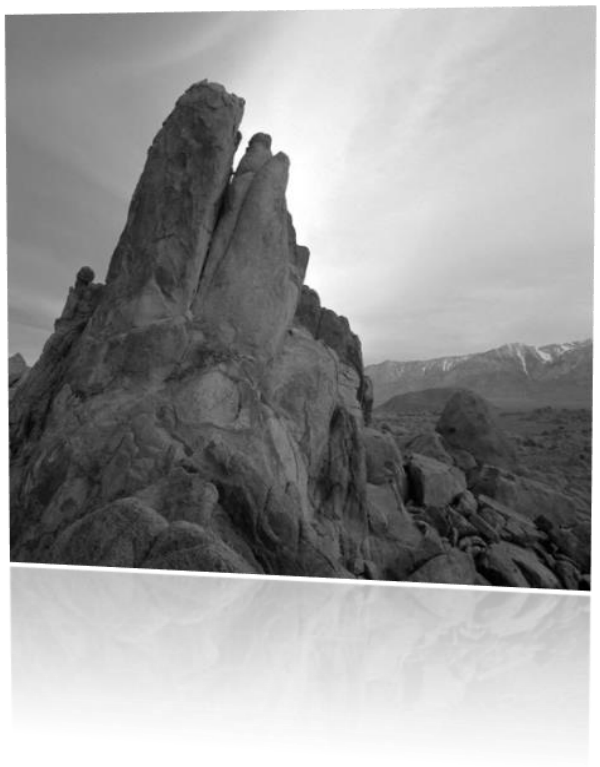
Integral Recovery Coaching Course

Integral Recovery Institute



Study Guide

Integral Recovery Institute

INTEGRAL RECOVERY INSTITUTE

Integral Recovery Coaching Course

Introduction

Welcome to the *Integral Recovery Coaching Course*. In this introduction, you will be provided with all the administrative information you need to successfully complete this course.

ICON KEY
Additional Material
Assignment
Audio & Video
Prescribed Books
Academic Articles

The text that you are reading is referred to as the *Study Guide*. As its name indicates, it will guide you through the 9 study units of this course. Throughout the Study Guide, we will use certain icons to indicate certain activities. On the left margin you will find an ICON KEY, which describes the action that each icon represents.

For each study unit, you will study material from the assigned textbooks, the additional material provided, listen to weekly live lectures, as well as listen to various audio and video clips.

Each study unit will end with a written assignment. To successfully complete this course, each assignment must be completed and sent to your Faculty Mentor.

How to Contact your Faculty Mentor

- Inquiries about administrative or other matters, email info@integralrecoveryinstitute.com

- Mail assignments to your Faculty Mentor

Study Material

Assigned textbooks, and required readings

There are two assigned textbooks and several required readings for this course. The assigned textbooks are *Integral Recovery: A Revolutionary Approach to the Treatment of Alcoholism and Addiction* by John Dupuy (2013), which you can order from SUNY Press by going online to http://www.sunypress.edu/p-5645-integral-recovery.aspx.; and *An Integral Guide to Recovery: Twelve Steps and Beyond*, which you can order from Amazon at http://www.amazon.com/Integral-Guide-Recovery-Twelve-Beyond/dp/0990441954/. All additional required readings will be provided to students.

The Study Guide:

The Study Guide will indicate the sequence of how the text for the course is to be studied. There are 9 study units in this course. Each study unit has one or more learning objectives, content pertaining to the theme of the study unit, the corresponding required study material, and a written assignment to assist in mastering the material.

Audio and Video:

Some study units have accompanying audio and video files; links will be provided in the Study Guide to assist in downloading the relevant material for each study unit.

Assignments:

Assignments are designed to help you integrate the information you have learned in the study unit. Each assignment will be composed of an essay question. The essay question is crafted in such a way as to engage one's critical thinking about the study material.

Grades and Course Requirements:

Students enrolled in the course will be graded on a *pass/fail* basis. Students are required to read the material outlined in this Study Guide, complete all written assignments and practice assignments, attend the weekly online lecture (or listen to the recorded version when unable to attend the live lecture), and interact with their Faculty Mentor.

Study Unit

1

What is Integral Recovery?

Learning Objectives for Study Unit 1:

1: This study unit serves as an introduction to the Integral Recovery approach to drug and alcohol addiction.

Introduction Study Unit 1

Addiction, whatever its form, has always been a desperate search, on a false and hopeless path, for the fulfillment of human freedom.

– M. Boss (1983, p. 283)

In this course, we will explore an integrally informed approach to the understanding of addiction and recovery, called Integral Recovery. This course presents an outline of a progressive recovery map and toolkit suitable for the complex 21st century. The Integral Recovery approach provides the necessary knowledge to guide an

individual in working a wholly comprehensive, inclusive, and sustainable recovery program, achieved through an integration of the best contemporary knowledge and personal development tools.

Integral Recovery is an approach that includes and honors all the essential aspects of the recovering individual's life in a comprehensive way. The Integral Recovery approach breaks the dichotomy between living life and having a recovery program by creating an Integral Recovery lifestyle that embraces all the important dimensions of one's life.

We can define the Integral Recovery approach or paradigm as mindfully practicing physical, emotional, mental, spiritual, social, and environmental dimensions as part of an Integral Recovery lifestyle that is geared towards continued personal growth in relation to self, others, and the transcendent—guided by and kept in balance using the Integral/AQAL map.

The Genesis of Integral Recovery

📖 ***The study material for this study unit is the introduction (pp. 1 – 14) of John Dupuy's book and (pp. 1-9) of Du Plessis' book. This gives an overview of how Dupuy developed his integrally informed approach to addiction treatment and recovery, and an overview of Du Plessis' model.***

Review of Current Integral Recovery Research

Read the following excerpt from Dr. Adam Gorman's doctoral thesis. It provides an overview of Integral Recovery and Integral Addiction Treatment. All references to citations in this section can be found in Dr. Goman's thesis.

Integral Recovery (IR) can be classified as a branch of Integral Psychotherapy. Beginning in 2007, a series of books was written by licensed therapists and published on both the theory and application of Integral Psychology in psychotherapy. Pioneers such as Mark Forman (2010), Elliot Ingersoll and David Zeitler (2010), and Andre Marquis (2007) have continued the work begun by Ken Wilber's publication of *The Spectrum of Consciousness*. While all of these authors touched on substance abuse and addiction, experts have only now begun to apply the first in-depth treatment models in an inpatient setting.

Integral Recovery remains in its infancy, having only recently entered academic discussions. To the knowledge of this author, only two facilities in the world apply AQAL programs as their primary addiction intervention. One such facility was founded by John Dupuy and is located in Utah. The second was founded by Guy Du Plessis, and is located in South Africa. Not coincidentally, these two men have been the primary authors of academic papers related to the field (Dupuy & Morelli, 2007; Dupuy, 2009; Dupuy & Gorman, 2010; Du Plessis 2010, 2012a, 2012b).

One of the first academic papers written on the subject of IR was a joint effort by Dupuy and Morelli (2007). These authors outlined a basic AQAL application in an inpatient treatment setting. Addiction is a comprehensive disease, "affecting not just the addict's body and mind but their family, their intimate relationships, their work, their finances, their home—in other words, all four quadrants of their life" (p. 26). This desire to treat the entire person and not just the isolated aspect of the disease of addiction inspired the publication of the first papers. In the following three years, basic applications

of the AQAL model have progressed to advanced programmatic designs incorporating the great depth and span that is the Integral model. Specifically, Du Plessis (2011) recently submitted articles for publication that outline more advanced approaches to clinical interventions using Integral Methodological Pluralism—a complex form of the four quadrant model—as well as articles detailing Integral Recovery's place as a branch of Integral Psychology.

Dupuy (Dupuy & Gorman, 2010) moved in a new direction, outside of conceptual and theoretical pieces, and conducted a case study that followed one of his clients throughout the course of treatment at the treatment center. The client's first-hand accounts of treatment and follow-up interviews suggested that Dupuy's program was effective in this one case and showed promise, but that it requires implementation and study with a broader range of clients to determine overall effectiveness. Dupuy acknowledged the historic role of AA in his writings, but did not incorporate the 12-step program as a primary piece of his treatment modality.

Du Plessis (2010) developed an integrally informed 12-step-based therapy called Integrated Recovery Therapy (IRT) that he uses in an inpatient setting. This model is an application of Integral Theory to traditional 12-step work. It utilizes the other elements of Integral Theory in addition to the quadrants—known as levels, lines, states, and types—in ways that are very similar to those of Dupuy (2009). The Integrated Recovery model is a "12-step abstinence based philosophy and methodology, mindfulness-based interventions, positive psychology, and Integral Theory" (Du Plessis, 2010, p. 4). Du Plessis expanded upon this basic application in his most recent theoretical writing, in which he proposed a multi-perspective orientation that allows therapists to work with individual clients based on the clients' specific developmental needs. Du Plessis (2012) wrote,

> IRT is the psychotherapeutic application of the Integrated Recovery model for psychotherapists and counselors to use as an orienting framework in therapy sessions. Because it deals with more than intra and interpersonal changes that

> commonly characterize counseling and psychotherapy, IRT is better understood as a broad based therapy. (p. 3)

The common thread in both Dupuy's (2009) and Du Plessis' (2010) programmatic designs is that the intent is to create a recovery culture that integrates Integral Theory, while at the same time providing client-specific interventions based on the clients' unique developmental level and specific type. Du Plessis summed up the goal of integral addiction counselors and therapists:

> The Integrated Recovery therapist helps clients to develop and practice an Integrated Recovery program, which can be described as mindfully practicing their physical, mental, emotional, spiritual, social, and environmental dimensions as part of a lifestyle-oriented approach that is geared towards continued personal development in relation to self, others, and the transcendent. (p. 4)

This move toward creating a specific program for each client that meets his or her unique needs is what differentiates Du Plessis' Integrated Recovery Therapy from the traditional 12-step program. IRT incorporates AA as a cornerstone of its treatment philosophy, while at the same time providing type-specific interventions.

Audio and Video for Study Unit 1

- ***Watch "The Why of Integral Recovery" and "The Birth of Integral Recovery" (Parts 1 A & 1 B of the John Dupuy video series on Integral Recovery), which can be downloaded from http://www.integralrecovery.com/2009/01/videos. Here Dupuy provides an overview of the genesis of Integral Recovery.***

Assignment for Study Unit 1

- *Write a 2 - 4 page essay why you are interested in this course.*
- *Send assignment to your Integral Recovery Institute teacher.*

Well done. You have come to the end of Study Unit 1!

Study Unit 2

What is Addiction?

Learning Objectives for Study Unit 2:

1: To gain an understanding of the nature of addiction from an Integral perspective.

2: To gain insight into how an integral approach can benefit the field of addiction treatment and research.

Introduction to Study Unit 2

> *Who will ever relate the whole history of narcotic? – It is almost the history of 'culture,' of our so-called high culture.*
>
> *– F. Nietzsche (1983, p. 83)*

Addiction, in its myriad forms, presents one of the foremost and mounting threats to the well-being of modern society (Fields, 1998; Kinney, 2003; Walters, 2007). Addiction is the most ubiquitous form of mental health disorder in the United States and its burden on health care is so excessive and disproportionate as to constitute a medical and economic crisis (Boji & Ruan, 2004; Virage, Cox, & Rachel, 1988). Addiction or substance dependence can be described as "a cluster of cognitive, behavioural, and physiological

symptoms indicating that the individual continues use of the substance despite significant substance-related problems. There is a pattern of repeated self-administration that usually results in tolerance, withdrawal, and compulsive drug-taking behavior" (DSM-IV, 1999, p. 176). In 2006, 23 million people needed treatment for illicit drug and alcohol abuse in the United States. The annual cost of illicit drug abuse to US society is estimated at 181 billion dollars (NINDA, 2008). This cost to society pales in significance in comparison to the daily human suffering that addiction causes.

As a consequence of the magnitude of this disorder, many scholars, institutions and clinicians have sought to understand this complex phenomenon – as is evident in the abundance of etiological models of addiction in existence today. How a society views and understands addiction has great significance for addicted individuals seeking treatment. In pre-modern times addiction was understood as possession by demons and seen as a moral aberration, and its consequent treatment was similarly archaic and punitive. It is only in the last 100 years that scientific theories and explanations for addiction have come into existence, and as a result, that treatment has become more effective (DiClemente, 2003).

Developing accurate theories, models and definitions of addiction is problematic in many ways. One reason is that addiction is an abstract concept, without an objective existence or clear boundaries. Furthermore, it is socially defined, and therefore opinions can legitimately differ about the most suitable definition – it cannot be said that one definition is unequivocally correct and another incorrect, only that one is more useful or less useful than others, or that one is mostly agreed upon by experts (West, 2005). Theories, models and definitions of addiction in authoritative texts on the subject have changed over the years. At one time, addiction was defined as a state of physiological adaptation to the presence of a drug in the body so that absence of the drug led to physiological dysfunction (DiClemente, 2003). West (2005) states that: "Nowadays the term 'addiction' is applied to a syndrome at the centre of which is impaired control over behaviour, and this loss of control is leading to significant harm" (p. 10).

Another problem faced in addiction science is that theories in the field of addiction are rarely tested adequately in real-world settings, because the dominant research methodology does not allow it. However, a good theory of addiction should explain a related set of observations, generate predictions that can be tested, as well as being parsimonious, comprehensible, coherent, internally consistent and not contradicted by any observations (West, 2005).

In the following section models and theories of addiction are explored. It should be noted that it is beyond the purpose of this study unit to provide an exhaustive discussion regarding theories and models of addiction.

Etiological Models of Addiction

Genetic/physiological models

The most substantial evidence concerning the role of genetics in addiction is derived from studies of alcohol dependence (Shuckit, 1980; Shuckit et al., 1972). Theorists have suggested that addiction runs in families and can be transmitted across generations. Twin studies suggest that a genetic transmission of alcoholism and chemical dependence is possible, and seem to support the importance of genetics as a contributing factor (Hesselbrock et al., 1999). What is, however, now becoming evident is that a genetic explanation for addiction will be polygenetic and complex, and will not lie in finding a single gene that can explain addiction (Begleiter & Porjesz, 1999; Gordis, 2000; Blume, 2004).

Historically, addiction and physical dependence were seen as synonymous. Addiction was traditionally characterised by increasing tolerance and onset of physical withdrawal symptoms. Theorists of the genetic/physiological model of addiction argue that the physiological aspects of tolerance and withdrawal are indicators that addictions are biological entities and medical problems. However, not all drugs and addictions produce withdrawal symptoms or create physiological dependence. Yet the physiological component of addictions remains an important one, and there have been major advances in our understanding of the neurobiology of addiction (Roberts & Koob, 1997).

Advanced neurobiological insight into addiction as having a physiological component and not constituting morally reprehensible behaviour has led to it being understood within the medical model as a disease. West (2005) states that "[t]he Disease Model of addiction seeks to explain the development of addiction and individual differences in susceptibility to and recovery from it. It proposes that addiction fits the definition of a medical disorder. It involves an abnormality of structure or function in the CNS that results in impairment" (p. 76). The disease model has played a significant role in shifting society's view of addiction from one of moral deviance to one that promotes treatment and understanding. Most neuroscientists studying addiction view it as a brain disease (Volkow et al., 2002). Addiction affects, amongst others, the mesolimbic system of the brain, the area where our instinctual drives and our ability to experience pleasure resides. This area contains the medial forebrain bundle, prevalently known as the pleasure pathway (Brick & Ericson, 1999). In addicts, the pleasure pathway of the brain is "hijacked" by the chronic use of drugs or compulsive addictive behaviour. Owing to the consequent neurochemical dysfunction, addicts perceive the drug as a life-supporting necessity, much like breathing and nourishment (Brick & Ericson, 1999).

It seems clear, based on our understanding of the neurobiology of addiction, that physiological mechanisms and genetic factors potentially play a role in addiction; however, there are many concerns about assigning sole causality to genetic/physiological factors. Although the genetic/physiological models are some of the most widely accepted models of addiction, they have also attracted much criticism (Blomqvist & Cameron, 2002; Moos, 2003). DiClemente (2003) states that "so many different individuals can become addicted to so many different types of substances or behaviors, biological or genetic differences do not explain all the cultural, situational, and intrapersonal differences among addicted individuals and addictive behaviors" (p. 11). Genetic/physiological theories apply empirical observation methodologies, but do not incorporate psychological, social and cultural perspectives.

Social/environmental models

Many models of substance abuse have been criticised for not sufficiently emphasising the role of social and contextual factors (Coppelo & Orford, 2002). In addition, many research studies have shown that some of the greatest risks of becoming addicted are related to the social factors to which a person is exposed (Srmac, 2010). The social/environmental perspective highlights the role of social influences, social policies, availability, peer pressure and family systems on the development and maintenance of addiction (DiClemente, 2003; Johnson, 1980). Furthermore, an influence on etiological factors of addiction is the prevailing degree of attitudinal tolerance toward the practice in the individual's cultural, ethnic and social class milieu. Research has pointed out that macro-environmental influences also play a significant role in the initiation of addiction (Connnors & Tarbox, 1985). For instance, since the breakdown of the apartheid system in early 1990s and the concomitant relaxation of border management, South Africa has been targeted as a conduit country for transportation of drugs, as well as a new lucrative market for the sale of drugs (Myers & Parry, 2003). Poor law enforcement, combined with sophisticated infrastructure and telecommunications systems, have further compounded South Africa's vulnerability as a lucrative drug trafficking destination, resulting in the increased use of heroin, cocaine and methamphetamine in the country (Parry et al., 2005).

Some supporters of the social/environmental models focus on the more intimate environment of family influences as a central etiological factor of addiction (Merikangas et al., 1992; Sher, 1993). They suggest that the onset of addiction is influenced by certain variables that emerge from dysfunctional family environments (Coleman, 1980; Kandel & Davies, 1992). These theorists emphasise that problematic family situations, such as conflicted and broken marriages, difficulties with relationships, and the use of alcohol and other drugs by parents, are important influences on the child's decision to experiment with drugs or continuing addictive behaviour (Chassin et al., 1996; Jessor & Jessor, 1977). Research has identified familial dynamics such as lack of parental support and ineffective parental control practices as high-risk factors for adolescent substance abuse (Hawkins et al., 1994).

It is clear that social/environmental models have relevance to our understanding of addictive behaviour at a population level, but they often fail to explain individual initiation or cessation in any comprehensive manner (DiClemente, 2003). The social/environmental models attempt to understand and study addiction from a cultural anthropological perspective, and from a systems theory perspective.

Personality/intrapsychic models

Proponents of the personality/intrapsychic perspective link personality/intrapsychic dysfunction and inadequate psychological development to a predisposition towards addiction (Levin, 1995; Kohut, 1977; Flores, 1997; Khantzian, 1994; Ulman & Paul, 2006). For example, pre-existing antisocial disorders, depression, low self-esteem, narcissistic disorders, hyperactivism, high novelty seeking and emotionality have been acknowledged to be possible precursors or predictors of later addiction (Jessor & Jessor, 1980; Kohut, 1977). This led theorists to seek a pre-addiction psychological profile for people who have become addicted. However, a single addictive personality type has not been established, in spite of commonly held beliefs that there is such a thing as an "addictive personality". Blume (2004) affirms this by saying that "there are certain psychological disorders with specific clusters of symptoms that have a high co-occurrence with substance abuse and dependence … but there is no single personality type for people with addictive behaviors" (p. 73).

A common explanation, from a psychoanalytic perspective, is to view the etiological and pathogenic origins of addiction as a narcissistic disturbance of self-experience (Wurmser, 1995; Meissner, 1980; Khantzian, 1999; Ulman & Paul, 2006). Kohut (1971, 1977) implies that there is an inverse relationship between an individual's early experiences of positive self-object responsiveness and their tendency to turn to addictive behaviour as replacements for damaging relationships. Scholars who support the "self-medication hypothesis" believe that addicts often suffer from defects in their psychic structure owing to poor relationships early in life (Khantzian et al., 1990; Flores, 1997; Levin, 1995). This leaves them prone to seeking external sources of gratification, e.g. drugs, sex, food, work in later life (Kohut, 1977). Khantzian (1995) says "that "substance abusers are

predisposed to become dependent on drugs because they suffer with psychiatric disturbances and painful effect states. Their distress and suffering is the consequence of defects in ego and self capacities which leave such people ill-equipped to regulate and modulate feelings, self-esteem, relationships and behavior" (p. 1). The self-medication model of addictive disorders points out that individuals are predisposed to addiction if they suffer from unpleasant affective states and psychiatric disorders, and that an addict's drug of choice is not decided randomly but chosen for its particular effect because it helps with the specific problem(s) that the person is struggling with. Therefore, initiation of drug use and the choice of drug are based on the particular psychoactive effect sought by the individual (Khantzian 1995; West, 2005).

Ulman and Paul (2006), in their fantasy-based self psychological model of addiction, believe that addiction is better conceptualised as a kind of self-hypnosis than a type of "self-medication". They state that an archaic form of narcissism, namely megalomania, is at the unconscious etiology of addiction. Like other forms of archaic narcissism, it could become developmentally arrested in the setting of a self-object milieu which lacks empathy. In certain cases, such a developmental arrest may lead to addiction in later life. When using, addicts enter into a hypnoid or dissociated state involving an archaic fantasy of being a self as a megalomaniacal being endowed with a form of magical control over psychoactive agents (things and activities), and addicts then imagine that through possession of these agents they will undergo a metamorphosis or transmogrification into a radically new state of being (Ulman & Paul, 2006).

Personality/intrapsychic approaches make a valuable contribution towards a better understanding of addiction, and personality (as well as intrapsychic factors) appears to contribute to the development of addiction. However, as DiClemente (2003) points out, personality factors or deep-seated intrapersonal conflicts account for a possibly important but relatively small part of a comprehensive explanation needed for addiction. The personality/intrapsychic models attempt to understand addiction from a phenomenological mode of inquiry.

Coping/social learning models

Some theorists argue that addiction is often related to a person's inability to cope with stressful situations. They believe that, as a result of poor or inadequate coping mechanisms, addicts turn to addiction as an alternative coping mechanism for temporary relief and comfort. An individual's inability to cope with stress and negative emotions has been identified as an etiological factor in many theories of addiction. Therefore, the coping/social learning models relate addiction to inadequate coping skills, which result from certain personality deficits in the individual (Wills & Shiffman, 1985). According to DiClemente (2003), emotion-focused coping has been identified as a particularly important dimension from a coping model perspective. Some believe alcohol is addictive because of its capacity for tension reduction and its dampening of the stress response (Cappell & Greeley, 1987). Researchers have shown that increased drinking after rehabilitation treatment is associated with both skills deficits and the failure to use alternative coping responses (Marlatt & Gordon, 1985).

The social learning perspective emphasises more than just deficits in coping skills; it emphasises social cognition. Bandura's social cognitive theory focuses more on cognitive expectancies, self-regulation and vicarious learning as explanatory mechanisms for addiction (Bandura, 1977, 1986). Also, this perspective highlights the role of peers and significant others as models. When advertisers use prominent public figures to promote a product, they are applying social influence principles.

Although coping and social learning perspectives have become popular in addictionology, generalised poor coping skills cannot be the only causal link to addiction. However, even if coping deficits do not sufficiently provide an etiological explanation, they certainly highlight an important consequence of addiction, namely the narrowing of the addict's coping repertoire (Shiffman & Wills, 1985). The coping/social learning models attempt to understand addiction from a phenomenological mode of inquiry, from a hermeneutical-interpretive perspective, from a cultural anthropological perspective, and finally from an autopoiesis theory perspective (as do many of the cognitive sciences). Although the

coping/social learning models do incorporate a multi-perspectival understanding of addiction they still chiefly focus on individuals' psychological processes.

Conditioning/reinforcement behavioural models

The compulsive use of addictive substances and process addictions is governed by reinforcement principles. Addictive substances and behaviours deleteriously affect the pleasure centres of the brain (Blume, 2004). The stimulation of the pleasure centre produces a euphoric experience that tends to positively reinforce addictive behaviour. Reinforcement can be positive or negative. Reinforcement models focus on the direct effects of addictive behaviour, such as tolerance, withdrawal and other physiological responses/rewards, as well as more indirect effects described in the opponent process theory (Barette, 1985; Soloman & Corbit, 1974). Positive reinforcement involves pleasurable consequences related to addictive behaviour. Negative reinforcement, as described by the opponent process theory, occurs when a person is rewarded through the substance reducing withdrawal or emotional distress. Both positive and negative reinforcement play a part in development and maintenance of the addictive process (Blume, 2004).

Some theorists have also suggested that Pavlovian conditioning is useful in understanding the addiction process. These individuals state that anticipatory drug-related behaviours can be linked to cues associated with the act of using the drug. Therefore, situational cues can elicit initial drug reactions and consequently lead to the resumption of the addictive behaviour (Hinson, 1985). More contemporary classical conditioning approaches include cognition and physiological mechanisms in their repertoire of cues and responses (Adesso, 1985; Brown, 1993). This has led to an integration of conditioning and social learning perspectives (DiClemente, 2003).

Today there is significant evidence for the role of conditioning and reinforcement effects in the addictive process, and as with all of the previously mentioned models it offers insight into the nature of addiction. However, conditioning/reinforcement behavioural models do not explain all initiation or successful cessation of addiction (Marlatt & Gordon, 1985). They predominantly attempt to understand addiction from a

phenomenological mode of inquiry, and by means of an autopoiesis theory perspective. These models tend to overemphasise a deterministic and behaviourist approach to addiction with disregard for many psychological factors, as well as providing an inadequate explanation from social and cultural perspectives.

Compulsive/excessive behaviour models

Some physiognomies of addiction, like the inability to successfully stop the behaviour, as well as its repetitive nature, have led theorists to link addiction with ritualistic compulsive behaviours. Theorists who link addiction to compulsive behaviours either come from an analytic or a biologically-based view. The analytic perspective views the compulsive component of addiction as reflecting deep-seated psychological conflict, whereas the biologically-based view understands the compulsive behaviour as a result of biochemical imbalances reflected in irregular neurotransmitter levels in the brain. Adherents of the first view would see treatment in terms of analysis, whereas adherents of the latter would explore psychoactive pharmacological treatments to bring the compulsive addictive behaviour under control (DiClemente, 2003).

Some theorists view addiction as excessive appetite (Orford, 2000). Increasing appetite leads to excess and the developmental process of increasing attachment, which is similar to elements of the social learning model. Potentially addictive substances share not only the potential for excess but also a similar process of leading to access. Both the compulsive and excessive behaviour models share the notion that an addicted individual's behaviour is out of control and that the addict is attempting to satisfy a psychological conflict or need (DiClemente, 2003).

Both the compulsive and excessive behaviour models add some explanatory potential to some of the existing models. However, they do not highlight all the variables needed in order to adequately explain the etiology of addiction or why individuals continue addictive behaviour. The compulsive and excessive behaviour models attempt to understand addiction from a phenomenological mode of inquiry, and by applying empirical observation methodologies when understanding compulsive addictive behaviours from a biologically-based view.

