

ORIGINAL RESEARCH

Mindfulness-Based Relapse Prevention as a Health Promotion Tool for Substance Use Disorders in Adults

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Abstract

Background: Substance-use disorders (SUDs) are a prevalent and destructive public health issue. Therefore, tools aimed at reducing/preventing relapse are critical in promoting positive health outcomes. **Objective and/or Significance of the Study:** Mindfulness-based interventions show promising results for a variety of issues/clientele, including adults with SUDs. One that is showing feasibility and efficacy in reducing/preventing relapse, thereby promoting well-being, is Mindfulness-Based Relapse Prevention (MBRP). **Methodology:** In addition to a literature review, this paper addresses role-specific information related to MBRP for SUDs. The six functional sub-roles include expert clinician, educator, counselor, collaborator, consultant, and researcher. **Results:** Nurses at all levels can utilize the techniques associated with this approach in their work with substance use disordered patients to help them stay in the present moment and be less impulsive when faced with triggers. **Conclusion and Recommendations:** MBRP for SUDs is considered one of the "third wave" interventions, has empirical support, and can be utilized after several weeks of training and practicing the techniques with ongoing supervision concordant to the patient. As an expert clinician, educator, counselor, collaborator, consultant, or researcher, nurses can promote MBRP as one of the methods shown to be effective when working with a SUD population.

Keywords: Substance-Use Disorders, Mindfulness-Based Relapse Prevention, Nurses, Treatment

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For thousands of years, the Buddhist tradition has used a practice called "mindfulness" to help alter negative behaviors and alleviate psychological suffering. Mindfulness is defined as "an intentional direction of attention toward experiences as they arise in the present moment, characterized by a non-judgmental, open receptivity toward all phenomena" (Bowen & Enkema, 2014, p. 1). Through this practice, one is an observer, becoming aware of one's thoughts, sensations, and the physical environment. Instead of reacting to, numbing, or trying to escape these stimuli, individuals learn to "stay with" their discomfort and instead choose their response (Bowen, Chawla, & Witkiewitz, 2014).

Mindfulness-based tools show promising results for a variety of issues/clientele, including adults with substance-use disorders (SUDs) (Bowen & Enkema 2014; Mumba et al., 2018). Evidence suggests that such practices may change brain function and thought processes in a way that mitigates the potential for relapse (Li et al., 2017). One that has shown to be feasible and efficacious when used for SUDs is Mindfulness-Based Relapse Prevention (MBRP).

MBRP is a manual-based protocol that incorporates three already established evidence-based practices, including formal Mindfulness, Motivational Interviewing, and Cognitive Therapy (Li et al., 2017). Through the integration of these approaches, there is a decreased risk of relapse and an increased chance of long-term sobriety. MBRP is generally eight weeks in length, with patients engaging in 2-hour group sessions each week. Patients are led in meditation practices (with different weekly themes) and taught healthier responses to substance use cravings and/or withdrawal. MBRP can be used to complement existing interventions or as a stand-alone tool (Grant et al., 2017).

Substances continue to be misused in the United States, which has resulted in a major health crisis. In particular, opioid misuse has led to increased numbers of unintentional fatal overdoses (Jones et al., 2020). As a society, we are in desperate need of effective tools promoting health that connect the mind, body, and spirit "and unity in health as well as the ability of humans to intentionally practice self-healing and participate in healing others and society" (American Holistic Nurses Association [AHNA], 2016, p. 1). Based on the most recent literature, the purpose of this paper is to explore the utility of MBRP in reducing/preventing substance-use relapse among adults to promote improved health. The utilization of MBRP is also examined through six functional sub-roles of nurses (expert clinician, educator, counselor, collaborator, consultant, and researcher). Role-specific information related to evidence-based practice, clinical judgement, interpersonal communication, intervention across levels of prevention, cultural competency, advocacy, quality assurance, and application of research are addressed.

