

Integral Theory and the Principles of Integral Psychotherapy

Integral Theory is primarily the creation of philosopher and theoretician Ken Wilber, who is one of the world's most widely read and translated living philosophers. Integral Theory is essentially a *synthetic philosophy*, and Wilber's greatest ability and contribution has been to weave together a wide array of seemingly disparate schools of thought (S. McIntosh, 2007). He has accomplished this in the realm of psychotherapy, offering a synthesis between different schools of psychotherapy, as well as between the therapeutic field as a whole and the esoteric, meditative traditions (see Wilber, 1973, 2000; Wilber, Engler, & Brown, 1986). However, the "how to" of putting Wilber's ideas about psychotherapy into practice has not always been clear to therapists, despite a great deal of appreciation for his insights. Because Wilber himself is not a clinician, it seems natural that the task of describing how these ideas apply to real clients in real therapeutic situations falls upon those of us who are. This chapter begins that process.

This discussion begins with some framing comments about the Integral system and its basic intent. We will then move to describe the five basic features of the model—quadrants, stages, lines, states, and types—staying close to practical considerations and leaving aside unnecessary theoretical complexities.¹ These five facets of the theory, which are addressed in greater depth in later chapters, will inform the five basic principles of Integral Psychotherapy. The chapter concludes by defining the major approaches to psychotherapy that the Integral approach attempts to synthesize. It should be said that this chapter, by necessity, is the most general of the text; the chapters that follow contain more nuances, suggestions, and ideas directly relevant to psychotherapy. The encouragement is for readers to stick with this chapter—even those who might be already familiar with Integral Theory—as the ideas set forth here create a foundation for the rest of the text.

The Overall Purpose of the Integral Approach

The major purpose of the Integral model—if one is trying to be concise—is to learn to use the insights of the various fields of human knowledge in a complementary way. Integral Theory attempts to bring together the most possible numbers of points of view on an issue, with the intention of creating more multifaceted and effective solutions to individual and social problems.

Why don't people already do this? Why does one even need an integrative approach? One way to answer this question is to point out the modern problem of *overspecialization*, or the tendency of different theorists and research traditions to stay confined within a very narrow niche or perspective, while tending to ignore what others are doing. Overspecialization manifests itself in many ways in our field and beyond. In psychotherapy, one negative consequence has been the proliferation in the number of available therapeutic modalities—some estimates are as high as 400 different systems (Garfield & Bergin, 1994; Karasu, 1986). Often, people who create new approaches try very hard to distinguish what they are doing from pre-existing approaches without attempting to incorporate or account for the value of what has come before.

The Integral approach would suggest that these problems of hyperdifferentiation and theoretical discord can be seen as the symptoms of a larger philosophical problem, whether they arise in psychotherapy or in other practical or academic disciplines. And that problem comes down to how we have tended to answer some very basic questions, including “What is real?” and “What can we really understand about ourselves and the universe, and how can we acquire this knowledge?”

People throughout history have answered these questions in a number of fundamentally different ways. Furthermore, they often hold unquestioned assumptions about their particular answers that can be used to deny or negate other views. If, for example, a biologist sees human biology as the “real” thing and human thought and emotion simply an extension of that, he or she has less incentive to see psychology as being equal in value to the facts of biology or neurology. Similarly, a psychologist may ignore or downplay issues of politics and economics because they are secondary (depending on his or her specific orientation), to the impact of childhood experience with the primary caregiver. There are many possible ways in which a person's main orientation and professional affiliation may contribute to the devaluation of other points of view.

Although specialization itself is not always bad news—great strides are made when people focus intently on one thing—problems do arise when there isn't a mode by which to bring insights and understandings from different points of view into a useful relationship with one another. The inability

of professionals and intellectuals to think from multiple perspectives, and to grant validity to competing perspectives, can indeed have a negative impact when working with complex individual problems and when conflicting ideas of the “real” contend with one another in the larger arena of human history (Wilber, 1995).

The Integral model represents a constructive response to overspecialization and positions itself as a kind of “next step” in intellectual dialogue and practical application. It looks to step back and identify general principles that can help reintegrate or draw meaningful connections between different disciplines. More specifically, it argues that there are many connections to be made between different schools of psychotherapy, different approaches to spirituality, as well as between the hard sciences (e.g., biology, chemistry), soft sciences (e.g., political science, economics), art, and morality. To make this somewhat clearer, and without getting too far ahead of ourselves, the basic gist of Integral philosophy is as follows:

- What is real and important depends on one’s perspective.
- Everyone is at least partially right about what they argue is real and important.
- By bringing together these partial perspectives, we can construct a more complete and useful set of truths.
- A person’s perspective depends on five central things:
 - The way the person gains knowledge (the person’s primary perspective, tools, or discipline);
 - The person’s level of identity development;
 - The person’s level of development in other key domains or “lines”;
 - The person’s particular state at any given time; and,
 - The person’s personality style or “type” (including cultural and gender style).

The shorthand for these aspects of the Integral viewpoint is often called AQAL, which stands for *all quadrants, all levels, all lines, all states, and all types*.

To illustrate this further, let’s consider a therapeutic situation with a depressed, single, working mother who reports having discipline and behavior issues with her strong-willed, 4-year-old son. Imagine the mother consults four different therapists. The first therapist meets with the mother individually to

dialogue about her feelings about parenting and her history with her own parents. This therapist recommends a longer course of therapy for the mother in order for her to work through her own family-of-origin issues. The second therapist takes a more behavioral approach, viewing the mother–child interaction through an observation window. Therapist 2 offers the mother basic communication skills and advice on how to set boundaries and structure their playtime together. A third therapist, a psychiatrist, looks primarily at familial genetic and temperamental dispositions, suggesting that the mother might benefit from medication and exercise because of her depression. Therapist 4, perhaps a social worker, notes how financial issues are placing strain on the mother and hopes to empower her economically and educationally through connecting her with resources in the community.

Now let's also consider that these therapists may be different in other ways besides orientation and the types of interventions they recommend. One might be more psychologically mature than the others. One might have been depressed lately. One might have been born and raised in Japan, whereas the others were born and raised in the United States. The Integral approach suggests, in short, that each of these therapeutic orientations and interventions, as well as each of these individuals, has something very important to contribute to the view of this one client. Indeed, we can bring their insights and interventions together in an organized and complementary way.