Spiritual/altered state of consciousness models

Apart from the more well-known models of addiction there are lesser-known models, perhaps equally important, that view the pathogenic and etiological roots of addiction from a spiritual, existential and altered state of consciousness (ASC) perspective. Empirical research has shown that an inverse relationship exists between spirituality and drug addiction, suggesting that spiritual involvement may act as a protective mechanism against developing an addiction, and that a lack thereof can contribute towards developing an addiction (Miller, 1997; Laudet et al., 2006). Some theorists have suggested that addiction is a spiritual illness, a disorder resulting from a spiritual void in one's life or from a misguided search for connectedness (Miller, 1998). For addicts, drugs become their counterfeit god. Therefore, addicts may be unconsciously pursuing the satisfaction of their spiritual needs through drugs or addictive behaviour. In a letter to Bill Wilson, the co-founder of AA, Jung (in Kurtz & Ketcham, 2002) pointed out that he believed "alcohol was the equivalent, on a low level, of the spiritual thirst of our being for wholeness, expressed in medieval language: the union with God" (p.113). In a sense, addicts and alcoholics, as Jung believed, are misguided mystics.

Many addicts state that they turned to drugs initially due to an existential void in their lives. Drugs instantly provided a new and often spectacular sense of meaning for them in an otherwise barren existence. Luigi Zoja (1989) states that:

The archetypal need to transcend one's present state at any cost, even when it entails the use of physically harmful substances, is especially strong in those who find themselves in a state of meaninglessness, lacking both a sense of identity and a precise societal role. In this sense it seems right to see the behavior of a drug addict who announces "I use drugs!" not only as an escape to some other world, but also as a naive and unconscious attempt at assuming an identity and role negatively defined by the current values of society (p. 15).

The author (Du Plessis, 2012b) has previously argued that viewing the etiological roots from an existential perspective is an important point of view to include in a comprehensive understanding of addiction. A sense of meaning and purpose is closely related to hope. Empirical findings show that recovering addicts who have hope are

better able to cope with life's crises (Sremac, 2010). Furthermore, (and closely related to existential etiological perspectives) the author is of the opinion that in some instances the etiological roots for certain individuals' addiction may be a dysfunctional attempt, borrowing the terms from Assagiloi (1975), at "self-realisation", and the consequent flawed channelling of "superconscious spiritual energies", energies to which these type of individuals are often sensitive - but which they have not found suitable ways to actualise. This type of transpersonal etiology (an existential quest for post-conventional meaning) should not be confused with a pre-personal etiology (narcissistic disturbance of self), which will result in a type of "pre/trans fallacy" (Wilber, 1995, 2000, 2006).

Some theorists believe that humans have an innate drive to seek ASCs, because they encompass systemic natural neurophysiological processes involved with psychological integration of orholotrophic responses and reflect biologically based structures of consciousness for producing holistic growth and integrative consciousness (Weil, 1972; Siegal, 1984; Grof, 1980, 1992). Winkelman (2001) believes that addicts engage in a normal human motive to achieve ASCs, but in a self-destructive way because they are not provided the opportunity to learn "constructive alternative methods for experiencing non-ordinary consciousness" (p. 340). From this viewpoint, drug use and addiction are not understood as an intrinsic anomaly, but rather as a misguided yearning for the satisfaction of an inherent human need. In considering possible etiological roots for our society's immense addiction problem through an ASC perspective, Winkelman (2001) states:

Since contemporary Indo-European societies lack legitimate institutionalized procedures for accessing ASCs, they tend to be sought and utilized in deleterious and self-destructive patterns - alcoholism, tobacco abuse and illicit substance dependence. Since ASC reflect underlying psychobiological structures and innate needs, when societies fail to provide legitimate procedures for accessing these conditions, they are sought through other means (p. 240).

For a comprehensive understanding of addiction, the inclusion of spiritual and ASC perspectives is essential, although addiction is too complex for its pathogenic origins to be

reduced to these elements alone. Furthermore, in some instances one could run the risk of a type of pre/trans fallacy by confusing developmentally arrested archaic narcissistic needs, and "symbiotic merging" and behaviour with post-conventional spiritual yearning, which is actually a fairly common phenomenon in certain drug subcultures (Almaas, 1996). The spiritual/altered state of consciousness models attempt to understand addiction from a phenomenological mode of inquiry, and a cultural anthropological perspective.

The biopsychosocial model

Dissatisfaction with the partial explanations proposed by the previously described single-factor models has prompted some theorists to propose an integration of these explanations (Donovan & Marlatt, 1988; Glantz & Pickens, 1992). By calling their model the biopsychosocial model, they suggest the integration of biological, psychological and sociological explanations that are crucial in understanding addiction. This model endeavours to unify contending addiction theories into an integrated conceptual framework. According to this model, addictive behaviour is therefore best understood as a complex disorder determined through the interaction of biological, cognitive, psychological and sociocultural processes. Addiction "appears to be an interactive product of social learning in a situation involving physiological events as they are interpreted, labelled, and given meaning by the individual" (Donovan & Marlatt, 2005, p. 7). The biopsychosocial model argues for multiple causality in the accusation, maintenance and termination of addictive behaviours.

Yet there are some academics who feel that the biopsychosocial model is also inadequate in explaining addiction, and that further integrative elements are needed to make this model's tripartite collection of factors functional. DiClemente (2003) states that "although the proposal of an integrative model represents an important advance over more specific, single-factor models, proponents of the biopsychosocial approach have not explained how the integration of biological, psychological, sociological and behavioral components occur" (p. 18). He further states that "without a pathway that can lead to real integration, the biopsychosocial model represents only semantic linking of terms or at best a partial

integration" (Ibid). DiClemente (2003) says that; "[t]he biopsychosocial model clearly supports the complexity of and interactive nature of the process of addiction and recovery. However, additional integrating elements are needed in order to make this tripartite collection of factors truly functional for explaining how individuals become addicted and how the process of recovery from addiction occurs" (p. 18). Without an orienting framework that can explain how these various areas co-enact and interlink, the biopsychosocial approach often represents merely a semantic linking of terms and exhibits limited integration.

Although the biopsychosocial model has not provided the field of addictionology with a truly comprehensive and integrative model, it was one of the first models to recognise the importance of treating the whole person, and not merely the addiction. This has contributed greatly to the application of more holistic treatment protocols (Sremac, 2010). The biopsychosocial model attempts to understand addiction from a multitude of perspectives, which include a phenomenological mode of inquiry, a hermeneutical-interpretive perspective, a cultural anthropological perspective, using empirical observation methodologies, an autopoiesis theory perspective, and finally a systems theory perspective.

The Transtheoretical Model

In an attempt to find commonality amongst the diverse models of addiction and seek integrative elements, DiClemente and Prochaska (1998) propose their Transtheoretical Model (TTM) of intentional behaviour change. The TTM "attempts to bring together these divergent perspectives by focusing on how individuals change behaviour and by identifying key change dimensions involved in this process" (DiClemente, 2003, p. 19). The primary developer of TTM, DiClemente (2003), argues for this model by stating that "[i]t is the personal pathway, and not simply the type of person or environment, that appears to be the best way to integrate and understand the multiple influences involved in the acquisitions and cessation of addictions" (p. 19).

The TTM proposes that the process of recovery from an addictive behaviour involves transition through stages described as the precontemplation, contemplation, preparation,

action and maintenance stages. Different processes are involved in the transition between these different stages, and individuals can move forwards and backwards through these stages of change (West, 2005). Proponents of this model believe a person's choices influence and are influenced by both personality and social forces, and that there is an interaction between the individual and risk and protective factors that influence the pathogenic origin or cessation of addiction. This process requires a personal journey through an intentional change process that is influenced at various points by a host of factors, as identified in the previously discussed explanatory models. "The stages of change, process of change, context of change, and markers of change identified in the TTM offer a way to integrate these diverse perspectives without losing the valid insights gained from each perspective" (DiClemente, 2003, p. 20).

Although this model indicates an integrative principle that is common to all the previous models, and although it highlights the dynamic and developmental aspects of addiction, it does not seem to provide a meta-theoretical framework that truly accommodates all the previous perspectives into an integrative framework. The TTM predominantly focuses on one dynamic integrating principle found in all the prominent addiction models, but does not provide the meta-paradigmatic framework needed for a metatheory of addiction. The model attracted substantial criticism, West (2005) states that "reservations have emerged about the model, many of which have been well articulated (p. 68). Yet the TTM has contributed greatly to our understanding of addiction and recovery as a dynamic process, by explaining it through a developmental-contextual framework. Furthermore, it has provided clinicians with a dynamic developmental framework to understand treatment resistance and ambivalence as well as to identify certain developmental markers indicative of positive change in recovery (Miller, 2006; Miller & Rollnick, 2002; Miller & Carroll, 2006). The TTM attempts to understand addiction applying structural-assessment techniques.

The need for integration

It is clear from the literature review that there appears to be very little consensus regarding the nature and etiopathogenesis of addiction. Furthermore, the integrative models have not yet been able to provide the sought-after integration.

From the discussion above it is clear that our explanation of addiction has become more sophisticated, there are still serious shortcomings in our understanding of it (DiClemente, 2003; Hill, 2010, Du Plessis, 2012b, 2014a, 2014b). Furthermore, there is such a cornucopia of theories and models of addiction that for treatment providers and policymakers, who see a direct link between etiology and treatment protocol, it has become exceedingly difficult to integrate this vast field of knowledge into effective treatment and prevention protocols.

The United States spends billions of dollars annually on the prevention and treatment of drug and alcohol abuse. For every dollar spent on addiction treatment there is a 4 to 7 dollar reduction in drug-related crime (NIDA, 2008). However, the unfortunate reality is that most treatment programmes have high levels of recidivism, limited annual and lifetime coverage with low success rates. Furthermore, studies show that many existing rehabilitation programmes may be no more successful than the spontaneous remission occurring in the untreated population (Alexander, 2008, 2010). Despite the magnitude of addiction's negative consequences for individual and civic well-being, we have failed to make adequate progress in controlling or preventing the spread of addiction on a global level. Alexander (2010) says that a "century of scientific research has not produced a durable consensus on what addiction is, what causes it, and how it can be remedied. (p. 1).

Consequently, some scholars believe there is a need for a theory that provides a parsimonious and integrative explanation for all the existing empirical data - a theory that can incorporate and integrate the exciting theories of addiction (DiClemente, 2003; West, 2005, Hill, 2010).

What is currently taking place in the field of addictionology is what Wilber (2003a) refers to as a "legitimation crisis" – a breakdown in the adequacy of a particular mode of

translating and making sense of the world. Subsequently, the current move in addictionology is towards more integrative models of addiction that can take into account new data in addiction studies, data which highlight the multidimensional, dynamic and complex nature of the addictive process.

Current integrative models lack a metatheory that adequately explains the simultaneous development, multi-causality and integration of the many factors in addiction (Hill, 2010; DiClimente, 2003). A truly comprehensive model of addiction should provide a meta-paradigmatic integrative framework highlighting how various perspectives co-arise and link together, without having to reduce one perspective to another.

The reason for Integral Theory

In this course we will point out that an Integral framework (Wilber, 2000, 2003a, 2003b, 2006; Esbjörn-Hargens, 2006, 2009) is a suitable philosophical foundation for the development of a comprehensive and inclusive approach to addiction. Wilber's (2000, 2006) Integral Theory is often referred to as the AQAL model, with AQAL representing all quadrants, all levels, all lines, all states and all types, with these five elements signifying some of the most basic repeating patterns of reality. Integral scholars believe that including all of these elements increases one's capacity to ensure that no major part of any solution is left out or neglected (Esbjörn-Hargens, 2009).

Integral Theory is both "complexifying", in the sense that it includes and integrates more of reality, and simplifying, "in that it brings order to the cacophony of disparate dimensions of humans with great parsimony" (Marquis, 2009, p. 38). The strength of Integral Theory is its ability to integrate vast fields of knowledge and, according to Marquis (2008), Integral Theory provides a "meta-theoretical framework that simultaneously honours the important contributions of a broad spectrum of epistemological outlooks while also acknowledging the parochial limitations and misconceptions of these perspectives" (p. 24). Wilber (2006) states that Integral Theory is comprehensive rather than reductionistic, and sees it as "a comprehensive map of human potentials" (p. 1).

Integral Theory has been applied in over 35 disciplines (Esbjörn-Hargens, 2006, 2009). The field of addiction studies and recovery is only one of these fields. Most of the articles published to date about the application of Integral Theory and substance abuse have focused on treatment design (Du Plessis, 2010; 2012a; Dupuy & Gorman, 2010; Dupuy & Morelli, 2007; Shealy, 2009; Amodia et al., 2005), and only recently have articles been published exploring the application of the Integral Theory in relation to etiological models of addiction (Du Plessis, 2012b, 2013, 2014a, 2014b).

What makes Integral Theory particularly useful is its post-metaphysical stance and metatheoretical ability. Integral Theory is "derived from the analysis of other theories, philosophies, and cultural traditions of knowledge" (Edwards, 2008a, p. 65). It is important to point out that Integral Theory is not strictly a theory. In theory, data is the relevant set of empirical and conceptual experiences about which the theory makes some validity claim (Meehl, 2002). Integral Theory is metatheoretical in that its elements are derived from the analysis of other theories. In other words, it "is not a theory because its subject matter is other theory and not the empirical world of immediate experience and the concepts and symbols that mediate those experiences" (Edwards, 2008a, p. 65). Edwards (2008a) points out a feature of Integral Theory which encapsulates the value it holds for this particular study, in that it "has the capacity to adjudicate on how theories, and the core second-order conceptual elements that constitute them, relate to each other, how they appear in balanced or in distorted forms, and how they are combined to develop systems of knowledge, categories of social policy, and forms of practice that can either emancipate or enslave us and our communities" (p. 66).

Simply put, Integral Theory could have the capacity (but is not limited) to evaluate:

- how existing etiological models of addiction arise, depending on the specific methodology applied, and accompanied by their underlying foundational worldviews (epistemological pluralism)

- how and why etiological models enact only certain specific features of addiction (ontological pluralism)

- a specific model's triadic relationship between epistemology, ontology and methodology
- the various conceptual shortcomings, as well as the strengths of different models
- how the various models give rise to specific injunctions, and
- how Integral Theory could provide an integrated meta-conceptual scaffolding.

All references to citation in the above introduction to this study unit can be found in Du Plessis (2014) Masters dissertation.

How do you know if you are an addict?

In Dupuy's teaching, he uses multiple definitions of what addiction is and what an addict is. This is part of the multi-perspectival efficacy of the Integral approach; we are not trying to reduce something to the simplest explanation, but we use the necessary complexity to gain a much clearer understanding of the disease and the treatment of addiction.

Integral Recovery was born in the smoke and the fire of the trenches, working in real-world situations with addicts, their families, and communities. When one is working with clients or patients who are in crisis and whose lives are threatened by the rapid progression of the disease, what matters most is what needs to be done to save and redeem the suffering individual's life, their families, and communities. As this course develops, we will begin to see clearly how the Integral model elegantly serves this purpose.

For years, when teaching students in treatment programs, I [John Dupuy] have begun with a talk entitled "Am I an Addict?" First, I assure the students that I have no agenda to prove that anyone there *is* an addict—I simply want to supply the information to enable them to honestly evaluate their situation in the light of what we know about this disease. Why is this important? Because if one is a drug addict or alcoholic, one has a terminal disease that will eventually land one in an early grave or,

at the bare minimum, affect the quality of one's life to such an extent that death often seems to be an acceptable alternative.

Let me define three terms: an addict, chemically dependent, a drug abuser. For many years, the terms chemical dependency and addiction were used synonymously. However, more recently, we have begun to differentiate between them. Here is an example: Say you were in an accident and suffered physical trauma and were given the powerful narcotic OxyContin to treat the pain. After three weeks of using OxyContin, you decide you have had enough and you quit. While quitting, you experience the symptoms of physical withdrawal from this addictive substance. However, after the withdrawal symptoms, there is no thought of returning to using the drug. This is a good example of being physically or chemically dependent on an addictive substance.

On the other hand, say you are a heroin user and you are sentenced to a long prison term, maybe eight years in the federal pen. Assuming, for the sake of our example, that you have no access to addictive substances while in prison and are eventually released after serving your full sentence. The first thing you do is go to a bar and then go on the prowl for more heroin. This is an example of addiction. In other words, chemical dependency is purely a physical dependency that goes away after the initial withdrawals, but addiction involves mental obsession with getting and taking drugs.

Now let's look at a drug abuser. I think it is safe to say that in our current culture most of us have some relationship with addictive substances, either during high school or college years or thereafter. Many of us even go through periods of abusing drugs or alcohol to the extent that this use and abuse begins to negatively affect our lives.

For example, we may often feel hung-over and this begins to affect our job, school performance, and relationships. Seeing these negative consequences of drug and alcohol use, the abuser can and does make the decision to quit or moderate the

intake of mind-altering substances. This is an example of drug abuse, which can be controlled and moderated by conscious decisions and willpower. The addict, on the other hand, is, by definition, a person who has begun to suffer negative consequences in their life because of their drug use, but is unable to moderate or stop using, even in the face of multiplying and, at times, catastrophic consequences.

These distinctions are important to note, because often when we encounter new patients and students, we don't know whether they are merely abusing drugs or whether they are addicted. The question "Am I addicted?" is an extremely important one to answer as it could have life or death consequences.

To start with, I ask my students, "What do you think about from the time you wake up in the morning until you pass out at night?" If the answer is getting and taking drugs, you are probably an addict. Normal people don't think that way. In other words, addiction is an overwhelming compulsion to get and take drugs, even in the face of catastrophic consequences in the life of the user. This compulsion is fuelled by overpowering cravings, which, in the reality of the addict, are more important than life itself. Obviously, addiction does not start off this way but rapidly progresses to this stage of terminal use and death.

One useful definition of addiction is the compulsive attachment to certain states of consciousness produced by the drug in order to avoid other states of consciousness, such as depression, fear, anxiety, despair, etc. Drugs produce temporary changes in states of consciousness, the "high", which can offer temporary relief from the above-mentioned negative states. This quickly leads to a compulsive craving for the desired states and a complete and compulsive avoidance of the detested and feared negative states.

Another powerful indication of addiction can be a radical personality change from the former, sober self to the using and addicted self. I refer to this as the Dr. Jekyll/Mr. Hyde Syndrome. In other words, if the formerly loving husband, wife,

son, daughter, boyfriend, or girlfriend turns into an angry and sociopathic Mr. Hyde-like character, we are probably dealing with an addict.

In conclusion, three important points to know about addiction are:

1) It is progressive. It starts out as a small thing and soon grows to being in complete control of the afflicted person's life.

2) The disease of addiction, as things now stand, is chronic. There is much talk about an addiction cure; however, I have yet to see convincing evidence of this.

3) Finally, if not treated, the disease is terminal. It will eventually kill you (if something else doesn't get you first). In our current society in the U.S., it is estimated that 10% of us have the propensity to become addicts. This means that virtually none of us are unaffected by the disease, either personally or in our relations.

The Nature of Addiction

As the disease progressively distorts the function of the brain and the neurocortex with its incessant demands for the desired substance(s), there is a radical negative transformation of the personality. Hence, the Dr. Jekyll/Mr Hyde Syndrome. For those of you who have read the book by Robert Louis Stevenson, or seen movies based on the book, you will recall the story of good Dr. Jekyll, a respected physician and pillar of society in Victorian London, who begins to experiment with ingesting chemicals in his laboratory and then transforms from the good and noble Dr. Jekyll to the sociopathic and murderous Mr. Hyde. It has been said that Robert Louis Stevenson was actually using this story as a metaphor for cocaine addiction, which was just coming into vogue at the time.

To us, this radical personality shift— from the formerly loving, good enough father, son, daughter, wife, boyfriend, girlfriend, employee, etc. into an angry, manipulative, self-centered, lying, stealing, cheating source of chaos and pain— has always been one of the slam-dunk proofs that we are dealing with addiction in an individual. Those of us who don't understand the disease of addiction are left with despair, anger, sadness, and puzzlement. How did this happen? Why is my husband acting this way?

For those who understand the disease, this is just part and parcel of the behavioral problems caused by this disease of the brain. The litany of addictive behaviors includes manipulation, lying, stealing, rage, and betrayal. Sometimes, the former self, or real self, will shine through the addictive trance and the addict will feel remorse and shame about what he has done and will promise to change and reform. This intention is often sincere, however, the very nature of the disease prevents him from carrying it out. This is then seen by the addict's loved ones as simply another betrayal, which it in fact is.

The Problem of Denial

Another characteristic of the disease is denial, which really involves self-deception. This usually goes something like, "I'm not an addict. I can stop anytime I want. I'm just not ready to stop." Another one I recently heard from a student was, "At least I never stole from my family." This was a story that he told himself, which allowed him to hold on to a bit of dignity. However, when his family members sent in their 'Impact Letters,' which are letters telling the addict how their addictive behaviors have hurt and influenced the writer personally (these letters are read out loud by the addict to other students and staff at the treatment center), it became clear that the individual had indeed stolen from his family in many subtle and not so subtle ways. This is an example of how denial is a defense mechanism to keep the addict from the awful truth of their addiction and how it is affecting others.

One of the classic denials that individuals come up with is, "It's my life. I can do whatever I want and it doesn't affect anyone else." In the early stages of treatment and recovery, this illusion is shattered. There is often a painful and shameful recognition of how much damage has been done to those the addict should care about most. Please note that this is not toxic shame, but a very real accounting and taking responsibility, and feeling emotions that were formally avoided while under the narcoticizing influence of the addictive substances. The realization, "Oh my God, what have I done!" should and often does become a strong motivator for the addict in recovery to continue their work.

An aside: One of the truisms that we teach our students is that relapse always begins with a case of the "F___ its." Recently, however, we had a student tell us that after a brainwave entrainment meditation session he thought, "F___ it. It's not just about me." This was one of the few times we saw the recovery process begin with the F____ its. :-)

The Addict Self

A key metaphor we use to describe the recovery process is as follows: A young man has a dream in which he sees two dogs savagely fighting each other. One dog appears to be a very beautiful and noble dog, the other an evil, dangerous-looking junkyard dog. The young man awakes very scared and disturbed by the dream. He goes to his teacher, which in this version of the story is a Native American medicine man, and says, "Grandfather, I had this very disturbing dream and I don't understand it." The young man recounts the dream to his teacher and the teacher says, "Grandson, the noble dog in your dream is your noble, true self. The evil-looking dog is your evil (addict) self. But have no fear, Grandson. The noble and good dog will win." The young man then says, "Grandfather, how can you know this?" The elder replies, "Because, Grandson, you're going to feed the good dog."

This is a beautiful metaphor for the recovery journey. In Integral Recovery, in all of our Integral Recovery Practices, we are feeding the good dog and starving the addict self. This can also be illustrated by imagining a large circle, which we call the addict self. Inside the large circle, there is a much smaller circle, which we will call the real self. When a student arrives at primary treatment, often the addict self is huge and calling all the shots. As the recovery process is initiated, continues, and deepens, the addict self, or the large circle, begins to shrink. The real self, the small circle, begins to grow. At the end of successful treatment, the big circle will be the real self and the small, subservient circle will be the addict self. Note that the addict self is still there and has not disappeared. That is to say, the potential for relapse in the addict self is always there and needs to be accounted for. In Integral Recovery, we account for and deal with this by continued abstinence and a lifetime adherence to Integral Recovery Practice.

Stages of Addiction

Stage 1 — The Romance Phase

The first stage in the progression of the disease, I call the romance phase. This is when the person is absolutely in love with the drug and has, as of yet, suffered no negative consequences, or very few, which pale in comparison to the good effects felt by ingesting the substance(s).

It is difficult to deal with an addict in this phase of the disease. (Note, we say, difficult, but not impossible.) In classic AA thought, as we mentioned above, one has to let the alcoholic "hit bottom" before change can happen. However, now it is generally agreed that family members working together can raise that bottom by no longer enabling the addict and forcing them to get into treatment. This means you don't have to wait to intervene until your teenage daughter is literally selling her body to get money for drugs. (Thank God.) Experience has shown that those who come

to treatment because of external motivators and those who come willingly seem to have the same success rates.

In the romance stage, it is love, love, love, and drugs are seen as not only the answer, but absolutely the meaning of life. A good film to illustrate this is Train Spotting. In the beginning of the film, the heroin users are beautiful, hip people having a grand time. As the film moves on, we observe their descent into hell.

Stage 2 — The Balancing Act

At this stage, the addict is more or less able to maintain a semblance of normal life. They will cover up their use, make excuses, tell lies, etc., in order to hide their drug use, and, depending on the individual, this can be carried off with some level of success for a time. However, as the disease continues to progress, the lies become too numerous and the falsehoods too obvious and the addict's life begins to break down in all four quadrants. Often addicts in this stage will compare themselves with other addicts, saying, "Well, at least I'm not as bad as Jimmy; he died." Or, "Jane is in prison….. so, I must still be okay."

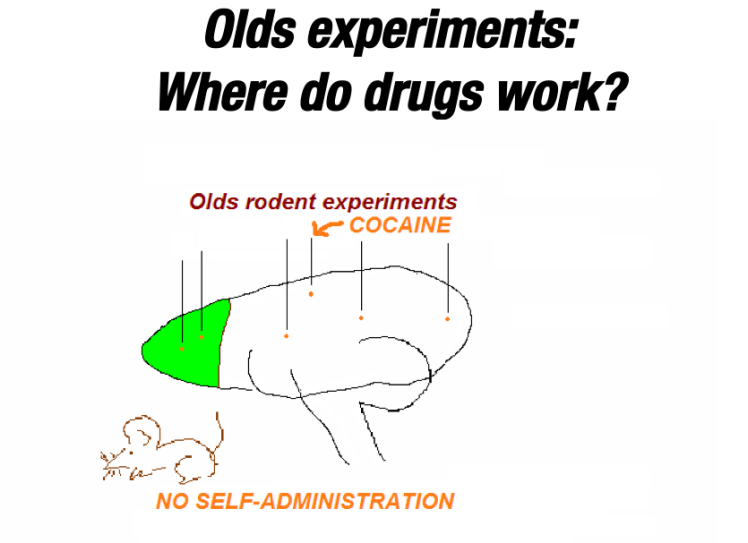
Stage 3 — Over the Edge

In the last stage of the disease, which we call Over the Edge, denial begins to break down and the addict accepts the fact that they are addicted and nothing else really matters. At this point, the charade has ended and even the personal narrative "I can quit whenever I want" is no longer believed. One is an addict and one gets and takes drugs and that is all that matters from moment to moment, minute to minute, hour to hour, and day to day.

Addiction as a "Brain Disease"

In the following section we look at addiction from a neurophysiology perspective, which accounts for the some mysterious behaviors of an addict. It must be noted that the "brain disease" model is not the only but one of many valid perspectives of addiction.

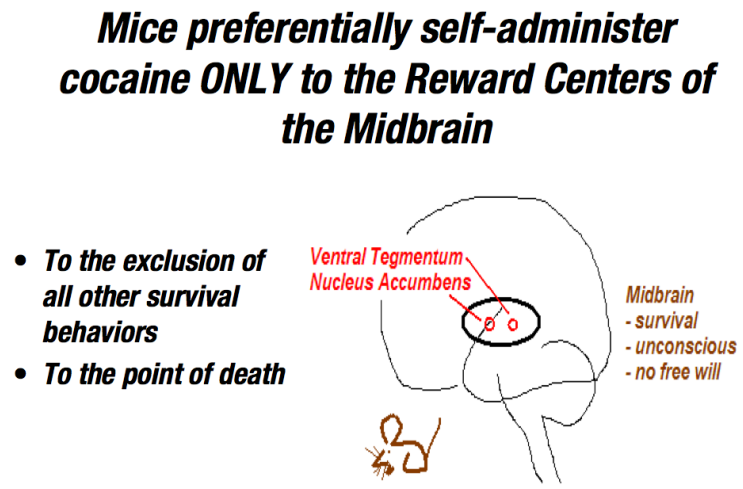
In the 1950s, there was a series of now-famous experiments, conducted by Dr. Olds and his associates, attempting to find out which part of the brain is affected by addictive substances. The scientists began by injecting cocaine into the frontal lobes of a laboratory mouse. It was suspected that this was the locus of the disease of addiction because of the notable and observable behavioral changes that happen when someone becomes addicted to drugs or alcohol.



