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Introduction to Integral Psychiatry

Baron Short

Pharmacological treatments are the mainstay of current psychiatric practice as effective treatments for a variety of mental disorders. Many recognize the inadequacy of a purely biological treatment for most patients. The psychiatric field appears to be shifting into a more integrative stance with biological and psychosocial treatments. With the vast array of therapies, the Integral approach attempts to embrace all schools of treatment into a coherent whole. Two elements of the AQAL framework—quadrants and levels—are introduced as relevant aspects for Integral Psychiatry.

Introduction

Today's psychiatric climate is primarily oriented to biological somatic treatments, and for good reason. Psychotropic medications effectively reduce the problematic symptoms that keep the severely mentally ill in hospitals rather than at home or in other residential care facilities, and with fewer side effects than older medications. Functional neuroimaging and psycho-pharmacogenetics promise new levels of sophistication and accuracy for the treatment of various psychiatric disorders as we further elucidate the neurophysiological correlates and underpinnings of mental disorders. Psychiatric classifications have continued to expand and refine the psychiatrist's focus and goals for improvement. Pharmaceutical companies profit from cutting-edge research of various disorders. It would seem that we are in a golden age of psychiatry.

Yet today's mainstream psychiatry is certainly not without its limitations. Critics offer a litany of complaints, from access to health care to pharmaceutical expenses that are relevant to improving psychiatry. But an even deeper, philosophical critique is that from an exclusive, materialist philosophy, patients are viewed only as disorders. Moreover, their disorders are viewed as exclusively neurochemically based. Most disturbingly, some patients prefer to view their illnesses this way to minimize their own responsibility towards wellness. However, many others,

often with less severe pathology, need and want psychotherapeutic interventions on their path to wellness. Numerous efficacy studies report that patients have improved outcomes with some form of combined psychotherapy and pharmacotherapy for a variety of mental disorders, including the most severe, such as schizophrenia and bipolar disorders. Unfortunately, the current neurobiological orientation, compounded by payment methods for medication management, minimizes physicians' efforts to appeal to the psychological aspects of their patients.

Fortunately, the psychiatric field is attempting to move into more integrative patterns that include biological, psychological, and social realities of patients. How are we to understand the multiple dimensions of a patient, optimize their mental health, and use the best, cost-effective, evidence-based treatments while simultaneously validating the providers' need to benefit the greater good? The evolving matrices of answers require a comprehensive approach that takes all available historical currents and human dimensions into account.

The Integral Approach

How would an Integral map change the field of psychiatry? How would a physician assess, research, and treat patients integrally? Answering these questions will be a primary mission of the Integral Psychiatry Center.

Before I discuss the impact of the Integral model on psychiatry, I want to briefly acknowledge some of the main approaches to psychiatric treatment. There are neurobiological approaches, including pharmacotherapy and brain stimulation techniques; individual psychotherapeutic interventions that may focus on cognition, affect, unconscious processes, or behavioral modifications; group interventions that focus on assessing and treating a group, whether it is a couple or a family; and theoretic approaches, which attempt a more inclusive biopsychosocial orientation. Given the dizzying array of psychiatric theories, modalities, and interventions,

Integral Psychiatry attempts to organize these multiple theories into a coherent whole. The first tool that Integral Psychiatry uses is the four quadrants.

There are many dimensions to human experience, but they can arguably be simplified to four foundational domains: the individual interior (subjective), the individual exterior (objective), the collective interior (intersubjective), and the collective exterior (interobjective). Everyone experiences these domains in every moment and we can see this in our use of language. “I” and “We” refer to the interiors of individuals and groups, while “It” and “Its” are the exteriors of individuals and groups. Conveniently, many psychiatric orientations and treatment modalities fit within one or two major domains. When these modalities are mapped out within their respective quadrant, we see that many psychiatrists address pathology only *partially* in both individuals and groups. Here is a visual representation:

Interior-Individual • Phenomenological • Psychoanalysis • Cognitive Therapy • Existential Therapy • Transpersonal Therapy	**Exterior-Individual** • Biological • Behavioral Therapy • Neuropsychology • Psychopharmacotherapy • Electroconvulsive therapy • Brain Stimulation Technologies • Various "Subtle Energy" therapies
Interior-Collective • Cultural • Cross-cultural Psychiatry • Feminism/Gender Therapy • Social/Family/Couples/MST Therapy • Narrative Therapy • Social Learning Theory	**Exterior-Collective** • Social • Social Psychiatry • Family Therapy • Multisystemic Therapy(MST) • Evolutionary Psychiatry

Figure 1. Psychiatric Schools within the Four Quadrants

Integral Psychiatry acknowledges these four domains of reality and their respective treatment modalities and orientations in a meta-orientation that is quite unlike any other approach. Quadrants are one of many theoretical components to Integral Psychiatry.

