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Integral Medicine

AN AQAL BASED APPROACH

Lawrence E. George

This article briefly outlines the AQAL model and describes the application of the model to family practice—specifically an Integral look at depression and anxiety. I discuss major problems facing the Western medical model, particularly gross and subtle reductionism and the mind-body split. I offer an AQAL perspective on clinical examples from family practice and then apply the AQAL model to the transformation of the physician.

Transformation of Healer and Patient

A woman named Lynn (not her real name) came to see me about 10 years ago with the rather unusual complaint of excessive tearing—referred to as epiphora. The most common cause of this condition is obstruction of the tear ducts that drain the tears into the nose. A less common cause is excess production of tears from the lacrimal glands that overwhelms the lacrimal ducts' ability to drain them. Lynn was about 32 years old. She had been dealing with this condition for a number of years and was very annoyed with it. I was not the first physician she had consulted for the problem and, in fact, she had seen several ophthalmologists who had gone as far as probing her tear duct several times, all to no avail. I listened carefully to her story and replied that if the tear ducts were open and functioning, it would appear that the cause of the excess tearing was more likely from excess tear production. I suggested that it was possible that, if she was suffering with some type of subconscious issue, she might be, in effect, crying due to this buried emotional wound, causing the lacrimal glands to overproduce actual tears. She gave me a funny look and rather abruptly announced she was leaving. At that point, I felt I was in need of some emergency surgery to extract my size 11 foot from my mouth.

One year later, Lynn returned to my clinic. She reported that during her visit the previous year, she left the office feeling that I was a crazy, quack-of-a-doctor. Three months after that visit, however, she began having flashbacks about being sexually abused by her father. After six months of psychotherapy, the epiphora had resolved and she was coming to the office to thank me. My intervention that day provided an opening through which her healing began.

At that time, I was not really sure why I said what I did, but the experience taught me a couple of things. First, I was empowered to trust my intuition with my patients. As Alanis Morissette says in her song "You Learn," "I recommend sticking your foot in your mouth at any time."[1] Second, I was motivated to expand the way I practice medicine to be more inclusive and holistic. I spent the next several years seeking in earnest a model of health care that would make sense of what I experienced in the doctor-patient relationship. After exploring many alternative and mind-body approaches, I found myself wanting an even more inclusive and comprehensive model. Unfortunately, many alternative techniques excluded some very important information and made the very same mistakes so prevalent in the Western medical model—excessive reliance on a single approach (more on this below).

The AQAL Model

After years of searching and learning, I discovered the work of Ken Wilber and immediately recognized that I had encountered a model worthy of extensive study. Here was a model of the evolution of human consciousness that included more truth from more disciplines of discovery in a more organized fashion than anything I had heretofore encountered. I began to apply the model and my new awareness to my medical practice, a practice that is now referred to as Integral Medicine. Previously, I often felt confused about prioritizing and making sense of complementary modalities and concepts; the Integral model helped me find my priorities and quite a bit more.

I think it is important to distinguish Integral Medicine from integrated or integrative medicine, which is the addition of alternative modalities of treatment (such as chiropractic, energy medicine, Reiki, herbology, homeopathy, etc.) to conventional or orthodox Western medicine. While these other treatment modalities can certainly be helpful to patients, without a comprehensive model to make sense of these diverse modalities, it is a bit like adding more instruments to the surgical tray without knowing how or when to use them during the operation, or whether they even apply to a particular procedure.

It is difficult to summarize the Integral model in a short article—a model that has been refined for over two decades—but a brief overview will help illuminate its very useful application to medicine. The reader is encouraged to read Wilber's *A Brief History of Everything* and *A Theory of Everything* for a more complete description.[2] After an extensive search of all the world's wisdom traditions, Wilber delineated some twenty or so principles that guide evolution, which he refers to as orienting generalizations.

Orienting Generalization #1: Holons

Everything that exists is a holon. A holon is a whole/part, meaning everything that exists is a whole in and of itself and also a part of something else.

Orienting Generalization #2: Transcend and Include

Evolution proceeds in a "transcend and include" fashion. For example, atoms are a part of molecules, which are a part of cells, which are a part of organisms and so on, with each level transcending the former by including the component parts and adding something new and unique not present in the parts themselves. These new and unique qualities that unfold in the "transcend and include" process are what produce the one-way direction to evolution (the lower in the higher but not vice versa) and lend significance to successive levels. In other words, each level becomes more significant as holons move up the evolutionary scale. The lower the level, the

more fundamental a holon is on the evolutionary scale (e.g., atoms are fundamental to molecules).

Orienting Generalization #3: Holons Have Four Aspects

A third orienting generalization is that all holons exist in four aspects, or quadrants, simultaneously:

- the individual exterior or behavioral aspect (Upper Right, UR);
- the collective exterior or social aspect (Lower Right, LR);
- the individual interior or intentional aspect (Upper Left, UL); and
- the collective interior or cultural aspect (Lower Left, LL).

In figure 1, you can see a greatly abbreviated version of the four quadrants, with the Lower Left represented by cultural worldviews, according to the stage evolution work of Jean Gebser and the Lower Right by the techno-economic base.[3]

