

Introduction

Why Another Book on Recovery from Addiction?

Chances are if you are reading this, there's an addict in your life. Maybe it's a family member, a friend, a client, a co-worker. Maybe it's you. For years, I have worked on the front lines of addiction treatment, working with families and individuals. This journey has taken me to the inside of jails, hospitals, AA meetings, wilderness quests, juvenile halls, funeral parlors, and countless other environments, where the toll of the disease can be seen in the naked suffering that it causes. In the case of my brother, addiction to pharmaceuticals coupled with depression led to his suicide; a beloved aunt died a slow, painful death of emphysema from a lifetime of smoking; and an uncle who had struggled with alcoholism for years ended his life with a shotgun. This is just a small part of *my* story. Each of you reading this will have your own stories and losses.

I hope it will be evident in the course of this book that the circle of our concern and care is not just for the suffering addict, but for all who have suffered from the ravages of this disease. When you begin to look comprehensively at addiction and make the connections to neglected and abused children, fetal alcohol syndrome, crimes committed, individuals locked up, suicides, families destroyed, talents and gifts never realized, and hopes dashed, the extent of the suffering you find is simply enormous. It is my hope and prayer that this book and Integral Recovery can begin to shine a new light of hope where before there has existed largely confusion and despair. This book is intended to work on the front lines of the fight against the disease of addiction: in the hands of addicts and their families, their loved ones, their health care providers, their therapists, their friends, their teachers and life coaches. Integral Recovery is about action, about practice, about commitment, and about service—not merely an intellectual exercise or discourse on a philosophical approach

(although it can be that too)—but something for you to study and then engage in, to move upon the knowledge. Integral Recovery is an urgent appeal to stand up, reach out, and set foot on the journey of recovery, self-discovery, and transformation.

As Americans, we must begin by asking the question, Why do we (the United States) use the lion's share of the illegal drugs on the planet, when we are such a small percentage of the population? What is going on, and what went wrong? Why has our war on drugs, which started as far back as the Nixon administration, failed to stop the spread and rise of drug use and abuse in our country, among all age groups and socioeconomic groups? Another way of putting this is, Why haven't we been able to protect generations of our children from drugs, tobacco, and alcohol?

Some years ago, I was trying to connect these dots on a personal level as well as at the larger national and world levels. At one point, I thought this might be a book I had to write. Happily, someone beat me to the punch. *High Society*,¹ a recently published book by Joseph A. Califano Jr., former director of the Department of Health, Education, and Welfare under Jimmy Carter, brilliantly illuminates the price that our civilization, culture, economy, families, and individuals are paying for the plague of drug abuse and addiction that is wreaking havoc on our country and our world. Califano does a masterful job of laying out the costs and causes of this human catastrophe in a clarion call of alarm and possible hope—if we change our attitudes and approaches to the myriad issues involving drug abuse and addiction in our country. “Although we are 4% of the world's population, we Americans consume 65 percent of the world's illegal drugs. One in four Americans will have an alcohol or drug disorder at some point in his or her life. And most of these people have parents, children, siblings, friends, and colleagues who will suffer collateral damage.”²

Califano's call is to sober up our “High Society” and to recognize that substance abuse and addiction together make up “the nation's number one serial killer and crippler.” And he calls for us to acknowledge these fundamental realities:

- Addiction is a chronic disease of epidemic proportions, with physical, psychological, emotional, and spiritual elements that require continuing and holistic [Integral] care.
- Addiction is a culprit implicated in our nation's high health care costs, crime, and social ills, including child abuse and

neglect, chronic poverty, homelessness, teen pregnancy, the wildfire spread of sexually transmitted diseases, and family breakup.

- There are statistical and biological (chemical and neurological) relationships among smoking, abusing alcohol, and marijuana use, and between abuse of those drugs and use of cocaine, heroin, prescription drugs, methamphetamines, hallucinogens, and other substances.

According to the National Institute on Drug Abuse, the economic cost of drug abuse in the United States reaches into the hundreds of billions of dollars.³ In 2006, the Schneider Institute⁴ estimated that 10 percent of the National Health Care Budget was being spent on drug abuse and addiction: \$230 billion and climbing every year. Hold this thought in the light and add to it that only around 10 percent of those who need treatment actually get it and that even in the blue chip treatment centers the success rates are approximately 30 percent.⁵ We can begin to see the magnitude of the problem. Although the dollar amounts are staggering, it hardly touches on the emotional and spiritual costs of addiction—the lost and wasted human potential, the devastation to families and communities.

One factor that bears constant repeating is that young people are much more susceptible to becoming addicted—the young brain is supremely vulnerable to this disease. Califano writes that for more than a decade, 12 to 17 year olds have named drugs as the number-one problem they face when responding to an open-ended question in the annual back-to-school survey of the National Center on Addiction and Substance Abuse (CASA) at Columbia University. As Califano points out, if you can keep individuals off drugs, cigarettes, and alcohol until they reach adulthood, the chances of them becoming addicted diminish almost to the point that it is no longer a threat.

I bring this up not only because it gives us more insight into the beginnings of this disease, but also because it should be shouted from rooftops across the land that there is a moral imperative to protect the young from the devastating effects of addictive substances. In all my years of listening to addicts and their stories, I cannot recall one story where the using did not begin when the addicted were in their youth. There of course may be exceptions, but this is a powerfully tragic truth and a strong indictment against those who would sell and market these life-destroying substances to the young. Again, it is not enough to tell young

people what not to do; we must also tell them and model what *to* do; this is the great hope and challenge of Integral Recovery.

So, why *another* book on recovery? A great and valid question. The answer is that by using the Integral map, developed by Ken Wilber,⁶ a philosopher of extraordinary breadth, depth, and erudition, and other Integral pioneers, we can look at the disease of addiction with new eyes and a new understanding that has never before been available to us. The Integral map enables us to avoid making the crucial mistake of neglecting key aspects of the addictive process and allows us to cover all the essential bases. Viewing the disease of addiction through the lens of the Integral map is what separates Integral Recovery from other holistic approaches to treatment.

The problem with prior models lies not in how they deal with some of the important aspects of the disease, but that they lack a means to deal with *all* the vital aspects of addiction. In Integral thought, we say that “everyone is right in what they affirm but err in what they neglect.” Because addiction affects and eventually destroys the addicted person comprehensively, in all the fundamental dimensions of his or her life, it is vital that all the affected and infected parts be addressed, understood, and healed. If we leave any holes in the dike, it will not hold back the ocean over time, and if we leave a big hole or many holes, the dike will collapse quickly, and those whom the dike was intended to protect will be swept away.

For example, while Alcoholics Anonymous includes great community support and inspiration, as well as acknowledging and working on the spiritual aspects of the disease, it does not include the latest neurological and genetic science, which has a huge part to play in healing the disease of addiction. And, even the most cutting-edge, holistic approaches to addiction, which do endeavor to include the body, mind, heart, and soul, do not include developmental stages or types, which, when used within an Integral framework, effect an absolute quantum leap in our understanding and approach to treatment.