Health Promotion Issue

Approximately 22.6 million Americans have a SUD (Witkiewitz et al., 2014). Research shows that in 2013, 9.4% of Americans 12 years of age or older (24.6 million) were using illegal drugs (Li

et al., 2017). Additionally, 25% of Americans 12 years of age or older (60.1 million) were considered binge drinkers, having 5 or more alcoholic drinks in one sitting (Li et al., 2017). Only a small percent of these individuals seek intervention (Bowen et al., 2014). Even if they decide to seek help, outcomes are unsatisfactory, with up to 60% relapse rates within a year (Li et al., 2017). Beyond these alarming statistics, SUDs have serious consequences, both personally (e.g., loss of family/jobs, associated medical/mental-health issues) and on society, e.g., economic burden and related crime (Bowen & Enkema, 2014, Grant et al., 2017, & Li et al., 2017). Because of this, additional supports must be accessible to help lessen the impact of this crisis (Grant et al., 2017). Health promotion interventions have always been a focus of the nursing discipline. With that said, there has been historically less attention paid, by way of research, practice, and policies, to those health promotion interventions that specifically relate to mental health (Calloway, 2007; Svedberg, 2011).

Methodology

This clinically based analysis is focused on best clinical practice and the articles were reviewed in-depth to provide support. While a systematic review was not completed, a critical analysis revealed a significant amount of literature focusing on mindfulness-based interventions for SUDs, namely MBRP. The referenced studies were published between 2008 and 2014 and were qualitative, quantitative, mixed-method, or systematic reviews. In addition, the authors addressed role-specific information related to MBRP for SUDs. The six functional sub-roles discussed include expert clinician, educator, counselor, collaborator, consultant, and researcher. This helps to identify the significance of each role in treating individuals suffering from SUD.

Theoretical Frameworks

One nursing theory that aligns with the focus of this paper and supports holistic practice is the *Theory of Human Relatedness*, which is based on the "various states of connectedness and disconnectedness" individuals have with the self, others, society, and the environment (Hagerty et al., 1993, p. 291). Any interruption to relatedness can result in biological, psychological, and social disorders. Strobbe et al. (2012) apply the *Theory of Human Relatedness* to alcoholism and recovery. According to Strobbe et al. (2012), during active alcoholism (or any active addiction), an individual's involvement with a substance or enmeshment [one of the four states of relatedness] can hinder [healthy] relatedness with the self, others, society, and the environment. Participation in MBRP can help provide a sense of belonging, reciprocity, mutuality, and synchrony.

A second relevant nursing theory is Martha E. Rogers' *Theory of Unitary Human Beings*. According to White (1993), Rogers' theory is based on the premise that a person is unitary and not merely the sum of their parts. The unitary human seeks self-actualization where changes and experiences in life are "recorded in our minds through feelings" (p. 124). As such,

recovery that focuses on feelings enables a gateway to freedom from the torment associated with addiction. This perspective is also supported by a long-standing belief that people addicted to substances are not as addicted to the substance itself but the feelings associated with use. Because individuals with addiction issues are closely connected to the environment of their origin, the environment itself becomes one of the focal points of treatment. Based on Rogers' theory, Compton (1989) proposes that while nurses cannot change the patterns of substance users per se, they can become both significant and supportive "growth-promoting" components of their environmental field through mentorship and guidance toward health and healing (p. 104).

Review of the Literature

Rigorous studies have been conducted showing the feasibility and efficacy of MBRP as a tool to prevent continued addictive behaviors since it was first developed in 2010 at the University of Washington. The following review offers a sample of the most recent and robust studies available in the literature.

Bowen et al. (2014) conducted a randomized control trial between 2009 to 2012 comparing MBRP, standard relapse prevention (RP), and treatment as usual (TAU) at a chemical dependency facility. A total of 286 participants (aged 18 and older) were included and followed for twelve months. Participants randomly assigned to the MBRP group engaged in the standard 2-hour sessions for eight weeks. Each week focused on a different theme. Participants were taught how to become more aware of their emotional, physical, and cognitive functions, practiced mindfulness in the face of triggers and learned to become aware of the thoughts associated with relapse, compassion, self-care, balance, and support. Guided meditation, daily mood and cravings monitoring, and out-of-session assignments were also incorporated. The TAU group engaged in an abstinence-based 12-step program (Alcoholics Anonymous/Narcotics Anonymous). Participants met 1 to 2 times per week for 1.5 hours. Sessions were open-group and included topics like stress management, communication, and recovery. In the RP group, participants worked on coping skills, goal setting, problem-solving, social support, and self-efficacy. Similar to the MBRP group, participants in TAU and RP were asked to monitor their moods and cravings daily.

