An Integral Taxonomy of Therapeutic Interventions

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ABSTRACT Given that therapists are confronted with literally hundreds of techniques or interventions to potentially utilize in their clinical practice—and a growing chasm separating research and practice—how do therapists dispel the confusion that so many of us feel as we confront this fragmented heap of techniques? In short, how do therapists decide which interventions to use with a given client? This question is both epistemological in nature and immediately tied to practice, as epistemologies have concrete clinical consequences. This article classifies nearly 200 therapeutic interventions according to the AQAL model of Integral Psychotherapy, followed by a critical discussion of the clinical utility of such a taxonomy. The author first presents the need for such a classification system and briefly overviews integral theory. The author ends with suggestions for how to use an integral taxonomy of therapeutic interventions with psychotherapy clients, the role and meaning of interventions, an algorithm describing how the interventions were classified, and a caution against the "tyranny of technique."

KEY WORDS: AQAL; interventions; psychotherapy; quadrants; taxonomies

The limitations of practicing within a single counseling approach have begun to outweigh the benefits offered by "pure form" therapies. Moreover, with only a few exceptions, there is very little research that demonstrates the consistent superiority of one single-school approach or intervention over others (Asay & Lambert, 2003). Now that the majority of therapists report practicing eclectically or integratively (Jensen et al., 1990), most of us have an overwhelming number of counseling interventions and techniques to draw from. Confronted with this plethora of counseling interventions—and a growing chasm separating research and practice (Miller, 2004)—how do therapists dispel the confusion that so many of us feel as we confront this fragmented heap of techniques? In short, how do we decide which interventions to use with a given client? This question is both epistemological in nature and immediately tied to practice; after all, epistemologies have concrete clinical consequences (Stolorow et al., 2002).

Although the five main categories of eclectic or integrative practice (eclecticism, common factors, assimilative integration, theoretical integration, and metatheoretical integration) each address the above questions and have contributed to the field, each approach also has noteworthy limitations or drawbacks (i.e., incompleteness, restrictedness, propagation of incongruent sub-therapies, unsuitability for practice, and a high level of abstraction, respectively) (Norcross & Goldried, 2003; Lampropoulos, 2001; Stricker & Gold, 1993). For now, let me suggest that integral theory provides a comprehensive yet parsimonious model and conceptual

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framework able to accommodate varying and highly divergent therapeutic systems, thus greatly aiding therapists in their decisions of what interventions to use with which clients (Wilber, 1999, 2000a; Marquis, 2007; Marquis, 2008; Marquis & Wilber, 2008).

Given that the primary purpose of this article is to provide a classifying system with which to lend order and coherence to what has been a gargantuan heap of techniques, I want to emphasize how imperative it is to retain a sense of humility when we assess and evaluate the therapeutic impact of our interventions. Our best appraisals remain conjectural. A thorough critique of empirically-supported treatment (EST) and evidence-based practice (EBP) research protocols would fill volumes of this journal (see Marquis & Douthit, 2006). This is not an expression of pessimism or nihilism, but rather an honest realism peering into the human condition, which is tremendously complex, multi-dimensional, and multiply-determined. In the mysterious region where facts and meanings mingle, traditional scientific methods (especially the controlled clinical trials used in EST research) seem to gaze in confusion at the shining surfaces, where they either remain mostly silent or hubristically pretend to know far more about the precise workings within the depths of human change processes than they actually do (Foucault, 1973). It is possible that a logic different than that of the biomedical model alone will be required to understand the workings of the human heart. Perhaps, just perhaps, that logic is integral, but before delving into the integral taxonomy of therapeutic interventions (ITTI), which is but one example of Integral Psychotherapy's clinical utility, I will present a condensed overview of integral theory. Although readers of this journal are already familiar with the tenets of integral theory, I feel they will still benefit from my presentation, as I use examples from psychotherapy to set the context for the ITTI. If you would rather skip this "tour of AQAL," please proceed to the section on page 21 titled "An Integral Taxonomy of Therapeutic Interventions."

Integral Theory

Integral theory (Marquis, 2007, 2008; Wilber, 1999, 2000a, 2000b) is a meta-paradigm that aims to foster—among other things—maximally comprehensive and effective psychotherapy. One of the purposes of integral theory is to provide therapists with a new way to integrate and unify existing approaches in a manner that embodies the essential qualities of a good single-school theory (see Fall et al., 2004, pp. 10-11). Another purpose of integral theory is to promote the recognition that disparate aspects of reality—such as our felt-sense of selfhood, biological constitutions, cultural worldviews, and social systems—are all critically influential and must, therefore, be incorporated into any genuinely holistic psychotherapeutic approach.

How can integral theory not only acknowledge the diversity and pluralism of counseling approaches, but also genuinely integrate such currently fragmented diversity into integrated wholes? Integral theory accomplishes this by providing an exquisitely self-reflexive and parsimoniously elegant conceptual scaffolding within which to order and organize the myriad approaches to counseling. An integrating, unifying framework such as integral theory is *not* intended to minimize the significant differences we find across counseling theories or across cultures and systems. However, in addition to acknowledging that differences are salient, vital, and add spice to life, integral theorists search for deep structural similarities that often pervade even the most striking surface variations between individuals and cultures. Thus, the integral approach prizes understanding *unity within diversity*.

Our search for patterns that unite and integrate has revealed that what appear, at first glance, to be significant

contradictions between counseling theories are often reconcilable and complementary within the appropriate (meta)framework. This, in turn, leads to more inclusive, holistic, and effective therapy in real clinical settings. I am of the position that each single-school and integrative counseling approach has its strengths and weaknesses; that the value of a theory resides in both its heuristic and practical consequences; and that integral theory provides the most comprehensively integrative approach to psychotherapy.

The aforementioned conceptual scaffolding is less a theoretical framework than a meta-theoretical framework that simultaneously honors the important contributions of a broad spectrum of therapeutic approaches while also acknowledging the parochial limits and misconceptions of those perspectives. What is this theoretical framework? Simply put: the AQAL model (pronounced *ah-kwahl*). AQAL is an acronym signifying five essential components in an integral approach to psychotherapy: *all-quadrants* (or four essential perspectives of any phenomenon), *all-levels* of psychological development (degrees of complexity exhibited by phenomena within the four quadrants), *all-lines* of development (aspects of humans that develop, such as cognitive, emotional, moral, interpersonal, etc.), *all-types* of personalities (typologies such as Myers-Briggs, gender, Enneagram, five-factor model, etc.), and *all-states* of consciousness (normal [waking, dreaming, deep sleep; altered], nonordinary, and meditative).