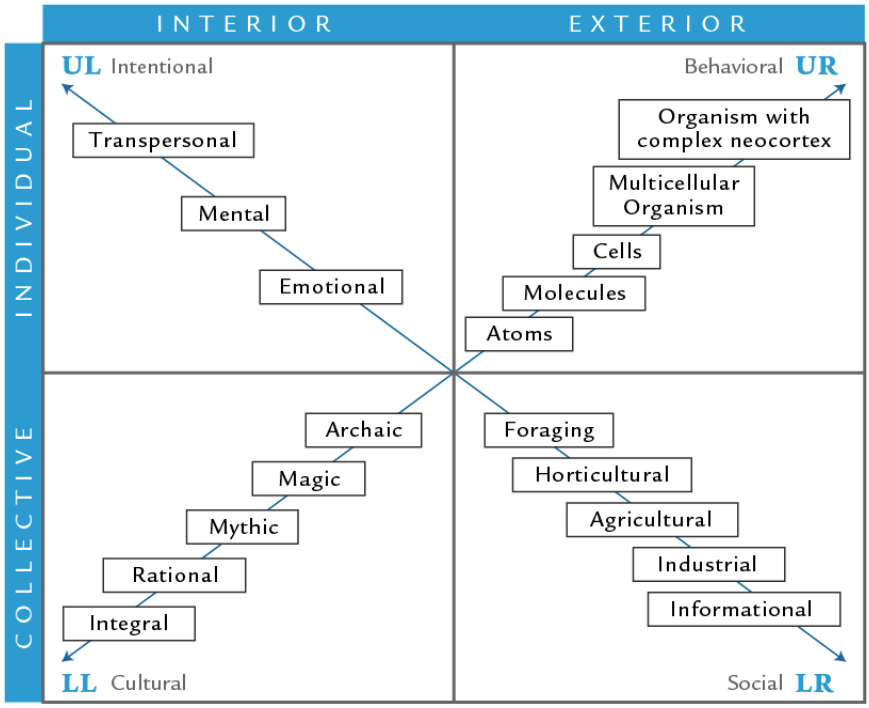

Figure 1. Evolution in the Four Quadrants

A simplified way to view the model for patient treatment is that each patient has dimensions of body, mind, and spirit (the levels), existing as a self in both cultural and social aspects (the quadrants). Hence the reason the Integral model is also called the AQAL (all-quadrant, all-level) model. The AQAL model is much more complicated and encompassing than this, as one will discover upon studying Wilber's work (e.g., lines of development, states of consciousness, types of personalities, etc.), but even these relatively straightforward principles can obviate some of the dissociation that is occurring in orthodox Western medicine today.

Application of the AQAL Model to Medicine

One can immediately see application to medicine in the few above-mentioned orienting generalizations. For example, since every thing that exists is a holon, all diseases are holons. And since every holon has aspects in the four quadrants simultaneously, every disease has interior and exterior aspects in the individual and the collective. Furthermore, since each quadrant has

multiple levels that increase in significance (also known as increased spiritual depth), each level (emotional, mental, and transpersonal in the Upper-Left quadrant) becomes more significant to both health and illness. What the model predicts for any individual is that each transcending level, for example, from physical to emotional to mental to transpersonal, becomes increasingly significant to that individual's health and/or illness.

As an example from the beginning of life, we know that you can feed an infant the highest quality breast milk (physical level, UR), but if the child is not loved and held (emotional level, UL), the child will not thrive and may even die.[4] At the other end of the spectrum, longevity studies have shown that one's attitude (emotional/mental/spiritual) is a better predictor of longevity than lifestyle or genetics (physical).[5] Based on my experience and study, as well as what the Integral model predicts about increasing significance of successive levels of development, genetics might be responsible for 10-20% of the illnesses we manifest (this obviously varies greatly from one disease entity to the next), environment (including smoking, excess drinking, pollution) approximately 30%, and emotional, mental, and transpersonal issues the remaining 50-60%.

Differences Between Traditional and Integral Medical Approaches

If we take an Integral look at depression/anxiety (see the following figures), we consider symptoms, etiology, prevention, and treatment from an AQAL (all-quadrant, all-level) perspective. Levels are indicated where appropriate. This is not meant to be a complete list, but rather to give an idea of an AQAL or Integral perspective in approaching any disease or illness and also how to view health. And even though illness is usually viewed as emotional, psychological, or physical, one will find interior (emotional, mental, and transpersonal) and exterior (physical) correlates, both individually and collectively, in every disease or illness.