Results showed that compared to TAU, the risk of relapse to heavy drinking was decreased by 59%, and the risk of relapse to drug use was reduced by 54% with MBRP and RP. MBRP and RP participants also had 31% fewer heavy drinking days than TAU participants. Although there were no significant differences between MBRP and RP participants at the six-month follow-up, MBRP participants showed a significantly lower probability of engaging in heavy drinking and 31% decreased drug use compared to the RP participants at the twelve-month mark. This points to the enduring effects of MBRP as a health promotion tool. Limitations include differences between TAU and the MBRP and RP programs [e.g., lack of homework or therapist training in TAU], self-reporting biases, and shortage of urinalysis data.

Witkiewitz et al. (2014) also conducted a randomized control trial for substance use at a women's residential treatment facility. A total of 105 women were referred from the criminal justice

system after they were detoxed and stable. For the inpatient portion, participants were randomly assigned to either MBRP or RP groups for eight weeks. For the women taking part in the MBRP group, sessions included guided meditation, exercises using mindfulness-based skills for real-life situations, and discussion. Homework was given and completed. Conversely, the RP group focused on skills-based learning, including balancing one's lifestyle, managing substance use cravings, and recognizing situations that may lead to relapse. Based on a sample of 6 participants, at the fifteen-week follow-up, 5 participants from the RP group had an average of 2.6 days of drug use while the 1 participant from the MBRP group had only 1 day of drug use. In addition to fewer days of drug use, the MBRP group also reported fewer legal and medical problems. This provides some support for the effectiveness of MBRP as a tool in preventing relapse.

Grant et al. (2017) conducted a systematic review and meta-analysis to determine the effectiveness of MBRP for SUDs. Trial registries from the World Health Organization and the National Institutes of Health, databases (PsycINFO and Allied and Complementary Medicine), reference lists from included studies, and prior studies were all used to collect material for this project. Grant et al. (2017) set substance use relapse rates, craving/withdrawal symptoms, amount and duration of substance use, treatment dropout rates, negative impact from substance use, feelings of depression and/or anxiety, and quality of life as components needed for inclusion in this study. After an extensive search, 9 randomized controlled trials met the criteria. A total of 7 took place in a substance abuse outpatient care setting, 1 in a residential treatment center, and the other in a prison.

Participants were primarily male (72%), with a median age of 39, and had abused various substances, including cocaine, alcohol, opioids, methamphetamines, and marijuana. Sessions followed the MBRP manual, such as guided meditation, learning and practicing skills to avoid relapse, daily mood and craving tracking sheets, and homework. Results showed no significant differences on average between MBRP and RP, TAU, Cognitive behavioral therapy (CBT), and health education focused substance use relapse in terms of frequency and quantity of use, feelings of anxiety or depression, mindfulness, and treatment dropout rates. MBRP showed a positive clinical effect related to cravings and withdrawal symptoms overall. There was also a medium positive clinical effect on the quality of life among the MBRP group participants. In patients with stimulant use disorder, indirect evidence showed that MBRP significantly decreased symptoms of depression. There were significant reductions in cravings and withdrawal symptoms in patients with an alcohol use disorder using MBRP. While differences did not specifically reduce relapse rates, improved quality of life, decreased symptoms of depression, and fewer cravings and withdrawal symptoms are supportive factors needed to achieve lasting sobriety.

Next, Hammerstein et al. (2019) piloted a prospective observational study focused on adult patients who participated in an eight-week MBRP program on an outpatient basis for alcohol use disorder. The program lasted for eight weeks and included 2-hour sessions weekly. Sessions included both mindfulness meditation exercises and elements from the Cognitive-Behavioral Therapy-Based Relapse Prevention intervention. The overall goal

of the MBRP program was to increase the level of mindfulness and help patients learn to manage their alcohol cravings. Data were collected at baseline, three months, and six months using several measures, including the Alcohol Time Line Follow Back (TLFB), the Alcohol Quality of Life Scale (AQoLS), The Craving Experience Questionnaire (Frequency; CEQ-F), the Acceptance and Action Questionnaire (AAQ-II), the Five Facets Mindfulness Questionnaire (FFMQ), the Impulsive Behavior Scale (UPPS-P), the Beck Depression Inventory (BDI 21), and the Beck Anxiety Inventory (BAI).