The Four Quadrants

The four quadrants are the primary component of the integrative model that Ken Wilber (1999, 2000a) developed in response to the multitude of apparently contradictory knowledge claims posited by contrasting disciplines and theoretical approaches. The quadratic model serves as a meta-theoretical framework within which to situate diverse perspectives such that they augment and complement, rather than compete with and contradict, one another. The four quadrants are formed by the intersection of two axes: interior-exterior and individual-collective (Fig. 1). In other words, the four quadrants are "dimension-perspectives" of—dimensions of, and perspectives on—reality that yield four interrelated yet irreducible domains/perspectives. Integral theory posits that comprehensive description of any phenomenon requires that we account for these four irreducible perspectives:

- *Intentional (subjective)*: the individual viewed from the interior; individual consciousness as experienced as *mind*. This is the Upper-Left quadrant (UL) and includes any noteworthy patterns in the client's self-experience, including self-image, self-concept, self-esteem, self-efficacy, issues regarding stability/instability, joy, zest, purpose, motivation, depression, sadness, emptiness, anxiety, "jitters," feeling "revved up," as well as political, religious, and/or spiritual beliefs and/or experiences.
- *Behavioral (objective)*:[1] the individual viewed from the exterior; individual consciousness as described by neurotransmission and the functioning of *brain* structures. This is the Upper-Right quadrant (UR) and includes any noteworthy patterns of behavior and, specifically, the behaviors that bring the client to therapy as well as the specific behaviors that will indicate successful outcome. In addition, the UR quadrant involves other *relatively* objective dimensions of the client such as pertinent medical disorders, medications, diet, alcohol and/or drug use, aerobic and/or strength training, as well as the client's patterns of sleep and rest.

- *Cultural (intersubjective)*: the collective viewed from the interior; this is the Lower-Left quadrant (LR) and includes not only the medium of the therapeutic relationship and how both the client and therapist experience their intersubjectivity but also the client's relationships with significant others (especially spouse/partner, boss, friends, and family), as well as the client's family dynamics, religious and other cultural systems and institutions to which the client belongs, and the client's culture's judgments regarding, race, gender, social class, age, etc.
- *Social (interobjective)*: the collective viewed from the exterior; this is the Lower-Right quadrant (LR) and includes the client's socioeconomic status; the condition of the client's neighborhood; environmental stressors and/or comforts; the layout of

UL (Interior-Individual Experience)	**UR (Exterior-Individual Behavior)**
• Any noteworthy patterns in the client's self-experience • Self-image, self-concept • Self-esteem, self-efficacy • Instability-stability • Joy, zest, purpose, motivation • Depression, sadness, emptiness • Anxiety, "jitters", feeling "revved up" • Political, religious and/or spiritual beliefs and/or experiences • Consciousness as experienced as mind • The experience of, for example, depression: sadness, loss of interest in pleasurable activities, fatigue, feelings of worthlessness, difficulty concentrating, frequent thoughts of death, suicidal ideation, etc. Also how one interprets events such as the death of a loved one, divorce, profound loss, or child birth	• Any noteworthy patterns of behavior: what specific behaviors bring the client to therapy and what specific behaviors will indicate successful outcome? • Medical disorders • Medication • Diet • Alcohol and/or drug use • Aerobic and/or strength training • Patterns of sleep and rest • Consciousness as described by neurotransmission and the functioning of brain structures • Observable changes in, for example, depression: appears tearful, no longer engages in pleasurable activities, significant weight loss or gain, psychomotor agitation or retardation, lower levels of available serotonin, social withdrawal
LL (Interior-Collective Culture)	**LR (Exterior-Collective Systems)**
• Client's experience of ethnicity • Client's experience of family dynamics • Client's meaning-making system(s) • Client's relationships with significant others, especially spouse, boss, friends, and family • The medium of the therapeutic relationship and how both the client and therapist experience their intersubjectivity • Cultural meanings assigned to, for example, depression: sick, lazy, irresponsible, heartbroken, hexed, bewitched, etc.	• Client's socioeconomic status • Condition of one's neighborhood • Environmental stressors and/or comforts; layout of household • Analyses of interpersonal dynamics, including family history • Treatment contexts (setting: inpatient/outpatient and physical nature of therapy setting; frequency and length of sessions; modality: individual/group /family therapy) • Social systems that contribute to, for example, depression: economic, educational, and medical systems: poverty, drug- and gang-ridden neighborhoods; poor/dangerous schools; minimal access to medical care (brief therapy or none at all); racism, sexism, classism, ageism, etc.

Figure 1. The four quadrants in psychotherapy.

> the client's household; analyses of interpersonal dynamics, including family history; as well as treatment contexts (setting: inpatient/outpatient and the physical nature of the therapy setting; frequency and length of sessions; and modality: individual/group/family therapy).

Thus, each of the four quadrants yields different information and meanings necessary for a more complete understanding of a person. This insight suggests that none of these four viewpoints can be reduced to another. For example, to reduce the felt-experience of depression or anxiety (UL) to nothing but brain structures and neurotransmission (UR) is to subjugate lived experience to that which can be objectively observed and measured. Conversely, to disregard recent breakthroughs in neuroscience (UR) and explore only phenomenology (UL) would simply be the reverse form of "quadrant absolutism," in which one quadrant is consistently privileged, devaluing the important insights of the other three quadrants. Similar to intersubjective field theory, integral psychotherapy is a contextual perspective, and thus experiential worlds (UL) and intersubjective cultural fields (LL), as well as observable behaviors and brain functions (UR) and social systems (LR), are viewed as "equiprimordial, mutually constituting one another in circular fashion" (Stolorow et al., 2002, p. 96).

Each quadrant provides an alternative and legitimate perspective for a given phenomenon. The significance of these four perspectives may become clearer with an example. According to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR), a client suffering from depression experiences (UL) sadness, loss of interest in pleasurable activities, fatigue, feelings of worthlessness, difficulty concentrating, frequent thoughts of death, suicidal ideation, and so forth. Also important from this experiential perspective is *how one interprets* events such as the death of a loved one, divorce, profound loss, or childbirth. At the same time, we can behaviorally observe (UR) that this client may often be tearful, engages in fewer pleasurable activities, and displays psychomotor agitation or retardation. Additional data from this behavioral perspective often include significant weight loss or gain as well as lower levels of available serotonin that are measurable. Another important dimension impacting clients who are depressed are the cultural meanings (LL) assigned to depression, which vary from sick, lazy, and irresponsible to heartbroken, hexed, bewitched, etc. Finally, social systems (LR) are clearly implicated as contributing to many clients' depression and these vary from economic (poverty, drug- and gang-ridden neighborhoods), educational (poor, overcrowded, and dangerous schools), and medical systems (minimal access to medical care—brief therapy or none at all); to racism, sexism, classism, ageism, and so on. As I have elsewhere noted, "The experience of depression is inextricably constituted by UL factors, including self appraisals of worthlessness, and UR factors such as sleep EEG abnormalities, dysregulated neurotransmitter systems, and alterations of neuropeptides" (2007, p. 167); by LL factors that influence both the likelihood of developing a depressive episode (a consumer culture in which energies are directed toward acquiring material goods rather than cultivating interior development and capacities for tolerance, acceptance, and compassion) as well as how the depression is interpreted (medical disease vs. inauthenticity vs. hexed); and LR factors such as living in poverty and being denied the appropriate mental health care because HMOs and other managed care systems dictate such.