Another core concept is developmental levels or stages. Developmental stages are commonplace in conceptions of individual developmental maturation, such as Erikson's psychosocial stages or Freud's psychosexual stages. Jean Gebser, a cultural philosopher, characterized developmental stages of consciousness as archaic, magic, mythic, mental, and integral in his work, *The Ever-Present Origin*.[1] He attempted to clarify collective mentality across human history and note the various modes of collective expression. His stages correlate well with historical reviews of etiologies of mental illness. The magical mode correlates with spirit possession, the mythic mode

with the agency and influence of mythic beings, and the mental mode with psychological and somatic causes. Gebser describes the "integral" mode, which he thought was the emerging sociocultural structure at his time of writing, as aperspectival and fluid, incorporating multiple viewpoints simultaneously, and transparently open to the present moment.[2] Stages of development are invariant and may proceed individually and collectively. Each successive stage is more comprehensive and inclusive than its predecessor.

In applying Integral Theory to psychiatry, we must first acknowledge that the patient's developmental stage has immense clinical application. Developmentally appropriate language facilitates better communication and ultimately a stronger therapeutic alliance and treatment compliance. Most psychiatrists already acknowledge this difference when dealing with a child versus an adult. A child's almost magical worldview and preoperational cognition significantly contextualizes communication between the child and psychiatrist. (For example, use of references to the cartoon character Pokemon might be a great vehicle for communication.) More refined developmental assessments and interventions with adults would be just as useful.

Second, as Integral Psychiatrists, acknowledging both quadrants and developmental patterns enlighten us about our own degree of partial and incomplete solutions for treating the mentally ill. It is in this space of humility and openness that we begin to embrace, albeit crudely, broader and more inclusive solutions. Acknowledging levels may also open us to the deeper, meaning-rich dimensions that some humans experience, such as Maslow's self-actualization or the insights of transpersonal psychology. These latter directions are clearly not the conventional course of mainstream psychiatry, but they are increasingly apparent currents in mainstream society. If psychiatry, and psychiatrists, are to remain as legitimate judges of mental wellness, then we must explore and create more inclusive maps of reality.

Just as there was integration of philosophy, science, humanities, and medicine during Greek civilization and during the Western Enlightenment, how does the integration of these fields apply

today? What would a "post-postmodern" psychiatry entail? How could it be actualized? I further explore these topics in the essay, "Integral Psychiatry: Five Elements of Clinical Theory and Practice."

In summary, psychopharmacological treatments are the current mainstay of psychiatric care, philosophically supported by an exclusive materialism, historically and scientifically supported by substantial evidence, and financed by the major payers, governments, and private insurance. Pharmacological treatments are an *essential but partial* treatment for most mental disorders. More integrative approaches (including psychological, biological, and sociological) have been emerging with varied success. A sustained, comprehensive approach to mental illness will likely require a developmental shift to a more comprehensive, inclusive society. This shift will require more integrated worldviews and maps of reality that include the best of the knowledge spheres of science and the humanities in order to understand what constitutes mental illness and its multidimensional etiologies and treatments. Integral Psychiatry, as an application of Integral Theory, is the most comprehensive attempt to date to integrate the knowledge spheres for the most complete psychiatric theory and practice. It honors the above schools of thought in an all-inclusive approach for the betterment of patients and practitioners. Rather than narrowing and excluding an aspect of a patient's reality that may be relevant to their suffering, the Integral practitioner reviews these dimensions to determine the most prudent and effective treatment. Of course, this approach will need to be systematically studied to find theoretically coherent, ethically sound, evidenced-based, and cost-effective interventions, which is a mission of the Integral Psychiatry Center. Hopefully, the psychiatric field will see the value in such an all-encompassing approach. *No single domain of treatment*, such as the biological or behavioral, is ultimately the best and most satisfying approach for all patients and practitioners.

