The Integrated Recovery Model for Addiction Treatment and Recovery

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ABSTRACT This article outlines an integrally informed model for addiction treatment and recovery that is being pioneered and developed at Tabankulu Secondary Addiction Recovery Center in Cape Town, South Africa. Tabankulu is the world's first inpatient addiction treatment center to implement an integrally informed treatment model. The Integrated Recovery model is a comprehensive, balanced, multi-phased, and multi-disciplinary approach to the treatment of and recovery from addiction. Its philosophy is derived from integrating a 12 Step abstinence-based methodology, mindfulness-based interventions, positive psychology, and Integral Theory. The case is made that addiction treatment facilities, therapists working with this population, and recovering addicts will become more proficient, effective, and consequently have higher success rates by becoming integrally informed.

KEY WORDS: addiction; 12 Steps; Integral Theory; mindfulness; positive psychology

> 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. The rise and self-perfection of wholes in the Whole is the slow but unerring process and goal of this Holistic Universe.
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> – *Jan Smuts* (1987, pp. 344-345)[1]

Addiction, in its myriad forms, is one of the most destructive societal problems facing the world today. Addiction or substance dependence can be described as "a cluster of cognitive, behavioral, 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" (American Psychiatric Association, 1994, p. 176).[2] 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 U.S. society is estimated at 181 billion dollars (NIDA, 2008).[3] This cost to society pales in significance in comparison to the daily human suffering addiction causes.

It follows that the treatment of addiction, as it is in many countries, should be a priority. The United States spends billions annually on the prevention and treatment of drug and alcohol abuse. For every dollar spent on addiction treatment, there is a four to seven dollar reduction in drug-related crime (NIDA, 2008). The unfor-

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tunate reality is that most treatment programs have high levels of recidivism, limited annual and lifetime coverage with low success rates. Furthermore, studies indicate that many existing rehabilitation programs may be no more successful than the spontaneous remission occurring in the untreated population. Consequently, many academics and treatment professionals believe that new policies and program directives for the management of drug dependence need to be developed (Alexander et al., 1994; Miller, 1998b; Sobell et al., 2000). It is suggested that the low success rate for addiction treatment is due to substance abuse programs applying *partial and outdated treatment models* (Fox, 1999; Jung, 2001; McPeake et al., 1991). Due to the limited effectiveness of contemporary substance abuse treatment programs, we have begun to see a consideration of alternative and complementary healing approaches to substance abuse rehabilitation, and an increasing openness towards traditional healing practice as well as interest in developing more holistic addiction treatment programs (McPeake et al., 1991; Winkelman, 2001). Many holistic addiction treatment facilities are doing remarkable work, but on closer inspection of the philosophy behind many of these "holistic" approaches, we find that they are merely stating the obvious—that an integrative approach is better than a partial approach—*without* providing a truly integal framework and method.

This article proposes a *comprehensive*, *balanced*, and *whole* approach to addiction treatment and recovery through the Integrated Recovery (IR) model. What is unique about this approach, relative to other holistic addiction treatment models, is that it applies Integral Theory as a meta-perspective in its theoretical and therapeutic construction (Wilber, 1997). The main premise of this article is that addiction treatment and recovery programs, therapists working with this population, and recovering addicts will become more competent and consequently have improved success rates by becoming integrally informed. The IR model is an example of such an integrally informed approach. The IR model is not the final word on integrally informed approaches to addiction treatment nor do I present it as conclusive, but rather it is as an initial attempt at an integral method for addiction treatment and recovery.

The aim of this article is to present a brief overview of the IR model. I provide a broad understanding of the model by exploring its core theoretical influences and looking at some of its clinical applications. To familiarize the reader with the IR model's clinical applications, I outline the clinical treatment program of Tabankulu Secondary Addiction Recovery Centre, where this model was developed and is currently implemented.[4]

Integrated Recovery Theory

The IR model was born both from my personal experience as a recovering heroin addict and from my work as an addiction treatment professional. After years of working as an addictions counselor, it became apparent to me that the conventional definitions and methods of addiction treatment and recovery were partial. I believed that more inclusive, comprehensive, and effective approaches were achievable. This led me to seek a more effective, integrative approach to addiction treatment and recovery. In 2004, I discovered Integral Theory. Apart from the immense personal cognitive shift Integral Theory caused in my life, I immediately realized that Integral Theory is exactly what is needed in to guide the development of a truly holistic approach to addiction treatment and recovery. In the summer of 2004, I designed and began to practice my first integral recovery program. Over the ensuing years, I began to formulate an integrally informed addiction treatment model for a clinical environment. In July 2007, in my capacity as Head of Treatment of Tabankulu, I implemented the initial version of the IR model, then known as the Integral-Based Recovery model (Du Plessis, 2007). The IR model has matured considerably since its initial inception. At that stage, my colleagues and I believed we were the only clinicians applying Integral Theory in the context of addiction treatment and recovery. In 2008, I discovered John Dupuy's website dedicated to his Integral Recovery® approach, and we became acquainted

later that year.[5] Since discovering Dupuy's approach, I have been greatly influenced by—and have great respect for—his pioneering work. Moreover, it helped me to improve the theoretical grounding of the IR model. Our integrally informed models overlap in most areas but depart in our emphasis regarding the application of 12 Step philosophy and methodology as a core theoretical component. The IR model is at its core a 12 Step–based approach. I believe these two integrally informed approaches can work in synergy to provide integrally informed methods to both 12 Step–based and non-12 Step–based institutions and individuals.