What Is Integral Recovery?

I am often asked, What exactly is “Integral”? And, What does it mean when you use it in the title *Integral Recovery*? I hope that this book will clarify exactly what Integral means in relation to recovery, but I will offer

a simple explanation from the start. Integral is holism with a map. Let me explain. Take the example of traditional medicine. Many of us, over the years, have come to realize that traditional medicine, while very effective in so many ways, completely misses the boat in many other very important ways (addiction for example). We have rightly seen and intuited that standard allopathic medicine seems to have emerged in a vacuum, often treating its patients as if they, too, had developed in a vacuum, where physical bodies are divorced from minds, spirits, relations, nutrition, cultures, and the world around us. The physicians and those of us who advocate for consideration of these things, when treating a patient, are kept outside the circle of acceptable “true medicine” and are thought to have moved into the realm of the fanciful and unscientific, even when our holistic leanings are totally in congruence with the leading edge of many fields of science.

Holism is an emergent way of viewing the world that was largely brought into the modern and now postmodern West, by the mind-blowing and paradigm-shattering findings in the field of quantum mechanics and quantum physics: Time is relative. Matter is energy. The observer affects the observed. Goodbye objective science and our firm grasp on the nature of reality!⁷

The psychedelic sixties also helped many of us deconstruct our divided and subdivided universe; in our psychedelic visions, we could clearly see that we were split within ourselves and separate from each other, the earth, and nature. Most of our academic disciplines and sciences would not even talk to each other. Of course, developmentally, there is a time when separation and autonomy are beneficial—for example, when science was let loose to advance on its own, rather than forced through the ecclesiastical filter of the Bible. As soon as science became unfettered and unthreatened by religion, the modern world could be born. But by the middle of the twentieth century, we had moved beyond the point where an atomistic and autonomous view of the world was useful. What had formerly been the way out became the trap. Humpty Dumpty had taken a great and useful fall, but now the task was how to put him back together again. How could so many diverse and beautiful pieces be reunited in a life-enhancing, world-restoring, unitive vision and practice?

The holistic intuition was that individual parts cannot be comprehended or treated effectively if they are not understood as part of a larger whole. The sum of the parts creates a greater whole, and the parts themselves are without meaning if placed into a vacuum. Try to imagine a human being with nothing else. It's impossible! The holistic quest became

to re-member the world and re-member our essential unity, so that we cease to act in unwise and harmful ways. The hope was that perhaps by bringing all these parts back together, we could create a better world and a better future for ourselves, our children, and all life forms.

Presently, the word “holistic” has been used so much that it has become somewhat of a cliché: there are so many versions of holistic, each one interpreted by someone claiming to be holistic in his approach and practice, that the word often loses its meaning. In the world of wilderness therapy (my field of endeavor for a couple of decades), the word holistic is all the rage when describing new programs. What it generally means is that a program may pay more attention to diet than in the past, and perhaps throw in some yoga and meditation (or something along these lines). I myself have struggled while developing programs, knowing that traditional treatment methods were missing big pieces of the puzzle and wondering if my model managed to include all that was necessary and essential for recovering the health of my students.

When I co-founded Passages to Recovery, a therapeutic wilderness program for adults suffering from alcoholism and other forms of addiction,⁸ I could see how previous wilderness models had left out major areas that needed attention if our students were to have a better chance of getting well and staying sober. So I studied the brain, nutrition, meditation, yoga, and any other fields of knowledge I thought would be useful and tried to put them all together in a new and creative way. It was pretty good, sort of like being an intuitive cook: add a little of this and a little of that, put it on the stove, and hopefully it will turn out not only edible but also tasting good. This is how the holistic approach developed: body, mind, spirit, nature, and yeah! Let’s see what we can do. It wasn’t very clear and rightly criticized as being rather mushy and murky. So, while intuiting and understanding that a holistic approach was necessary and superior, I struggled with how to identify all that was necessary to consider and how to fit it all together.

Then, in 2004, when I read a paper by Ken Wilber that was published on the internet,⁹ in which he described the Integral (or AQAL¹⁰) map, I immediately understood that this was the map that the emerging holistic world view needed to become radically more holistic and hence effective. It included the essential dimensions of reality (the four quadrants), multiple human intelligences (lines), stages of growth (developmental maps), states of consciousness, and typologies, with a clear understanding that we had to deal with our personal and collective shadows and

that the way to bring this understanding beautifully into fruition—into our world, our lives, and our bodies—was through dedicated, ongoing Integral practices. The more I looked at it, the more I saw.¹¹

The Integral map shows us all that is absolutely essential for us to consider on every occasion and also how it all fits together.¹² The map is what makes the Integral approach both revolutionary and powerful. In our times of increasing complexity, this map serves as an operating system that allows us to organize information and integrate it in ways that were unimaginable in the past. The Integral map enables us to embrace complexity and change, whether in the life of an individual or concerning any issue, challenge, or problem—in our case the treatment of addiction—rather than throwing up our hands in despair or retreating to simplistic solutions that don't work because essential dimensions are being neglected or left out. The Integral map takes holism from a brilliant intuition to a brilliant blueprint, and Integral practice takes the brilliant blueprint into life-changing, multidimensional reality.

A short definition of Integral Recovery is a lifetime Integral Recovery Practice illuminated by the Integral map. *Integral Recovery Practice*, at the core of Integral Recovery, is a sophisticated system of personal development that engages body, mind, heart, and spirit in daily practices designed to produce extraordinary health and awakening on all levels of our being. I will introduce these essential practices in the second half of the book; as the chapter headings denote, the focus is on building the body, transforming the brain, healing the emotions, the power of transmuting the shadow, and healing the spirit. Maintaining the practices with ongoing, lifelong dedication is the key to mastering a life of recovery.

The framework offered by the Integral approach to recovery from addiction is self-correcting in that it expects, encourages, and integrates change and evolution of the model itself as new information, data, and modalities emerge and come online. The model will become more effective, more elegant, and more beautiful as it evolves and grows. I make no claims that Integral Recovery is a cure for addiction—it is not a magic bullet—but each part of the map, each practice, and each insight is a nudge in the right direction. And as these many nudges accumulate and synergize each other, soon we find that we are nudged right off the board and into an entirely new game altogether: the disease of addiction has become the adventure of creating our highest and best selves.

