Beating the urge: Implications of research into substance-related desires

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Abstract

Despite the advent of improved pharmacological treatments to alleviate substance-related desires, psychological approaches will continue to be required. However, the current psychological treatment that most specifically focuses on desires and their management—cue exposure (CE)—has not lived up to its original promise. This paper argues that current psychological approaches to desire do not adequately incorporate our knowledge about the factors that trigger, maintain, and terminate episodes of desire. It asserts that the instigation and maintenance of desires involve both associative and elaborative processes. Understanding the processes triggering the initiation of intrusive thoughts may assist in preventing some episodes, but occasional intrusions will be inevitable. A demonstration of the ineffectiveness of thought suppression may discourage its use as a coping strategy for desire-related intrusions, and mindfulness meditation plus cognitive therapy may help in accepting their occurrence and letting them go. Competing tasks may be used to reduce elaboration of desires, and competing sensory images may have particular utility. The application of these procedures during episodes that are elicited in the clinic may allow the acquisition of more effective strategies to address desires in the natural environment.

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1. Introduction

Over the last 10 years, there has been a resurgence of interest in craving or desire\(^1\) for alcohol and other substances \([Alcohol Research & Health, 23 (3); Addiction, 95, Suppl. 2]\), perhaps partly fuelled by the release of pharmacotherapies for alcohol misuse in which a reduction or alteration in the experience of craving or desire for alcohol is the key focus \(\text{(O’Malley, Krishnan-Sarin, Farren, Sinha, & Kreek, 2002; Paille et al., 1995)}\). However, this increased interest appears to have had relatively little impact on the development of innovative psychological treatments for craving.

It might be argued that developments in relevant psychological therapies are unnecessary, given the pace of refinements in pharmacotherapies. However, an understanding of the ongoing need for relevant psychological intervention may be obtained by considering the possible targets for pharmacotherapy. Three main medication targets may be identified. First, the agent may provide temporary symptomatic relief from craving for alcohol. However, such relief is unlikely to completely and universally eliminate desire \(\text{(Monti et al., 1999)}\). Furthermore, since episodes of desire are reported by people in the context of alcohol cues years after the cessation of alcohol use, an agent that focuses on symptomatic relief may leave the person vulnerable to difficulties after its discontinuation. For example, once naltrexone is ceased, its maintained effectiveness appears to substantially rely on the person’s acquisition of skills in controlling consumption \(\text{(O’Malley et al., 1996)}\).

A second focus could be a reduction of desire by reducing positive expectancies from drinking. For example, there is some evidence that repeated trials of drinking while taking naltrexone may reduce the pleasure associated with alcohol use \(\text{(Volpicelli, Alterman, Hayahida, & O’Brien, 1992)}\) and thereby have an indirect effect on future craving. But such results would be rapidly reversed if the person drank after cessation of naltrexone—in fact, the elimination of opiate tolerance would open the possibility of short-term increases in the pleasure obtained from alcohol use. Other strategies to deal with the desire would still be required.

A third focus could be a reversal of neural sensitization to alcohol-related cues or cognition \(\text{(cf. Robinson & Berridge, 1993, 2003)}\) that was developed over repeated occasions of alcohol use. If a permanent and specific reduction of this sensitization could be achieved without substantial negative effects, this would be a major breakthrough in the management of craving, but the prospect of such an intervention appears remote at this stage. Even if this therapy was successfully developed, it would still leave the person with the need to deal with some level of desire for alcohol and with a risk of renewed sensitization if medication was discontinued and alcohol use resumed. In relation to all three targets of pharmacotherapy, there remains a critical role for psychological interventions that can provide lifetime coping strategies.

\(^1\) In the clinical literature, craving is usually used to refer to very high levels of desires \(\text{(Kozlowski, Mann, Wilkinson, & Poulos, 1989)}\). However, we can identify little evidence to support the idea that increasing intensity of desires displays a qualitative change rather than operating as a continuous variable. We therefore use the terms “desire” and “craving” interchangeably in this paper.
2. Implications of known features of desires

A maximally effective strategy to deal with desires requires an application of a wider theoretical approach that is currently used. This approach, outlined in our recent paper (May, Andrade, Panabokke, & Kavanagh, 2004), incorporates a wide range of empirical data on desires into a single coherent theory (Elaborated Intrusion, or EI Theory). The theory asserts that associative processes, triggered by environmental and internal cues, initiate episodes of desire and contribute to the maintenance of desire alongside controlled elaborative processing of target-related information. These two processing routes result in the experience of intrusive thoughts and desire imagery. Desire imagery is initially pleasurable, hence its persistence, but ultimately worsens mood. Desire is only one of many factors controlling consumption; its effects on behavior are moderated by competing incentives, negative expectancies, and perceived behavioral control. We argue that the primary tenets of the theory each have important implications for the management of desires.