Welcome to the frontiers of Integral Psychiatry! Please explore the resources provided by the Integral Psychiatry Center and get involved in this cutting-edge approach.

Endnotes

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[2] Combs, *The radiance of being: Complexity, chaos and the evolution of consciousness*, 1996, p. 113

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Integral Psychiatry

FIVE ELEMENTS OF CLINICAL THEORY AND PRACTICE

Baron Short

This article describes the major psycho-philosophical options available to a practicing physician including a single-school, eclectic, integrative, and Integral orientation. An Integral approach is the most comprehensive—treating the patient, their illness, and the practitioner. The basic five elements of the AQAL model (quadrants, levels, lines, states, and types) are introduced in an attempt to construct a psychiatric meta-theory and advance clinical practice.

Introduction

The acceleration of knowledge acquisition in the world is simultaneously impressive and overwhelming. Humankind has immediate access to all of the world's cultural developments of the past and present, including the methodologies of science and its subsequent, almost magical technologies. In the medical field, such interventions as vaccinations, antibiotics, and organ transplants have revolutionized our abilities to maintain physical health. In the psychiatric field, neurochemical modulating medications have transformed chronic mental illness, creating opportunities to manage even the most severe disorders in an outpatient environment. Despite these medical advances, North Americans spent approximately 36 to 47 billion dollars in 1997 on "alternative treatments" for their physical and mental health, with no suggestion of this trend changing.[1] Why is this? Obviously there are multiple answers, but a common one from the average consumer of alternative therapy is, "I'm treated as a whole person, not as a disease." Many physicians balk at such comments. Many others know we have something to learn from our patients' desires to be treated as complete human beings.

The scientific medical field is perceived as reducing many health issues to the physical body.[2] Despite this perception, there are many physicians who include psychological, social, cultural, and religious issues. However, these efforts toward a more inclusive medical model have not made an appreciable impact in standard, clinical medical practice.[3] Psychiatry is the only conventional field of medicine that includes the mind (via a biopsychosocial model), if not the whole person, in the assessment and treatment of various psychopathologies. Historically, psychiatry theorized that pathology arises from unconscious conflicts/drives, cognitive distortions, maladaptive behaviors, poor interpersonal interactions, pathological family systems, existential concerns, arrested transpersonal development, marginalizing cultures, and neurobiological imbalances, to name a few.

In today's psychiatric climate, neurobiological interventions are the mainstay of treatment, often accompanied by some type of psychotherapy, usually drawing from one or two psychotherapeutic schools. One may wonder how to choose the best theory and intervention given the immense variety of psychotherapeutic thought. Yet many of our patients ask for more than just the conventional pharmacotherapy and a limited psychotherapeutic perspective. The intent of this article is to briefly describe three broad, psycho-philosophic approaches available to the psychiatric community and offer an evolving, fourth option that transcends and includes the prior options in a larger meta-context.

The first option is a *single-school* approach. Although this may connote a pejorative meaning, it is entirely necessary and appropriate for the initial development of a distinct school. For example, Freud's psychoanalytic theories and subsequent psychodynamic theories required sustained attention, exploration, and description of unconscious patterns, functions, and processes in order to establish a collection of psychoanalytic/dynamic theories. B. F. Skinner and subsequent behavioral theorists required similar efforts to advance learning theories and behavioral techniques that focused strictly on observable human behavior.[4]

The limitations arise when important theoretical distinctions become unyielding boundaries that protect an approach from being influenced by other schools of thought. The advantage of a single-school approach is that one knows where one stands and feels comfortable maintaining that position. For example, a neurobiologically oriented psychiatrist may subscribe to the idea that a pathological brain equals a pathological mind and use only pharmacotherapy and somatic therapies to alleviate psychiatric disorders. A psychiatrist's cognitive dissonance is thus minimized (or repressed), since a particular theory/practice is correct and other schools are incorrect. The limitation of a single-school approach includes incessant theoretical gridlock with other schools of thought, which often leads to further confusion and knowledge dissociation rather than integration. A more significant limitation of an exclusory approach is that particular dimensions of a patient that are incongruent with the theory are simply ignored. Currently, the psychiatric-medical field is embroiled in this dilemma, as many patients may feel treated like an illness or a brain disorder rather than a whole person.