Four-Quadrant Basics

So what would it be like if we took for granted that each one of these therapists had important truths and important recommendations to offer? And how would we organize those truths and the accompanying interventions without getting overwhelmed? The best way to begin to understand how Integral Theory conceptualizes this multiperspectival approach is to start with the four-quadrant model. This model serves as something of a meta-narrative for Integral Theory—it is the backdrop on which everything else sits. It also informs our first principle of Integral Psychotherapy.

Principle 1: Integral Psychotherapy accepts that the client's life can be seen legitimately from four major, overarching perspectives: subjective–individual, objective–individual, subjective–collective, and objective–collective. Case conceptualizations and interventions rooted in any of these four perspectives are legitimate and potentially useful in psychotherapy.

The four-quadrant model suggests that there are four basic perspectives humans take on reality. When humans ask the question, “What is real, important, and true?” they tend to answer most often from one of these

four major perspectives. Although each of these perspectives is considered legitimate in the Integral view, they also are different in important ways. Depending on the perspective one takes, one will describe phenomena differently and use different methods to gather and evaluate evidence.

The first major distinction made in the four-quadrant model is between viewpoints that look at things *subjectively*, or from the interior, and *objectively*, from the exterior. The left side of the model represents the subjective, whereas the right side represents the objective. The second major distinction is made between the *individual* and *collective* perspectives. The individual perspective is represented in the upper half, and the collective in the lower.

For example, in psychotherapy some people look primarily at the client's subjective (or intrapsychic) thoughts, feelings, and memories as being the cause of a particular issue. This is a subjective-individual perspective, or upper-left (UL)-quadrant perspective. Others argue the importance of understanding people by looking at intersubjective relationships, most notably familial, intimate, and community (cultural) relationships. This is a subjective-collective perspective, or lower-left (LL) quadrant perspective.

In contrast, some therapists tend to look to the person's biology and genetics when trying to understand issues of mental health. This is an objective-individual perspective or upper-right (UR)-quadrant perspective. Behavioral approaches, for reasons we will touch on later, also fall into this category. Finally, there are other therapists who emphasize the sociopolitical situation of the client and his or her access to systems such as political representation, health care, education, and housing. This is an objective-collective perspective or the lower-right (LR)-quadrant perspective. For a visual overview of the four-quadrant model, see Fig. 1.1.

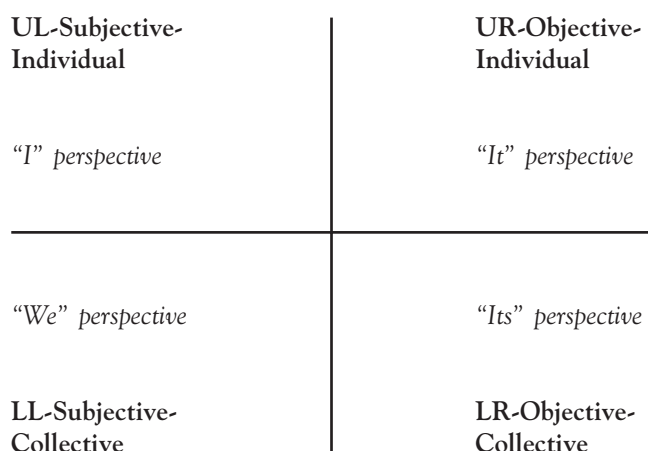


Figure 1.1. Basic Overview of the Four-quadrant Model

To review and add a bit to each, the four quadrants can be broken down in the following way:

The UL quadrant represents the *subjective-individual*. This is the first-person perspective or the perspective of “I.” The most important mode of knowing from this perspective is direct phenomenological experience—what the person experiences in thought and emotion that only he or she can access directly. As we will discuss further, this quadrant addresses the client’s stage of identity development, state of consciousness, mood, affect, cognitive schemas, fantasies, and memories.

The LL quadrant represents the *subjective-collective*. This relates to the second-person perspective or the perspectives of “we”—those shared values and meanings that can only be accessed through dialogue and empathy between people. In terms of psychotherapy, this quadrant addresses the client’s intimate relationships, family experience, and cultural background and values.

The UR quadrant represents the *objective-individual*, or the third-person perspective of “it.” Knowledge from this perspective is gained through various empirical measures such as biology, chemistry, neurology, and so forth. These methods are sometimes called *monological* (Wilber, 1995), meaning that they don’t require dialogue—information is gathered through impersonal observation. Behavioral interactions are included in this quadrant because behavior can be observed from the outside without reference to thoughts, feelings, or empathy (i.e., one can observe that a school-aged child disrupts class with inappropriate behavior without having a conversation about it). Overall, this quadrant addresses the client’s genetic predisposition, neurological or health conditions, substance usage, and behaviors (general, exercise, sleep, etc.), among other things.

The LR quadrant represents the *objective-collective*, or the third-person perspective of “its.” This includes the functioning of ecological and social systems, which also can be understood through impersonal observation. More specific to our topic, the issues addressed here focus on the external structures and systems of society. The socioeconomic status of the client, work and school life, and the impact of legal, political, or health-care systems are included. The natural environment would also be considered an important factor in the life of the client from this point of view (i.e., the client’s access to nature and to clean water, air, etc.).

Additional Aspects of the Four-Quadrant Model

Now that we have laid out the basics of the model, we need to emphasize two other aspects of four-quadrant theory that will help guide the rest of the text.

The first additional point is that *the four quadrants can be seen to be four complementary perspectives on any given phenomena*. Each of the four viewpoints has a particular truth, and by encompassing all four perspectives, we get the fullest picture possible. We also see a correspondence between the four perspectives—there are important points of interconnection.

As a simple illustration, we might take the example of a single thought (Wilber, 1997) such as, “I want to be in a relationship.” This is a common thought people will bring with them into therapy. What can we say about this thought that is *real* and *true*?

Some people might emphasize the thought in its UL aspect, which is the subjective meaning and feeling of wanting to be in a relationship as experienced by the person thinking it. In therapy, taking this approach, we might help the client to explore the thought and the accompanying emotion in order to help him or her arrive at a clearer, more authentic sense of the motivation behind it.

