

## Chapter 1

# Introduction



In 2015, Nobel Prize-winning economists Anne Case and Angus Deaton found that for the first time in many decades, the mortality rate among U.S. middle-aged adults was rising precipitously, which they attributed in large part to the opioid crisis (Case & Deaton, 2015)—a crisis that has been termed a “disease of despair” in the epidemiological and sociological literatures (Stein et al., 2017). This term is not a mere metaphor but actually strikes right at the heart of the pathogenic mechanisms driving this crisis. For indeed, despair has fueled the opioid crisis into a conflagration, a raging fire that has consumed countless lives all the way through today.

The disease of despair has many sources, from the rising tide of income inequality to the lack of opportunity, from intergenerational violence and trauma to the egocentric materialism and social isolation of modern culture—so empty of the humanistic values that once guided and anchored our ancestors in a collective bond. In the face of this vacuum of meaning, it was perhaps inevitable that life would become more painful, insofar as emotional pain begets physical pain in the brain (Wiech & Tracey, 2009). Indeed, rates of chronic pain have soared across all Western societies, but perhaps nowhere more severely than in the United States, where an estimated 50 million Americans experience chronic pain per year (Dahlhamer et al., 2018).

## How the Opioid Crisis Began

The opioid crisis arose in part due to well-intentioned efforts to alleviate untreated pain. For much of the 20th century, opioids were prescribed primarily for postoperative and cancer-related pain. However, fueled by misleading and unethical marketing practices of certain pharmaceutical companies (Keefe, 2021), in the 1990s prescription of opioids to treat all forms of pain became part of the standard of care, and consequently, opioid prescriptions climbed to 208 million by 2011. By 2015, approximately 38% of the U.S. adult population had used prescription opioids in the prior 12 months (Han et al., 2017). Though opioids have been thought to be useful in managing a wide continuum of pain from acute and procedural pain to chronic pain, evidence for their long-term efficacy and safety is limited (Chou et al., 2015). Surprisingly, few studies have

demonstrated whether the immediate, pain-relieving effects of opioids persist when opioids are taken over the years to address long-standing chronic pain. To the contrary, it is well-known that regular use of opioids leads to specific neuroadaptations resulting in *tolerance*, whereby an individual must take higher and higher opioid doses to achieve the same degree of pain relief. And prolonged, high-dose use of opioid analgesics can inadvertently lead to other hazards, including opioid overdose, opioid misuse, and the development of opioid use disorder (OUD). Indeed, the dramatic increase in opioid prescriptions in the first decade of the 21st century was accompanied by a rising incidence of opioid misuse and OUD that affected 8.5 million and 6.5 million Americans (respectively) in 2022 (Substance Abuse and Mental Health Services Administration [SAMHSA], 2023).

Misuse of prescription opioids continues to dwarf the heroin problem in the United States, with misuse of opioids like oxycodone, hydrocodone, and fentanyl being 17 times more prevalent than heroin use (SAMHSA, 2023). The opioid crisis only worsened under COVID-19 (Becker & Fiellin, 2020)—with a 38.4% increase in opioid deaths in May 2020 from the year before the declaration of the COVID-19 national emergency in the United States (Centers for Disease Control and Prevention, 2020). Though opioids are misused by people without pain, some individuals with chronic pain who are prescribed long-term opioid therapy (LTOT) are at heightened risk for opioid misuse and OUD. Meta-analytic estimates indicate that approximately 25.0% of people who are prescribed opioids for chronic pain engage in opioid misuse behaviors like taking higher doses than prescribed, obtaining opioids from multiple providers, or using opioids to alleviate symptoms other than pain (e.g., to relieve negative emotional states like sadness, anxiety, or anger; Vowles et al., 2015). Approximately 10.0% of people on LTOT go on to experience the loss of control over opioid use that distinguishes OUD from opioid misuse (Vowles et al., 2015).

Addressing opioid misuse and OUD is complex and difficult in its own right, but the comorbidity of chronic pain increases this difficulty significantly. Indeed, chronic pain worsens OUD treatment outcomes (Potter et al., 2010; Worley et al., 2015) and significantly increases risk of relapse for patients treated with medications for opioid use disorder (MOUD; Vest et al., 2020)—the gold standard medical treatment for OUD. Chapter 2 details the downward spiral of behavioral escalation linking chronic pain to opioid misuse and OUD, but in brief, the pharmacological effects of prolonged opioid use on the brain increase sensitivity to emotional distress and physical pain while decreasing sensitivity to the pleasure derived from natural rewards in the social environment (Garland, Froeliger, Zeidan, et al., 2013; Koob, 2020). These neurobiological changes undermine the ability to regulate emotions, leading to dysphoria. Opioid dose escalation ensues in an effort to preserve a dwindling sense of well-being, which only serves to perpetuate and hasten the downward spiral, ensnaring the individual in a vicious cycle that magnifies pain and fuels addiction.