Every event or experience irreducibly has a subjective, an objective, an intersubjective, and an interobjective dimension, and to dismiss or ignore one or more of these dimensions is to be reductionistic or incomplete. Thus, integral therapists understand an individual's psychological development—which many therapists

view as a fundamentally individual, internal phenomenon (UL)—*not* as a merely isolated, internal process of increasing complexity, but as a phenomenon with at least four distinct dimensions that are mutually constitutive of one another.

The four quadrants are the primary feature organizing this proposed ITTI, the guiding idea being that by including therapeutic interventions from each quadrant, we can identify those contexts in which each intervention is most effective. For example, when counseling an anxious upper social class man whose family life and career are just as he had always hoped they would be, we would likely begin with those interventions that facilitate our understanding of his inner world (primarily UL and LL interventions). After all, from an "exterior" perspective he does not appear to be systemically disadvantaged. On the other hand, when a client presents with anxiety and her systems are not meeting her basic needs (living in poverty and marginalized due to social class and race issues), we will often intervene with social liberation as more of an overall goal, working more as a systems consultant or resource advocate (primarily LR interventions) than as an intrapsychic excavator. This should become clearer as you peruse the ITTI and the discussion that follows.

All-levels: The Spectrum Model

According to Integral Psychotherapy, attending carefully to clients' development is a key factor in treatment planning, profoundly influencing which categories of interventions are likely to be optimal, neutral, or contraindicated. This is a relatively common notion (see Ivey, 1986; Kegan, 1982; Mahoney, 1991, 2003). The term *all-levels*, however, refers to including and honoring the most complete spectrum of human development, from birth to "the farther reaches of human nature" (Maslow, 1971). As such, Wilber's spectrum model of human development spans three broad realms:

- *Prepersonal/body*: from birth to early childhood; development is largely bodily-focused (differentiating physically and emotionally), during which time the child's psychological self, or person, has yet to fully emerge; hence the term *prepersonal*
- *Personal/mind*: later childhood and early adulthood; development is largely mind-focused (learning social roles and mental rules), during which time our selfhood becomes increasingly autonomous, stable, and coherent; hence the term *personal*
- *Suprapersonal/spirit*: the remainder of one's life; potentially more self-realizing/spiritual, during which time one may recognize that one's deepest/truest self is not merely the separate, isolated-mind, individual self, but something including yet beyond the personal self; something more akin to a spiritual, though not necessarily religious, Self; hence the term *suprapersonal*

Several caveats are in order. Because the ITTI currently attends to only three broad levels/realms within each quadrant, I will not delve into the details of the three to four distinct stages within each of the three broad realms mentioned above.[2] For readers who are interested in the details of those stages, and in Wilber's thesis that corresponding to each stage of development is a corresponding psychopathology, mode of psychological defense, and an optimal treatment modality, please see Table 1 and consult Wilber (1999, vol. 4) and/or my previous work (2008, chapter 4). As one example of how treatment modalities differ depending upon clients' developmental levels, "uncovering approaches/processes" (such as offering interpretations and working through defenses and resistance) are ideal for a neurotic client who has repressed certain aspects of herself,

Realm	Level	Pathology	Defenses	Treatment
Prepersonal (body)	Sensoriphysical	Psychoses	Hallucination, delusional projection, wish fulfillment	Pharmacotherapy with psychotherapy as adjunct (Behavioral and Cognitive-Behavioral approaches)*
	Phantasmic/ emotional	Borderline and narcissistic personality disorders	Splitting, (projective identification), self-object fusion	Structure-building approaches: object relations, self psychology (Dialectical Behavior Therapy)
	Representational mind	Neuroses	Repression, (projection), reaction formation	Uncovering approaches: Psychodynamic: Jungian, ego psychology; Gestalt; Focusing; (experiential/Person-centered)
Personal (mind)	Rule/role mind	Script pathologies	Displacement, duplicitious transaction, covert intention, (repression)	Script analysis (collaborative empricism, cognitve therapy, REBT, Adlerian, Choice Therapy, etc.)
	Formal-reflexive	Identity neuroses	Sublimation, anticipation, suppression	Introspection, philosophizing, Socratic dialogue (experiential)
	Vision-logic	Existential pathologies	Inauthenticity, deadening, aborted self-actualization, bad faith	Existential psychotherapy (experiential approaches)
Suprapersonal (spirit)	Illumined mind	Psychic disorders	Pranic disorder, yogic illness	Path of yogis (sometimes temporary suspension of contemplative work)
	Intuitive mind	Subtle disorders	Failed integration, archetypal fragmentation	Intensification of contemplative practice, increased contact with spiritual teacher
	Overmind	Causal disorders	Failed differentiation, Arhat's disease	Collaboration between student and spiritual teacher
	Supermind			

Table 1. The spectrum of human development, pathology, defenses, and treatment. Adapted from Wilber (2000b). *Items in parentheses are from the author, based upon empirical research of the professional literature.

perhaps to accommodate an authoritarian, narcissistic father, and now a similar husband. However, those same uncovering processes may be iatrogenic to a person with borderline or narcissistic personality organization. This example is corroborated by object-relations and self-psychological approaches that have demonstrated that clients with borderline or narcissistic personality organization need to develop their egos/selves such that they are capable of the relatively mature defense of repression, compared to less mature defenses such as splitting, projective identification, delusional projection, and so forth (Kernberg & Aronson, 1980; Kohut, 1977, 1984). Thus, clients struggling with "disorders of the self" need structure (ego/self) building approaches (supporting and reinforcing acts toward autonomy, encouraging differentiation), not uncovering approaches. For any therapist who has experienced such clients' splitting, expressing narcissistic rage, or entering the dissociated darkness of rigid, hostile perspectives and overwhelming sadistic impulses, such differential courses of action in how to attune to and help clients is welcome indeed.

Most importantly, integral therapists do *not* conceive of these stages/levels of development as reified, rigid structures. Rather, we view them as *probability waves*, which means that a client's developmental level is less a matter of being "at" some "stage" than it is a function of that individual's inhabiting a psychological space from which the probability is relatively high that the particular patterns of thinking, feeling, and acting that characterize a given stage of development are present, whether these are felt from within or observed from without. For more details on the differences between the *linear logic* of the spectrum model of development (conveyed in Table 1) and the *non-linear dynamics* of those developmental processes as they actually play out in the life of every person, consult Marquis (2008, chapter 4).

