

Missing the Point

Addiction treatment has refined everything except the one capacity that decides relapse: attention.

Paul · ERA-Institute · July 2026

I worked for many years as a nurse in addiction services, in the Netherlands and the UK, and in that time I watched willpower fail more often than I can count. Clients who wanted to stop more than they had ever wanted anything... and who used anyway. For a long time I believed we were simply not offering enough — better plans, more strategies, more cognitive tools. It took me years, and clients who taught me what I could not yet see, to accept that something essential was missing. Not only in the services I worked for; in what I myself had to offer.

The numbers have been telling us this for a long time. Between 40 and 60 percent of people relapse after treatment — a figure first documented in JAMA in 2000, and essentially unchanged since. From my own experience on the work floor, and colleagues in the field tend to agree, roughly one in ten clients entering a treatment service will genuinely outgrow their dependency. Twenty-five years of refinement — better detox protocols, better medication, better cognitive-behavioural therapy — have improved many things, and I have seen them improve many lives. They have not moved that number. When a quarter of a century of optimisation leaves the primary outcome flat, I no longer believe the problem is effort or execution. Something structural is missing.

Here is what I have come to see, and what the trial evidence increasingly supports. Almost everything we offer trains clients to manage or fight the craving. Detox addresses the substance. Medication addresses the receptor. Trauma therapy addresses the wound, and CBT the thinking. All of these matter — I have delivered them myself for years. But none of them trains what happens in the thirty seconds after an urge arises: the moment when a wave of urgency moves through the body and a person either becomes it, or watches it. Our cognitive approaches ask the thinking mind to out-think craving... and the nervous system does not negotiate on those terms. Physiology, as I learned slowly and sometimes painfully, trumps intention.

There is another option, and it is not a metaphor. It is a trainable capacity with randomized controlled trial evidence behind it — evidence that is still accumulating. 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 two 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 results are the strongest yet: in a 2024 trial in JAMA Psychiatry, attentional training delivered by video call and added to methadone treatment produced a 42 percent greater reduction in return to drug use — and 59 percent less treatment dropout — than methadone care alone, while a second 2024 trial, in the American Journal of Psychiatry, reduced both opioid use and chronic pain in veterans. Brain-imaging work has meanwhile identified the mechanism's neural signature: training reduces reactivity in the posterior cingulate cortex — the hub that becomes active when a person is caught inside a craving — and the degree of that neural change predicts how much their use drops.

What are these programmes actually teaching? Not relaxation. Not distraction. Not thinking better thoughts. They invite a person to experience an urge as an observable event — to feel it as sensation, locate it in the body, become curious about its texture, watch it rise and crest and pass — without obeying it and, just as important, without fighting it. The research literature calls this decentering. The clients I have accompanied describe it more simply: the discovery that they are not the craving. The urge is loud, but it is being watched... and whatever is watching is not craving anything.

This, I believe, is the shift the field keeps missing, because it is a shift of a different kind. Every treatment I was trained to deliver answers the question: how do we fix what is wrong with this person? Attentional training quietly replaces the question. It shows someone, through direct and repeated experience, that alongside the machinery of addiction there is a capacity in them that was never broken — an awareness that can hold even the worst wave without drowning in 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 tell us how that ends — but the quieter freedom of discovering that the urge, however violent, 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.

I can hear the objections, because I have voiced most of them myself. Mindfulness is not new — true. Marlatt was writing about urge surfing in the

1980s. But we have consistently filed it as a coping technique, one more tool in the toolbox, something to offer when the real treatment needs a supplement. That filing, I have come to believe, is backwards. The evidence pattern — comparable at six months, superior at twelve — is the signature of a capacity, not a strategy. Strategies fade when the programme ends. Capacities keep growing. Second objection: the meta-analyses are mixed — also true, and it deserves saying plainly. Reviews show high heterogeneity, with stronger effects on craving than on abstinence. Much of that heterogeneity reflects diluted, low-fidelity implementations delivered from a script rather than from practice. The strongest protocols, offered by practitioners with a genuine practice of their own, produce the strongest trials in the literature. For me that is an argument for fidelity and depth... not for dismissal.

So my proposal is deliberately modest. Keep everything that works — the medication, the trauma-informed therapy, the CBT, the peer support. Then add the layer that none of them trains: structured attentional training, delivered with care and fidelity, measured against your own baseline — before-and-after craving ratings, retention, time-to-return after a lapse — 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 standing... not because they became better fighters, but because they discovered the place in themselves where the fight was never necessary.

What does recovery mean to you? I ask because the field's answer to that question quietly shapes everything it does. For most of my working life, recovery meant the successful management of a chronic condition. The clients who taught me the most showed me something else: a still point in themselves that no wave could reach — not created by treatment, only uncovered by attention. We have been refining our tools for twenty-five years and missing that point... and it was here all along.

*Paul du Buf worked as a registered nurse in addiction services in the Netherlands and the UK, and is the author of *Shadow Dancing: Embodied Recovery from Trauma and Addiction*. He is the founder of ERA-Institute (Evidence-based Recovery through Attention), which supports treatment organisations in integrating attentional training into existing care pathways. 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.*