That said, not all people with chronic pain misuse opioids or become addicted to them; in fact, most don't. Yet, due to changes in opioid prescribing practices following publication of the 2016 Centers for Disease Control and Prevention opioid guidelines (Dowell et al., 2016), many people who were experiencing satisfactory levels of pain relief and who functioned well from opioid treatment are now suffering due to being forcibly and rapidly tapered off of

Prolonged opioid use changes the brain by increasing sensitivity to pain while decreasing sensitivity to pleasure.

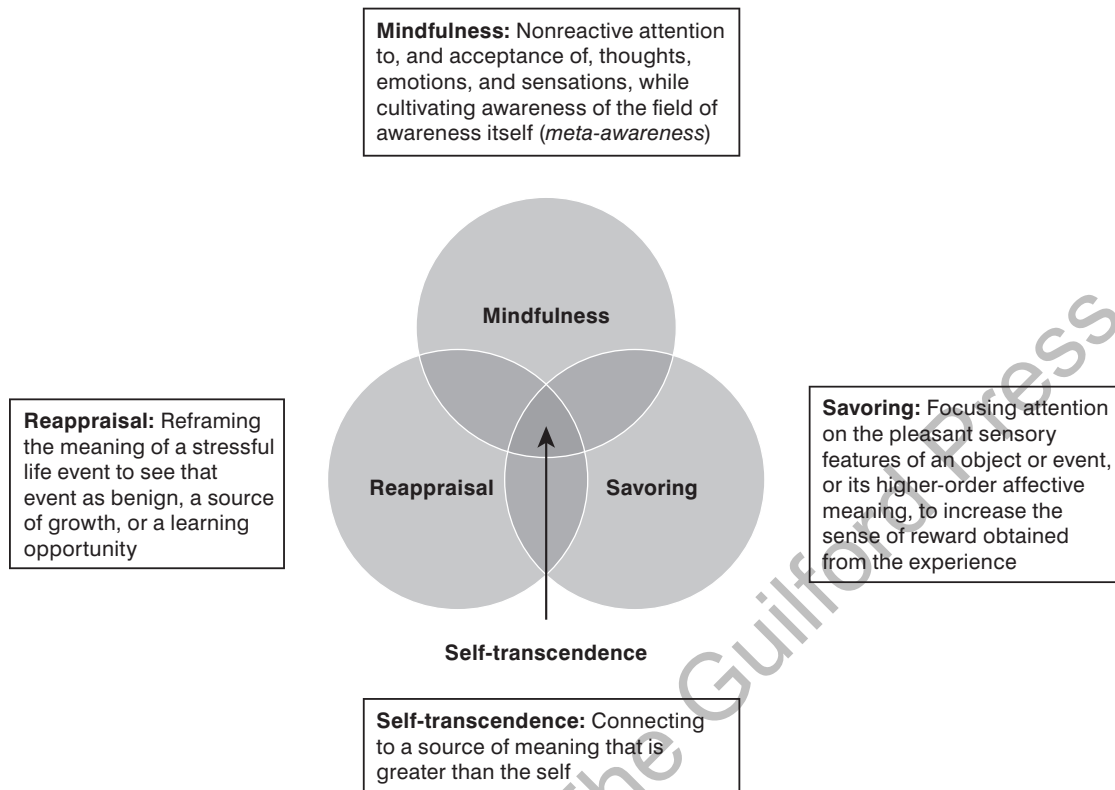
opioids. Opioid tapering without the proper support has now been linked with an increased risk of mental health crises, suicide, and overdose (Agnoli et al., 2021; Mackey et al., 2020). So clearly, the many millions of people prescribed opioids for chronic pain cannot be asked to stop their opioid use without an effective alternative pain management approach. Given the reluctance of many health systems to continue to prescribe opioids to patients, there is a huge need for approaches to support people with chronic pain who once depended on opioids for pain relief. This unmet need only complicates the current opioid crisis even further, by driving some people who previously took opioid analgesics as prescribed by their physicians to the street in search of illicit opioids, including fentanyl and heroin, as a means of alleviating their anguish.

Due to the complexity of the mechanisms linking chronic pain to opioid misuse and OUD, successful treatments for opioid misuse and OUD among people with chronic pain have proven elusive. A 2015 National Institutes of Health–Agency for Healthcare Research and Quality systematic review found no evidence for the effectiveness of any interventions for reducing opioid misuse or addiction among people receiving LTOT for chronic pain (Chou et al., 2015). More than 9 years later this gap remains.