The IR model is a comprehensive, balanced, multi-phased and multi-disciplinary approach to addiction treatment and recovery. Its philosophy is derived from an integration of 12 Step abstinence-based philosophy and methodology, mindfulness-based interventions, positive psychology, and Integral Theory. The aim of the IR approach is twofold: 1) to arrest any addictive behavior, and 2) to develop an "Integrated Recovery Lifestyle" that enables recovering addicts to achieve their full potential and satisfy their innate needs as unique human beings. There are two central premises behind the IR model. The first is that addiction affects all the fundamental aspects of an individual's existence and therefore, for recovery to be optimally effective, it should include practices that stimulate healing and growth in all the same areas—as part of a *lifestyle-oriented approach* that is geared towards continued personal development in relation to self, others, and the transcendent. The second is that addiction is the pathological manifestation of the frustration of the innate human need for wholeness, belonging, meaning, and the quest for the transcendent. Therefore, the IR process is about *realigning* the recovering addict with healthy manifestations of these innate universal needs.

Integral Theory

The reputable Minnesota Model of addiction treatment acknowledges that addiction is multifarious and multi-phased (Cook, 1998). It affects the physical, emotional, cognitive, social, and spiritual dimensions of the individual and therefore, the treatment process should include therapeutic intervention in *all these dimensions*. This approach is difficult to implement or even fully conceive because of the vast fields of therapeutic knowledge that need to be incorporated into methodologies that truly treat the individual holistically. Moreover, addiction counselors often have difficulty working therapeutically with such a multitude of variables. What distinguishes the IR process from other biopsychosocial, spiritual, and holistic approaches to addiction treatment and recovery is that Integral Theory informs the IR model.

The strength of Integral Theory is its ability to integrate vast fields of knowledge and therefore, by using an integral map in the context of addiction treatment and recovery, we provide the most comprehensive, inclusive, cross-cultural, and transdisciplinary conceptual map of human potential thus far developed. According to Andre Marquis (2008), Integral Theory provides 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" (p. 24). For recovering addicts, an integrally informed recovery process is attractive because its emphasis is on personal growth and not just on addiction. Additionally, it provides the recovering pilgrim with a roadmap for their own personal development (Dupuy, 2007). Integral Theory assists one when striving for the most comprehensive understanding of any phenomenon—in our case, recovery from and treatment of addiction (Marquis, 2008). If our aim is to find a model to support a *truly comprehensive* and holistic approach to recovery, then it seems that Integral Theory is currently best suited for the task.[6]

Integrated Recovery and the Quadrants

Integral Theory states that reality has at least four irreducible perspectives, the subjective, intersubjective,

objective, and interobjective, which must be consulted when attempting to fully understand any aspect of it (Esbjörn-Hargens, 2009). These four universal perspectives are known as the quadrants. This section of the article briefly explores addiction and recovery from these four perspectives in an attempt to show that any treatment program will be partial if it does not account for all four quadrants in its therapeutic understanding and design.

Upper-Right Quadrant

When we attempt to understand addiction and recovery by exploring objective aspects of an individual—from the Upper-Right quadrant perspective—we will notice all the positivistic and objective perspectives of individual structures, events, behaviors, and processes (Marquis, 2008). From this perspective, addiction can be classified as a "brain disease." Addiction affects the mesolimbic system of the brain, the area where our instinctual drives and our ability to experience emotions and pleasure resides. In this area is the medial forebrain bundle, popularly known as the pleasure pathway (Brick & Ericson, 1999). The pleasure pathway of the brain is "hijacked" by the chronic use of drugs or compulsive addictive behavior. Due to the consequent neurochemical dysfunction, the individual perceives the drug as a life supporting necessity, much like breathing, thirst, and hunger (Brick & Ericson, 1999). This explains why most addicts cannot stop on their own in spite of adverse consequences and why addicts need external support.

As addiction affects both physical and neurological well-being, an effective recovery model needs to address these areas. Patrick Holford (2008) emphasizes the importance of diet and nutritional supplements in treating addictions and maintenance of recovery. Holford believes that most addicts suffer from *reward deficiency*, which is a neurochemical imbalance in brain chemistry that translates into negative effects like anxiety, feelings of emptiness, and hypersensitivity. Many addicts have deficiencies in brain chemistry even prior to their addiction, but there are many factors that can create a reward-deficient brain chemistry such as genetics, prenatal conditioning, malnutrition, stress, lack of sleep, physical or emotional trauma, and the long-term use of mood-altering substances. If not rectified, this brain chemistry deficiency will continue indefinitely into an addict's recovery, resulting in recovering addicts being prone to relapse even though they are abstinent and engaging in psycho-spiritual work. The symptoms of reward deficiency will only abate when the neurochemical imbalance is corrected. Tabankulu applies therapies like neurotherapy and nutritional supplementation, as they increase the probability of physiological healing and neurochemical balance in the brain, which translates into many possible cognitive, emotional, and spiritual benefits for the person in recovery. Erickson (1989) suggests that without improving an addict's neurophysiology, treatment is often *fruitless or incomplete*. To ensure an effective addiction treatment program and sustainable recovery, physical and neurological health is imperative.

Upper-Left Quadrant

Exploring addiction and recovery from the Upper-Left quadrant perspective includes the subjective and phenomenal dimensions of individual consciousness. Addiction wreaks havoc in the addict's inner phenomenal world and has disastrous consequences for the addict cognitively, existentially, emotionally, and spiritually. The addict starts to lose control of his inner world as the "addict voice" becomes progressively "louder." Addicts often *regress developmentally* to egocentric childlike states of self-centeredness and unreasonableness, and addiction will eventually negatively alter the interior phenomenal world of the addict. Craig Nakkin (1998) believes addiction develops from a definite, though often seemingly indistinct beginning, toward a specific endpoint. The endpoint of the addictive process is complete control of the self by the illness.