Some might emphasize the thought in its UR aspect, which is the brain neurochemistry and the behavior that corresponds to the desire for a relationship. If the thought is accompanied by depressive affect, for example, one might become concerned about the negative neurochemistry that the thought is generating, particularly if the client has a past history of depression or has a familial (genetic) predisposition toward depression. One might also consider what objective behaviors or actions the client might take to best respond to the thought. Might he or she try new ways to meet potential partners, for example?

Still others might point out the LL aspect of the thought, which highlights the fact that the idea of wanting to be in a relationship is informed by the person’s culture and family and the meaning given to relationships within those groups. Focusing his comment specifically on culture, Wilber (1997) offered, “The cultural community serves as an intrinsic background and context to any individual thoughts [a person] might have” (p. 11). In terms of therapy, assuming it is a romantic relationship that is desired in this case, how is romance understood in the specific cultural group or family of the client? Is it given a high or low priority? What are considered appropriate ways to meet a potential partner and carry a relationship forward? What are the gender roles assigned by the family or culture? And do the values of the client and his or her family or culture conflict, or are they congruent?

Finally, the thought can also be seen in its LR or objective-collective aspect. Having a relationship entails certain activities and actions that take place within a natural environment and within economic and social realities. That is, the nature of the relationship may function quite differently

according to the person's age, economic status, legal status, and the political and natural milieu. Does the person have the time to have a relationship right now, or does his or her job require working 70 hours a week? Does the person have children, or is he or she in the middle of a legal separation or divorce that might complicate things? Does he or she live in a setting where a potential partner can be met, or must additional steps be taken?

These are just simple examples; there are many other factors we might consider and questions we might ask. But what we can see is that to truly get the most complete understanding of this thought—to get the best sense of what it really means “to want to be in a relationship”—we need to take all four perspectives into account to some degree. If we leave one out, we will have a more limited view of the client's situation.

To put this another way, because the four-quadrant model holds that each view of the thought is a simultaneously valid “take” on the same event or thing, the model supports the cultivation of multiperspectival knowing. *Integral Theory emphasizes multiperspectival knowing, based on the assumption that when we gather knowledge from multiple points of view, we are much more likely to arrive at something closer to the truth than we would otherwise.* As the text proceeds, this form of knowing and its developmental and practical implications will be discussed many times. Why is this emphasis necessary? Because many people fail to think in this fashion and tend toward wanting simpler, single-cause explanations and solutions, despite the fact that most people (especially therapists), are confronted with highly complex problems that defy such easy answers. It should be quite a natural fit for therapists to recognize that there are many sides to any given story. The four-quadrant model takes this truth and organizes it.

The second feature of the model we need to address is how the quadrants relate to the other aspects of the Integral approach—to levels, lines, states, and types. Briefly, *there are distinct levels, lines, states, and types seen from the perspective of each quadrant.* For example, in the UL quadrant, there are levels of self- or identity development; different lines or capacities (such as emotional, moral, and creative capacities); different temporary states of cognition and emotion, such as altered states, sleep states, and regressive states; and different types or personality orientations, such as masculine and feminine. The same is true for the LL. There are different levels of cultural development, such as mythic-religious societies and rational societies; a number of different lines or capacities that cultures may emphasize or cultivate, such as art or science or religion; different temporary states that cultures may experience, such as collective grief or elation; and different types or styles of cultures, such as collectivistic and individualistic. We can see levels, lines, states, and types when looking from the right-hand quadrant perspectives as well. One simple illustration of the levels (along a single line) in each quadrant is depicted in Fig. 1.2.

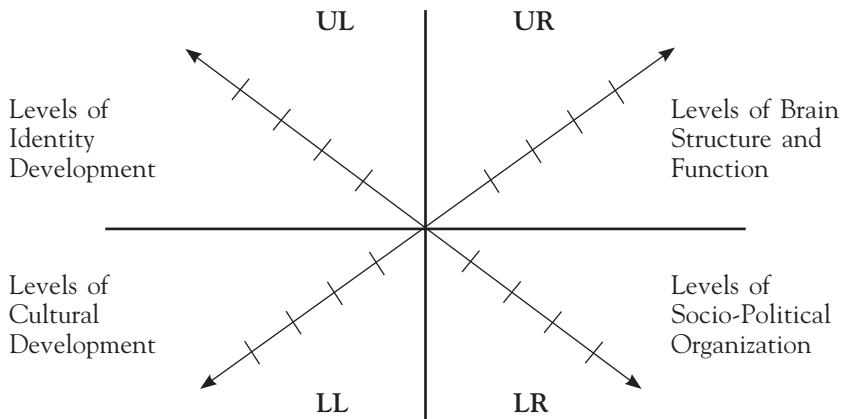


Figure 1.2. Four-quadrant Model with Levels of Development

For the purposes of this text, we focus most closely on levels, lines, states, and types in the left-hand quadrants and particularly in the UL. This perspective is the best starting place for the practice of psychotherapy.² At the same time, as chapter 2 suggests, psychotherapy is always a four-quadrant affair. We will continue to address and include all four quadrants in our discussions throughout the text.

Stages (or Levels)

Levels of development—or levels of complexity—are important to consider, no matter from which quadrant perspective one begins one's orientation. In the UL quadrant, the stages or levels of identity development are particularly important; they constitute one of the major focal points of Integral Psychotherapy and have deep implications for mental health, psychopathology, and therapeutic intervention. The importance of stages of identity development informs the second principle of Integral Psychotherapy.

Principle 2: Integral Psychotherapy accepts that the identity development of the client will significantly impact the therapeutic encounter, including the shape and severity of the presenting problems, the complexity of the therapeutic dialogue, and the types of interventions that can be successfully employed. The identity development of the therapist also impacts his or her ability to empathize fully with the challenges of the client.

Before we elaborate on this principle, it must be said that by attempting to describe people in terms of levels or stages, we aren't arguing what makes one person *better* than another. To say someone is at a particular stage of development is not a value judgment about the intrinsic worth or goodness of that person. *People are good just as they are.*³ The model is simply an attempt to understand how humans grow and deepen in their ability to make sense of the world and how therapists can use that understanding to support greater growth and healing in their clients and themselves. Robert Kegan (1982)—a developmentally orientated psychotherapist referenced often in this text—stated, “Persons cannot be more or less good than each other; the person has an unqualified integrity. But stages . . . can be more or less good than each other” (p. 292).