Courtesy of Dr Kevin McCauley, MD – www.instituteforaddictionstudy.com.

Much to the experimenters' puzzlement, however, no effects were noted from these frontal lobe injections. The experimenters' second choice was to inject cocaine into the limbic system, or the emotional center of the mouse's brain. Again, surprisingly, there were no effects. Finally, experimenters injected cocaine into the reptilian brainstem of the mouse, the most primitive part of the mammalian brain.

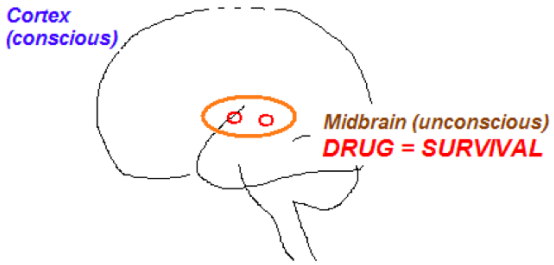
This time, the effects of the cocaine were immediately noted. The mice quickly became addicted to the extent that they preferred a supply of cocaine over any other essential needs, including food, safety, or sex.



Courtesy of Dr Kevin McCauley, MD – www.instituteforaddictionstudy.com.

The mice were given control over their own supplies of cocaine, and, completely overwhelmed by cravings for the drug, they would keep the supply of cocaine going to their brains and eventually starve to death, even when ample food was available in their cages.

The Drug becomes Survival at the level of the unconscious . . .



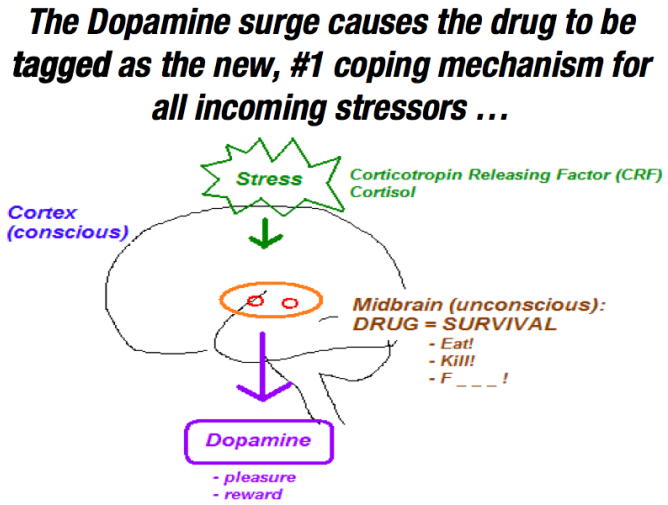
Courtesy of Dr Kevin McCauley, MD – www.instituteforaddictionstudy.com.

As Dr. Olds and his colleagues' understanding grew, they saw that cocaine and other addictive substances were affecting the primitive reward system in the brain, which supplies dopamine (the "feel good" neurochemical) as a reward for behaviors necessary to survival, such as fight, flight, food, sex, etc. The drugs were having the effects of a pseudo-dopamine, replacing the brain's natural dopamine (which is quickly exhausted and depleted by continued drug use) and leading the mice to equate fulfilling their drug cravings with their actual survival. In fact, taking drugs became more important than actual survival, because the drugs produce more dopamine-like substances than actual survival activities (sex, eating, etc.) produce dopamine.

The brain subscribes the utmost importance to the activities that supply the most chemical reward, in this case, the drugs or the pseudo-dopamine. This explains why, when the drugs are removed in early recovery, addicts become anhedonic; in other words, they cannot experience pleasure in any of the normal pleasurable activities of life, such as relationships, exercise, sports, TV shows, etc. Without any drugs, and with their natural supplies of the "feel good" neurochemicals, dopamine and serotonin, depleted from drug use, the addict experiences no pleasure–at least

temporarily until the brain has a chance to rebalance itself. This, as one might imagine, leads to continued relapse, because without the drugs there is no pleasure, and without pleasure there is no hope for a better life. Life seems virtually unlivable without the highs that the drugs provide.

These experiments were later replicated with other mammals and it soon became clear that in the brain of the addicted animal or person, the drug and the associated high becomes identified with survival itself. This is often difficult for the non-addicted to understand, but it's perfectly clear and understandable to those of us who have suffered from the disease of addiction. Initially, the user experiences great pleasure from the pseudo-dopamine provided by addictive substances, but, based on studies conducted by NIDA (the National Institute on Drug Abuse) the drug then begins to change the function of the neo-cortex, where the supply of dopamine and pseudo-dopamine is determined as being more important than absolutely anything else. Quickly, in the brain of the addict, the drug becomes the only thing that can cause pleasure or has any degree of importance.



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This, therefore, explains an addict's behavior, where all normal human relationships are disregarded and abandoned in the never-ending quest for the drugs and the high. We now know that addiction is a disease. The organ affected is the brain. The defect is in the reptilian brainstem and the reward system of the brain, which soon compromises the other functions of the brain as well, especially in the neo cortex. The symptoms of the disease are 1) overpowering cravings for the addictive substance(s), and 2) the negative behaviors associated with the addict's single-minded drive to use and take drugs.

This means that addiction is not caused by lack of willpower, sin, or an "addictive personality." However, the disease will cause an individual to sin and it will destroy one's willpower and cause catastrophic damage to one's character.
More discoveries are constantly coming online regarding addiction's effect on the functions of the brain. Given our new and ever-increasing understanding of addiction as a brain disease, what then should we do? This raises huge moral, ethical, legal, and philosophical questions. Is addiction something to be punished or treated as a medical disease? We will explore these topics further as the course progresses.

Courtesy of Dr Kevin McCauley, MD – www.instituteforaddictionstudy.com.

3 Basic Neurochemicals Associated with Addiction

1. Dopamine is the neurotransmitter that is associated with the brain's reward system. That which supplies the most dopamine is interpreted by the neocortex as that which is most important. In the case of the addict, this is not love, not God, not family or country–this is drugs.

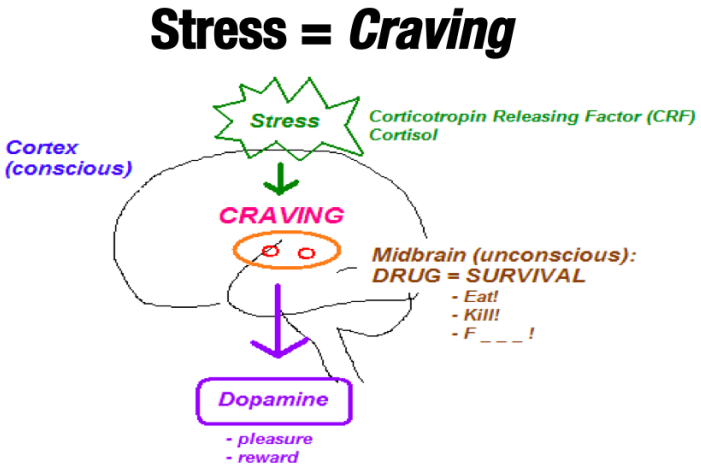
Dopamine-Releasing Chemicals

- **Alcohol & Sedative/Hypnotics**
- **Opiates/Opioids**
- **Cocaine**
- **Amphetamines**
- **Entactogens (MDMA)**
- **Entheogens/Hallucinogens**
- **Cannabinoids**
- **Inhalants**
- **Nicotine**
- **Caffeine**
- **Steroids**

Courtesy of Dr Kevin McCauley, MD – www.instituteforaddictionstudy.com.

2. Serotonin, on the other hand, has a calming effect. It is the neurochemical that is associated with balance, as it balances out the high energy of dopamine with a satiated, contented feeling. For example, after sex, which hopefully has been a pleasurable activity, we feel satiated. That is because after the powerful spike of dopamine during lovemaking and orgasm, the dopamine decreases but serotonin increases, which leaves us with the pleasant afterglow of good feelings and satiation. Serotonin is an essential neurochemical that is often lacking in sufficient supply in the brain of the addict to begin with and is further depleted through the use of the addictive substances. The lack of serotonin leads to depression and the inability of the addict to ever be satiated. In other words, the highs are never enough because there is not enough serotonin left to balance out the pseudo-dopamine highs supplied by the drugs.

3. Cortisol is a neurochemical that is associated with high levels of stress and anxiety. It is often found in greater than normal amounts in the brain of the addict. It is the high levels of stress-inducing cortisol that lead to increased cravings and relapse.

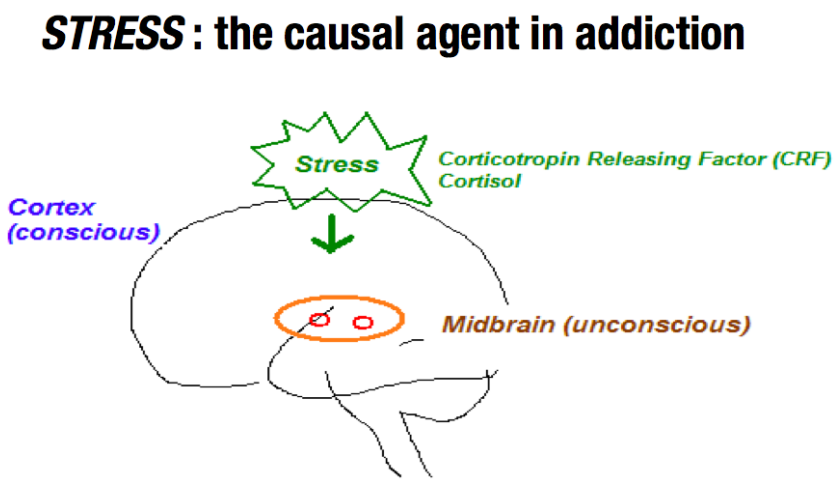


Courtesy of Dr Kevin McCauley, MD – www.instituteforaddictionstudy.com.

If a treatment modality is to be neurologically sound, it has to account for these three very important and causative neurochemicals, i.e. low levels of serotonin and dopamine, and high levels of cortisol.

Public Enemy #1 is Stress

As Dr. Kevin McCauley brilliantly illustrates in his lecture and DVD, *Pleasure Unwoven*, stress is the number one factor in the activation of addicted genes. It is the primary cause, neurologically, of relapse in the brain of the addict. In other words, you could have identical twins, both with the same genetic predisposition to become an addict, and one will become an addict while the other will not. Why? Because the key to activating one's addicted genes and genetic potential is chronic and unrelieved stress.



Courtesy of Dr Kevin McCauley, MD – www.instituteforaddictionstudy.com.

This chronic and unrelieved stress might be caused by chemical imbalances in the brain; unresolved trauma from the past; negative personal narrative stories about one's self and the world; the inability to cope with the present; the lack of meaning or connection in one's life (also known as existential despair); and toxic environments, which could be spiritual, chemical, emotional, a poor diet, etc. All of these conditions cause stress, which, in the brain, neurologically speaking, means low serotonin and high cortisol and other stress-related neurochemicals. The stress-related neurochemicals cause the individual to feel anxious, depressed, a prisoner in their own skin, and the beginning addict will self medicate with addictive substances in order to avoid these feelings. In the case of the addict in recovery, trying to stop using creates stress, which then leads to increased cravings for drugs and, more often than not, to eventual relapse and a continuation of the downward spiral of the progression of the disease.

A simple but very accurate way of looking at recovery is that it is the treatment of stress. When one looks at Integral Recovery and the Integral Recovery practices, each of them can be seen as a means of coping more effectively with stress and at the same time reducing its harmful effects. Together, the practices work

synergistically and are extremely powerful in combating Public Enemy #1 and keeping the individual sober and healthy.

Study Material for Study Unit 2

📖 *The first reading assignment for Study Unit 2 is Chapter 1 of Integral Recovery (Dupuy, 2013. pp. 15 - 30). This chapter provides an introduction to addiction, and gives a good overview of addiction when viewed from a neurological perspective as a "brain disease".*

📖 *Note what facets of addiction are highlighted by Integral Theory and often overlooked by the majority of researchers and clinicians.*

✍ *Read "Toward an Integral Model of Addiction By Means Of Integral Methodological Pluralism as a Meta-theoretical and Integrative Conceptual Framework" by Du Plessis (2012b). This article introduces and briefly outlines some orienting generalizations of an integrally informed model of addiction. Du Plessis argues that by applying Integral Theory as a meta-theoretical and transdisciplinary framework, we may be able to arrive at a comprehensive integrative model of addiction that honors all the existing single-factor etiopathogenic models as well as the integrative and dynamic models.*

✍ *Read Du Plessis, G. P. (2014). An Integral Ontology of Addiction: A multiple object existing as a continuum of ontological complexity. Journal of Integral Theory and Practice, 9(1), 38–54. This article serves as a critique and*

expands conceptually and metaparadigmatically on his previous article (2012b).

Audio and Video for Study Unit 2

- *Watch the 4- part video "Are You an Addict?" (Parts 5A, B, C, & D of the John Dupuy video series on Integral Recovery), which can be downloaded from http://www.integralrecovery.com/video/introduction-to-integral-recovery-video-series-part-5a-are-you-an-addict).*

- *Also watch, "What IS Addiction?" (Part 6 of the John Dupuy video series on Integral Recovery), which can be downloaded from http://www.integralrecovery.com/video/introduction-to-integral-recovery-video-series-part-6-what-is-addiction. Here Dupuy provides a succinct discussion on the nature of addiction from an Integral perspective.*

Assignment for Study Unit 2

- *Write a 2 - 4 page essay on what you believe to be the most important insights an Integral perspective brings to our understanding of addiction.*

- *Send assignment to your Faculty Mentor.*

Well done. You have come to the end of Study Unit 2!

Study Unit 3

Alcoholics Anonymous: The Beginning of the Modern Recovery Movement

Learning Objective for Study Unit 3:

1: To understand the history of Alcoholics Anonymous as foundational to the modern recovery movement and therefore of Integral Recovery itself

2: To understand both the strengths and the weaknesses of the AA model.

Introduction to Study Unit 3

"…Spiritual experiences, James thought, could have objective reality, almost like gifts from the blue, they could transform people. Some were sudden brilliant illuminations; others came on very gradually. Some flowed out of religious channels; others did not. But nearly all had the great common denominators of pain, suffering, calamity. Complete hopelessness and deflation at depth were almost always required to make the recipient ready.

- Bill W.

12-Step Philosophy and Fellowship

Twelve-step programs are considered by many to be the most effective treatment protocol in the treatment of addictions. Furthermore, "Alcoholics Anonymous has been called the most significant phenomenon in the history of ideas in the twentieth century."[i]

Research shows that 12-step affiliation buffers stress significantly, and therefore, leads to an enhanced quality in the recovering person's life.[ii] A recent longitudinal study found that AA affiliation and the application of AA-related coping skills were predictive of reduced substance abuse. The same study found a causal relationship with AA affiliation and self-efficacy, changes in social network support and abstinence; thus expanding existing literature that suggests the same relationships.[iii]

Winkelman believes that AA is currently the most successful substance abuse rehabilitation approach and that its success is due to its emphasis on spirituality. It is AA's understanding that spirituality ultimately dries out the possessive spirit of addiction.

Flores believes that 12-step meetings provide identification, support, and sharing of common concerns, which are powerful curative forces. Only recently have professionals understood the therapeutic value of groups. What AA intuitively realized, Yalom and others are only now taking advantage of. Peers are often more significant than professionals in producing behavioural change. It is imperative that recovering individuals recover by 'living in consultation' and that their recovery process is contained within some form of a larger supportive community.

Any recovery approach that does not include a supportive informed community will generally be unsustainable. The 12-step fellowships (Alcoholics Anonymous, Narcotics Anonymous, etc.) provide extensive, easily accessible, well established and knowledgeable recovering communities.

The Minnesota Model (MM), a 12-step abstinence-based approach, has been the principal model of treatment in the United States for the past 30 years. It is a client-centered approach, maintaining that the resources for recovery lie within the addict, with treatment merely providing the therapeutic environment and opportunity for the individual to discover his/her own potential. In line with AA's existential philosophy, the MM requires addicts to recognize personal choice and responsibility in all their affairs.

The History of the Twelve Steps

The official starting date of AA is 1935, but actually it originated much earlier with its founder William Griffith "Bill" Wilson. Wilson was a seemingly hopeless alcoholic who made and eventually lost fortunes on Wall Street. He tried a multitude of techniques to control his drinking and failed every time. In November 1934, during Wilson's fourth and final hospitalization—at the point of hopelessness and despair—he was visited by Ebby Thatcher, a "hopeless" alcoholic like Wilson who was sober. Ebby T. revealed to Wilson that he would get sober after joining the Oxford Group Movement due to a recommendation by Rowland Hazard, who was treated by Carl Jung. Roland travelled to Zurich, Switzerland in 1931 to enter analysis with Jung after trying virtually every then-known cure for alcoholism. Shortly after his return to the US, he relapsed.

After the relapse, he was told by Jung that he was "frankly hopeless as far as any further medical and psychiatric treatment was concerned."[iv] The only possible source of hope, Jung suggested, might be a "spiritual or religious experience—in short a genuine conversion."[v] Jung cautioned him "that while such had sometimes brought recovery to alcoholics, they were…comparatively rare".[vi]Only much later did Wilson realize the significance of the story. Thatcher also introduced him to the work of William James.

Wilson shared this information with his doctor, William D. Silkworth. Through the influences of Jung, Silkworth, and Ebby T., a series of events was set in motion that would help to create the foundation of the AA program. It was Silkworth's influence that helped to lay the foundation of the disease concept.

On the 14th of November 1934, Wilson found himself in a hospital, being treated for a severe drinking spree. On this occasion, he had what is typically described in philosophical and religious literature as a mystical experience. Wilson said of this experience: "I now found myself in a new world of consciousness which was suffused by a Presence. One with the universe, a great peace stole over me."[vii] The day after Wilson's mystical experience, Ebby T. gave him James's *Varieties of Religious Experience.* Wilson poured over James's writing and this helped him to understand and contextualize his own mystical experience, and provided valuable insight for the future development of the Twelve Steps. Wilson states that: "…Spiritual experiences, James thought, could have objective reality, almost like gifts from the blue, they could transform people. Some were sudden brilliant illuminations; others came on very gradually. Some flowed out of religious channels; others did not. But nearly all had the great common denominators of pain, suffering, calamity. Complete hopelessness and deflation at depth were almost always required to make the recipient ready. The significance of all this burst upon me. *Deflation at depth*—yes, that was *it*. Exactly that had happened to me".[viii]

Kurtz goes on to explain the historical significance that the above insight of Wilson had for the development of AA.

> This was the substance of what Wilson had come to understand; also important was the meaning he found inherent in it, for his moment was—taken together with his "spiritual experience"—the third of the four founding movements of Alcoholics Anonymous. One-half of the core idea—the necessity of spiritual conversion—had passed from Dr. Carl Jung to Rowland. Clothed in Oxford Group practice, it had given rise to its yet separate other half—the simultaneous transmission of deflation and hope by "one alcoholic talking to another"—in the first meeting between Bill and Ebby. Now under the benign guidance of Dr. Silkworth and the profound thought of William James, the two "halves, joined in Wilsons's mind to form an as yet only implicitly realized whole."[ix]

Wilson intuitively realized that this "deflation at depth" was a crucial component of his recovery process. Consequently, surrender has become a cornerstone of AA's Twelve Steps to recovery. "One submits to the alien and becomes diminished through submission, one surrenders one's isolation to enter a large unit and enlarges one's life."[x]

In Wilson's incessant attempt to understand his "mystical experience" he studied the works of William James, contemplated the statements of Jung, and observed the practices of the Oxford Group Movement.

Jung's influence proved to be important in Wilson's development of AA philosophy. In a letter to Wilson, Jung wrote, "You see alcohol in Latin is "spiritus" and you use the same word for the highest religious experience as well as for the most depraving poison. The helpful formula therefore is: spiritum contra spiritus."[xi]. This confirmed Wilson's and subsequently AA's belief that only a spiritual awakening will keep an alcoholic sober.

Christina Groff, co-creator of Holotropic Breathwork with her husband Dr. Stanislav Groff, says this about her own recovery from alcoholism in an interview:

> I had spent a lot of time in kind of non-ordinary worlds and being interested in the spirit, and I had to get right back down to ground zero. And then what was very surprising was that in the recovery community there were spiritually-based recovery programs, and I became familiar with, for example, the Twelve Step programs, and I began to realize that something like the Twelve Steps contains within it the same wisdom as other spiritual traditions that I'd been attracted to. It was a much more ordinary kind of grounded language than a lot of traditions I'd been interested in, and there was this large community of people who had been doing the work who knew how to guide me that I could ask questions of and ask for support. And it was like coming home.[xii]

What follows is the letter of appreciation that Wilson wrote to Jung in January 1961. It superbly sums up the development of AA. I quote the letter in its entirety as it provides wonderful insight into the historical roots of AA.

My dear Dr. Jung:

This letter of great appreciation has been very long overdue.

May I first introduce myself as Bill W., a co-founder of the Society of Alcoholics Anonymous. Though you have surely heard of us, I doubt if you are aware that a certain conversation you once had with one of your patients, a Mr. Rowland H., back in the early 1930s, did play a critical role in the founding of our Fellowship.

Though Rowland H. has long since passed away, the recollections of his remarkable experience while under treatment by you has definitely become part of AA history. Our remembrance of Rowland H.'s statements about his experience with you is as follows:

Having exhausted other means of recovery from his alcoholism, it was about 1931 that he became your patient. I believe he remained under your care for perhaps a year. His admiration for you was boundless, and he left you with a feeling of much confidence.

To his great consternation, he soon relapsed into intoxication. Certain that you were his "court of last resort," he again returned to your care. Then followed the conversation between you that was to become the first link in the chain of events that led to the founding of Alcoholics Anonymous.

My recollection of his account of that conversation is this: First of all, you frankly told him of his hopelessness, so far as any further medical or psychiatric treatment might be concerned. This candid and humble statement of yours was beyond doubt the first foundation stone upon which our Society has since been built.

> Coming from you, one he so trusted and admired, the impact upon him was immense. When he then asked you if there was any other hope, you told him that there might be, provided he could become the subject of a spiritual or religious experience—in short, a genuine conversion. You pointed out how such an experience, if brought about, might re-motivate him when nothing else could.

But you did caution, though, that while such experiences had sometimes brought recovery to alcoholics, they were, nevertheless, comparatively rare. You recommended that he place himself in a religious atmosphere and hope for the best. This I believe was the substance of your advice.

Shortly thereafter, Mr. H. joined the Oxford Group, an evangelical movement then at the height of its success in Europe, and one with which you are doubtless familiar. You will remember their large emphasis upon the principles of self-survey, confession, restitution, and the giving of oneself in service to others. They strongly stressed meditation and prayer. In these surroundings, Rowland H. did find a conversion experience that released him for the time being from his compulsion to drink.

Returning to New York, he became very active with the "O.G." here, then led by an Episcopal clergyman, Dr. Samuel Shoemaker. Dr. Shoemaker had been one of the founders of that movement, and his was a powerful personality that carried immense sincerity and conviction.

At this time (1932-34) the Oxford Groups had already sobered a number of alcoholics, and Rowland, feeling that he could especially identify with these sufferers, addressed himself to the help of still others. One of these chanced to be an old schoolmate of mine, Edwin T. ("Ebby"). He had been threatened with commitment to an institution, but Mr. H. and another ex-alcoholic "O.G." member procured his parole and helped to bring about his sobriety.

Meanwhile, I had run the course of alcoholism and was threatened with commitment myself. Fortunately I had fallen under the care of a physician—a Dr. William D. Silkworth—who was wonderfully capable of understanding alcoholics. But just as you had given up on Rowland, so had he given me up. It was his theory that alcoholism had two components—an obsession that compelled the sufferer to drink against his will and interest, and some sort of metabolism difficulty which he then called an allergy. The alcoholic's compulsion guaranteed that the alcoholic's drinking would go on, and the allergy made sure that the sufferer would finally deteriorate, go insane, or die. Though I had been one of the few he had thought it possible to help, he was finally obliged to tell

me of my hopelessness; I, too, would have to be locked up. To me, this was a shattering blow. Just as Rowland had been made ready for his conversion experience by you, so had my wonderful friend, Dr. Silkworth, prepared me.

Hearing of my plight, my friend Edwin T. came to see me at my home where I was drinking. By then, it was November 1934. I had long marked my friend Edwin for a hopeless case. Yet there he was in a very evident state of "release" which could by no means be accounted for by his mere association for a very short time with the Oxford Groups. Yet this obvious state of release, as distinguished from the usual depression, was tremendously convincing. Because he was a kindred sufferer, he could unquestionably communicate with me at great depth. I knew at once I must find an experience like his, or die.

Again I returned to Dr. Silkworth's care where I could be once more sobered and so gain a clearer view of my friend's experience of release, and of Rowland H.'s approach to him.

Clear once more of alcohol, I found myself terribly depressed. This seemed to be caused by my inability to gain the slightest faith. Edwin T. again visited me and repeated the simple Oxford Group's formulas. Soon after he left me I became even more depressed. In utter despair I cried out, "If there be a God, will He show Himself." There immediately came to me an illumination of enormous impact and dimension, something which I have since tried to describe in the book "Alcoholics Anonymous" and in "AA Comes of Age", basic texts which I am sending you.

My release from the alcohol obsession was immediate. At once I knew I was a free man. Shortly following my experience, my friend Edwin came to the hospital, bringing me a copy of William James' "Varieties of Religious Experience". This book gave me the realization that most conversion experiences, whatever their variety, do have a common denominator of ego collapse at depth. The individual faces an impossible dilemma. In my case the dilemma had been created by my compulsive drinking and the deep feeling of hopelessness had been vastly deepened by my doctor. It was deepened still more

by my alcoholic friend when he acquainted me with your verdict of hopelessness respecting Rowland H.

In the wake of my spiritual experience there came a vision of a society of alcoholics, each identifying with and transmitting his experience to the next - chain style. If each sufferer were to carry the news of the scientific hopelessness of alcoholism to each new prospect, he might be able to lay every newcomer wide open to a transforming spiritual experience. This concept proved to be the foundation of such success as Alcoholics Anonymous has since achieved. This has made conversion experiences—nearly every variety reported by James—available on an almost wholesale basis. Our sustained recoveries over the last quarter century number about 300,000. In America and through the world there are today 8,000 AA groups.

So to you, to Dr. Shoemaker of the Oxford Group, to William James, and to my own physician, Dr. Silkworth, we of AA owe this tremendous benefaction. As you will now clearly see, this astonishing chain of events actually started long ago in your consulting room, and it was directly founded upon your own humility and deep perception.

Very many thoughtful AAs are students of your writings. Because of your conviction that man is something more than intellect, emotion, and two dollars worth of chemicals, you have especially endeared yourself to us.