Most reputable addiction treatment centers spend a considerable amount of time working in this quadrant of recovery. Therapeutic practices like 12 Step work, psychotherapy groups, lectures, trauma work, meditation, and individual therapy are all geared towards psycho-spiritual healing. Any recovery process that does not provide cognitive, emotional, existential and spiritual healing and education will be partial and ineffective in providing sustainable sobriety. Therefore, Tabankulu and the IR model incorporate methodologies that *create healing and growth* in the cognitive, emotional, existential, and spiritual dimensions. Cognitive insight into the nature of addiction and recovery is an essential feature of the treatment. At Tabankulu, clients are educated in the basic elements of Integral Theory and Integrated Recovery Theory, which provides them with a "meta-recovery structure" that illuminates their entire recovery process. The cultivation of emotional intelligence is supported by therapies like Dialectic Behavior Therapy, Rational Emotive Behavior Therapy, 12 Step work, and individual and group psychotherapy. Due to Alcoholics Anonymous' (AA) influence on addiction treatment, *spirituality* is traditionally considered an essential element in effective treatment protocol. Integral Theory can help treatment providers with a more effective understanding of spirituality and spiritual methodologies. AA views addictions as resulting from a lack of spirituality. Spiritual practice plays an important existential role in the "healing" of addiction by providing a sense of meaning often found lacking among the addict population (Miller, 1998a). Rioux and colleagues (1996) illustrate how certain spiritual healing techniques can play a role in a holistic addiction counseling approach, as they focus on inner realities that produce *harmony and self wholeness*. Winkelman (2001) further suggests that spiritual practices can also free addicts from ego-bound emotions and provide balance for conflicting internal energies. Spiritual practices can achieve a sense of "wholeness" that counters the sense of self loss, which is at the core of addictive dynamics, thereby enhancing self-esteem by providing connectedness beyond the egoic self (i.e., the "higher power" suggested in the 12 Steps of AA).

Lower-Left Quadrant

Understanding addiction and recovery from the Lower-Left quadrant means looking at the "we" space, or the intersubjective dimension of the collective (Marquis, 2008). Addiction progressively *erodes relationships and is often caused by eroded relationships*. Moreover, it is often viewed as an intimacy disorder, as addicts often have an inability to form healthy intimate relationships (Carnes, 2008). Family and friends often become perplexed and outraged by the addict's behavior, as they often transgress cultural norms. Eventually, many addicts undergo a *cultural shift* and find themselves in a new (sub)culture where their addictive behaviors are accepted and often encouraged. William White (1996) states:

> 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. (p. xxiii)

It is these cultural and relational aspects of addiction that many addicts find the hardest to give up. It is very difficult for non-users to understand the thrill, meaning, brotherhood, and adventure that addiction can provide—that is while the going is good. Obviously, in the end, all the benefits of the addiction culture are also destroyed by addiction, but often the addict continues searching in vain for those early carefree days. The novelist William Burroughs says this about heroin addiction: "Junk is not just a habit. It is a *way of life.* When

you give up junk, you give up a way of life" (As cited in White, 1996, p. 2). It is this way of life, or the illusion that certain "fun" aspects of this way of life can be lived once more, that draws many addicts back again. Any form of treatment that does not acknowledge and understand the principles behind the culture of addiction as well as the need for a healthy recovery culture is bound to be ineffective. White (1996) 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. (p. xxvii)

I believe the right cultural affiliation is one of the most *important curative* aspects of the recovery process, especially in early recovery. The main reason I think that 12 Step methods are so successful is because they offer *well-established recovery cultures* that provide an immediate sense of acceptance and belonging for the recovery neophyte. For treatment programs to be effective, a recovery center needs to establish a healthy recovery culture that is more appealing for addicts than the culture they came from. Few people understand the sense of intimacy and of belonging that certain drug cultures provide. Many social clubs, religions, or institutions are sorely lacking when compared to the camaraderie and intimacy of some drug cultures. Noted Jungian psychoanalyst Luigi Zoja (1989) believes that the pervasive use of drugs in our society can to a large extent be ascribed to the resurgence of a collective need for ritual and initiation—a longing for the sacred underlies the ritualized world of addiction, a need for "participation mystique." An effective recovery culture needs to provide *new healthy rites of passage*. The "chip" or key ring that addicts receive during their milestone meetings satisfy deep "archetypal" human needs; they function as "symbols of initiation" and are often proudly displayed. At Tabankulu, our phased-based approach is designed to provide clients with many "initiation rituals" throughout their process. A pivotal feature of the IR model is to inform and provide access to a supportive and informed recovery community that provides new healthy cultural norms, belonging, and support. This becomes even more apparent if we explore the phenomenon with an understanding of Wilber's (2006) stages of development (i.e., altitudes). As addicts move out of red altitude, egocentric stages of addiction into amber altitude and early recovery, they enter a stage of development where their "group" or "clan" plays a significant role in healthy development and integration.

Lower-Right Quadrant

Exploring addiction and recovery from the Lower-Right quadrant includes the interobjective perspective of systems, addressing observable aspects of societies such as economic structures, civic resources, and geopolitical infrastructures (Marquis, 2008). Addiction affects this realm profoundly, especially those addicted to "hard drugs' like crack and heroin. Drugs cost a lot of money. Addicts often lose their jobs, get evicted, get into trouble with the law and may be incarcerated. As they say in Narcotics Anonymous, the result of addiction is "Jails, Institutions, and Death." While there are many acultural addicts who manage to keep their jobs and have financial stability, for the majority of addicts this quadrant is severely compromised. The culture of addiction has its own infrastructure—crack houses, bars, night clubs, casinos, strip clubs, areas of prostitution, and so on. As addicts progressively migrate from one culture to the next, they start spending more time within the infrastructure of addiction culture. The more addicts frequent and live within the *infrastructure of the culture of addiction*, the more it normalizes their behavior and ultimately reinforces their denial of the problem.

