



## Brief article

## G. Alan Marlatt: 1941–2011

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**Abstract**

In his extraordinarily productive research career, G. Alan Marlatt contributed to and anticipated by decades a variety of major changes in the treatment of substance use disorders. This article briefly reviews and comments on his contributions to addiction psychology, cognitive–behavior therapy, alcohol expectancies, relapse prevention, moderation goals, harm reduction, and mindfulness meditation research. He departed suddenly and too soon, but left us with a rich heritage for more effective and humane treatment of those who suffer with addiction. © 2011 Elsevier Inc. All rights reserved.

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From the vantage point of 2011, it is difficult to appreciate just how far ahead of his time Alan Marlatt was. He was doing federally funded research on alcohol treatment before the founding of the National Institute on Alcohol Abuse and Alcoholism. He was a model and mentor encouraging psychologists to get involved in addiction treatment at a time when it had even less academic status, and colleagues asked, “Why would you ever want to work on *that*? No one ever gets better!” His was a voice for humane treatment in an era when the norm was harsh authoritarian, often punitive measures that could be considered malpractice in the treatment of nearly any other disorder.

In this article, we briefly recount some of the important contributions that Alan Marlatt planted in this field. Some of them seemed heretical at the time but have subsequently become mainstream practice. What appears remarkable in retrospect is how early he perceived and championed these trends. We will particularly focus, therefore, on early work in his prolific career.

**Psychology of addictive behaviors**

First, there is the application of psychological science in treating addictions as behavioral problems rather than

criminal acts. When Marlatt entered the field, the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1968) classified alcoholism and drug dependence as personality disorders along with antisocial personality, homosexuality, and inadequate personality. The dominant professional and public view of addiction was as an irreversible character disorder marked by pathological loss of control, dishonesty, and denial. Alan Marlatt proceeded from a very different perspective, that alcohol and other drug use are behaviors, subject to the same principles of learning and social influence as other behaviors. He pioneered careful behavioral assessment and functional analysis of drinking patterns (Marlatt, 1976b) and studied contextual influences on drinking (Caudill & Marlatt, 1975; Lied & Marlatt, 1979; Marlatt, Kostum, & Lang, 1975; Okulich & Marlatt, 1972), and he applied behavioral analysis to understand the phenomena of craving and loss of control (Marlatt, 1978). He was also among the first to recognize similarities across addictive behaviors that at the time were regarded as very different disorders (Cummings, Gordon, & Marlatt, 1980; Marlatt & Rose, 1980).

**Cognitive–Behavior therapy for addiction**

If alcohol and other drug use were a type of behavior, it followed that addictive behaviors should be responsive to therapies directly targeting those behaviors (Marlatt &

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Nathan, 1978; Nathan, Marlatt, & Løberg, 1978) and to teaching self-control strategies (Chaney, O’Leary, & Marlatt, 1978; Marlatt & Marques, 1977). The idea of a therapy applied directly to change a behavior was anathema in those days when psychoanalytic thinking dominated psychiatric treatment. His first federal grant (from the National Institute of Mental Health) was for a randomized trial of counterconditioning, conducted in the 1970s at the alcohol treatment unit at Mendota State Hospital in Madison, WI. He was describing cognitive strategies for treating alcohol problems at a time when “cognitive” was still a controversial prefix for “behavioral” (Marlatt, 1976a, 1979a). The current widespread acceptance and use of cognitive–behavior therapies for addictions is quite different from their status as a castigated fringe approach in the 1970s.

### Alcohol expectancies

Drawing on a broader social learning perspective, Marlatt recognized early the importance of cognitive expectancies in the effects of drugs on behavior. He pioneered use of the balanced placebo design (Marlatt & Rohsenow, 1980; Rohsenow & Marlatt, 1981), the innovation of including a condition in which people believed that they had received alcohol when in fact they had not, thus studying the impact of cognitive expectancy in alcohol’s apparent effects on loss of control (Marlatt, Demming, & Reid, 1973) and aggression (Lang, Goekner, Adesso, & Marlatt, 1975). Alcohol expectancies are now widely recognized as an important factor in the onset of and return to drinking (Goldman, Del Boca, & Darkes, 1999; Jones, Corbin, & Fromme, 2001).

### Preventing relapse

Perhaps his most salient cognitive–behavioral work was the development of a model for understanding relapse as a preventable process rather than a discrete event (Cummings et al., 1980; Marlatt, 1979b) across addictive behaviors in general (Brownell, Marlatt, Lichtenstein, & Wilson, 1986). He introduced the concept of relapse prevention (Marlatt, 1982; Marlatt & Gordon, 1985) at a time when the idea of discussing relapse at all during treatment was considered implicit permission. Marlatt responded in a professional and scientific manner when a multisite study failed to replicate details of his widely cited taxonomy of relapse antecedents (Lowman, Allen, & Miller, 1996; Marlatt, 1996b, 1996c), and he revised his model to incorporate the new findings (Marlatt & Donovan, 2005; Witkiewitz & Marlatt, 2004). Relapse prevention is now an omnipresent component of addiction treatment.