Lines, Types, States, and the Self-system

Clients' *lines* of development are also important to consider. Wilber (1999, vol. 4) posited approximately two dozen different aspects (lines) of human development, such as cognition, emotion, self-identity, morality, object relations, creativity, role taking, psychosexuality, aesthetics, values, needs, spirituality, and worldviews. Attending to clients' developmental lines helps us narrow clinical attention to those aspects of our clients that are most implicated in their current struggles and most need a developmental "jump start."

Tailoring a therapeutic approach to a client's personality *type* is also crucial because different types of people emphasize different ways of being-in-the-world. Personality types are radically different from levels. As is the case with gender, the Myers-Briggs Type Indicator, the five-factor model, or the Enneagram, no particular type is inherently privileged over any other, but therapists will better serve their clients if they assess their clients' types and mindfully work with, rather than against, their clients' preferred style of being-in-the-world.

Whereas developmental stages are relatively enduring traits, altered *states* of consciousness are relatively temporary. Whether induced by drugs, fasting, or contemplative practice; an aspect of a client's presenting problem (most episodes of depression, mania, psychoses, etc., are just that—episodic states—not permanent, enduring traits of clients); or a quality of a master therapist, altered states of consciousness are another important component in Integral Psychotherapy. Furthermore, depending on their state of consciousness, clients may be more or less open to certain counseling interventions. Likewise, the therapist's own state of consciousness has tremendous impact relative to both understanding clients and impacting them:

> When I am at my best…when I am closest to my inner, intuitive self…when perhaps I am in a slightly altered state of consciousness in the relationship, then whatever I do seems to be full of healing. Then simply my *presence* is releasing and helpful… when I can relax and be close to the transcendental core of me, then I may behave in strange and impulsive ways in the relationship, ways which I cannot justify rationally, which have nothing to do with my thought processes. But these strange behaviors turn out to be *right*, in some odd way. At those moments it seems that my inner spirit has reached out and touched the inner spirit of the other. Our relationship transcends itself and becomes a part of something larger. Profound growth and healing and energy are present. [emphasis in original] (Rogers, 1986, pp. 198-199)

Last but not least, integral therapists also attend closely to each client's *self*, for not only is the self the experiential center of each individual's psychological universe; it also balances, navigates, and integrates the many levels, lines, states, and so forth. Integral therapists resist inclinations to transgress into an "objective expert" role, falling prey to the "tyranny of technique," and thereby losing resonance with the client's unique lived-experience. Elliott Ingersoll and Susanne Cook-Greuter (2007) discuss the self, its defenses, and its pathologies in detail from an integral perspective. Analogous to the issue of "quadrant absolutism" previously mentioned, one can also commit absolutisms with regard to lines, types, or states (i.e., if one values, privileges, and considers only cognitive development, only rational states of consciousness, or only masculine types, respectively). For more in-depth discussion of any of these four constructs and related issues, consult Wilber (1999, vol. 4) or Marquis (2008).

UL (Interior-Individual)	UR (Exterior-Individual)
Body • Eugene Gendlin's Focusing and attunement to immediate "felt-sense" • Self-comforting and basic centering exercises *Mind* • Awareness/consciousness raising • Dialogues with parts of self *Spirit* • Meditation/contemplative prayer • Cultivating mindfulness, love, compassion, forgiveness, etc.	*Body* • Self-management programs; self-monitoring and recording • Pharmacotherapy *Mind* • Cognitive restructuring • Reality therapy's WDEP system *Spirit* • EEG biofeedback and brain/mind machines that help induce theta and delta states of consciousness • Yoga
LL (Interior-Collective)	**LR (Exterior-Collective)**
Body • Attending to and mending ruptures in the therapeutic bond • Finding stability in relationships *Mind* • Establishing the therapeutic relationship • Role playing *Spirit* • Compassionate understanding as the heart of counseling • "Selfless service": compassion, social interest, social liberation	*Body* • Basic session management skills and structure of sessions • Involving the client's social support system in at least one session *Mind* • Social skills training • Genogram analysis *Spirit* • Serving others: social justice and advocacy • Relating responsibly to the environment

Figure 2. A miniature integral taxonomy of therapeutic interventions.

An Integral Taxonomy of Therapeutic Interventions

An ITTI is an ordered system for classifying the procedural methods and practical skills used by therapists to facilitate their clients' healing, growth, and well-being. I chose the word *therapeutic* instead of *counseling* or *psychotherapeutic* because a client's healing and welfare often necessitate changes that may revolve more around diet, spirituality, or more societally-systemic issues than the merely intra- and interpersonal changes that characterized counseling and psychotherapy for much of their early histories.

Ideally, the ITTI would be displayed on a single, poster-sized sheet of paper such as represented in Figure 2. In my attempt to be thorough, the number of interventions is too great to fit on a single journal page. Bear in mind that although Figure 3 spans four pages, it represents the four quadrants, with three levels within each quadrant. As will be discussed subsequently, four quadrants x three levels yields twelve dimensions of human beings. Furthermore, space constraints prohibit my describing most of the interventions. However, descriptions of more than 95% of these interventions can be found in three books by Raymond Corsini and Danny Wedding (1995), Gerald Corey (2001), and Michael Mahoney (2003). A few of the remaining interventions are taken from Irvin Yalom (2002), Kevin Fall and colleagues (2004), and Michael Lambert (2004).

UL (Interior-Individual)

Body

- Eugene Gendlin's focusing and attunement to immediate "felt-sense"
- Basic centering techniques: slow, deep breathing; breath counting; pause breathing; release breaths; alternate (control vs. surrender) breathing
- Body balance and other embodiment exercises: standing center, one-leg stand, range of movement/stretching
- Rhythm exercises: walking meditation; music listening, participation, tapping a beat; dance (both spontaneous and/or choreographed)
- Structure-building approaches (especially Kernberg, Linehan, and Kohut for borderline and narcissistic disorders)
- "Distress-tolerance" skills and other emotional/affect regulation skills
- Following flow (i.e., tai chi)
- Catharsis, dramatic relief
- Self-comforting exercises
- Therapeutic touch: massage therapy; Rolfing; self-massage; handcrafts such as woodwork, needlework, etc.
- Voicework: laughing/crying meditations, singing, voice play, yelling/screaming exercises