In contrast to the exclusory or single-school approach, another approach embraced by practicing psychiatrists is *eclecticism*. In more recent decades, there has been a greater trend towards eclecticism as practitioners realize that a combination of techniques from various psychotherapeutic schools may help a patient more than only one technique. A major weakness to such an approach is an unsystematic foundation of practice. Thus a subcategory of eclecticism, *technical eclecticism*, has emerged as a response to provide a systematic approach to treatment.[5] Technical eclecticism employs a particular personality theory to guide assessment and goals, while applying techniques from various other schools of treatment. A prime example of technical eclecticism is Lazarus's multi-modal approach that relies on social learning and systems theory as an underlying theory for a multi-modal treatment of various psychopathologies.[6] For many, technical eclecticism is clearly an improvement from single-school adherence; however, its position is a transitional solution between a single-school approach and an integrative approach

that avoids the syncretism of eclecticism and provides a theoretical framework for using therapeutic techniques from varied approaches.

A third orientation available to practicing psychiatrists is that of *integration*, which is often referred to as integrative or a trans-theoretical approach. This is similar to technical eclecticism in that it applies multiple treatment techniques from single schools, but it differs by constructing a theoretical model that transcends established theoretical constructs. Two examples are Norcross and Prochaska's trans-theoretical model of change and Millon's personologic therapy. Norcross and Prochaska's model describes stages and processes of change in a way that allows other schools' theories and techniques to be systematically applied based on a patient's stage of change and specific mental disorders.[7] Millon's personologic therapy incorporates sociobiological theory in personality development and explicitly notes where various modalities (cognitive, behavioral, intrapsychic, etc.) may be more useful for particular personality disorders.[8]

Integrative approaches have great appeal for those seeking theoretical unity in psychopathology, while applying diverse treatments systematically guided by a single theory. However, there are limitations to such an approach, since not all psychopathology requires an integrative approach. For example, some depressive syndromes can be effectively treated solely with short-term pharmacotherapy (single-school approach). Many psychiatrists and therapists often routinely combine relevant therapies for a particular disorder in a particular patient, such as cognitive-behavioral therapy and pharmacotherapy (eclectic approach) for a depressive syndrome, which seems to work quite well.

This raises a number of questions. What is the need for or value of integration? Would a systematic approach help? How comprehensive is an integrative model? Do the above integrative models adequately include feminist and Asian therapies? If not, does it matter if "other" modalities are deliberately excluded in an integrative model? These questions arise from the

limitations of the integrative modalities. There is a fourth psycho-philosophic option, *Integralism*, emerging as a framework for a more comprehensive and responsive psychiatric model. The Integral approach arose from the movement from a single-school approach, to an eclectic multiple-school approach, to a trans-theoretical integrative approach, and finally to an Integral meta-theoretical approach. Let's begin with Integral Theory's general guiding principles.

The Integral approach may be described as a means of radically including and organizing all human knowledge and modes of knowledge acquisition into a coherent whole.[9] The most prominent Integral theorist, Ken Wilber, created what are called "orienting generalizations" that organize how various knowledge fields fit within a comprehensive meta-theoretical framework with five elements: quadrants, levels, lines, states, and types (often referred to as "all-quadrants, all-levels" or AQAL).[10] Although a supremely comprehensive model may at first seem quite bold and overwhelming, Integral Theory actually streamlines and simplifies psychiatric theory. The AQAL model describes aspects of reality that are readily apparent to our own being and relationship with the world right now. (AQAL is described further in other texts listed in the references, but these aspects will be mentioned below in order for the reader to gain an initial understanding.)

The first aspect of AQAL is the *quadrants*, which consist of the interior and exterior dimensions of both individuals and collectives (i.e., subjective, objective, intersubjective, and interobjective domains). These quadrants are already present in our awareness and apparent in all languages: first person (I, me, mine); first-person plural (we); second person (you, yours); and third person (he, him, she, her, they, them, it, its). Thus, if I am speaking to you about this article, then "I" am first person, "you" are second person, and the article ("it") is third person. Below is a visual representation of the quadrants and some of their qualities:

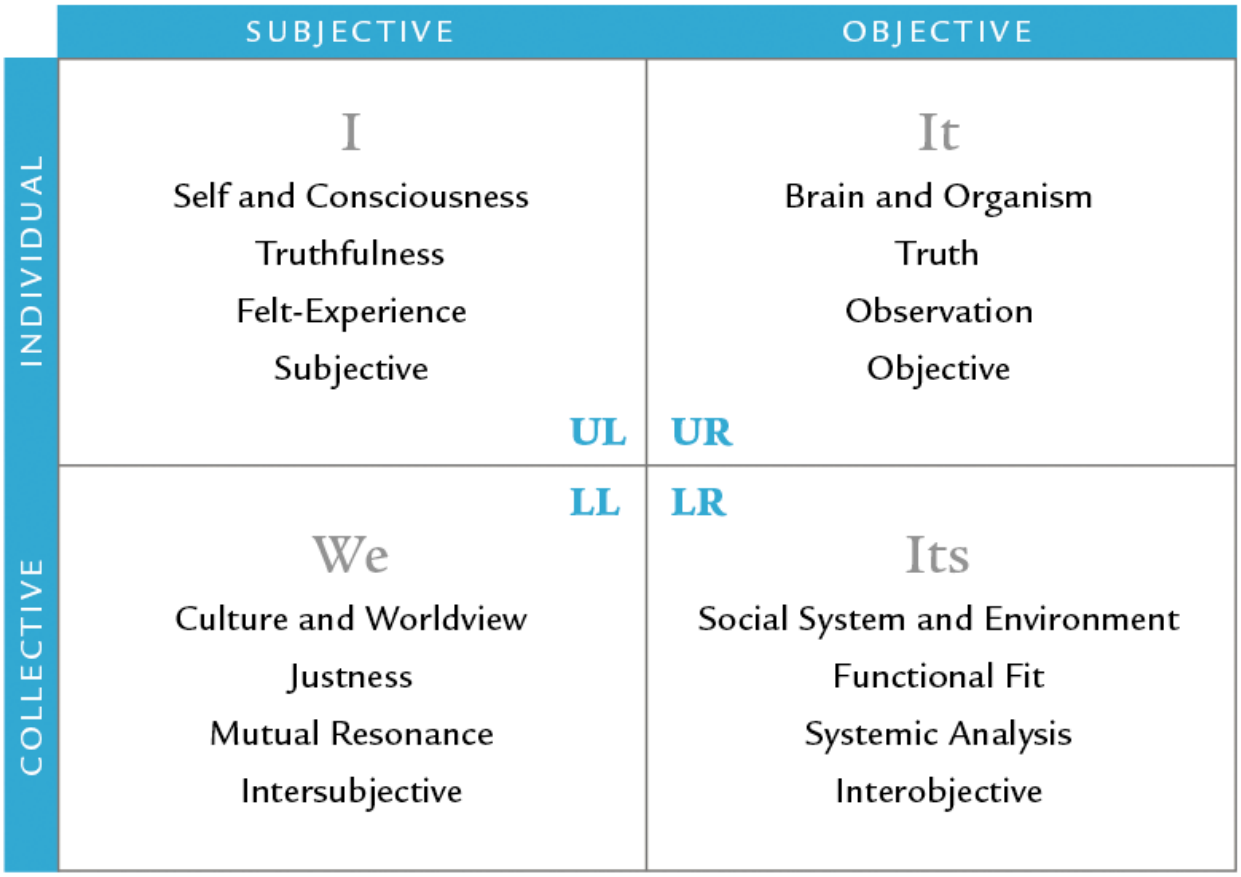

Figure 1. The Four Quadrants

Psychiatric therapies often specialize in or emphasize one or two of the quadrants, even if they occasionally make use of all four quadrants. The figure below highlights the quadrants that various approaches are associated with (but not limited to).