Overall, the MBRP program demonstrated good feasibility and acceptability among participants, with significant reductions in cravings, days of use, depression, and anxiety. In addition, there were significant improvements in flexibility of the mindfulness and overall quality of life at the six-month mark. In terms of the reductions in cravings, Hammerstein et al. (2019) suggest that MBRP may be particularly efficacious to patients because, unlike most traditional interventions, the model helps individuals focus on acceptance of cravings versus attempts to resist or suppress them. The key is to help individuals recognize that they do not have to react to the discomforts associated with cravings. In terms of improved mindfulness and psychological flexibility, results suggested that participants were better able to experience their emotions rather than trying to suppress them. Finally, regarding mindfulness, participants showed progress in the 'non-reactivity' component of mindfulness, which involves allowing thoughts and feelings to come and go without getting caught up in them. This is thought to suggest improvement in self-control.

Glasner-Edwards et al. (2017) compared the effects of a health education (HE) control condition and MBRP with stimulant-dependent individuals also receiving contingency management. Participants received four weeks of contingency management of a twelve-week program, and then were randomly assigned to either HE ($n=32$) or MBRP ($n=31$). A total of 51% of the participants were methamphetamine users, and 49% used cocaine. The program included contingency management twice weekly for twelve weeks, eight weeks of either HE or MBRP, weekly assessments, and at one-month follow-up. For participants in the HE group, weekly sessions for eight weeks of group psychoeducation were used and included physical, emotional, spiritual, environmental, social, and intellectual components. More specifically, participants learned about physical activity, nutrition, sleep activity, and cancer screening. The content was derived from a smoking cessation wellness manual. On the other hand, the typical protocol was employed for the MBRP group participants. The only caveat was that the length of the sessions was reduced from 120 minutes to 75 minutes to improve engagement.

Results showed no significant difference between the MBRP and HE participants, ".73 versus .70, $p>0.05$ " with regard to the urine samples collected over the eight-week intervention phase (Glasner-Edwards et al., 2017, p.7). However, MBRP was significantly beneficial (compared to HE) to the participants with Major Depressive Disorder after controlling for Generalized Anxiety Disorder, demographics, and alcohol dependence. Similarly, among the participants with Generalized Anxiety Disorder, when controlling for Major Depressive Disorder, demographics, and alcohol dependence, those who participated in

MBRP (compared to those in HE) reduced their odds significantly of using stimulants over time. In addition, the severity of depression, measured by the Beck Depression Inventory-II, significantly decreased in the MBRP group (compared to the HE group). Also, Addiction Severity Index scores showed significant improvement over time for those in the MBRP group (compared to the HE group). The Emotion Regulation Scale revealed that the MBRP participants had notably lower scores indicating less of a challenge in emotion regulation as well. Finally, the MBRP group also showed clinically significant improvements in anxiety and substantial improvements in overall psychiatric severity. This study provides additional evidence for the usefulness of MBRP as a tool that fosters health among patients suffering from a SUD.

Finally, Davis et al. (2018) investigated substance use outcomes after MBRP was used as an intervention for young adults in residential treatment. The authors assessed differences among TAU plus MRBP and TAU plus 12 step meetings on cravings, substance use, and perceived stress. The MBRP portion of the intervention included eight group sessions (1.5 hours each at two times per week) to ensure completion of the protocol. Each session was focused on a different theme ranging from personal triggers to emotional and physical experiences. Participants were also assigned homework daily [mindfulness-based and written exercises]. Participants were low-income patients with SUDs residing at a substance use treatment center. Measures used included the Substance Frequency Scale (SFS), the Perceived Stress Scale (PSS), the Global Appraisal of Individual Needs (GAIN), and the Timeline Follow Back (TLFB).

Results suggested that MBRP is beneficial. Participants had lower substance use, cravings, and stress levels. For example, participants in the MBRP group abstained from substance use immediately post-treatment and maintained this trajectory through the post-treatment follow-up points (through 28 weeks). In terms of cravings, participants assigned to the MBRP group continued to report significant decreases in their level of cravings throughout the study. The MBRP group also showed significant improvements in the overall stress level throughout the study. Davis et al. (2018) propose that MBRP may help mitigate stress, resulting in decreased cravings and substance use.