3. Desire involves both associative and elaborative processes

While it is well established that people can voluntarily initiate episodes of desire (e.g., by creating a sensory image of a substance; Cepeda-Benito & Tiffany, 1996), desires often emerge in the form of intrusive verbal thoughts or sensory images without a conscious effort being involved. The distinction of intrusive and elaborative thoughts is a specific instance of the distinction between ‘automatic’ and ‘controlled’ processing, which has a long empirical history in cognitive psychology (Shiffrin & Schneider, 1977). ‘Automatic’ processes occur without conscious direction, while ‘controlled’ processes subjectively involve cognitive effort. Examples of automatized processes include elicitation of “overlearned” motor responses and conditioned stimulus associations. Associative or automatic involvement in desires is supported by a body of research, including studies on lexical priming during deprivation (Jarvik, Gross, Rosenblatt, & Stein, 1995), and on the salience of substance-related verbal associates among heavy users (Stacy, 1995). There are at least three important implications of this distinction for management of desires.

3.1. Understanding the elicitation of intrusive desires may aid in their prevention

We now have substantial information regarding the factors that elicit intrusive thoughts about a desired target. Exposure to the sight, smell, or taste of a substance tends to trigger or increase desire (Cooney, Gillespie, Baker, & Kaplan, 1987; Niaura, Abrams, Pedraza, Monti, & Rohsenow, 1992), as do other contextual stimuli in which consumption usually occurs (Palij, Rosenblum, Magura, Handelsman, & Stimmel, 1996). There is also evidence that initially neutral cues can be conditioned to elicit craving by association with the drug (Dols, Willems, van den Hout, & Bittoun, 2000). An attentional bias to substance-related cues has now been demonstrated (Mogg, Bradley, Field, & De Houwer, 2003), and in some studies
using a masking procedure, psychophysiological effects can even be obtained preattentively (Ingjaldsson, Thayer, & Laberg, 2003).

Interoceptive cues may also elicit desires. When people are able to consume alcohol, priming of positive expectancy words results in greater consumption than priming of neutral words (Roehrich & Goldman, 1995)—an effect which we argue is probably mediated by associations with alcohol. Deprivation such as withdrawal from a substance also elicits intrusive desires (Jarvik et al., 1995), but the deprivation does not necessarily have to be to the same substance, as long as the target is salient (Alsene, Li, Chaverneff, & de Wit, 2003). In fact, a negative mood can be sufficient to elicit desire for a substance (Maude-Griffin & Tiffany, 1996), perhaps especially where there are strong associations between substance use and relief of the mood. Conscious desires can also be elicited or enhanced by the awareness of anticipatory responses, such as salivation in response to alcohol cues (Monti, Rohsenow, Rubonis, Niaura, Sirot, Colby, & Abrams, 1993a).

The psychological intervention that has specifically focused on conditioned associations has been cue exposure (CE). CE was designed both to reduce the potency of the external cues that triggered drinking and to train behavioral resistance to alcohol use (Hodgson & Rankin, 1976; Rankin, 1982). Drawn from conditioning models of psychopathology, and originally applied in anxiety disorders (Rachman, Hodgson, & Marks, 1973), CE involves successive exposures to the sight and smell of alcohol, with instructions to attempt to resist drinking (Blakey & Baker, 1980). Studies of alcohol-dependent people in treatment show that differential reductions in desire and salivary reactivity or swallowing occur over successive exposure sessions (Staiger, Greeley, & Wallace, 1999), with these reductions being restricted to individuals who show an initial response to the alcohol cues (Monti, Rohsenow, Rubonis, Niaura, Sirot, Colby, & Abrams, 1993a). Consistent with other research on craving and on emotion (Lang, 1979), some desynchrony across response domains is sometimes seen (McCusker & Brown, 1995).

