Alcoholism. He received the Distinguished Psychologist award for Professional Contribution to Knowledge from the Washington State Psychological Association in 1990 and the Distinguished Scientist Award from the Society for a Science of Clinical Psychology in 2000.

Dr. Dave: Dr. Alan Marlatt; welcome to Shrink Rap Radio.

Marlatt: Thank you, it's good to be here.

Dr. Dave: I'm so pleased to have this opportunity to speak with you, because your name keeps popping up in my other interviews; a couple of recent instances where my interviews with both Elisha Goldstein and his wife Stefanie Goldstein on clinical applications relating to mindfulness; and then even more recently in an interview with Patt Denning on harm reduction. And what I've been hearing is that your research is providing the foundation for some very innovative clinical approaches.

Marlatt: Well thank you, we are hoping that would be the case.

Dr. Dave: Speaking of innovative clinical approaches, I see that you got your Ph.D. in clinical psychology, as did I. How did you come to be so involved in research?

Marlatt: At first I was thinking that I wanted to be a therapist, and clinical psychology was a very appealing way of doing that; and I'm from Canada, and back in 1964 when I started graduate school, there were no Ph.D. clinical psychology training programs in Canada. Now there are several very good ones. So if we wanted to go on we had to come to the US to get our training; and I got accepted by Indiana University, and they have a good clinical program, but they also have a very strong research scientist practitioner sort of orientation. And by the time I was halfway through, I realised this is really what I want to do: clinical research.

Dr. Dave: Interesting.

Marlatt: Yes, because it was working well there; and I began to think this is something not only can you help people on an individual basis doing one on one therapy, but if you could come up with some clinical programs that would help even more people, so much the better.

Dr. Dave: You must have run into a good adviser, or maybe your doctoral dissertation adviser who maybe brought you into the research world?

Marlatt: Yes, Kenneth Heller was my Ph.D. adviser, and actually when I was in graduate school I was thinking about doing research for my dissertation on something to do with alcohol; and actually my adviser said "you don't really want to go into that area, it's kind of low prestige." (laughs)

Dr. Dave: Low prestige – a morass! (laughter)

Marlatt: Exactly, not very much good work going on there, and he discouraged me, and so I didn't do my dissertation on anything to do with alcohol or drugs. I ended up looking at vicarious reinforcement of problem disclosure, which was a good study; but it wasn't until I got on my internship at Nappa State Hospital in 1967-68 when I got a chance to work with people with drinking problems. And that got me going in terms of thinking of how to help people, especially around relapse issues.

Dr. Dave: Yes, and Nappa State Hospital: boy that's just quite close to where I am actually, it's about 20 minutes away from here. I actually used to lead student groups over there, from I think it was an Abnormal Psychology class that I was teaching.

I definitely want to talk to you about your research on alcohol and drugs and relapse, but let's get started with your research on meditation and mindfulness. How did you first become interested in this area?

Marlatt: Well I moved to Seattle at the University of Washington where I am now; this was in 1972. I had a kind of a high blood pressure problem, so I went to see a physician here in Seattle, who said "well it's not too high but it could be getting up there." And he asked me what kinds of things I did to relax, because I was still under a lot of – they used to say – "publish or perish" anxiety.

Dr. Dave: Yes, at a major university, that's the name of the game.

Marlatt: That's right (laughing). So I said, I do what most people do, watch TV, go to movies, get together with friends, have social hours, things like that. And he said "what about meditation?" So I said, well actually I'm trained as a behavioral therapist: we don't do that. (laughs)

Dr. Dave: What year would this be?

Marlatt: 1973.

Dr. Dave: OK.

Marlatt: So he said "well you do research though, right?" And I said yes. He pulled out his desk drawer and gave me a reprint, and he said "look, here's a study on people doing transcendental meditation and how it affects their blood pressure." And he showed me this graph, where clearly 90 days of TM led to significant decreases in diastolic blood pressure.

Dr. Dave: This must have been Herbert Benson, or one of his students.