Roles

Expert Clinician

Clinical expertise involves a "hybrid of practical and theoretical knowledge" (McHugh & Lake, 2010, p. 277). The intuitive perspective inherent in experts enables them to make clinical decisions at critical times while remaining cognizant of the situation as a whole. All aspects of practice are influenced by the "expert" status, including clinical judgment and quality of care (Benner, 1984). In the context of MBRP, an expert clinician should have an advanced knowledge base in mindfulness practices, Motivational Interviewing, Relapse Prevention Cognitive Therapy, and SUDs and experience working with patients using this approach. With the ability to make sound clinical judgments while never losing sight of the bigger picture, expert clinicians are in a unique position to manage the more complicated patient cases. Another component best suited for an expert clinician is that of an expert rater. As MBRP evolves, integrity-type measures

are being developed. Expert clinicians have the ability to rate clinicians in training adherence and competence to MBRP skills (Chawla et al., 2010).

Expert rater tasks encompass the Quality and Safety Education in Nursing (QSEN) Competency of Quality Improvement in the sense that it is focused on improved quality and safety (American Association of Colleges of Nursing [AACN], 2012). Expert clinicians can provide secondary and tertiary-level interventions given the skill set that they possess. For example, they can proactively and accurately detect SUDs through appropriate screening tools [early on]. Given their knowledge base, they may even participate in developing said screening tools. Also, helping patients navigate their treatment options given their unique circumstances is one example of a tertiary-level strategy an expert clinician may utilize.

Educator

According to the World Health Organization (2016), educator core competencies within the nursing realm include (1) theories and principles of learning, (2) curriculum and implementation, (3) nursing practice, (4) research and evidence, (5) communication, collaboration, and partnership, (6) ethical and legal principles and professionalism, (7) monitoring and evaluation, and (8) management, leadership, and advocacy. At the crux, educators have an essential role in professional development and advancing practice within the field (Sayers et al., 2011). Aligned with these aspects, educators have the unique challenge and privilege of training other clinicians and patients on how to implement MBRP techniques appropriately. According to the UC San Diego Center for Mindfulness (2019), educators use various methods, including role-play, simulated exercises, demonstration, and discussion.

Using knowledge to promote and advance health is subsumed in the Roles and Responsibilities Competency (Competency 2) of the Core Competencies for Interprofessional Collaborative Practice and addresses the important aspects of the educator role (Interprofessional Education Collaborative [IPEC], 2016). Educators are particularly useful at implementing primary prevention strategies. One example is educating young people before they start using or experimenting with drugs and alcohol.

Counselor

There are 14 qualities and actions that make up an effective counselor, including 1) refined interpersonal skills, e.g., empathy, verbal fluency, 2) understanding and trust, 3) ability to form an effective working alliance with a broad range of patients, 4) provides adequate explanations for a patient's distress, 5) offers a treatment plan aligned with a patient's explanation, 6) influential, persuasive, and convincing, 7) monitors patient progress in a genuine way, 8) flexible, 9) uses difficulties in therapeutic ways, 10) communicates hope, 11) aware of the nuances of each patient, 12) mindful of their own psychological process and does not project this on patients inappropriately, 13) implements evidence-based treatments, and 14) continually seeks improvement (American Psychological Association, 2011).

According to Bowen et al. (2009), counselors providing MBRP optimally endure several weeks of intense training, participate in their own daily meditation practice, and receive weekly

supervision from expert clinicians in this arena. University of California San Diego Center for Mindfulness (2019) proposes that counselors ensure delivery of MBRP through a variety of ways, such as demonstrating an understanding of the principles inherent in the intervention, practicing, inquiring, leading the core MBRP techniques, and working toward developing or deepening their own mindfulness practices.

It is important to note that counselors have been successful at implementing MBRP techniques with culturally diverse populations (Amaro et al., 2014). Cultural competency is associated with the QSEN Competency of Patient-Centered Care in that care is based on "respect for patient's preferences, values, and needs" (AACN, 2012, p. 4). In a more general sense, establishing strong therapeutic relationships/partnerships with patients is essential. This is arguably most important in the role of the counselor because it is the foundation that helps to determine the success of the intervention (American Psychiatric Nurses Association [APNA], 2014; National Organization of Nurse Practitioner Faculties [NONPF], 2003). Counselors are most likely to use secondary (e.g., drug screening) and tertiary (e.g., employing evidence-based interventions such as MBRP, Alcoholics Anonymous, Motivational Enhancement to lessen the likelihood of relapse) level interventions.