Mind

- Awareness or consciousness raising: this general process is emphasized by more approaches than any other, the counseling relationship notwithstanding
- Mindfulness meditation; facilitating "de-hypnosis" and "de-automization;" "de-conditioning of old habits;" "thought stopping;" and controlling disturbing thoughts/panic management
- "Relaxing into center" and other relaxation exercises/scripts
- Facilitating the assumption of personal responsibility for one's self and experiences (owning and accepting one's feelings and reactions)
- Narrative reconstructions, "re-storying"
- "Turning points exercise" (see Mahoney, 2003, p. 103)
- Assessing early recollections and personality priorities
- Guided imagery
- Adlerian lifestyle investigation
- Here-and-now immediacy: experiencing and processing present experience
- Dream interpretation and interpretation in general
- "Staying with the feeling" exercise; exaggeration exercise (see Corey, 2001, p. 215)
- Confronting clients, especially with the idea that they are not merely victims; that they can choose how to respond to trauma and tragedy
- Confronting the client with Irvin Yalom's four "givens of existence" (death, freedom, isolation, meaninglessness) and deeply pondering them
- Therapeutic double-binds
- Analyses and interruptions of clients' games; script analyses; script reversals
- Analyses of the strokes the client is receiving from the games she plays
- Reframing
- Dialogues with parts of self/disowned sub-personalities or others: empty chair with underdog/topdog or unfinished business; two-chair dialogue (for conflict splits within a person that need integrating)
- Client self-evaluation/reflection
- Free association/stream of consciousness
- Therapeutic writing: personal journaling, unsent letters, life review exercises and narrative reconstructions
- Bibliotherapy: self-help; inspirational; wisdom/religious traditions; stories of others who have endured and emerged healthily from similar experiences
- Mirror time
- "Identity clarifications" (see Mahoney, 1991)
- "Kindly self-control"
- Teaching self-relational skills
- Fantasy and dreamwork
- Brainstorming possible solutions/alternatives
- Personal experiments and considerations
- "Catching oneself"
- Push-button technique
- Art therapy: sand tray, clay, painting, music, etc.
- Giving up demanding-ness
- Changing one's verbiage from needs, musts, and shoulds to preferences and conveniences
- Confronting irrational beliefs, expectations, and demands
- Visualizations; imagery; cognitive rehearsal
- "Deserted island fantasy technique" (see Lazarus, 1995, p. 346)
- Desensitization, in fantasy with mental images
- Restructuring self-image
- Use of projective assessments such as Rorschach and Thematic Apperception Test

Spirit

- Meditation: concentrative/centering; awareness/insight/decentering
- Prayer/contemplation
- "Self-inquiry" and the intense pondering of profound questions such as, "Who am I?", "How shall I live?", "Am I really living the values I claim to hold?"
- Tonglen, a meditation of compassion, and teaching clients about self-compassion
- Forgiveness
- Jungian dream interpretation
- "Coming home to process" (Mahoney, 2003, p. 104)
- "Spiritual skills and personal development" (Mahoney, 2003, p. 161, 256)
- Practicing compassion for one's self
- Morita therapy's acceptance, reattribution, de-reflection, and active engagement
- Cultivating mindfulness, concentration, calm, equanimity, love, compassion, forgiveness, gratefulness, etc.
- The person/being of the therapist and her ability "to enter a variety of distinct states of consciousness" (Sollod, 1993, p. 241)
- Having clients write their epitaph (Yalom, 2002)
- Identity clarifications and personal epilogues (Mahoney, 1991, p. 314)

UR (Exterior-Individual)

Body

- Pharmacotherapy
- Behavioral techniques (in general); more specifically:
- Problem identification and assessment
- Behavioral analysis and assessment/self-monitoring: keeping detailed records of the specific situations in which the maladaptive behavior is more likely to occur; analysis of antecedents and consequences of the behavior; keeping detailed records of specific activities, events, and reactions; frequency counts
- Exposure therapy (exposure and response prevention; in vivo desensitization): graduated or flooding
- Operant conditioning
- Behavioral rehearsals
- Self-management programs: self-monitoring; self-reward/reinforcement
- Self-control strategies such as restricting caloric intake, alcohol/drug use, etc.
- Shaping: small steps/improvements (successive approximations)
- Physiological recording: monitoring and recording heart rate, skin temperature, etc. (regarding anxiety, sexual dysfunction, etc.)
- Relaxation training (also UL): deep breathing; systematically tensing and releasing/relaxing all muscle groups; systematic desensitization
- Resistance exercises/strength training: weight training, isometric exercises
- Cardiovascular exercise
- Yoga
- Bioenergetics, breath and movement work
- Eating a healthy, balanced diet, possibly including vitamin/mineral supplements
- Regular and sufficient sleep
- Sensory pleasuring

Mind

- Cognitive restructuring (in general; see "A Few Clarifications" section in this article); more specifically:
- Help clients learn to identify maladaptive automatic thoughts and record them, as well as accompanying feelings, events, etc.
- "Empirical disconfirmation": analyze the evidence supporting automatic thoughts and assumptions
- Modifying dysfunctional, maladaptive assumptions and schemas
- Decatastrophizing, reattribution, redefining, de-centering
- Diversion techniques, used to reduce strong emotions and decrease negative thinking: physical activity, social contact, work, play, visual imagery, etc.
- Scaling, cost/benefit analysis, "examining criteria," "defining terms," double standard technique, "downward arrow technique," 3-column technique (Fall, et al., 2004, pp. 326-327)
- REBT's ABC analysis
- Disputing client's irrational beliefs
- Various cognitive homework assignments
- Reality therapy's WDEP system
- Developing "positive addictions"
- BASIC ID analysis
- Modality assessments and modality profiles
- Bridging
- Tracking
- Adlerian "task setting"
- Eye Movement Desensitization and Reprocessing (EMDR)
- Standardized, nomothetic assessment instruments such as the Minnesota Multiphasic Personality Inventory (MMPI-2); California Personality Inventory (CPI); Sixteen Personality Factor Questionnaire (16PF)

Spirit

- EEG biofeedback and brain/mind machines that help induce theta and delta states of consciousness
- Yoga

LL (Interior-Collective)

Body

- Attending to and mending ruptures in the therapeutic bond
- Finding stability in relationships
- Petting and playing with pets

Mind

- Establishing the therapeutic relationship
- Therapist's capacity to enact and communicate empathy, genuineness, positive regard (listening, understanding, accepting, prizing)
- Creating a climate of safety and trust
- Basic attending skills: eye contact, facial expressions, minimal encouragers, body posture, etc.
- Role playing (role reversal, role switching), role playing "as if"
- Dramatic enactments/psychodrama
- George Kelly's fixed role therapy
- Encouraging social interest
- Silence (see "A Few Clarifications" section in this article)
- Experiments in directed awareness
- Metacommunicating; disengaging; and "unhooking" (Stricker, 1993, p. 536)
- Transference: emergence and analysis/interpretation
- Analysis/interpretation of resistance
- Confronting clients about incongruence, denying responsibility, etc.
- Socratic dialogue
- Guided discovery
- I/thou relating: authentically engaging clients
- Therapist's use of self-disclosure, especially regarding how she experiences the client (counter transference)
- Therapist's presence and use of authentic self in the here-and-now encounter
- Gender-role analysis and interventions
- Family sculpting
- Circular questioning
- Encouraging social, political, and civic action