Here are just a few of the benefits of the Integral Recovery approach to treating addiction:

1. It's a much more encouraging and attractive model than those currently in use, as the emphasis is on personal growth, not just the negativity of addiction. The focus is not merely on "not using," but on emotional, intellectual, and spiritual growth and physical well-being.
2. It transcends the traditional dichotomy of "addict" and "non-addict." In the Integral Recovery approach, everyone is a practitioner, including the treatment provider.
3. It offers a more complete accounting of the causes of addiction, and therefore it points the way as to how one can address those causes.
4. It features a deeper understanding of the internal mechanisms of healing, growth, and transcendence and how they relate to the recovering individual.
5. It provides a framework with which to rationally examine and judiciously use a variety of treatment approaches, uniting multiple partial modalities into an integrated whole.
6. It supplies skillful treatment and relapse prevention, teaching an individualized Integral Recovery Practice as the fundamental vehicle of the recovery process.
7. It presents a comprehensive and detailed map of the journey of recovery—one that's inspiring, enlightening, and immediately practical.

The Integral model represents the cutting edge of thinking on the integration of science, spirituality, and human development, presenting a conceptual framework that allows many different schools of thought to meaningfully and usefully coexist and at the same time inform and enrich each other. The Integral map not only enables us to understand the problem of addiction and how best to approach it, but perhaps even more importantly, it helps us understand ourselves and our place in the world. It illuminates the journey of recovery in comprehensive and compassionate terms. In teaching this model to adolescents, I have seen the scales fall from their eyes as they begin to understand and put it together. They often say, "Why hasn't anyone told us this before?" I answer, "Because until very recently, nobody knew it."

Christian theologian Matthew Fox¹³ has written that in a culture where young people are not given any method for transcendence, substance abuse and addiction are assured. A method of transcendence is exactly what the Integral map and an Integral Recovery Practice *do* offer us; Integral Recovery is an antidote not only for addiction, but also for the cultural soil that nourishes the disease. The Integral map is illuminating and inspiring and, in my experience, generally finds immediate resonance in the minds of health care professionals as well as those suffering from the disease of addiction and their families.

Having been a professional wilderness guide for many years, I know the need for good maps. As this book unfolds, we will explore what an Integral approach looks like, and how it can dramatically improve our understanding of addiction and vastly improve the successful outcome of treatment, moving beyond mere sobriety to a lifelong journey of optimal health, self-actualization, and ultimately Self-realization. But first, here is how I arrived at this Integral approach to recovery.

My Life: The Short Version

As a baby boomer, I was born into an era where alcohol use and smoking tobacco were socially accepted norms, at least in the professional, upwardly mobile circles my family moved in. Alcohol was used in my home, but never apparently abused, and I can find no instance of alcoholism in my genetic makeup. However, drinking was part of the cultural landscape of both my parents' worlds, Cajun Catholic on my father's side and Mississippi Scotch Irish WASP on my mother's side.

Enter the sixties. My first experience of illegal drugs was through my older brother, who was an early hippie and was experimenting with marijuana and psychedelics by 1967. He told me enthusiastically about his experiences, and on occasion, I witnessed him under the influence. I personally was caught up in the brilliant, drug-catalyzed music of the late sixties—the Beatles, Jimi Hendrix, Bob Dylan, Cream, and the Doors were some of my favorites. I began experimenting with pot and psychedelics when I was 13. I was attracted to the transcendental and idealistic aspects of the counterculture, including the altered states of consciousness that could be experienced with drugs.

Early in 1970, however, I began to notice the changing nature of the drug scene where I lived; peace and love were turning into greed

and paranoia. I lost my best friend over this shift, as he became seriously hooked on heroin. I was struggling with my own use, looking for some kind of spiritual clarity and intuiting that something had gone very wrong and that somehow drugs were not doing it—whatever “it” was.

That summer, I dropped out of the drug world and embarked on an eight-year journey into radical, evangelical, counterculture Christianity. Eight years later, I found myself sober, disillusioned, and directionally clueless. I joined the army, became a military police investigator in Germany, and found myself on the law enforcement side of the illegal drug problem. To me, the issue appeared cut and dried: There are rules. If you break the rules, you need to pay the price. Besides, I thought, protecting free Western Europe from the Soviet juggernaut was important. I didn't think being messed up on drugs was mission-friendly. Morally, the issues seemed clear to me, but I was not blind to the suffering of the addicted soldiers I busted and interrogated in the course of my investigations.

After my discharge, I went to college. It was 1982. Cocaine was king. In the course of things, I tried cocaine twice. I loved it. Some deeper, wiser part of me said, “You can never do this again.” I listened, and I didn't. I did fall in love with a young woman who was dependent on marijuana and saw how she smoked not to get high, but to feel normal; when the pot ran out, there was anxiety and chaos. The popular thinking at the time, and even now, was that pot was not addictive. It clearly was. In short, I was coming to see drug abuse and addiction from another perspective.

My first job out of college was as a counselor at a residential wilderness program in East Texas, the Salesmanship Club Boy's Camp. I worked with a group of 12, 13, and 14 year olds in an isolated part of the woods in structures we built ourselves. In the woods with the boys and my co-counselors, I found something very important for an idealistic young man: direction. My inner compass started pointing at a rather foggy north. I began to see rather vague signs that read “spirituality . . . healing . . . wilderness.” As nebulous as this might seem, here was something that I could give my life to—something of value.

This led to my traveling to the San Francisco Bay area and enrolling at John F. Kennedy University to study Transpersonal Psychology. I learned a lot about spirituality, some about psychology, made some good friends, and met the woman who would later become my wife and life companion. But I learned virtually nothing about addiction or chemical dependency. I later found out this was commonly true of almost all of the

graduate psychology programs at the time, not to mention the medical schools. Fortunately, there are some signs that this may be changing. Psychology and medical students are now beginning to learn a bit about the disease of addiction, but it's still not much, and it's definitely not enough.

During this period, I worked at an adolescent treatment center in Oakland called Thunder Road. This was real work, in the trenches, with teens of all ethnic and socioeconomic backgrounds. I learned the Twelve Steps of Alcoholics Anonymous, taught them, ran groups, had an individual caseload, and worked with the families. I was delighted that the AA model allowed us to talk about spiritual matters, and I was amazed to see beautiful people emerge from their angry, self-centered, addictive spell. I attended dozens of AA meetings with my clients and listened to many stories of drug abuse, addiction, and despair. But I felt terrible fear when my clients graduated and went back to their lives. Many of them had accomplished coming out of their drug-induced haze, healing, and getting the first inklings of something spiritual, but I knew that for most of them, the traditional injunction to attend 90 meetings in 90 days, get a sponsor, and work the steps, was not going to see them all the way through to a successful recovery.

After eight years in the Bay Area, I heard the call of the wild again and moved with my partner to the Southern Utah desert. We spent six months knocking around in an old four-wheel-drive truck—exploring, hiking, learning about the animals, plants, geology, and history, and vision questing. It was a very rich time with new vistas of beauty and revelation seemingly behind every turn in the road and bend in the canyon. Eventually, our wanderings brought us to an outdoor wilderness therapy program for adolescents, the Aspen Achievement Academy in Loa, Utah. It was mutual love at first sight, and we were hired on the spot. That was 1994.

