Mindfulness Training in Opioid Withdrawal: Does It Help?

To the Editor: Opioid use disorder (OUD) remains an important cause of morbidity and mortality in the United States.[1] OUD is a chronic and relapsing condition,[2] with patients frequently going through cycles of intoxication and withdrawal. This cycle causes significant suffering that cannot always be alleviated by available treatments.[1] Some addiction settings employ mindfulness training (MT) to decrease stress, cravings, and cue reactivity.[2,3] Clinical lore suggests that MT can be particularly helpful during withdrawal states, despite scarce empirical data to support this view.[4]

In a recent study, Kundal et al[4] evaluated the effects of a novel MT, rhemercise, to improve the opioid withdrawal experience. Rhemercise consists of slow breathing, smiling, and yawning as well as reflecting on soothing words. The goal is to help individuals tolerate distressing thoughts, emotions, and body sensations associated with opioid withdrawal.[4] In this study, 126 male participants were assigned either to treatment as usual (TAU) or TAU plus rhemercise. Investigators found that at 2-week follow-up, measures of well-being and positive affect were higher in the TAU plus rhemercise group compared to TAU. Additionally, at 4 weeks, there was significantly higher reduction in pain in the intervention group compared to TAU alone.[4]

These results appear consistent with MT studies in this population focusing on pain outcomes. In 1 meta-analysis[5] employing samples of prescription opioid users, MT had significant effects on pain, with moderate to large effect sizes in severity, unpleasantness, and interference. Many subjects described their pain as "shorter, softer, and accompanied by less dwelling."[6(p10)]

Of interest, Kundal et al[4] hypothesized on putative mechanisms underlying the effects of rhemercise. They suggested that rhemercise may work by reducing opioid cravings, aversive emotions, and visceral reactivity. Such mechanisms appear similar to other MT practices (eg, body scan), which are theorized to improve somatic and emotional pain. MT may decrease pain by engaging central nervous system regions (eg, insula) with high concentrations of opioid receptors.[5]

Of note, this study focused on testing efficacy of MT by comparing rhemercise with TAU only. While this comparison is important, this does not address whether rhemercise surpasses other MT strategies. Further, this open-label study consists of an all-male inpatient sample in India. The study excludes patients with medical and psychiatric comorbidities, as well as patients suffering from severe withdrawal and other substance use disorders, who we routinely treat in US addiction settings. This broad list of exclusions may affect the generalizability of these findings. Despite being portrayed as a novel strategy, rhemercise's effect or proposed mechanism of action appears to be similar to other commonly used MT methods. Further investigation in head-to-head comparison trials with specific focus on opioid withdrawal patients is needed to warrant the implementation of this modality in OUD treatment. Studies in outpatient settings and with less strict exclusion criteria are also needed to increase the generalizability of these results.

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Dr Kundal was shown this letter and declined to comment.

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