INTEGRATED RECOVERY THERAPY

Toward an Integrally Informed Individual Psychotherapy for Addicted Populations

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ABSTRACT This article outlines an integrally informed individual psychotherapy adapted for treating addicted populations. Integrated Recovery Therapy, as a therapeutic orientation, is a psychotherapeutic Integral Methodological Pluralism. As with any Integral Methodological Pluralism, it has paradigmatic and meta-paradigmatic features. The paradigmatic aspect refers to the recognition, compilation, and implementation of various methodologies in a comprehensive and inclusive manner. The meta-paradigmatic aspect refers to its capacity to weave together, relate, and integrate the various paradigmatic practices while providing a metatheoretical and transdisciplinary framework. Integrated Recovery Therapy is a meta-therapy that provides a comprehensive and multiperspectival therapeutic orientation for therapists who treat addicted clients in individual psychotherapy. Its core philosophy is derived from an integration of 12-Step abstinence-based philosophy, mindfulness, positive psychology, and Integral Theory. Integrated Recovery Therapy represents one of the various novel, integrally informed methodologies in the budding field of Integral Addiction Treatment and Integral Recovery—a nascent discipline that holds much promise for developing more comprehensive and sustainable addiction treatment approaches.

KEY WORDS 12-Step program; addiction; mindfulness; positive psychology; therapy

> Drug addiction is not, as generally believed, an escape from society, but a desperate attempt to occupy a place in it. Insofar as the addict perceives that his family is revolving hypnotically around him and that society is judging his behavior as an attack on civic unity, he always remains *homo oeconomicus* while playing out his societal role as the negative hero.
>
> – *Luigi Zoja* (1989, p. 15)

> All things overflow their own structural limits, the inner Action transcends the outer structure, and there is thus a trend in things beyond themselves.
>
> – *Jan Smuts* (1927, p. 327)[1]

Addiction is one of the most ubiquitous and complex social problems in developed nations.[2] Understanding the multidimensional etiology of addiction is an ongoing challenge to social scientists and academics. Although there are many different and sophisticated etiopathogenic theories of addiction, our current understanding is far from complete (DiClemente, 2003). Moreover, the methodologies of those who treat addicts are influenced by a cornucopia of etiological models, and it has become exceedingly difficult to integrate this vast field of knowledge into effective treatment protocol. Mark Forman (2010), a pioneer in the development of Integral Psychotherapy, states, "Psychotherapists, perhaps more than any other group of

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professionals, are confronted with the full complexity of the human condition. So many factors—biographical, genetic, cultural, and social—come into play in the life of the client, mixing and interacting with largely unpredictable results" (p. 1). This statement is particularly relevant when working with addicted populations, since addiction is a holistic disease to the extent that it leaves no area of the addict's life untouched. To successfully treat and understand addiction, all of the affected areas must be treated, or at least acknowledged. Consequently, therapists working with this population need a truly comprehensive and integrative therapeutic orientation to accomplish this goal (Donovan & Marlatt, 1988; Glantz & Pickens, 1992).

Beyond the Biopsychosocial Model

In attempts to address the multifariousness of addiction, scholars and therapists often use the biopsychosocial model to explain and treat addiction, because "the inadequacy of any single factor to explain addiction highlight[s] the need for a more complex, multicomponent model across addictions" (DiClemente, 2003, p. 17; also see Short, 2006). Carlo DiClemente (2003) states that, "Although the proposal of an integrative model represents an important advance over the 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" (2003, p. 18). This article will attempt to show that, through the application of Integral Theory, true integration of all these components is possible. In order to treat the numerous areas affected by addiction, many therapists working with addicted populations recognize their approach as eclectic. Without a sound orienting framework, this can result in syncretism, wherein therapists haphazardly pick techniques without any overall rationale, resulting in syncretistic confusion (Corey, 2005). Below, I argue that by applying Integral Theory as a metatheoretical conceptual framework, a therapist can avoid syncretistic confusion by means of a genuine integrative meta-therapeutic orientation in the treatment of addicted populations.

This article explores the theory and practice of an integrally informed individual therapy for treating addictions, called Integrated Recovery Therapy (IRT). IRT represents one of the various novel, integrally informed methodologies in the newly emerging field of Integral Addiction Treatment and Integral Recovery (Du Plessis, 2010; Dupuy & Gorman, 2010; Dupuy & Morelli, 2007; Shealy, 2009).[3] Because IRT is informed by Integral Theory, therapists are provided with a multiperspectival orientation that enables them to work in an inclusive and comprehensive manner. In addition, this approach provides a metatheoretical and transdisciplinary orientation (Forman, 2010; Ingersoll & Zeitler, 2010). IRT is derived from the Integrated Recovery Model, which was designed as an integrally informed clinical model for inpatient addiction treatment (Du Plessis, 2010). IRT is the psychotherapeutic application of the IRM for psychotherapists and counselors to use as an orienting framework in individual therapy. Because it deals with more than intra- and interpersonal changes that commonly characterize counseling and psychotherapy, IRT is better understood as a broad-based individual therapy.

Integrated Recovery Theory

IRT is a meta-therapy in the sense that it provides a multiperspectival and metatheoretical perspective when guiding addicted clients in their recovery processes. A foremost aim of IRT is to help clients develop a healthy lifestyle by practicing an Integrated Recovery Program (IRP). A client's IRP can be described as a mindful practice of the client's physical, mental, emotional, spiritual, social, and environmental dimensions as part of a lifestyle-oriented approach that is geared toward personal development in relation to self, others, and the transcendent.

IRT can be understood as a practical application of Integral Methodological Pluralism (IMP) in the

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context of the therapeutic encounter with addicted clients (Wilber, 2002a, 2002b). Wilber (2006) states that "any sort of Integral Methodological Pluralism allows the creation of a multi-purpose toolkit for approaching today's complex problems—individually, socially, and globally—with more comprehensive solutions that have a chance of actually making a difference" (p. 14). As with any IMP, IRT has paradigmatic and meta-paradigmatic features (Wilber, 2002a, 2002b).[4] An IR therapist constantly functions from a paradigmatic and meta-paradigmatic perspective. Therefore, he or she works in a comprehensive and non-exclusive way with clients, while maintaining a meta-perspective on the interrelatedness and relevance of the recovery paradigms that are simultaneously in play during the client's recovery process.

The *paradigmatic aspect* of IRT refers to all therapies and recovery practices available to and practiced by the client. This is similar to "Integral Transformative Practice (ITP), wherein a full range of human potentials are simultaneously engaged and exercised in order to enact and bring forth any higher states and stages of human potential, leading individuals through their own legitimating crisis to an increase in authenticity" (Wilber, 2006, p. 13). The IR therapist applies therapies and recommends practices that the client applies and practices in all essential recovery dimensions, according to what is appropriate for his current recovery altitude and stage of change, as defined by the transtheoretical model (DiClemente & Prochaska, 1998).[5]

The *meta-paradigmatic aspect* of IRT refers to its capacity to weave together as well as relate various recovery paradigms. The IR therapist, by applying Integral Theory, "generates a meta-practice of honoring, including, and integrating the fundamental paradigms and methodologies of the major forms of human inquiry" (Wilber, 2006, p. 16). From this meta-paradigmatic perspective, the IR therapist acknowledges that all the available recovery-based therapies and practices potentially offer value in the client's recovery when applied at the right time. Furthermore, the therapist is able to observe how certain therapies and recovery practices relate to and strengthen each other when practiced concurrently. The therapist is then able to orchestrate these recovery paradigms in the client's process.[6] Moreover, and equally importantly, the IR therapist also assists the client to achieve a meta-perspective of his own recovery process. This enables the client to apply the principles, tools, and meta-structure of the Integrated Recovery approach outside of formal individual therapy.

Informed by the AQAL model, Integrated Recovery Theory identifies six recovery dimensions (physical, mental, emotional, spiritual, social, and environmental) that provide a multiperspectival-hexagonal lens on a client's therapeutic process. Integrated Recovery Theory states that it is vital that these six recovery dimensions be maintained at an essential level of health (the definition of essential health is relative and unique to each client) for sustainable recovery. If there is pathology in any of these areas, the whole recovery system suffers (Du Plessis, 2010). The IR therapist functions like the conductor of an orchestra, keeping a meta-perspective of the client's process and ensuring that the various therapies and recovery practices fit together in a balanced way, as well as ensuring that all essential areas of a client's recovery process are addressed. The IR therapist works within a continuum of change agents and therefore does not need to be trained in all the therapies or practices needed in the client's process. He or she works together with other therapists when necessary, yet always maintains a meta-perspective on the client's process. A primary function of an IR therapist is to assist and coach a client in finding the most suitable and customized IRP, and ensuring that all the essential areas of the client's Integrated Recovery Lifestyle are addressed and functioning adequately.