The next decade was dedicated, for the most part, to wilderness therapy. During that time, I worked with hundreds of students and their families. The underlying problems for most of the students were the old nemeses: drug abuse, alcoholism, and addiction. There is no doubt in my mind that therapeutic wilderness programs can be a powerful clinical intervention and that most of the people in the industry are skillful, caring, intelligent people with the highest motivations. But wilderness does not cure addiction. What it does do is temporarily break the ever-downward-spiraling addictive cycle, at least for a time, giving both students and their families time to regroup and consider their options.

The problem I began to look at was what happens when the program is over. Sending students back to their old stomping grounds almost never works if they are addicts. For most, the old playgrounds and playmates are overwhelming relapse triggers. The more money the family has, the greater the options, and the standard aftercare plan among those with the means consists of sending the afflicted student to a therapeutic boarding school of some sort until they are eighteen, keeping them safe, and hoping for the best. Sometimes this works; sometimes it doesn't. If addicts want drugs, they will find a way to get them. You could send an addict to a penal colony in Siberia, and if he wanted to, he would still manage to get high.

In the late nineties, I began working on an idea for a new type of wilderness program, one that would face the beast of addiction eye to eye, instead of treating it as a secondary concern. I was given the opportunity to build such a program under the corporate aegis of the Aspen Education Group, the parent company that owned Aspen Achievement Academy, my original employer in Utah. On January 15, 2001, I had built my team and gathered my first group of students. We wandered for a month in the San Rafael Desert in Southern Utah, most of the time in heavy snow and subfreezing weather. The results were exhilarating. We had taken a group of seven ne'er-do-well alcoholics, addicts, and thugs from New Jersey and hiked hundreds of miles in an isolated, freezing desert; we had meditated, sweated, prayed, told our stories, and worked the Twelve Steps; and we had culminated the experience with a vision quest. We had deeply bonded as a group, and almost every person had experienced a moral and spiritual awakening.

This was so impressive that it was decided we should continue the project; this program became Passages to Recovery. We attracted an exceptional staff who were inspired by the blatantly spiritual nature of our program. I also spent a lot of time attempting to hire recovery "experts," but I soon found out that what passes for an expert in the field of recovery is normally an alcoholic or addict who has a respectable amount of sober time. This is a helpful perspective; however, it is limited in determining an individual's skills or qualifications to counsel, teach, and lead recovering addicts through the wilderness.¹⁴

Having a hard time finding the experts I sought, I set out to make myself one. I read, researched, and built a personal recovery and treatment library. I listened to story after story of people afflicted with the disease, both in and out of our program. I studied the *Big Book* of AA and other AA literature. I worked the Twelve Steps. I developed and

wrote a curriculum for Passages and taught it to our staff and students. I became known as “John, the recovery expert.” I found this somewhat ironic and amusing, but I stepped into the role.

As inspiring and powerful as Passages to Recovery was, I soon discovered it was not enough. The problem with Passages—and all treatment centers, no matter how good they are, or how poor for that matter—is that eventually the patient has to leave. In the case of Passages, our students would often leave positively radiant in a glow of inspiration and new hope for their lives. However, in many cases, this light would soon fade, and we were acutely aware of this.

Two courses of action typically recommended for students leaving a program were either, 1. Go to a secondary treatment center, where you can further your education or get a job; where there will indeed be opportunities for relapse to occur, but at the same time you will have support around learning to live a sober life. (Yet in this case, you will eventually have to leave the secondary center and return to the world.) Or, 2. The traditional possibility was to leave the program, find an AA or an NA meeting, get a sponsor, work the steps, eventually become a sponsor, and continue working the program for the rest of your life. This sometimes works, but not often enough.

The idea has often been that it is not AA or the program that is flawed, but you. It works if you work it, etc. Well, that idea didn’t work for me. Something was terribly amiss; more was needed. I had some vague ideas but couldn’t quite put it together. As time went on, I took the whole thing very personally, exhausted myself, and fell into a deep depression. I was not alone. Exhaustion and burnout are all too common among those laboring on the front line in this field.

Enter Integral. At some point in 2004, I was browsing through the magazine *The Utne Reader* and saw an advertisement for a website¹⁵ that mentioned Ken Wilber and a host of other luminaries, whose books I had read or at least heard of. I checked it out, signed up for a month’s free membership, and read a forty-page PDF file by Ken Wilber called “Introduction to Integral Theory and Practice: The AQAL Map.”¹⁶ The more I read, the more excited I became. My discouraged, fragmented, and exhausted mind opened with tremendous clarity. “This is it!” I thought. Here, in Integral theory, were the missing ingredients, the organizing principles that had been lacking in the recovery field.

I was completely captivated and spent the next couple of months looking for the Integral authority who was applying the AQAL map to

the treatment of addiction. After a couple of months, the sobering (pun intended) notion dawned on me that no one was doing this yet and that perhaps I was the guy who needed to step up to the plate. I had no idea of the extent of the journey I was about to embark on. What started as an attempt to find a better way of treating addiction also became a personal journey of renewal and self-transformation. What follows is what I have found so far on this journey. This is not to be the last word on Integral Recovery, but the first.

Recovery from What?

The Disease of Addiction

When the *Big Book* of Alcoholics Anonymous was published in 1939,¹ the neurological basis of addiction was completely unknown. In a foreword to the *Big Book*, there is a brief chapter titled “The Doctor’s Opinion,” in which the writer, Dr. William Silkworth, describes alcoholism as an allergy. This conclusion was based upon years of working with alcoholics and looking at alcoholism from an outside, third-person perspective. This seemed to fit the facts as they were then known: some people drink, and they are fine; and some people drink, and they are possessed by booze, eventually drinking themselves to death.

Identifying alcoholism as an allergy was a plausible explanation. Unfortunately, this medical explanation did not catch on. Despite the proposition that addiction could be seen as an objective, physical problem—one that, presumably, could be treated through medical means—the notion persisted that addiction must be some kind of moral and ethical deficiency and not the purview of medicine. Doctors washed their hands of the whole messy issue and shifted responsibility for the problem to law enforcement. This has caused a health care catastrophe. It does not mean that law enforcement has no role to play in an overall Integral approach. But, first and foremost, we must realize that addiction is not a crime but a disease. Let me state it clearly at the beginning of our discussion: addiction is a disease of the brain, which involves relapse and requires a lifetime strategy of ongoing practice and care. I would like to note here that I am not attached to the idea that a lifetime of care and treatment will always be the only answer to addiction. But the word “cure” is tossed around a lot these days in the context of addiction, and I do not believe that it is accurate or helpful to use it.