The aspect of the mind that develops through levels is what Wilber (2000) called the *self-system* and what we also call the *self*. The self-system is both the *center of identity* as well as the *center of meaning-making* for humans—it is the primary frame of reference that we project onto ourselves and the world around us. It helps determine the general depth and quality of our experience. It is also, as we will review, the aspect of development most directly related to psychopathology. The Integral model assigns to the self-system the following characteristics:

- It is the locus of identification (“I” vs. “not-I”);
- It gives (or attempts to give) organization or unity to the mind;
- It is the center of will and free choice;
- It is the center of defense mechanisms;
- It metabolizes experience; and,
- It is the center of navigation or the holding on versus letting go of identification.

Although we will address this model in much greater depth as the text proceeds, there are a few important points worth mentioning now about self-system development.

First, the Integral model holds that the self can develop through three major groupings of stages—pre-personal, personal, and transpersonal—and one mode of identification called nondual identification, which is not technically a stage (for reasons discussed later).

The first stages in the model are *pre-personal* or pre-egoic in nature. Pre-personal means that the personality or ego (a mental sense of “I”) hasn’t

yet fully coalesced, or that it is otherwise highly fragile. Identity is centered in the body and in the emotions. Younger children most often are found at these stages, although some adults might be identified here as well. This is one way to understand severe personality disorders in adults, for example.

The next stages are *personal* or egoic in nature. Here the self is primarily mental; personality and ego are more fully formed. The bulk of people identify at these stages, and the age range includes older children all the way through senior citizens. However, the challenges, needs, and capacities of the various personal stages differ significantly from one another. The type of work that a therapist might do with a client in one of the earlier personal stages is often markedly different from what a therapist will do with a person in one of the later personal stages.

The next stages in the model are *transpersonal* or trans-egoic in nature. What the term *transpersonal* signifies is that a person no longer identifies primarily with his or her mental, egoic self or personality, and rather experiences him or herself in terms we might properly call “mystical.” An important point to make here is that being identified in these stages does not mean a person does not have any sort of functioning ego or that the ego of the person will be fully healthy. Rather, to be in the transpersonal stages is to say that the person no longer *identifies* primarily or exclusively with the ego. He or she is no longer highly attached to a life narrative, individual traits, or self-image—even as the ego itself still functions.

The final form of identification in the Integral model is called *nondual identification* or *nondual realization*, and refers to what is apparently the deepest form of self-understanding that a person may obtain. Nondual realization involves a conscious breakdown in the notion of a separate, individual identity, which is an insight only partially achieved at the transpersonal stages. As this primary duality of “self and other” is broken, other major dichotomies such as “inner and outer,” “here and there,” “spiritual and mundane,” and “good and bad” are seen through as well. As we will discuss here, nonduality has a highly complex relationship to these other stages, although it itself is not a stage of development proper.

In total, we will use 11 stages divided among the pre-personal, personal, and transpersonal groupings, along with the nonstage of nondual realization in this approach to Integral Psychotherapy. We will assign the 11 stages both descriptive names—such as the mythic-conformist—as well as numerical designations. The numerical approach we use closely mirrors that of developmental researchers Loevinger (Hy & Loevinger, 1996), Cook-Greuter (2002), Kegan (1982), and (to a lesser extent) Fowler (1995). As we will see here, this approach essentially divides development in six “pure” stages in which a specific type of cognition is applied to self-identity and five “mixed stages” in which a person is using two central forms of cognition as applied to self.

The pure stages, which are sometimes thought of as more stable—in that a person is more likely to settle there—will be designated 1, 2, 3, 4, 5, and 6. The mixed stages, in contrast, are sometimes thought of as transitional, although the person can still stabilize at the stages for long periods of time, and will be designated by 1/2, 2/3, 3/4, 4/5, and 5/6. Although this distinction between pure and mixed stages is by no means crucial, it can be helpful conceptually. It is also useful to become familiar with this general numbering sequence, as it shows up often in the developmental literature and can also aid us in our understanding of cognitive development (see chapter 5).

Table 1.1 presents a complete listing of these stages, as well as how they fall within the larger pre-personal, personal, and transpersonal schema. For practical reasons—because there are so many stages that are considered “personal” in nature—we will divide these up into the early personal, mid-personal, and late-personal stages.

What is the therapeutic importance of looking at stages of development? As was hinted in Principle 2, a central thrust of an Integral approach to therapy is of *clinical-developmental psychotherapy*. The clinical-developmental approach argues “that the shape of the problems, symptoms, or syndromes will be intricately tied to the developmental level achieved” (Noam, 1988, p. 235).

Table 1.1. Stages of Identity Development

<i>Nature of Stage</i>	<i>Stage</i>
Pre-personal stages	Stage 1: Sensorimotor–undifferentiated Stage 1/2: Emotional–relational Stage 2: Magical–impulsive
Early personal stages	Stage 2/3: Opportunistic–self-protective Stage 3: Mythic–conformist
Mid-personal stages	Stage 3/4: Conventional–interpersonal Stage 4: Rational–self-authoring Stage 4/5: Relativistic–sensitive
Late-personal stages	Stage 5: Integrated–multiperspectival Stage 5/6: Ego-aware–paradoxical
Transpersonal stages	Stage 6: Absorptive–witnessing
Nonstage	Nondual identification

This argument—which has empirical support, which we will review—goes further to suggest that as people pass through these various levels of growth, they gain increased psychological capacity relative to their previous stages, encounter unique developmental challenges, and manifest different types of psychopathology. As they develop, individuals will also continue to hold the remnants and features of past stages within themselves—that is, *new stages transcend old stages in functional capacity, but the self includes (or incorporates) many aspects of past stages as well*. An intricate understanding of these levels of development and how they relate to psychological problems and interventions is a major part of Integral Psychotherapy.