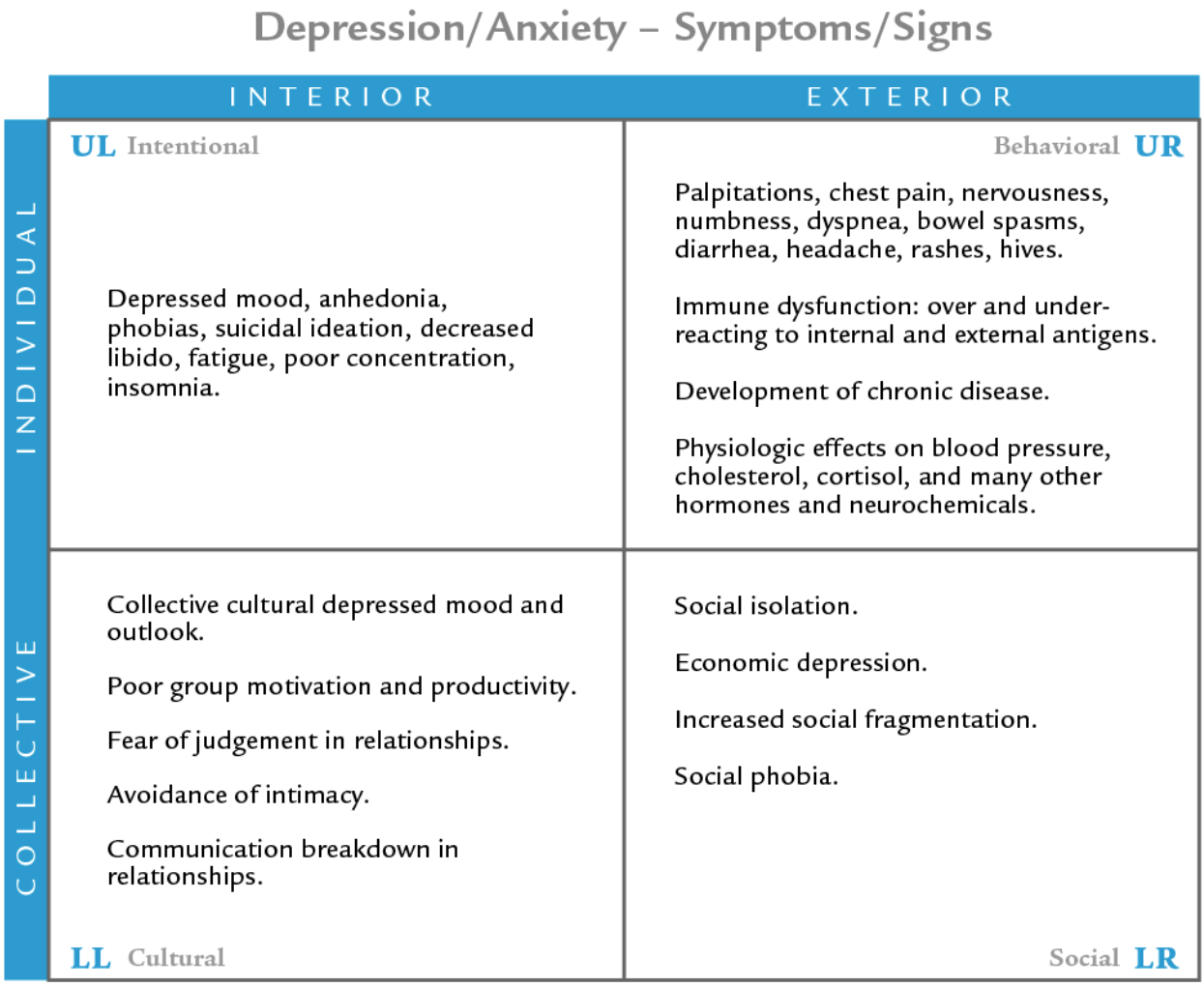

Figure 2. The Symptoms of Depression and Anxiety in All Quadrants

Western medicine typically treats medical, and often psychiatric illness, from a purely UR viewpoint and misses the interior side. Notice, for example, that the UR quadrant of the etiology of anxiety/depression is filled with common to very rare causes of anxiety, which patients often assume they have, even though they account for a relatively small percentage of cases. Even these conditions can be viewed from an interior aspect.

Depression/Anxiety – Etiology

	INTERIOR	EXTERIOR
INDIVIDUAL	**UL** Intentional Transpersonal level: Death and Dying issues. Existential fears, meaning and purpose of life. Mental level: Stress of job, relationships, and diseases. Emotional level: Adolescent emotional trauma. School age and preschool emotional wounds. Toddler abuse issues. Unmet infancy needs.	Behavioral **UR** Pheochromocytoma, supraventricular tachycardia, thyrotoxicosis, adrenal hyperplasia, carcinoid syndrome, genetic influence (bipolar affective disorder), physical stress.
COLLECTIVE	Destructive and dissociated worldviews. Dysfunctional cultural attitudes and perceptions. Cultural isolation. The tug of Eros – the evolutionary drive to evolve. Unhealthy family dynamics. Lack of intimacy and connection with others. **LL** Cultural	Lack of food and physical shelter. Physical dangers, terrorism, war. Social isolation. Economic and financial problems. Social issues of fragmentation. Unhealthy environmental conditions. Negative work conditions. Social **LR**