Collaborator

Collaboration with other professionals is central to nursing practice (Wiltjer, 2017). Collaboration and teamwork can be a complex undertaking and a process that takes time. As the healthcare system evolves, it is becoming more and more critical for the purposes of quality outcomes (Gardner, 2005). Several factors promote collaboration, with effective communication being one of the most important (Hughes, 2008). Interprofessional Communication (Competency 3) and Team and Teamwork (Competency 4) of the Core Competencies for Interprofessional Collaborative Practice underscore the need for interprofessional communication and the value of teamwork (IPEC, 2016). Collaboration, as it relates specifically to MBRP, might include advocating for the use of these techniques with providers and educating providers in various subspecialties on the importance of referrals when appropriate. Collaborators may be particularly helpful in the primary prevention realm. Collaborators could work with others to develop approaches to prevent drug and alcohol use in the United States, e.g., programs focused on cultivating good mental health hygiene practices in youth.

Consultant

Nurse consultants are leading experts involved in various tasks focused on quality improvement within their specialty area (O'Connor & Chapman, 2008). Part of their duties might include identifying problems and developing solutions to improve standards of care and treatment (McCutcheon & Perkin, 1996). As it relates to MBRP, professionals may rely on the help of a consultant to advise on treatment plans, supervision, and to assist with the more complicated clinical issues (Boyce & Tobin, 1998). Providers from the various subspecialties might request the assistance of a consultant when treating behavioral health issues or in the development of a more integrated behavioral health care

approach at their facility. Consultants are probably best suited for tertiary prevention-related tasks. For instance, consultants have the expertise to work with the various systems, e.g., healthcare, criminal justice, to provide high-quality treatment options.

Researcher

Researchers play an essential role in the delivery and improvement of safe and effective healthcare practices (Pick et al., 2011). Like other disciplines, research is used to support the practices nurses use day-to-day in the provision of care they provide. Researchers have already played a significant role in establishing MBRP as an evidence-based practice/empirically supported intervention based on the results from numerous studies (Witkiewitz & Bowen, 2010; Witkiewitz et al., 2013).

Evidence-based practice is one of the QSEN Competencies and integrates evidence, clinical expertise, and patient preferences/values (AACN, 2012). Researchers will continue to be important in refining and advancing the approach in the future. Recognizing the importance of using evidence-based practices and applying research findings to patient care is also essential (NONPF, 2003). Actively participating in research-related activities personally and/or integrating evidence and research findings into practice is also necessary (APNA, 2014). Researchers play an integral role in all three prevention levels, primary (e.g., researching the causes of substance use, so primary intervention is possible), secondary (e.g., through developing valid and reliable screening and assessment tools), and tertiary (e.g., in developing evidence-based treatments, assessing the efficacy of mindfulness-based clinical interventions such as MBRP).

Conclusion

Mindfulness as an alternative strategy has been utilized favorably with a variety of clientele and issues. In general, mindfulness is a good practice for all, regardless of the context. Nurses can begin by first studying and becoming proficient in their own mindfulness practices and then begin to transfer their knowledge to promote health among their patients.

MBRP for SUDs is considered one of the "third wave" interventions, has empirical support, and can be utilized after several weeks of training and practicing the techniques with ongoing supervision concordant to the patient. As an expert clinician, educator, counselor, collaborator, consultant, or researcher, nurses can promote MBRP as one of the methods shown to be effective when working with a SUD population. These techniques can be used to ground patients and provide concrete methods to deal with the cravings and triggers associated with substance use relapse.

Those who abuse drugs and alcohol typically have difficulty delaying gratification and frequently act on triggers to use despite knowing intellectually that continued use can be destructive to every facet of their life. By teaching MBRP techniques, it is thought that patients will become better at thinking through the decision to use. By slowing this process down and teaching alternative coping skills when cravings and triggers arise, nurses can help cultivate healthier and more intentional choices among patients with whom they work.

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