Let's diverge for a moment and consider a better understood disease: type 1 diabetes. The organ affected is the pancreas. The defect is that the organ is no longer producing sufficient insulin. Some of the symptoms are excessive thirst, extreme hunger, unusual weight loss, increased weight, irritability, and blurred vision. Left untreated, diabetes results in death. With treatment, which includes insulin injections and appropriate diet, the symptoms disappear, and the diabetic can begin to live a normal and productive life. As far as I know, there is no Diabetics Anonymous. Anonymity is not necessary when there is no social stigma associated with the disease.

Let us look at addiction in the same light. The organ is the brain. The defect is the brain's inability to produce sufficient dopamine and other essential neurochemicals. The symptoms are uncontrollable cravings for the drug of choice, and the behaviors that accompany these overpowering cravings are, among others, lying, stealing, radical negative personality changes (which I call the Dr. Jekyll/Mr. Hyde syndrome), and withdrawal from formerly important relationships. Looking at these behaviors, the assumption has been that addicts are "bad" people and have what has been popularly called an "addictive personality." This interpretation has been further reinforced by the fact that approximately 80 percent of our 1.8 million prison population is incarcerated on drug- and alcohol-related charges or crimes that stem directly from addiction, including the use and sale of these substances.²

A further challenge presented by addiction, as well as by other brain diseases such as schizophrenia and depression, is that there has been no objective test for diagnosis. Instead, all we have to go on is first looking at the behaviors and then listening to the patients' subjective descriptions of their experiences, along with subjective reports from family or friends.

So we say addiction is a brain disease, but how do we know this? Our first knowledge came as a result of the famous Olds experiments in the 1950s, when Olds set out to find the locus of addiction in the brain.³ As often happens, the first experimental subjects were rats. Rats, like humans, have a triune brain (albeit in the case of the rat, much less sophisticated than its human counterpart), whose main parts are the cortex, the limbic system, and the midbrain, sometimes called the reptilian stem. These three layers contain our evolutionary neurological history and inheritance. The neo or frontal cortex governs the higher human functions such as love, meaning, values, and spirituality. The limbic system deals with emotions, and the midbrain, or reptilian stem, with very powerful, primitive survival instincts, such as killing, eating, and reproductive urges.

Since the addict (in the mid to latter stages of the disease) seems to lose touch with the higher human functions and values, it was assumed, quite logically, that the problem had to be in the neocortex. So Olds and colleagues injected cocaine into the brain of a rat—expecting that the behaviors associated with cocaine use and addiction would rapidly manifest. What happened? Zip. They continued this line of research throughout the cortex, thinking they had maybe missed a spot; again, nothing. Olds and his colleagues then proceeded through the limbic system—again with no results.

Finally, as we might imagine, a bit discouraged, they tried the earliest and least suspect part of the brain, the midbrain. Eureka! They had it. The rats exhibited many of the behaviors associated with cocaine use and, quickly, addiction. The rats were given a lever with which they could self-regulate injections of cocaine into their midbrains, and they simply continued to hit the lever until they starved to death. (Is this starting to sound familiar?) Then the scientists experimented with sending increasing voltages of electricity through the floor on which the rats had to stand in order to move the cocaine-injecting lever, and the rats went right on hitting the lever until they were electrocuted.

The conclusion? The first part of the brain that is taken over and altered by the disease is the midbrain, which controls our most primitive and basic survival instincts. In short order, this hijacking will change the form and function of other parts of the brain as well.⁴ But already, in the brain of the addict, addictive cravings have become equated with survival—not pleasure, not fun, but survival. Incessant cravings for drugs have become so primary that all other instincts and drives are secondary in importance. Eventually the cravings become more powerful than the instinct for life itself.

What these experiments with rats show us is that addiction has nothing to do with character defects, moral failings, or sin. I doubt theologians would agree that it is possible for a rat to sin, but it is clear that rats can, and do, become addicts. Behaviorally, this is all very perplexing, but neurobiologically, when looking at the brain, it is very simple.

In a healthy brain, successful accomplishment of essential survival activities controlled by the midbrain, such as hunting, eating, and sex, is rewarded with a pleasurable surge of dopamine. This neurochemical produces the rush, the thrill, the sense of “Yes!” (This certainly explains our attraction to war, violence, and contact sports.) The surge of dopamine is then followed by a surge of serotonin, a neurochemical that produces an experience of satiation and satisfaction, which balances out the dopamine.

However, in the brain of the addict, this natural reward system is hijacked; naturally occurring and necessary survival behaviors no longer produce pleasurable feelings. This is because our drug use has quickly exhausted and depleted our natural supplies of dopamine and serotonin, so, we, as addicts, can no longer feel pleasure and satisfaction *without the addictive substance* (which serves as artificial dopamine). In the absence of the drug, and with virtually no serotonin and dopamine supplies left, the brain kicks in large amounts of norepinephrine, the brain's adrenaline, which causes the addict to suffer anxiety, the shakes, and sweating—otherwise known as symptoms of withdrawal.

As the brain continues to reduce the number of dopamine receptors in response to the flooding of the brain with pseudo dopamine (drugs), the addict must take ever greater quantities in an attempt to achieve the same effects. This is known as tolerance. One sees this reflected in the using patterns of late-stage addicts, when they are able to consume mass amounts of drugs that would normally kill a horse. A slight exception is found in the latter stages of the alcoholic's disease, when the alcohol begins to destroy the liver. At that point, it takes very little alcohol to achieve the desired effect. A particularly dangerous aspect of tolerance, in the specific case of heroin addicts, is that as the heroin addict detoxes, the brain begins to try and heal itself, causing more dopamine receptors to come back online. If the heroin addict then leaves treatment, relapses, and attempts to use the same dosage he was formerly using, he often overdoses and dies, not realizing that his tolerance had been significantly decreased during detox and his time of abstinence from using drugs.

Brain chemistry in the "addictive personality" can also be changed with behaviors besides drugs. A person who is identified as having an addictive personality might be one who falls into a series of compulsive behaviors involving, for example, sex, video games, food addictions, internet pornography, exercise, shopping, or gambling—all of which are attempts to alter their brain chemistry in order to feel "okay." A person with a healthy, balanced brain can make choices about pleasurable activities, whereas the person with neurochemical imbalances feels constant anxiety, depression, or dissatisfaction. The use of different activities to try to feel better then leads to a reliance on the activities that is compulsive. Now the activities are no longer freely chosen, but acted out in a trance-like and robotic manner, and they lead not to satiation and satisfaction, but to progressively stronger cravings and suffering. So what looks to the outside observer like a personality or character issue is actually the outward manifestation of a neurological disorder.

When addicts suffer cravings, these are not like a nonaddicted person's cravings for a good meal, or a new car, but cravings so powerful that in the brain they are equated with existence and survival. It's not, "I sure would like . . .," but "I've got to have!" The locus of control is no longer the moral, caring neocortex, but the powerful, primitive reptilian brain. In a psychologically healthy situation, our higher self controls our lower drives. In the addict's brain, this is turned upside down. This explains perfectly the addict's bad behaviors: the lying, the stealing, the manipulative use of others, and the radical negative personality changes. The more highly evolved cortex becomes the slave of the reptilian midbrain and its overpowering, "gotta have it," compulsively perceived survival needs.