Figure 3. Depression and Anxiety Etiology in All Quadrants

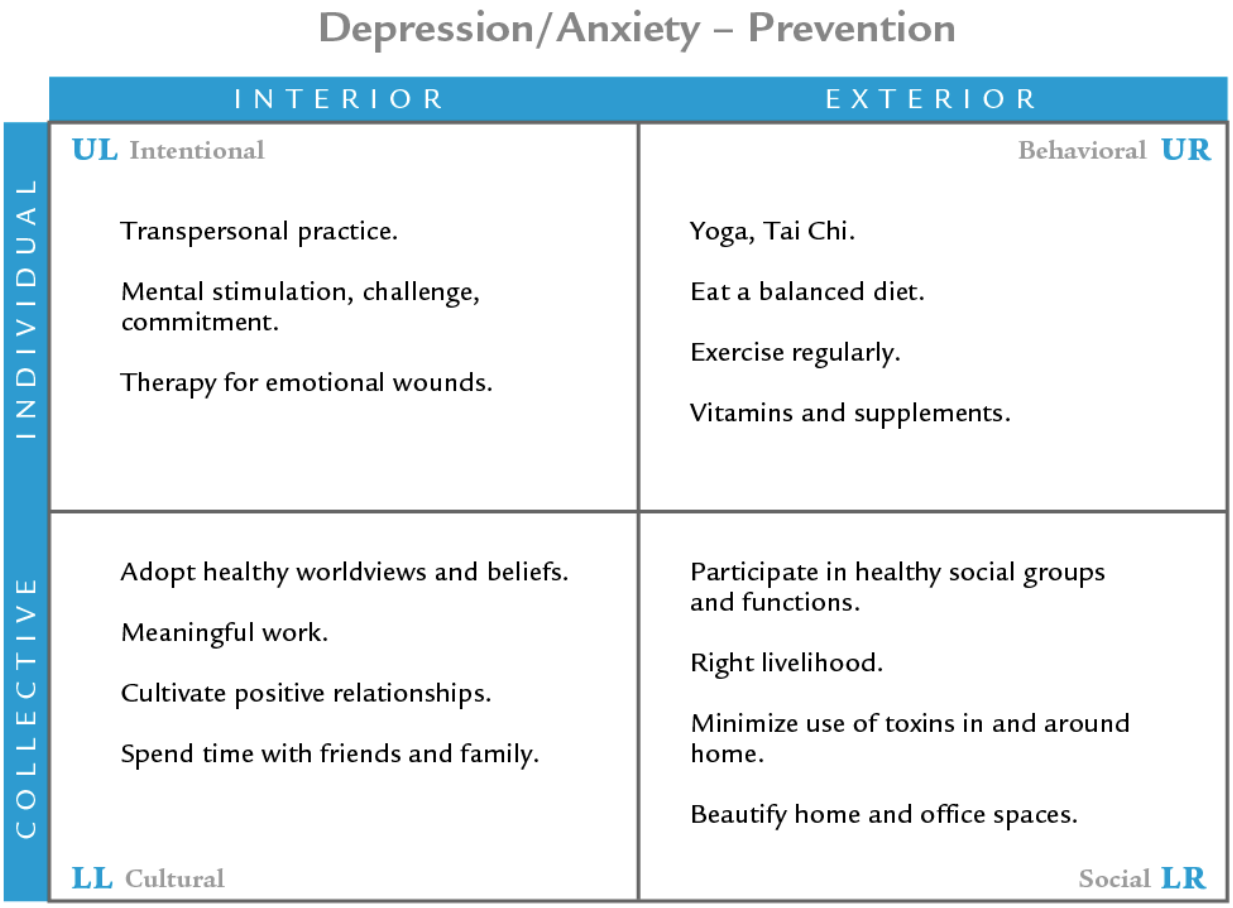

Figure 4. Depression and Anxiety Prevention in All Quadrants

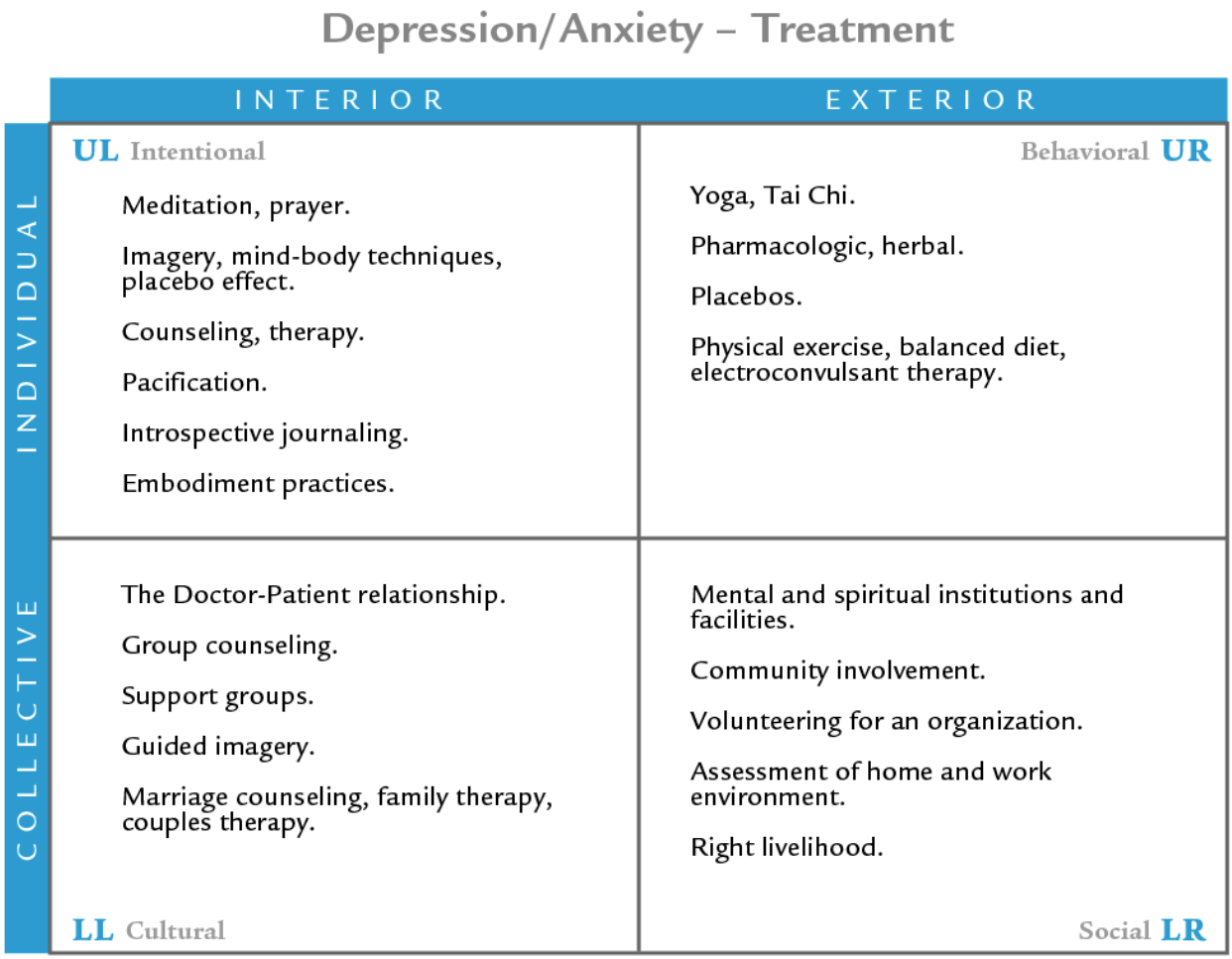

Figure 5. Depression and Anxiety Treatment in All Quadrants

The Four Quadrants in Application

A recent article from the American Academy of Family Practice reveals an approach to interstitial cystitis that is typical of the Western medical model.[6] The author states that there has never been an association with psychological issues in this condition but goes on to say that there is an association with multiple other conditions and illnesses (e.g., fibromyalgia, migraine headaches, chronic fatigue syndrome, and endometriosis), which incidentally have also been shown to be associated with psychological wounds.[7] It appears to be, in part, a case of not being

aware of all of the diverse studies that are published, and certainly a lack of an Integral awareness of the patient's interiors.

A psychiatrist once sent me a patient for evaluation of chronic pelvic pain. After I evaluated the patient, and because I was aware of studies that reveal an association between chronic pelvic pain and a history of previous sexual abuse, I called the psychiatrist to inquire whether any evaluation or treatment of her sexual abuse issues had been done, to which he replied, "We usually don't get into that."[8] The problem tends to be that a dialogical, interior evaluation of the patient is usually not thoroughly done, even by psychiatrists who are traditionally trained for this type of intervention.

In Integral Medicine, the treatments we recommend may be quite specific to the respective level of the problem. Bill, a 47 year-old patient came in for a physical exam regarding hypertension, chronic back pain, and migraine headaches. He had been engaged in regular meditation practice, thirty minutes a day, for more than five years, a yoga practice, fairly regular aerobic exercise, a decent diet and yet his medical problems suggested to me that there were still unresolved emotional issues that were subconscious in nature. When I suggested this to him, he replied that he felt he had completed this work previously through reading, counseling, and workshops. I then offered that his spiritual practice would not heal old wounds (although the practice might loosen the lid, so to speak, on the subconscious and help bring these issues to the surface), and that the signs and symptoms of his physical body were telling me that there was more emotional work to be done. He called a few days later to say that, after our discussion, he was beginning to experience some previously repressed emotion and would like to get back into psychotherapy. The typical Western medical approach would likely have limited the treatment to medication and perhaps physical therapy, missing the opportunity for a deeper and more comprehensive, Integral approach—in effect, climbing only two or three trees and completely missing the forest.

Certain interventions are not appropriate for all patients, especially depending on their level of development (this is true for interventions in physical, emotional, mental, and transpersonal issues). For example, with regard to the spiritual line, some Christians consider meditation to be evil, and therefore, meditation would not be an appropriate therapeutic intervention for their particular spiritual level.[9] The Integral practitioner must be sensitive to each individual and avoid a one-size-fits-all type of intervention.

A young couple came to me with their three year-old daughter with the complaint that her behavior was so out of control that the father was on the verge of divorcing his wife to get away from all the stress associated in dealing with his daughter. He requested that I prescribe some type of medication for his daughter to make her more manageable. The child's mother was equally, if not more, stressed than her husband and both were eager for a solution. The little girl was absolutely beautiful and, interestingly, very well-behaved during the visit. After a long interview, it became evident that the problem began around 18-24 months of age, during her toddler separation phase, and around the same time that the father insisted that the child's pacifier be taken away. I pointed out that their daughter was going through a rather difficult psychological transition when they took away one of her coping skills, her pacifier.