Marlatt: Well I had never even heard of Herbert Benson and the relaxation response then, but later I did of course. But this physician was very tuned into that. He basically said "you know, wouldn't you rather do meditation than be on medication for this?" So I thought well OK I'll give it a try. So I signed up for transcendental meditation class here in Seattle. In those days the class initiation cost $100; now I think it's $2,500 that's what I was told last.

Dr. Dave: Wow.

Marlatt: This is the maharishi's program where you get a mantra, a word that you say to yourself, as you meditate two 20 minute periods a day. So I started doing that, and of course I could measure my blood pressure with a blood pressure kit; and sure enough, I found that after about 2 months my blood pressure had dropped about ten points on the diastolic. Not only that, but it was really the most relaxing thing I had ever experienced in terms of stress reduction.

So I began to think, wow maybe there are other applications for this, especially in terms of working with people with addiction problems. Because we know that a lot of addiction is driven by stress, and self

medication as ways to cope with stress, and this might be helpful for people with those kinds of problems. So that is what got me into it.

Dr. Dave: And now, more recently I believe you have gotten involved with an approach known as mindfulness meditation. Can you tell us how that happened, and give us your own brief definition of what's meant by mindfulness?

Marlatt: Well after doing TM for several years I felt a little frustrated in terms of the literature, and the theories related to behavior change that was in the TM literature. Although I must say they were doing a lot of research for people with addiction problems, finding good results.

We had done a study here with college student binge drinkers, where we taught them TM and they practiced it for one academic quarter; and compared to muscle relaxation or just periods of quiet reading, the meditation group had significantly lower rates of drinking in the follow up. And most of them wanted to continue meditating because they liked it.

There was a book that came out talking about positive addictions at the time, and there were descriptions of meditation and exercise for people with addiction problems could be very helpful.

So what happened actually was I went to a retreat that TM people put on down in California, I think this was in 1981.

Dr. Dave: OK.

Marlatt: And I was there, and everybody was all excited because they said the maharishi had said that there was a comet coming through the skies the same weekend that we were on the retreat, Kohoutek's Comet. Do you remember that?

Dr. Dave: Oh I remember that, sure.

Marlatt: And everybody was thinking it would be even more brilliant than Halley's Comet, even though it really didn't turn out to be. People were saying that the maharishi had said that anybody touched by the tail of Kohoutek's Comet will be instantly enlightened. So at that point I packed up my bags, and left. I thought this is not what I call empirical approaches here (laughing). And I got back, and one of my graduate students said "what about Buddhist meditation, or mindfulness?" I said I don't know

anything about that. So she handed me a book by Chogyam Trungpa, who was the director of the Naropa Institute, the Tibetan meditator.

Dr. Dave: Yes.

Marlatt: This was one of his many books; this one was called Meditation In Action. And I read this book – I was on an airplane travelling to a conference, and I read it – and I thought my gosh, this guy really knows what's happening in my mind! It's like the book is written just for you.

Dr. Dave: Wow.

Marlatt: And that's what turned the corner for me; and since then I have really become more involved in working with Buddhist teachers who teach mindfulness.

Dr. Dave: Yes.

Marlatt: And mindfulness mainly is described as a state of meta cognition; a state of awareness where you are aware of what you are thinking, what you are feeling; what's happening in terms of your emotions; but in a non judgemental position of observing.

It's like you are sitting on the banks of a river, watching the river go down and there are all these different leaves and things in the river, that are all your different thoughts and different feelings; and you are trained to just observe them, and let them go. Instead of what we usually do, especially our egos, we hook onto different thoughts and sort of become obsessed with them, and go on to ruminate about them; and especially when you are feeling an episode of stress, that can make it even more stressful. In Buddhism they call stress and suffering Dhuka; and if you start thinking about it "oh how did I get into this, I'm so bad, I can't get out of it", they call that Double Dhuka. So you are adding on all this additional difficulties in terms of being able to accept what's going on.

Then I did a number of meditation retreats since then; these ten day retreats. The ones I am mostly familiar with are called Vipassana, which means seeing things the way they really are. I did a number of retreats with S N Goanka who is an amazingly powerful teacher of Vipassana from India, in the Buddhist tradition.