The IRP planner and Integrated Recovery Wheel (IRW) are graphic tools that provide an easily accessible, quantifiable recovery structure for both client and therapist to plan and gauge the recovery process. These recovery tools also serve an underlying psychodynamic purpose for recovering addicts. Most addicts suffer from various degrees of pathological narcissism, which can be understood as the regression/fixation to the stage of the archaic nuclear self (Kohut, 1971, 1977). The narcissistically regressed/fixated individual often has a need for omnipotent control, a characteristic of the grandiose self. In active addiction, such power is sought through fusion with an omnipotent self-object (drug of choice), and manifests as impulsivity. Once in recovery, this need for control will initially manifest as obsessive-compulsive personality traits of ritual and

rigidity. Without some clear recovery structure, and in the absence of the previously idealized self-object, the narcissistically regressed individual will be subject to massive anxiety, stemming from fear of fragmentation of self and depression, which reflects the scantiness of psychic structure and good internal objects (Levin, 1995). The structure of an IRP and IRW can help satisfy the need for ritual and rigidity in a healthy way, and once this recovery structure is internalized, will help build much-needed psychic structure.

I will now briefly discuss the primary theoretical influences of IRT, which are Integral Theory, mindfulness, positive psychology, and 12-Step philosophy, and describe how they influence the therapeutic orientation of an IR therapist.

Integral Theory

What distinguishes IRT from other biopsychosocial, holistic, and eclectic therapeutic orientations to addiction treatment is the application of Integral Theory as an integrative meta-paradigm. It has been argued that applying Integral Theory as an orienting meta-framework can assist treatment professionals in creating more comprehensive and inclusive approaches to addiction treatment (Du Plessis, 2010, 2012; Dupuy & Gorman, 2010; Dupuy & Morelli, 2007; Shealy, 2009). How can Integral Theory help integrate all the diverse therapeutic practices available to a therapist into a comprehensive, yet accessible therapeutic orientation? Andre Marquis (2009) states that, "Integral Theory accomplishes this [the integration of diversity into an integrated whole] by providing an exquisitely self-reflexive and parsimoniously elegant conceptual scaffolding within which to order and organize the myriad approaches to counseling" (p. 14).

Integral Theory is often referred to as the AQAL model, with AQAL representing all quadrants, all levels, all lines, all states, and all types; these five elements signify some of the most basic repeating patterns of reality. Therefore, 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; Wilber, 2002a, 2002b). IRT is informed by all five elements of the AQAL model and guides the therapeutic orientation of the IR therapist.

The Quadrants

Integral Theory states that reality has at least four interrelated and irreducible perspectives—the subjective, intersubjective, objective, and interobjective—that should 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 indicates how, in aiming to be as comprehensive as possible, the six recovery dimensions of IRT cover the same ground as the quadrants.

Upper-Right Quadrant

Observing the recovery process from an Upper-Right (UR) quadrant perspective, we notice all the positivistic and objective perspectives of individual structures, events, behaviors, and processes of the individual (Marquis, 2008). This area includes neurotransmission levels, diet, medication, physical health, brainwave patterns, and observable behavior of the individual. The *physical recovery dimension* of IRT refers to aspects of a client's recovery process that reside primarily in the UR quadrant.[7] The physical recovery dimension includes therapies and practices that address physiological and neurological well-being.

Upper-Left Quadrant

Viewing the recovery process from the Upper-Left (UL) quadrant perspective, we see the subjective and phenomenal dimensions of individual consciousness (Esbjörn-Hargens, 2009). Integrated Recovery Theory

groups the various elements of this quadrant into three recovery dimensions, namely the emotional, mental, and spiritual. The *emotional recovery dimension* refers to practices and psychotherapies that create emotional literacy and psychological well-being. The *mental recovery dimension* refers to practices that stimulate cognitive insight, such as reading and 12-Step written work. The *spiritual recovery dimension* refers to the spiritually oriented aspects and practice of recovery, such as meditation as well as existential pursuits.[8]

Lower-Left Quadrant

Looking at the recovery process from the Lower-Left (LL) quadrant, we see the intersubjective dimension of the collective (Esbjörn-Hargens, 2009). The *social recovery dimension* refers to all the therapies and recovery practices relating to the LL quadrant. This dimension refers to all the relational, social, and cultural aspects of recovery, and includes elements such as 12-Step fellowship meetings and the quality of relationships.

Lower-Right Quadrant

The Lower-Right (LR) quadrant includes aspects of the collective viewed from the exterior, addressing observable aspects of clients' recovery infrastructure (Marquis, 2008). The *environmental recovery dimension* refers to all the socioeconomic and environmental aspects, such as the monetary, residential, and administrative features of an individual's life, which usually relate to the LR quadrant.

Lines

According to Integral Theory, each aspect of the quadrants has distinct capacities that progress developmentally; these are known as lines of development (Esbjörn-Hargens, 2009). Wilber (2000) has theorized that each person has multiple lines of development, similar to Howard Gardner's (1993) conception of multiple intelligences. These developmental lines can be plotted on a psychograph. Although the concept of multiple lines of development is a non-dominant notion in developmental psychology, and empirical proof for separate lines of development remains inconclusive, it nevertheless remains a useful clinical metaphor (Forman, 2010; Ingersoll & Zeitler, 2010). The six recovery dimensions of a client can be understood as separate yet interrelated lines of development, each of which can be at a different stage of development from the others.[9]

Furthermore, each of these lines of development is actually a composite of various other developmental lines; however, for pragmatic reasons I use these six lines. Viewing and quantifying the recovery process metaphorically from a lines-of-development perspective provides easily accessible insight to therapists and clients as to what aspects of the client's IRP can be improved. When each of the six recovery dimensions is plotted on an Integrated Recovery Graph (IRG), analogous to the psychograph, we get a simple graphic illustration of aspects of an individual's recovery process. The IRG is to be understood as a metaphor and used as a clinical tool rather than an empirically valid developmental measurement instrument.

Levels

When viewed as lines of development, each of these six recovery dimensions progress and fluctuate through a sequence of developmental altitudes, known in Integral Theory as stages or levels of development (Wilber, 2006). An insight into addiction and recovery from a stage perspective is imperative for truly all-inclusive understanding and treatment (Du Plessis, 2010; Dupuy & Gorman, 2010; Dupuy & Morelli, 2007).

The IR therapist could incorporate three types of developmental stage models in his/her therapeutic orientation. The first is the client's general stage of development (Cook-Greuter, 2004; Piaget, 1977; Wilber, 2006). A client's overall development or center of gravity "is a key factor in treatment planning, profoundly

influencing which categories of intervention are likely to be optimal, neutral, or contraindicated" (Marquis, 2009, p. 18). The second type is the client's stage of change as defined by the transtheoretical model of intentional behavior change (DiClemente & Prochaska, 1998). It must be noted that a client can be at different stages of change for different aspects of his addiction and elements of his Integrated Recovery Lifestyle: for instance, at the maintenance stage for crack addiction, the pre-contemplative stage for sex addiction, and the contemplative stage for giving up junk food and adopting healthier eating habits. Finally, the third type is the general recovery altitude of a client based on clean time and stage of recovery using recovery-based developmental approaches (Bowden & Gravitz, 1998; Nakken, 1998; Whitfield, 1991). Depending on the client's stages of development, various recovery practices and therapies are suggested.[10]

Figure 1 indicates various developmental models often used in Integral Theory, developmental models of addiction and recovery, as well as my own composite developmental model. Although the stages of addiction and recovery may be better understood as chronological stages or phases, I believe there is a correlation between the stage model as articulated in Integral Theory and the various stages (or phases) of recovery models. Simply put, earlier stages of recovery may correlate with early developmental stages, and higher altitude stages of recovery may correlate with more complex developmental stages. The figure is a simplified example of the developmental stages that a client's center of recovery gravity can possibly rest at. It must be noted that the figure is speculative regarding how the stages of recovery and addiction relate to other developmental models, and is best used as a clinical metaphor.