CE appears to be more effective than control interventions such as relaxation training (Drummond & Glautier, 1994). It is at least as effective as other cognitive–behavioral treatment (CBT; Heather et al., 2000; Sitharthan, Sitharthan, Hough, & Kavanagh, 1997), although it is not consistently better than other CBT (Dawe et al., 1993; Dawe, Rees, Mattick, Sitharthan, & Heather, 2002; Heather et al., 2000; cf. Sitharthan et al., 1997). A systematic review by Conklin and Tiffany (2002) obtained an overall effect size against comparison treatments that was not significant ($d = 0.0868$). An additive response from CE might be expected if it provided an important missing element. However, CE does not significantly add to the impact of CBT, even when the exposure occurs within a dysphoric affective context (Kavanagh et al., in submission).

Why has CE not shown stronger effects? One possibility is that a very limited view of relevant stimuli is usually applied, where the primary focus is on exposure to alcoholic drinks rather than contextual cues that trigger desire. For example, the training usually focuses on exposure in the clinic (albeit with attempts to simulate a drinking environment and include self-administered exposure between sessions; Sitharthan et al., 1997; cf. Dawe et al., 1993). Even where CE involves in vivo exposure in the person’s own drinking environment (e.g., Dawe et al., 2002), most people have been drinking in a wide range of situations and could potentially encounter alcohol in many settings in the future. Significant practical difficulties
would be posed for a CE procedure that attempted to ensure that all of the important contexts were incorporated in treatment (Conklin & Tiffany, 2002). The standard procedure is also limited by its failure to incorporate advances in knowledge about classical conditioning and extinction (Conklin & Tiffany, 2002). Examples include the use of an extinction cue to inhibit renewal of responses in a new context, spacing of sessions to restrict spontaneous recovery, and a requirement of extinction across multiple domains (Conklin & Tiffany, 2002). A critical ongoing problem with demonstrating more powerful effects from CE than from other treatments may be that any effective treatment will result in self-administered CE in the natural environment, as long as the person does not flee from critical situations and has effective behavioral control.

Even if CE within therapy sessions was further improved, it is unlikely that it will be able to eliminate desires to the full range of external and internal cues that will later be experienced. One strategy to deal with the ongoing risk of craving and relapse has been to assist the person to predict and avoid situations where associations with the substance are particularly strong and related coping strategies are too weak to allow resistance of substance use (Chaney, O’Leary, & Marlatt, 1978). While affective and physiological contexts are often included in this process, we argue that there has been insufficient attention to the maintenance of positive mood and control of physiological deprivation (e.g., hunger, thirst, fatigue) as a preventive strategy to avert or ameliorate craving episodes. As we will argue below, pleasurable activities that demand attention may be especially useful in limiting elaboration of desires. However, prevention will not always be successful, and situational avoidance is a primitive and functionally limiting approach. The person also needs to be able to deal with episodes of desire that continue to occur. Attempts have been made to address this issue, for example, by training resistance to substance use during CE trials (Monti, Rohsenow, Rubonis, Niaura, Sirotta, Colby, Goddard et al., 1993b). However, strategies to control craving within CE (as against behavioral resistance) have been less developed. Further development of strategies that may be practiced within CE sessions is required.

One of the distressing aspects of desire episodes during periods of attempted control or abstinence appears to be a concern over the meaning of the event (e.g., “I am not in control if I have any thoughts about the substance at all”). Demonstrating the involuntary nature of intrusive thoughts provides a basis for challenging overly negative attributions about these thoughts. Desire induction within the laboratory could not only illustrate that desires can be elicited without an implication of weakness or unconscious wishes. It could also demonstrate the nonspecific nature of deprivation and the possibility for errors in the attribution of eliciting conditions (e.g., by using contexts where the person is hungry, thirsty, or tired). Participants could be taught to evaluate the accuracy of their attribution (Beck, Wright, Newman, & Liese, 1993), lower unwanted arousal, and use substitutive behavior to reduce the sense of deficit (e.g., drinking orange juice instead of alcohol).

3.2. Suppression of intrusive desires is ineffective

When people attempt to suppress thoughts about substances, they actually think about them more (Salkovskis & Reynolds, 1994)—a phenomenon that is captured by the familiar
example, “Don’t think about white bears.” From empirical work on thought suppression in other contexts, we would expect this tendency to be particularly pronounced when there are other significant task demands (Wegner, 1994). This is because the attempted suppression of intrusions requires a significant investment of limited cognitive resources, and concurrent tasks also place demands on these resources. Furthermore, the monitoring of suppression violations also triggers intrusive thoughts (“Have I thought about white bears yet? Oops, I have now”).