At this point, the father became angry and insisted that under no circumstance would they ever give the pacifier back. He evidently preferred divorce to experimenting with this rather simple intervention. In addition, the parents were using age-inappropriate discipline techniques, such as time-outs, which only further upset the girl. I suggested that instead of alienating their daughter when she acted out, they try holding her, rocking her, and loving her. The mother seemed willing to try this intervention, but the father seemed rather disappointed that I had not simply prescribed a medication. I almost suggested pharmacological treatment for the parents instead of the child (a little Xanax might go a long way for this particular father). I did see the mother about six months later and was pleased to hear that the intervention was very helpful.

Analysis of this problem from an Integral perspective gives a more complete understanding of the factors involved and suggests a more comprehensive solution to the problem. Western medicine has increasingly moved toward a relatively exclusive UR pharmacologic approach. While this has certainly been very helpful in the treatment of numerous medical and psychological problems, there has been a dangerous and dissociated over-reliance on this UR approach. Certainly, knowledge of childhood psychological stage development (levels) is critical to help the parents understand what their daughter might be experiencing and how to comfort her through this process. Equally important, however, is understanding the LL negative cultural attitude toward nursing beyond a certain age, and the widespread lack of acceptance of a child's need to suckle to comfort him or herself, which may continue to age four or five. In addition, the parents would do well to begin to understand their own unmet emotional needs and family system cultural beliefs from their respective childhoods (UL and LL), in order to be more effective in their parenting.

Problems in Medical Education: Gross and Subtle Reductionism

A majority of medical schools today have included complementary and alternative classes in their curricula, but it is apparent to me from working with medical students and family practice resident physicians in my office that these courses are often optional and are treated as another tool one can consider applying. The fact remains, medical schools today have no comprehensive model for understanding how various treatments fit together or how and when they should be used.

One of the misuses of science, known as scientific materialism, involves subtle reductionism. That is, the interior perspectives of a human being—thoughts, feelings, beliefs—are treated as though they are not real. The interior perspectives are in effect reduced to their respective physical or material aspects—for example, emotions are reduced to neurotransmitters. In my medical education, students often treated courses in psychology or psychiatry as less important

than the "hard" sciences. In addition (and this is particularly true in medicine), upper level holons such as human beings are frequently reduced to their component parts. Wilber refers to this as gross reductionism. In other words, instead of treating a complex, highly evolved human individual who might be suffering from depression with an all-quadrant, all-level awareness, the patient is subtly reduced to a physical machin, and grossly reduced to a chemical imbalance of neurotransmitters stemming from a genetic defect. It is not that a reductionistic look at who humans are from the UR perspective is incorrect, but it is partial and negates other aspects of human existence. Although science has uncovered the entire human genome (and this will lead to some wonderful, new physical discoveries), it will never tell us much about love.

The Mind-Body Split in Western Medicine

Family Practice has attempted to be more inclusive in its approach to the Western medical model and has succeeded in at least acknowledging the importance of the interior aspect of individuals and the relevance of the collective sociocultural quadrants (LR and LL), such as the family. There is, however, a persistent tendency to split the psychological and the physical. Namely, traditional medicine often asserts that a patient has *either* a psychological problem *or* a physical organic problem but usually not a complex combination of both. In addition, transpersonal issues are not discussed in the Western medical model, even in Family Practice, because we have no appreciation of how this might impact an individual's health or illness. As Wilber says, everything transrational is discarded along with everything that is prerational (e.g., magical and mythic levels, see figure 1) simply because both are nonrational. This amounts to throwing out the spiritual baby with the mythic and magical bath water. It seems to me that much of the new age and some of the alternative therapies suffer from a similar failure to see where on the evolutionary spiral the various treatment modalities are located.

Integral Medicine Diagnostics

For the last ten years or so, I have routinely taken an Integral history from my patients to understand where they are from a developmental and cultural perspective. This might include everything from what type of parenting they had, to current and past emotional stressors, to mental stressors, to spiritual issues such as their current beliefs, spiritual practices, meaning and purpose in life, and issues concerning death and dying. This interview varies considerably depending on many factors including the patient's age, beliefs, level of psychospiritual development, receptiveness, illnesses, and so on. To be a more effective, integrally aware physician, we must dialogue to discover the interior quadrants of our patients.

Clinical Examples

A patient I recently treated for hypertension remarked that her blood pressure was only elevated when she was in a doctor's office—so called "white coat hypertension." I commented that there are studies that suggest that particularly labile hypertension such as "white coat hypertension" can be correlated to subconscious emotional wounds, perhaps a bad experience as a child in a doctor's office (current recommendations for immunizations sometimes include up to four or five separate shots at each visit) or other childhood emotional traumas.[10] She then said, "Doctor, I don't know if you believe in past lives or not, but I was a physician during the [American] Civil War in a previous life, and had to amputate limbs without anesthesia, and that is why I believe my blood pressure goes up in a doctor's office." Whether the doctor believes in past lives is not as important as the awareness that, for this particular woman, belief alone could be responsible for her "white coat hypertension." Counseling her with regard to her beliefs might lead to improvement in the blood pressure and obviate the need for medication.

Another recent patient of mine was scheduled for a rotator cuff shoulder operation, but her orthopedic surgeon was reluctant to perform the operation until her blood pressure was under

control. During her pre-op physical, I asked her how she felt about having the operation, and she replied, "I feel fine about the operation, but I am just so damn mad at myself that I got up on that step ladder in the first place. If I hadn't done that, I wouldn't have fallen and injured my shoulder." I told her that it was very important that she forgive herself and go to the operation with self-love and not self-hatred. She smiled and seemed relieved by this suggestion. I rechecked her blood pressure and it had immediately dropped twenty points. She said that she wished she could take me with her to the operating room to remind her. I told her that she could, in fact, bring me with her through imagery. She did this and sailed through the operation without a rise in blood pressure. Simply having an Integral awareness, and using it to make some carefully considered remarks, can have a profound effect on medical outcomes.

The above examples illustrate the importance of incorporating the "interior" in the evaluation of patients and their illnesses—which, in my opinion, is largely missing in the Western medical model. Unlike alternative approaches, the Integral approach recognizes that focusing excessively on the UL quadrant, or any quadrant for that matter, is simply another form of quadrant absolutism that is best avoided. Unfortunately, I believe this has become fairly common in alternative medicine and integrative approaches. I have witnessed many patients who have succumbed to the belief that "I create my own reality" to such a degree that important treatment has been delayed or discontinued, leading to significantly increased morbidity.