When an addict enters recovery via treatment, therapy, or a 12 Step program, he enters the infrastructure of recovery. It is of utmost importance that the neophyte avoid dangerous "people, places, and things," as they say in Narcotics Anonymous. This folk wisdom is obvious when we look at it from this quadrant's perspective—when the addict enters recovery, he is avoiding the infrastructure of addiction where his additive behavior is welcomed and reinforced. An effective recovery program needs to address this area by 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 often do not consider education, money, or administrative maintenance as an essential part of their recovery, which often become stumbling blocks to their psychospiritual well-being when left unattended. Many addicts relapse due to the distress caused by the unmanageability of these areas. Tabankulu and the IR model advocate healthy participation in recovery infrastructure and promote financial and administrative manageability.

Six Recovery Dimensions of the Integrated Recovery Model

Informed by Integral Theory, the IR model includes therapeutic practices in all four quadrants to create a comprehensive and balanced treatment protocol. The IR model focuses on six areas of recovery called *recovery dimensions*. These six dimensions are designed to honor all vital aspects of the recovering individual's life. The six recovery dimensions are defined as: *physical* (the physical and neurological aspects of recovery), *mental* (the cognitive aspects of the recovery process), *emotional* (the emotional and therapeutic aspects of recovery), *spiritual* (the spiritual and existential aspects of recovery), *social* (interpersonal, cultural, and social relationships of the individual), and *environmental* (the administrative, legal, monetary, and environmental aspects of the individual's life). Below is an example of the therapeutic protocols implemented at Tabankulu covering the six recovery dimensions:

1. *Physical*. Walks on nearby beaches and mountains; surfing lessons; yoga; tai chi; kung fu; nutritional assessment and supplements (based on the 12 keys of Holford [2008]); partly organic menus, including filtered drinking water; nutritional education; acupuncture; psychiatric assessment and pharmacological intervention by a psychiatrist, if necessary; neurological assessment and neurotherapy using EEG biofeedback and QEEG assessment
2. *Mental*. Psychosocial education in the form of lectures, workshops, and written work; Dialectic Behavior Therapy adapted for addicted populations; Rational Emotive Behavior Therapy workbooks; Cognitive Behavior Therapy; 12 Step education and written work; psychological assessments
3. *Emotional*. Individual counseling; psychotherapeutic groups, including gender groups; grief groups; eating disorder groups (incorporating mindful eating practices); sex and love addiction groups; emotional literacy and regulation skills
4. *Spiritual*. Daily mindfulness meditation adapted from a Mindfulness-Based Stress Reduction program and assisted by Brainwave Entrainment technology; mindfulness practice groups using *Ikebana* and *Bonsai* as focus activities; music and art groups; spirituality group focusing on spiritual education and discussion; existential group focusing on the pursuit of meaningful activities in recovery
5. *Social*. Regular attendance of 12 Step fellowship meetings and service activities; 12 Step sponsor; family program; family conjoints; use of ritual and initiation in phase-based treatment processes

6. *Environmental*. Community and environmental service; participation in recycling activities; permaculture gardening; *curriculum vitae* design; administrative life skills and financial education; guidance in finding safe accommodation

Clients at Tabankulu are educated in, and therapeutically experience, these six recovery dimensions and are provided with the skills to function optimally in all of these recovery dimensions. Recovery within the IR model context becomes a lifestyle, called an *Integrated Recovery Lifestyle*. This Integrated Recovery Lifestyle approach provides an accessible recovery map that is simple and to a degree quantifiable. It also places 12 Step practices within a comprehensive and inclusive worldview, which many clients and therapists report to be of great value. It provides the counselor with a set of criteria by which to judge their client's progress. It defines how well they are doing in each of these six dimensions and therefore highlights the dimensions requiring improvement. This approach provides a structure and a more accurate language to describe and measure the multi-phased and complex recovery process. Clients experience and are educated in how to work and design their individualized Integrated Recovery Program (IRP). An IRP is about mindfully practicing one's physical, emotional, mental, spiritual, social, and financial dimensions as part of an Integrated Recovery Lifestyle that is geared towards continued personal growth in relation to self, others, and the transcendent.

The IR approach is also used by therapists working outside a formal treatment environment; clients who have completed treatment; clients in individual therapy; and individuals in recovery with substantial clean time. The IR approach is also applied from a *coaching* perspective. Coaches use a behavioral and solution-focused approach by *educating and monitoring* their clients in various practices, enabling them to function optimally in each of these recovery dimensions.

Levels and Lines of an Integrated Recovery Lifestyle

Each aspect of reality, as represented by the quadrants, has distinct capacities that progress developmentally. These are known as lines of development (Esbjörn-Hargens, 2009). Each of the six recovery dimensions of the IR model can be understood as separate lines of development within the recovering addict's overall development. For every individual, each of the six recovery dimensions can be at different stages of development. When each of the six recovery dimensions is plotted on a "recovery graph," we get a visual representation of an individual's recovery process. This simple visual presentation of an individual's recovery process provides accessible insight into what aspects can be improved. At Tabankulu, it is called the *Integrated Recovery Graph* (IRG); clients compose and then update an IRG and IRP at the end of every week to assess, with their counselors, the week's progress and areas of concern. Clients and counselors respond positively to these tools and find it of great therapeutic benefit. Moreover, clients state that the structure these tools provide promotes a sense of security and self-efficacy.