I developed Mindfulness-Oriented Recovery Enhancement (MORE) to fill this gap. Specifically, MORE is a mind–body therapy approach informed by discoveries from cognitive psychology, affective science, and neurobiology, as well as by ancient contemplative wisdom traditions (e.g., Mahāmudrā, Dzogchen, Nondual Shaiva Tantra), and select Western philosophies that emphasize the primacy of consciousness in human experience (e.g., second-order cybernetics, stoicism, phenomenology). MORE unites complementary aspects of mindfulness training, third-wave cognitive-behavioral therapy (CBT), and principles from positive psychology into an integrative treatment for addictive behavior, emotional distress, and chronic pain. MORE is a sequenced treatment. It begins with a foundation of mindfulness training, which by virtue of its effects on strengthening the mind, synergizes later training in reappraisal and savoring, which ultimately may lead toward self-transcendence, the sense of being connected to something greater than the self (see Figure 1.1). These treatment components are designed to activate a series of cognitive, affective, and physiological mechanisms that are in turn intended to produce stepwise change in a range of clinical targets relevant to the treatment of chronic pain, opioid misuse, and OUD. Chapter 2 describes these treatment targets. Then, Chapter 3 discusses the conceptual framework underlying MORE, with the remaining chapters and structured session guides thereafter describing the MORE program in detail.

MORE is an integrative treatment for addictive behavior, emotional distress, and chronic pain.

This book describes how MORE can be used to support people with chronic pain and opioid-related issues. MORE may be useful for several types of patients. First, MORE can be used to treat people with chronic pain who are misusing or at risk for misusing opioids. Second, MORE can be used to treat people with chronic pain who have progressed to OUD and who may (or may not) be receiving addictions treatment. Third, MORE can be used to help people in chronic pain who are being asked by their physicians to taper their opioid medication. Finally, MORE can be used to support people who are seeking chronic pain relief and/or are self-motivated to reduce their opioid use or come off of opioids entirely. The MORE program, as detailed here, has been used successfully with all four of these types of patients.



**FIGURE 1.1.** Visual representation of the MORE approach.

## History of the MORE Program

In 2006, rooted in my own personal mindfulness practice and inspired by Jon Kabat-Zinn's (1982, 2003, 2011, 2019) seminal Mindfulness-Based Stress Reduction program and its later offshoot, Mindfulness-Based Cognitive Therapy (Segal et al., 2002, 2013; Teasdale et al., 2000), I began to contemplate developing a mindfulness-based intervention (MBI) for the treatment of addiction. At the time, there were no empirically supported mindfulness-based treatments for addiction, and few studies of mindfulness for addictive behavior had been published in the scientific literature. As one key exception, a quasi-experimental study of traditional vipassana meditation (Buddhist insight meditation) for incarcerated substance abusers had been published that year (Bowen et al., 2006). Motivated in part by this study, I saw the need for a secular mindfulness program for addiction that was founded on mechanistic insights from basic biobehavioral research and neuroscience. To begin, I first reviewed the literature on the cognitive, affective, and neurobiological mechanisms underpinning addiction. This review identified two key mechanistic targets that might be treated by mindfulness: *automaticity* and *allostasis*. With regard to the first mechanistic target, automaticity, research suggested that addiction was largely governed by unconscious cognitive and behavioral habits (Everitt & Robbins, 2016; Tiffany, 1990)—a conclusion echoed in the accounts of people with substance use disorders who described feeling automatically compelled to use substances even when they wished to abstain from drug use. As a manifestation of automaticity in addiction, people with substance use disorders exhibit an *attentional bias*, or hyperfixation

of attention, toward cues associated with past drug use episodes (e.g., the sight of an opioid pill bottle), which can trigger craving for substances (Field & Cox, 2008). With regard to the second mechanistic target, allostasis, addiction neurobiology indicates that the progression to compulsive substance use involves an allostatic process (i.e., a process by which the body adapts and changes in response to stress in order to maintain internal equilibrium). Specifically, as mentioned earlier, prolonged drug use in the context of chronic stress increases sensitization to drug cues and aversive experiences (e.g., pain) while decreasing sensitivity to the healthy pleasure and meaning derived from natural rewards in the socioenvironment (e.g., food, sex, social relationships, the beauty of nature; Koob & Le Moal, 2001). This allostatic shift in brain stress and reward thresholds leads to an overwhelmingly negative emotional state, driving drug use as a means of self-medicating intense feelings of dysphoria and anxiety, and trapping the individual in a downward spiral of escalating addictive behavior (Koob & Le Moal, 1997).