An additional, key assumption of the clinical-developmental approach is that *the therapist's own development is a key aspect of the therapeutic encounter*. Each stage of development represents a different way of making meaning about the world and ourselves. If we are trying to empathize with clients at a stage we ourselves are not in or have not been through, we will tend to unconsciously simplify the challenges those clients face and project the features of our worldview onto theirs. Additionally, if we are working with clients at an earlier stage than ourselves, and we are not explicit with ourselves about our relatively greater developmental capacity, we are very likely to place undue expectations on the client or use inappropriate and overly complex interventions. Further development allows us to see our own developmental positions more objectively and to follow “the contours of a client’s way of knowing and match it closely” (Kegan, 1994, p. 260). This sets up the best possible conditions for an authentic and healing therapeutic encounter.

Although increased development does not automatically make one a good therapist—therapy being a skill requiring a host of personal features and natural talents that aren’t strictly tied to identity development (Okiishi, Lambert, Nielsen, & Ogles, 2003)—it does appear it promotes many attributes that are important in carrying out effective therapy. For example, empathic ability (Carlozzi, Gaa, & Liberman, 1983) and multicultural awareness (Watt, Robinson, & Lupton-Smith, 2002) have been shown to positively correlate with identity development.

Increased cognitive complexity, another attribute that appears to be a key feature of strong therapists, is also deeply intertwined with identity development. In their qualitative study of peer-nominated “master therapists,” Jennings and Skovholt (1999) noted that one of the central characteristics of these master therapists is that they “value cognitive complexity and the ambiguity of the human conditions” (p. 6). Relating this finding to the overall literature on therapeutic expertise, they state, “A central tenet in this literature involves an embracing of complexity and reflecting on this complexity in order to grow professionally” (p. 9). It will become clearer as we go along how strongly the development of cognitive complexity is

connected to the process of identity development. We will address other important correlates of deeper development, including deeper therapist development, more fully in upcoming chapters.

Finally, before we leave our introduction to stages, there is one final issue that we should address: It is crucial that during our study of the Integral approach to development we don't underestimate the value and importance of other approaches to the study of human development. Needless to say, the topic of human development is enormously complex, with a significant place for debate and competing, alternative perspectives. The argument in this text is simply that Integral model of development is the single best foundational framework for understanding human psychological development, in that it offers a meaningful, coherent way to integrate so many perspectives on the topic. But it isn't, by itself, a final or total explanation, which may simply not be possible with our current understanding. Integral Psychotherapists, therefore, will need to study others points of view—including those with neurological, psychodynamic, psychosexual, cognitive, linguistic, cultural, socioeconomic, and transpersonal emphases—as well as whatever arises from emerging research.

Lines

The concept of stages of development describes a core self-identity, the central pillar of the person. The notion of lines of development highlights the more multifaceted and even disjointed aspects of development. In short, lines describe the many different capacities and talents that a person or culture might promote. To say that a client (or a society) has developed in one capacity or line is not to say that they will be developed in another. This leads us to our third principle of Integral Psychotherapy.

Principle 3: Integral Psychotherapy accepts there are multiple lines or capacities in addition to self-system development. It expects that clients will be developmentally uneven and posits that interventions aimed at different lines can be useful in therapy.

From the UL perspective, the notion of lines of development can be traced to a critique of the original studies of cognitive development carried out by Piaget and associated researchers. As you may know, Piaget (1954) identified four general stages of cognitive development: sensorimotor, pre-operational, concrete-operational, and formal operational. He also originally posited that once a person became capable of his or her next stage of cognitive development, that it would generalize throughout the person's life.

Stages were therefore believed to happen all at once to a person and show up simultaneously across a variety of domains.

Research since that time has shown a more complex picture, however. Cognitive developments do not easily generalize to other aspects of life, and when they do, they do so at different rates. For example, an adolescent might use formal operational capacities in math, but not in analyzing an English text. Piaget himself eventually recognized these discrepancies and termed them *decalages*, which essentially means “gaps” or, as an adjective, that something is “out of phase.” However, both Piaget as well as later proponents of his work downplayed this uneven nature of growth (Crain, 2005; Wilber, 1997).

Perhaps one of the most visible theories of developmental unevenness has come from Howard Gardner (1983, 1995), who has formulated a model of *multiple intelligences*. For those who might not be familiar, Gardner—instead of positing just the logico-mathematical intelligence that Piaget favored or additional verbal and visuospatial intelligences that IQ tests favor—argued that human capacities are highly differentiated. Specifically, Gardner has argued that there are a wide variety of intelligences, each of which may develop relatively independent of the others. These include linguistic intelligence, musical intelligence, logico-mathematical intelligence, visuospatial intelligence, intrapersonal intelligence, interpersonal intelligence, kinesthetic intelligence, and intelligence related to the natural world.

Although it is unclear at this point how well Gardner’s specific model is supported empirically (B. Visser, Ashton, & Vernon, 2006), Wilber has employed the similar concept of lines of development heavily in his more recent work (Wilber, 2000, 2006). Specifically, Wilber has offered a model that includes a dozen or more distinct lines, even more than Gardner has proposed. Wilber (2006) offered a clear synopsis of the 12 lines he believes are most central to human psychological functioning. This information is shown in Table 1.2 (next page).

As we will discuss in depth in chapter 5, the notion of lines of development is one of the more complex topics in Integral Theory. It also may be the hardest of the five major tenets (quadrants, levels, lines, states, and types) to apply in therapy. In order to make application easier, we will use a simplified lines model, focusing on three in particular:

1. the cognitive line of development;
2. the self or identity line (synonymous with the stages of development previously mentioned), and
3. what we call the maturity line, which can be considered a mixture of interpersonal, emotional, and morals aspects of self.

Table 1.2. Important Lines of Development According to Wilber (2006)

<i>Line</i>	<i>Life's Question</i>	<i>Proponent/Researcher</i>
Cognitive	What am I aware of?	Kegan, Piaget
Self	Who am I?	Loevinger
Values	What is significant to me?	Graves, Spiral Dynamics
Moral	What should I do?	Kohlberg
Interpersonal	How should we interact?	Selman, Perry
Spiritual	What is of ultimate concern?	Fowler
Needs	What do I need?	Maslow
Kinesthetic	How should I physically do this?	
Emotional	How do I feel about this?	Goleman
Aesthetic	What is attractive to me?	Housen

This tripartite model not only offers a more precise understanding of development (thus keeping us from some of the original mistakes made by developmental theorists), but also retains a simple and practical framework with which to work with developmental unevenness in our clients.