If you have been to one of those you realise this is ten days of silence; sitting meditation and walking meditation. The only time that there is any

talking going on is in the evening, when the teacher gives a Dharma talk about the Buddhist philosophy. You can talk to your teacher if you are having problems, but you don't talk to anyone else who is at the retreat with you. So it's an amazing experience: not only do you not do talking, but there is no email, there is no telephone contact, no news.

Dr. Dave: What? No email! (laughs)

Marlatt: Yes, no email (laughing) – you go into email withdrawal. And after a couple of days, you realise, my god it's good not to have to do email every day!

Dr. Dave: I take it this must have been a positive experience for you, because you have done it more than once.

Marlatt: I have done it several times. Most recently I have been working with two teachers, who are both former students of Chogyam Trungpa. One is Pema Chodron, who has written many books, but the one that really caught my attention in the beginning is called "When Things Fall Apart".

Then I went to a ten day retreat that she taught at the Rocky Mountain Shambhala Center in Colorado, on that theme; and it was so powerful I decided at the end of it I wanted to take the first step in terms of becoming a Buddhist student – which is called Taking Refuge. Taking Refuge means simply that you are going to take refuge in the Buddha; refuge in the Dharma, the teachings of the Buddha; and refuge in the Sangha, which is the support group that you meditate with; and they give you a Buddhist name at that point, and hope that you will continue in your Buddhist studies. So I did that with her.

Dr. Dave: Excellent.

Coming out of an academic environment – one far less traditional, I suspect, than the one that you're in – I'm just wondering if this involvement has in any way affected your standing, or the way that you are perceived there in the "Academy."

Marlatt: I think in the beginning, because we were in a pretty traditional behavioral psychology program, people were saying "that's a bit woo woo isn't it, what you're doing there in terms of meditation?" But then it turns out a couple of the other faculty here got very interested in meditation, and one of them is Marsha Linehan.

Dr. Dave: Yes, I've interviewed her as a matter of fact.

Marlatt: Yes, her Dialectical Behavior Therapy; she calls it Wise Mind – it's mindfulness techniques for people who have borderline personality disorder, or who are at risk for suicide. She is a student of Zen meditation, and even though she is trained in the traditional cognitive behavioral she has really integrated mindfulness in a big way.

Dr. Dave: I just find it so fascinating; the various people who have married it to mainstream techniques of either behavioral techniques, and in some cases psychodynamic techniques.

Marlatt: Yes, in fact in terms of psychodynamic techniques, another colleague here, Robert Kohlenberg, has integrated mindfulness as a way of looking what happens in the therapeutic alliance.

Dr. Dave: Oh, I don't know him.

Marlatt: Yes, he has got a program; he calls it FAP, Functional Analytic Psychotherapy. There is one book out with that title; he is coming out with a second edition. In his case he is talking about the mindfulness of the therapist when dealing with clients, and how that can enhance the therapeutic alliance. He is working with a number of clients and he is also working with people who are depressed who are also heavy smokers, using mindfulness as a way to help them deal with problems and quit smoking.

What we did was, we had a program called Relapse Prevention, and we published a book in 1985 with that title. And what that book does is try to talk about triggers for relapse – if you have been in a program, so it's kind of during the after care stage – to help people understand what might throw them off the wagon in terms of their abstinence based program, through alcohol or other drugs, or smoking, or whatever people are doing trying to quit.

It's a cognitive behavioral approach: we teach cognitive coping skills, looking at your expectations about drug use; looking at self efficacy, how confident you are you can get through difficult situations without relapsing; attributions for relapse; and teaching people behavioral coping skills, how to say no if a friend is trying to get you to use. The biggest trigger for relapse we found are negative emotional states: anxiety, stress, depression, anger. That for most people is the biggest category of triggers.

So we did mention in the relapse prevention book that meditation could be helpful, because of the work that John Cabot Zinn had been doing on what he calls Mindfulness Based Stress Reduction, at the University of Massachusetts Medical School. So I actually met with John and talked to him about his program; and later Zindel Segal at University of Toronto also developed a mindfulness program for depression, called Mindfulness Based Cognitive Therapy.