Each of these six recovery dimensions or lines progress and fluctuate through a sequence of developmental altitudes, known in Integral Theory as stages or level of development. Wilber (2006) describes stages as representing a level of organization or a level of complexity. Teaching vertical developmental theory to clients in recovery has proven to be *instructive and inspirational*. The fact that clients know they are aspiring to a higher vision of themselves provides meaningful direction for their recovery process and, more importantly, having a developmental understanding of addiction gives clients a useful perspective on their problem (Dupuy, 2007).

From a moral developmental perspective, a simple way to understand stages is to describe their progression

from egocentric (preconventional) to ethnocentric (conventional) to worldcentric (postconventional) (Wilber, 2006).[7] By being taught a developmental approach, clients gain further insight into the nature of addiction and more importantly, they receive a *conceptual map of their recovery path*. Clients gain insight into how addiction arrests personal development and in many cases causes developmental regression into red altitude and even lower egocentric levels. This helps them understand why they exhibit such self-centered behavior during active addiction. Explaining the nature of the amber ethnocentric level gives clients an understanding of why it is necessary to follow the often rigid structure and "rules" of early recovery. Understanding levels in the context of addiction and recovery gives clients and therapists a conceptual developmental map that charts the decline of addiction and personal growth in recovery. For clients, this emphasizes that they are in pursuit of personal growth and provides additional depth to their recovery process. This vertical recovery developmental approach gives counselors and treatment centers a more detailed understanding of where their clients are developmentally, and what the next developmental stage could be. An example of working with an understanding of vertical development is the multi-phased approach used in Tabankulu, recognizing that recovering individuals need different interventions and care at the various stages of their recovery process.

Much work is needed in designing developmental maps that accurately chart the stages of addiction and recovery. Current addiction and recovery developmental maps—apart from the Stages of Change model for addiction as outlined by Prochaska and DiClemente (1992)—are too clumsy to provide useful therapeutic knowledge. What will be especially useful for addiction treatment institutions is a developmental map that charts the stages addicts pass through in their first year of recovery. This will provide addiction specialists with an invaluable therapeutic assessment tool.

States and Types

"In addition to levels and lines, there are also various kind of states associated with each quadrant. States are temporary occurrences of aspects of reality" (Esbjörn-Hargens, 2009, p.13). Understanding addiction and recovery from a state perspective may be one of the missing links in contemporary addiction treatment programs' attempts to create sustainable treatment protocol. McPeake and colleagues (1991) point out that the majority of addiction treatment programs have failed to integrate the vast body of literature that indicate the *therapeutic benefits* for addicts in experiencing altered states of consciousness (ASC). They suggest that one of the primary reasons there is such a high relapse rate in treatment programs is the failure of these programs to address the basic needs for achieving ASC and providing those ASC. It is obvious that drug use and addiction are associated with alteration of consciousness; however, addiction has seldom been analyzed from the perspective of consciousness theory or cross-cultural patterns of the use of ASC. Siegal (1984) and Weil (1972) propose that humans have an innate drive to seek ASC. From this perspective, drug use and addiction are not understood as an inherent abnormality but a striving for an innate human need:

> Widespread Western biases against ASCs, manifested in efforts to marginalize, persecute or pathologize them (Noll, 1983; Grinspoon and Bakalar, 1979; Harner, 1973) contrast with most cultures' group rituals to enhance access to ASC. These cultural biases inhibit recognition of the factors that contribute to drug abuse and prevention (Amaro, 1999; Jung, 2001).
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> Even with cultural repression of ASCs, they are still sought because they reflect systemic natural neurophysiological processes involved with psychological integration of orholotrophic responses (Winkelman, 2000; c.f., Grof, 1980, 1992). Although cul-

> tures 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.
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> 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. (Winkelman, 2001, pp. 199, 240)

From the above perspective, it seems imperative that addiction treatment provide *healthy, non-destructive ways to access ASC*. AA acknowledges the importance of an alteration of consciousness for recovery to be effective. Deemed "a new state of consciousness and being," the new state must replace the self-destructive pursuit of alcohol-induced states with a healthy, life-enhancing approach (Alcoholics Anonymous, 1987, p. 106). AA advocates meditation, a change in consciousness, and spiritual awakening as *fundamental* in achieving and maintaining sobriety.

Many of the therapeutic practices at Tabankulu promote ASCs in non-invasive and life enhancing ways. Neurotherapy and brainwave entrainment (BWE) technology are particularly effective in producing ASCs with many beneficial therapeutic consequences. At Tabankulu we use BWE technology, more specifically isochronic tones (which have the advantage of working over speakers without headphones), in our mindfulness-based meditations. This BWE technology helps individuals enter alpha/theta brainwave states that are conducive to meditative states traditionally not easily accessible to inexperienced meditators (Harris, 2004). The clinical application of neurotherapy with addicted populations, more specifically alpha/theta training, is shown to *significantly improve* the outcome of addiction treatment (Peniston, 1994). The theory is that many addicts and alcoholics have a deficiency in alpha/theta brain waves, and this deficiency translates into many psychological problems. Neurotherapy attempts to rectify this brain-state imbalance by "training" the clients' brains in a non-invasive way that naturally increases alpha/theta brain waves. Fahrion (1995) suggests that addicts often have a neurologically based inability to experience pleasant feelings within simple life experiences. Blum (1995) concurs with this idea and suggests that a *neurological-normalizing* shift may happen as result of neurotherapy that rectifies the endless quest for neurotransmitter balance (as explained by his Reward Deficiency Syndrome model). I believe neurotherapy may one day become an *essential modality* within the ideal treatment package, as it appears that neurotherapy addresses the Reward Deficiency Syndrome and Feel Good Response model (Blum, 1995), the Altered-State Fulfillment model (McPeake et al., 1991), the Natural Mind models (Weils, 1972), and the Tension Reduction and Stress-related hypothesis.