Because the attentional training inherent in mindfulness meditation had been classically conceptualized as a means of de-automatization (i.e., undoing automaticity; see Deikman, 1966), and mindfulness meditation appeared to be an efficacious means of stress reduction (Kabat-Zinn, 1982), it seemed likely that mindfulness would be effective for treating addictive behavior. But, I suspected that mindfulness alone might be insufficient for producing long-term addiction recovery—a process centered on reclaiming meaning in life (see the “Recovery Enhancement” section below). Similarly, I thought mindfulness alone might not fully remediate the reward system deficit underpinning addiction. Clinical wisdom, cognitive science, and modern neurobiology suggested the need for additional therapeutic techniques, including *reappraisal*, the process of reframing the meaning of adverse life events, and *savoring*, the process of appreciating and amplifying positive life experiences. I began to weave these techniques together in my primary care-based integrative medicine practice working with adults and adolescents suffering from a wide array of mental health problems, substance use disorders, chronic pain conditions, and psychosomatic complaints. As an outgrowth of my training in clinical hypnosis, I knew that indirect suggestion could facilitate access to profound alterations in one’s state of consciousness, leading to a significant restructuring of associations and reorganization of the patient’s inner life (Erickson, Rossi, & Rossi, 1976). As such, I began to use indirect suggestion to potentiate my delivery and processing of mindfulness, reappraisal, and savoring techniques. Patients who had previously struggled to practice mindfulness through more traditional routes of meditation instruction began to report having great success with the method I was developing. Some of these patients reported becoming better able to see the stressors in their lives as opportunities for psychological growth, and others reported a greater sense of fulfillment and meaning in life. Still others reported experiencing transitory flashes of self-transcendence, where their normal sense of self, typically caught in the trap of pain or addiction, was momentarily eclipsed by a spacious, open, and clear state of awareness, blissful and free from suffering. These early clinical successes let me know I was on the right track in developing this new treatment approach.

Building upon what I was learning from the “living laboratory” of my clinical practice and my study of contemplative wisdom traditions, in 2008 I received a Francisco J. Varela Award from the Mind and Life Institute to develop and test MORE as an intervention for people in inpatient treatment for alcohol use disorder. Results from this pilot trial suggested that MORE might reduce addictive behavior by modifying addiction attentional bias and increasing autonomic recovery from stress and addiction-related cues (Garland, Gaylord, et al., 2010). Given these promising

mechanistic findings, in 2009 I began testing MORE in a 5-year Stage 3 randomized controlled trial (RCT) at the same treatment facility: a long-term therapeutic community that served a large number of formerly homeless Black, White, and Latino men with histories of incarceration, addiction, trauma, and psychiatric disorders. In this study, associated with a grant from SAMHSA, MORE was found to outperform both CBT and usual addictions care on multiple mental health and addiction-related outcomes (Garland, Roberts-Lewis, et al., 2016). Before the completion of this trial, I met a physician colleague who encouraged me to combine my clinical experience providing mind–body therapies for chronic pain with my research focus on addiction. I took his advice. Although my colleagues and I have continued to study MORE as a treatment for a wide array of addictive behaviors (e.g., smoking cessation, internet addiction, obesity), the majority of the next 15 years of research on MORE focused on studying the therapy as a treatment for opioid misuse, OUD, and chronic pain.

In 2011, when the opioid crisis was beginning to reach an early peak, I was awarded an R03 grant from the National Institute on Drug Abuse (NIDA) to test a modified version of MORE as a treatment for opioid misuse among people with chronic pain being treated with long-term opioid analgesics. In this Stage 2 RCT, MORE led to clinically significant reductions in chronic pain symptoms, opioid misuse, and craving (Garland et al., 2014). In fact, MORE was twice as powerful as standard supportive group psychotherapy in reducing the occurrence of opioid misuse symptoms consistent with having an OUD diagnosis. My colleagues and I also made a number of mechanistic discoveries with data from this trial. We found that MORE reduced automatic attentional bias and improved cognitive control under conditions of stress (Garland, Baker, et al., 2017; Garland, Bryan, et al., 2019; Garland & Howard, 2013). We also found that MORE increased positive emotion regulation; patients in MORE had 2.75 times the odds of those in supportive psychotherapy to be able to increase or maintain positive moods from moment to moment in everyday life (Garland, Bryan, Finan, et al., 2017). Most notably, we found that the effects of MORE on reducing opioid craving and opioid misuse were associated with a restructuring of reward processing from valuing drug-related rewards back to valuing natural rewards, as indicated by electroencephalography (EEG; Garland, Froeliger, et al., 2015b) and autonomic measures (Garland et al., 2014; Garland, Howard, et al., 2017). In 2015, a pilot study of MORE as a treatment for smoking cessation found similar evidence of restructuring reward processing via functional magnetic resonance imaging measures of brain reward system function (Froeliger et al., 2017). Taken together, these data suggested the allostatic process of addiction might be reversed by teaching people how to savor natural healthy rewards—a signal discovery in the history of MORE (and the treatment of addiction, for that matter) that led me to catalyze my *restructuring reward hypothesis*: Shifting valuation from drug-related rewards back to valuing natural rewards will reduce craving and addictive behavior (Garland, 2016, 2021).