So what we have got now is a program called Mindfulness Based Relapse Prevention. We are going to be publishing a book next year describing the program, in a kind of a therapist manual. We have a grant from National Institute on Drug Abuse to evaluate the program in a randomised control trial here in Seattle. We have got preliminary four month outcome data already available, and it's definitely looking good: significantly less relapse, less negative emotional states for people that did the mindfulness course compared to the "treatment as usual" control group.

Dr. Dave: Excellent.

Marlatt: And this program is a group based program; so just like Cabot Zinn's program that meets weekly for eight weeks, two hours in duration, and that's the same for Zindel Segal's program, and it's the same for our program. So it's a two hour meeting; so one hour we do meditation practice, different kinds of practice including things like body scans, paying attention to your physical sensations especially associated with craving for alcohol or other drugs.

We do a thing called urge surfing: if you are having a strong urge to smoke a cigarette for example after you have been trying to quit – instead of giving in to it, just imagine it is like a wave that is going to rise up and you pay attention to your breath as a kind of a surf board, keep your balance while the urge passes, and goes down the other side. Because most urges are like conditioned responses – you know Pavlov's dog, you ring the bell and start salivating – and yet if you don't give in at that point, you can ride it through. So we teach them that kind of technique.

We teach them mini meditations, one is called SOBER. So if you have a strong urge and you feel like you are on the brink of giving in and using, SOBER just says: first S stands for Stop what you're doing, just take a break here; O Observe how you are feeling; B focus on your Breath as your surfboard whatever you want to call it, your centering technique; E Expand your awareness, so feel feelings throughout your body, and also what happens if you did give in to the temptation, what would happen later, sort

of "thinking through the drink" is what they call it sometimes; and finally, R Respond mindfully.

So these little mini mediations people have been telling us, who just went through the program, were very helpful. The little tools that they could use when they were on the spot.

Dr. Dave: That sounds great.

Marlatt: So far, so good. We put in a bigger application to NIDA to do a larger study – that grant just went in last week, so we won't know for a few months whether we are funded, or whether there is any funding for health research left (laughs) at the National Institutes for Health.

Dr. Dave: We hope.

Marlatt: Yes so that's where we are at with it. It feels like a good combination: the mindfulness and the cognitive behavioral skills seem to go together, to compliment each other.

Dr. Dave: Yes, you know I've thought so; actually before I started talking to people like you, I was telling my students that it seemed to me that the East and West were coming together. That they were coming to the same conclusion; that a lot of the action was in the mind, and self talk.

Marlatt: Yes, exactly.

Dr. Dave: So it's so wonderful to discover that that kind of sense that I had was in fact on track somehow.

Now you are also involved with something called the Harm Reduction Movement. Tell us a bit about that – what's meant by harm reduction?

Marlatt: Well harm reduction really originated in The Netherlands when they realised that injecting drug users were at risk of HIV if they shared their needles. It was actually the users themselves that formed what they called a Junkie Bond – that's a union of users. They went to the government, saying "people are coming down with HIV because of the needles being shared. We need the needles to be more available so that people don't have to share them: lower the price, make them more accessible." And that was the birth of needle exchange programs.

I was on sabbatical in Amsterdam in the early 80s and I was working in the drug treatment center there, the Jellinek Center they call it, and I was teaching them about relapse prevention, and they said we are going to teach you about harm reduction. So they told me that if you go to the Red Light District in Amsterdam, there is a lot of sex workers who are all licensed by the government; they have to go through regular health checks, condoms are required for their services, if there is any problems they are having with their clients the police are available and they can get help right away.

I noticed by the way on the election today, there is a plebiscite or something in California to try and decriminalise prostitution for similar reasons, to do a harm reduction approach.

They are saying, look, people are going to do these things anyway; they are also going to want to experiment with illegal drugs, so we are going to set up these coffee shops where people can legally, not exactly legally, but people can consume marijuana and it will be monitored, sales will be taxed, and the money goes back into drug education in the schools.