Individual Interiors • Phenomenological • Psychoanalysis • Cognitive Therapy • Existential Therapy • Transpersonal Therapy	**Individual Exteriors** • Biological • Behavioral • Therapy • Neuropsychology • Psychopharmacotherapy • Electroconvulsive therapy • Other Brain Stimulation Technologies • Various "Subtle Energy" therapies
Collective Interiors • Cultural • Cross-cultural Psychiatry • Feminism/Gender Therapy • Couples/Marriage Therapy • Social/Family/Couples/MST Therapy • Narrative Therapy • Social Learning Theory	**Collective Exteriors** • Social • Social Psychiatry • Family Therapy • Multisystemic Therapy (MST) • Evolutionary Psychiatry

Figure 2. Various Psychiatric Approaches in the Four Quadrants

Integral Psychiatry uses the quadrants to establish a meta-framework for various psychotherapeutic theories and practices. Thus, an Integral psychiatric approach realizes that each *partial* perspective has something to contribute and would transcend and include each individual theory and therapy into a greater whole. By its nature, it includes all psychiatric approaches, even the integrative forms. Integral Psychiatry acknowledges the strengths of various therapies and recognizes the aspects of reality with which they are concerned. Then it makes relevant connections that generate a more comprehensive psychiatric theory and practice. In subsequent articles on Integral Psychiatry, this will be explained further.

Another component of AQAL is *lines* of development. People have varying degrees of development in different capacities, such as cognitive skill, moral judgment, aesthetic perception, emotional capacity, and interpersonal communication. This echoes Howard Gardner's concept of multiple intelligences, wherein humans do not have a singular type of intelligence but a variety, including logical-mathematical intelligence, musical intelligence, and linguistic intelligence.[11] A particular person might excel in one or two lines, but remain average or underdeveloped in others. These lines are often interrelated but may develop relatively independently.[12] Lines can be intuitively grasped; many people know others who are cognitively brilliant, but interpersonally inept or morally bankrupt. Lines are in accord with Lazarus's multi-modal approach wherein the practitioner recognizes that, within a particular cross-section of time, an individual has specific cognitive, affective, behavioral patterns that correspond to that individual's pathology. Assessing these modular contents, as Lazarus does, is an essential clinical aspect of lines. For example, lesions along a particular line will impede development along that line. Someone who experienced a lesion in his or her moral line of development, whatever the etiology, is unlikely to develop moral maturation.

The full concept of lines must include levels or developmental stages, which can be quickly seen in the diagram below. Lines can be visually represented in a psychograph, which shows an individual's progressions along various levels or stages:

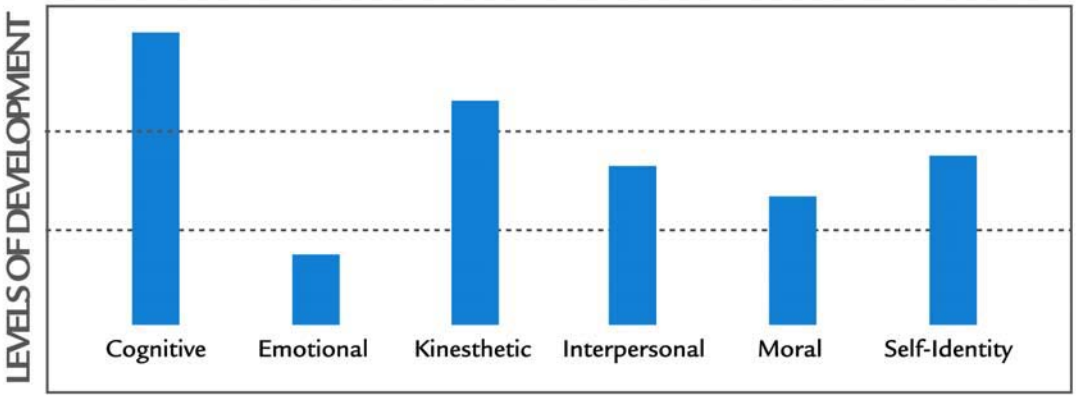

Figure 3. Psychograph

There are many variations on this model, and relevant lines for Integral Psychiatry include those modalities already researched in psychological theories such as cognition, behavior, mood, intrapsychic structures, defense mechanisms, and self-identity, among others. Essential questions for Integral Psychiatry include: what are the most relevant lines? How do they interrelate? How do we assess and treat them?

As we just saw, *stages* are implicit in the description of lines. Stages or *levels of development* represent successive degrees of organizational complexity of specific lines. Within the Upper-Right quadrant, objective aspects of nature progress through the sequence of atoms to molecules to cells to multicellular organisms. Regarding humans, one must consider neurophysiological stages of development throughout the human life span that we are just now studying with advanced neuroimaging techniques. There are various stages of complexity in all the quadrants described in other articles and books, such as Ken Wilber's *Sex, Ecology, Spirituality*. This paper will briefly discuss relevant stages of different lines in the Upper-Left quadrant; they have already been studied fairly well and have significantly contributed to psychological theories and subsequent treatment of pathology.