Am I an Addict?

Why are some people addicts and others not? We are not sure, but it seems that 10 percent of us have the propensity to become addicted.⁵ I would venture to say that it is rare in our society when a young person gets through high school and college without some contact with potentially addictive substances. This is unfortunate, because studies⁶ tell us that if young people can make it to adulthood without using alcohol, drugs, or tobacco, the chances of their becoming addicted are virtually nil—or, if not nil, greatly decreased. In any case, a lot of us move through these years, experimenting, partying, and in some cases abusing, but we don't become hooked; we stop altogether or moderate to some level that works for us in a reasonable way.

In one of the initial talks I give to students in treatment, titled "Am I an Addict?" I make it clear from the outset that I have no agenda to prove somebody *is* an addict; I simply want to conduct an inquiry, consider the facts, examine the symptoms, and allow people to make an honest self-diagnosis. If you dissect your own experience using the following three characteristics of addiction, it's usually very clear whether you are an addict or not, and to what degree.

1. Addiction Is Progressive

It starts out as a small thing, seemingly harmless, like a minor cut or a localized infection. But with time, if left untreated, it spreads throughout the body and eventually kills the patient. This means that in the initial phases of the disease, it is often difficult to tell whether one is clinically

addicted or merely abusing a substance. It's important to remember that not everyone who uses or even abuses is necessarily addicted, and in the early stages of the disease abusers and addicts look very much the same. But as the disease progresses to its later stages, it becomes obvious to an informed person what is going on, and eventually it becomes clear to the addict himself. The first key to understanding the disease is that it is progressive. Addiction starts out as a small thing and progresses into a huge, uncontrollable thing.

What distinguishes the addict from the abuser? It's just this: at some point the abuser gets sick and tired of the negative consequences of his abuse and makes a decision to quit or moderate his use—and does. For addicts, this is virtually impossible. They see and recognize the negative consequences of their use (at least some part of them does), but they have lost the capacity to control the intake of the substance. When working with late-stage clients, I often ask the question, “What do you think about 24/7, from the time you get up until the time you pass out?” Usually, this will lead to an “Aha!” moment of self-recognition. The answer, of course, is drugs and/or drinking. The cravings and the urge to use or drink have become all consuming.

Often there is an initial phase of the disease that I call the “romance phase,” when the addict discovers the substance or substances, and it is as if he has found the answer to all of his problems. “I don't have to be sad anymore. I don't have to be shy or depressed. I don't have to feel unattractive or uncool. This is wonderful!” As you might imagine, this phase of the disease is hard to treat. Why? Because, normally, the last thing on earth that the addict wants to do at this point is stop using—the drug(s) is meeting so many needs. This can involve, for example, a new peer group and social acceptance within that circle or a new profession, which often entails dealing drugs or otherwise carrying out illegal or objectionable actions in order to support one's habit. In fact, a whole new life can open up, which seems very appealing at first but then changes over time to become a complete hell.⁷ Feeling peace or even feeling ecstatic for the first time in one's life is very powerful. While relating their first experience of using their favorite drug, many addicts have described it to me as love at first swallow, snort, or fix. The addict, in short, has fallen in love.

A teacher of mine once looked into my eyes and told me, “You have some good pain in you.” What he was saying was that I had suffered deeply enough that I might get real and get down to work on myself.

This is often the case with addicts. Frequently, they have to become sick of their relationship with the drug and its consequences before they can begin to do the hard work of healing. In AA parlance, this is known as “hitting bottom” and is generally seen as a necessary condition for beginning the day-to-day work of returning to health. All too often, an addict will come to a meeting and say, “I can control my drinking.” The response is, “Okay, go and try some controlled drinking.” The alcoholic eventually returns after much suffering, not at all in control of her drinking, and admits that she has lost the ability to control her drinking (the first step of AA). Then the work begins.

There is a certain validity to this concept, but it is not acceptable if one is a parent and the idea is, Oh, wait until your teenage daughter is selling her body to get drugs—then we can intervene. Absolutely not! One does not have to wait until someone destroys his or her life before one acts. In the recovery industry, this is called “raising the bottom.” (A former student of mine recently quipped, “You hit bottom where you stop digging.”) There are plenty of external motivators that can be, and usually must be, put into place to supply the necessary incentives to get and stay sober.

The overwhelming majority of people who enter treatment are not there because they want to be, but because they have to be. Each stage of the disease, the romance stage, the balancing act stage (where the addict is still trying to maintain some semblance of normalcy), and the over-the-edge stage (when the addict has stopped even trying to fool himself—when it’s just all about taking drugs) is treatable, but each stage presents its own challenges. It is interesting to note that success rates in treatment seem to be the same for those who enter voluntarily and those who enter treatment through the use of external motivators such as the threat of jail time or the loss of their job, marriage, or financial support.⁸ I have seen everything from “F___ you, I don’t want to be here,” to a young man sobbing in my arms the second day of treatment saying, “I can’t use heroin again. If I do, I’m going to put a pistol in my mouth and pull the trigger.” He knew that heroin was killing him (in fact it had killed his father), but he felt powerless to stop. Self-annihilation looked like a better alternative than further descent into the maelstrom of heroin addiction.

Another interesting aspect of the progression of the disease is that one’s addiction seems to become more powerful, even during periods of abstinence. I have often observed this phenomenon: a person will enter

treatment, clean up, restore some degree of her health, leave treatment, stay sober for a while, and then suddenly relapse. Many times the addict will tell herself: "This time it will be different. Now that I've worked on some of my issues, and I'm healthier and stronger, I will be able to handle it." Not only does this *not* happen, but instead of picking up where she left off, the addict self now seems to want to make up for lost time. She uses more than before she went into treatment! Why is this so? We don't know, but, based on many years of experience and reams of anecdotal evidence, this appears to be the case. There does seem to be a consensus emerging that if the original complaints or sufferings that started the person using and self-medicating in the first place are addressed on emotional, spiritual, physical, neurobiological, and even cellular levels, then this sort of relapse does not have to occur. This is the bright promise of the future as we begin to move from treatment to cure.

2. *Addiction Is Chronic*

Once you have crossed the line from use to addiction, there is no going back. Addiction doesn't just get up and go away. It is not just a phase, and one does not outgrow it. As Bill Wilson wrote in the *Big Book* of Alcoholics Anonymous, it is the dream of every alcoholic to be able to drink like a normal person. Unfortunately, the alcoholic relates to his drinking in a completely different way than the "normal" person. For example, an alcoholic seated in a restaurant who sees someone leaving half a glass of wine unfinished will simply, viscerally, not be able to understand how this is possible. Likewise, the nonalcoholic will not comprehend how the alcoholic can't stop drinking when he is staggeringly drunk and his life, health, and relationships are collapsing all around him because of his drinking.