They basically started this over 25 years ago, and they found – I was just looking at some recent statistics – that adolescent marijuana use in The Netherlands is quite a bit lower than it is in US, where it is completely illegal.

Dr. Dave: Yes, some of the thrill is gone, when it's legal. I went to Amsterdam, and some of the thrill is gone in a way (laughing).

Marlatt: When you can just do this, as an adolescent you don't get that additional sense of violating tradition (laughing).

So that is what they basically feel.

So I started to look at harm reduction in terms of drinking.

So most of the work we have done over the last ten years has actually been with heavy drinking adolescents, and especially college students. College students are a particularly high risk population, because of freshmen coming in, they are away from home usually for the first time, and they are with other people who are drinking a lot.

Dr. Dave: Yes I was on your site, and you quote a statistic: that 44% of college students report binge drinking at least once in a two week period.

Marlatt: Yes and actually 20% are frequent binge drinkers; they are doing this several times a month. The National Institute on Alcohol Abuse and Alcoholism – if you go to their website there is a report called Call to Action, about college drinking – and they reported that anywhere from 1,200 to 1,400 college students die every year from alcohol related causes.

Of course there are car crashes, but the last death we had here at University of Washington was in the residence halls, where a woman student turned 21, so she wanted to have her 21st birthday party, which of course means getting loaded, legal drinking age. But a lot of her friends with her at the party were not yet 21, so they didn't want to get caught by the residence hall adviser who checks about underage drinking. So one student said, there is a balcony up on the 7th floor and they never go there, so why don't we take our stuff up there and have our party up there. There was about eight of them, and so up they went and then they thought we had better drink fast, because we don't want the bottles around as evidence. The young man who died, tragically, he was drinking a lot, and he was telling a funny story and sitting on the balcony there was a little railing there, and he just lost his balance, and went over head first on the concrete below and he was killed on impact. And his blood alcohol level was .26. Here in Washington State the legal level for intoxication is .08 so he was over three times that.

Dr. Dave: Oh my goodness. Yes.

Marlatt: There have been other students, just in terms of turning 21, they have this game where you have to drink 21 shots of whisky in one hour.

Dr. Dave: Oh my goodness. That sounds fatal.

Marlatt: It has been fatal for a number of students; they overdose. Many college students don't realise you can overdose, and kill yourself from drinking because it can paralyse the respiratory system. They know that maybe about heroin but they don't realise that can be true about alcohol.

Dr. Dave: Yes.

Marlatt: So we actually had two programs that we developed through funding from the National Institute on Alcohol Abuse and Alcoholism.

One is for groups of students that we call the Alcohol Skills Training Program. That program is similar in a way to what students do when they take a driver's course, learning safe driving techniques to get their licence.

And what we are saying is that drinking and driving are both dangerous, especially if you do them together of course. But either way, people that are learning how to drive get a lot of information about the regulations, about speed limits, about how to deal with difficult situations on the road; but we don't do that in most cases for drinking.

So in our program, that is what we do: we teach them about blood alcohol levels; we teach them about their individual risk factors, if they have a family history of alcohol problems how that increases their risk; what the cognitive effects are in terms of blackouts, in terms of not being able to anticipate consequences, what we call the alcohol myopia effect that puts people into situations where they do things that get them into big trouble just because they couldn't think through what was going to happen; dealing with immediate gratification.

Also most students don't realise that alcohol is a biphasic drug: in other words the first few drinks you feel good, you feel high, you feel a little euphoria. But if you keep drinking, the depressive effects kick in: so you start going down, instead of further up on the emotional reaction side. That is when you start losing your co-ordination, you are going to have more problems in terms of memory, in terms of possibly getting into fights, passing out, blackouts, and all that stuff.

Dr. Dave: Yes, I remember being a young person myself, and at some point I learned – first of all I couldn't tolerate alcohol very well and would get horribly hung over, so I was never going to become an alcoholic (laughing), and I did have my share of binge drinking on at least a few occasions – but somewhere along the line I learned that there was a point where I would have that enjoyable sense of intoxication, and after which it was only going to go downhill. And so as a "mature drinker" I just know when to stop, and which for me probably is two drinks (laughs).