As a result of these discoveries, I realized savoring was an exceptionally important component of MORE. So I began to strengthen this aspect of the program by embedding an implicit emphasis on savoring throughout, in addition to the explicit savoring training session. I also began to perfect the MORE approach to teaching mindfulness and other mind–body skills. After listening to hundreds of hours of tapes of therapists delivering MORE, I began to distill the basic processes integral to helping patients successfully consolidate what they had learned from their practice of mind–body skills during the MORE sessions and to generalize that learning to coping with symptoms of pain, distress, and opioid misuse in everyday life. These insights ultimately blossomed into

the PURER (phenomenology, utilization, reframing, education/expectancy, and reinforcement) processing approach described in Chapter 5.

As a result of the clinical and mechanistic research findings from our preliminary studies, in 2016 my colleagues and I were awarded two major, multiyear, federal research grants: an R01 grant from NIDA to conduct a definitive efficacy test of MORE as a treatment for chronic pain and opioid misuse in civilians, as well as a clinical trial award from the U.S. Department of Defense's Congressionally Directed Medical Research Program to test MORE for the same indication in U.S. veterans and military personnel. These studies became the central focus of my clinical research program for the latter half of the decade and were instrumental in the continued development of the MORE program.

While these studies were in progress, I continued to investigate the therapeutic mechanisms of MORE. In 2019, I conducted a second Stage 2 RCT of MORE for people with chronic pain who were prescribed opioids but who had not yet progressed to opioid misuse (Garland, Hanley, Riquino, et al., 2019), and found that MORE reduced opioid misuse risk by decreasing pain and enhancing a range of positive psychological functions, including positive emotions, savoring, meaning in life, and self-transcendence—the sense of being connected to something greater than the self. This was the first evidence in the scientific literature that a relatively brief mindfulness therapy could elicit self-transcendent experiences, and that increasing self-transcendence had important clinical consequences. This discovery led us to optimize MORE by including a greater focus on self-transcendence during PURER and developing additional session material aimed at stimulating self-transcendent experiences (see Chapter 7). Also in this study we found that MORE decreased opioid dosing by 32%, and the effects of MORE on reducing opioid dose were explained in part by increased autonomic self-regulation during mindfulness meditation (Garland et al., 2020). This was the first time we directly tied a key clinical outcome to the state of mindfulness as cultivated during the foundational MORE meditation practice.

At the same time, we embarked upon a major series of mechanistic experiments and found additional evidence for the restructuring reward hypothesis across four studies of MORE. Specifically, we found MORE decreased EEG responses to drug cues while enhancing EEG responses to natural reward cues during savoring. In addition, we found that the effects of MORE on reducing opioid misuse were mediated by increases in positive emotional responses to natural healthy rewards (Garland, Atchley, et al., 2019). These data represented the first finding in the scientific literature from an RCT that an MBI could reduce drug cue-reactivity in the brain—a completely novel finding with major significance to the science of addiction. At the same time, my colleague Adam Hanley and I found that MORE led to a sevenfold increase in the ratio of pleasant to unpleasant sensations in the body (Hanley & Garland, 2019a). Then, a little over a year later, we found MORE increased frontal midline theta EEG oscillations during meditation that were associated with increased reports of self-transcendence and decreased opioid use over time (Hudak et al., 2021). Most recently, in another mechanistic trial, we replicated earlier findings showing that MORE increases EEG responses to natural rewards, brain changes that were linked with an improved ability to experience healthy pleasure in everyday life (Garland, Fix, et al., 2023).

As we awaited completion of the full-scale clinical trial of MORE, my colleagues and I launched a pilot study funded by the National Center for Complementary and Integrative Health to test

**MORE aims to  
restructure reward  
processing in the brain.**

MORE as an adjunct to methadone treatment for people with OUD and chronic pain. In a highly racially diverse, urban sample, we found that MORE led to significantly greater decreases in days of opioid use, other drug use, craving, pain, and depression than methadone treatment as usual (Cooperman et al., 2021). Furthermore, we found that MORE decreased the intensity of opioid craving in everyday life by about 50%, and the effects of MORE on decreasing craving were linked with increases in momentary positive emotions (Garland, Hanley, Kline, et al., 2019), again providing support for the restructuring reward hypothesis.