A recent patient believed so strongly that her abdominal pain was purely a psychosomatic manifestation of her childhood emotional wounds—which she felt would best be treated by visual imagery—that she delayed getting to the hospital for treatment of a serious, potentially life-threatening bowel obstruction. Another patient with asthma was convinced by a Naturopathic physician that the best way to strengthen the immune system against influenza was to avoid the flu vaccine and hope to get the actual influenza infection. A third patient was convinced to go off her thyroid medicine (a patient with documented anti-body positive

hypothyroidism) and instead use an herbal product. The scientific truth of the Upper-Right quadrant must be honored along with every quadrant in the Integral approach. Social (LR) and cultural (LL) perspectives are no less important, as we will see below.

The Socio-Cultural Quadrants in Medicine

The collective or socio-cultural aspects (LR and LL) of medicine today are more important than ever. The financing of health care (LR) is badly in need of an overhaul and is a huge factor in medical practice. Ten years ago, it was relatively easy to care for all patients, even those without insurance. Physicians were much more willing to give discounted or free care since financial margins were large. Since the advent of increased insurance "management" of health care, margins are thin and the willingness to give charitable care has significantly dropped. Approximately 40 million Americans are without health insurance, and as many as 8 million more will lose their insurance in the coming year.[11] This will have an increasingly negative impact on access to health care and, though there may be good treatments available for a particular disease, patients may actually die from a lack of insurance (LR), in addition to the illness itself. A recent study has demonstrated that death rates for the uninsured are up to 25% higher.[12]

An example of how cultural beliefs (LL) can impact health and disease is exemplified by a young man who was dying of AIDS, and was cared for by my wife, a hospice physician at the time. While the newer AIDS drugs, which made a profound impact on survival, were available, he refused to follow through with treatment, which led to the terminal worsening of the disease. As he became near death, my wife learned that he had grown up gay in a Mormon community where homosexuality is strictly proscribed. His culturally induced shame (LL) and self-judgment (UL) prevented him from accepting treatments for the disease and ultimately led to his death.

Integral Awareness

In my opinion, providers of health care, whether in Western medicine, CAM, or some combination of both, would benefit by becoming educated about the Integral model so that they are at least integrally informed and can bring this awareness to each patient encounter. This might avoid some of the reductionistic approaches and single quadrant dissociations that currently affect the way that medicine is practiced. It has been said that Western medicine treats the disease and integrative medicine treats the patient. Integral Medicine incorporates both and also treats the doctor by offering a model that puts meaning, purpose, and love back into the practice of medicine.

Transformation of the Healer

Most importantly, the Integral approach suggests that providers of health care work on their own development so as to actually experience what the model represents. As Wilber puts it, do not confuse the map with the territory; having a map of Hawaii is not like actually being there. As the saying goes, one cannot lead another where one has not gone oneself. For me, the ability to see the divine in everyone, and treat each individual as though he or she were Christ or the Buddha himself, can transform the suffering of illness into the grace of healing. In my early days in medicine, I commonly heard the discussions of interesting patients in the hospital lounges and clinic hallways. Today, it is much more common to hear complaints of the deterioration of the medical profession, hospitals, insurance companies, and loss of income. To become integrally informed, begin an Integral practice, and bring this new awareness to the practice of medicine, which can ultimately transform the practitioner so as to rekindle the enjoyment of the doctor-patient relationship. To see each patient as a luminous jewel, tarnished to be sure from the imperfect unfolding process of human development, is to experience medicine as an Integral path of awareness. It also empowers us to make changes in the socio-cultural problems that we see in

medicine today. This tarnish, which is manifested as disease ("dis-ease") in our patients, can be the grace through which both healer and patient transform their lives.

Endnotes

[1] Morrisette, "You learn," 1995
[2] Wilber, *A brief history of everything*, 1996; *A theory of everything: An integral vision for business, politics, science, and spirituality*, 2000
[3] Gebser, *The ever-present origin*, 1986
[4] Stanhope, "Failure to grow: Lack of food or lack of love?" 1994
[5] Chopra, *Ageless body, timeless mind*, 1993; Thomas & Duszynski, "Closeness to parents and the family constellation in a prospective study of five disease states: Suicide, mental illness, malignant tumors, hypertension and coronary heart disease," 1974; Russel & Schwartz, "Narrative descriptions of parental love and caring predict health status in midlife," 1996
[6] Metts, "Interstitial cystitis: Urgency and frequency syndrome," 2001
[7] Waldie & Poulton, "Physical and psychological correlates of primary headache in young adulthood," 2002; Chohen; et al., "Prevalence of post-traumatic stress disorder in fibromyalgia patients or post-traumatic fibromyalgia syndrome," 2002; Peveler, Edwards, Daddow & Thomas, "Psychosocial factors and chronic pelvic pain: a comparison of women with endometriosis and with unexplained pain," 1996; Shephard, "Chronic fatigue syndrome: An update," 2001
[8] Lampe et al., "Chronic pain syndromes and their relation to childhood abuse and stressful life events," 2003; Lampe et al., "Chronic pelvic pain and previous sexual abuse," 2000
[9] For a helpful discussion of the spiritual line of development, consult Wilber, *Integral psychology: Consciousness, spirit, psychology, therapy*, 1999
[10] Mann, "The mind/body link in essential hypertension: Time for a new paradigm," 2000
[11] Himmelstein, Woodhandler & Hellander, *Bleeding the patient: The consequences of corporate healthcare*, 2001
[12] Himmelstein, Woodhandler & Hellander, *Bleeding the patient: The consequences of corporate healthcare*, 2001

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Diagnostics in Integral Medicine

Lawrence E. George

This article outlines an Integral approach to family practice and discusses Integral Medicine Diagnostics—a "how-to" manual for integrally aware family practitioners. Although a truly comprehensive practice is impossible for one individual, becoming an integrally aware practitioner is something that we would all do well to strive toward.

Introduction

Just how does one practice Integral Medicine? Surely, if one tried to learn all that is known in the universe with the intention that it might in some way help a patient, one would be quickly overwhelmed. Even mastering traditional Western medicine can bring the average medical student to tears. Attempting to learn and incorporate everything into the practice of medicine is obviously impossible. Although a truly comprehensive practice is impossible for one individual, becoming an integrally aware practitioner is something that we would all do well to strive toward.