Marlatt: Yes, we call it the point of diminishing returns, where one more drink is not going to make you feel any happier, it is going to take you the other way.

Dr. Dave: Right, exactly.

Marlatt: And how long it takes for the body to come off alcohol: a lot of students don't realise that for every point, say if you are .08, it is going to take you 8 hours; it takes one hour for each "point" to come back down to zero. So many of them don't realise that if they party all night, in the morning their blood alcohol levels are still fairly high.

So we teach them all about that, and we have gotten very promising results in terms of the Alcohol Skills Training Program.

The most recent program – it's a one on one program, not a group based program – it's called BASICS, and it stands for Brief Alcohol Screening and Intervention for College Students. We have the manual; Gilford Press publishes all of our manuals, by the way. Anyway, BASICS uses motivational interviewing, which of course is Bill Miller's approach, so rather than confronting the student about his or her drinking problems – most of the students that we see by the way on the campus are referred to us by the housing authorities, or by the campus police, or sometimes we get volunteers, but that's mostly how they come in – and they are expecting there is going to be a lot of confrontation and certain coming down on them.

But motivational interviewing: no, we are trying to meet people where they are at, talk about what's going on, what they like about drinking, what could be some of the problems, and give them feedback about their risks after we give them a number of questionnaires about that. Whether they are diagnosable as alcohol abuse, or alcohol dependence, or just high risk drinking – which is mostly what we see.

Most of these college students actually mature out of this heavy drinking as they get into their 20's; so it's just a very high risk period. Now of course some of them will continue and will have more serious alcohol problems, so we are trying to reach both groups.

So the first session we give them feedback about their drinking, we are being very accepting of the person and working with them rather than coming down on them; and then in the second session we come up with a new action plan.

You know the stages of change model of course: a lot of these students are in pre contemplation about their drinking, they are not thinking that there is any problem. But then they get into some trouble, so they are in the contemplation stage: maybe I should do something, what are the pros and the cons. We try to look at those with the student. And finally the action stage: here is my new drinking plan, and we collaborate with them, and it is a different plan for each person depending on their risk factors and their gender, and so forth.

Anyway, BASICS – we have done lots of studies with it. We have done four year follow ups comparing BASICS to "treatment as usual" or whatever else they would get. We are getting significant reductions not only in drinking rates; but from a harm reduction perspective, significant reductions in harmful consequences. We use things like the Rutgers Alcohol Problem Inventory that looks at things that we were talking about, like: passing out, or getting into fights, or blackouts, or driving under the influence.

So the program has now been designated a model program by the Substance Abuse and Mental Health Services Administration and it is being used in up to about 2.000 colleges now.

Dr. Dave: OK, I was going to ask you about that; so it has been taken up by others; that's great.

Marlatt: Yes, we get calls every week, especially when school starts (laughs).

Dr. Dave: Yes.

Marlatt: It's like the beginning, the freshmen are at the highest risk; it's a whole new environment for most of them. It depends on whether the college is like here at the University of Washington – most of the students commute in, they don't live here on campus; although some of them do.

Dr. Dave: It's a beautiful campus, I've been there.

Marlatt: Yes. But if you go to Washington State University everybody lives on campus, because it's little tiny town, and the drinking rates are much higher in those kinds of places. So a lot of it is dealing with interpersonal influence, and what friends of yours are doing, so we look at all that as potential risk factors.

Dr. Dave: Yes. Now we often hear that alcoholism is a disease; but you say that alcoholism is not a disease. Can you say a bit about that?

Marlatt: Well, it's the same with smoking and things like that – some people would say that smoking is a disease – well smoking from my perspective is a habit, highly reinforced through nicotine, which has huge disease consequences. In fact smoking is the biggest killer in terms of any of the addictive behaviors; in terms of lung cancer, and heart failures and things like that. Yet most people don't see smoking itself as a disease.