How our Society grew, developed its Traditions for unity, and structured its functioning will be seen in the texts and pamphlet material that I am sending you.

You will also be interested to learn that in addition to the "spiritual experience," many AAs report a great variety of psychic phenomena, the cumulative weight of which is very considerable. Other members have—following their recovery in AA—been much helped by your practitioners. A few have been intrigued by the "I Ching" and your remarkable introduction to that work.

Please be certain that your place in the affection, and in the history of the Fellowship, is like no other.

Gratefully yours,
William G. W.
Co-founder Alcoholics Anonymous[xiii]

Due to Wilson's interactions with the leader of the Oxford Group Movement, many of the group's spiritual principles "were to become the foundation upon which AA operates: (1) self-examination; (2) acknowledgment of faults; (3) restitution of wrongs done, and above all; (4) constant work with others. The formulation of AA's basic tenants of character defects, restitution of harm done, and working with others can be directly traced back to the Oxford Group Movement, Ralph Waldo Emerson, and the influence of the Transcendentalists. The application of these principles would eventually lead to the development of the treatment modality that would soon be unsurpassed in the treatment of alcoholism and drug addiction."[xiv]

It Works If You Work It

There is much criticism of the Twelve Steps and their effectiveness from many individuals and organisations. In principle, I [Guy du Plessis] am not against any criticism of the Twelve Steps, for healthy criticism is needed for any growth process, since everything has a shadow side. Unfortunately, however, I believe most of the criticisms of the Twelve Steps are simply wrong. For example, the most common criticism against 12-step programs is that they promote a "theistic religious" philosophy and expect their members to believe in a supernatural God or Higher Power. This is one example of a gross misinterpretation of 12-step programs' 'pluralistic spiritual' philosophy. Twelve-step philosophy accommodates individuals with religious or secular worldviews. I find it very unfortunate that many addicts are put off by the Twelve Steps—not due to their own experience or insight—but due to others' uninformed and misrepresentation of the Twelve Steps basic tenants.

In the following sections, I [Guy du Plessis] show some of the reasons why the Twelve Steps have historically been effective, and why they will continue to be effective. It is beyond the scope of this work to provide an exhaustive discussion on why 12-steps programs work. Rather, I will provide a succinct argument in favour of the effectiveness of the Twelve Steps and its fellowships by exploring it from a few perspectives. Although I am biased in favour of the Twelve Steps, I have not come across much valid critique of it. As Flores states:

> As far as many professionals are concerned, Alcoholics Anonymous is a much-maligned, beleaguered, and misunderstood organisation. A great many of AA's critics who write disparagingly of the organisation do so without the benefit of attending AA meetings or familiarizing themselves with its working on more than a passing, superficial, or purely analytical level. They fail to understand the subtleties of the AA program and often erroneously attribute qualities and characteristics to the organisation that are one-dimensional and misleading and sometimes even border on slanderous. AA has been called by some a cult, a religion, ideological, unscientific, unempirical, and totalitarian. Its members are said to be coerced into regressive dependency that fosters servitude, compliance, and the surrendering of individual control to a higher power. Nothing could be further from the truth. Such a stance completely misses the point of AA.[xv]

I believe most of the criticism against AA and the many other 12-step fellowships is invalid due to the perspective from which the criticism originates. The Twelve Steps is an injunctive paradigm, a set of social practices, and the only claims it makes is the likely results of following its suggested practice. To truly understand the nature of the Twelve Steps, one has to follow the three strands of valid knowledge accumulation—injunction, apprehension, and confirmation/refutation. This is where the problem originates with much of AA critique—to refute or validate the claims of AA, we have to follow the injunction first. It has to be "experienced" before one can confirm or refute the validity of the practice. It is an injunction that only reveals its true nature when practiced and understood from a subjective and experiential point of view—it is empirical-phenomenological.

Wilber states that "each cultural worldview (in the LL)[12-step fellowship culture] is accompanied by a series of paradigms or social practices (in the LR) [practicing a 12-step program], and these practices or injunctions generate, enact, and bring forth the type of experiences that are held to be true, good, and right by the knowledge community, experiences that are codified in the legitimate worldview, which in turn helps govern the behaviour (UR) [carrying recovery principles into all affairs] and the types of phenomena held to be significant (UL) [psycho-socio-spiritual transformation] by individuals who are members of that culture (with all of them, of course, mutually tetra-evolving and tetra-enacting)."[xvi]

Therefore, attempting to understand the Twelve Steps objectively without a subjective perspective gained by following the injunctive practices, is as absurd as trying to understand Zen by reading books on Zen, without any practice and direct experience. Any Zen master would tell you it is impossible and you are bound to have an incorrect interpretation. The same goes for any experience like eating an apple or swimming; you can never truly understand the experience of being in the sea by reading or talking about it—only by diving into the water. Like Zen sutras, the Twelve Steps are merely the "finger pointing to the moon" and not the moon itself. Much criticism is of the finger pointing. If you confuse the map with the territory, you are in trouble.

Pragmatic philosopher John Dewey calls this type of distal knowledge "Spectator knowledge." Dewey believes that authentic knowledge is only derived from "the experience of action in the world." Wilber echoes this; "One of the great values of Thomas Kuhn's work (and that of the pragmatist before him, and in particular Heidegger's "analytic-pragmatic" side) was to draw attention to the importance of injunctions or actual practices in generating knowledge, and further, in generating the type of knowledge in a given worldspace." Or, phrased more simply, "the first strand of knowledge is never simply "Look;" it is "Do this, then look."[xvii] Therefore, if you want to claim any real understanding of the Twelve Steps, then "do" it—experience it—according to the suggestions. Without the

"do," all consequent interpretations will necessarily be partial and likely inaccurate and misguided.

We will now explore the efficacy of the Twelve Steps paradigm by viewing it from various perspectives. These are by no means exhaustive, and we could add many other perspectives.

An Existential Perspective on 12-Step Philosophy

Ernest Kurtz, Ph.D., author of *The Spirituality of Imperfection*, states that AA works because it shares and addresses many features found in existential philosophy. When analyzed, AA displays many existential themes. A prominent theme in existential philosophy is the realization that as humans we have a limitation of being. By admitting our powerlessness over alcohol in Step 1, we recognise and admit this fundamental limitation. "Powerlessness over alcohol and the acceptance of one's limitation in relation to alcohol serves as a prototype for the alcoholic facing and accepting other limitations of the human condition."[xviii]

Apart from the acceptance of this limitation, AA requires alcoholics to share this limitation with other alcoholics. "The invitation to make such a connection with others and the awareness of the necessity of doing so arise from the alcoholic's very acceptance of limitation."[xix] Although AA suggests the acknowledgment of limitation, it does not abdicate the alcoholic of responsibility. The sense of limited control is summed up skilfully in the well known Serenity prayer used in fellowship meetings: "God grant me the serenity to accept the things I cannot change, the courage to change the things I can, and the wisdom to know the difference."

Being confronted by our limitations "engenders the dread, fear, and trembling of Kierkegaard, the angst of Heidegger, the angoisse of Sartre, and the abyss of Burber."[xx]Like AA, these great philosophers share the common opinion that a prerequisite for individuals to question their existential predicament is an emotional upheaval.

A common theme in existential philosophy is the problem of suffering. AA recognises suffering as an innate aspect of existence, with potential positive influence on our lives. In the context of AA, suffering is given meaning due to it creating impetus in the alcoholic to question his existence and to be open for change. In 12-step meetings, one often hears that people's addictions were the best thing that happened in their lives. Why this bizarre statement? Because it forced them to change, and what they are now is better than what they were—even before their addiction.

Victor Frankl, inventor of logotherapy, believes that when we can place our suffering within some meaningful context, we are not defeated by it but are helped to transcend it. He came to this conclusion as a prisoner in a Nazi concentration camp in WW2. Frankl noted that in the concentration camp, those who found meaning for their suffering were more likely to survive than those who did not, and he often quotes Nietzsche, who said, "He who had a why for life can endure any how."

Similarly, AA members share "the kinship of suffering." AA believes that recovery depends on the mutual sharing of suffering. Kurtz states that it teaches the alcoholic "that to be fully human is to need others."[xxi] Consequently, AA provides alcoholics with a universally shared explanation for their suffering.

From a Buddhist perspective, suffering, or dukkha, is caused by our unwillingness to accept the world as it is and our insistence on trying to make it fit our expected image. Addiction is, in essence, a refusal to accept things as they are and an attempt to avoid the reality of suffering at all costs. An important aspect of recovery is the realization of the inevitability of suffering. Happiness is earned only through hard work—not through instant gratification. "Happiness purchased cheaply is hollow and leads to little sense of mastery. Happiness attained without understanding is purchased at the price of self-respect."[xxii] Schopenhauer echoed this when he wrote, "What a person is contributes more to his happiness than what he has." Kant expressed a similar sentiment, "Morality is not properly the doctrine of how we make ourselves happy, but how we make ourselves worthy of

happiness."[xxiii]In the sense that our happiness is earned through hard work, working a recovery program makes us worthy of happiness. For addicts to "grow" up, they "must relinquish the paradise of limitless abundance and arrogance."[xxiv] Flores sums up this existential predicament of the alcoholic:

> Many existential writers believe that in such a confrontation between the realistic acceptance of the world as it is and the self-centered demands for unlimited gratification, reason would prevail and the individual would choose more realistically between the alternatives—continued unhappy struggles with old patterns of expectations or authentic existence with expanded freedom of choice and responsible expression of drives and wishes. With Socrates, we argue to "know thyself." In this fashion, AA members are taught to believe that the authentic existence advocated by the AA program holds the key to self-examination, self-knowledge, emancipation, cure, and eventual salvation.[xxv]

A Phenomenological Perspective on 12-Step Philosophy

Phenomenology is an investigative procedure "that was intended to help the investigator get past, through, or around the presuppositions, assumptions, and abstractions that dominated science and western philosophical thought."[xxvi] Heidegger applied this method in an attempt at getting to the core of experience. "He believed that examining the phenomenon of experience and existence, without permitting ourselves to be distracted by our analytic minds, would give us a less contaminated view of what it means to be truly human (Dasien)."[xxvii] There are similarities between Heidegger's view and the Buddhist doctrine which defines enlightenment as "the complete and pure awareness of the immediacy of the moment."[xxviii] Heidegger and Buddhism attempt to bypass the bias that is naturally inherent in any analysis and explanation of reality.

Carl Thune interprets AA from a phenomenological perspective and believes one reason AA is effective is due to its members sharing their life histories in AA meetings. He believes that in recounting their life stories, alcoholics are "taught how to interpret their past in a way

that gives meaning to the past and hope for the future."[xxix] Thune writes about the importance of life histories:

> In a sense, then, one of the first lessons AA must teach new members is that their lives were incoherent and senseless as they knew them. Simultaneously, it must reveal the "correct" understanding and interpretation of the drinking alcoholic's vision of the world before a new member can accept the full benefits of the program—a program which offers a different coherence and meaning in their active alcoholic lives. In other words, according to AA, not only do drinking alcoholics incorrectly perceive and understand the world, but they cannot even correctly perceive and understand their perceptions and understanding of it. Through therapy, they must learn new methods for evaluating them. More abstractly, it is not just a revised and now coherent vision of the world which AA offers, but one which has altered the relation between its components.[xxx]

AA states that the alcoholic suffers from a spiritually defective mode of being rather than a mere physical disability. For that reason, AA uses a more spiritually orientated vocabulary "in the absence of a more accurate but inaccessible philosophical-ontological terminology."[xxxi] AA believes that alcoholism is only one, albeit the most important, manifestation of a defective lifestyle or mode of being. Stopping drinking, therefore, is the first, but only one aspect of recovery. The alcoholic needs a complete lifestyle change. From a phenomenological perspective, alcoholics must give up their "self-perceived construction of his or her self that is associated with the alcoholic lifestyle."[xxxii]

Thune concludes that "AA's 'treatment,' then involves the systematic manipulation of symbolic elements within an individual's life to provide a new vision of that life, and of his world. This provides new coherence, meaning, and implications for behaviour."[xxxiii]

Another feature of AA that Thune feels is significant to its success is the constant introduction of oneself as an alcoholic. The self proclamation of "I am an alcoholic" constantly reminds alcoholics that they are a drink away from their old lives. This is often a problematic issue for those whose interest in AA is superficial or purely academic. Unfortunately, they often fail to see the significance of this ritual. They tend to erroneously equate this statement with a form of self-debasement. What they fail to understand is that alcoholics practice this ritual proudly, and with every introduction they are indirectly conveying an important message about and to themselves. Flores states that:

> The term "alcoholic" signifies everything (self-centered *behaviour*, negative attitudes, corrupt values) that sober AA members must guard themselves against if they are to maintain a healthy sobriety. By constantly utilizing the self-definition of alcoholic, AA members automatically imply the opposite, which is everything a healthy, recovering, and sober member of AA must attain. AA members are thus reminded with each pronouncement of themselves as an alcoholic that they are just a drink away from losing what they have become, which is a person whose values, attitudes, and *behaviour* is the direct opposite of an alcoholic. From this perspective, alcoholism is viewed as more than just excessive drinking. This is why AA believes that alcohol consumption cannot be curtailed without addressing and treating the rest of the alcoholic's personality disturbances. Abstinence from alcohol is the first step required for breaking the alcoholic style of living.[xxxiv]

Understanding addiction from this perspective validates the need for a new recovery lifestyle. The Integrated Recovery Lifestyle builds on this aforementioned assumption that without a shift in lifestyle and a new set of healthy practices, the addict will eventually gravitate towards his/her old mode of living and being.

A Self-Psychology Perspective on 12-Step Philosophy

An additional explanation for why AA is effective arises from a self-psychology perspective. Self-psychology can broadly be described as "a generic label for any approach to psychology that makes the self the central concept against which all other events and processes are interpreted."[xxxv]

Self-psychology views addiction as a disorder of the self and understands narcissism (which is a common trait for addicted individuals) as "the problematic expression of the need for self-object responsiveness."[xxxvi] Addiction can then be described as a misguided attempt at self-repair. Heinz Kohut understands narcissistic disorder as a consequence of an injury of the self. Kohut implies that individuals' early dysfunctional experiences with others (self-objects)[1] creates a potential for addiction in later life. Drug addiction, alcoholism, or any addictive *behaviour* is then understood as a misguided substitute for these missing relationships. Put simply, poor relationships in our early development make us more prone to addiction in later life. Typically, addicts have unmet developmental needs, therefore some of us were left with an injured, un-cohesive, or fragmented self. This leaves us feeling empty and incomplete and is the "hole in the soul" that addicts often speak of. Because our internal resources are limited, we remain in constant need (object hunger) of having our self-regulating resources met externally. Since relationships were the source of our initial wounding, we feel we cannot turn to others to have these needs met. As a result, we project this "object hunger" onto external sources like drugs, alcohol, sex, work, etc.—all of which take on a regulating function while also constructing a false sense of self-sufficiency, sovereignty, and denial of the need for others.

I believe, therefore , that the "type of damage" to the self—in many cases—determines what type of drug or addiction we are attracted to. Early wounding will create neurochemical and dysfunctional metabolism in the brain. Addicts seek out specific drugs—according to

[1]Self-object's is a term used in Object-Relations Theory. Flores describes it as "mental representations of others that we experience as part of ourselves."

their psychoactive action—that attempt to rectify the brain's imbalances caused by early traumatic relationships. Drug addicts acts as their own doctors—they attempt to "fix" what is "damaged" in them. It is not a coincidence that ingesting a drug is often referred to as "a fix." Kohut writes:

> And… the addict finally craves the drug because the drug seems to him to be capable of curing the central defect in his self. It becomes for him the substitute for a self-object which has failed him traumatically at a time when he should still have had the feeling of omnipotently controlling its responses in accordance with his needs as if it were a part of himself. By ingesting the drug, he symbolically compels the mirroring self-object to sooth him, accept him. Or he symbolically compels the idealized self-object to submit to his merging into it and thus to his partaking in its magical power. In either case, the ingestion of the drug provides him with the self-esteem which he does not possess. Through the incorporation of the drug, he supplies for himself the feeling of being accepted and thus of being self-confident; or he creates the experience of being merged with a source of power that gives him the feeling of being strong and worthwhile. And all these effects of the drug tend to increase his feeling of being alive, tend to increase his certainty that he exists in this world.[xxxvii]

The perceptive reader may already begin to see why 12-step fellowships are so effective in the treatment of addiction. In recovery, we learn to have healthy interpersonal relationships "in which the needs for self-object responsiveness (mirroring, merger, and idealization) are satisfied in a gradual, gratifying way."[xxxviii] Twelve-step programs accomplish the above in a variety of ways. They supply "a predictable and consistent holding environment that allows addicts and alcoholics to have their self-object needs met in a way that is not exploitive, destructive, or shameful."[xxxix] Because as addicts we have unmet developmental needs, we have very strong and often overpowering needs (Object Hunger) for "human responsiveness" that may feel insatiable. We also feel ashamed by these needs. Through identifying with other addicts, we start to accept these previously unacceptable needs and realize we are not unique or alone. As one recovering alcoholic said after

attending his first AA meeting, "I told everyone all these terrible, horrible, and shameful things about myself and instead of being disgusted with me, everyone gave me their phone number."[xl] In 12-step meetings we begin to feel the responsiveness and gratification we missed for most of our lives.

> If Freud was right about the apparent libidinal autonomy of the drug addict, then drugs are *libidinally invested*. To get off drugs, or alcohol (major narcissistic crisis), the addict has to shift dependency to a person, an ideal, or to the procedure itself of the cure.[xli]

As a holding environment, AA "becomes a transitional object—a healthy dependency that provides enough separation to prevent depending too much on any single person until individuation and internalization are established. Gradually, alcoholics or addicts are able to give up the grandiose defences (narcissism) and false-self personae for a discovery of self (true self) as they really are."[xlii] Through working a12-step program, our infantile ways of getting our needs met are progressively exchanged for more mature ways of establishing healthy, intimate human contact, thereby we are able to internalize more self-care.

Kohut states that there are three types of transference disorders that addicts with narcissistic disorders may have—idealizing, mirror-hungry, or merger-prone. Twelve-step fellowships provide addicts with an idealized other (i.e., a 12-step program, fellowship, etc.) and a goal that is practical and attainable. If addicts follow the suggestions of the fellowship, then they will get all the mirroring and confirmation they need. AA or NA meetings are always accepting and open and act as a "good-enough mother that serves as a transitional object until the principles of the program are internalized."[xliii] Kohut states further that in 12-step fellowships, sponsors and other sober members act as idealized others with whom they can merge. "Merger with the idealized other serves as a container for the depleted self of the alcoholic."[xliv]Flores states that:

> AA works because once initiation into the program occurs, contact with others is sustained, and through continued interaction with others, alcoholics

> are able to alter the dysfunctional interpersonal style that up to now has dominated their life. Khantzain explains that only through this maintenance of contact with others can the disorders of the self be repaired. He identifies the four aspects of the disordered alcoholic as: (1) relation of emotions; (2) self-esteem or lack of healthy narcissism; (3) mutually satisfied relationships; and (4) self-care. He agrees with Kurtz that it is shame that makes the engagement and contact difficult, if not sometimes impossible, for many practicing alcoholics.[xlv]

References for the above section to be found in the endnotes (adapted from an earlier version of Du Plessis' An Integral Guide to Recovery: Twelve Steps and Beyond).

Twelve Steps from an Integral Perspective

AA was the beginning of the modern recovery movement. We have read that there are as many as 200 different 12-step groups based on the original Twelve Steps of AA, working on different issues (Narcotics Anonymous, Cocaine Anonymous, Marijuana Anonymous, Overeaters Anonymous, Al Anon, etc.). Prior to AA, there was very little help for hardcore alcoholics, not to mention drug addicts. The disease simply got rolling, followed its progression, and the sufferers normally died and died young. AA has been tremendously influential and has saved many, many lives.

AA was a tremendous leap forward in the treatment of alcoholism and possibly the first widespread transpersonal psychology to hit the mainstream. This is one of its tremendous gifts and strengths and perhaps also one of its weaknesses, as many find it hard to wrap their heads around the not-so-covert religious nature of the AA program. In looking at AA through the Integral lens, we have often found AA to have a Blue or Amber center of gravity. This can be extremely useful, as many recovering alcoholics or addicts are coming from a pathological, egocentric Red center of gravity. The structure, discipline, and teaching of humility that AA provides

is often exactly what is needed in Upper-Left and Lower-Left quadrants. The difficulties with AA, however, arise in two regards.

1. The Amber/Blue structure is often prohibitory to those who are moving to a higher level of development. AA has many of the characteristics of the Blue mythic organizations, for example: the sacred texts, the Prophet, there is only one way to sobriety, if one leaves the group one is seen as either backsliding or relapsing, etc.

One of the characteristics of Blue organizations and/or cults (and we are in no way saying AA is a cult) is that there is no honorable way to leave. Imagine a young man who has spent 30 years in the Mormon church, standing up on a Sunday morning, and announcing to his community in church, "I love you guys, it's been a great 30 years, but now I feel called to go study Buddhism." Imagine. That is often the way it is. So often, those who are in recovery and feel that they are moving on to higher developmental ground feel rejected and abandoned by the group.

2. The second problem occurs in the recognition of one of the essential truisms of Integral theory, namely people are generally correct in what they affirm but err in what they neglect. In the case of the Big Book of AA, written in 1939, we have learned a LOT about a LOT since then. We have learned an immense amount about the human brain and the disease of addiction; about ego psychology; genetics; epigenetics; and the formerly esoteric spiritual practices of the world, such as different types of meditation and yoga, which have virtually become available to all of us. At the time of the founding of AA, this was not so. Therefore, AA does not include a lot of this essential information. And, because of the rather closed nature of the organization, the new information is not allowed in.

What Integral Recovery attempts to do, and, we believe, succeeds in doing, is to use

the AQAL map as a means of incorporating the essential wisdom of AA as well as all we have learned in the meantime. Not only that, but the AQAL map is imminently friendly to evolution, continued growth, and transformation. The model continues to evolve and become more beautifully complex and effective; it seems we are constantly in a process of reorganizing at a higher level, while still holding the basic structure that the AQAL map provides. We believe that AA could quite gracefully become more Integral by including quadrants, levels, lines, states, and types, and using some of the practices that we are now using in IR, such as enhanced meditation, yoga, strength training, nutrition, and the Enneagram.

In summary, the Twelve Steps and Integral Recovery are not mutually exclusive and we often work with clients who are active members of AA. We support AA and other 12-step groups and almost always find the occasional meetings we attend very moving and useful. AA meetings, at their best, are often overflowing with gratitude, humility, and personal honesty. They are great places to learn the 1st person perspective of addiction if one is not an alcoholic or an addict. They can be very supportive and inspiring for those who are on the path of recovery. AA also provides a built-in community of like-minded recovering people, with whom one can associate and celebrate life without the use of mind-altering substances (except for coffee and tobacco!). Having said all of this, we see AA as the foundation and the starting point of the modern recovery movement.

Service Material from the General Service Office

THE TWELVE STEPS OF ALCOHOLICS ANONYMOUS

1. We admitted we were powerless over alcohol—that our lives had become unmanageable.

2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God *as we understood Him.*

4. Made a searching and fearless moral inventory of ourselves.

5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.

6. Were entirely ready to have God remove all these defects of character.

7. Humbly asked Him to remove our shortcomings.

8. Made a list of all persons we had harmed, and became willing to make amends to them all.

9. Made direct amends to such people wherever possible, except when to do so would injure them or others.

10. Continued to take personal inventory and when we were wrong promptly admitted it.

11. Sought through prayer and meditation to improve our conscious contact with God, *as we understood Him*, praying only for knowledge of His will for us and the power to carry that out.

12. Having had a spiritual awakening as the result of these Steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

Rev.5/9/02

INTEGRAL RECOVERY TWELVE STEPS

1. I acknowledge that I have a problem and that because of _____ my life has become unmanageable.

2. I take full responsibility for this problem and am willing to do the work necessary to heal.

3. I am coming to believe that there is a way out and that the way out consists of an Integral Recovery Practice that simultaneously exercises my body, mind, heart, and soul.

4. I am ready to conduct a comprehensive evaluation of my past and find the source of my pain, fear, and suffering.

5. Having found the source of this pain, I am willing to release it.

6. Having found and identified the sources of my trauma and suffering, I am willing to do the healing work that is available and necessary for my continued growth and happiness.

7. I have made a list of everyone and everything that I have harmed as a result of my unconscious and compulsive behaviors.

8. I have made restitution and reconciliation wherever wisely and compassionately possible.

9. As a part of my awakening process, I am examining my core beliefs, values, and life callings.

10. I continue to examine my ego structure with rigorous honesty and how my unconscious maps and stories limit or empower my life's progress and unfolding.

11. I continue to evaluate my Integral Recovery Practice and make changes or adjustments as necessary.

12. As a result of this awakening journey, I commit myself to a life of integrity and service.

The Big Book of Alcoholics Anonymous

📖 *For Study Unit 3, read Chapters 5 & 6 of the* Big Book *of Alcoholics Anonymous as well as "The Doctor's Opinion" at the beginning of the Big Book. You can find the entire Big Book 4th Edition online at http://www.aa.org/bigbookonline/.*

. Assignment for Study Unit 3

✎ *Write a 2 - 4 page essay discussing what you think are AA's strengths and also its possible weaknesses.*

✎ *Send assignment to your Faculty Mentor.*

Well done. You have come to the end of Study Unit 3!

Study Unit 4

AQAL Map: Quadrants and Lines of Development

Learning Objectives for Study Unit 4:

1: To gain a basic understanding of the AQAL map's four quadrants and how this knowledge can effectively be applied to the understanding and treatment of addiction.

2: To gain a basic understanding of the lines of development and how this knowledge relates to Integral Recovery Practice.

If you are trying to fly over the Rocky Mountains, the more accurate a map you have, the less likely you will crash. An Integral approach ensures that you are utilizing the full range of resources for any situation, with a greater likelihood of success.

- *Ken Wilber*

Why Integral the Integral Map?

The Integral Recovery approach is about finding the simplest and most effective solution to a complex problem. It can do this because it uses the Integral map.

Integral Theory by itself is not a simple model but when applied in any field it actually simplifies one's understanding of it—due to the fact that it increases one's field of perception of the territory, thereby providing a big picture that holds together all the many threads. When Integral Theory is applied in the context of recovery, although it is initially more information to ingest, it actually makes the recovery process easier to understand and practice, in the same way a more detailed map, although it contains more information than a simpler one, makes navigation and understanding the territory more effective.

Dr. Andre Marquis, a pioneer in Integral Psychotherapy, states: "Integral Theory is a way of knowing that helps one strive for the most comprehensive understanding of any phenomenon"—in our case, recovery from addiction. If our aim is to find a model to use as a framework to support a truly comprehensive and holistic approach to recovery that is the most effective, it seems that Integral Theory is best suited for the task. He states further:

> "How can Integral Theory incorporate elements such as counseling, social work, biomedicine, psychology, and diversity into higher-order, unified wholes? It does this by providing a parsimonious and self-reflective conceptual scaffold on which to order the myriad approaches to understand and helping others, from psychoanalytic, cognitive-behavioral, existential-humanistic, and transpersonal perspectives to biomedical, sociological, philosophical, and economic ones. Integral Theory is actually a meta-theoretical framework that simultaneously honors the important contributions of a broad spectrum of epistemological outlooks while also acknowledging the parochial limitations and misconceptions of these perspectives. In other words, Integral Theory provides us with a meta-perspective that allows us to situate all the diverse knowledge approaches (from pre-modern to modern to postmodern) in such a way that they synergistically complement, rather than contradict, one another."