A developmental approach to recovery is also useful for therapy with recovering addicts at high altitude stages of recovery. An individual's recovery can progress through various levels of development along different lines of recovery. Consequently, at each new developmental stage, the individual requires a new set of recovery tools to function satisfactorily. Advancing through the stages of recovery requires that a client's IRP become increasingly more sophisticated in order to remain optimally successful. This suggests that the vague notion of the destination of "serenity," often used to refer to a type of "recovery nirvana," is often misleading, because each new stage presents new struggles all the way up the spectrum of development. As a holon, the recovering individual is always caught in a tension between a desire to be part of something larger and to be a whole unto himself. The discontent and drive of Eros is ever present and encourages this evolution.[11]

On the one hand, addiction is characterized by constricted awareness, which results in low developmental altitude (Block & Block, 2005a). Recovery, on the other hand, is characterized by an increase in awareness, which is accompanied by an increase in developmental altitude. Ultimately, the IR therapist aims to promote vertical development in the client by introducing practices and therapies that stimulate growth, insight, and awareness in all six recovery dimensions of a client's Integrated Recovery Lifestyle. Apart from vertical growth (also called transformation), the IR therapist helps clients to translate (achieve competence at a certain stage of development) in healthy ways within their current stage of recovery, by providing more efficient recovery tools to navigate their current stage(s) of development.

States

In Integral Theory, *states* refer to the various states of consciousness available at any stage of development (Wilber, 2006). Addicts are obviously experts on states. Using substances or any mind-altering behavior is an attempt to create an altered state of consciousness (ASC), and the specific psychoactive effect of various drugs and mind-altering behavior creates various types of ASCs (Milkman & Sunderwirth, 2010). It follows that viewing addiction in terms of an ASC perspective is crucial for a complete understanding of the nature of addiction (Winkelman, 2001). Some researchers have argued that the majority of addiction treatment programs fail to integrate a huge body of literature that highlights the therapeutic benefits for addicts in experiencing ASCs. They propose that a principal reason for the high relapse rate in treatment programs is the failure of those programs to address the basic need to achieve ASCs (McPeake et al., 1991).

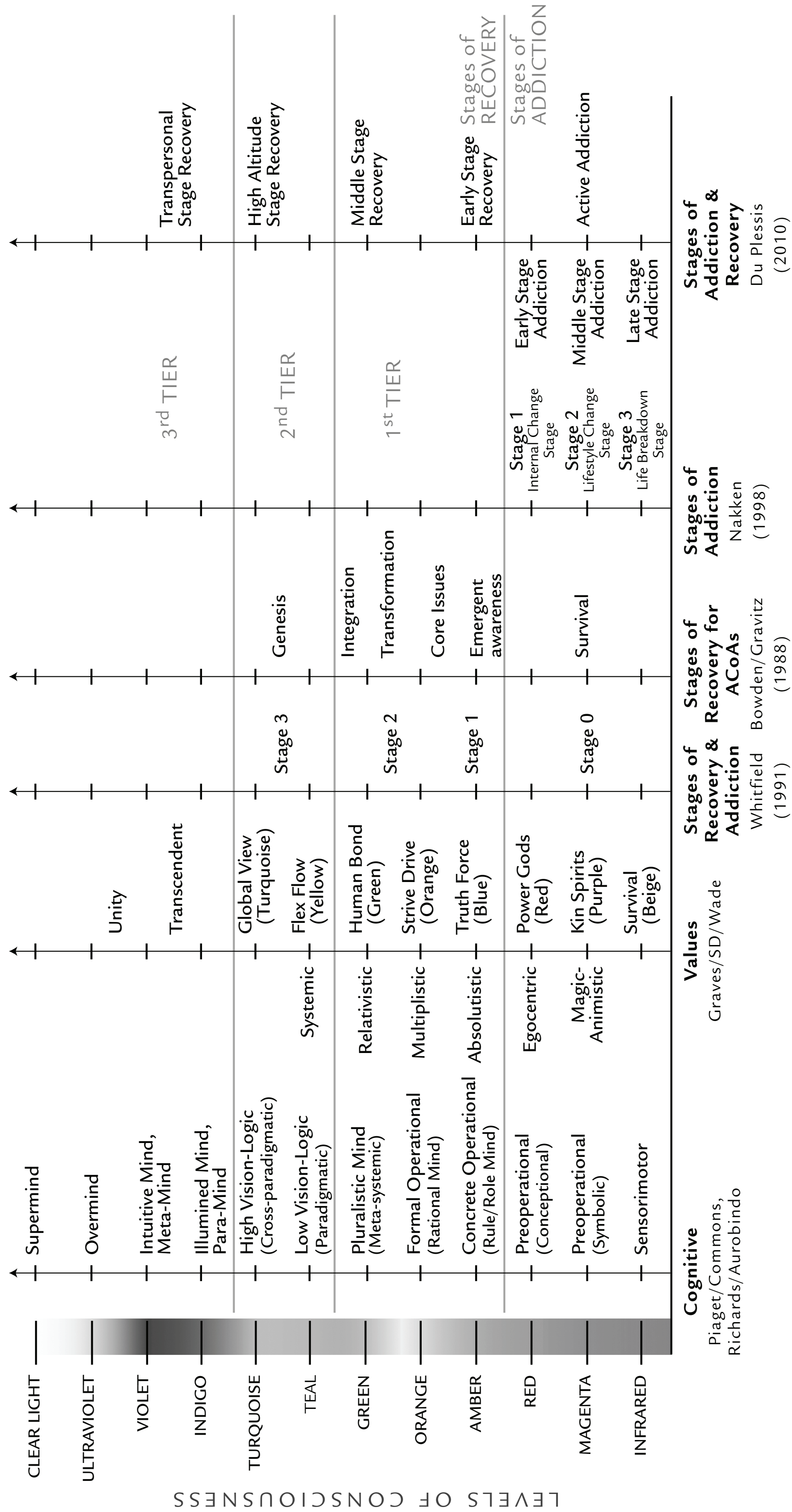

Figure 1. Developmental stages of addiction and recovery.

Some scholars believe that humans have an innate drive to seek ASCs (e.g., McPeak et al. 1991; Weil, 1972; Winkelman, 2001; K. Wilber, personal communication, January 13, 2011). They believe that addicts engage in a normal human motive to achieve ASCs, but in depraved methods because they are not provided the opportunity to learn "constructive alternative methods for experiencing non-ordinary consciousness" (McPeak et al., as cited in Winkelman, 2001, p. 340). From this viewpoint, drug use and addiction are not understood as an intrinsic anomaly, but rather as a yearning for an inherent human need. I believe that in some instances the etiological roots for certain individuals' addiction may be a dysfunctional attempt, borrowing terms from Robert Assagiloi (1975), at "self-realization," and the consequent flawed channeling of "superconscious spiritual energies," energies to which these individuals are often sensitive to but have not found suitable ways to actualize.

Every human being engages in various activities to feel good. Feeling good and avoiding unnecessary pain are universal needs. To feel good, we seek out activities that alter our brain chemistry. Addiction can be understood as this normal need gone awry. Harvey Milkman and Stanley Sunderwirth (2010) state that, "In light of the seemingly universal need to seek out altered states, it behooves researchers, educators, parents, politicians, public health administrators, and treatment practitioners to promote healthy means to alter brain chemistry" (p. 6). Addicts have found a dysfunctional way to meet this innate need through substances or certain behaviors to which they become addicted. Addicts normally have three dominant ways of seeking comfort and altering their consciousness:

> We repeatedly pursue three avenues of experience as antidotes for psychic pain. These preferred styles of coping—*satiation, arousal*, and *fantasy*—may have their origins in the first years of life. Childhood experiences combined with genetic predisposition are the foundations of adult compulsion. The drug group of choice—depressants, stimulants, or hallucinogens—is the one that best fits the individual's characteristic way of coping with stress or feelings of unworthiness. People do not become addicted to drugs or mood-altering activities as such, but rather to the satiation, arousal, or fantasy experiences that can be achieved through them. (Milkman & Sunderwirth, 2010, p. 19)

The quotation above clearly illustrates the need for addicts in recovery to find healthy behaviors and activities to manifest their preferred coping style, since this preferred coping style (satiation, arousal, or fantasy) correlates with their drug of choice. The IR therapist helps clients to alter their consciousness and channel their preferred coping style in ways that are life-giving and non-destructive.