Interestingly, standard CE procedures avoid thought suppression during the actual exposure sessions, requiring that attention be paid to the stimuli. However, there is no current treatment that provides a demonstration of the effects of thought suppression within sessions. Preliminary pilot data from our laboratory on 10 participants with alcohol misuse suggest that the contrast between the strength of an urge before and after thought suppression offers credible evidence that this strategy is counterproductive. We intend to collect further on the efficacy of this technique in addressing the problem of suppression.

If suppression of desire-related thoughts is ineffective, what can a person do? Deliberate elaboration of the thought is likely to increase the range of positive features about the target and the extent of current deprivation. It will therefore increase the strength of the desire and the difficulty in resisting it. Attentional factors in resisting temptation were demonstrated clearly in research on delay of gratification (e.g., Mischel, Ebbeson, & Raskoff-Zeiss, 1972). In these studies, children were typically given the choice between a small immediate reward and a larger, delayed reward. One important finding was that those who thought about desirable features of the delayed reward were less likely to wait than were those who thought about other things. Results such as these seem to leave the person in a cleft stick between the choice between attempted suppression and elaboration of desires.

Part of the answer may lie in the nature of intrusive thoughts. Preliminary unpublished data from our own group support the notion that at least some thoughts about alcohol are relatively transient, even for people who are attending treatment for alcohol misuse and who are in the first 2 weeks of their attempt. Of an initial 49 participants who reported on their thoughts about alcohol in the previous 24 hours, 92% reported experiencing at least some thoughts about drinking that “just pop in and vanish” without an attempt to eliminate them. This suggests that if both suppression and elaboration can be avoided, many intrusive thoughts will be relatively transient. A cognitive approach based on mindfulness meditation is one method that may allow this to occur (Kabat-Zinn, 1990; Teasdale, 1999). Up to now, mindfulness-based cognitive therapy has mainly been applied to dysfunctional cognitions, such as in depression (Ma & Teasdale, 2004; Teasdale et al., 2000). The person learns to maintain a calm detachment to mental events, where their presence is observed and accepted, rather than attempting to suppress the thoughts or ruminate upon them. As has already been noted by other writers (Breslin, Zack, & McKain, 2002), this method may also be applicable to episodes of desire. The “accept and move on” strategy provides an opportunity for the intrusion to remain a fleeting thought. Furthermore, the instruction to adopt a detached acceptance of desire-related thoughts may assist in avoiding problematic secondary distressing cognitions about the desire. A mindfulness-related technique has been employed in a multicomponent treatment for people with borderline personality disorder and substance
misuse (Linehan, Dimeff, & Reynolds, 2002; Van den Bosch, Verheul, Schippers, & Van den Brink, 2002). However, a literature search (using both Medline and PsychLit) did not reveal any randomized controlled trials of mindfulness-based techniques in the management of desires in people without personality disorders. There is clearly a potential for the wider application of the method to be evaluated.

3.3. Elaboration of desire demands limited attentional and memory resources

The ability of desires to capture attention and working memory resources is no news to anyone who has experienced a strong desire, and it also has empirical support. For example, probe reaction time is slowed during exposure to substance-related cues, and this slowing is associated with the level of desire immediately after the task (e.g., Sayette et al., 1994). An interference of desire with a concurrent cognitive task is primarily seen where the task places heavy demands on working memory (e.g., reading complex sentences or reading material that approaches the limits of reading ability; Zwaan & Truitt, 1998). Brain activation studies also provide support for the involvement of areas related to working memory, explicit episodic memory, facilitation of emotional memory encoding, and obsessive thoughts (e.g., Grant et al., 1996).

The competition of desires and other tasks for limited working memory resources offers an intriguing possibility for intervention. It may not only be that desires can interfere with other tasks—perhaps a task that demanded working memory resources may also inhibit the intensity of desires or at least interrupt elaboration. Consideration of the types of desire cognitions that are most closely related to the affective intensity of desires may suggest which types of task may be most beneficial.

4. Imagery is a key type of desire cognition

Imagery is frequently used to elicit desires (Tiffany & Drobes, 1990), and the vividness of the mental image is positively correlated with the intensity of the desire it induces (Harvey, Kemps, & Tiggemann, in press). Imagery is also reported to be a frequent feature of naturally occurring desires (May et al., 2004; Salkovskis & Reynolds, 1994). Furthermore, anxiety-related imagery is a prominent feature of anxiety disorders and probably is involved in the development and maintenance of symptoms (Holmes, Grey, & Young, in press).