States

The fourth major facet of Integral Theory is the notion of states. In the most general sense, the idea of states highlights the simple fact that phenomena tend to change and flux. This is true whether we are looking at a person's inner life (UL), the functioning of an organism (UR), the collective values of a group or culture, (LL), or the functioning of a political or ecological system (LR). At certain times there are pronounced—albeit temporary—shifts that occur and that push the person, biology, culture, or system out of its homeostatic state. These states introduce new factors, new information, and new forces. As it relates to our topic of psychotherapy, the most important example of this is the *altered state of consciousness*, which can either be positive, such as a mystical or positive emotional state, or negative, such as a psychotic, depressive, or regressive state.

Principle 4: Integral Psychotherapy acknowledges the importance of temporary, altered states of consciousness, including psychopathological, regressive, and mystical states. Open discussion of altered states can be a major avenue of therapeutic dialogue, and the appropriate facilitation of positive altered

states in therapy can provide the client with additional insight and healing.

There is much to say about states of consciousness. As suggested by Tart (1993), “Our ordinary state of consciousness is not something natural or given. It is a highly complex construction” (p. 34). Similarly, Siegel (2001) noted that a given state of mind—or what he called a *self-state*—consists of a number of different mental components that must be brought together in a cohesive whole. These include the following:

- a perception of the world
- an emotional tone
- a memory process
- a mental model of the self
- a set of behavioral-response patterns.

For example, a client who is in a highly depressed state may

- perceive the world as meaningless (perception of the world);
- experience feelings of sadness or loss (an emotional tone);
- recall recent events where failure or rejection was perceived (a memory process);
- possess a model of the self that focuses on his or her perceived faults and shortcomings (model of the self); and,
- act out an isolating behavioral pattern (behavioral-response pattern).

Therefore, to say someone is in a state of mind is to imply a highly interconnected and coordinated construction involving a number of mental processes; a state is not an inherently unitary phenomena.

Because so many components go into a given state of consciousness, *even those we think of as normal states are fragile and subject to change*. One event, perceived as positive or negative, such as losing one’s keys or randomly finding a \$20 bill, can shift one’s state in fairly significant ways. Negative or positive thoughts can have the same effect, as can substance usage, exercise, and so on. Of course, most systems of therapy attend in some ways to these changes in the client’s state, whether apparently caused by

internal forces, such as an existing mental illness or negative self-schema, or external forces, such as a substance or the end of a relationship. In fact, *current understandings of mental health and psychopathology are completely bound up in the notion of states*—although it isn't clear how many clinicians think in exactly those terms. States such as acute psychotic episodes, panic attacks, depersonalization, and dissociative states (and so on) are commonly discussed and attended to in clinical practice (Ludwig, 1990). One can clearly see that *helping clients adjust to intense states and changes in state of consciousness are central aspects of psychotherapy*.

From the Integral perspective, the problem is that many approaches to therapy tend to focus exclusively on psychopathological and (to a somewhat lesser extent) regressive states and ignore positive and nonpathological altered states. Many of these positive states have been consistently seen as outside of the province of mainstream psychotherapy, such as meditative altered states, psychedelic altered states, and lucid dreaming. Other types of altered state work were once a major part of therapeutic practice, such as dream analysis and hypnosis, but are now much less so. Integral Psychotherapy, in contrast, holds the underlying assumption that everyday waking consciousness is simply one of many legitimate modes of experience. It is open to discussing and processing a variety of states of consciousness with clients, and furthermore *assumes that altered state work is necessary in many cases for growth and healing*. Integral Psychotherapy, therefore, is very open to the deliberate use of altered states within the therapeutic sessions to the extent that a client is developmentally prepared and interested. Using hypnosis, guided imagery, relaxation, meditation, breathing techniques, or emotional focusing, all temporarily shift clients out of normal waking consciousness and allow for different types of information to emerge into awareness. In that it accepts other states of consciousness as legitimate sources of knowledge and healing, Integral Psychotherapy is what is known as *polyphasic*.

Types

The last of the five major components of Integral Theory is that of *types* or *typologies*. The notion of types attempts to describe the various inclinations that a person may have in translating or constructing reality within a given level or stage of development. A person at a given level of development will tend to be more masculine or feminine, introverted or extroverted, and see the world with an emphasis suggested by his or her culture or religious affiliation.

Principle 5: Integral Psychotherapy accepts that there are a wide variety of styles or types of knowing—according to gender, culture, and individual personality—and that are all equally valid.

From the point of view of Integral Psychotherapy, stylistic or typological differences may be useful in understanding a client's behavior, motivations, and point of view. At the same time, no style can in and of itself be said to be better than another. Types simply represent different flavors, accents, and biases that we have when approaching life from a given quadrant perspective or stage of development. Put another way, types determine *ways of knowing*, but certainly not *depth of knowing*. As Kegan (1994) argued, "The differences between types are non-normative differences of epistemological style, not hierarchical differences of epistemological capacity" (p. 201).

It is important for the therapist to develop a sense of how typological factors—individual, cultural, and gender-related—appear in the life of the client. The assumption of Integral Psychotherapy is that when the therapist can understand and appreciate a client's particular style, he or she will be in a stronger position to communicate and empathize effectively with the client; that *typological misunderstanding can impede therapeutic progress*, even if the therapist is acting in a developmentally appropriate fashion and is balanced in his or her approaches to the quadrants (e.g., the therapist addresses intrapsychic, biological, cultural, and socioeconomic issues). Furthermore, a therapist should work to understand his or her own preferred and culturally influenced style as deeply as possible, as that, too, will impact the therapeutic relationship.

There is an important caveat that we need to keep in mind when it comes to types, however. We need to take the idea of types as fully discrete and easily organized into categories with something of a grain of salt. It has been Wilber's (1999) contention, for example, that the evidence for universally applicable types is less consistent than it is for stages or states.⁴ Kegan (1994) has made a similar argument. He underscored the fact that although many people strongly resemble a certain type or category, individual variation exists to a very high degree, and many people don't fit easily into typological categories such as introverted or extroverted, masculine or feminine. He argued, "Some of our meaning-making is completely idiosyncratic and falls under no governance or regularity other than the regularity of our unique personalities" (p. 206).