Types

For a comprehensive understanding of addiction and recovery, knowledge of the concept of *types* is essential. Mark Forman (2010) states that, "The notion of types in the Integral model describes the diverse styles that a person (UL or LL) may use to translate or construct reality within a given stage of development" (p. 231). For a therapist to have a comprehensive understanding of a client, she needs to identify the different addiction/recovery types the client displays in each of the six recovery dimensions.[12]

The usefulness of viewing addiction and recovery from a typology perspective is illustrated in the following two examples. First, in the discussion of states, we saw that among addicts there are typically three different types of coping styles (satiation, arousal, or fantasy) that correlate with their drug of choice (depressants, stimulants, or hallucinogens).[13] Milkman and Sunderwirth (2010) state that, "After studying the life histories of drug abusers, we have seen that drugs of choice are harmonious with an individual's usual means of coping with stress" (p. 19).[14] Applying this simple typology to a client's drug of choice enlightens

the therapist as to a couple of important factors. It enables the therapist to identify the client's primary mode of stress reduction by correlating it to their drug of choice. When in recovery, the client will continue to use a preferred coping style and will be attracted to activities that produce a similar effect as their drug of choice. For example, an amphetamine user will likely be attracted to high-risk, physically demanding activities that are stimulating. The IR therapist helps the client to find healthy recovery-based activities that correlate with the preferred coping style. If a client is not guided toward finding alternate, healthy way of coping with stress, he will likely cross-addict to other destructive behaviors and addictions that correlate with the preferred coping style. Secondly, another useful typology is the bioself-psychological typology of addiction by Richard Ulman and Harry Paul (2006), which is a synthesis of the self-psychological and biological-psychiatric versions of bipolarity. Heinz Kohut (whose concept of the bipolar self represents the foundation for the model by Ulman and Paul) states that:

> The self should be conceptualized as a lifelong arc linking two polar sets of experiences: on one side, a pole of ambitions related to the original grandiosity as it was affirmed by the mirroring self-object, more often the mother; on the other side, a pole of idealizations, the person's realized goals, which, particularly in the boy though not always, are laid down from the original relationship to the self-object that is represented by the father and his greatness. (as cited in Ulman & Paul, 2006, p. 390)

In the bioself-psychological typology, addiction is understood as a psychological end result of developmental arrest in the bipolarity of the formation of the self. Biological psychiatrists, in their conception of bipolar spectrum disorder, devote considerable attention to depression and mania as they manifest in this disorder. These mood disorders correlate with disorders of the bipolar self as understood by Kohut:

> In general, a disturbance in the pole of grandiosity may find expression in either an empty, depleted depression or, in contrast, in over-expansive and over-exuberant mania or hypomania; whereas a disturbance in the pole of omnipotence may appear in either depressive disillusionment and disappointment in the idealized or, in contrast, in manic (or hypomanic) delusions of superhuman physical and/or mental powers. We maintain that an individual may be subject to specific outcomes resulting from a disturbance in either or both of these poles of the self. (as cited in Ulman & Paul, 2006, pp. 395-396)

Due to the specific accompanying mood disorder of each of the possible disturbances of the poles of the self, individuals will be attracted to certain psychoactive substances, which can be understood as an unconscious attempt at rectifying a specific deficit in self and coping style (Wieder & Kaplan, 1969).

Using the masculine and feminine typology as articulated in Integral Theory, we can see from the above two examples how the psychopharmacological properties of certain classes of substances correlate with masculine and feminine typologies (for instance: depressants/feminine and stimulants/masculine), and how these poles of the self can also be classified within a masculine and feminine typology (pole of grandiosity/feminine and pole of idealizations/masculine). We can therefore see how certain "masculine or feminine drugs" acts as "structural prosthesis" in an attempt of rectifying dysfunctional masculine or feminine poles of the self and coping styles (Du Plessis, 2010).[15]

Mindfulness

In 12-Step fellowships, members are advised to live "just for today." This simple yet profound slogan can be seen decorating the walls of thousands of 12-Step meeting venues all over the world. In essence, this slogan

refers to the concept of mindfulness. Mindfulness is a way of being that originated 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 philosophy of mindfulness, with its mindfulness-based interventions, is one of the core influences of IRT. The practice of mindfulness increases awareness. This is a necessary aptitude in recovery, since participation without awareness is a feature of impulsive, mood-dependent, and addictive behavior (Linehan, 1993). Mindfulness is a way of cultivating and strengthening awareness. This is one of the primary reasons IRT implements mindfulness-based interventions. Addiction over a period of time diminishes awareness and arrests vertical development (Du Plessis, 2010; Dupuy & Gorman, 2010; Dupuy & Morelli, 2007). Stanley Block (2005) describes collapsed awareness as the root of addiction or any dysfunction. The defense mechanism of 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 Perls (1976) writes: "Without awareness there is no cognition of choice" (p. 66). With increased awareness there is increased choice, and consequently, for the addict, increased ability to break the cycle of addiction.

There are many mindfulness-based methods and programs available to therapists. Examples of awareness training programs are the mindfulness-based stress reduction program (Kabat-Zinn, 1991), mindfulness-based cognitive therapy (Teasdale et al., 2000), dialectic behavior therapy (Linehan, 1993), and mind-body bridging (Block & Block, 2005, 2010).

Positive Psychology

What is a good life and how do we achieve it? These questions are of fundamental importance in IRT. Positive psychology attempts to answer this enigmatic question. IRT is informed by the philosophy and methodology of positive psychology. Seligman and colleagues (2005) state that "*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, and not merely on psychopathology as do the majority of psychotherapeutic approaches. IRT includes a solution-focused approach to therapy, which is similar to the ambitions of positive psychology, as they both focus predominantly on the solution rather than spending an inordinate amount of time investigating the problem, and both aim at increasing the quality of life for individuals. This is not to say that IRT does not acknowledge or work with psychopathology, but rather that it uses a balanced approach to the understanding of suffering and happiness and their respective methodologies.[16]

Some of the answers that positive psychologists suggest to the question of what makes us happy and what constitutes a good life are of particular relevance for IR therapists and their clients. According to positive psychology, there are three possible routes to happiness available to us, each with a different effect on our well-being (Peterson & Seligman, 2004). The first route is called *pleasurable life*. This is any past, present, or future activity that creates positive emotions and pleasure. Such activities create immediate pleasure or positive affect in any number of ways, but this pleasurable experience normally fades in a short period of time. The second—and considered the more enduring—route to happiness is called *engaged* or *good life*. This includes activities that are characterized by absorption, engagement, and flow. These gratifications come about through exercising one's strengths and virtues. The therapeutic application of flow theory is particularly useful with addicts, as the use of flow principles allows therapy to be reoriented towards building on interests and strengths (Nakamura & Csikszentmihalyi, 2005). Finally, there is *meaningful life,* which is characterized by using one's signature strengths in the service of something larger than oneself. Signature strengths refer to the character strengths that a person displays most frequently. When signature strengths are applied daily, they lead to a good or engaged life; when applied to something truly meaningful, they contribute to a meaningful life. I believe these concepts are clinically useful in guiding clients to find an integrated recovery lifestyle that is truly fulfilling by incorporating all three routes to happiness.

Twelve-Step Philosophy

The central component of IRT is the philosophy and methodologies of the 12-Step program as originated by Alcoholics Anonymous (AA). There is substantial evidence that the 12-Step program of AA is an effective treatment modality (Bourne & Fox, 1973; Laudet et al., 2006; Laffaye et al., 2008). Much of the work of the IR therapist involves helping clients internalize the principles of the 12 Steps and assisting them to integrate into 12-Step fellowships.

It is imperative that recovering individuals recover by "living in consultation" and that their recovery process takes place within a supportive and informed community (Carnes, 2008). I am of the opinion that any therapeutic process that does not help recovering addicts integrate into a supportive community will generally be unsustainable. Twelve-Step fellowships provide easily accessible and well-established recovering communities (Du Plessis, 2010). When addiction is viewed from a self-psychology perspective and understood as a disorder of the self, with narcissism as the problematic expression of the need for self-object responsiveness, we begin to appreciate why 12-Step programs are curative for addicted populations (Flores, 1997; Khantzian, 1994; Levin, 1995). Kohut (1977) viewed narcissistic disorder as the manifestation of a reaction to injury of the self, and healthy object-relations in early life as crucial for psychological growth and health. He implies that there is an inverse relationship between an individual's early experiences of positive self-object responsiveness and their propensity to turn to addictive behavior as a substitute for damaged relationships. If addicts are to successfully give up these misguided attempts at self-repair, they must learn how to form new healthy interpersonal relationships in which their needs for self-object responsiveness (mirroring, merger, and idealization) are fulfilled in gratifying ways. Twelve-Step programs accomplish this in several ways.