For a comprehensive understanding of addiction and recovery, knowledge of types is essential. "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" (Esbjörn-Hargens, 2009, p. 15). We can therefore have various classifications of different types in the context of addiction and recovery in each of the four quadrants (i.e., types of addictions, types of cultural enmeshment, types of dual-diagnosis, types of "kinship" in sub-cultures, "brain state" types, *DSM-IV-TR* axis II disorder types, and many more). The

classification of different types in the context of addiction and recovery, spanning all four quadrants, is an area where there is much work to be done. Theoretical refinement in this area will provide valuable assessment and methodological tools for designing more individualized treatment protocols for certain "types of addicts" (by identifying etiological factors that play a significant role in contributing to an individual's addiction). Therefore, personalized protocols will address the specific causal factors or unmet needs particular to an "addiction type." Furthermore, an adequate understanding of personality and cultural types in the context of recovery and addiction will aid in preventing addictions therapists from trying to "squeeze" everyone into the same *generic framework* of what a healthy recovering individual should be.

There are many personality types that can be applied 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" (Dupuy, 2007, p. 37). Dupuy has done invaluable work exploring the value of what an understanding of "male" and "female" types can offer to addiction treatment and recovery. Johnson (1994) describes addiction as a "mother complex," a tendency to regress back to earlier stages where one feels safe. I believe the psychoactive properties of drugs and even aspects of process addictions can have a masculine or feminine "voice." "Downers," like tranquilizers, barbiturates, and heroin, can be understood as having a feminine voice, and moreover addictions like co-dependency, love addiction, certain behaviors of sex addiction, and certain aspects of gambling (particularly slot machines) have a similar voice. In contrast, "uppers," like cocaine, methamphetamine, and aspects of process addictions like sex addiction and gambling (especially those who play tables), have a more masculine voice. I believe these masculine or feminine voices may correlate with certain "addiction neuropathways" (Carnes, 2008). The masculine addictions activate the *arousal neuropathways* of the brain that are concerned with pleasure and intensity, while the feminine addictions activate the *numbing neuropathways* of the brain that produce a soothing effect.

Furthermore, I have observed a correlation between the "object-relations" that addicts have with their parents and their drug(s) of choice (Kernberg, 1975; Kohurt, 1977; Mahler, 1979). I believe the reason for this is that the addict's "object-relations" can have *pathological* masculine and/or feminine aspects and consequently alter brain chemistry, resulting in the individual being more prone to certain masculine or feminine addictions—these function to *rectify* the neurochemical abnormalities the dysfunctional object-relations caused. This may explain my observation that many heroin addicts have distant or absent fathers, while enmeshed with their mothers, whereas many cocaine addicts tend to have distant or absent mothers with domineering fathers. Therefore, from one perspective addiction might be seen as a *dysfunctional attempt to rectify* the addict's pathological masculine and feminine object-relations. Consequently, the relationship addicts in early recovery have with their counselors or therapists are crucial in healing these dysfunctional "object-relations". Left untreated, the addict will seek to rectify imbalances in dysfunctional ways. I have also observed that when addicts have cross-addictions, they tend to stay within the masculine or feminine addiction types. Understanding the "voice" of the addiction can help in choosing an appropriate therapeutic treatment plan. Furthermore, many addictions and addiction systems only survive in the *dialectic between the masculine and feminine* voices (i.e., the alcoholic and the co-dependant enabler; the "dance" of the love addict and the love avoidant) (Schaeffer, 1997; Whitfield, 1991). It is important for the treatment professional to know which "voice" has become pathological and to bring that voice back into healthy balance.

Mindfulness

The clinical application of mindfulness-based interventions is one of the core methodologies of the IR model.

Mindfulness is a way of being that originates in Eastern meditation practices. Jon Kabat-Zinn (1994) describes mindfulness as "paying attention in a particular way: on purpose, in the present moment and non-judgmentally" (p. 4). The practice of mindfulness increases awareness, a necessary aptitude in recovery, because participation without awareness is a feature of impulsive, mood-dependent, and addictive behavior (Linehan, 1993). Within 12 Step fellowships, mindfulness is described by the slogan of "Just for today." In 12 Step culture, recovering addicts are advised by their sponsors to stay "in the moment," not to regret the past or worry about the future. From experience, sponsors know what the danger of not being mindful holds for a recovering addict. Marsha Linehan (1993) believes that without the necessary capacity to be present and aware, no amount of skill will be of any benefit. Mindfulness is a way of cultivating and strengthening this awareness (Kabat-Zinn, 1993).