Spirit

- "Compassionate relationship as the heart of psychotherapy" (Mahoney, 2003, p. xv)
- Being "recruitable" (Kegan, 1982, pp. 16-17)
- Presence, "invoking the actual," "vivifying and confronting resistance," and "meaning-creation" (Schneider & May, 1995, pp. 174-175)
- Therapist's giving/instilling affirmation and hope "into" the client
- The therapist's self-awareness and development: her capacity for empathy, presence, unconditional positive regard, genuineness
- Selfless service: compassion; social interest/generativity; social liberation
- Encouraging clients to consciously create maximally empathic, compassionate, loving relationships with their friends, families, coworkers, etc.
- Helping those in need

LR (Exterior-Collective)

Body

- Basic session management skills: maintaining the therapeutic structure, framework, or "container;" opening and closing sessions
- How sessions are structured: number, frequency, and consistency of sessions
- Therapeutic stance: face-to-face vs. couch; "blank screen" neutrality, anonymity, "objectivity" vs. self-disclosing, transparent, authentic encounter, intersubjectivity
- Environmental manipulation by therapist and client
- Involving the client's social support system (family, friends, significant others) in at least one counseling session (Beck, cited in Fall et al., 2004, p. 318)
- Home visits (Yalom, 2002, p. 171)
- Encouraging clients to exercise responsibilities to the earth such as consuming fewer resources and recycling
- Social advocacy
- Providing clients with appropriate referrals (to other therapists; to city and/or state welfare agencies and/or other social services; to appropriate legal services so that they are not being taken advantage of in ways that violate their constitutional rights; etc.)

Mind

- Role induction (regarding the roles of client and therapist)
- Therapist as model of appropriate, functional behavior
- Skills training: assertiveness training; social skills training; role training
- Restructuing of client's core schema (if client does on her own: UR; if done with help of therapist: LR)
- Eye Movement Desensitization and Reprocessing (EMDR)
- "Typical day" exercise (Corey, 2001, p. 397)
- Family therapy in general; more specifically:
- Genogram analysis
- De-triangulation
- Defining roles and boundaries within a family system
- Family sculpting
- Joining and accommodating
- Family mapping
- Family reconstruction
- "Disequilibriating" techniques: blocking, boundary marking, reframing, etc.
- Enactments
- Use of directives
- Paradoxical injunctions
- Virginia Satir's family life chronology

Spirit

- Serving others: friends and family; community agencies such as hospice, Big Brothers/Big Sisters, etc.; visiting people in nursing homes; helping any person in need: "Inasmuch as you do this to the least of my brethren, you do this to me."
- Relating responsibly to nature/the environment, whether this involves recycling, advocating for more stringent standards for corporations polluting the environment, etc.
- Social liberation: working as a systemic change agent to promote social justice, and encouraging clients to do the same; encouraging people to engage in social activism according to their own sense of justice, provided it is from a worldcentric (in contrast to ethnocentric) perspective.

Figure 3. A preliminary integral taxonomy of therapeutic interventions. Note: figure spans pp. 22–25.

Discussion

I am well aware that the unifying order in this taxonomy is a function of my inclination toward Wilber's integral theory (see the "Taxonomies and Classification" section below). Nonetheless, I think that even those readers who do not resonate with integral theory will still find the ITTI clinically helpful, both heuristically and by its organization of a large number of commonly used therapeutic interventions. A relatively quick scan through the ITTI suggests numerous general courses of action as well as specific methods and interventions to utilize with a given client. Yes, some of the quadratic placements are contestable. As but one example, Robert Stolorow and colleagues (2002) compellingly contend—contrary to the continuing ascension of the bio-psychiatric model (UR)—that the entire domain of counseling and psychotherapy is intersubjective (LL). In a very real sense, all counseling interventions, because they occur *between* a therapist and one or more clients, are relational (LL) acts (Prochaska & Norcross, 2003). Thus, I expect some disagreement and dialogue regarding my assigning interventions to a particular quadrant, which may be perceived as "pigeonholing." Moreover, many of these interventions apply to more than one level; thus in some cases it may be more accurate to think of which quadrant a given intervention *emphasizes* rather than which quadrant it resides in. For example, practices such as yoga or meditation can be accurately described as spanning all three of the levels/realms. They are primarily bodily when used to relax and calm the body or reduce bodily tension; primarily mental when used to observe thoughts or images or to reduce anxiety; and primarily spiritual when used to transcend the personal self. I further discuss the rationale behind my placement of interventions below (see "A Preliminary Integral Algorithm" section below). Bear in mind that the primary goals of the ITTI are to honor and incorporate the interventions of each single-school approach into a more unified system of care and treatment and to prompt thoughtful dialogue that may heuristically serve the mending of our fragmented health professions. I will structure this discussion around eight themes: taxonomies and classification; the "gist" of the ITTI; the role and meaning of interventions in counseling and psychotherapy; suggestions regarding implementing some of the interventions; how to use the ITTI; attempts to clarify reactions that I anticipate among some readers; a preliminary algorithm; and a caution against the mechanical implementation of interventions.

Taxonomies and Classification

Classifying involves sorting things or processes into categories; the sorting is non-arbitrary because it affords the basis upon which communities dialogue about those things that are classified as the same. Classifying is also natural or artificial, with the former supposedly reflecting nature's internal order and assuming other naturalistic philosophical assumptions, whereas the latter is more often associated with specifically human intentions and thus reflects an external order that derives from humans' needs and purposes (Sadler, 2005).[3] Traditionally, taxonomies have referred to specifically "scientific" classifying systems. In contrast, folk taxonomies are scientifically "agnostic" in that they are not necessarily scientific, although neither are they necessarily nonscientific (Sadler, 2005); Elizabeth Flanagan and Roger Blashfield (2002) argue that the DSMs are folk taxonomies. Given that what I am classifying are artifacts—therapeutic interventions—rather than "givens" in the natural world, the ITTI is most accurately an artificial classification, or perhaps a folk taxonomy. Nonetheless, because psychological and psychiatric literatures often use *taxon* (the group of things constituting a category in a given classification scheme) and *category* interchangeably (Sadler, 2005), I chose to refer to my classification as a taxonomy.

The "Gist" of the ITTI

There are a lot of therapeutic interventions! As always, therapists should use only those interventions with which they have competence, based upon education, training, supervised experience, study, consultation, and/or professional experience (American Psychological Association, 2002; American Counseling Association, 2005). I am *not* suggesting that you need to use most of these interventions in order to be an effective therapist; I certainly do not. There are some therapists and some approaches—Gestalt comes to mind—that use a great many interventions; when used judiciously, such an approach can work quite well. On the other hand, as Friedrich Perls and colleagues (1977) have noted, merely using lots of techniques or exercises can be very gimmicky, ineffective, and even abusive. As Yalom (2002) has emphasized, many therapists make the mistake of developing a "grab bag of exercises" to reach into when they feel the need to "jazz up" the therapy. Part of developing as a therapist is learning and appreciating that often times, less is more (i.e., at times, sitting in silent communion with a patient—with an unconditionally acceptinging presence—is the best response; at other times, following a clinical hunch is best) (Yalom, 2002; Mahoney, 2003; Welwood, 2000).