Twelve-Step programs provide predictable and consistent holding environments that allow addicts to have their self-object needs met in healthy ways. Furthermore, a 12-Step program, as a holding environment, also becomes a transitional object—a healthy dependency that provides enough separation to prevent depending too much on any single person until internalization is established. Gradually, "alcoholics or addicts are able to give up the grandiose defenses (narcissism) and false-self persona for a discovery of self (true self) as they really are" (Flores, 1997, pp. 292-293). As addicts form new healthy relationships and apply the principles of 12-Step programs, they internalize more self-care and are able to monitor affective states (transmuting internalizations).

Twelve-Step fellowships work because they naturally support addicts to engage in continued interaction with other members of the fellowship, allowing individuals in recovery to modify the dysfunctional interpersonal style (object relations) that dominates their lives, which is a significant etiological factor in their addiction (Flores, 1997). Edward Khantzian (1994) believes that only through this maintenance of connection with others can people repair the disorders of the self that lie at the root of all addictions.

Integrated Recovery Therapy Praxis

The Six Recovery Dimensions of Integrated Recovery Therapy

I will now explore in more detail how an IR therapist works within each of the six recovery dimensions, as defined by Integrated Recovery Theory, to ensure a comprehensive and balanced lifestyle for the client. As noted before, Integrated Recovery Theory identifies six interrelated yet irreducible recovery dimensions that provide a multiperspectival conceptual framework on a client's therapeutic process. For a client's IRP to be sustainable, a certain measure of health is needed in each of their recovery dimensions. What defines necessary health in each of the recovery dimensions is relative for each client. A skilled IR therapist applies therapies and assists clients in finding practices that are relevant to their specific needs and stages of recovery.

1. Physical Recovery Dimension

Addiction is often classified as a disease of the brain. Addiction affects the mesolimbic system of the brain, the area where our instinctual drives and our ability to experience emotions and pleasure resides. The pleasure pathway of the brain is hijacked, so to speak, 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, food, and water (Brick & Erickson, 1999). This explains why most addicts cannot stop using the substance or behavior on their own, in spite of adverse consequences. Furthermore, the chronic use of drugs does remarkable damage to the whole body, including the subtle energy bodies.[17] Traditionally, addiction treatment and therapy place very little emphasis on healing the body (and subtle energy bodies) and brain. Erickson (1989) suggests that for treatment to be effective, a combined physiological and psychological approach is required. Treatment that does nothing to improve an addict's neurophysiology often proves fruitless or incomplete.

The IR therapist assesses a client's physiological condition and recommends suitable therapies and practices. The *physical recovery dimension* of a client's IRP may include therapies and practices such as neurotherapy, nutritional supplementation, exercise, tai chi, yoga, pharmacotherapy, acupuncture, and nutritional education.[18] Moreover, physical activities, especially team sports, also serve a social and existential function.

2. Mental Recovery Dimension

Addiction is characterized by limited cognitive insight and cognitive distortions fueled by defense mechanisms such as projection, denial, and repression (DiClemente, 2003; Flores, 1997). Much of the therapeutic process of working with addicts is about cognitive restructuring, helping them work through their defenses to find a more accurate perspective on the nature and consequences of their addiction. The mental recovery dimension includes therapies and practices that create cognitive insight for the client into both the nature of addiction and the client's participation in an Integrated Recovery Lifestyle. The IR therapist assists the client in gaining the necessary cognitive insight into the recovery process. Furthermore, the therapist teaches the client the basic elements of the IR approach, and the why and how of its tools, thereby providing the client with a meta-recovery structure that is easy to understand and use.

The *mental recovery dimension* of a client's IRP may include therapies and practices such as psychoeducation and coaching by a therapist, 12-Step "written work," workshops, lectures and reading recovery-based literature.

3. Emotional Recovery Dimension

All psychotherapeutic and psychological factors relating to an individual are covered by the *emotional recovery dimension*. Obviously the mental and spiritual recovery dimensions are related to the emotional dimension, but, as mentioned before, this division is a pragmatic and abstract one.

Addicts are known to have turbulent and overwhelming inner worlds. From a psychodynamic perspective, addiction is often referred to as an attempt at self-medicating the addict's painful and confused inner world (Khantzian, 1985, 1999). Owing to defects in ego and self-capacities, the substance of choice becomes the addict's main method of mood management, which temporarily restores inner equilibrium:

> 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. Deprivation 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. (Flores, 1997, pp. 232-233)

Therefore, an essential component of recovery is learning healthy ways to self-soothe and cope with stress (Khantzian, 1999; Levin, 1995). Furthermore, if they do not deal with unresolved trauma, addicts may stay prone to relapse or cross-addiction. If not addressed, these individuals' addictions will continually migrate, seeking dysfunctional ways to deal with their turbulent inner worlds, ineffective object-relations, and unresolved trauma (Dayton, 2000; Flores, 1997).

A vital component of a client's IRP is some form of psychotherapeutic process that deals with unresolved trauma, family of origin issues, shadow work, and the building of emotional literacy. The IR therapist helps clients to find the most appropriate form of psychotherapy and practices referent to their recovery altitude, stage of development and stage of change. The Integral Taxonomy of Therapeutic Interventions (ITTI) of Marquis (2009) can prove useful in this area. Different therapies have their value at different developmental stages (Forman, 2010; Ingersoll & Zeitler, 2010; Marquis, 2007; Wilber, 2000). According to Ulman and Paul (2006), psychotherapy can serve as a transitional self-object, dispensing functions that serve as "psychopharmacotherapeutic" relief. In other words, a psychotherapist can replace the faulty self-object–like functioning of a client's drug of choice, and help the client to re-experience "archaic moods of narcissistic bliss" in a therapeutic as opposed to an addictive fashion. "Such an altered state of consciousness may eventually supersede and supplant an addicted patient's dependence on an addictive state of mind" (Ulman & Paul, 2006, p. 63). Clients can also be referred to group psychotherapy, which has been shown to be particularly effective with addicts (Flores, 1997).

As individuals progress in recovery, new issues emerge, and the psychotherapy that helped at a previous recovery stage may no longer be effective. Moreover, once addicts have dealt with their primary addiction(s) and have been in recovery for a while, other less obvious yet often equally destructive addictions begin to surface (e.g., codependency, love addiction) (Whitfield, 1991; Schaeffer, 1997). It is important for an IR therapist to have insight into which psychotherapies are appropriate for different stages of recovery (in addition to their developmental altitude), as well as an understanding of comorbidity and dual-addictions.

4. Spiritual Recovery Dimension

In a letter addressed to Bill Wilson, the co-founder of AA, Carl Jung stated: "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: *spiritus contra spiritum*" (Kurtz & Ketcham, 2002, p. 118). Jung was pointing out to Wilson that at the heart of a cure for alcoholism there often is a spiritual transformation, because he also believed that the thirst for 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" (Kurtz & Ketcham, 2002, p. 113). So, in a sense, addicts and alcoholics are misguided mystics. Avital Ronell (1993) echoes this sentiment and states that addiction is "a mysticism in the absence of God, a mystical transport going nowhere"

(p. 103). Thanks to the influence of Jung and others, such as William James (1901/1961), whose book *The Varieties of Religious Experience* was studied by Bill Wilson in depth, AA and subsequent 12-Step groups have seen the need for healthy spirituality as a central component of the recovery process (Kurtz & Ketcham, 2002). Furthermore, James's pragmatic thinking—he was one of the primary proponents of the philosophical system of pragmatism—had a huge influence on AA's pragmatic and pluralistic approach to spirituality (Flores, 1997; Kurtz, 1982).[19]

Integrated Recovery therapists promote spiritual well-being in their clients by working with therapies and practices that help clients to translate healthy spirituality in their lives appropriate for their particular stage of spiritual development. Rioux (1996) illustrates 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 help addicts achieve a sense of wholeness to counter the sense of self-loss which lies at the core of addictive dynamics. These practices enhance self-esteem by providing connectedness beyond the egoic self, with a "higher power of your understanding" as suggested in 12-Step programs.