The practice of mindfulness and mindfulness meditation has many other therapeutic benefits. For example, it may lead to a reduction in emotional reactivity typically elicited by anxiety symptoms (Kabat-Zinn et al., 1992). Researchers suggest that self-observation skills developed as a result of mindfulness training may lead to an improved recognition of satiety cues in binge eaters, as well as the increased ability to merely observe binges without giving in to them (Kristeller & Hallett, 1999). Linehan (1993) notes that observing one's thoughts and feelings and applying descriptive labels to them will encourage the understanding that they are not always accurate reflections of reality. When this technique is applied to cravings, it is obviously of great benefit. Alan Marlatt, in his cognitive-behavioral treatment package designed to prevent relapse, uses similar mindfulness techniques to cope with cravings (Marlatt & Gordon, 1985). They use the metaphor of "urge surfing" in which the client "rides" the urge or craving, therefore learning that the *craving will pass* (Marlatt & Gordon, 1985). Marlatt (2002) states further that:

> Meditation practice helps clients with addictive behavior problems to develop a detached awareness of thoughts, without "over-identifying" with them or reacting to them in an automatic and habitual manner. Urges and craving can be monitored and observed without "giving in" and engaging in the addictive behavior in an impulsive manner. (p. 47)

Mindfulness and the practice of mindfulness meditation provide a non-dogmatic spiritual portal for entering a more spiritually oriented life for recovering individuals who are seeking a more secular approach to the 12 Steps. As identified in our discussion about states, it is imperative that treatment provides accessible and healthy opportunities for ASC for their clients. Mindfulness meditation is an example of such a practice. Practices like mindfulness mediation that produce ASC also have many physiological benefits for addicted populations. Some scholars outline a neuroendocrine model for the mechanisms by which meditation reduces addiction (Walton & Levitskuy, as cited in Winkelman, 2001). (Meditation's ability to reduce stress and enhance serotonin functioning addresses the dysfunction of addiction on a physiological level.)

One of the primary reasons the IR model implements mindfulness-based interventions is that it *increases the client's general awareness*. Addiction over a period of time diminishes awareness and arrests vertical development. Stanley Block (2005) ascribes collapsed awareness as the root of addiction or any dysfunction.[8] Denial, which is one of the primary obstacles to recovery, is in essence a profound narrowing of the client's awareness. This in turn leads to a fragmented understanding of the damages and reality of their addiction, which perpetuates the addictive cycle. As Fritz Pearls (1976), co-founder of Gestalt Therapy, states: "Without awareness there is no cognition of choice" (p. 66). With awareness there is *choice* and consequently for the addict, the *ability* to break the cycle of addiction.

Positive Psychology

The IR model is informed by the philosophy and methodology of positive psychology. Seligman and colleagues (2005) state, "Positive psychology is an umbrella term for the study of positive emotions, positive character traits, and enabling institutions" (p. 410). Positive psychology focuses on what makes people happy, not merely on psychopathology, as do the majority of contemporary psychological approaches. Positive psychology and the philosophy of the 12 Steps are in keeping with each other, as they both focus on increasing the quality of life for individuals. Both focus on the *solution* rather than solely on the problem. This is not to say that the IR model does not acknowledge or work with psychopathology, but rather that it uses a balanced approach to the understanding of suffering, happiness, and their respective methodologies. The IR model implements some methodologies associated with positive psychology. It focuses on character strengths and virtues as outlined in the book *Character Strengths and Virtues: A Handbook and Classification* (Peterson & Seligman, 2004). Addicts in early recovery are in desperate need of affirmation. The classification of the 6 virtues and 24 character strengths, as outlined by Peterson and Seligman (2004), gives both therapist and client a structure to assess the individuals' strengths. Specific therapy groups at Tabankulu focus exclusively on the identification, acknowledgement, and strengthening of character strengths. Treatment within the IR model context, as in positive psychology, is not merely focused on fixing what is dysfunctional, but also nurtures the positive resources of the individual.

As in positive psychology, where the focus is on the solution, the Integrated Recovery Lifestyle approach of the IR model is geared to *increase the happiness and quality of life* of the recovering individual without dwelling too much on the problem of addiction or the psychodynamic roots of the disorder. Many interventions of positive psychology are similar to those of the 12 Steps of AA. Within 12 Step fellowships, the cultivation of *spiritual principles* like honesty, gratitude, and open-mindedness is essential. These correlate with what Peterson and Seligman (2004) call character strengths. Part of recovery is to internalize these spiritual principles until they are permanent character strengths. The practice of spiritual principles is known to increase the recovering individual's chances of remaining abstinent as well as increase their quality of life (Laudet et al., 2006).

12 Step Abstinence-based Philosophy

At the heart of the IR model is the philosophy and suggestions of the 12 Steps, as originated by AA (Wilson, 2002). There is substantial evidence that the 12 Steps is an effective treatment modality. Research has shown that 12 Step affiliation buffers stress significantly, and therefore leads to an enhanced quality in the recovering person's life (Laudet et al., 2006). 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, which expands on existing literature that suggests the same relationships (Laffay et al., 2008). Winkelman (2001) 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 (Miller, 1998a). Although "Alcoholics Anonymous has been called the most significant phenomenon in the history of ideas in the twentieth century," it has also received a vast amount of criticism (Kurt & Ketcham, 2002. p. 4).[9] Clinical psychologist Philip Flores (1997) has the following to say about much of the criticism against AA:

> 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 familiarising 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. (p. 249)

The IR model is informed by and expands on the Minnesota Model (MM), which is a comprehensive, interdisciplinary, 12 Step abstinence-based treatment approach for addiction. The MM 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 only providing the therapeutic environment and opportunity for the individual to discover his own potential. In line with AA's existential philosophy, the MM requires addicts to recognize personal choice and responsibility in all of their affairs. The IR model is not presented as an alternative to the MM, as it agrees with and includes much of its treatment philosophy and methodology, but rather as an approach that *encapsulates, expands, and reframes* the MM from an integral perspective.