Assuming that a practitioner is integrally aware, how does he/she make use of this awareness in practical ways with each patient? What does an Integral medical practice look like? An integrally informed practice might appear similar to a traditional practice in terms of the treatment modalities offered. However, the relationship between the doctor and patient is significantly different. Integral awareness not only gives the practitioner a more complete palate, but also provides a container for a deeper relationship from which perhaps even a more profound form of healing can arise than that which the allopathic model can provide. This article outlines such an approach in family practice and discusses Integral Medicine Diagnostics.

An important component of an Integral practice is that the practitioner is aware of the wide spectrum of scientific inquiry currently available. There are now a large number of scientific studies available to support fields such as psychoneuroimmunology, mind-body medicine, spirituality in medicine (prayer studies), energy medicine, imagery, sound and light therapies, and many more. Most importantly, familiarity with a truly Integral approach such as Ken Wilber's AQAL (pronounced *ah-qwul,* short for "all-quadrants, all-levels, all-lines, all-states, and all-types") is crucial to an Integral practice.

In medical school, physicians learn various ways to take a patient history, which, in addition to the physical exam and perhaps some laboratory, x-ray, or other testing, will help determine the etiology of the patient's problem. This usually consists of a Chief Complaint (C.C.), Past Medical History, a Medication history (which recently has been expanded to include herbs, vitamins, and supplements), a Family History, a Social History (which includes a history of drug, alcohol, and tobacco use), and finally, a Review of Systems (R.O.S.). The first time a newly-trained physician takes a history and physical, it tends to be excessively long in an attempt to include everything. Over time, the physician becomes increasingly skilled at asking just the right questions to hone in on the diagnosis. With the advent of managed care, doctors were forced to document more to justify the coding and reimbursement, which lengthened patient histories but helped physicians become more efficient at arriving at a diagnosis.

If it were simply a matter of asking all possible questions, computers would be much better at arriving at an accurate diagnosis than humans, which is not the case. A large part of our human advantage in accurate diagnosis is the intersubjective, interpersonal doctor-patient relationship that is not present in the computer-patient relationship. Our intuition, which can be developed, is a powerful aid in this diagnostic process. A human being has the potential, especially if integrally aware, to bring the entire spectrum of consciousness into a relationship with another

human being, which includes body, mind, and spirit in self, culture, and nature. This is simply not available in a computer.

In my own practice, I expand on the traditional history, directed by the patient's chief complaint and/or past medical history, to ascertain information regarding quadrants, levels, lines, states, and types (I will give examples of each of those in a moment). It was common during my training to divide patients as having a mental or a physical problem, but usually not both. If no physical problem could be found, and if the Review of Systems was mostly positive, patients were said to have a functional problem, or even derisively referred to as "crocks" with varying "porcelain titers" depending on the degree of their craziness. Certainly, if one attempts to delve into all of the interior and cultural aspects of a particular patient, one can quickly reach information overload. It is not necessary to do this, or even advisable, but I do believe better results will be achieved with at least the *awareness* of the complexity of the disease process.

Questions from All Quadrants

What becomes readily apparent from an Integral or AQAL perspective is that every patient has intentional (interior-individual), behavioral (exterior-individual), cultural (interior-collective), and social (exterior-collective) dimensions, which reflect the four quadrants. Therefore, their disease or problem is represented in all four quadrants—intentional, behavioral or physical, cultural, and social. A patient with deep emotional wounds (intentional) will often come from a dysfunctional family (cultural and social) and have a neurochemical imbalance (behavioral or physical) as well. Conversely, a patient with heart disease (physical) will also tend to have emotional or psychological issues (e.g., type "A" personality), set in a socio-cultural background which contributes to the physical and interior factors. There is always a relational exchange between the four quadrants. This all-quadrant approach reaches beyond the typical Cartesian dualistic approach and avoids unfortunate labeling and its subsequent tendency toward discrimination.

I always add a brief geneogram as a part of the family history, which is a good example of the Lower-Right quadrant in the AQAL model. I usually include grandparents, parents, siblings, and children (if any), with particular attention to deaths in the family, divorces, multiple marriages, combination families, and adoptions. I am often amazed at the type of information revealed by this visual. It is a non-threatening way to get information on tender issues, such as a death in the family. Unresolved grief is a huge source of emotional, mental, and physical problems.

The Past Medical History often helps direct the line of questioning. Certain problems are often strongly associated with emotional wounding, and although I might not want to delve very far into a particular wound (some patients are rather obsessed with their wounds), I almost always follow my intuitions and suspicions and ask personal issues with the thought that therapy might be warranted. For example, migraine headaches, pelvic pain, irritable bowel syndrome, interstitial cystitis, menstrual disorders, and/or endometriosis can suggest a history of sexual abuse in female patients. Patients with labile hypertension often have subconscious emotional wounds; heart patients often have emotional issues involving anger, unresolved grief, and abuse.

Patient Type

Gender is one readily apparent classification of patient type. Some generalizations regarding gender can be helpful in treatment and compliance issues. For example, males tend to be more autonomous/focal and females more relational/permeable in their thinking. This, in turn, might suggest different treatment approaches and better success rates. Personality types, whether ascertained formally by the Enneagram or Myers-Briggs schemes, or more informally during the interview process, can yield valuable information to aid in a more effective treatment plan. Simply recognizing whether a person is an introvert or extrovert, or whether they are open or uninterested to new information has great pragmatic value. If a patient is completely uninterested in the idea of exploring emotional wounds, a pharmacologic approach might be appropriate.

Unfortunately, the trend in psychiatry has become a poly-pharmacologic treatment without even exploring emotional wounds.

Levels of Development

In my expanded social history, I always inquire about a patient's spiritual beliefs or practices. I begin with a relatively non-threatening question such as "Were you raised in a particular faith?" or "What religion did your parents practice?" I usually follow with "Are you still active in this religion?" If the patient is not, I ask "What would you consider your spiritual orientation to be now?" or, "Do you believe in a higher power, or are you more agnostic?" "Do you have any sort of spiritual practice such as prayer, meditation, or yoga?" This can quickly determine the developmental stage of a person's spiritual and values lines. I have only had one patient in twenty years become defensive with this line of questioning (which in and of itself also helps determine stage of development), and when I explained that knowing my patient's beliefs helps me to better treat them, he was immediately put at ease. Level of development can be suggested by other clues such as occupation, level of education, political views, presentation of the chief complaint, and to which type of treatment a patient is inclined.