This whole controversy about addiction – is all addiction a disease. We find that all drugs affect the brain, and the brain reward centers are extremely important – the dopamine release and things like this. But what's driving that is the behavior, and the behavior gets started through reinforcing consequences: people drink and start to get the reward effects and that increases the habit. You can develop dependence of course, or what they call abuse – continued potentially harmful drinking – not necessarily with physiological dependence; or alcohol dependence – where you are physically hooked. At that point there are still disease consequences, but I don't think it's helpful to say that the drinking itself is a disease: it's the behavior and the habit that increases the risk of these consequences.

Right now there is much more emphasis, even within the National Institute of Drug Abuse to call drug addiction a disease of the brain, or a brain disease. Now I understand what they are saying, but I don't know if that's the best way to look at it in terms of behavioral change; because what they are saying is that the best treatment are pharmacotherapies, things that affect the brain, like Naltroxene, or Acomprasate, or various drugs to reduce craving. Or with smoking cessation it would be nicotine replacement. Now they can be helpful, but the best research shows that you need a combination of some cognitive behavioral approach plus pharmacotherapy to get the best effects.

So it's a big debate: I think most behavioral people are on the – let's look at the disease consequences, but let's look at the habit that's running this thing; and how we can do habit change to reduce the negative consequences.

Dr. Dave: OK. Now coming back to the mindfulness meditation we started with, it seems to me that the process of mindfulness meditation is very much like practicing for relapse prevention. In meditation you are trying to sustain your concentration; at some point you fail; but instead of getting upset, you accept that the mind is prone to wander, and you gently bring it back. So it seems to me that every time you do that, in a way you are practicing being more gentle with yourself about your lapses, while still keeping your overall focus on the goal.

Marlatt: That's very true, yes. We have a concept that seems to distinguish between people who have a lapse, and then kind of completely fall off the wagon and have a total relapse; compared to people who have a lapse but seem to get back on the wagon again, they learn from their

mistake or whatever. The big difference is what we call the "abstinence violation effect"; and that means that people who have that are likely to say "oh my god I had a cigarette (or I had a drink), and that means I can't do this I have no willpower, I failed" and they get really down on themselves. And that makes them more stressed out, so they are even more likely to look for self medication, and it goes into a vicious cycle.

Dr. Dave: Right.

Marlatt: So being able to look at a lapse, and say "lapses occur, that's the way it goes" – you are trying to learn new ways of coping, and sometimes you have a setback, but take a look at what happened, what could you do differently next time, accept the fact that you can still make good progress, and get back on track.

So you are right, that's very true, in terms of people's reactions to slips.

Dr. Dave: OK, well I am going to make sure that I put some links in the show notes to your website, and particularly to the presentation site that you showed me, where a lot of powerpoint presentations are available for download, that review the research that you have been discussing here.

Marlatt: OK.

Dr. Dave: And as we wrap up, is there anything else you would like to leave our audience with?

Marlatt: Yes, I just was mentioning earlier, that there were two meditation teachers Pema Chodron, that was very helpful; but the one that I have been working with most recently, his name is Reginald Ray, and he is trying to integrate things like yoga and working with the body, with mindfulness meditation. His new book I would highly recommend, called Touching Enlightenment. It's all about what he's trying to integrate; and working with the body especially with cravings and urges and drug effects is very powerful, especially for working with people with addiction problems. So he is somebody I would recommend if people are interested in where to go. He has several other books, but that is the most recent one.

Dr. Dave: Well you have been very generous with your time here, and information; so Dr. Alan Marlatt, thanks so much for being my guest on Shrink Rap Radio.

Marlatt: Well thank you David, I enjoyed our conversation.

Links to information referred to in the interview:

Dr. Alan Marlatt's website and presentations for download:

http://depts.washington.edu/abrc/marlatt.htm
http://depts.washington.edu/abrc/presentations.htm

Related interviews on Wise Counsel podcast series:

http://www.mentalhelp.net

Dr. Patt Denning on Harm Reduction – November 16 2008;

Dr Annie Fahy on Motivational Interviewing – interview will be available late in November 2008