The fact is that once you're addicted, you don't become unaddicted. This means you can never safely use the addictive substances again. This also means that if you were addicted to heroin, for example, it's not okay for you to drink alcohol or smoke pot. All of these drugs affect the same part of the brain and can trigger the same renewed, virtually uncontrollable cravings.

As our understanding of addiction continues to grow, let me make this clarification. Up until very recently, most recovery experts spoke of chemical dependency synonymously with addiction. Presently, a new understanding is emerging that one can become chemically dependent without becoming an addict. An example of this would be if an individual was in a traumatic accident and had injuries so severe as to require

powerful narcotics to treat the pain. After a few weeks of using these drugs, the individual decides, or his physician decides, it's time to quit. By that time, the individual has become chemically dependent on these drugs. When he quits, he experiences all the symptoms of withdrawal from an addictive substance. However, after that, it's over. He never craves these substances again. That is chemical dependency without addiction.

In the case of the addict, however, one could be separated from her drug of choice, alcohol, for example, for years, maybe in prison, and when she is released, the cravings that have never left her take over again, and she is right back where she was, or quickly even lower than before. This is an addict. What we're finding is that the brain of the addict has been changed in its function by the disease of addiction. We can actually see the change in the function of the brain through CAT scans and other brain imaging technologies.

THE DR. JEKYLL/MR. HYDE SYNDROME

The "Dr. Jekyll/Mr. Hyde syndrome" describes the radical personality change that happens to the addict as the disease takes its course. The formerly good, kind Dr. Jekyll transforms into the monstrous Mr. Hyde. This is not a loose literary parallel. Robert Louis Stevenson was actually writing a metaphorical story about the effects of cocaine. The once loving son, daughter, husband, wife, mother, father, friend, or other loved one turns into a raging, manipulative, self-centered addict. The change is dramatic and horrifying.⁹

Periodically, the healthy self will reemerge, feel great remorse for her behaviors, and promise to quit using and change. This is sincerely felt by the individual. But this is no longer possible without treatment and outside help. The addict self comes back, sooner or later, and those close to the addict experience it as another betrayal, which, in fact, it is. The addict realizes this also, which only adds to the shame and despair, fueling renewed use and self-narcotization.

3. Addiction Is Terminal

The last point is that the condition is terminal; if not treated, the patient dies. What we are treating is the progressive, uncontrollable compulsion to use drugs, which, if unchecked, leads finally to death (and/or in many cases incarceration). This does not mean there aren't what we call "functional drunks," addicts who can muddle through life and hold it

together for years, and some who can even accomplish great things, such as Ernest Hemingway, Henry the VIII, Jack Kerouac, Trungpa Rinpoche, and so on. Often these are very creative people, but if one looks at the quality of their interpersonal relationships and their ultimate demise, one can clearly see the footprints of the disease, subtle at first, and eventually grinding them into the ground.

The Villains of the Story: Causes of Addiction

Whether we become addicts or not is often largely a matter of genetics and the newly emerging field of epigenetics. If a person has a grandparent that is an alcoholic, there is a four times greater chance that he will also become addicted. If both parents are addicted, the chances are eight times greater. Also, some ethnic groups are apparently more susceptible than others. For example, among the Cherokee there is almost no chance of using alcohol and not becoming addicted. In my work with students in recovery programs, one of my first questions is, "Is there a history of alcoholism or addiction in your biological family?" The response is almost always 100 percent, "Yes."

While genetics seem to play a very important role, not every person who has the genetic potential becomes addicted. In most cases, genes seem to be a necessary factor but not a sufficient causal factor. What is the other factor that triggers the genetic potential for addiction? Stress. Let me state that again. *Stress*. Chronic, inescapable, unavoidable stress is public enemy number one in the brain of those who possess the genetic potential for addiction. This is a good reason treatment should not be punitive; treatment involves healing and rebalancing the brain and learning to have pleasure in natural, drug-free ways. Being punitive, however, only causes stress in the individual, hence renewed cravings and then relapse.

Stress that happens early and stress that is chronic and inescapable¹⁰ is the most harmful. Stress works directly on the midbrain, triggering the release of cortisol and corticotrophin-releasing factor (CRF), both of which are key neurological ingredients in depression and addiction.¹¹ As a nonaddict, these neurochemicals and hormones will make you feel anxious and exhausted and make you susceptible to premature aging and a myriad of other diseases. For an addict, in addition to all of that, elevated amounts of these substances in the body sensitize the brain to compulsive and uncontrollable cravings for addictive substances in the following manner.

Stress elevates CRF and cortisol in the blood, the natural “feel okay” dopamine system is repressed, the anhedonic individual encounters a drug, which powerfully (if temporarily) relieves this condition, and the brain interprets this relief as the key to survival itself. We are then off to the races.

In the presence of these chronically elevated stress hormones, and lacking cortical coping mechanisms, the dopamine, or healthy reward, system is suppressed or broken. Stress-related hormones in the blood cause a down regulation, or decrease, in dopamine receptors, and the person becomes anhedonic, unable to experience pleasure in the normally rewarding experiences of life. Although the brain is releasing dopamine in response to these activities, the cells do not receive it. If a person with the genetic burden and elevated levels of cortisol and CRF experiences chronic, unrelievable stress and gets a hold of any addictive substance, the brain is flooded with substances that mirror the effects of dopamine in the brain, and the person finds immediate relief and release. The feeling is, My God, this stuff works! The flood of artificial dopamine is interpreted by the dopamine-starved cells as the most important way of securing one’s survival, and securing drugs quickly rises to become the organizing principle of an addict’s life.

The fascinating new field of science known as epigenetics (which I’ll cover in more detail in chapter 9) also plays a very important role in whether or not we will become addicts. Around fifteen years ago, after the human genome was finally enumerated, many scientists felt that the majority of the job was complete—that we had finally discovered the keys to human life and health. Well, as it turned out, our genetic makeup doesn’t tell the whole story. Perhaps even more important than which genetic cards we’ve been dealt is how our genes turn on or turn off. According to the epigenetic scientists, these mechanisms, both chemical and electromagnetic, control our health, our happiness, our intelligence, our creativity, and so on, to a very large extent—90 percent.¹² This 90 percent is absolutely within the control of our environment. When I say environment, this means our inner as well as our outer environments, or all four quadrants (as we shall explore in the next chapter). And what is the determining factor in how our genes either turn off or turn on? You guessed it, stress.