Philip Flores (1997) 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, Irvin Yalom (1985) and others are only now taking advantage of. Peers are often *more significant* than professionals in producing behavioral change. From a self-psychology perspective, AA works because through continued interaction with other members of AA, alcoholics modify the dysfunctional interpersonal style that dominates their lives. Khantzain (1994) believes that only through this maintenance of connection with others can the disorders of the self be repaired. Flores (1997) notes that:

> 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 persona for a discovery of self (true self) as they really are. (pp. 292-293)

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 (Carnes, 2008). I believe that 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.

Conclusion

Integrally informed recovery approaches are in their infancy. The IR model is one of the world's first integrally informed recovery models and the first integrally informed clinical addiction recovery model applied within an addiction treatment center. As with any new approach, there is much room for improvement. The IR model is constantly evolving and its methodology is being refined and it is viewed as *open ended* and up for constant evaluation and revision, so as to upgrade and incorporate new technology and theory to enhance its effectiveness and sustainability.

Since implementing the IR model at Tabankulu Secondary Addiction Recovery Center, it has shown tremendous potential within a treatment environment and, equally importantly, for recovering communities. An informal study conducted at Tabankulu, as well as a post-graduate research project conducted through the University of Cape Town (UCT) regarding the efficacy of the Integrated Recovery Model, yielded promising results.[10] Furthermore, the Integrated Recovery model, since its inception in 2007, has been applied in five Cape Town addiction treatment facilities and many clinicians have been trained in its protocols. Clients respond positively to the IR approach and many have stated that it has *contributed greatly to the quality of their lives*. Furthermore, this approach has been well received in the recovery communities. The IR model can be applied with ease in most treatment settings, as it does not clash with existing evidence-based approaches but merely expands on and strengthens them.

This article sought to demonstrate that addiction treatment facilities, therapists working with this population, and recovering addicts will become more proficient and effective; and consequently will have *higher success rates* by becoming integrally informed. The IR model is an example of one of the initial, open-ended, and humble attempts at an integrally informed method to addiction treatment and recovery.

NOTES

[1] General Jan Christiaan Smuts, a South African philosopher-statesman and I believe one of the first modern integral thinkers, is mostly forgotten by contemporary academia as the father of Holism Theory. Fritz Perls, co-founder of Gestalt Therapy, was greatly influenced by his work, but unfortunately system sciences has largely forgotten or neglected him.

[2] This is the *DSM-IV*'s definition of substance dependence. The *DSM-IV* definition of substance dependence includes alcohol dependence; furthermore, the *DSM-IV* does not use the term *addiction*, since the World health Organization concluded in 1964 that it is no longer a scientific term. However, for the purpose of this article, the term *addiction* refers to substance and alcohol dependence and process addictions like sex addiction and pathological gambling, but does not refer to more severe eating disorders like anorexia nervosa.

[3] Data in the first two paragraphs were retrieved from the National Institute on Drug Abuse website (NIDA, 2008).

[4] Tabankulu Secondary Addiction Recovery Center is a second stage recovery facility. The term *second stage* refers to addiction treatment centers that treat recovering addicts who have completed a primary treatment program usually between 3 to 12 weeks in length. The therapeutic focus of a primary and second stage or secondary care facilities are different, as they treat individuals at different phases in the recovery process. Tabankulu is part of a larger group of treatment centers, including primary care and tertiary care centers in Cape Town and London. For more information, visit www.tabankulu.co.za. I left Tabankulu after its secondary care facility closed in July 2010, and am currently implementing the Integrated Recovery model in Seascape Recovery Centre while acting as Program Director. During its years of operation, Tabankulu treated thousands of patients from all over the globe and was internationally known as a first-class treatment destination.

[5] See www.integralrecovery.com for more details on John Dupuy's work. Also see Dupuy's article in this issue (pp. 86-101) and his earlier work (Dupuy, 2007).

[6] Integral Theory is often referred to as the AQAL model (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. Therefore, by including all of these patterns, one ensures that no major part of any solution is left out or neglected (Esbjörn-Hargens, 2009). The IR model is informed by all five elements of the AQAL model.

[7] Addiction is characterized by constricted awareness and therefore low developmental altitude, whereas recovery is characterized by an increase in awareness and developmental altitude. Ultimately, the aim of the IR model is to *encourage clients' overall vertical development* by including practices that stimulate growth and awareness in each of

the individual's six recovery dimensions of their Integrated Recovery Lifestyle.

[8] The author is currently incorporating Dr. Block's work, based on his Identity System™ Theory, into Tabankulu's program and believes it holds great promise for treating addictions. Dr. Block's theory elegantly expounds the value of mindful practices; he has created a set of uncomplicated methods that individuals in recovery can use to increase awareness, prevent relapse, and combat negative internal dialogue.

[9] The most well-known statement of this idea appears in the wording of the American Public Health Association's LaskerAward, awarded to AA in 1951, which can be found reprinted in *Alcoholics Anonymous Comes of Age* (1957, p. 301). More recently, the same perception can be found in several articles in a special issue of the *Journal of Psychoactive Drugs* (Vol. 19, No. 3., 1987)

[10] This informal research was conducted by the staff at Tabankulu Secondary and was measured by the amount of ex-clients who achieved a year's clean time (abstinence from all mood altering substances). The study showed a success rate of 80%. Tabankulu's program is between four to twelve weeks in duration. The author is aware of the questionability of the validity and reliability of the results and does not wish to present these results as conclusive proof, but merely as an indication of the possibility of increased success rate of an integrally informed treatment approach. A sample of 23 clients was used in this study. Lynda Duffett (2010) completed a postgraduate research project at Tabankulu Secondary, "Outcomes-based Evaluative Research at an Integrally Informed Substance Abuse Treatment Centre using the Integrated Recovery Model," under the supervision of Catherine Ward, Ph.D., at the University of Cape Town.

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