Finally, it is important to recognize that typological issues, especially when tied to male and female differences or to issues of culture and ethnicity, *inevitably dovetail with complex and emotionally charged cultural and political*

issues. It is for this reason that this text discusses the notion of typology specifically in relation to gender and culture/ethnicity—they are the two most difficult typologies and in need of address for any system of psychotherapy. We will engage in lengthy discussion about the uses and dangers of such typologies, along with some critiques about how these issues are currently seen within therapeutic literature and training.

The Integral View of Psychotherapies

Now that we have introduced the basic facets of Integral Theory and the principles of Integral Psychotherapy, it is important that we define more clearly the “major approaches” to psychotherapy that Integral attempts to incorporate, including physiological/pharmacological, behavioral, psychodynamic, cognitive, humanistic, multicultural, feminist, somatic, and transpersonal approaches. Although these definitions will be a review for many readers, it is important as we go through them to begin asking a different set of questions than we usually do. These questions include: What developmental expectations does this particular approach to therapy place on the client? What self-understanding would a client have to have in order to really benefit from this perspective? What quadrant perspective is represented or privileged by this school? Is the approach rooted in the UL, UR, LL, or LR perspective—or in some combination of two?

These questions are central because the Integral approach presented here argues two things: First, that each of these approaches has important truths to contribute to psychotherapy, but each meets serious limitations when it attempts to become an absolute or “true for everyone in all situations” perspective. Second, that the strengths and limitations of these approaches can be understood most clearly by considering the developmental implications and quadratic perspectives of each, as well as to a lesser extent the way each relates to lines, states, and types. Here we will address the quadrant perspectives of these forms of therapy. Issues of development and integration—bringing these approaches together in a mutually supportive way—are both addressed later in the text.

Biological–Pharmacologic

Sigmund Freud famously commented that one day his theory of human psychology would be understood in physiological terms. The spirit of that perspective is alive and more than well in the approach to therapy that sees human psychology as a play of genetic, neurological, and neurochemical forces. Interventions from this perspective are usually pharmacological,

medical (e.g., electroconvulsive therapy), or occasionally surgical. This is a UR quadrant, medical approach to psychotherapy.

Behavioral Therapy

In the most basic sense, behaviorism looks at the way positive and negative reinforcers, and punishments affect behavior. One aspect of behavioral therapy can, therefore, consist of the use of consequences to influence the behavior of the client. An example might be designing rewards to offer a school-aged client for not acting out during an in-session game of cards, or working with parents of a teenager to design appropriate consequences for skipping school. In addition, behavioral therapy also refers to assigning the client-specific actions, tasks, or homework to complete as a part of therapy. This might include assignments outside of the office, such as exercise to improve mood, reducing caffeine intake to help with anxiety, or seeking out conversations with strangers as a way to practice social skills. It also might include forms of meditation (in its earlier developmental expressions), relaxation techniques, or exposure therapy in the cases of phobias. One key component that purely behavioral perspectives have in common is that they are much less concerned with cognitive or unconscious variables. They place the emphasis on action and consequences as the most important curative factors. Because they focus on *objective actions* and not subjective states, cultural issues, or socioeconomic status, behavioral approaches are primarily UR in orientation.

Psychodynamic Therapy

Psychodynamic approaches to therapy suggest that, beginning from infancy onward, there are tensions, drives, or “energies” at play in the human psyche. Although there are multiple versions of this—Freudian, Jungian, and object relations among them—they all tend to agree that these “energies” are patterned in significant ways during childhood, function in conflicted ways, and remain largely unconscious. Being unconscious, however, does not mean being *inactive*. Rather, internal conflicts find ways to express themselves through thoughts and actions, particularly in romantic and familial relationships. The goal of therapy from the psychodynamic perspective is to unearth and bring these unconscious tensions into conscious awareness, so that the client can avoid unhealthy patterns of unconsciously driven reaction and response. Dialogue and reflection on family and childhood history, analysis of client transference and therapist countertransference, active imagination exercises, expressive artwork, and dream analysis are some of the primary interventions in this approach. Because they focus primarily on

individual subjective experience and intersubjective relationships, psychodynamic therapies combine elements of the UL and LL perspectives.

Cognitive Therapy

The major assumption of the cognitive approaches to therapy is that people's beliefs and self-statements (or mental "scripts") cause them to suffer more than any particular event. More specifically, when something happens in people's lives, whether positive or negative, it is their *interpretation* of that event that impacts their happiness most drastically, rather than the event itself. From the perspective of cognitive therapy, most people carry highly idealistic and absolutistic views of themselves and the world and how each should be. These beliefs need to be identified, examined, questioned, and reformulated in a more realistic and rational way. The role of the therapist—which is usually considered active in cognitive therapy—is to help clients to identify and modify such thoughts, in order to reduce symptoms and maximize functioning. This may include openly questioning or challenging the client on certain unrealistic beliefs that he or she holds. Because they focus primarily on subjective cognitive schemas and interpretations, cognitive therapies are essentially UL in perspective.

Humanistic Therapy

Humanistic approaches to therapy share several major characteristics. They tend to focus on the strengths and higher potential of the individual for growth and change and the clearer exploration of authentic individual identity. This is as opposed to a focus on consequences, early childhood patterning, or on reworking irrational thoughts. Humanistic approaches also tend to be more process-orientated than goal-orientated—focusing less on achieving a set outcome for therapy, and instead, attending to the "here-and-now" of the therapeutic encounter. Additionally, they envision a more collaborative and less directive role for the therapist; they place more responsibility and trust in the client for his or her own growth and healing. In their focus on issues of meaning, personal identity, and authenticity, humanistic approaches represent a UL approach to therapy.