In 2021, we completed the NIDA R01-funded clinical trial of MORE, and obtained conclusive evidence of MORE's efficacy as a treatment for chronic pain and opioid misuse (Garland, Hanley, Nakamura, et al., 2022). In this trial, we enrolled 250 patients with chronic pain, all of whom were showing signs of opioid misuse at the beginning of the study. Before the trial began, patients reported a mean pain level of 5.5 out of 10, and were taking on average about 100 morphine milligram equivalents a day. At baseline, nearly 70% of patients met criteria for major depressive disorder, and 62% met criteria for full-blown OUD. Nine months after completion of the study treatments, MORE had reduced opioid misuse by 45%, nearly tripling the effect of standard supportive therapy. MORE also significantly reduced opioid use through the 9-month follow-up, and 36% of patients were able to cut their opioid dose in half or greater. In addition, MORE significantly reduced chronic pain symptoms, with 58% of patients reporting clinically meaningful decreases in pain-related functional impairment. MORE also had robust antidepressant effects and led to clinically significant decreases in posttraumatic stress symptoms. At the same time, MORE significantly increased positive emotions, a sense of meaning in life, and self-transcendence, with these effects maintained 9 months later. In addition to treating their symptoms of pain and opioid misuse, MORE had helped the patients become happier people in general—attesting to the life-altering impacts of this therapeutic approach.

Then, in 2022, we completed the U.S. Department of Defense-funded clinical trial (Garland, Nakamura, et al., 2024). In a sample of 230 veterans and active duty military personnel who had been in pain an average of 20 years, we again found that MORE led to statistically significant reductions in chronic pain and opioid dosing through an 8-month follow-up. Patients in MORE were able to reduce their opioid use by 21%, on average. MORE also significantly decreased opioid craving and opioid attentional bias, while reducing anhedonia and increasing positive emotions. These findings replicated our NIH R01-funded study of MORE, providing additional strong support for MORE's efficacy in a second, independent, full-scale RCT.

That same year, we completed the largest neuroscientific study of mindfulness as a treatment for addiction ever conducted (Garland, Hanley, Hudak, et al., 2022). We replicated our earlier results (Hudak et al., 2021) by showing that the effects of MORE on reducing opioid misuse through a 9-month follow-up were mediated by increases in frontal midline theta EEG activity during mindfulness meditation. Frontal midline theta is a well-known biomarker of cognitive control, but it increases during states of flow, when the sense of self is suspended and transcended during deep cognitive absorption with ongoing activity. Thus, mindfulness-induced self-transcendence was associated with a brain signature of self-control with clear anti-addictive properties. Replicating these results across two RCTs with two independent samples indicates that we may have indeed found a key mechanism by which mindfulness reduces addictive behavior.

Most recently, in 2023, we completed a full-scale clinical trial of MORE for people with OUD and chronic pain (Cooperman et al., 2023). In this study, we examined the efficacy of MORE as



delivered online by telehealth in a highly racially diverse, low-income sample of 154 patients receiving methadone treatment at addiction clinics in an urban area of New Jersey. Patients treated with the telehealth MORE intervention showed a significantly lower rate of relapse back to drug use, significantly fewer days of drug use, lower chronic pain symptoms, and less depression relative to patients who received a standard addictions treatment approach. These data suggest that MORE is accessible to a wide range of people from varying socioeconomic and education levels, and that this novel therapeutic approach can substantially improve addiction treatment outcomes.

To date, MORE's efficacy across a wide range of patients has been supported by 12 RCTs and two meta-analyses (Li et al., 2021; Parisi et al., 2022). Of these trials, six RCTs involving more than 800 patients clearly demonstrate that MORE is an efficacious treatment for treating chronic pain, opioid misuse, and OUD. In light of this body of evidence, I felt it was now time to disseminate MORE to clinicians and patients in the real world.

## Mindfulness

Though the concept of mindfulness will be expanded upon throughout this book, this term deserves a brief introduction here. *Mindfulness* is an English word for a range of concepts and techniques that emerged in Asia millennia ago in multiple Buddhist, Hindu, Yogic, and Taoist traditions, but also has parallels in the mystical branches of Judaism, Christianity, and Islam, as well as in the shamanic practices of multiple indigenous cultures around the world. Acknowledging and drawing upon these ancient contemplative roots, the entire MORE approach is oriented toward and grounded in a secular form of mindfulness practice that began to be integrated into health care 4 decades ago (Kabat-Zinn, 1982).