It must be noted that in some instances one could run the risk of a type of pre/trans fallacy by confusing developmentally arrested archaic narcissistic needs and behavior with postconventional spiritual yearning, which is actually a fairly common phenomenon in certain drug subcultures (Wilber, 2006). In treatment, this type of pre/trans fallacy, when it forms part of an individual's denial system, is fairly difficult to deconstruct. The individual needs to realize that, very often, what s/he thought of as an experience of "oneness with the Kosmos" and a mystical quest for the transcendent, was in fact a developmentally arrested infantile yearning for "symbiotic merging" (Almaas, 1996) with the mother, which does not sound quite so spiritual—this does not easily appeal to a narcissistically wounded individual who believes that his drug-taking was based on lofty transcendent values and pursuits.[20]

An essential component of the *spiritual recovery dimension* is the focus on finding existential meaning for the individual in recovery. Spiritual practice plays an important existential role in the healing of addiction by providing a sense of meaning to life often found lacking among the addict population (Miller, 1998). Once addictive behavior is given up, most recovering addicts are faced with an existential vacuum in their lives. Without finding meaning in recovery, which is generally a long, difficult process, most addicts will revert back to addictive behavior. The practices of the spiritual recovery dimension encourage the formation of meaning within the recovering lifestyle.

Spiritually and existentially oriented therapies and practices may include existential analysis, meditation, prayer, reading spiritual literature, joining a spiritual sangha, sports, hiking, reading, playing a musical instrument, or learning an art form.

5. Social Recovery Dimension

Addiction progressively erodes relationships and is often caused by eroded relationships. Addiction is often viewed as an intimacy disorder, as addicts tend to have an inability to form healthy intimate relationships (Carnes, 2008). Scholars who support the self-medication hypothesis believe addicts often suffer from defects in their psychic structure due to poor relationships when they were young (Flores, 1997; Khantzian et al., 1990; Levin, 1995). This leaves them prone to seek external sources of gratification, such as drugs, sex, food, work, and so forth, in later life (Kohut, 1971, 1977). Edward Khantzian (1994) asserts:

> Substance abusers are predisposed to become dependent on drugs because they suffer with psychiatric disturbances and painful affect 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)

It is for this reason that the *social recovery dimension* is of utmost importance for an effective and sustainable recovery process. For addicts to develop a healthy and stable sense of self, they need to be in a supportive and knowledgeable social environment. The addict's psychic troubles are born from poor relationships and can only be modified via new relationships (Kohut, 1997; Khantzian, 1994; Kurtz, 1982). The social recovery dimension refers to all the relational, social, and cultural components of a client's Integrated Recovery Lifestyle. Apart from the corrective relationship the client has with the therapist, the client is also assisted in forming new healthy relationships with friends, family, a spouse or partner and, ideally, within a supportive community. An essential component in IRT is helping the client integrate into a 12-Step fellowship or similar supportive communities.

Some object-relation theorists believe 12-Step fellowships provide the ideal social environment for addicts to heal their psychic deficits:

> Ernest Kurtz (1979) views the mutuality of AA—one alcoholic needing and helping another—as the cornerstone of the recovery process and the main reason why Twelve-Step programs are so successful. Isolation of one's self from the rest of humanity is one consequence of shame and the driving force behind addiction, since the use of chemicals enhances the denial, fuels the grandiose defenses, and keeps one isolated. (Flores, 1997, p. 245)

Twelve-Step fellowships provide opportunities for supportive friendships, group participation, and mentoring. When actively participating in social fellowship activities such as sponsoring, being sponsored, service, meetings and informal fellowship activities, the individual starts to internalize these new healthy object-relations experienced within the fellowship; this results in a more stable, cohesive, and realistic sense of self and ways of relating to others. Without improving these capacities, the recovering addict would continue to be plagued by a feeling of emptiness, boredom, and poor relationships—which would of course continue to make the addict vulnerable to addictive behavior (Flores, 1997).

Participation in 12-Step fellowships helps the transition from the culture of addiction to the culture of recovery, an essential element for sustainable recovery. William White (1996) states that:

> Addiction and recovery are more than something that happens *inside* someone. Each involves deep human needs in interaction with a social environment. For addicts . . . the culture of 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)

The right social and cultural affiliation is one of the most important curative aspects of the recovery process, especially in early recovery. In my view, the main reason 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.[21]

6. Environmental Recovery Dimension

Abraham Maslow (1968), in his theory of human motivation, proposes that motivation is determined by

a hierarchy of needs. He suggests that there are at least five sets of basic needs. These are physiological, safety, love/belonging, esteem, and self-actualization needs. Simply put, these five needs form a hierarchy that orders our urgency to satisfy these needs—for example, a hungry person with no home is usually not that concerned with aesthetic or spiritual well-being until his/her hunger and safety needs have been satisfied.

Addiction exemplifies this theory. In most cases, addicts' addiction needs take precedence over most of their other higher needs. Addiction primarily manifests as physiological/safety needs, with the result that when these are not satisfied, all other needs become much less of a priority, resulting in a compulsive drive to meet the addiction needs at the expense of all other areas of life.

Maslow's theory of human motivation is useful for an adequate understanding of the *environmental recovery dimension.* The environmental recovery dimension collectively refers to a client's monetary, occupational, administrative, legal, and residential precincts. Using Maslow's model, it is clear that most of the aforementioned recovery dimensions are related to the three higher needs (love/belonging, esteem, and self-actualization), whereas the environmental and physical recovery dimensions relate to the two lower needs (physiology and safety). Therefore, when a client's environmental recovery dimension is unmanageable, he will likely struggle to actualize in the other recovery dimensions. If a client has serious financial, legal, and/or residential problems, the more lofty goals of their Integrated Recovery Lifestyle are often compromised.

Often recovering addicts tend to make a distinction between "working a recovery program" and the reality of their lives. They may rationalize that even though they are unable to manage in their finances or work, they are still "working a good program" because of the amount of psychospiritual work they are doing. The Integrated Recovery approach warns against and prevents such faulty thinking. If an addict's financial, administrative, legal, and residential needs are unmanageable, the whole recovery system may be compromised. Although they may be engaged in a lot of psychospiritual work and 12-Step program participation, it is not uncommon for recovering addicts to relapse because of severe unmanageability in their environmental recovery dimension. Integrated Recovery Theory states that the environmental recovery dimension is interlinked with all other aspects of an IRP, and includes this dimension when evaluating what constitutes working at a good recovery program.

Practicing an Integrated Recovery Program

The foremost aim of an IR therapist is to assist clients in constructing and practicing a comprehensive and sustainable IRP. When a client has identified adequate practices in all six recovery dimensions, each dimension strengthens the others. Consequently, in this way the client will heal and grow more rapidly than by only practicing one or two of these elements. Thus, Integrated Recovery can be seen as a type of recovery cross-training spanning all the dimensions. IRT is similar to certain features of therapies such as dialectical behavior therapy (Linehan, 1993), many coaching approaches, and solution-focused brief therapy (Berg, 1994; De Shazer, 1985) in the sense that the therapy primarily aims at teaching clients the necessary skills to eventually practice their own IRP without the assistance of the therapist.

I will now briefly explore some of the tools used in IRT: the template clients use to plan their IRP, the Integrated Recovery Wheel (IRW), and the Integrated Recovery Graph (IRG). These three tools provide a graphic, visual, and easily assessable structure for therapist and client to help plan and navigate the recovery process. My aim with these aids was to create the most simple and pragmatic structure that would graphically represent the recovery process. These aids have been used by many counselors and clients in inpatient treatment environments, many of whom have reported them to be of great value.[22]

Transformation and Translation in Recovery

According to Susanne Cook-Greuter (2004), human development can happen vertically (transformation) and horizontally (translation). This is an important distinction for a therapist when working with clients:

When we talk about . . . human development, we distinguish between lateral [translation] and vertical [transformation] development. Both are important, but they occur at different rates. Lateral growth and expansion happens through many channels, such as schooling, training, self-directed and life-long learning as well as simply through exposure to life. Vertical development in adults is much rarer. It refers to how we learn to see the world through new eyes, how we change our interpretations of experience and how we transform our views of reality. (pp. 2-3)

Integrated Recovery Program

Name: ______________________ Date: ______________________

The Six Recovery Dimensions

Physical
Exercise: ____________________
Diet: ____________________
Medication: ____________________
Supplements: ____________________
Other: ____________________

Spiritual
Meditation: ____________________
Prayer: ____________________
Spiritual Literature:____________________
Existential: ____________________
Other: ____________________

Mental
12 Steps Written Work: ____________________
Literature: ____________________
Other: ____________________
____
____

Social
12 Step Groups: ____________________
Family/Friends: ____________________
Sponsor: ____________________
Service: ____________________
Other: ____________________

Emotional
Individual Therapy: ____________________
Group Therapy: ____________________
Step 10 Daily Journal: ____________________
Other: ____________________
____

Environmental
Work: ____________________
Monetary: ____________________
Residential: ____________________
Legal: ____________________
Other: ____________________

Integrated Recovery Graph

RECOVERY ALTITUDE

PHYSICAL MENTAL EMOTIONAL SPIRITUAL SOCIAL ENVIRON-MENTAL

Figure 2. Integrated Recovery Program planner.