Integral Theory is also known as the AQAL model, referring to the five elements of Integral Theory: all quadrants, all stages, all lines, all states, and all types. We will use the terms Integral Theory and the AQAL model interchangeably, as both refer to the same model. These perspectives or elements dominate the most basic patterns of reality, therefore by including all these perspectives in any situation, you are ensured of not neglecting any aspect of the situation or event you are investigating. Therefore, by using an AQAL map in the context of addiction and recovery, you are provided with the most comprehensive, inclusive, cross-cultural, and trans-disciplinary conceptual map of human potential thus far developed.

Quadrants

"According to Integral Theory, there are at least four irreducible perspectives (subjective, inter-subjective, objective, and inter-objective), four modes of being-in-the-world, that must be consulted when attempting to fully understand an issue or aspect of reality. Thus, the quadrants express the simple recognition that everything can be viewed from two fundamental distinctions: 1) an inside and outside perspective and, 2) from a singular and plural perspective."[xlvi] The quadrants are not merely abstract constructs of reality but are also part of your very essence of "being-in-the-world" in the here and now, therefore you can actually feel every one of these perspectives. They are the "I", "We," and "It" (or 1st person, 2nd person, and 3rd person pronouns) which the languages from all cultures possess, because they point to the reality of each moment. These quadrivia are always present in each moment, whether we choose to acknowledge it or not.[2]

The AQAL model represents these four perspectives as:

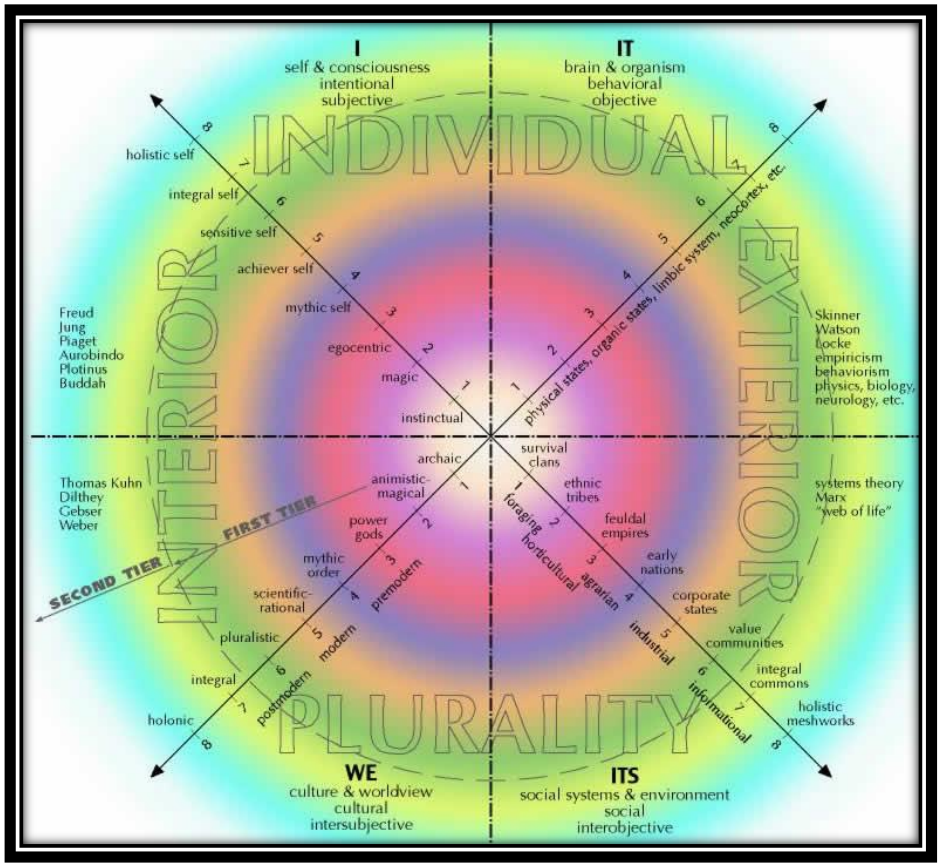
Upper-Left Quadrant, Interior-Individual "I": This quadrant represents the interior of the individual: thoughts, beliefs, emotions, and intentions. This quadrant is your subjective experience, your internal world, that only you can experience and observe.

Upper-Right Quadrant, Exterior-Individual "It": This quadrant is the individual's objective dimension, representing his physical body and its processes. Here we can observe and quantify it is as realm of medicine, biological psychiatry, and health sciences.

[2] *Quadrivia* refers to four ways of seeing.

Lower-Left Quadrant, Interior-Collective "We": This quadrant is the collective subjective dimension of "We." It represents aspects like our shared beliefs, culture, language, and relationships.

Lower-Right Quadrant, Exterior-Collective "Its": This quadrant is the collective objective dimension and signifies the tangible world. This is the realm of nature, economy, observable infrastructure, politics, and all the observable aspect of civilization.



Four Quadrants of Integral Theory

Let's look at the phenomenon of depression as an example of applying the quadrants. To truly understand the etiology and treatment of depression, we need to view it from all four quadrants, otherwise our understanding and treatment run the risk of being partial and possibly ineffective. From an Upper-Right

quadrant perspective (It), depression can be caused due to a lack of serotonin and/or dopamine in the brain. It can also be caused by toxicity, allergies, or poor diet. From an Upper-Left quadrant perspective (I), depression can be due to mental, emotional, spiritual problems, and/or unresolved trauma. From a Lower-Left quadrant perspective (We), depression can have its roots in familial problems, loss of relationships, and/or social isolation; or due to being part of a repressive religious group or culture. From a Lower-Right quadrant perspective (Its), depression can be caused by unemployment, war, political instability, or natural disaster. As a result, depression may be due to dysfunction in one quadrant or a combination of quadrants, but it will always manifest in all four quadrants.

Therefore, to view depression as merely low levels of certain neurotransmitters like biological psychiatry often tends to do, without considering its possible psycho-social causes or solutions is a gross oversimplification and partial view of the problem. In the same way, to view addiction as only a brain disease, or only a psychological or social issue, or only a techno-economic problem is also partial. Wilber calls this "Quadrant Absolutism"—when we view and explain a phenomenon by reducing it to only one quadrant. The etiology, anatomy, and symptoms of addiction will necessarily span all four quadrants. For this reason, if the treatment of addiction is to be optimally effective, healing should occur across all four quadrants.

Addiction and Recovery Viewed Through the Quadrants

Let's take a look at addiction and recovery by viewing them through the four quadrants of the AQAL model. This will demonstrate why it is necessary to include practices corresponding to each of the quadrants as part of your Integrated Recovery Lifestyle for it to be sustainable. Furthermore, you will see why it can be detrimental and even fatal for a recovery program to ignore practices in any of the quadrants. When we teach quadrants and lines to our clients and students, we normally find that it has immediate intuitive resonance. Many approaches in the past have been uni-quadrant-focused, or maybe focused on two quadrants, as in the case of AA. These approaches tend to fail or run into problems when the other quadrants are neglected or excluded. The tendency to exclude some quadrants or lines is natural, as we tend to reinforce the ones that we feel most at home with. In the case of a skilled psychotherapist, this would be the Upper Left quadrant, or, in the case of a skilled athlete or gym rat, the body line. This is fine, but an integrally informed therapist

will realize that the Upper-Left quadrant is not the whole story, and the Integrally-informed athlete will know that there is more to health and success in life than just physical health and strength.

In Integral Recovery treatment, we begin to talk about the four quadrants when we show clients how the disease of addiction has infected and caused damage to their brain and body in the Upper-Right quadrant, and how that concurrently effects the other three quadrants of their lives. It is easily understandable, when one shows the work that needs to be done in all these essential dimensions. Not only that, but hope begins to emerge from understanding clearly the work that needs to be done.

In his book, *Mindsight*, Dan Siegel says that mental and emotional illnesses are characterized by rigidity and chaos, while mental, emotional, and spiritual *health* are characterized by coherence and integration. We are finding that the AQAL map in combination with Integral Recovery Practice creates exactly that—coherence and integration—to an unprecedented extent.

The "It" of Addiction & Recovery

Understanding addiction and recovery by exploring objective characteristics of an individual from an Upper-Right quadrant perspective (the "It" space) requires that we view all the positivistic and objective perspectives of an individual's behaviors, structures, processes, and events.

From the viewpoint of this quadrant, addiction may be classified as a brain disease. Addiction affects the mesolimbic system of the brain. This area of the brain houses our instinctual drives as well as our aptitude to experience emotions and pleasure. This part of the brain includes the medial forebrain bundle, which is popularly known as the pleasure pathway. The chronic use of drugs and/or compulsive addictive behavior, "hijacks" the pleasure pathway of the brain. The resulting neurochemical dysfunction causes the individual to perceive the drug as a life supporting necessity similar to breathing, drinking, and eating. In spite of the adverse consequences of addiction, this clarifies why most addicts cannot stop on their own, and why they often require external support.

Addiction has an impact on both physical and neurological well-being; therefore a successful recovery approach must address both of these areas. It is unfortunate and not clear why most treatment programs and facilities do not emphasize these aspects of treatment. In the treatment of addiction and maintenance of recovery, Patrick Holford emphasizes the importance of diet and nutritional supplements. He believes that most addicts suffer from reward deficiency. This neurochemical imbalance in brain chemistry results in

negative effects including feelings of emptiness, hypersensitivity, and anxiety. Even prior to addiction, many addicts have deficiencies in brain chemistry.

In addition to the long-term use of mood altering substances, many factors can create "reward deficient" brain chemistry. Among these are genetics, prenatal conditioning, malnutrition, stress, lack of sleep, and physical or emotional trauma. Unless rectified, brain chemistry deficiency continues indefinitely into an addict's recovery. This means that recovering addicts remain prone to relapse even if they are abstinent and doing psycho-spiritual work. Only after the neurochemical imbalance is corrected will symptoms of reward deficiency abate.

Some researchers argue that effective treatment requires a combined physiological and psychological approach as well as improving an addict's neurophysiology. Physical and neurological health is vital for an effective addiction treatment program and sustainable recovery. In this area of recovery, our health is fuelled by exercise, diet, supplements, sleep, limited or no caffeine intake, as well as neurotherapy and various physically-oriented therapies. Simply put, our physical and neurological health is a critical component of an Integrated Recovery Lifestyle.

The "I" of Addiction & Recovery

From the perspective of the Upper-Left quadrant (the "I" space), the exploration of addiction and recovery includes the subjective and phenomenological dimensions of individual consciousness. Addiction wreaks havoc in the addict's inner phenomenological world with disastrous, negative consequences cognitively, existentially, emotionally, and spiritually. The addict loses control over his/her inner world as the "addict voice" becomes progressively louder. Developmentally, addicts often regress to egocentric and childlike states of self-centeredness and unreasonableness. Addiction is a progressive illness that eventually and negatively alters the interior phenomenological world of the addict. Addiction develops from a definite, but often seemingly indistinct, beginning to a specific end point. The end point being the complete control of the self by the illness.

This quadrant of recovery receives a considerable amount of attention in most reputable addiction treatment approaches. Psycho-spiritual healing is achieved through therapeutic practices like 12-step work,

psychotherapy, lectures, trauma counseling, meditation, and individual therapy. Recovery processes that exclude cognitive, emotional, existential, and spiritual healing, as well as education, are partial and ineffective in providing sustainable sobriety.

An essential feature of treatment is cognitive insight into the nature of addiction and recovery. Becoming familiar with the basic elements of Integral Theory provides one with a "meta-recovery structure" that illuminates the whole recovery process.

Therapies like Dialectic Behavior Therapy (DBT), Rational Emotive Behavior Therapy (REBT), 12-step work, as well as individual and group psychotherapy are often used in addiction treatment centers to support the cultivation of emotional intelligence.

By tradition, and as a result of AA's influence on addiction treatment, spirituality is considered an essential element in effective treatment protocol. Through Integral Theory, treatment providers and recovering addicts gain a more complete understanding of spirituality and spiritual methodologies. According to AA, addiction results from a lack of spirituality. Spiritual practices play an important existential role in 'healing' addiction because it provides a sense of meaning to life that is often lacking in the addict population.

Winkelman argues that spiritual practices can also free addicts from ego-bound emotions and provide balance in contradictory internal energies. A sense of 'wholeness' can be achieved through spiritual practices that counteract the sense of self-loss that is at the core of addictive dynamics. Consequently, and as is suggested in the Twelve Steps of AA, self-esteem is enhanced by providing connectedness with a "Higher Power," and this supersedes the egoist self.

The "We" of Addiction & Recovery

Developing an understanding of addiction and recovery from the Lower-Left quadrant perspective (the "We" space) includes the inter-subjective element of the collective. All cultural and interpersonal features of addiction and recovery fall into this domain. While addiction is often caused by eroded relationships, it also progressively erodes relationships. Because addicts are often unable to form healthy intimate relationships, addiction is commonly seen as an intimacy disorder.

Family and friends are often perplexed and outraged as the addict's behavior progressively transgresses cultural norms that are held by family, friends, and colleagues. Many addicts undergo a cultural shift and eventually enter the "world of addiction" that has its own rules and cultural norms. Addictive behaviors are accepted and often encouraged in this new culture. Addicts are now given a new set of culturally relevant information as well as a new set of rules. William White writes:

> The physiological, psychological, and spiritual transformations that accompany the person-drug relationship occur within and are shaped by the culture of addiction. The progression of addiction is often accompanied by concurrent disaffiliation from society at large and on enmeshment in the culture of addiction. This cultural affiliation touches and transforms every dimension of one's existence. What begins as person-drug relationship moves toward an all-encompassing lifestyle. No part of the persona is left untouched by the culture of addiction.[xlvii]

Many addicts find these cultural and relational aspects of addiction the hardest to give up. Non-users find it difficult to understand the thrill, meaning, brotherhood, and adventure provided by addiction—at least while the going is good. Eventually addiction destroys all the supposed benefits of the addiction culture, but often the addict continues searching in vain for those early carefree days that are like a tantalizing mirage, always out of reach. Writing on heroin addiction, William Burroughs says this: "Junk is not just a habit. It is a way of life. When you give up junk, you give up a way of life."[xlviii] It is the illusion that certain "fun" aspects of this way of life can be re-lived that draws many addicts back to it.

Treatment that does not acknowledge and understand the ideology behind the culture of addiction, and the need for a healthy recovery culture, is likely to be ineffective. William White echoes this:

> Addiction and recovery are more than something that happens inside someone. Each involves deep human needs in interaction with a social environment. For addicts, addiction provides a valued cocoon where these needs can be, and historically have been, met. No treatment can be successful if it doesn't offer a pathway to meet those same needs and provide an alternative social world that has perceived value and meaning.[xlix]

We believe that the correct cultural association is one of the key remedial aspects of the recovery process, particularly in early recovery. The central reason we think the 12-step methods are so successful is because the recovery neophyte is introduced to established recovery cultures that provide an immediate sense of acceptance and belonging.

For treatment programs to be effective, recovery centers need to establish a healthy recovery culture that appeals more to addicts than their former addiction cultures. Not many people understand the sense of intimacy and belonging provided by certain drug cultures. Many social clubs, religions, and institutions are sorely lacking in comparison with the camaraderie and intimacy of some drug cultures. A cold, aloof, and intellectually-based recovery culture cannot compete with that.

Luigi Zoja, a renowned, Jungian psychoanalyst, believes that the pervasive use of drugs in our society can be ascribed—to a large extent—to the revival of a collective need for ritual and initiation. A longing for the sacred underlies the ritualized world of addiction—a need for 'participation mystique.' A successful recovery culture should provide new healthy rites of passage. The "chip" or key-ring that addicts receive on their milestones in NA meetings satisfies deep "archetypal" human needs. These tokens function as "symbols of initiation" and are often proudly displayed. A pivotal aspect of any recovery structure is to enlighten and provide access to a supportive and informed recovery community, which provides new healthy cultural norms and a sense of belonging and support.

The above becomes even more apparent when we explore the phenomenon with an understanding of Wilber's developmental stages (or levels). As addicts move from the "red" egocentric stages of addiction to the "amber" stages of ethnocentricity in early recovery, they enter a stage of development where their group, or clan, plays a major role in healthy development and integration. The Integrated Recovery Lifestyle is designed to be lived "in consultation" within a supportive and knowledgeable fellowship.

The "Its" of Addiction & Recovery

Exploring addiction and recovery from the Lower-Right quadrant perspective (the "Its" space) includes the inter-objective perspective of systems. The latter considers the observable aspects of societies, such as

economic structures, civic resources, and geopolitical infrastructures. Addiction affects this realm profoundly, and this is especially true for those addicted to "hard drugs' like crack and heroin. Drugs are expensive. Addicts often lose their jobs, get evicted, get into trouble with the law, and are sometimes incarcerated. As it is said in Narcotics Anonymous (NA), the result of addiction is "Jails, Institutions, and Death." There are many acultural and bi-cultural addicts who manage to stay employed and have financial stability, but for most addicts this quadrant is severely compromised.

The culture of addiction's infrastructure includes crack houses, bars, night clubs, casinos, strip clubs, areas of prostitution, and so on. Progressively, addicts move from one culture to another and begin to spend more time within the infrastructure of addiction culture. The more complete this migration becomes, the more resolutely it normalizes their behavior, which ultimately reinforces their denial of the problem of addiction.

The addict enters recovery through treatment, therapy, or 12-step programs, and in doing so he or she enters the infrastructure of recovery. It is vital that the beginner avoid dangerous "people, places, and things," as is said in NA. This folk wisdom of NA is obvious when viewed from the "Its" space perspective. The addict in recovery avoids the infrastructure of addiction in which his addictive behavior is welcomed and reinforced. An effective recovery program must address this area by, at the outset, providing a new infrastructure, dealing with legal, monetary, and accommodation issues.

A sustainable discharge plan concerning this dimension of recovery is an absolute necessity. Recovering addicts in 12-step fellowships seldom consider their education, legal, monetary, residential, or administrative aspects as a fundamental part of their recovery. Financial and administrative unmanageability can be serious stumbling blocks to psycho-spiritual well-being. The distress of unmanageability in these areas has caused many addicts to relapse. Healthy participation in recovery infrastructure as well as financial and administrative manageability are strongly promoted and advocated by the Integrated Recovery approach.

All Lines

Each facet of reality, represented by the quadrants, has individual capacities that continually develop or regress. These are referred to as *lines of development*. Lines may be viewed as "multiple intelligences" and these can develop independently. Each quadrant comprises many lines of development.

Lines of development from the individual-interior quadrant of experience include cognitive, emotional, spiritual, moral, interpersonal, as well as many others as identified by Wilber and other developmental theorists. It is likely that you are well-developed in some of the above lines and less so in others. For example, you may be well developed along the cognitive line while lacking in interpersonal growth. Through an understanding of the lines, we realize that different aspects of ourselves are at different levels of development.

In the context of recovery, this is a crucial insight. Certain aspects of our recovery are likely to be more advanced than others. Furthermore, if certain aspects of your recovery are poorly developed, then these aspects may jeopardize your entire recovery process.

The Integrated Recovery approach identifies six essential lines of development that are referred to as recovery dimensions. These are; physical, mental, emotional, spiritual, social, and environmental. As pointed out earlier, these six recovery dimensions are founded on the four quadrants and are essential to an Integrated Recovery Lifestyle.

As with lines, each of the six recovery dimensions can be at different stages of development for individuals in recovery. Unless these six recovery dimensions are functioning at a reasonable level of development, the whole system is in jeopardy. Acknowledging that we need to practice our physical, mental, social, emotional, spiritual, social, and environmental dimensions will not suffice. Action is required to bring each dimension to a minimum level of development before the whole system is considered to be healthy.

Study Material for Study Unit 4

📖 *Read Chapters 2 and 4 (Dupuy, 2013, pp. 31 - 40, pp. 65-81) of the assigned book. These chapters provide an in-depth exploration of addiction as well as recovery/therapy from the perspective of the four quadrants and lines of development.*

📖 *Next read Du Plessis (2015) pp. 10 – 24. In this section Du Plessis discusses quadrants and lines of development from an Integrated Recovery perspective.*

Audio and Video for Study Unit 4

Watch Parts 2, 3, and 4 of the John Dupuy video series on Integral Recovery (Intro to AQAL as Applied to Integral Recovery, AQAL is Psychoactive, and the Four Quadrants of the AQAL Model), which can be downloaded from http://www.integralrecovery.com/2009/01/videos. Here Dupuy provides various discussion of the AQAL model as applied to recovery and addiction treatment.

Listen to Ken Wilber: Four quadrants in development and ideas 4:20: http://www.formlessmountain.com/kw_audio/KW_44.mp3 and

Ken Wilber: Raising lines of development with meditation 6:05: http://www.formlessmountain.com/kw_audio/KW_13.mp3

. Assignment for Study Unit 4

- *Do a Quadrant and Lines of assessment of a person you know that has an addiction problem (do not mention the person's name in your assignment). If you do not know somebody personally use a fictional character.*

- *Send these assignments to **your Faculty Mentor.***

Well done. You have come to the end of Study Unit 4!

Study Unit 5

The AQAL Map: Stages of Development

Learning Objectives for Study Unit 5:

1: To demonstrate a basic understanding of the stages of development, as well as a basic understanding of the developmental stages in Spiral Dynamics.

2: To be able to explain how the inclusion of stages of development radically alters our understanding of the nature of addiction.

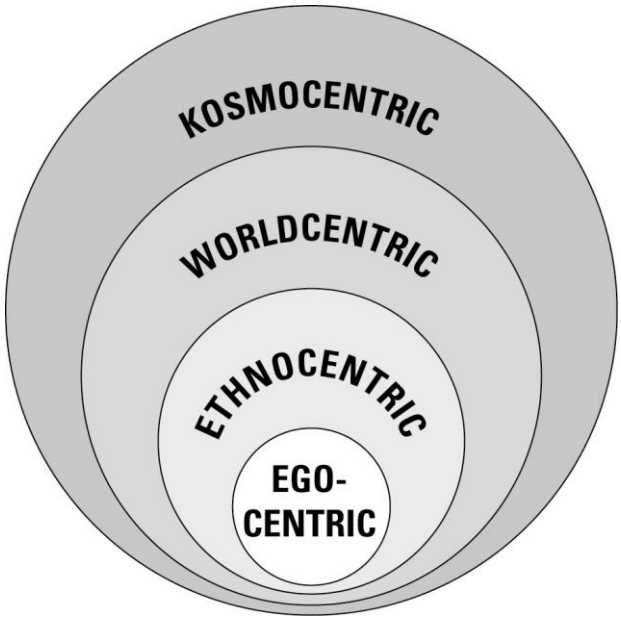
Introduction: Stages of Development

Each "line of development" progresses and fluctuates through a sequence of developmental altitudes that, in Integral Theory, are referred to as stages or levels of development. Wilber states that:

> "Stages of development" are also referred to as "levels of development," the idea being that each stage represents a level of organization or a level of complexity. For example, in the sequence from atoms to molecules to cell to organisms, each of those stages of evolution

involves greater levels of complexity. The word "level" is not meant in a rigid or exclusionary fashion, but simply to indicate that there are important *emergent* qualities that tend to come into being in a discreet or quantum-like fashion, and these developmental jumps or levels are important aspects of many natural phenomena. Generally, in the Integral Model, we work with around 8 to 10 stages or levels of consciousness development. We have found, after years of field work, that more stages than that are too cumbersome, and less than that, too vague.[1]

From a moral developmental perspective, an easy way to understand stages is to describe their progression from egocentric (pre-conventional) through ethnocentric (conventional) to world-centric (post-conventional). All of us grow through these stages and different "intelligences" or lines of development.



Moral Stages of Development

Prior to the Integral move of including developmental maps in our understanding of addiction, the way we looked at addiction was primarily binary—this or that, black or white, sober or not. By using developmental stages to understand addiction, the vertical dimension of the addictive process becomes eminently clear. What we have

discovered from our experience working with addicts over the years is an addictive process whereby one will be at a particular developmental level at the onset of the disease and, very quickly as the disease progresses, one will move down the developmental spiral from a higher stage of moral development to a lower one, at times several stages lower. For example, one may move from a fairly functional, worldcentric Orange level to a very pathological and even sociopathic egocentric Red or lower.

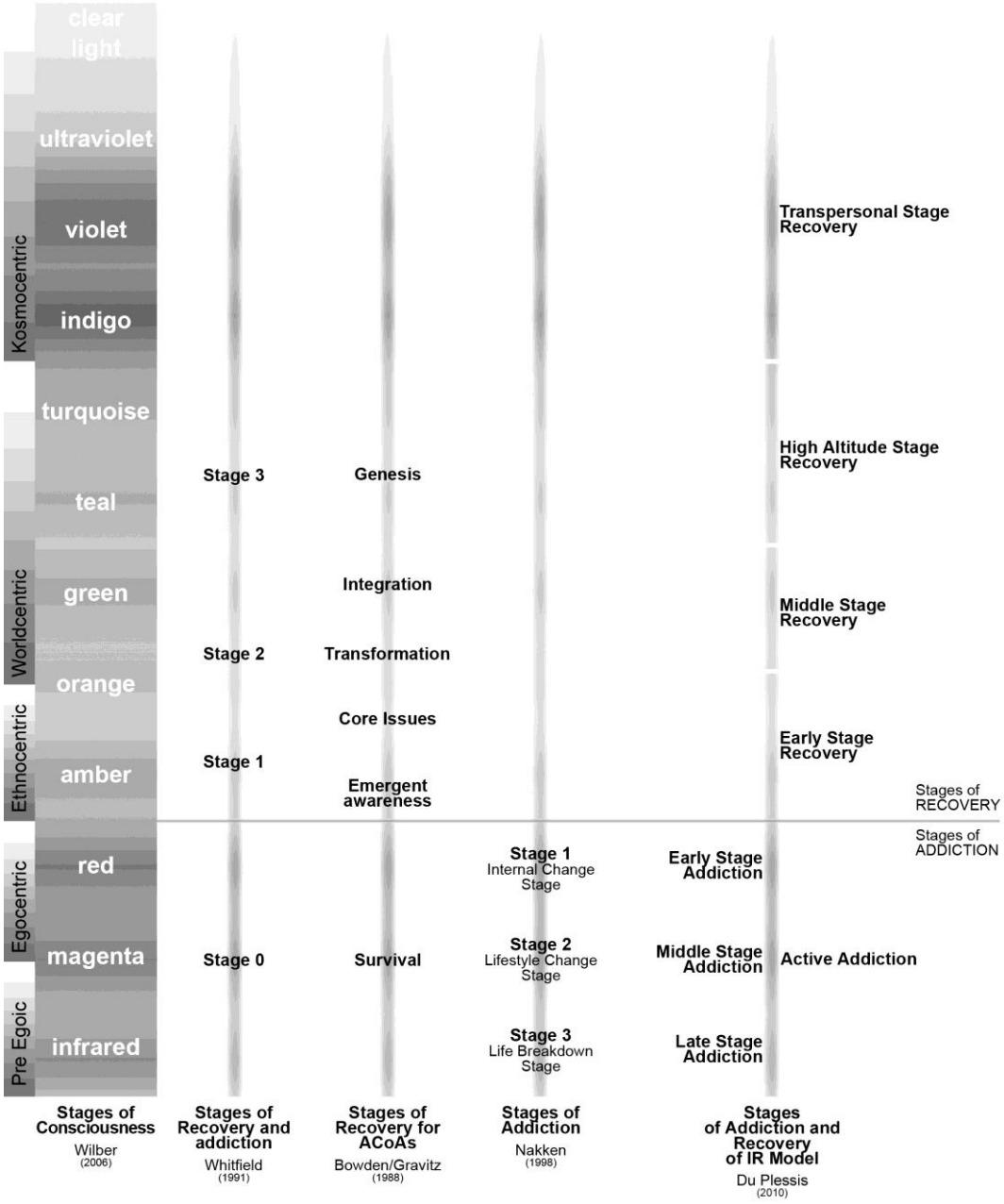
This is a very important event in our understanding of addiction: it helps the individual suffering from addiction to understand the cost that the disease has requested of them, as well as allowing them to understand their changes in attitude, values, and behaviors throughout the progression of the disease. While this is often a painful realization, this type of pain can be healthy and supportive of continued growth, sobriety, and practice. It is also very useful for loved ones and family members to understand what has happened to their loved one who has been affected by the disease. The brain has been kidnapped, the reptilian brainstem is the controlling locus of the brain, the moral high ground has been lost, and the personal growth of a lifetime has been reversed.