In Integral Theory, any number of legitimate models can be used to determine the client's level of development. Spiral Dynamics—based on the work of Clare Graves and refined by Don Beck and Christopher Cowen—has a simple color scheme that identifies developmental characteristics according to their values. This information can be helpful in selecting a treatment plan. A brief description of these levels:

- Beige: instinctual (e.g., infants, demented patients);
- Purple: magical-animistic, tribal (e.g., 18 month to 2 year olds, tribal adults);
- Red: egocentric, power, feudalistic (e.g., 3-4 year olds; war lords, gang members);

- Blue: mythic-membership, conformist, fundamentalist, ethnocentric, traditional (e.g., 5-7 year olds, religious fundamentalism and patriotism);
- Orange: rational, scientific, modern, achievement (e.g., beginning at around age 8; corporate America);
- Green: postmodern, multicultural, sensitive, pluralistic (e.g., approximately 10% of the adult population, Canadian Health Care, Greenpeace, political correctness).

These first six levels are referred to as First Tier. A defining characteristic of these First-Tier levels is that each assumes that their values are basically the only correct values. Beyond these levels is Second Tier:

- Yellow: systemic, flexible, flowing (e.g., systems sciences, meta-maps);
- Turquoise: cosmic unity, integrative, nested hierarchies of interrelationships, one-in-many holism (e.g., Integral Theory).

At Second-Tier development, one can see the crucial but relative value and importance in every previous stage of development, as long as they do not marginalize or repress any other levels. The client's responses, along with simple observations, can roughly ascertain a patient's level along the values line, which can be used to tailor the treatment to the patient's values. This will ultimately achieve better compliance and better results. For example, someone at the Orange value-meme will value scientifically validated treatment approaches, whereas a person at the Green value-meme might be more open to "new age" treatments. A patient at the Blue value-meme might be very comfortable with a mythic religious interpretation of an illness, while someone at the Orange value-meme might reject this completely.

Lines of Development

In addition to the values line described above, there are multiple lines that we each progress through. These include: cognitive, kinesthetic, moral, aesthetic, mathematic, creative, interpersonal, and several lines that could be described as spiritual (openness, care, etc.). An appreciation for the presence of these lines and their respective developmental levels will aid the formulation of a successful treatment plan. For example, a patient may be at the rational level of intellectual development while spiritually at the mythic level. Though studies may indicate that meditation may be a helpful treatment modality for this patient's particular condition, it may conflict with the patient's spiritual beliefs and therefore be rejected. The questions above (and many more like them depending on the style of the practitioner) will help delineate this information case-by-case.

States of Consciousness

There are three basic states of consciousness—waking, dreaming, and deep, dreamless sleep—to which everyone has access. In traditional Western medical practice, physicians are usually only concerned with various types of waking consciousness, from alert to confused (or the *absence* of waking consciousness, such as a coma). In Integral practice, we also acknowledge non-ordinary states of consciousness. It is important to recognize that people can have peak (temporary) experiences with higher states of consciousness that should not be confused with prerational or lower stages of consciousness. Having an awareness of these higher states of consciousness will help differentiate a pre-rational psychosis, which often requires neuroleptic medication (an anti-psychotic), from a truly transrational experience (e.g., a near death experience or an epiphany), which would definitely require a different intervention.

Translation vs. Transformation

All individuals have the potential for transformation to higher stages of development and consciousness. Translation, on the other hand, is the interpretation of what is occurring on any particular level. Much of our work as physicians and health care workers involves translating. That is, we translate to the patient's level of development. However, an integrally aware practitioner is also cognizant of the potential for transformation or evolution whenever two people enter into the intersubjective space of the doctor-patient relationship. Transformation can arise through any translational approach. Recognizing the difference between translation and transformation, and what this might represent for a particular patient, is part of an integrally aware practice.

Mission and Margin

One of the questions I am asked most often by the medical students and residents with whom I work is how can one make a living in today's medical system, given all the time that it must require to practice with Integral awareness? The pressure to produce in today's medical market forces many physicians and health care providers to spend less time with each patient. A larger volume can offset the higher cost of running a practice and eroding reimbursement. An administrator I worked with was fond of quoting the mantra from one of the Catholic health care non-profit systems: you cannot have a mission without tending to the margin. I also believe that one should never compromise their mission for the margin. An integrally informed practice makes room for both—mission and margin.

What I have found is that patients feel much more cared for with my Integral approach, which results in a large referral network, much more satisfied patients, and a quickly-growing, stable practice population. In addition, Integral awareness helps create business perspectives and structures necessary in today's medical system to optimize reimbursement. Although the system

is badly broken in my estimation, we still need to find a way to survive until we can fix it or create something new from the collapse that might be in our near future. I typically gather the AQAL information during a one to one and a half hour history and physical, and perform two to three of these a day. The rest of the day is spent giving as much time as is required for each patient (often very short for the typical respiratory infection, for example) and working for that necessary, but less significant, margin. During these short visits, I will often ask just a few questions (if I have not already during a previous history and physical) that will indicate to me whether or not a particular patient is interested in, and open to, internal exploration. For example, if I have a patient with their fourth respiratory infection in six months, I might inquire if they are experiencing stress in their life.

Authenticity and Quality of Attention

The most important action you can take in your Integral medical practice is to bring awareness of your authentic self to the intersubjective interaction with each patient. To be fully present in the moment with each patient will create the unique interaction between two individuals that can bring forth healing for patient and practitioner alike. Angeles Arrien's four-foldway is a useful guide: show up, pay attention, speak the truth (relative and absolute), and, most importantly, do not attach to a particular outcome.[1] Although patients and doctors would both love to arrive at a cure, not attaching to a preconceived outcome can provide, in some cases, the possibility of transformation.

A spiritual practice, such as meditation, awareness training, or consciousness practice, is the best way for me to bring forth my authentic self. It reminds me of the "Absolute" within each patient encounter. I often use my meditation mantra between patients in an attempt to temporarily connect with this higher state of consciousness. I believe that it is from the Absolute that all healing and transformation arise.

Summary

Treating patients with an AQAL perspective, which includes awareness of quadrants, levels, lines, states, and types, greatly improves the quality of the doctor-patient relationship. High quality relationships correlate with better compliance and improved outcomes. The most important aspect of an Integral medical practice is the practitioner's commitment to their own ongoing development of Integral consciousness.

Endnotes

[1] Arrien, *The four-fold way,* 1993

REFERENCES

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