Again, a four-quadrant, three-level classifying scheme such as this ITTI does *not* imply that a therapist needs to use most of the 200 interventions indexed here; nor does it suggest that each therapist needs to regularly use interventions from each of the 12 dimensions. What it does suggest, however, is that therapists conceptualize their clients as having these 12 dimensions as part of their wholeness as human beings. Thus, therapists will likely benefit their clients by asking themselves questions such as, "Am I addressing these 12 dimensions in my clients? If not, why not?" and "Have I overlooked how one or more of these 12 dimensions may be significantly implicated in this person's struggles and healing?" In those cases in which a particular therapist is more of a specialist in three or four of those dimensions and does not feel competent to address the others, an indexing scheme such as the ITTI can also goad such a therapist to be humble and not to pretend to be comprehensively attending to the complete richness and fullness of what it is to be human. A key point of the ITTI and this article is to encourage therapists to be aware of and to attempt to "touch base" with each of these 12 dimensions—as needed—in the people they serve.

You may be asking yourself, "Exactly how many important dimensions of people are there?" Although I cannot answer that question, there are probably *at least* several dozen, if not several hundred. However, one simple conceptual framework I suggest using is the AQAL model; and even if we use a "scaled down" version with only 12 dimensions (4 quadrants x 3 levels; in contrast to 4 quadrants x 10 levels x 10 lines x 3 states x 9 types!), it is still going to urge us to consider and be aware of as many dimensions of human wholeness as we can, and thus not ignore or reduce important aspects of a person's being-in-the-world. This ITTI is intended to—first—help therapists approach each client as a full, whole person (even if that person is experiencing problems in some of the dimensions of their wholeness) and realize each person has at least these 12 dimensions. Second, the ITTI will hopefully help therapists open themselves to understanding and empathically resonating with all of the different aspects of human beings. Fundamentally, the purpose of a classifying scheme such as the ITTI is to remind us of the whole human being, of which these 200 interventions are a reflection.

Importantly, theorists and practitioners have devised interventions in each of the 12 dimensions—I did not create any of the 200 interventions indexed here—because 1) these 12 dimensions actually exist; they have a reality that theorists or practitioners have recognized; 2) each of those dimensions can be relatively functional or relatively dysfunctional in any given person; and 3) interventions in each of those dimensions are geared toward ameliorating the dysfunctions that arise within those specific dimensions within a given person. It is also important to recognize that these 12 dimensions are not the full expression of an AQAL approach. The ITTI incorporates the four quadrants and three levels within each of those quadrants, but it does not address the eight zones (the inside and outside of each quadrant [see Wilber, 2006]), the three to four stages of development within each of the three levels I address in this ITTI, or lines, states, and types. However, the utility of the ITTI and its 12 dimensions highlights a highly appealing and practical aspect of integral theory: its scaleability. Although the 12 dimensions of this ITTI will make most therapist's conceptualizations and practice more comprehensive, one could still be more comprehensive by including more of the other dimensions of human nature that are addressed by integral theory.

To be a bit more concrete, the ITTI can be clinically helpful if it assists your noticing that most or all of the interventions you use fall primarily within one or two quadrants, or primarily within one or two levels; in such cases you may increase your effectiveness merely by using interventions that address other dimensions—whether quadratic or developmental—of your clients. This is one of the simple meanings of an AQAL approach—being aware of all the quadratic and developmental dimensions of ourselves and our clients and attempting to touch on all of them.

Although incorporating some of the spiritual interventions into your clients' treatment plans may serve their well-being, one glaring contraindication involves the use of insight meditations (often called *vipassana*) with clients suffering from psychotic, borderline, or narcissistic personality organization. Similar to the previous discussion of how such clients require structure *building* approaches (whether more behaviorally- or psychodynamically-oriented) rather than uncovering approaches, insight meditations have as their aim the dissolution of psychic structure (ego, self), which is the worst possible "treatment" for such clients. Concentrative meditations, however, may be highly calming, soothing, and distress-ameliorating for such clients (see Boorstein, 1997; Epstein, 1995). Likewise, Mahoney's stream of consciousness, identity clarifications, and/or personal epilogue techniques are contraindicated or strongly cautioned against in the following situations: with clients who are struggling to maintain, recover, or develop an integrated, personal sense of self; with clients who are feeling highly unstable, emotionally vulnerable, or suicidal; with clients who have recently experienced a trauma; with clients who are reluctant to engage in experiential, process-level work; with clients who are not skilled in centering or regaining their sense of psychological balance; in early sessions prior to the establishment of a therapeutic alliance; or late in a given session or late in the course of therapy, when there may not be sufficient time afterward to adequately process the experience (Mahoney, 1991, pp. 296 and 314-315; Mahoney, 2003, p. 143).

Another appealing aspect of an integral approach to therapy that the ITTI makes quite clear is that you do not have to abandon your preferred single-school approaches and their associated interventions to practice integrally. After all, an integral approach includes and honors *all* of the interventions in the ITTI, while situating them within a more comprehensive conceptual framework. However, certain clinical situations will call for an emphasis or de-emphasis on different classes of interventions, as noted in the previous paragraph.

The Role and Meaning of Interventions

It has been argued that therapy, at its best, is spontaneous, dynamic, and creative. Yalom has gone so far as to say that we should "create a new therapy for each patient" (2002, p. 33). Additionally, he stated that therapy is:

> ….grotesquely distorted by being packaged into a formula that enables inexperienced, inadequately trained therapists (or computers) to deliver a uniform course of therapy. One of the true abominations spawned by the managed-care movement is the ever greater reliance on protocol therapy in which therapists are required to adhere to a prescribed sequence, a schedule of topics and exercises to be followed each week. (Yalom, 2002, p. 34)

What *is* paramount is empathic attunement to our client's experience such that the therapeutic relationship—which is itself a primary component of the change process—is fostered (Hubble et al., 1999). Which is *not* to suggest that evidence-based approaches or the specific interventions in this ITTI are unimportant. Rather, the potency of any intervention greatly increases when used within a genuine, caring, attentive engagement with the *client-as-person*, not as object of our "expert gaze" (Foucault, 1973) and technical mastery. Regarding this issue, Viktor Frankl wrote:

> ….the two extremes, encounter and technique, seem to be a matter of theoretical importance only. Live practice hovers between the extreme poles. Neither should be looked upon contemptuously or disparagingly....[However,] Technique, by its very nature, tends to reify whatever it touches….Worshipping technique at the expense of encounter involves making man [sic] not only a mere thing but also a mere means to an end….Seeing in man [sic] a mere means to an end is the same as manipulating him. (1967, p. 80)