There is even evidence beginning to emerge from studies conducted in Europe that actual physical changes occur in the brain, depending on what developmental level the observed subject is currently at. Obviously, there is a lot more research that needs to be done here, but the implications are fascinating. Another thing that understanding developmental levels does is allow us to chart the journey of recovery from the lower stages back to our formerly-achieved higher levels of development and from there moving on to even higher levels as our practices continue. As you will read in Integral Recovery, addiction is devolutionary—a negative evolutionary force that causes moral regression to lower stages—while recovery and the essential practices are evolutionary, helping us to gain lost ground and moving on from there.

From a 2nd-person perspective, as in understanding how to communicate with our clients or patients and their families, an understanding of Spiral Dynamics is extremely useful. We have found that we do not need written tests to figure out what developmental center of gravity individuals are coming from. It is usually quite clear from the first five minutes of conversation, even over the phone. For example, if a family member is calling you about getting help for one of their loved ones who is suffering from addiction, we can quickly pick up the signals and markers as to what level they are speaking from. So, if they are a Blue/Amber Christian, we speak in terms of prayer, faith, healing, forgiveness, and redemption. If they are coming from an Orange place, we talk about our successes, the scientific data, etc. If the person is coming from a largely Green developmental level, we speak in terms of things that appeal to

our Green friends: the organic foods, the meditation, the yoga, the compassion, and the loving nature of our program.

Often in the case of the recovering addict, one can speak to their current regressed level, while at the same time speaking to their previous level of development and beyond, because those parts begin to awaken in the recovery process. For example, we might be very firm and directive in talking to the Red addict self, giving them very little choice or wiggle room, while, at the same time, speaking to the lost values of the healthier self that we are working to bring back online through the detoxification, recovery, and Integral practice process. As Integral teacher Jeff Salzman has elucidated, we can often do what he calls simulcasting—in other words, if you are addressing a group of students and their family members, you can speak to all the levels that are currently in the room simultaneously. In this situation, the speaker gives each level enough value-related information for them to hang onto in order to keep them engaged in the process. With a little practice, this skill becomes almost second nature and one begins to do it naturally.



Various developmental stages & stages of addiction and recovery

In the figure titled *Various developmental stages & stages of addiction and recovery,* various developmental models as well as developmental models of addiction and recovery that are based on the work of certain

addiction/recovery scholars (Whitfield; Prochaska, DiClemente & Norcross; Bowden & Gravtiz; Nakken), as well as my own [Guy du Plessis] composite developmental model relating to addiction and recovery are indicated. The figure shows the different developmental stages that our center of 'recovery gravity' can possibly rest at.

At each developmental stage, an addict will require a new set of 'recovery skills' to function satisfactorily. This is an important insight for recovery pilgrims—for continued growth, you must exert effort throughout your journey of recovery. What worked for you in the past might not apply today. In the same way, the skills used to pass first grade mathematics will not be adequate to pass tenth grade. This phenomenon is true for all facets of life as it is for the recovery process. Many recovering addicts believe that the program they worked when they were two years clean will work when they are ten years clean; this is a common fallacy among those in recovery. Of course, this does not mean that we should discard the initial practices, but rather, that we continuously add to the existing practices.

Following is a brief description of each of the stages that explains each stage through a worldview line or worldview perspective (we can explain the stages from many perspectives, each denoting a possible line of development.) Bear in mind that a person's or a culture's worldview varies at each stage and that each stage of consciousness has a unique worldview.

INFRARED – Archaic Worldview

Survival is the main purpose of this worldview. A need for food, water and safety dominate. This is often where street addicts regress to, where the need for their drug (survival) is their overriding purpose.

MAGENTA – Magic Worldview

In this worldview the individual's safety and security is provided by bonding (fusing) with a tribe, which will protect against outsiders. "Mystical signs and the desire of powerful spirit beings must be followed for the continued safety of the tribe."[li]

RED – Power Worldview

"This worldview marks the emergence of a sense of self (ego) distinct from the tribe, although it often acts impulsively on behalf of its favored group."[lii] Red individuals see themselves as the center of the world and live by the motto, "It's all about me!" They are impulsive and seek to fulfill their wants and desires immediately. Red is often the center of gravity of addicts. That is why addiction is frequently referred to as a "disease of self-centeredness."

AMBER/BLUE – Mythic Worldview

In this worldview rules provide life with order, purpose, and absolute meaning. "There are higher principles that must be followed. Everyone has their proper place in society, held together by laws and religious [or fundamental secular] commandments. Conservative and traditional, the Amber worldview emphasizes order, consistency, and convention."[liii] This is often the first stage that addicts progress to from their Red egocentric levels. Consequently this is why treatment centers of 12-step fellowships emphasize healthy Amber fundamentals, something most addicts sorely lack.

ORANGE – Rational Worldview

Orange is the rational and scientific worldview of modernity. As the first truly wolrdcentric view, it gave rise to the ideals of liberty, equality, and justice for all. "As the history of modernity demonstrates, Orange strives for progress, success, independence, achievement, status, and affluence. The future is not predetermined or locked into place by traditions. A new tomorrow can be created through goal-orientated actions taken today."[liv]

GREEN – Pluralistic Worldview

The Green worldview can see multiple points of view where everything is interconnected. "Green first made itself known on the world stage in the 1960s. Indeed, all the major social revolutions of the time have Green footprints from environmental movements to the holistic health movement to the human potential movement."[lv] AA and NA have strong Green elements in their pluralistic stance. When individuals in recovery move into the Green stage, they start to realize the need for a more holistic method to recovery. Unfortunately Green can easily become pathological, a condition known as "Boomeritis," where one becomes lost in a pluralistic flatland hall-of-mirrors of political correctness and relativity.

TEAL – Integral Systems Worldview

"As awareness keeps growing into Teal, it notices something essential: every perspective [worldview] captures some important aspects of reality extremely well, and yet each also de-emphasizes, or marginalizes, other aspects of things (that is, each is true, but partial). Teal also realizes that some views are more true, and less partial, than others. In other words, every view is not equal; depth exists."[lvi] At the Teal-Integral worldview one develops the capacity to perceive and work in more complex and interconnected systems. One of the aims of the Integrated Recovery paradigm is to eventually foster a Teal-Integral perspective in the recovering addict, therefore providing him with the perspective and tools to function adequately in our complex information age. Teal is the first stage of consciousness that is capable of navigating individuals and societies in a truly worldcentric manner.

TURQUOISE – Integral Holistic Worldview

Turquoise is the start of more transpersonal modes of awareness. "The Turquoise worldview recognises more deeply how all ideas are constructs, even one's own sense of self. As this level of awareness dawns, people realize the automatic limits of all conceptual processes. And they begin to become naturally sympathetic not with any perspective, but with the space in which all perspectives arise."[lvii]

INDIGO and BEYOND – Super-Integral Holistic Worldview

"Indigo is the first truly transpersonal worldview, meaning a person's self awareness extends beyond the personal. It goes beyond an exclusive identification with the personality in its signature uniqueness. By its very nature, the Indigo worldview begins to transcend the separation of the subject from the object. Both are seen to arise in an interconnected unity. This level is also marked by a shift to a highly intuitive, flexible, and flowing relationship with experience and phenomena."[lviii]

With knowledge of the various stages available to us in recovery, we recognize that at each stage of the recovery process, we will view ourselves and our relationship with the world in a different way. Moreover, in order to be effective, each stage of recovery will require different recovery practices. Advancing through the stages of recovery requires that our Integrated Recovery Program must become increasingly more sophisticated in order to remain optimally successful. This suggests that the vague notion of serenity is often

misleading, because each new stage presents new difficulties and struggles. This is not to say that one becomes less serene with development, but rather that the individual is an evolving holon, which means there is always a tension between our desire to be part of and to be whole. The discontent and drive of Eros is ever present and encourages our evolution.

Understanding the nature of the Amber/ethnocentric level allows us to see why it is necessary to follow the often rigid structure and "rules" of early recovery.[3] In order to advance from the Red egocentric stages of addiction to higher stages, we must first pass through and internalize the ethnocentric Amber level. The Amber level concerns structure, rules, and conformity. These are features that most addicts rebel against, even though they desperately need them. This is why treatment centers and early recovery protocols provide rigid structure, which assists the addict to internalize the stage-structure of Amber. Without internalizing 'un-cool' Amber-structures, no further vertical development is possible, and the addict will remain stranded in a narcissistic-Red stage.

Further research and work is required to design developmental maps that accurately chart the stages of addiction and recovery.[4] A developmental map that charts the stages that addicts move through in their first year of recovery will be particularly useful for addiction treatment institutions and their staff. Information captured in such maps will provide addiction treatment specialists with an invaluable therapeutic assessment tool.

After many years clean, addicts in late recovery are often puzzled when they find themselves in psychological turmoil. This is often mistaken to mean that they are not working the fundamentals of their program. Sometimes this may be the case, but more often it results from the fact that they have entered a new recovery stage and are confronted with new challenges. Returning to basics is not always the answer. Instead, the basics are included and augmented with practices relevant to the new recovery stage.

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[3] Wilber uses a certain colour scheme to represent his different stages of vertical development. See the figure on previous page. Wilber's developmental model is a combination of evidence-based cross-cultural and trans-disciplinary developmental models of both Eastern and Western origins.

[4] I [GdP] believe what will be very useful for recovery therapists and recovering addicts is further investigation into the nature of the worldviews at each of the recovery stages as well as the recovery paradigms (practices) necessary to function legitimately at each stage. This will provide recovering addicts and therapists with more accurate maps of each recovery stage–therefore highlighting the challenges of each, as well as providing possible practices relevant for that stage.

On the one hand, addiction is characterized by constricted awareness, which results in low developmental altitude. On the other hand, recovery is characterized by an increase in awareness, which is accompanied by developmental altitude. Ultimately, the Integral Recovery approach aims to promote your overall vertical development by including practices that stimulate growth and awareness in all six recovery dimensions of your Integral Recovery lifestyle.

Study Material for Study Unit 5

- *Read Chapter 3 (Dupuy, 2013, pp. 41-63).*
- *Read Du Plessis (2015) pp. 24 – 29, and pp. 202 – 205*
- *Read Gary Nixon's article. Nixon, G. (2011). Transforming the addicted person's counterfeit quest for wholeness through three stages of recovery: A Wilber transpersonal spectrum of development clinical perspective. International Journal of Mental Health and Addiction. 1-21. Published online: 24 November 2011, 1-21. doi:10.1007/s11469-011-9365-y*

Audio and Video for Study Unit 5

- *Watch Parts 7 A -F of the John Dupuy video series on Integral Recovery (AQAL - Stages- Spiral Dynamics), which can be downloaded from http://www.integralrecovery.com/video/introduction-to-integral-recovery-video-series-part-7a-aqal-stages-fundamentals.*
- *Listen to Wilber: Therapy , Levels of Development and Being Present 8:20: http://www.formlessmountain.com/kw_audio/KW_34.mp3 (First tier to second tier leap)*

. Assignment for Study Unit 5

- *Write a 2 – 4 page essay on what insights a stage of development perspective provides to the understanding of addiction and recovery.*

- *Send assignment to your Faculty Mentor.*

Well done. You have come to the end of Study Unit 5!

Study Unit 6

The AQAL Map: States and Types

Learning Objectives for Study Unit 6:

1: To be able to explain how an understanding of states, as provided by the AQAL map, illuminates and facilitates recovery from addiction.

2: To demonstrate a cursory understanding of masculine and feminine types, as applied to addiction and recovery, as well as a cursory understanding of Enneagram types, as applied to addiction and recovery.

Introduction to Study Unit 6

"In addition to levels and lines there are also various kinds of states associated with each quadrant. States are temporary occurrences of aspects of reality."[lix] Regardless of our stage of development, states are available to us. Addicts are experts on states. Using substances or any mind-altering *behavior* is an attempt to create an altered state of consciousness and various drugs correlate with various types of altered states.

It follows that viewing addiction in terms of altered states is crucial for a complete understanding of the nature of addiction. It is curious that addiction is seldom

explored from a state perspective. An understanding of recovery from a state perspective may be one of the missing links in current addiction treatment programs' efforts to construct sustainable treatment protocol.

An understanding of states is absolutely essential to the emotional and spiritual work that we do in Integral Recovery. Recovering addicts have a very deep experiential and quick intuitive grasp of states, as the whole addictive process can be characterized as the compulsive avoidance of certain states and the compulsive attraction to other states, which are provided by the consumed substances.

When students begin to understand, both cognitively and experientially, that states are just states, that they come and go, and that they can actually become the raw materials of healing and higher developmental growth when dealt with mindfully, the whole game changes. In the words of Integral artist and rock n' roller Stuart Davis, our clients learn to "never trust a state." This means that emotions and feelings, thoughts and beliefs, arise in consciousness and then go away. One of the main objectives in our deep brainwave entrainment meditation practice is to begin to differentiate between context and content, between the pure awareness, or Witness, and the contents of consciousness—thoughts, feelings, moods, etc.

When we teach our clients to use mindfulness when their cravings for drugs arise, for example, they often come back from the experience with what amounts to awe and amazement. In other words, "It was just a feeling!" "It came, I observed it, it left, and I'm okay!" There is often the realization, "Oh, my God, *this* is what has been running my life? It's just a state!" Or, as a former student once said, "It's just a state. Don't make a philosophy out of it." So, when a negative state such as depression or cravings for drugs arises, it has no truth validity with a capital T. It is just the thoughts that emerge from the particular state. When craving drugs, the thought might be, "I've got to have it or I will die." In the case of depression, the message is often, "Life is hopeless. There is no meaning. Death would be better than this." If we bring acceptance, mindfulness, awareness, as well as spaciousness to these states,

they release and go away quite rapidly. We begin to understand the nature of states and their associated thoughts, and that they are not in any ultimate sense real, or to be trusted. Rather, states are to be understood, released, and transmuted.

This is fantastic stuff and extremely useful, whether or not we are addicts. In a conversation with Ken Wilber, he called this type of state practice "a true science of happiness." Wilber talks about four major states that are recognized by the great spiritual traditions, namely gross, subtle, causal, and nondual. This is very interesting because our modern understanding of neuroscience and brain waves has helped us to understand the different brain waves associated with these different states. For example, beta and alpha brain waves are associated with gross level consciousness, theta waves with subtle states, and delta waves with causal and/or nondual states. These brain wave states of consciousness are also very important, because one of our foundational practices in Integral Recovery is brainwave entrainment meditation, which takes one's brain from very high, rapid brainwave states, such as beta and alpha, to slower and more transformational states, such as theta and delta.

We would suggest that each of you begin to notice the subtle state changes that you go through when you are practicing your brainwave entrainment meditation, and that you begin to witness states as they arise and fade away in your day to day, moment to moment experience of being alive. What begins to occur with time and practice is that one realizes, "Oh my! I am not these states. I am the spaciousness or the pure awareness in which they arise. As this awareness stabilizes and deepens, it causes a tremendous shift and a deepening of our emotional and spiritual health. This has been characterized in Zen as recognizing your Original Face, and is perhaps the answer to the koan of Body Mind Drop. Or, as developmental psychologist Robert Kegan describes it, our former subjects or controlling subjects have become the objects of our awareness. In the case of both addiction and spirituality, this realization can be truly characterized as liberation.

Researchers argue that the majority of addiction treatment programs fail to integrate the huge body of literature that highlights the therapeutic benefits for addicts when experiencing altered states of consciousness (ASC). They propose that a principle reason for the high relapse rate in treatment programs is the failure of those programs to address the basic needs in achieving ASC and to provide addicts with those ASCs. Obviously drug use and addiction are associated with alteration of consciousness. Yet, addiction is rarely evaluated from the perspective of consciousness theory or cross-cultural patterns in the use of ASC. Some argue that humans have an innate drive to seek ASC. From this viewpoint, drug use and addiction are not understood as an intrinsic anomaly, but rather as a yearning for an inherent human need..

> Widespread Western biases against ASCs, manifested in efforts to marginalize, persecute, or pathologize them, contrast with most culture's group rituals to enhance access to ASC. These cultural biases inhibit recognition of the factors that contribute to drug abuse and prevention. Even with cultural repression of ASCs, they are still sought because they reflect systemic natural neurophysiological processes involved with psychological integration or holotrophic responses. Although cultures differ in their evaluation of and support of ASCs, people in all cultures seek ASC experiences because they reflect biologically based structures of consciousness for producing holistic growth and integrative consciousness. This near-universality of institutionalization of ASC induction practices reflects human psychobiological needs. Since contemporary Indo–European societies lack legitimate institutionalized procedures for accessing ASCs, they tend to be sought and utilized in deleterious and self-destructive patterns—alcoholism, tobacco abuse, and illicit substance dependence. Since ASC reflect underlying psychobiological structures and innate needs, when societies fail to provide legitimate procedures for accessing these conditions, they are sought through other means.

> Incorporation of practices to induce ASC through non-drug means could be useful as both a prophylactic against drug abuse, as well as a potential treatment for addiction.[lx]

From the above perspective it seems imperative that addiction treatment should provide healthy non-destructive ways to access ASC.

AA acknowledges the importance of an alteration of consciousness for recovery to be effective; it calls for "a new state of consciousness and being,"[lxi] designed to replace the self-destructive pursuit of alcohol-induced states with a healthier life-enhancing approach. AA advocates meditation, a change in consciousness, and spiritual awakening as fundamental to achieving and maintaining abstinence.

Meditation is a popular method to access ASC. This is one of the reasons why the Integrated Recovery approach advocates mindfulness-based meditation. We explore this issue in more detail in the discussion about mindfulness in a later chapter.

Therapeutic practices like neurotherapy as well as brainwave entrainment (BWE) technology in the vein of *Holosync* or *the Profound Meditation Program* are especially successful in producing ASCs in non-invasive and life-enriching ways with many beneficial remedial outcomes. BWE technology promotes alpha/theta brainwave states that are conducive to meditative states. Traditionally, the latter are not readily accessible to inexperienced meditators. Dupuy states that addicts who use binaural beats "appear to more easily let go of trauma and resentments, increase their cognitive functioning and awareness, and experience a sense of greater well-being. The feeling of "I'm getting better," and that life is and can get better, is major turning point in treatment."[lxii] The clinical application of neurotherapy to addicted populations, more specifically alpha/theta training, is shown to significantly improve the outcome of addiction treatment.[lxiii]

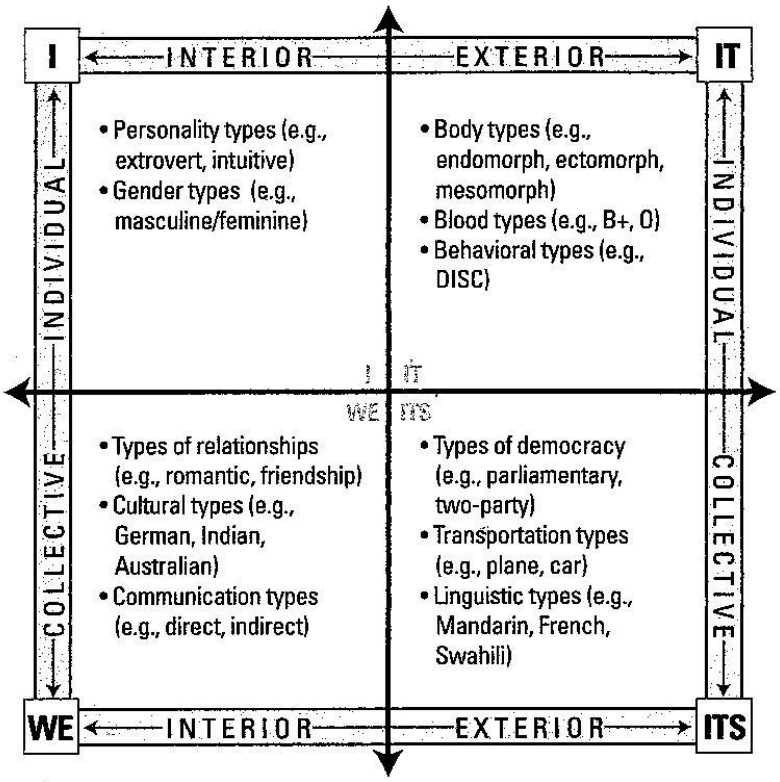
In theory, many addicts and alcoholics are deficient in alpha/theta brain waves and this results in numerous psychological problems. Neurotherapy aims to repair this brain state imbalance through exercising the client's brain in a non-invasive manner that naturally enhances alpha/theta brain waves. According to Fahrion, addicts are often incapable of enjoying pleasant feelings during simple life experiences that results from a neurologically-based inadequacy. Blum's *Reward Deficiency Syndrome* model concurs with these ideas. He argues that a neurological-normalizing change can take place as result of neurotherapy, because it rectifies the continuous pursuit for neurotransmitter equilibrium. Because it appears that the effective mechanism of neurotherapy addresses the *Reward Deficiency Syndrome* and *Feel Good Response* model, the *Altered-State Fulfillment* model, the *Natural Mind* models, *Tension Reduction* and stress-related hypothesis, I believe that neurotherapy will become an essential component of the ideal treatment package .

The above should make it obvious that a recovery practice that promotes healthy modes of changing consciousness will automatically be more successful. Because of this, the Integrated Recovery model advocates healthy, non-invasive, life-and-recovery-supporting practices and therapies that encourage alteration of consciousness.

Types

Types provide another essential lens in our Integral approach to recovery. The two most fundamental typologies we look at are the masculine and the feminine. We look at the strength and pathologies of both, the necessity of integrating these two typologies for optimal health, spiritual as well as emotional, and individuation, to use the Jungian term. Types is the fifth and final element of Wilber's AQAL model that is investigated here. Knowledge of types is essential to a comprehensive understanding of addiction and recovery. "Types are the variety of consistent styles that arise in various domains and occur irrespective of developmental levels. As with the other elements, types have expression in all four quadrants".[lxiv]

It follows that, in each of the four quadrants, we can have a variety of classifications of different "types" in the context of addiction and recovery. These include but are not restricted to types of addictions (heroin, crack etc), types of cultural enmeshment (a-cultural, bi-cultural, and culturally enmeshed), types of dual-diagnosis, types of "kinship" in sub-cultures (punk, metal, trance, hip hop, criminal etc.), "brain state" types and DSM-IV-TR axis II disorder types.



Types in All Quadrants

Classifying various "types" in the framework of addiction and recovery that span the four quadrants is an area in need of considerable work. Theoretical fine-tuning in this area of integrally informed recovery theory will present valuable evaluation and procedural tools for designing individualized treatment protocols for specific types of addicts (by identifying etiological factors that play a significant role in contributing to an individual's addiction). So, custom-made protocols will deal with definite causal factors

or unmet requirements particular to an addiction type. In addition, and in the context of recovery and addiction, an understanding of personality and culture types will help to prevent addictions therapists from "squeezing" every person into the same, nonspecific framework of what a healthy recovering individual ought to be.

There are many personality types in the context of addiction and recovery. One example is that of feminine and masculine types. "When we speak of "masculine" and "feminine" we are not necessarily speaking of a biological "male" or "female". Rather, we are referring to a spectrum of attitudes, behaviors, cognitive styles, and emotional energies".[lxv]

In my opinion (GDP), the psychoactive properties of drugs as well as aspects of process addictions can include a masculine and/or feminine "voice." "Downers," like tranquilizers, barbiturates, and heroin can be said to have a feminine "voice" (Thanatos). In addition, addictions like co-dependency, love addiction, certain behaviors of sex addiction, and certain aspects of gambling (particularly slot machines) have a similar voice. On the other hand, "uppers," like cocaine, methamphetamines, and process addictions like certain high-risk aspects of sex addiction and gambling (especially those who play tables) represent a more masculine "voice" (Phobos). I believe that these masculine or feminine "voices" of specific addictions are likely to correlate with specific "addiction neuropathways".

"Masculine" addictions trigger the "arousal neuropathways" of the brain and these are about pleasure and intensity. "Feminine" addictions stimulate the "numbing or satiety neuropathways" of the brain that produce a calming, relaxing, and soothing effect. I also observed a connection between the "object-relations" that addicts have with their parents and their drug(s) of choice. I believe that addicts' "object-relations" can have pathological masculine and/or feminine aspects. As a result, these alter brain chemistry that cause individuals to be more prone to certain "masculine or feminine addictions", and the purpose of these is to rectify the neurochemical malfunctions caused by dysfunctional "object-relations." This could explain my observation that many heroin

addicts have distant or absent fathers, so they are enmeshed with their mothers. In contrast with this, many cocaine addicts tend to have distant or absent mothers with authoritarian fathers.

From one perspective then, addiction can be seen as a dysfunctional attempt to rectify the addict's pathological masculine and feminine "object-relations." In early recovery, the relationship between addicts and their counselors or therapists are crucial in remedying these dysfunctional "object-relations." If not treated, then the addict will seek to cure such imbalances by dysfunctional means.

Interestingly, I also observed that when addicts cross-addict they are inclined to remain within masculine or feminine "addiction types." Because of the above, understanding the "voice" of the addiction can help in choosing a suitable therapeutic treatment plan. Many addictions and addiction systems can only survive in the dialectic between masculine and feminine "voices": For example, that between the alcoholic and the co-dependent enabler and the "dance" of the love addict and the love avoidant. To return it to healthy balance, the treatment professional must identify which "voice" has become pathological.

Let's use the heroin addict as an example. S/he is addicted to a "feminine" drug and there are few things in the world that instantly soothe and 'nurture' as a shot of heroin. Evidently the heroin addict needs self-soothing and nurturing—possibly due to being enmeshed with an over-involved mother or distant/absent mother. Consequently, the addict never learns how to self-sooth, nurture, and take care of him or herself. This may manifest itself in areas like administrative unmanageability (common among heroin addicts). This may also explain why heroin addicts are known to enter relationships in early treatment and often have love addiction traits (a feminine-voice addiction). The heroin addict has unresolved nurturing and self-soothing needs, and if not taught how to satisfy these needs in a healthy way, then s/he will continue to cross-addict.