Aspects of several developmental theories can be conceptualized in Integral Theory as developmental lines progressing through stages in the Upper-Left quadrant. For example, Jean

Piaget's cognitive theory describes the line of cognitive development, following it through successively more complex stages (sensorimotor, preoperational, concrete operations, and formal operations) with increasingly complex cognitive capabilities.[13] In Kohlberg and Gilligan's respective studies of male and female moral development, they refer to moral stages as preconventional, conventional, and postconventional.[14] With each successive stage, one's degree of egocentricity decreases and the degree of concern for "the other" widens. In self-identity, a simple stage conception in which more complex stages result in decreased egocentricity is represented by prepersonal, personal, and transpersonal. Stage conceptions provide a template for understanding developmental lesions and why there might be diverse disorders, such as personality dysfunction, cognitive-social identity confusion, and existential, even transpersonal, crises in different patients.[15]

We can use the AQAL framework to recontextualize diverse lines as they proceed through their developmental stages. An Integral psychiatrist, adept at evaluating the interior terrain of patients, may assess approximately the developmental stage of an individual and then ascertain which treatments would be most effective. For example, treating a depressed patient who possesses the capacity of formal operational cognition and postconventional morality will differ from treating a depressed patient with concrete operational cognition and conventional morality. While both might respond well to antidepressant medication and cognitive-behavioral treatment, this may not be enough to ensure a sustained, euthymic mood for the postconventional patient. He may additionally require a more existential approach, as prior religious, political, and social conventions may no longer provide adequate meaning for an authentic existence. Someone at a postconventional stage may have needs that are better addressed by existential, humanistic, and transpersonal therapies. Currently, conventional psychiatry is relatively uncomfortable with the transpersonal dimensions of the human experience. Integral Psychiatry would assess which lines and their respective stages are emerging within the individual or group and determine relevant therapies.

The fourth aspect of the AQAL model is *states*. States include waking, dreaming, deep sleep, and altered states such as hypnosis and experiences induced by psychedelics. Psychiatrists are already commonly involved in studying sleep-state dysfunctions; for example, researching insomnia for the treatment of depression or analyzing dream content. Other exciting areas of research involve transpersonal states. Potentials documented in contemplative traditions and meditation research include lucid dreaming and awareness or basic wakefulness in all states of consciousness.[16] Many of our patients are already exploring these potentials, and thus it is important to have, at minimum, a conceptual understanding of these realities so that we can discriminate between pathology and the further reaches of human development. In reference to psychedelics, Integral Psychiatry does *not* endorse the use of illegal drugs, but would acknowledge that their use does alter one's state of consciousness and subsequent contents of consciousness, for better or worse. Why people experiment with and abuse various substances could be an inappropriate attempt to experience altered, non-ordinary states. Research that involves teaching addicts other healthy means of altered states, such as sports or meditation, would be an especially interesting topic from an Integral perspective.

The fifth aspect of AQAL is *types*. In the Upper-Left quadrant, this would include personality types. At minimum, this includes polarities such as gender disposition (masculine or feminine), active/passive, thinking/feeling, sensing/intuiting, judging/perceiving, and introversion/extroversion, the latter of which are derived from Myers-Briggs. A particular interest in psychiatry is personality disorders and their effect on Axis I clinical syndromes and social interactions. An Integral personality theory would ideally discern how personality pathologies might have "type" deficits or extremes and "level" developmental lesions, as well as predict what treatments will be most effective.

The aim of this article is to highlight various options available to practicing psychiatrists who want to include more of the human condition than current models of psychiatry allow, and to do

so in a coherent and effective way. Integral Theory is already being applied to diverse fields such as ecology, business, politics, art, and medicine. Psychiatry is uniquely suited for the Integral framework, since psychiatry's founders have already explored in some detail all the components of an Integral approach: quadrants, levels, lines, states, and types. However, no other framework has explicitly included insights from all the available approaches. This pioneering goal and vision is unique to Integral Psychiatry.