In the modern parlance of psychology and neuroscience, the term *mindfulness* has applied to both a set of mental training practices (i.e., meditation techniques), as well as to the mental states and traits cultivated by these practices. Simply put, mindfulness is the process of observing and accepting present-moment thoughts, emotions, sensations, and perceptions from the perspective of a witness, while reflecting back upon of the field of awareness in which those mental contents arise. This meta-awareness, or “awareness of awareness,” is a critical aspect of mindfulness. On the one hand, the capacity to be mindful is a basic property of the human mind resting in its natural state. On the other hand, with disciplined practice, mindfulness

Mindfulness is the practice of observing and accepting present-moment thoughts, emotions, sensations, and perceptions, and witnessing them unfold in the field of awareness.

may deepen over time such that for brief moments the normal sense of one's self as separate from the world begins to fade, leaving a profound sense of expansive wholeness or pure consciousness in its wake (Metzinger, 2024). In those self-transcendent moments, “Mind is like space; it has the nature of space; equal to space, it encompasses everything” (Namgyal, 2006, p. 192).

How then is the concept of mindfulness, whether as the mind's basic nature or a rarified state of consciousness, related to the treatment of people suffering from chronic pain and problematic opioid use? Chapter 3 provides a detailed theoretical response to this question. To summarize here, chronic pain, opioid misuse, and OUD are all conditions that are often preserved and exacerbated by maladaptive mental habits—for instance, feeling helpless to cope with pain, or fixating

on thoughts about the next dose of opioids. These unhelpful patterns of attending, thinking, and reacting often occur in spite of the patient's well-intentioned effort to control them due to the process of automaticity—that is, they sometimes occur autonomously and unconsciously, against the patient's will. In this sense, these automatic, maladaptive mental habits operate in a context of *mindlessness*. Given the role that mindlessness plays in perpetuating pain and addictive behavior, a treatment oriented around mindfulness is a logical solution to these prevalent and pernicious problems. Through mindfulness, automatic habits can be deautomatized—that is, they can be surfaced in awareness, brought under conscious control, and thereby transformed.

## Recovery Enhancement

At the outset, it is important to emphasize MORE's focus on *recovery enhancement* as distinguished from *relapse prevention*. The goal of relapse prevention is to help patients maintain abstinence from substance use by teaching them skills to cope with high-risk situations where relapse is likely (Marlatt & Donovan, 2005). In contrast, *recovery* may be defined as “a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential” (SAMHSA, 2011). In this sense, recovery is a holistic process that attends to the multiple dimensions of hedonic and eudaimonic well-being, extending far beyond abstinence from drug use. Furthermore, the recovery perspective regards lapses back to drug use as part of the normative developmental pathway in which a person using substances eventually reaches a state of optimal functioning. This consideration is particularly appropriate for individuals with chronic pain who have been prescribed long-term opioid therapy, who, due to their medical condition, may remain taking opioids for the rest of their lives. Here, the goal is harm reduction (i.e., reduced opioid overuse or misuse, as well as prevention of the negative sequelae of that use), not abstinence. At the same time, the recovery perspective involves an ethos of optimism: the belief that given enough time and coping resources, people can heal from physical and emotional pain, and ultimately, liberate themselves from destructive habits. MORE was designed to enhance the recovery process for people striving to overcome addiction. MORE is philosophically grounded in this recovery-enhancement perspective, and built upon the belief in the inherent capacity of individuals to transcend and transform their limitations into opportunities for growth and meaning making. This philosophical perspective permeates MORE and serves as the living core of the intervention from which its many concepts and techniques radiate.

Thus, from the perspective underlying MORE, a person suffering from chronic pain, emotional distress, and problematic opioid use has, like all human beings, the innate resilience and “basic goodness” (Trungpa, 1985) needed to access an inner wellspring of well-being that transcends the travails and tragedies of life. However, this radical transformation from viewing oneself as deficient and broken to experiencing oneself as full of basic goodness does not occur through magic—it develops from the repeated and incremental practice of adopting salutogenic ways of thinking and behaving in the world, day after day, moment by moment. Each time a person intentionally challenges negative mental states and cultivates positive ones, the process of recovery advances toward its ultimate end goal of inner awakening and self-liberation (Teasdale, 2022). MORE is founded on this foundational recovery perspective pointing to the possibility of transformation through training. MORE is, at its core, a system of mental training aimed at enhancing

flourishing and meaning in life amid the endless cycles of suffering and joy that characterize human existence.

Because mindfulness is, at heart, an experiential rather than conceptual process, it is necessary for you, as a MORE therapist, to develop your own disciplined mindfulness practice. There is no better way to come to understand mindfulness than through the practice of mindfulness itself. Chapter 3 provides some recommendations in that regard. In addition to having their own personal practice of mindfulness, MORE therapists should aim to cultivate attitudes of compassion and empowerment toward their patients, as described in the next section.