As I was preparing this chapter for publication, I heard a family physician being interviewed on NPR, who said that fully 60 percent

of all the patients he sees are there for stress-related and stress-caused complaints and diseases. Interestingly enough, while enumerating all the diseases that were caused by stress, he did not mention addiction. So not only is stress a major causative factor in the disease of addiction as well as many other life-threatening diseases, but unhealthy stress-coping mechanisms, such as drugs, tobacco, and alcohol, become life-threatening diseases themselves.¹³

According to Dr. Hans Selye,¹⁴ a pioneer in the field of endocrinology who actually coined the term “stress,” stress has two poles: di-stress and eu-stress. Distress is the negative stress that we are talking about as a causative factor in many of our diseases, including addiction, and eustress is the positive stress that leads us to create, to grow, and to heal. In our Integral Recovery Practice, we treat for distress and use eustress as a means of transforming our lives and as a clear pathway to sobriety and lifelong health and happiness.

What are the causative factors behind chronic distress and the resulting neurobiological cravings for dopamine? They could be any or all of the following:

1. Chemical imbalance in the brain
2. Unresolved trauma from the past
3. Negative narrative stories about one’s self and the world
4. Inability to cope with the present
5. Lack of purpose, meaning, or connection in one’s life (also known as existential despair)
6. Toxic relationships. Often these relationships occur between people, but a toxic (stress-inducing, unhealthy) relationship can also be with the place where a person lives, when one is living under a constant threat from which there is no escape, as in a war zone, or an area that has suffered severe environmental degradation.¹⁵

These causative factors are biological, emotional, cognitive, and spiritual. Without addressing these issues, there is no long-term cure for addiction; by cure I mean reestablishing the locus of control in the neo-cortex and away from the needy, craving, compulsive, reptilian midbrain.

Addressing these causative factors using the AQAL map as our organizing, three-dimensional framework is what Integral Recovery is all about. This is what will make the difference between long-term sobriety and chronic relapse and death for an addict.

Let's look at these factors individually and see what is to be done.

1. Chemical imbalance in the brain. There is much that can be done in this regard. There are now affordable tests that use saliva and urine to measure the levels of all known essential neurochemicals that factor into the chemical imbalances that cause stress and suffering for the afflicted individual and lead to constant relapse. Prior to this, short of a spinal tap, there was just no way of knowing for sure. A spinal tap is expensive and invasive. This led physicians to look at the symptoms, offer educated guesses, and prescribe medications accordingly. This was a hit-and-miss method at best and led to a lot of tweeking and experimenting with types of medications and dosages. Having been on medications for severe depression, I experienced this dance firsthand. This may also take a long time, which prolongs the suffering and danger to the patient.

As I used to say to my students, there is simply no dipstick that I can put in your brain and tell you that you are two quarts low on dopamine, one quart low on serotonin, a quart high on cortisol, and about a gallon high on norepinephrine! Well, now the "dipstick" is available. Thank God. We now have affordable procedures that can tell us the levels of all of the essential brain chemicals, and we can track the rebalancing progress, thereby offering our patients and students more effective and efficient treatment. We have a number of ways to do this rebalancing of brain chemistry, which include targeted supplementation, improved diet, medication (if indicated), exercise, and brainwave entrainment meditation.¹⁶ This is excellent news.

2. Unresolved trauma from the past. This is a big one. I have found, more often than not, that in most cases my students have suffered some sort of major trauma in their past.¹⁷ In the late eighties, I befriended a group of homeless men who lived on the streets of San Francisco. Almost all of them were

Vietnam vets who had experienced some real hell during the war and could not quite make it back into the mainstream of American life. For the most part, I found them to be great guys, very loyal to each other, but haunted by demons from their past. Unresolved trauma also came up frequently among the young people I worked with for many years in wilderness programs. In the girls' groups, the majority had suffered some sort of rape or sexual molestation, and this was often true of the boys groups as well. Remember, just having the genetic profile is not sufficient in itself; one must also have an external or internal source of constant, unrelieved stress. Unreleased trauma is very often the source of this stress. In another chapter, I will talk about the very specific techniques I have developed for getting at these repressed materials and getting free of them.

3. Negative narrative stories about one's self and the world. From our lives, histories, and impressions, we all build stories about ourselves and the nature of reality. Often, these stories are largely unconscious, but they exert tremendous power over our lives and brain chemistry. Part of the process of getting well in Integral Recovery involves looking at these stories and the narratives we have created and seeing how they affect us. When they are negative and not optimal, we can see them for the creative fictions they are and rewrite them so that they are optimal and help us to achieve our goals and create the kind of lives that we want to live.
4. Inability to cope with the present. I have found that, almost across the board, addicts do not have a healthy ability to cope with the day-to-day vagaries of life. Day-to-day events—even watching or reading the news—can cause unacceptable levels of stress, which lead to a case of the “F___ it!” that is almost always a prelude to relapse. One of the most amazing things that we have found with brainwave entrainment technology is that when you continue to use it on a daily basis, your stress threshold continues to rise and that after a number of years of dedicated practice, almost nothing can knock you off center for long. We become like those punching bag toys we had when I was a boy. You slug and whack 'em, and they pop

right back up. With practice, we become resilient and nearly unflappable.

5. Lack of purpose, meaning, or connection in one's life. This is simply not a healthy option for the recovering addict. It has been said that if you have a why you can almost always find a how. Victor Frankl in his classic work, *Man's Search for Meaning*,¹⁸ wrote how his experience in the Nazi death camps taught him that those inmates who found in themselves a reason to live were the ones who survived. As the disease of addiction drags the individual down into toxic egocentric narcissism, the journey of Integral Recovery makes us look for and find what matters to us—what we are willing to live for and to what higher purpose we can dedicate our lives. Viktor Frankl teaches us that happiness is not something that one can successfully pursue as an end in itself, but emerges as a byproduct of our meaningful activities.
6. Toxic relationships. If we understand stress as the ultimate triggering factor of the addictive craving response, it follows that we can treat addiction by reducing stress in the addict's relationships and life circumstances. This involves family therapy, making amends where necessary, and, when needed, leaving behind toxic unhealthy relationships. William Glasser, in his excellent book *Choice Theory*,¹⁹ contends that we have a handful (maybe five or ten) of key relationships in our lives and that how we navigate and negotiate these relationships is a major factor in the quality and happiness that we achieve in our lives. Cleaning up these key relationships, even if the cleaning means ending the relationships in some cases, is one of the ongoing tasks of our Integral Recovery journey.

We must learn to be effective in the world, which means providing for ourselves and those we are responsible for. This includes learning how to work, how to study, how to pay our bills and taxes, and how to meet our responsibilities. It also means learning how to invest, how to be a leader, an entrepreneur, how to actually achieve our dreams and give our gifts to the world. An Integral Recovery model will necessarily include these topics and will provide teachers who have achieved some degree of mastery in these areas.

In addition to becoming successful in our relationships and our work, we must at the same time become successful at navigating our interior worlds, increasing our stress-coping skills, and raising our stress threshold. We must cultivate our interior gardens and grow connections to our strength, wisdom, and love, which will, in turn, bless and illumine all our relations and endeavors. This is precisely what the Integral Recovery model is designed to do.