The development of Integral Psychiatry will ideally proceed in phases. The first and most immediate step is for individual psychiatrists to become informed by the Integral model. This does not mean one would necessarily assess and treat integrally**,** but would acknowledge the quadrants, levels, lines, types, and states that one focuses on. This would paradoxically amount to greater freedom in one's chosen psychiatric specialties (e.g., cognitive-behavioral and pharmacotherapy) by setting limits on one's scope of treatment. The practitioner would cultivate expertise in a chosen area**,** while being aware of when a patient's needs have surpassed one's expertise. This is done all the time in psychiatry when**,** for example**,** a depressed patient is diagnosed with hypertension. The psychiatrist will refer the client to a primary care physician for treatment. Ideally, a psychiatrist could refine their own map of "interiors" (Upper-Left quadrant) and notice when someone is having an existential or transpersonal crisis (level/state issues) or experiencing maladaptive personality processes (level/type issues), rather than just social disturbance and neurochemical depression. In the case of the latter issues, the patient might be referred to other appropriate psychiatrists or practitioners for those specified areas. The AQAL map allows a psychiatrist to be well informed about the complexity of their patients' lives. The result is better care for patients, more appropriate referrals for patients' needs that fall outside one's specialty, and greater freedom in working within one's own psychiatric niche.

A second development of Integral Psychiatry would involve transforming the psychiatrist, in addition to the patient, for her own happiness and freedom. Just as Integral Medicine emphasizes

treating the physician's own body, mind, and spirit, Integral Psychiatry encourages psychiatrists to cultivate their own awareness, as this is crucial for a rewarding life and career. Psychiatry is emotionally demanding, since patients test our skills and limits. When psychoanalysis was a dominant modality, many therapists were required to undergo their own analysis for self-improvement and to minimize countertransference difficulties with patients. Since today's clinical environment focuses most extensively on neurobiology, such practices are not as actively encouraged. Integral Psychiatry would renew the spirit of self-discovery for the psychiatrist. Not only would a psychiatrist work through psychodynamic conflicts, cognitive distortions, and behavioral maladaptations, but he would extend into the existential and transpersonal levels if and when those issues became relevant. He would explore the meaning of being alive, the meaning of his work, and the experience of reality in a supportive framework.

Workshops are being developed to stimulate psychiatrists, residents, and others in the health care community to access these simple but important dimensions in their own being. Integral Theory describes Integral Practice as involving at a minimum body, mind, and spirit in self, culture, and nature. The goal of an Integral Practice is to enliven the practitioner and improve patient care. As practitioners work through their own AQAL map, they will embody the wisdom and experience required to coach patients through their own Integral Practice. In subsequent works, Integral Psychiatry will explore these practices in general and how specific psychiatric treatments fit into this meta-modality.

A third phase of Integral Psychiatry would entail further maturation of Integral Theory as it applies to the field of psychiatry. Millon describes a mature clinical science as including theories, nosology, instruments, and subsequent interventions.[17] Theories include heuristic, explanatory schemas, which are deduced from current available knowledge bases. Nosology is a taxonomic classification of mental disorders derived from a theory that organizes the efforts of constructing tools (instruments) for assessing these psychiatric disorders. Therapeutic techniques

(interventions), including psychotherapeutic and somatic treatments, are designed in accordance with the theory and enacted by a practitioner in conjunction with the patient.

Obviously there is no standard, universal clinical science for the human mind and its possible pathology. Integral Psychiatry is attempting to get one step closer to such a development by integrating and transcending prior partial attempts. A matured Integral Psychiatry will embody these principles: constructing a theory that provides a consistent nosology, reliable assessment tools, and elegant Integral therapeutic interventions. This maturation could lead to significant improvements in our current multi-axial, diagnostic framework. Integral Institute, the epicenter for current Integral education, is in the process of creating many of these reliable products. Training workshops will offer a hands-on, real time experience of Integral Psychiatry in practice. Please stay tuned for these upcoming developments.

If you are wondering whether such a venture is too good to be true or how this will apply in the "real world," then you are asking the right questions. We realize that all developments in Integral Psychiatry will not occur overnight and are looking for others to collaborate with us in these pioneering efforts. Everyone has something to offer in this Integral expedition and we need your feedback and contributions to effectively create a truly new and revolutionary step in psychiatry. This is your invitation to Integral Psychiatry and its means of transforming your life and career.

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