What Is the Essence of the Craving Trap?

For addiction services ready for their next step — an invitation.

Paul du Buf · ERA-Institute · July 2026

In my nursing career in addiction services, in the Netherlands and the United Kingdom, I watched the systems I worked within fall short of their core purpose: supporting people to reduce or outgrow their dependencies. The medical model, willpower, the disease concept… they didn't seem able to touch the fundamental drivers of cravings and addiction. Clients wanted to stop more than they had ever wanted anything — and continued to use.

For a long time I believed the services were not offering enough and needed better plans, more strategies, more cognitive tools. It took clients who taught me what I didn't recognise to accept that a crucial element was missing. Not only in the services but also in what I myself had to offer.

What the numbers keep saying

That something essential is missing is backed by the data. Between 40 and 60 percent of people relapse after treatment — a figure first documented in JAMA in 2000, and remarkably unchanged since. From my own years on the work floor with clients with complex backgrounds, roughly one in ten entering a treatment service genuinely outgrows their dependency. Two and a half decades of refinement have improved many things, and I have seen them improve many lives. They have not moved that number. I no longer believe the problem is effort or execution.

Transcend and include

There is a principle from Ken Wilber's Integral Theory that names what I believe has happened. It is called transcend and include. All healthy growth — in nature, in a person, in organisations, in a field of medicine — moves beyond a previous stage while keeping its essential gifts. A molecule transcends the atom but fully includes it; a cell transcends the molecule but fully includes it. Nothing that works is thrown away; it is wrapped in something larger.

And growth can falter in two ways. A system can include without transcending — repeating and refining the same level forever, which is called fixation. Or it can transcend without including — leaping ahead while rejecting what came before, which is dissociation… and in healthcare, dissociation carries real risk.

A field that stopped growing

Seen through that lens, addiction treatment has become fixated. Detoxification, medication, trauma-informed care, counselling — each of these holds value, and each contributed value for clients for decades. Yet for three decades the field has been optimising within the same level: refining protocols to change, numb or otherwise manage the urge, asking the thinking mind to out-think craving. The nervous system does not negotiate on those terms; physiology, as the somatic lens keeps teaching us, trumps intention. Including without transcending… and the flat relapse rate is what stagnated development looks like in the outcome data.

The opposite error

Parts of the community make the dissociative move: discontinue the medication, leave the therapy, focus on meditation. That is transcendence by rejection — and for someone on methadone or in fragile early recovery it can put a life at risk. Nothing in what follows asks anyone to abandon a layer of care that is holding them. That is not a disclaimer; it is the principle itself. What came before, and works, deserves to be included.

Healthy growth, measured

So what can healthy growth — transcending and including — look like for our field? The trial evidence has been quietly demonstrating it for a decade. In a 2014 trial in JAMA Psychiatry, 286 people leaving addiction treatment were randomized to standard cognitive-behavioural relapse prevention, mindfulness-based relapse prevention, or twelve-step treatment as usual. At six months, the structured programmes performed comparably. At twelve months, the attentional training group had pulled ahead — significantly fewer days of substance use, significantly less heavy drinking.

In a Yale trial with smokers, mindfulness training beat the American Lung Association's gold-standard programme five-to-one on abstinence at follow-up: 31 percent versus 6. In

a 2022 trial in JAMA Internal Medicine with 250 people misusing opioids, 45 percent of those trained in attentional skills were no longer misusing at nine months, versus 24 percent in active group therapy.

And the newest result is the purest example of the principle at work: in a 2024 trial in JAMA Psychiatry, attentional training was added to methadone treatment — nothing replaced, everything included — and produced a 42 percent greater reduction in return to drug use and 59 percent less treatment dropout than methadone care alone. Transcend and include, measured.

Strategies fade when the programme ends. Capacities keep growing.

Meeting the urge

What are these programmes actually training? Not relaxation, not distraction, not better thoughts. They invite a person to meet an urge as an observable event — to feel it as sensation, locate it in the body, become curious about its texture, watch it rise, crest and pass — without obeying it and without fighting it. The research literature calls this de-centering. Notice the structure of the change: nothing is rejected. The urge is not exiled or amputated — it is included, welcomed even, inside a larger awareness that was not itself craving anything. The experience is present… and the one observing it is not that. This is not work to be done unheld: it asks for a safe-enough context, support of the kind the existing layers of care already provided and a new context inviting this process.

Including the addiction itself

This matters for how we hold the addiction itself. The dependency was not an adversary; it was a coping mechanism — often the only recourse available to a nervous system carrying trauma. Growth that dissociates from that history carries shame, and shame can trigger relapse. Growth that includes it can finally say: that strategy protected you once, and you have outgrown it. Recovery stops being a repair project and becomes a recognition.

And with that recognition comes what I believe every client I ever worked with was seeking, sometimes through the substance itself: freedom. Not the exhausting freedom of

successfully resisting — the relapse statistics reveal its limits — but the quieter freedom of discovering that the urge, however intense, has no authority over the one watching it. Ask people with long-term recovery what changed, and versions of the same sentence keep returning: I stopped fighting.

The objections

Mindfulness is not new. Marlatt was writing about urge surfing in the 1980s, and my claim was not that the capacity is novel. It is that the field filed it as one more coping tool inside the existing toolkit — attempting to include a higher capacity within a lower level. That is the fixation move, and it explains the evidence pattern: comparable at six months, superior at twelve.

And yes, the meta-analyses are mixed, which deserves saying plainly: reviews show stronger effects on craving than on abstinence, with high heterogeneity that tracks the quality of delivery. The strongest protocols, offered by practitioners with a practice of their own, produce the strongest trials in the literature. For me that is an argument for fidelity and depth… not for dismissal.

An invitation

So my proposal is an invitation, and it will not be for every organisation: explore the next step. Include: keep the medication, the trauma-informed care, the counselling, the peer support — every layer that holds people, and that provides the safe-enough context this work depends on **and** add the one capacity the other layers can hold but rarely train in its own right — structured attentional training, delivered with skilled care and fidelity, measured against your own baseline, the same standard of evidence we apply to everything else. If the trial literature is right, the difference will not show in week one. It shows at month twelve, in the people who are still connected — not because they became better at resisting, but because they found the place in themselves where the struggle was no longer needed.

The door was never locked

What does recovery mean to you? I ask because the field's answer quietly shapes everything it does. For most services, recovery means the successful management of a

chronic condition. Clients and my own experience showed me something else: a capacity that is different from addiction — not created by treatment, but uncovered by attention, including earlier chapters of the story without being any of them. And the essence of the craving trap, it turns out, is this: the trap was never locked. The fighting is what held it shut — the opening was quietly there all along waiting to be discovered.

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Sources for all trial figures: Bowen et al., JAMA Psychiatry 2014 · Brewer et al., Drug and Alcohol Dependence 2011 · Garland et al., JAMA Internal Medicine 2022 · Cooperman et al., JAMA Psychiatry 2024 · Garland et al., American Journal of Psychiatry 2024 · Janes et al., Neuropsychopharmacology 2019 · McLellan et al., JAMA 2000. Transcend and include: Wilber, K. (2000). A Theory of Everything. Boston: Shambhala, p. 9.