Feminist Therapy

Although there are a wide variety of feminist perspectives (see Rosser & Miller, 2000), feminist views tend to focus on the way that one's gender—the culturally constructed view of the male and female sexes—limits and distorts human, and particularly female, experience. A major focus of both

feminist theory and therapy is to bring keen awareness to power differentials, to the way that a gendered worldview tends to view male and masculine values as being more important than females and feminine values. A goal of feminist therapy is to help the client recognize and challenge cultural and societal norms; there isn't simply a focus on individual or behavioral change. Also, feminist therapists feel that it is important to work with power differentials in the therapeutic encounter itself. Perhaps even more than humanistic therapists, they see the client–therapist relationship as collaborative and co-created. Because they focus heavily on relational, cultural, and socioeconomic perspectives, feminist approaches to therapy represent a mixture of LL and LR quadrant approaches to psychotherapy.

Multicultural Therapy

Multicultural therapists, much like feminist therapists in regards to gender, seek to illumine the ways in which culture and ethnicity help inform and construct our views of the world. In particular, they focus on how majority cultures may consciously or unconsciously create racist, prejudicial, or oppressive viewpoints and how these might be internalized by and impact minority clients. Multicultural therapists will look at forms of mental distress as being consequences of exposure to these viewpoints, particularly in clients from minority cultures or ethnic groups, and may further see that the label of “mental illness,” itself, is a construction based on prejudiced conventional norms. More than others, therapists practicing from this perspective will focus on bringing issues of race and racism to light in session, both with majority and minority clients, so as to raise awareness, self-esteem, and empower clients to challenge conventional, cultural norms. Multicultural therapy primarily represents a LL quadrant approach to psychotherapy.

Existential Therapy

According to Corey (2001), a basic premise of existential therapy is “that we are not victims of circumstance, because to a large extent, we are what we choose to be” (p. 143). The existential therapist envisions his or her client as an autonomous and free individual who must learn to accept personal responsibility for the choices that he or she makes. Existential therapies accept that we will sometimes feel isolated, anxious, and guilty as a normal consequence of our freedom and responsibility—that we are alone and mortal in a universe with no inherent meaning or purpose. As part-and-parcel of this, existential therapy also suggests that the meanings or purposes given to us by society, religion, or our culture only buffer us against the difficult process of finding our own meaning in life—a meaning that is seen as ulti-

mately the highest one we can achieve. The goal of existential therapy is therefore to assist the client in developing this self-generated meaning. Because they focus primarily on the issue of subjective meaning-making, existential therapies offer a UL quadrant approach to therapy.

Somatic Psychotherapy

Somatic psychotherapies are based on the understanding that the mind and body, although not identical, mirror one another very closely. By working closely with the body, the somatic psychologist looks to help the client become much more aware of his or her psychological issues. Somatic work involves noticing habitual body postures in the client, with close attention paid to the holding of physical tension, so that these can be connected to important emotional and psychological issues. In addition, somatic therapy involves having the client physically express certain feelings and emotions in order to somatically “work through” them, much the way a verbally orientated therapist might encourage a client to “talk through” a problem. Two fundamental assumptions of somatic therapy are that (a) psychological issues are “stored” unconsciously on a physical level, and that therefore (b) verbal processing alone tends to be partial and often fails to get at the root of most issues; it is only through an approach that integrates the mental with the physical that a full healing experience can be had for the client. Because they combine issues of subjective meaning and objective physical action, somatic therapies represent a combination of UL and UR approaches to therapy.

Transpersonal Therapy

The transpersonal approach to psychotherapy was initiated by many of the same individuals who initiated humanistic psychology, most notably Abraham Maslow (Hastings, 1999). The transpersonal approach holds that people have the ability to move beyond normal ego identifications with their body, personality, culture, or gender in both temporary (state) and stable (stage) ways. Transpersonal psychotherapy, which has been highly influenced by Wilber himself, normalizes discussion of these spiritual experiences and also seeks to use spiritual practices (i.e., meditation, imagery, breath work) and facilitated altered states as a part of practice to help the healing of trauma, wounding, and for personal growth (Grof, 1993; Rowan, 2005). This approach, which shares many humanistic perspectives concerning the therapeutic relationship—that it is collaborative and client-centered—also puts a very strong expectation on the therapist that he or she work toward spiritual

maturation and engage in a spiritual practice of his or her choosing. More than other approaches to therapy, the transpersonal views the therapist's own development as central to psychotherapy. Transpersonal approaches to therapy are UL in orientation.

Conclusion

This chapter reviewed the five basic features of Integral Theory (quadrants, levels, lines, states, and types) and how these inform the central principles of Integral Psychotherapy. It also discussed the major schools of psychotherapy that the Integral approach attempts to incorporate. In the following chapters, an expanded consideration of the major elements of Integral Theory and how each can be applied in practice is detailed. We will begin this discussion with the four-quadrant model.

Notes

1. For those interested in gaining a deeper background in the theoretical foundations and complexities of the Integral model as Wilber has outlined it, I recommend Wilber (1995, 2006). For a text that addresses additional theoretical issues and highlights the contributions of other seminal Integral thinkers, I recommend McIntosh (2007). For a text that addresses some core criticisms of Integral Theory, see Rothberg and Kelly (1998). For a more comprehensive background discussion of philosophical issues in psychotherapy, see Forman (2004).

2. Although the most natural "home" of psychotherapy is the upper-left (UL) quadrant perspective, one could construct an equivalent therapeutic text using one of the other quadrants as the primary perspective, focusing on genetics or behavior (UR), socioeconomic issues (LR), relationships (LL), or cultural issues (LL).

3. To state this more specifically, the Integral perspective draws a lot of its inspiration from the contemplative spiritual traditions. And these traditions universally agree that there is an inherent dignity and worth to all human beings, and that each person has an innate spiritual nature as well. To say that a person has inherent worth from an Integral perspective is therefore both to say that each person has rights, freedoms, and dignity as an individual (a humanist perspective), but also to say that we share some underlying spiritual connectivity as well (a contemplative perspective).

4. Specifically, Wilber (1999) suggested, "[Typologies] simply outline some of the *possible* orientations that may, or may not, be found at any of the stages, and thus their inclusion is based more on personal taste and usefulness than on universal evidence" (p. 485). Although this caveat is important, this text takes a slightly stronger position, and suggests that there is good evidence for some typological differences (masculine-feminine and cultural being the most central to this text). But it also suggests, for many reasons, that the notion of types must be wielded with care.