The IR therapist views and quantifies the client's recovery progress on two planes—the horizontal and vertical—referred to as translation and transformation in Integral Psychology (Forman, 2010; Ingersoll & Zeitler, 2010). A client's vertical growth in recovery refers to how he grows developmentally. Here we can use various developmental models (Cook-Greuter, 2004; Wilber, 2000). As clients slowly and painstakingly grow through these vertical stages, their perspective of themselves and the world changes—it gradually becomes less self-centered, more inclusive and embracing (Wilber, 2000).

On the IRP planner, clients specify their IRPs and indicate their vertical development in each of the six recovery dimensions on the IRG (Fig. 2). As we have seen, each of a client's six recovery dimensions can be at a different stage of vertical development. The IRG helps therapist and client to see which of the recovery dimensions are functioning at adequate or less than adequate levels. Clients need not excel in each of these recovery dimensions unless they choose to, but they do need to function at a reasonable level of health at least in each recovery dimension for their overall recovery to be sustainable. For the sake of simplicity, the IRG plots three stages: poor, good, and excellent. These three stages could also be articulated as low, medium, and high levels of development, but do not correlate with the general stages of development of Integral Theory (Wilber, 2000) because certain recovery practices will be interpreted differently (and be of different value) at different stages of recovery. Obviously, these are not precise scientific measurements, but inexplicit estimates of the developmental level of each of the recovery dimensions. It is important to remember that what would be considered adequate health in a certain recovery dimension is relative to the client's recovery altitude.

I use a hexagonal-circular model called the Integrated Recovery Wheel (IRW) to illustrate fluid aspects of horizontal (translation) development of a client's Integrated Recovery Lifestyle (Fig. 3). The inner circle represents relapse, the middle circle signals dangerous or toxic behaviors, and the outer circle signifies healthy practices in the six recovery dimensions. Vertical as well as horizontal development in a client does not fluctuate on a daily or weekly basis and takes considerable time to progress or regress. On the other hand, when viewed within a short time frame, horizontal growth can fluctuate dramatically.

The IRW is an assessment tool of how well clients are translating their IRPs within a chosen time frame, which could be daily or weekly. For each recovery dimension, clients write down in the outside circle the practices that promote healthy growth (protective factors), and in the middle circle activities that are det-

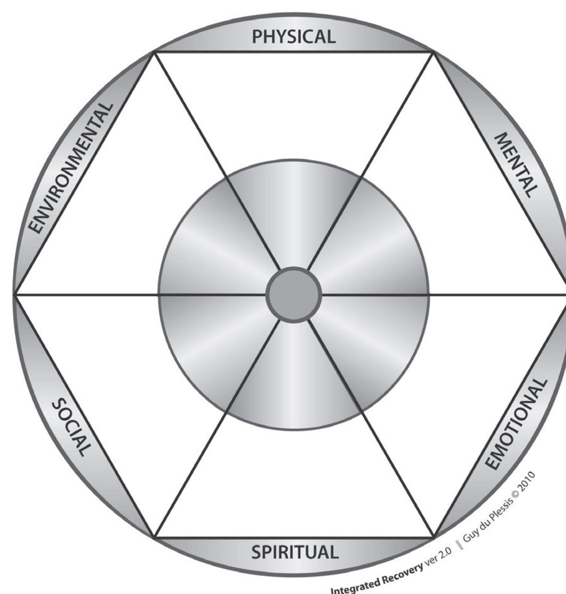

Figure 3. Integrated Recovery Wheel.

rimental (risk factors). This provides a visual structure for observing the healthy and unhealthy practices in a client's Integrated Recovery Lifestyle within a certain time frame. Consistent horizontal practice or translation in a recovery dimension leads to vertical development or transformation in that recovery dimension, which in turn contributes to overall vertical development. It is important to note that the principal aim of an IR therapist is to help clients translate effectively at their current stages of development, instead of just aiming at vertical growth.

Conclusion

This article provides a cursory sketch of the theory and practice of an integrally informed, 12-Step–based individual psychotherapy for treating addicted populations, with the premise that the inclusion of the meta-paradigmatic Integral model may result in a more comprehensive and sustainable treatment outcome. I am fully conscious of the deficiencies of this article; such deficiencies are necessarily characteristic of pioneering and exploratory work. Integrated Recovery Therapy and the Integrated Recovery Model have shown great promise in several addiction treatment centers in Cape Town, South Africa, since their inception and application in 2007 (Du Plessis, 2010). Clients and therapists alike have reported this approach to be of great value, and anecdotal reports are promising. This article is not the final word on Integral Addiction Treatment; it is merely a tentative and modest attempt to show what possibilities exist when applying Integral Theory in the context of individual psychotherapy with addicted populations, and hopes to stimulate interest toward the eventual development and full flowering of a well-researched, comprehensive Integral Addiction Treatment theory and practice.

Notes

[1] In my opinion, General Jan Smuts, South African statesman, philosopher, and author of *Holism and Evolution* (1927), was one of the first truly modern integral thinkers. Smuts, who coined the term "holism" and who was the first to promote a holistic epistemology, is mostly forgotten by contemporary academia. It is well known that Fritz Perls, co-founder of gestalt therapy, was greatly influenced by Smuts' holistic theory while living in South Africa after fleeing Nazi Germany, as was Alfred Adler. Adler used *Holism and Evolution* for his classes in Vienna (and had it translated into German) and describes holism theory, in a letter to Smuts, as "supplying the scientific and philosophical basis for the great advance in psychology which had been made in recent years" (as cited in Blackenberg, 1951, p. 81). Furthermore, in his book *Psychosynthesis* (1975), Roberto Assagioli acknowledges Smuts as the originator of the holistic approach as well as of the psychology of personality, subsequently influencing thinkers like Maslow and Allport. Assagioli (1975) describes Smuts' holistic approach as one of the most "significant and valuable contributions to the knowledge of human nature and its betterment" (p. 14). Unfortunately, the majority of modern holistic thinkers seldom acknowledge his pioneering work. However, Ken Wilber holds Smuts' work in high regard, and was influenced by him in the early stages of his career (personal communication, May 26, 2009).

[2] The *DSM-IV-TR* does not use the term "addiction" but rather "substance abuse disorders," since the World Health Organization concluded in 1964 that addiction is no longer a scientific term. However, the soon-to-be-published *DSM-V* will use the term "addictive disorders" instead of "substance dependence." For the purposes of this article, the term *addiction* refers to substance use disorders and process addictions such as sex addiction and pathological gambling.

[3] *Integral Addiction Treatment* and *Integral Recovery* are used as umbrella terms to represent integrally informed theory and practice in the field of addictionology, addiction treatment, and recovery. Integral Addiction Treatment refers to the more academic and clinical applications of integrally informed approaches to addiction treatment and research, whereas Integral Recovery refers to integrally informed approaches to early as well as late stages to the recovery process.