Considering the above, an understanding of the "masculine" and "feminine" voice of our addition can guide us in recovery because it can point out our individual needs. So we can understand the "masculine addict" (Phobos) as agency gone awry, and "feminine addiction" (Thanatos) as communion gone off-center. Those driven by Phobos (unhealthy agency) need balancing through healthier agency, while those driven by Thanatos (unhealthy communion) need balancing through healthier communion.[5]

It follows that, understanding 'types of addicts' in recovery can be a very helpful resource. Appreciating the characteristics of various types that you exhibit—personality types, brainwave state types, neurological constitution types, and so forth—will identify your specific requirements. This will alert you to the specific features that your Integral Recovery lifestyle must include.

Study material for Study Unit 6

🕮 ***Read Chapters 5 & 6 (Dupuy, 2013, pp. 83-102).***

🕮 ***Next read Du Plessis (2015) pp. 30 – 36.***

Audio and Video for Study Unit 6

✇ ***Watch Part 9C of the John Dupuy Integral Recovery video series (States of Consciousness): http://www.integralrecovery.com/video/introduction-to-integral-recovery-video-series-part-9c-states-of-consciousness***

[5] Obviously many addicts suffer from both masculine and feminine voice pathologies and addictions, yet most will have a tendency to lean more towards one side of the masculine/feminine addiction continuum or certain environments will activate a certain pathological voice. This concept is meant to be used as a general orienting framework not as an exact diagnostic tool.

Assignments for Study Unit 6

- *Write a 2-page essay on how an understanding of states facilitates work in the emotional and spiritual lines in Integral Recovery.*

- *Write a 2-page essay on why understanding types is important for having a comprehensive understanding of addiction.*

- *Send assignments to your Faculty Mentor.*

Well done. You have come to the end of Study Unit 6!

Study Unit 7

Trauma and Shadow Work

Learning Objectives for Study Unit 7:

1. Students will be able to explain why shadow and trauma work is an essential part of the recovery process.

Introduction to Study Unit 7

All emotions are pure which gather you and lift you up; that emotion is impure which seizes only one side of your being and so distorts you.

— *Rainer Maria Rilke*

We now realize that feelings are much more important than originally thought. Silvan Tompkins believes feelings are the primary biological motivating force of human behavior. He believes "the primary blueprint for cognition, decision, and action is provided by the effect system."[lxvi] For Tomkins, feeling is a mode of thinking and therefore, inseparable from decision and action.

In his book *Descartes' Error,* neuroscientist Antonio Damasio supports Tompkin's position in pointing out that when we damage the part of our brain that controls feelings, we cannot make decisions. Tompkins goes on to say that "without feeling, nothing matters, and with feeling, anything can matter."[lxvii] Emotional intelligence is therefore essential for effective living. Fritz Perls adds:

> If emotion is, as I have hypothesized, the basic force that energizes all action, it exists in every life situation. One of the most serious problems of modern man is that he has desensitized himself to all but the most overwhelming kind of emotional response. To the degree that he is no longer capable of feeling sensitively, to the degree he becomes incapable of the freedom of choice, that results in a relevant action.[lxviii]

Addicts are known to have turbulent and overwhelming inner worlds. Addiction is often referred to as an attempt at "self-medicating" the addict's painful and confusing inner worlds. According to object-relations theorist Khantzian, the reason that addicts have such fragmented inner worlds is that they often have "defects in ego and self capacities, which leave such people ill-equipped to regulate and modulate feelings, self-esteem, relationships, and behavior."[lxix] It is widely believed in reputable treatment centers that emotional intelligence must be acquired for the recovering addict to achieve sustained recovery. Addiction is caused by, and causes, emotional illiteracy.

The Cycle of Addiction and Trauma

For humans to survive when young, they need close, bonded relationships. Tian Dayton calls these essential relationships "survival bonds." We are designed in such a way that we are rewarded when forming these bonds, because the survival of our species depends on it. When, as infants, we are in intimate contact with our mothers, our brains release a "reward chemical" known as beta endorphin, similar to morphine. When these bonds are threatened, we experience terror or rage, and when these bonds are ruptured, we feel as if "our inner and outer worlds are falling apart."[lxx] When these ruptures occur, the infant experiences serious trauma. Rupturing of early bonds is the most traumatic, but any subsequent bond dysfunction creates further trauma. These traumatic memories are stored in our minds and bodies (and likely energy bodies as well) and are collectively referred to as cellular memory. Candace Pert states that, "Intelligence is located not only in the brain, but in cells that are distributed throughout the body… The memory of trauma is stored by changes at the level of the neuropeptide receptor … This is taking place bodywide."[lxxi]

"When our basic life needs are not met adequately early in life, we develop an emotional hunger that is never met and is characterized by our seeking to redo the past—to meet our early unmet needs with the wrong people at the wrong time and place."[lxxii] If we were traumatized as children, we will be left with significant deficits in psychological development as well as the ability to engage in healthy nurturing relationships—making us prone to addiction in later life. This inner emptiness, loneliness, and pain, coupled with a fear and deficit in the ability to form intimate relationships, leaves us with few options to meet our needs other than to reach out for something "non-intimate"—like substances. When traumatized, our ability to self-regulate is compromised. That is why addicts are often characterized by poor self-regulation skills and poor impulse control. Addiction is often a dysfunctional attempt to self-soothe and bring some peace to our anxious, empty, and confusing inner worlds.

> A traumatized person does not have access to the left hemisphere of the brain, which translates experience into language, therefore, they can't make meaning out of what is happening to them or put it into any

> context. The right hemisphere evaluates the emotional significance of incoming information and regulates hormonal responses. Traumatized people have been known to have trouble tolerating intense emotions without feeling overwhelmed and thus continue to rely on disassociation. This interferes with their ability to utilize emotions as guides for action. Such individuals go from stimulus to response without being able to figure out what upsets them. They overreact, shut down, or freeze.[lxxiii]

Addicts are known to be out of touch with their emotions. They have difficulty feeling certain emotions as well as naming and tolerating them. Addicts often experience feelings as vague, overpowering sensations over which they perceive they have little control. This lack of inner-control is often a frightening experience. In this context, addiction is seen as addicts' dysfunctional attempt to control their out-of-control inner worlds. Our substance of choice becomes our main method of mood management, which temporarily restores our inner equilibrium. That is why we often hear addicts say things like, "I never felt normal until I started using drugs," or, "I always felt like there was something missing inside, and when I took drugs I felt complete." One of the many problems with this method is that it further denies access to our internal world, which we must access in order to resolve our trauma. "While trauma victims gain the temporary relief they are seeking [by self-medicating], they do so at the expense of self-knowledge and the potential for self-mastery."[lxxiv] I will quote Flores at length as he superbly describes the cause and progress of addiction from a psychodynamic perspective.

> Addiction... is viewed as a misguided attempt at self-repair. Because of unmet developmental needs, certain individuals will be left with an injured, enfeebled, uncohesive, or fragmented self. Such individuals often look good on the outside, but are empty and feel incomplete on the inside. They are unable to regulate affect and in many cases are even unable to identify what it is that they feel. Unable to draw on their own internal resources because there are not any, they remain in constant need (object hunger) of having those self-regulating resources met externally–out there. Since painful, rejecting, and shaming

> relationships are the cause of their deficits in self, they cannot turn to others to get what they need or have never received. Derivation of needs and object hunger leaves them with unrealistic and intolerable affects that are not only disturbing to others, but shameful to themselves. Consequently, alcohol, drugs, and other external sources of gratification (i.e., food, sex, work, etc.) take on a regulating function while creating a false sense of autonomy, independence, and denial of need for others... addiction is an attempt at self-help that fails.[lxxv]

What makes matters even worse, is that the addictive process becomes autonomous—it begins to take on a life of its own. "The withdrawal from authentic emotions and alienation from the self that the drug induces leaves trauma victims helpless before their own internal world, and the "learned helplessness" of the trauma victim is thereby reinforced."[lxxvi] Addiction becomes a vicious cycle—the more we medicate our unresolved pain, the less able we are to deal with it. Addiction then creates further trauma that also remains unresolved. The result of years of unresolved and repressed feelings and trauma is that many addicts reach a point where mere feelings associated with being "straight" become an unbearable torture. This enlightens us as to why a good self-help book cannot break this vicious cycle. Literally, the addict has lost all volition of his inner world and behavior and now sits in the passenger seat of his dysfunctional "psychic bus. "

Breaking the Cycle through Emotional Literacy

An essential component of recovery is becoming emotionally literate and dealing with unresolved trauma. If this does not happen, our addiction will continually migrate, seeking dysfunctional ways to deal with the unresolved trauma. This is a very common occurrence in 12-step fellowships. One of the most commonly used defenses, when faced with trauma, is to go numb, or freeze, therefore we are often not conscious of these areas of disowned pain. Some scholars believe this is why we re-enact our early traumas in adult relationships. It is an attempt to make the unconscious conscious. The re-enactment of trauma is often

seen when addicts enter into relationships in early recovery. From this perspective, we see why relationships in early recovery are often disastrous. Addicts in early recovery are by default attracted to somebody who will re-enact the unresolved trauma. When the trauma is re-enacted, they lack the emotional maturity to cope with the resulting emotional turmoil, and then often revert to the coping skills they know best.

To deal with our unresolved issues and un-metabolized pain, we must become emotionally literate in order to have the ability to accurately tune in to our internal world and then to act appropriately on the information we've received. We need to put feelings into words, so that we can understand these feelings within some form of psychological context. The problem with memories of trauma is that they bypass the cortex and are stored in other parts of the brain such as the basal forebrain and amygdala. We cannot access these memories by thinking—we do not have ready access to them. On the other hand, talking about trauma allows us to name our feelings, which allows our memories to be lifted from out of a semiconscious state into our consciousness. As a result, we can begin to modulate our emotions and slowly gain mastery of our inner worlds. Tian Dayton identifies four stages of progression in developing emotional literacy:

Stage One: Feel the Fullness of the Emotion

We need to learn to sit with our feelings. We cannot begin to understand our inner worlds if we first do not learn to fully experience them. The first stage is merely to feel the feeling in all of its dimensions.

Stage Two: Label it

Next we need to name our emotional experiences. Naming or labeling emotions makes us feel better. Scientists have shown that labeling feelings elevates the immune system. Furthermore, labeling and the development of emotional

awareness help build emotional resilience, which enables us to handle difficult emotions better in the future.

Stage Three: Explore the Meaning and Function Within the Self

In this stage, we explore the meaning that feelings and state-experiences have within our inner worlds. Is your behavior in line with your feelings? Are they congruent? Understanding the nature of our inner worlds is a complex process. Moreover, knowing the function that thoughts and feelings have within the self-system requires considerable self-reflection.

Stage Four: Choose Whether or Not to Communicate Our Inner State to Another Person

At the fourth stage we have a choice. We now understand our inner experiences and can choose what to do with this information. To have full emotional literacy, we must have the capacity to share our inner worlds with others. Moreover, we must be able to know with whom it is appropriate to share our experiences and also be able to engage in back-and-forth communication.

Emotional literacy is an acquired skill, like playing guitar. Jimi Hendrix did not wake up one morning and start to jam Voodoo Chile. No, he practiced for years. In the same way, to be emotionally literate, we need to be educated and practice the skill. Addicts are profoundly emotionally illiterate—either because it was never taught to them and/or due to years of addiction. Therefore, a pivotal aspect of any recovery process needs to be guidance and practice in the development of emotional literacy.

The Shadow

The shadow, Carl Jung says, represents everything that we, as individuals, refuse to acknowledge about ourselves. Therefore, the shadow is always forcing itself upon us, directly or indirectly. The aspects of our traumas and experiences that, for whatever reason, we were unable to integrate and process become unconscious and turn into shadow material. Freud listed many primary and secondary defenses that we use to protect ourselves against overwhelming anxiety—all of which contribute to our shadow. These processes do not only happen when we are young but may continue throughout our lives, as we continue to disown parts of our personalities that do not fit in with our image of ourselves. We may then repress, reject, deny, or project this onto others. Moreover, addiction, by default, creates vast amounts of shadow material; it is commonly known that denial is one of the biggest stumbling blocks for sustainable recovery. Denial is the denial of our shadow.

The purpose of shadow work is to undo these repressions and bring our shadow material into the light and finally integrate it, which leads to psychological health and clarity. There are many ways to do shadow work. One of the greatest contributions of Western academia is its contribution to our understanding of the shadow and the consequent field of psychology and methods of psychotherapy. Traditionally, the realm of shadow work is that of psychotherapy. The field of psychotherapy is incredibly diverse and often confusing to practitioners and scholars, because different schools of thought wrestle for dominance and credibility. Traditionally, many schools of psychotherapy prove themselves right by proving others wrong. This is most unfortunate, as it merely causes fragmentation within the discipline.

Eclectic and integrative approaches to psychotherapy have gained recent popularity, which has certainly counteracted some of the fragmentation. The emerging field of Integral Psychotherapy is an attempt to integrate and make sense of all these diverse approaches by finding value in all the diverse schools of psychotherapy. *The Handbook of*

Integral Psychotherapy[6] is currently being written, and many health professionals are applying an integrally informed method to psychotherapy.

For recovery to be effective and sustainable, we need to be in a continual process of shadow work. Addiction thrives in our shadow, and, if our shadow material is left unprocessed and unchecked, it is most certainly bound to cause relapse and/or cross-addiction. The problem with the shadow is that even though it is unconscious, it requires a great deal of energy to keep it unconscious; furthermore, it sends negative signals and destructive impulses to our consciousness. The more shadow material we have, the less conscious control we have in our lives; we become controlled by unconscious impulses, like leaves blowing in the wind.

Have you ever heard somebody say, "I promised myself I would never be like my father/mother, but I have become just like him/her?" This is shadow in action. How else could we end up doing things that we consciously want to avoid? Put simply, the shadow often lets you do the things you least want to do. Working through shadow material gives us conscious control of our lives. This is as important for people in long-term recovery as for those in early recovery. As we develop to higher levels of consciousness in recovery, our shadow material becomes more complex, and often more intense and even more difficult to navigate. It was only after many years clean—and with the naive belief that by then I had worked through my issues—that I was confronted with some very powerful shadow impulses and was plunged into deep confusion and pain.

Integral Psychotherapy will help addicts choose which type of psychotherapy they need at different stages of their recovery; each new level brings new possible shadow pathologies. Just because you are clean for ten years, have done a couple of Step 4's and spent two years dealing with adult child issues, does not mean you are "shadowless." As

[6] Written by Marquis & Ingersoll. Also see *Integral Psychotherapy.* Ingersoll & Zeitler and *A Guide to Integral Psychotherapy,* Forman, both these books give a brilliant introduction to the newly emerging field of Integral Psychotherapy.

soon as you have kids, or get married, or enter a new stage of personal growth, pathology lurks somewhere. A healthy Integral Recovery lifestyle means to be in a constant process of shadow work and emotional health. Don't worry. This does not mean endless therapy and daily emotional excavation work. There are simple methods to keep us psychologically healthy, as well as more intensive methods for if and when the need arises.

The 3 - 2 - 1 Shadow Process

Ken Wilber's 3-2-1 Shadow Process is a simple yet powerful technique that you can incorporate into daily Step 10 journaling.[7] This technique can also be applied in the here and now. This technique is the distilled essence of shadow work that happens in psychotherapy. Seeing that resentments are the number one cause of relapse, this technique can prove invaluable—it is a powerful resentment buster. This practice is also useful when doing the resentment part of your Step 4. Apply this technique to each resentment. The problem with resentments is that they take a huge amount of psychic energy and literally poison our body-mind. I often visualize resentment as a little man living in my psyche—the bigger the resentment, the bigger his house. Some are so big, they even get married to other resentments and have children; eventually they start planting crops and may even build a little village. Over time, your psyche may become densely occupied with theses villagers, harvesting the land of your psychic energy.

After I completed the resentment part of my Step 4, it felt like my psyche was detoxed. I had all this new psychic land to inhabit with constructive and healthy populations. We cannot become spiritually well while hanging onto resentments. This is so, because spirituality requires receptiveness and "openness" for a spiritual transformation to take place. Spiritual transformation cannot occur amongst villages of resentments.

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[7] I am providing an abridged version of this practice; for more in-depth information, see Ken Wilber et al. *Integral Life Practice*

> When addicts bottle up their angry feelings, their rage congeals into resentment—a destructive force that can be aimed towards others, themselves, and the universe itself. In Dostoevsky's *Notes from the Underground,* there is an analysis of resentment as the chief attitude that smolders in the Underground Man, killing his love and creativity. Nietzsche, in *On the Genealogy of Morals*, calls resentment the sickness of the *Untermensch*, the person who fears creativity and who tries to kill it in themselves and others. Resentments are also underlined in the *Big Book* of Alcoholics Anonymous as the "number-one offender" that destroys more alcoholics than anything else. Their resentment is seen as the major force behind recovering addicts' return to their addiction. From resentment stems all form of spiritual disease.[lxxvii]

There are two ways to recognize the shadow. First, that which "makes you negatively hypersensitive, easily triggered, reactive, irritated, angry, hurt, or upset. Or, it may keep coming up as an emotional tone or mood that pervades your life."[lxxviii] In short, anything that pisses you off. Or, that which "makes you positively hypersensitive, easily infatuated, possessive, obsessed, overly attracted, or perhaps it becomes an ongoing idealization that structures your motivation or mood."[lxxix] It is important to know that our shadow not only contains repressed negativity, but also the positive aspects of ourselves that we do not acknowledge.

In the book *Integral Life Practice,* Ken Wilber et al. describe the 3–2–1 Shadow Process in three simple steps.

3 – Face It

Observe the disturbance very closely, and then, using a journal to write in or an empty chair to talk to, describe the person, situation, image or sensation in vivid detail using 3rd-person pronouns such as "he," "him," "her," "they," "it," "its," etc. This is your opportunity to explore your experience of the

disturbance fully, be specific about what it is that bothers you about them. Don't minimize the disturbance—take the opportunity to describe it as fully and in as much detail as possible.

2 – Talk to it

Enter into a simulated dialogue with this object of awareness using 2nd–person pronouns ("you" and "yours"). This is your opportunity to enter into relationship with the disturbance, so talk directly to the person, situation, image, or sensation in your awareness. You may start by asking questions such as, "Who/what are you? Where do you come from? What do you want from me?" Then allow the disturbance to respond back to you. Imagine realistically what they would say and actually write down or vocalize it. Allow yourself to be surprised by what emerges in the dialogue.

1 – Be it

Now, writing or speaking from the 1st person, using the pronouns "I," "me," and "mine," be the person, situation, image, or sensation that you have been exploring. See the world, including yourself, entirely from the perspective of that disturbance and allow yourself to discover not only your similarities, but how you really are one and the same. Finally, make a statement of identification: "I am _____" or " _____ is me." This by nature, will almost always feel very discordant or "wrong" (after all, it's exactly what your psyche has been very busy denying!). But try it on for size, since it contains at least a kernel of truth. To complete the process, let the previously excluded reality register not just abstractly but on multiple levels of your being. This engenders a shift in awareness, emotions, and subtle energy that frees up the energy and attention that was taken up by your denial. You'll know that the process has worked, because you'll actually feel lighter, freer, more peaceful and open, and sometimes even high or giddy. It makes a new kind of participation in life possible.[lxxx]

Mindfulness of Your Current Emotion

The next technique we will discuss originated from Dialectic Behavior Therapy (DBT). "DBT is a broad-based cognitive behavioral treatment developed specifically for Borderline Personality Disorder," but is also used with many other populations, like adolescents and addicts.[lxxxi] DBT uses psychosocial skills training in group and lecture settings and is clinically proven to be very effective. I [GdP] used it with great success in a clinical environment with addicts. One of the modules of DBT focuses on emotional regulations skills. The technique I describe is from that module.

According to DBT, painful emotions are part of the human condition, and it assumes there are valid reasons for these painful emotions. It also assumes that we cannot get rid of them, and therefore the only real option is to find ways of relating to emotions so that they do not induce unnecessary suffering. It suggests that the way to do this is through accepting the emotions. This is in line with the principle of mindfulness, which is the core module in DBT. The psychosocial skill of "Mindfulness of Your Current Emotion" comprises four simple steps; simple, but powerful.[8]

The four steps are as follows:

1. **Observe your emotion**

   Just note the presence of the emotion. Step back and recognize what is arising. It is also useful to name it. Say to yourself I am experiencing _____ right now.

2. **Experience your emotion**

   Do not suppress or block the emotion. Rather experience it with all of its accompanied bodily sensations. Feel its presence in various parts of your body. Just experience it fully. Give yourself permission to feel it, whatever it is.

[8] This technique is similar to the Sedona Method. See www.sedonanmethod.com.

3. **Remember: You are not your emotion**

   Do not necessarily act on the emotion. Remind yourself that this too shall pass, that you are more than your feelings, and that it is merely something that is happening to you—it is not you. You can also remember times when you have felt differently to remind yourself that this current feeling will pass.

4. **Practice loving your emotion**

   Don't judge your emotion—accept that this is what is happening now, and say to yourself, it is okay. Do not engage in self talk about the appropriateness of the emotion. Practice loving your current emotion by accepting it.

The purpose of this simple technique is not to avoid acting responsibly relative to the emotion, but to give you greater clarity, so as to act in the best possible way. Much of our suffering results from secondary emotions. These are emotions resulting from our response to emotions we experience: such as feeling shame that we are angry or angry that we are scared. By totally accepting your emotion first, and experiencing it without judgment, you can act responsibly. Addicts often have labile emotions that are not connected to reality. More often than not, the best thing is not to act, but rather to ride them out.

Using the phrase "This too shall pass," is a powerful mantra to repeat in emotionally distressing episodes. The more we learn to sit with difficult feelings, without acting destructively or medicating them, the less power they hold over us in the future, and consequently, the less we suffer. This technique can also be applied when experiencing strong emotions while meditating.

Therapy

It is common for recovering addicts to be in therapy at various stages of their recovery. I believe it is an essential aspect of a sustainable Integral Recovery lifestyle.

The question is not whether I do therapy or not, but rather, what therapy is appropriate for the current stage of my recovery.

The problem with therapy, in the context of recovery, is that certain types of therapy and/or therapists can become counterproductive to the recovery process—and this is sometimes fatal. It is not unheard of that certain therapists unfamiliar with addiction have advised their clients that controlled drinking or using is an option, that they are not addicts now that they have resolved the psychodynamic causes of their addiction; they are cured of it, and so on. These are extreme examples, but there are also less severe degrees of danger. For example, therapists working on trauma or family of origin issues too early in the recovery process might create such emotional turmoil that their client relapses.

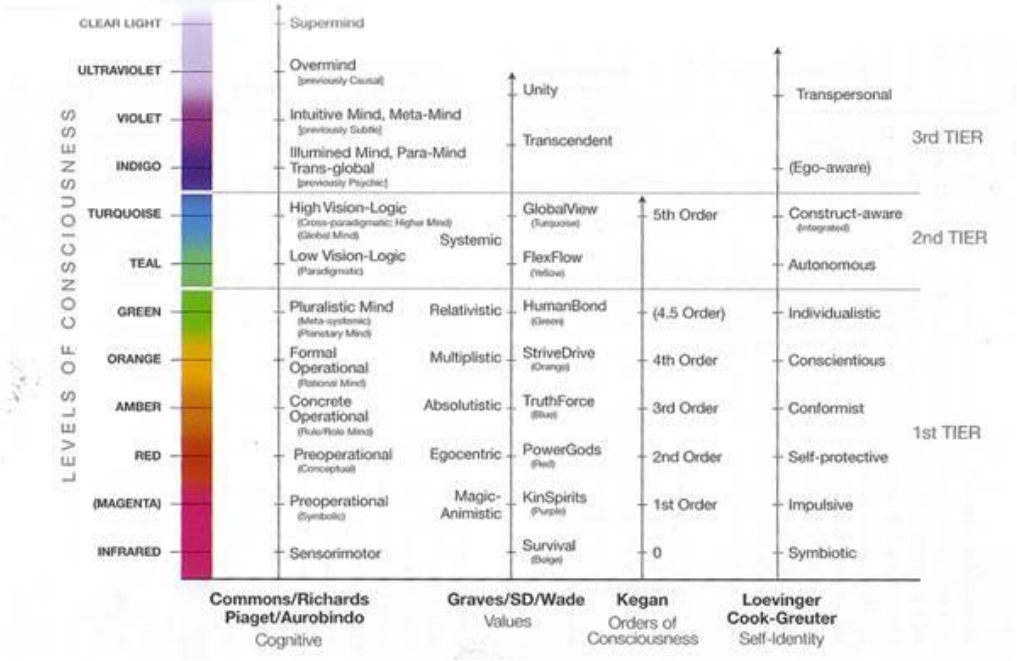
Another danger of therapy for recovering addicts is when they do so much therapy that they start equating therapy with recovery and, as we have seen, therapy is only one of many components. This attitude can create more self-obsession through constant morbid introspection. This is the "shadow side" of therapy. Another potential danger is that therapists are, in general, unfamiliar with existing recovery theory and conditions like co-dependency and adult-child syndrome. Trying to "treat" these conditions using pathology frameworks like the DSM-IV can cause more harm than good.

Now let's look at the upside of therapy. My simple advice, to avoid the above-mentioned dangers, is that you should not consult a therapist who is not knowledgeable about addiction or up to date with contemporary recovery theory.

Recovering individuals require different therapies at different stages of recovery, because each stage presents its own set of unique challenges. Clearly, if you are ten years clean, married with kids, or if you are three months clean and fighting cravings, then the challenges that your life situation present are different. Additionally, from a self-developmental perspective, as we progress to new and higher levels of personal development, new needs and potential pitfalls will arise. Shadow work is required at

each of these new stages. A question remains, What type of therapy is optimal at your current level of personal development? For those interested in exploring this issue further, I recommend Wilber's *Integral Psychology*.

In our previous discussion on stages of development, I pointed out that our different lines of development take place through a range of stages that can be classified in many ways. A simple stage model is presented comprising three stages: pre-personal, personal, and supra-personal—or egocentric, ethno-centric, and world-centric. Each stage can be further subdivided.



Different developmental stage models

For this discussion, I use nine stages, or levels, as indicated by Wilber, each pertaining to a certain fulcrum of development. As pointed out before, our developmental lines do not rest at the same stage of development, but are at various levels. But our self's center of gravity rests predominantly at a certain stage of development. Each of the nine stages has its own range of potential pathologies, with

certain therapies being particularly effective in their area. The beauty of using a developmental approach to therapy is that it provides the ability to choose a therapy that is most appropriate for the stage of development you are experiencing difficulties with. Different types of therapy are stronger at certain stages of development. For instance, existential therapy is more relevant for the vision-logic level of development in dealing with meaning-of-life issues than for the sensori-physical level when dealing with psychoses.