The involvement of imagery in desires offers the possibility, in principle, for the control of desires through the modification of desire imagery. An attempt at imagery modification is made within covert sensitization. In this method, the desired target or its image is paired with an extremely negative one (such as vomiting) on successive conditioning trials. Despite the sound theoretical grounding of this approach, covert sensitization has not displayed a consistently strong impact on sustained response control (Elkins, 1980; Lichstein & Sallis, 1981; Miller & Dougher, 1989). Better results are obtained where the induced nausea is consistently elicited (Miller & Dougher, 1989). Part of the problem may be a difficulty some
people experience in voluntarily generating images—and perhaps their aversive nature may discourage image retention by participants. Some increased effect can be obtained with the addition of an aversive physical stimulus such as a noxious odor (Miller & Dougher, 1989). A significant ongoing weakness of counterconditioning is that it runs a risk of rapid extinction if the desired target is encountered outside treatment sessions in the absence of the added noxious stimulus (especially if it is paired with some positive effects). There is also a risk of patient dropout whenever aversive techniques are used in therapy (Kavanagh et al., in submission).

Modification of the imagery may be more effective if it were done in ways that are less likely to be later disconfirmed. One way to accomplish this would be to pair the object or its image with negative consequences of consumption (Miller & Dougher, 1989). This might be especially effective where the negative consequences are proximal events of high probability. Rapid smoking attempts to do exactly this. In that procedure, participants are asked to smoke a series of cigarettes in rapid succession and to pay attention to sensations of nausea, increased heart rate, and respiratory discomfort (Barkley, Hastings, & Jackson, 1977). This technique has been demonstrated to impact on subsequent craving (Houtsmuller & Stitzer, 1999), although its effect on smoking has been variable (Poole, Dunn, Sanson-Fisher, & German, 1982), and its application in cardiopulmonary disease has been controversial (Hall, Sachs, Hall, & Benowitz, 1984).

Frequently our anticipation of the stimulus is more positive than the actual experience—our coffee, for example, is too weak, too bitter, or is stewed. In this situation, an approach based on cognitive therapy may be employed to test and modify the beliefs (Beck et al., 1993). This method at least initially operates via controlled or elaborative processing rather than directly on associations. An implication is that the modification of an image or verbal proposition will typically occur after the initial thought or image and its affective accompaniment have emerged. Substantial relearning may be required before the less positive memory is the more salient and new affective responses are automatized.

Even if the imagery cannot easily be modified, imagery may be a particularly fruitful target for an interference task. Our own research on affective imagery showed that a concurrent visuospatial task detracted from the intensity of concurrent imagery about distressing events and also moderated the distress that was elicited (Kavanagh, Freese, Andrade, & May, 2001). However, consistent with a distinction between separate working memory subsystems for visuospatial and auditory material (Baddeley, 1986), a concurrent auditory task did not impede the maintenance of visual images or affect the emotional responses to them (Kavanagh et al., 2001).

Since other data from our laboratory suggested that visual imagery was more significant in smoking than was auditory imagery (May et al., 2004), we anticipated that the formation of visual images would interfere with a desire to smoke to a greater extent than would auditory images. An experiment by Panabokke, May, Eade, Andrade, and Kavanagh (under review) confirmed that this was the case in smokers who were deprived of cigarettes overnight and then underwent an imagery-based urge induction. A study by Harvey et al. (in press) found similar results when dieters were given a food-related imagery task and then were asked to form other auditory or visual images.
This area of treatment development is still in its infancy. A variety of other tasks may also be useful in addressing desires—for example, preliminary data from our own laboratory suggest that even a verbal working memory task such as serial sevens may assist (i.e., starting with a large number and successively subtracting seven). However, we predict that tasks that key most closely to the aspects of the experience that have the greatest affective piqunacy—and we suggest that these aspects are typically sensory in nature—will be most effective.

5. While craving is initially rewarding, expected delays in consumption are aversive

Consistent with the everyday view that thinking about a desired object is at least initially very pleasurable, the induction of desire in the context of expected ability to obtain the object is accompanied by positive affect (Zinser, Baker, Sherman, & Cannon, 1992). Subjective desire also tends to be associated with an activation of limbic regions that are implicated in emotional processing and reward (Childress et al., 1999). However, where deprivation is significant and there is no immediate prospect of obtaining the desired object, negative emotion is experienced (Zinser et al., 1992) and the sense of deprivation is heightened. During an attempt at behavioral restraint, the emotion may be experienced as guilt (McDiarmid & Hethrington, 1995) or anxiety (Monti, Rohsenow, Rubonis, Niaura, Sirotta, Colby, & Abrams, 1993a). Over time, there is evidence that the extent of the positive reaction is blunted, even though the desired object is highly salient (Robinson & Berridge, 1993).