## Ethical Values Underlying MORE: Compassion and Empowerment as the Foundations of Healing

Before embarking upon a description of the scientific and theoretical synthesis underlying the MORE program, I would like to speak to the ethical values foundational to its authentic and successful implementation. First and foremost, the MORE therapist should have compassion for their patient. It is easy to become judgmental, to blame the patient for having a “victim stance” or a “personality disorder,” or suggest the client is exaggerating their painful symptoms by “somaticizing” or “catastrophizing.” So too, the labels of “drug seeker” and “addict” are unfortunately a part of the common lexicon in health care. These clinical labels stigmatize the patient (Slade et al., 2009), drive a wedge between clinician and client, undermine the development of an authentic therapeutic relationship (itself a precondition to effective MORE therapy), and belie the true anguish of chronic pain. Though the experience of pain may or may not be directly proportional to tissue damage, the potential lack of a nociceptive basis for a given patient’s pain does not in any way diminish the suffering that person is experiencing. Someone who has not experienced pain for months, years, or decades on end has difficulty appreciating the terrible impact of such an experience. Chronic pain is demoralizing, dis-spiriting, fatiguing, and can rob a person of their sense of self, their very identity (Armentrout, 1979). Indeed, when someone who has lived a life full of vigorous, athletic activity experiences an accident resulting in severe and debilitating back pain, and then has trouble walking up the street, picking up their young children, or carrying groceries from the car, this can erode the sense of being a man, a woman, a husband or wife, a parent, or a capable person. Imagine what it is like to experience such a loss of self. Imagine what it is like to have your every waking thought and concern bent toward the sense that your own body was betraying you. Imagine what it is like to have your attention inexorably drawn toward sensations of stabbing, searing, cutting, gripping, aching, and burning for what seems like every minute of every day.

This kind of suffering goes far beyond physical pain—it can be heartbreaking. To help someone suffering from pain, one must adopt a stance of compassion toward that person, accepting the reality of their suffering and letting go of judgment and blame. A human being is a biopsychosocial system, embedded in and constituted by larger biopsychosocial systems, and thus an innumerable number of forces impinge upon that being in any given moment to shape one’s behavior and internal state (Bateson, 1972; Engel, 1977). So any reductive causal account of that state is bound to be biased and at best only a partial view. We cannot know why the person behaves and feels as they do. Therefore, if we aim to help our client to shift their behavior and internal state, we must

accept the reality of their suffering, regardless of its source, and respond to it with empathy (Feldman & Kuyken, 2011). This root of compassionate action is the ethical precondition for effective MORE practice.

Second, the MORE therapist should adopt an empowerment mindset. As just discussed, some people with chronic pain on LTOT come to feel powerless over their conditions. Indeed, the depression that often co-occurs with chronic pain, opioid misuse, and OUD is marked by a sense of learned helplessness and hopelessness—the sense that nothing can be done to make things better. This depressed attitude is understandable, given that many people in this situation have come to believe their bodies have been permanently damaged. They may have been told they suffer from incurable conditions, or that they have mental health disorders caused by faulty brain circuitry or defective genes. Furthermore, many such individuals have had multiple medical procedures, have seen a seemingly endless succession of health care providers, and have tried a veritable pharmacy worth of prescription medications and supplements, with little relief in return. Finally, opioid use (prescribed or illicit) is marked by stigma and shame. Our society labels those who take opioids as prescribed by their physicians as “addicts” and assumes that opioid use implies criminality. No wonder why such individuals feel so disempowered, and judge themselves so harshly.

The empowerment mindset works against that hopelessness and helplessness (Deegan, 1997). It is the idea that one can help oneself, the conditions of a person’s life can be improved, and progress can be made, no matter where the starting place. Empowerment begins with the unwavering belief in the individual’s capacity to act to transform and heal themselves. Empowerment must be balanced with compassion, for without compassion, this attitude could devolve into victim blaming or the notion that one can pull themselves up by their own bootstraps. In MORE, we first acknowledge that the client has become trapped in a web of forces from which it is difficult to escape, and then we recognize that the client also possesses an untapped wellspring of healing power from which the energy for change, however distant and latent, can be summoned. Thus, in MORE we adopt a nonpathologizing view of the patient. We regard people as resilient survivors, not diagnoses or victims. We believe that no matter the starting place, a person is capable of significant growth and healing, because their true nature is rooted in basic goodness. And we know such growth can emerge only from hard work and from persistent and determined application of mental force, just as the waters of a mountain stream can polish a rough piece of granite into smooth pebbles given enough time, or even carve solid earth into a grand and majestic canyon.

With these dual attitudes of compassion (Lama & Vreeland, 2001) and empowerment (Deegan, 1997), you are ready to embark upon learning how to use MORE to help your patients free themselves from the clutches of chronic pain and addictive behavior. In the next chapter I discuss the complexities of how chronic pain can lead to opioid misuse and OUD.

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