### Moderation goals

In the 1970s, individuals with alcoholism were thought to be constitutionally different from normal people,

automatically losing control whenever drinking alcohol. Although this form of the disease model had already been critiqued as a limited understanding of alcoholism (Jellinek, 1960), it largely dominated professional treatment in the United States. Marlatt’s research championed a public health approach for understanding substance use disorders as continuously distributed in the population along a spectrum of severity—again, a heretical view at a time when popular thought and treatment recognized only “alcoholics” and “normal drinkers.” Although he had not himself been conducting research on moderation training, he became a lightning rod for polemic attacks on “controlled drinking” and behavioral approaches more generally (Marlatt, 1983). Diagnostic criteria have since moved to recognizing substance use disorders as occurring along a smooth continuum (Slade, Grove, & Teeson, 2009), and counseling for moderate drinking has become standard in health care and in prevention (National Institute on Alcohol Abuse and Alcoholism, 1996, 2005). Marlatt later pioneered teaching self-control skills as a method for preventing harmful drinking among college students (Baer et al., 1992; Kivlahan, Marlatt, Fromme, Coppel, & Williams, 1990; Thomas et al., 2009) and Native Americans (Marlatt et al., 2003).

### Harm reduction

The controversy over “controlled drinking” reemerged as Marlatt extended the logic of substance use as a continuous behavioral phenomenon in most populations. This public health view led naturally toward efforts both to prevent those with less severe problems from increasing the severity and consequences of their substance use and to engage and provide treatment to those with more severe disorders without the prerequisite of a total abstinence goal (Marlatt, 1998; Marlatt, Larimer, Baer, & Quigley, 1993). At issue was how to work with people who continued to drink or use illicit drugs and declined to abstain—which had been the only acceptable goal for any intervention. A public health approach seeks to promote ongoing engagement with the health care system and corresponding efforts to work with people where they are rather than refusing treatment (Marlatt, 1996a). His writings advocated compassionate treatment for people at their current level of readiness for change (Logan & Marlatt, 2010; Marlatt, 1998; Tatarsky & Marlatt, 2010). In the United States we are still at a relatively early stage in implementing such harm reduction strategies.

### Mindfulness meditation

Most recently, his research has focused on applications of mindfulness meditation in the prevention and treatment of substance use disorders, an interest that surfaced early (Marlatt & Marques, 1977; Murphy, Pagano, & Marlatt, 1986) and reflected his personal practice (Marlatt, 2006). His

group reviewed research (Zgierska et al., 2009) and evaluated meditation as an intervention in correctional facilities (Bowen et al., 2006; Parks et al., 2003) and in relapse prevention (Bowen et al., 2009; Witkiewitz, Marlatt, & Walker, 2005).

## Reflections

In many respects, Alan Marlatt anticipated and played a significant role in the development of some of the most important changes that have occurred in addiction concepts and treatments over the past four decades. Few readers will remember a time when it was widely assumed that people with substance use disorders were categorically different from normal people, that only those who were themselves in recovery could successfully treat them, and that their personality characteristically imposed almost insurmountable walls of immature defenses such as denial. Alan Marlatt was prominent among those who changed the thinking and politics of the substance abuse treatment field. Psychologists now play a substantial role in substance abuse prevention, treatment, research, and policy. Journals focus on psychological research in addictive behaviors, and the American Psychological Association has a large Division (50) on Addiction Psychology.

As has happened with hypertension and diabetes, diagnostic conceptions have shifted from categorical to continuous, with increasing emphasis on earlier detection and treatment (Institute of Medicine, 1990). Addictive behaviors (itself once a controversial term) are increasingly recognized as having much in common whether or not a drug is involved. We now have a sizeable menu of evidence-based treatment methods for substance use disorders. Cognitive-behavior therapy and relapse prevention are mainstays of addiction treatment. Teaching safe limits and skills for moderation is common, at least in universal, selective, and indicated prevention. If it is difficult now to imagine a world without these things, it is in part because Alan Marlatt's scientific and clinical work contributed substantially to these changes.

If it continues to be that Marlatt's work presages widespread acceptance three decades later, we are just at the beginning of the implementation of harm reduction and mindfulness meditation in addiction treatment. In Everett Rogers' (2003) model of the diffusion of innovations, these treatment strategies are currently in the hands of "early adopters." The seeds are there and appear to be growing.

Marlatt also trained and mentored many other productive addiction psychologists. As the reference section attests, he was generous in collaboration and co-authorship. The work described here was in fact the product of his larger and ever-changing research group, for which he was the solid and enduring hub. We value and learned from our many interactions with him across four decades. When we disagreed, he remained gracious, and it never interfered with our collegial relationship.

In summary, we admire and appreciate the extraordinarily productive career of Alan Marlatt. Devoting one's entire professional lifespan to a field allows one's contributions to accumulate and bear new fruit. He departed suddenly and too soon but left behind a rich heritage for more effective and humane treatment of those who suffer with addiction.

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