[4] I use the term *paradigm* to mean a set of social practices or behavioral injunctions, as was originally intended by Thomas Kuhn (1970).
[5] For example, a client in early recovery and at a pre-contemplation stage of change will be assigned certain practices appropriate for his/her recovery altitude as well as practices that will help the client to move from a pre-contemplation to a contemplation stage of change (DiClemente & Prochaska, 1998). The client's recovery altitude and stage of change, as well as his/her general stage of development, must be considered in choosing appropriate therapies and recovery practices.
[6] It may be useful in the future to develop a taxonomy of recovery-based interventions, similar to the Integral Taxonomy of Therapeutic Interventions (ITTI) devised by Andre Marquis (2009).
[7] Although many of the observable behaviors of a client's IRP that are grouped under other recovery dimensions should theoretically be classified under the UR quadrant, I will classify therapeutic and recovery practices relative to the quadrant in which they primarily create change and healing.
[8] Clearly the mental, emotional, and spiritual recovery dimensions are interrelated and overlap, making it difficult to group certain practices under specific dimensions. However, it should be remembered that these are abstract and not ontological classifications for pragmatic therapeutic purposes.
[9] My perspective on lines of development is that certain lines have developmental limits. Therefore, I believe using a generalized developmental index for all types of lines normally used in integral studies is theoretically incorrect. In my view, this is one of the reasons why current integrally informed psychographs run into problems—they are not dynamic enough and use the same stage developmental models for all types of lines. If we use Wilber's stage model, it seems that the body-related lines can only progress to pre-personal levels, the mind-related lines to personal, and the spiritual-related lines to transpersonal. Therefore, it would be incorrect to refer to body- or mind-related lines as transpersonal.
[10] It must be noted that these stage models are meant to be used only as orienting generalizations, not as rigid tools for treatment protocol. It is not clear how ego development correlates with the various stages (or phases) of recovery models, yet I believe they are related. This is another area for future research in the emerging field of Integral Addiction Treatment.
[11] Understanding the nature of the amber-conformist stage (Cook-Greuter, 2004; Wilber, 2006) and its relation to development in recovery allows us to see why it is necessary to follow the often rigid structure and rules of early recovery. Twelve-Step fellowships are often criticized for having too much dysfunctional amber structure (Kasl, 1992). I believe this particular criticism against 12-Step fellowships is misguided. Apart from the fact that most 12-Step fellowships' cultural norms function more from a green-pluralistic stage perspective (hence its non-exclusionary pluralistic attitude towards spirituality and membership), they provide the necessary healthy amber structure that is imperative to sustainable early recovery. In order to advance from the red-egocentric stages of addiction to higher stages, recovering addicts must first pass through and internalize the amber-conformist stage. The amber level concerns structure, rules, and conformity. This is why treatment centers and early stage recovery protocols often provide rigid rules and structure, which help the addict to internalize the stage structure of the amber-conformist stage. If the addict fails to internalize amber structures, vertical development may be arrested and the addict could remain stranded in narcissistic red-egocentric stages.
[12] Typologies in the context of addiction and recovery are an area open to future research. Developing comprehensive typologies of addiction and recovery spanning all four quadrants would be a useful tool for addiction treatment professionals. Furthermore, from a meta-paradigmatic perspective, using statistical tests such as factor analysis, we could identify how different addiction/recovery typologies interact with one another and possibly share similarities that cluster together. We may also be able to develop an addiction/recovery typology questionnaire(s) to define different addiction/recovery types that can assist in more personalized addiction treatment protocols.
[13] A research study found a striking relationship between personality, preferred coping style, and drugs of choice (Milkman & Frosch, 1973). It showed that individuals who preferred depressants such as heroin used passive with-

drawal, as well as reduced sensory stimulation, as their primary coping skills. On the other hand, those who preferred stimulants, such as amphetamines, were prone to confront a hostile environment with intellectual or physical activity. Those who used hallucinogenics such as LSD used daydreaming and imagery to reduce tension.
[14] I believe Ulman and Paul (2006) would disagree with Milkman and Sunderwirth (2010) about fantasy being an independent coping style. In their self-psychological model of addiction, Ulman and Paul posit that fantasy (in particular an archaic narcissistic fantasy of being a megalomaniacal self) is the underlying principle in all forms of addiction.
[15] According to Ulman and Paul (2006), stimulants (masculine drugs) provide an idealized self-object like function (for the feminine pole) and depressants (feminine drugs) provide a mirroring self object–like function (for the masculine pole).
[16] The IR therapist implements certain methodologies associated with positive psychology which focus on character strengths and virtues, as outlined in the book *Character Strengths and Virtues: A Handbook and Classification* (Peterson & Seligman, 2004). The classification of the 6 virtues and 24 character strengths, as outlined by Christopher Peterson and Martin Seligman (2004), gives therapist and client a structure to assess individual strengths. The IR therapist focuses on the identification, acknowledgement and fortification of the character strengths of the client. Therapy is then not merely focused on fixing what is dysfunctional, but also on nurturing the positive resources of the individual.
[17] Most subtle body practices originated in the Far East, where they have been in use for thousands of years. This system assumes that, apart from our gross bodies, we have a non-physical or subtle energy that permeates and circulates throughout our bodies. In various medical traditions it is called different names, but it essentially refers to the same phenomenon—in Indian medicine it's knows as *prana*, in Chinese medicine as *chi*, and in Japanese healing traditions as *ki*.
[18] Nutrition and dietary supplements can play a significant role in recovery. However, many dietary and nutritional approaches that have become available in recent years for treating addictions promise rather outlandish results. Most of these approaches are based on a similar premise used in biological psychiatry (a discipline often viewed as reductionist in "holistic" circles): in its extreme form, it states that abnormalities in brain chemistry and metabolism are primary risk factors and/or causes of addiction. Rectifying the imbalance will eliminate addiction. Clearly, from an integral perspective this amounts to quadrant absolutism, as irregular neurophysiology is only one of the (possible) etiological risk factors in this multidimensional disorder. I used to value the work of Patrick Holford in the context of addiction, but have become increasingly skeptical of his theories, particularly his "cherry picking" of research results to validate his claims (and range of products). I believe many physiological theories of addiction have great merit as etiological risk factors, but once addiction has hijacked, so to speak, an individual's brain chemistry, supplements or medication is not going to reverse the complex neurophysiological adaptation that an addict's brain will have undergone as a result of addiction.
[19] Unfortunately, no aspect of 12-Step philosophy is as misunderstood and misrepresented as its spiritual component. Twelve-Step programs are often criticized for being religious, fundamentalist, or promoting an amber stage belief in a "higher power" (Kasl, 1992). This is simply not true. Actually, 12-Step programs adopt a pluralistic stance toward the idea of spirituality and the concept of a higher power. They promote the pluralistic concept of a "higher power of your understanding" and suggest that members choose a spiritual orientation they are comfortable with at their current stage of development.
[20] In certain subcultures, drug use is often glorified for its mystical and transcendent properties, and the individuals in these subcultures often justify their frequent use of drugs through spiritual values. The problem is not that the ingestion of psychoactive substances cannot produce authentic mystical experiences, or that some of these individuals are not authentically driven to find spiritual enlightenment through the use of psychoactive substances, but rather that the prevalent drug use in these cultures is often driven simply by a need "to get high," and not a spiritual motivation. Consequently, most individuals are there to get high, not to become enlightened, but use these lofty ideals as rationalizations for more primitive impulses. The problem is that the frequent use of these drugs has long-term effects that are damaging physiologically, psychologically and, ironically, spiritually. Psychedelics, including marijuana, which

are often described as harmless by these subcultures, cause profound damage to the subtle energy bodies. It is no coincidence that Timothy Leary used the *Tibetan Book of the Dead (Bardo Thödol)*, a funerary book, as a guide for the psychedelic experience, as it describes the process of dying and indicates how consequently the subtle energy bodies loosen from each other. A psychedelic experience has this temporary effect of loosening the subtle energy bodies from the gross body, and replicates a partial death process. When these subtle energy bodies are loosened from the gross body too often, it can have disastrous consequences for the whole person, and hinders authentic spiritual development. For a brilliant discussion of the social and spiritual implications of these types of pre/trans fallacies, see *A Sociable God* (Wilber, 1983).

[21] When viewing the process of recovery from the perspective of Wilber's (1997) developmental model, we can see why a community is so important, especially in early recovery. As addicts move out of the egocentric red altitude of addiction into the ethnocentric amber altitude of early recovery, they enter a stage of development where their group plays a significant role in healthy development and integration.

[22] Subsequent to its inception at Tabankulu Secondary Recovery Center in 2007, the Integrated Recovery Model has been applied in several other treatment facilities in Cape Town. At Tabankulu Secondary, informal quantitative research was conducted by the staff, measured by the amount of ex-clients who achieved a year's clean time (abstinence from all mood-altering substances) using a sample of 23 ex-clients. The study showed a success rate of 80%. The author is aware of the extreme weakness of the validity and reliability of these results and does not wish to present these results as conclusive proof, but merely as an indication of the possibility of the increased success rate of an integrally informed treatment approach. A postgraduate outcomes-based evaluative research project was done at Tabankulu Secondary through the University of Cape Town, Department of Psychology. The research project showed promising results (Duffett, 2010). Furthermore, since 2007 many addictions counselors have been trained in the Integrated Recovery approach by the author in his capacity as Head of Treatment at Tabankulu Secondary and Program Director at Seascape House Recovery Centre, some of whom are currently applying it in their private practice.

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