Using a developmental approach, we—possibly with our therapist—can decide on the type of therapy that will be most effective for our present issues. Wilber writes, "So it is not that a given therapy applies to one narrow wave of development, but that, in focusing on one or two waves, most forms of therapy increasingly lose their effectiveness when applied to more distant realms."[lxxxii]

In the table below, I provide a spectrum of human development and point out nine correlated levels, classes of Psychogenic Pathology, Defenses, and Treatments. Consulting a chart like this can help in choosing the most appropriate form of therapy.[lxxxiii]

Table 4.1 The Spectrum of Human Development, Psychogenic Pathology, Defenses, and Treatment

General Realm	Level/Fulcrum	Class of Psychogenic Pathology	Common Defenses	Optimal Treatment
Prepersonal (body)	Sensoriphysical	Psychoses	Hallucination, delusional projection, wish fulfillment	**Pharmacotherapy with psychotherapy as adjunct** (behavioral and cognitive-behavioral approaches)
	Phantasmic/ emotional	Borderline and narcissistic disorders	Splitting, (projective identification), selfobject fusion	**Structure-building approaches:** object relations, self psychology (dialectical behavior therapy)
	Representational mind	Neuroses	Repression, (projection), reaction formation	**Uncovering approaches:** Psychodynamic: Jungian, ego psychology; Gestalt; focusing; (experiential/person-centered)
Personal (mind)	Rule/role mind	Script pathologies	Displacement, duplicitous transaction, covert intention, (repression)	**Script analysis** (collaborative empiricism, cognitive therapy, REBT, Adlerian, reality therapy, etc.)
	Formal-reflexive	Identity neuroses	Sublimation, anticipation, suppression	**Introspection, philosophizing, Socratic dialogue** (experiential)
	Vision-logic	Existential pathologies	Inauthenticity, deadening, aborted self-actualization, bad faith	**Existential psychotherapy** (experiential approaches)
Suprapersonal (spirit)	Para-mental	Psychic disorders	Pranic disorder, yogic illness	**Path of yogis** (sometimes temporary suspension of contemplative work)
	Meta-mental (Illumined mind)	Subtle disorders	Failed integration, archetypal fragmentation	**Intensification of contemplative practice, increased contact with spiritual teacher**
	Over-mental (Intuitive mind) Super-mental	Causal disorders	Failed differentiation, Arhat's disease	**Collaboration between student and spiritual teacher**

Adapted from *The Collected Works of Ken Wilber* by Ken Wilber © 1999, vol 4. Reprinted by arrangement with Shambhala Publications, Inc. Boston, MA, www.shambhala.com. (Note that items in parentheses were added by the present author, based upon empirical research presented in the professional literature.)

Below I quote Andre Marquis at length as he skillfully summarizes the rationale for applying different therapies at different stages of development.

> Because psychotic, borderline, and narcissistic clients (with disorders that derive from the first two prepersonal levels of development) lack the psychological structure (i.e., ego or self) required to make their experiences cohere in a relatively stable manner—which promotes the sense of being an individuated self that is separate from yet related to others—some form of structure-building approach is the most helpful to these people. Examples of structure-building approaches include those of Kernberg (1980); Kohut (1977, 1984); Masterson (1981); Linehan (1993); Stolorow, Atwood, and Orange (2002); and Stolorow, Brandchaft, and Atwood (1987).

For individuals struggling primarily with neuroses—in which disturbing symptoms arise that are symbolic of repressed, projected, or otherwise defended-against impulses—uncovering approaches are most useful. In the case of the neurotic client, he has enough psychological structure to repress, project, and so on. That is, after all, why his issues are seeking expression in symbolic symptoms such as disturbing dreams, somaticized bodily pains, phobias, and so forth. Thus, these clients do not need to build structure (as was the case with those with psychotic, borderline, and narcissistic disorders). Rather, they will benefit the most from uncovering what they have kept out of their awareness; hence, the general category of uncovering approaches (which span the entire spectrum of psychoanalytic, psychodynamic, and other "depth" approaches).

The next general category of treatment involves those clients who have acquired the sense of a relatively coherent and individuated sense of self but are challenged with struggles revolving around the process of further elaborating and defining their autonomy and/or interdependence in terms of the rules and roles they abide by, and by deeper answers to questions such as, "Who am I?" and "How can I live as fully and authentically as possible?" (In other words, clients with disorders that derive from personal levels of development).

For clients with script pathologies and/or systematic biases in reasoning and thinking, a generally cognitive approach (such as transactional analysis, Beck's cognitive therapy, Ellis' Rational Emotive Behavior Therapy) is most effective.

For clients with identity neuroses—in which the individual struggles with establishing autonomy and self-directedness rather than merely conforming to societal, cultural, and other collective standards—an introspective, experiential, philosophical approach will likely be maximally helpful. Given

> that the brunt of an identity neurosis involves the epistemological and moral conclusions one arrives at through formal reflexive thinking (rather than merely swallowing conventional mandates, as is common at the preceding stages), philosophical problems are central to identity neuroses, and thus philosophical education or counseling is a legitimate and often primary component of the therapy.
>
> For clients whose primary concerns are existential in nature—such as deeply assuming responsibility for one's life, acknowledging one's morality, isolation, freedom, and striving to live an authentic, self-actualizing life—existential-humanistic approaches (Yalom, Burgental, Perls, Rogers) are most effective. However, if a client is dealing with transpersonal or suprapersonal issues (i.e., most conventional mental health professionals would consider her healthy, perhaps even significantly self-actualizing, but she nonetheless intuits that she could experience more joy, meaning, and interconnectedness with the Kosmos; in other words, clients with disorders that derive from supra-personal levels of development), a Jungian approach, Assagioli's psychosynthesis, or other transpersonal approaches (e.g., Washburn, 1988, 1994; Welwood, 1985, 2000) are most appropriate.[lxxxiv]

Healthy Boundaries

An aspect of psychological health that is worth mentioning, and that provides a balance to our discussion so far, relates to boundaries. Psychological health does not only mean that our inner worlds are stable and healthy, but also that we relate to others and the world in healthy ways. For that, we need healthy boundaries. Most addicts have problems with their boundaries; they are either too rigid (pathological masculine) or too porous (pathological feminine) features. Depending on the nature of a relationship, we can switch from one to the other. Nowhere are pathological boundaries exemplified more poignantly than in the myth of Narcissus and Echo.

Echo was the fairest of the wood nymphs and one of the most talkative. But her talkativeness got her into trouble with Hera, the wife of Zeus. Known for her jealous outbursts, Hera thought that Echo was purposely distracting her with talk, while Zeus was cavorting with her friends. So Hera condemned Echo to remain speechless, except for repeating what others said. This was hardest to bear when Echo, like many before her, fell in love with the handsome Narcissus. She had no way to tell Narcissus how she felt. All Echo could do was follow him about, hoping for a crumb of attention.

Her big chance came one day when Narcissus called out to his companions, "Is anyone there?" Thrilled, but too shy to meet him face-to-face, Echo instead remained hidden behind a tree and called back, "Here . . . here!" Narcissus looked but saw no one. "Come," he shouted. That was what Echo had been waiting for, and stepping forward, she beckoned to Narcissus and said sweetly, "Come." But Narcissus turned away in disgust from her outstretched arms and said, "I will die before I give you power over me," to which Echo responded forlornly, "I give you power over me." His rejection left her feeling ashamed. She could not be comforted, yet she continued to love Narcissus.

Because Narcissus scorned those who adored him and was oblivious to their affection, Nemesis, the goddess of righteous anger, punished him. Furious over his treatment of Echo, she made Narcissus lean over a clear pool for a drink and fall hopelessly in love with his reflected image. Consumed by the futile desire to have his affection returned, Narcissus slowly wasted away. When death eventually overtook him, Echo was helpless to reach out to him until his last breath. As he said his final "Farewell, farewell," to his own image, she repeated the same words to him. Then Echo's flesh also wasted away, and her bones turned to stone. Today, all that remains of Echo is her voice, in canyons and caves, still repeating only what others have said.[lxxxv]

In the myth, Narcissus (Phobos) represents the pathological masculine with over-rigid boundaries, and Echo (Thanatos) represents the pathological feminine with weak or no boundaries; or, it can be understood as unhealthy narcissism and co-dependence. This myth also points out how certain types are attracted to each other. When your friendships, work relationships, or romantic relationships are characterized by either one of these unhealthy extremes, you need to take note and get the appropriate help. Many addicts, once clean, tend to find themselves on the other side of the street and are now attracted to others with narcissistic conditions and/or addictions.

After extensive therapy, we often tend to look at our part in all situations and think we are capable of dealing with any situation or person, if we remain psychologically healthy and keep our side of the street clean. And yes, this is true to a large extent, but when we find ourselves in relationships with really unhealthy people or institutions, no amount of individual therapy will necessarily resolve our difficulties. The reality is that there are certain situations, institutions, and people, that, regardless of the psychological work we do, will always cause us great distress for whatever reasons. Sometimes the best form of "therapy" is simply to avoid or leave the person, situation, or institution.

Study Material for Study Unit 7

📖 ***Read Chapters 10 and 11 (Dupuy, 2013, pp. 147 - 174) of the assigned book. Chapter 10 provides a discussion of the 3-2-1 Shadow Process as well as other methods of doing shadow work, and chapter 11 is about the importance of healing the spirit and Integral Spiritual Practice.***

📖 ***Read Chapter 5 (Du Plessis, 2015, pp. 104-130) on the Psychological Recovery Dimension.***

Audio and Video for Study Unit 7

- *Watch Parts 8C through 8G of the John Dupuy video series, which can be downloaded from the Integral Recovery website at http://www.integralrecovery.com/video/introduction-to-integral-recovery-video-series-part-8c-emotional-healing.*

These segments cover emotional healing, emotional releasing, spiritual practice, the 3-2-1 Shadow Process, and "Not Just for Addicts," which is about how immensely important doing our emotional work is for all of us—not just for addicts.

- *Listen to Ken Wilber: Being in the Now and Shadows (6:53)*

https://www.youtube.com/watch?feature=player_embedded&v=XFrb7vdrteQ.

Assignment for Study Unit 7

- *Write a 2 - 4 page essay on why you think shadow work is an important component of recovery.*

- *Send assignment to your Faculty Mentor.*

Well done. You have come to the end of Study Unit 7!

Study Unit 8

Integral Recovery Practice

Learning Objectives for Study Unit 8:

1: Students will learn the essential elements of an Integral Recovery Practice.

Introduction to Study Unit 8

Nobody will save you but you. You alone have to engage your own contemplative development. There are all sorts of help available, and all sorts of good agency to quicken this development, but nobody can do it for you... Spiritual development is not a matter of mere belief. It is a matter of prolonged difficult growth, and merely professing belief is meaningless and without impact... Reality... is not interested in your beliefs; it's interested in your actions, what you actually do...

- Ken Wilber

Recovery is all about action—no action, no recovery. And not just any action—the right action. To adopt an Integral Recovery lifestyle, you need to learn how to work

and follow an Integral Recovery program. As pointed out before, the Integral Recovery paradigm is a set of social practices.

We are all unique, so therefore our recovery paths will also be unique. One size recovery does not fit all. Many of you reading this, or clients of yours, are between a rock and a hard place—either the hard work of recovery or the hard work of active addiction. And, as you know, and contrary to popular belief, addiction is very hard work. Actually, we think addiction is harder work than recovery. The difference is that the hard work of addiction leads only to misery and eventual destruction, whereas the hard work of recovery leads to freedom and happiness. Addiction and recovery share the common denominator of hard work, but have radically different outcomes. So your reality is this: You have hard work to do either way; the choice lies in the outcome you desire—either misery and destruction or freedom and happiness.

In a nutshell, we believe recovery is the process where we discover and start actualizing our true potential and become the person we were meant to be. So from this perspective, we might say that we are not recovering from addiction, but rather recovering our "unique selves." From a spiritual perspective, we might say we awaken to our "true nature," which can be understood as part of a manifestation of universal consciousness, and which is *always* "good enough."

But on the relative plane, as Jan Smuts and Aristotle have said, we have a universal innate need, like all things in the Kosmos, to better ourselves (driven by Eros), striving towards higher versions of ourselves. Recovery is not merely "recovering" from addiction, therefore, but also recovering our innate universal drive or vision to aspire to more awakened versions of ourselves, as an inseparable and interrelated part of the universe.

We believe that what ultimately makes the recovery process so effective is that it is fundamentally the same process that most spiritual seekers have walked in their quest for enlightenment. The recovery path is the path of saints and mystics, of Buddhas, and of all those who have and will transcend, and accept, their limitations. Jung supports this

notion by saying that addicts are "misguided mystics." Of course, most of us did not choose recovery for these noble transcendental reasons. And that is just fine. As they say in Narcotics Anonymous, you might come for the wrong reasons, as long as you stay for the right ones. Most addicts are initially only motivated by pain. "The world owes all its forward movement to men of dissatisfaction."

It may seem complex and a bit overwhelming when we talk about Integral Recovery Practice. But actually, the practice isn't that complicated, although it does require dedication and discipline. The idea that "that which costs you nothing is generally worth nothing" applies. A lifetime sustained in disciplined Integral practice will cost plenty, but the rewards are so beyond the costs as to make quibbling about the costs seems silly by comparison. If you *knew* a $5 lottery ticket was a winner, the cost would pale in comparison to the millions it would net. This is the way I (JD) feel about IRP. At this point, I simply can't imagine life without it—because I well remember my past life without it, which was characterized by tremendous pain and despair.

The Integral Recovery Practice that I have developed for Integral Recovery includes the following (and you will learn about these techniques in detail, when you read the assigned chapters for this study unit):

- Brain entrainment-enhanced meditation done on a daily basis (not sporadically).

- Using Cranial Electrical Stimulation extensively for 45 days, and then occasionally as needed thereafter. CES is a very effective technology for rebalancing essential brain chemicals and dealing with complaints and diseases, such as addiction, depression, anxiety, and sleep disorders. Also to be noted is that there are no known negative side effects from using CES, unlike with so many pharmaceuticals.

- Practicing shadow and trauma work to increase our spiritual and emotional awareness and skillfulness.

- Practicing healthy nutritional habits—generally lean, green, and clean. I think each of us has to work on this and tweak our diets according to our individual needs. I also think top shelf supplements can be very useful, especially in the case of those who are recovering from early addiction, because they are nutritionally and physically at such a deficit level.

- Last but by no means least, becoming a lifetime athlete. Dedicating yourself to an intense physical training program that includes mindfulness, and a sacred intention to use your increased health as a means of being of greater service to the world. The longer one trains, the more intuitive the process becomes over the years. In other words, one adapts one's practices to one's current needs and interest and it is an ongoing delight and revelation as one continues to practice throughout the decades of one's life.

Outlines of an Integral Recovery Practice

📖 ***Read chapters 7 - 9 and chapters 12 - 14 (Dupuy, 2013, pp. 103 - 146 and pp. 175 - 223). These chapters provide an overview of what an Integral Recovery Practice can look like, and explain how to compile an Integral Recovery Practice for one's self and/or for a client.***

📖 ***Read chapters 3-9 (Du Plessis, 2015, pp. 63-219). These chapters provide the "what" and the "how" of an Integrated Recovery Program.***

Audio and Video for Study Unit 8

- *Watch Part 8A and Part 8B of the John Dupuy video series, which can be downloaded from the Integral Recovery website at: http://www.integralrecovery.com/video/introduction-to-integral-recovery-video-series-part-8a-binaural-brain-entrainment. These segments describe how the use of binaural brainwave entrainment technology supports meditation, emotional healing, and strengthens our resiliency.*

- *Watch also Integral Recovery & Strength Training, where John Dupuy interviews Rob McNamara. http://www.integralrecovery.com/video/integral-recovery-strength-training.*

. Assignment for Study Unit 8

- *Write a 2 - 4 page where you design an Integral Recovery Practice for yourself or if you are a therapist, design one for a client.*

- *Send assignment to your Faculty Mentor.*

Well done. You have come to the end of Study Unit 8!

Study Unit

9

The Future of Recovery is Integral

Learning Objectives for Study Unit 9:

1: Students will understand how the various pieces of Integral Recovery fit together: diagnosis, treatment, practice, etc.

2: Students will explore the future of addiction treatment in light of what they have learned in this course, and read the case study of a client who experienced an integrally informed inpatient intervention.

Introduction to Study Unit 9

The groaning and travailing of the universe is never aimless or resultless. Its profound labors mean new creation, the slow painful birth of wholes, of new and higher wholes, and the slow but steady realization of the Good which all the wholes of the universe in their various grades dimly yearn and strive for. It is the nature of the universe to strive for and slowly, but in ever increasing measure, to attain wholeness, fullness, blessedness. The real defeat for men as for other grades of the universe would be to ease the pain by cessation of effort, to cease from striving towards the Good. The holistic nisus which rises like a living fountain from the very depths of the universe is the guarantee that failure does not await us, that the ideals of Well-being, of Truth, Beauty and Goodness are firmly grounded in the nature of things, and will not eventually be endangered or lost. Wholeness, healing, holiness – all expressions and ideas springing from the same root in language as in experience – lie on the rugged upward path of the universe, and are secure of attainment – in part here and now, and eventually more fully and truly.

\- *Jan Smuts*

To be a successful Integral Recovery treatment provider, one must first and foremost be an Integral Recovery Practice practitioner—whether or not one suffers from addiction personally. This has been a great key to the success of Integral Recovery. We are all practitioners.

The second key is diagnosis—bringing together what we have learned earlier in this class. How do you know if you are dealing with an addict? The quickest test we use is whether there is a mental obsession to get and take drugs. However, do remember that when you are dealing with new clients, there is often a large amount of denial about the extent of their drug use. Initially, what a client will admit to is often just the tip of the iceberg. It is important to determine whether you are dealing with an addict or someone who is merely chemically dependent or going through a period of rebellion and abuse.

Remember, if one is an addict, they can never safely use these addictive substances again. The one exception might be pain medication for severe pain, done under the supervision of health care practitioners who understand that the patient they

are dealing with is an addict. I have seen this done gracefully and successfully on a number of occasions. Without supervision and sensitivity to the disease of addiction, however, using pain medication and opioids can lead to relapse and the downward progression of the disease.

On the treatment side of the street, after diagnosis has been made, we have found that some clients can do very well without residential treatment, simply by doing the recommended practices and doing the educational and therapeutic work with an online coach. This is a determination that must be made; one can often start working with a client online, via Skype, and if that doesn't work, recommend residential treatment. In the case of someone in the latter stages of the progression of the disease, where medical detox is required, a client will almost always require residential treatment. The online approach does not suffice in this case. A sort of psychological triage is required, which means getting the patient out of the burning building and away from a supply of drugs before anything else can happen. Remember, residential treatment is first, foremost, and foundationally a safe place away from drugs and alcohol. Having established that, the rest of the work can begin.

Four Quadrant Integral Treatment Plan

• Individual Therapy. • Treatment for trauma and PTSD, such as the 3-2-1 Shadow Process. • Meditation, to include binaural brainwave entrainment technologies, such as the Profound Meditation Program. • State training: neurofeedback. • Working the Integral Twelve Steps.	• Physical exercise program to include cardio vascular training, resistance training, and stretching/yoga. • Appropriate dietary support. • Psychotropic medications. • Bodywork, acupuncture, Reiki, etc.
• Group Therapy. • Family Therapy. • Appropriate support groups for family and client, such as AA, NA, Alanon, etc.	• Residential treatment. • Using wilderness as a context and treatment modality. • Aftercare support.

• Support from client's church, synagogue, temple, mosque, sangha, tribe etc. • Education of the involved individuals and parties as to the nature of the disease and the recovery process. • IRP Groups.	• Vocational training. • Educational support. • Financial planning and education. • Renew health insurance.

In many cases, there is a resistance from the addict about going into treatment, and this is when exterior motivators must come into play. These can look like the following, singularly or together: Go to treatment or go to jail. Go to treatment, or we are writing you out of your inheritance. Go to treatment, or I am divorcing you and leaving with the kids. Go to treatment, or I am changing the locks on the door. And so forth and so on.

In some cases, the services of an interventionist may be indicated. An interventionist is a person who is trained how to coach a family and conduct an intervention, in which the addicted individual is confronted by friends, family members, and often bosses and co-workers as to the extent that their addictive behaviors have affected everyone in the room. This is often very powerful and effective as the addict is quite normally, and par for the course with this disease, in denial about the pain, suffering, and hardships his addiction has caused for the other people in his life. At this point, the addict does not pass Go, does not collect $200, but goes directly to treatment—often accompanied by the interventionist. There are many good interventionists out there, you will want to get to know some.

Often, it is very important to have an addict medically detoxed before checking into residential treatment. If in doubt, this determination can be made with the assistance of a physician. One should do some shopping around when it comes to detox centers; we have found some to be really awful and others to be very good. We encourage everyone to find the good detox centers in your area.

Generally, treatment can be broken down into three phases.

- The first is primary treatment, which begins directly after medical detox and lasts hopefully for at least 90 days. It is very useful that such a primary treatment center be located in a beautiful and isolated environment, as this facilitates the early work and healing process.

- Next, there needs to be the step down of secondary treatment, and this is ideally done in a community that offers more access to community services, such as gyms, Zendos, universities, employment opportunities, yoga studios, bookstores... basically all the cool things that cities provide.

Finding good secondary treatment is currently extremely challenging. An integrally informed treatment center would feature an environment that would allow the students to continue their Integral practices in a supportive environment with others, as well as continue working on their educational and professional careers. It would be an alcohol and drug free environment, of course, which would be supported by regular, random, if not daily drug and alcohol screening tests.

- Tertiary treatment, which generally occurs after about a year of secondary treatment, would feature ongoing support counseling and coaching. In Integral Recovery, we are beginning to develop an online support system, working with clients on Skype, for example, one or two times a week, or as deemed necessary. This ,continues until it appears to everyone involved that it is no longer necessary. This can also be decreased gradually, from 2 times a week to once a week, to 2 times a month, etc.

Study material for Study Unit 9

📖 *Read the afterword and appendices 1, 2, and 3 (Dupuy, 2013, pp. 225 - 266) of the assigned book. Appendices 1 and 2 talk about becoming an Integral treatment provider and Integral Recovery in relation to the greater field of addiction treatment.*

A Case Study

Appendix 3 is a case study done by Dupuy, J., & Gorman, A. (2010). Integral recovery: An AQAL approach to inpatient alcohol and drug treatment. This essay provides an in-depth study of one client's recovery experience while attending Dupuy's Integral Recovery treatment center.

Towards an Integral Addiction Treatment

Read Du Plessis, G. P. (2010). Toward an integrated recovery model for drug and alcohol addiction. AQAL: Journal of Integral Theory and Practice, 5(3), 68-85. This article describes Du Plessis' initial integrally informed treatment model. Next read Du Plessis, G. P. (2012a). Integrated recovery therapy: Toward an integrally informed therapy for addicted populations. AQAL: Journal of Integral Theory and Practice, 7(1), 37-55. This article describes Du Plessis' initial integrally informed treatment model. psychotherapy for addicted populations

Audio and Video for Study Unit 9

Watch the video for Study Unit 9: What does an Integral Recovery treatment program look like?

http://www.youtube.com/watch?feature=player_embedded&v=nG7dU-Cjdps

Assignment for Study Unit 9

Write a 5 page essay about how you will take this model and apply it to your particular vocation in this field - whether it's starting a treatment center, working with clients, influencing the educational system, or bringing this knowledge into the legislative or governmental process in your country, or any other ideas you might have for implementing this model for the good of the many.

Send assignment to your Faculty Mentor.

"I often teach that the vision quest begins when one decides to go on a quest, and that the most difficult and, indeed, important part of the quest is not the time alone and fasting itself, but in living the wisdom and guidance that one has been shown on the mountain or in the sacred place. As a Native Elder once said, upon hearing a grandiose vision from someone who had come off a quest, "But will it grow corn?" In other words, the purpose of the vision quest is not just to achieve altered states, but to achieve inner transformation and altered traits and behaviors, as well as direction, and to bring this back into the world, thereby blessing one's people and relationships. In the Lakota language, the most common greeting is, "Metaquiescen," which means all our relations, a wonderful teaching in itself.

Whatever we do affects all our relations, and in determining our life, our goals, and our practices, we must always include this knowledge that it is not only about us but about all our relations."

- John Dupuy

Congratulations!

You have come to the end of the Study Guide.

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[iii] See Laffaye, C., McKellar, J.D., Ilgen, M. A., & Moos, R. H. (2008). Predictors of 4-year outcome of community residential treatment for patients with substance use disorders. Addictions, 103, 67-680

[iv] Jung in Flores, *Group psychotherapy with addicted populations,* p. 263.

[v] Jung in Flores, *Group psychotherapy with addicted populations,* p. 263.

[vi] Jung in Flores, *Group psychotherapy with addicted populations,* p. 263.

[vii] Wilson in Flores, *Group psychotherapy with addicted populations,* p. 264.

[viii] Wilson in Flores, *Group psychotherapy with addicted populations,* p. 265.

[ix] Kurtz in Flores, *Group psychotherapy with addicted populations,* p. 265.

[x] Angyal in Flores, *Group psychotherapy with addicted populations,* p. 266.

[xi]Jung, personal correspondence to Bill Wilson

[xii]Groff from website www.integratedrecovery.weebly.com

[xiii]http://www.barefootsworld.net/wilsonletter.html

[xiv] Flores, *Group psychotherapy with addicted populations,* p. 266.

[xv]Ibid., p. 249.

[xvi]Wilber, Excerpt A from website www.kenwilber.com, pp. 14-15.

[xvii]Wilber, *Sex Ecology, Spirituality,* p. 282.

[xviii]Flores, *Group psychotherapy with addicted populations,* p. 273.

[xix]Kurtz in Flores, *Group psychotherapy with addicted populations,* p. 274.

[xx]Flores, *Group psychotherapy with addicted populations,* p. 274.

[xxi] Kurtz in Flores, *Group psychotherapy with addicted populations,* p. 276.

[xxii]Flores, *Group psychotherapy with addicted populations,* p. 278.

[xxiii]Ibid, p. 278.

[xxiv] Ibid., p. 280.

[xxv] Ibid., p.280.

[xxvi] Ibid., pp. 280-281.

[xxvii] Ibid., p. 281.

[xxviii]Ibid., p. 281.

[xxix] Thune in Flores, *Group psychotherapy with addicted populations,* p. 281.

[xxx]Thune in Flores, *Group psychotherapy with addicted populations,* p. 281.

[xxxi]Flores, *Group psychotherapy with addicted populations,* p. 283.

[xxxii] Ibid., p. 283.

[xxxiii]Thune in Flores, *Group psychotherapy with addicted populations,* pp. 284-285.

[xxxiv]Flores, *Group psychotherapy with addicted populations,* p. 286.

[xxxv] Drever, *A Dictionary of psychology,* p. 680.

[xxxvi] Flores, *Group psychotherapy with addicted populations,* p. 292.

[xxxvii]Kohurt in Flores, *Group psychotherapy with addicted populations,* p. 187.

[xxxviii] Flores, *Group psychotherapy with addicted populations,* p. 292.

[xxxix]Ibid., p. 292.

[xl]Ibid., p. 292.

[xli] Ronell, Crack wars, p. 25.

[xlii] Flores, *Group psychotherapy with addicted populations,* pp. 292-293.

[xliii]Ibid., p. 296.

[xliv] Ibid., p. 296.

[xlv] Ibid., p. 293.

[xlvi] Esbjorn-Hargens, *An Overview of Integral Theory,* p.2.

[xlvii] White, *Pathways: From the culture of addiction to the culture of recovery*, pp. xxiii – xxiv.

[xlviii] Quoted in White, *Pathways: From the culture of addiction to the culture of recovery*, p. 1.

[xlix] White, *Pathways: From the culture of addiction to the culture of recovery*, p. Xxvii.

[l] Wilber, *Integral Spirituality,* p. 5.

[li] Wilber et. al.,*Integral Life Practice*, p. 92.

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