Several implications for treatment follow. One is that some elaboration of this very rewarding or highly salient cognition will be hard to prevent. Therefore, as in the management of chronic pain (Turk, 2002), some “breakthrough” of desire related thoughts may be expected, even if the person is highly skilled at preventing desire episodes or diverting attention when they do occur. Increased tolerance for some discomfort from craving, without engaging in consumption, will still be needed. This once again suggests that mindfulness training may be of assistance. A second implication is that cognitive therapy to deal with secondary negative cognitions underpinning anxiety or guilt may often be required. Mood maintenance techniques may not only be useful in preventing episodes, but also in addressing the negative consequences of desires. Finally, given these affective links to desire, an activity may more effectively divert attention from a desire if the competing activity itself is highly rewarding. Specific techniques that could be used during episodes of desire may include relaxation or positive mood induction (Salkovskis & Reynolds, 1994). Cue-assisted relaxation with pleasurable multisensory imagery might be especially useful because of its potential to interfere with the creation of target-related imagery.

6. Desire is not the only factor in consumption

None of the above should be taken to imply that we see the control of desire as routinely being the sole focus of treatment for substance misuse. A proximal measurement of desires
demonstrates a significant association with subsequent lapses (Shiffman et al., 1997), and we argue that a low correspondence between desires and usage is often due to inadequacies in measurement (e.g., retrospective judgements of averaged desires over extended time periods). However, many people who experience an intense desire are able to resist using the substance, and lapses can occur even when desires are relatively mild (Tiffany, 1990). Within Elaborated Intrusion Theory, consumption is determined by multiple social–cognitive variables (Bandura, 1986), including the extent that competing incentives are present (Cohen, Liebson, Faillace, & Allen, 1971) or negative expectancies of consumption predominate (Breiner, Stritzke, & Lang, 1999). Consumption is also expected to be affected by availability of the target and situational challenges involved in behavioral control (Shiffman, Paty, Gnys, Kassel, & Hickcox, 1996) and by the person’s abilities (and related self-efficacy) in obtaining or resisting consumption in those situations (Sitharthan & Kavanagh, 1990).

A focus on desires may therefore be useful in reducing the risk of reversion to substance misuse, and it may reduce the disruption and distress that often accompanies them. However, it is unlikely to be the whole story in an effective treatment, unless the person already has other requisite skills in their repertoire. Evidence on the efficacy of brief intervention for alcohol misuse suggests that many people do indeed have these skills already (Miller & Wilbourne, 2002), but some additional skills training may often still be required (Kavanagh, Sitharthan, Spilsbury, & Vignanendra, 1999). We therefore view control-oriented approaches such as CBT (Galanter & Kleber, 1999) as being of continued importance. This treatment typically includes elements such as self-monitoring of behavior, examining the functional relationship between environmental cues and consumption, and training a range of relevant control skills (Mattick & Jarvis, 1994). In some cases, the development of a context that prompts and rewards resistance to substance use on an ongoing basis may be critical to success (Hunt & Azrin, 1973).

7. A summary of a proposed intervention for desires: a new role for CE?

We suggest that existing evidence, as summarized in the tenets of Elaborated Intrusion Theory (May et al., 2004), offers plausible suggestions for the development of improved strategies to address desires for substances. While habituation of desires in CE may have some utility, the wide range of eliciting cues will continue to limit the impact of this procedure. We propose that the elicitation of desires within the laboratory and clinic—whether by CE, deprivation, or directed imagery—can be used to illustrate factors that can induce desires and the potential for attributional errors during nonspecific deprivation. It can be used to demonstrate the ineffectiveness of suppression and, in contrast, the effectiveness of accepting and moving on during mindfulness meditation. The distinction between the use of competing tasks in suppression and in the process of accepting thoughts and moving on can be illustrated, and the person can discover and practice effective distraction techniques such as the use of unrelated sensory images. At the same time, the tendency for some “breakthrough” of desire cognitions and the tendency for these thoughts to swamp the attentional field can be shown. Cognitive therapy for dysfunctional beliefs about desires can be
undertaken during episodes of desire, with attributions of poor control being avoided, while retaining the use of the desire as a flag for increased behavioral vigilance. We anticipate that, when combined with empirically supported techniques for behavioral control, such an approach to desires will be a powerful intervention.

References