Like drives from contemporary psychoanalytic points of view (which primarily serve to maintain object relations, as every drive is always directed toward some object), interventions have been suggested as primarily functioning to establish, maintain, and deepen the therapeutic relationship (Gold, 1993; Yalom, 2002). In addition to whatever power and effectiveness interventions may have in and of themselves, interventions serve other functions: from ideological functions (distinguishing therapists from the uninitiated and untrained) and ritualistic functions (providing a sense of control, competence, comfort, and hope through repetitive action) to justifying the ongoing interaction of the participants such that the relationship continues and develops (Gold, 1993). In contrast, some behavior therapists have claimed that because their treatments and interventions derive from specific and powerful behavior change technologies, that theirs is the only approach that transcends the common factors "persuasion" that Jerome Frank (1961) maintained is the heart of psychotherapy. However, studies have revealed that when clients who undergo behavior therapy are asked what they think has been most helpful from their treatment, they do not appear to report very differently from those who undergo other (more relational) forms of therapy; they, too, most often emphasize relational and interactional factors (Sloan et al., 1975; Gold, 1980).

Given the apparently essential importance of the therapeutic relationship, integral therapists practice embodying Carl Roger's "core conditions" of empathy, genuineness, and unconditional positive regard. According to Robert Kegan, the best therapists are those who deeply resonate with a client's phenomenological experience, "…rather than to help solve the problem, or try to make the experience less painful" (1982, p. 274). Kegan emphasized that good therapy requires far more than merely implementing techniques: "Its delicacy lies in the fact that the therapist is actually trying to join another person in an extraordinarily intimate way; he or she is trying to become a helpful part of the person's very evolution" (1982, p. 278). Kegan also stressed that the therapist's "recruitability"—the ability to *care* for clients such that the therapist is vulnerable and moved by their "interbeing"—is as important in helping clients as is the therapist's technical knowledge.

A related issue involves the different meanings that interventions, or "techniques," have for novices and experts. I remember my first clinical supervisor, John Garcia, saying, "Techniques are what you'll use until the therapist arrives," meaning that until we became truly effective agents of change (in part due to our abilities to form safe, trusting, empathic, intimate relationships), we would have to rely solely upon counseling techniques, a far cry from what optimal therapy is. Yalom (2002) used a musical analogy to explain this notion: a pianist needs technique to play, but to play beautifully, one must transcend technique and trust one's intuition and creativity. Mahoney (2003) often likened techniques to languages. Obviously, one is more likely to successfully communicate with more of earth's people if one knows more languages. At the same time, the language is not equivalent to a meaningful message; just because someone can speak many languages does not mean he is saying something important! Similarly, someone can graduate with a Ph.D. and have received supervised training in numerous techniques and still not practice in a genuinely therapeutic manner.

Essential aspects of constructive integral practice involve experimenting, exploring, and constructing novel experiences in order to challenge clients' old patterns of activities. This technical "risking" often demands a spirit of adventure and creativity from the integral-constructive practitioner (Mahoney & Marquis, 2002). As Mahoney stressed, "...that creativity and spirit cannot be formalized in a particular procedure…[Likewise,] *constructive practice recognizes that the power to change lies in processes* rather than specific procedures" (2003, p. 58, italics in original, brackets added). For example, the *process* of learning to relax can be acquired from numerous different techniques, from meditation, yoga, and self-massage to progressive muscle relaxation, autogenic training, and guided imagery. The dynamic tensions between human change processes that unfold in the company of novel encounters and the results of applying techniques as they are expounded in training manuals are essential tensions with which all therapists and educators of therapists must struggle. Although I will later caution against "technolatry," or the "tyranny of technique," and what Rogers referred to as to the "appalling consequences" of reducing helping to a mechanical use of technique (1980, p. 139), bear in mind that most therapeutic practice, as Frankl and Yalom have suggested, involves integrating technique in a genuine encounter with another human being.

A Few Suggestions

Most interventions will be far more effective if both the client and the therapist are *prepared* for them and in an appropriate state of consciousness. Thus, it is critical that therapists prepare for powerful, experiential interventions (whether empty-chair work, guided imagery, early recollections, etc.) with some form of centering method, which might involve a few deep cleansing breaths, a few moments of silent contemplation,

and the setting of positive intentions (Mahoney, 2003). Equally important is the client's informed consent (rationale) about the intervention itself. Allowing plenty of time after the intervention in order to process the experience with the client and reflect upon the meanings it disclosed is also essential.

Another caveat regarding powerful, experiential interventions: it is helpful if the therapist has experienced these as a client. In other words, the maximally-ethical therapist has not only studied and practiced such interventions under supervision, she also has firsthand knowledge of what interventions stimulate within the person on the "receiving end," which helps the therapist appreciate the resistance that clients often display when asked to participate in such interventions. Regarding pharmacotherapy, it is best for therapists to work *collaboratively* with psychiatrists; an excellent resource in this arena is the work of Elliott Ingersoll and Carl Rak (2006).

How to Use the ITTI

Integral counseling is an all-quadrants, all-levels engagement. It is important to remember, however, that the acronym AQAL refers also to all-lines, all-states, and all-types of the client's self-system. Due to space constraints, I will address only quadratic and developmental issues, beginning with the latter. Readers interested in further discussion can consult Marquis (2008).

As stated earlier, Wilber has posited that clients suffering from struggles associated with specific developmental stages will be optimally helped by interventions that are most appropriate to those particular developmental dynamics (Table 1). As an example involving common clinical sense, consider that although philosophical introspection and Socratic dialogue may be very helpful for a client capable of formal-operational thinking who is in the process of establishing a relatively autonomous identity (Wilber's formal-reflexive stage), using such methods, or speaking in complex metaphors, will be far less helpful to someone who has yet to grow into those developmental capacities. With a client who thinks very concretely (Wilber's rule/role mind stage), we would likely use more concrete cognitive approaches (script analysis, cognitive therapy, rational emotive behavior therapy, etc.). However, although such cognitive interventions are of some help to clients struggling with more profound disturbances, strictly cognitive approaches are not as helpful as uncovering approaches and structure-building approaches are for clients with neurotic and borderline/narcissistic personality organizations, respectively (see Table 1). In general, use those interventions that target each individual client's "developmental center of gravity."[4]

On the other hand, because mental health is actually not completely separate from physical or spiritual health, anyone's well-being may be optimized by engaging practices from each of those three domains. With regard to exercising one's body, some people respond better to weight-lifting; others to swimming or hiking. Similarly, the same diet is not optimal for all people. Central to integral therapy is Integral Life Practice (ILP), practices that celebrate and nurture the entire human being—from the body, emotions and mind, all the way to soul and spirit—as *each* unfolds in self (UL), culture (LL), and nature (UR and LR). Thus, independent of how developed one's *lines* are (affective, moral, interpersonal, etc.), one strives to be as all-quadrants, all-levels as one can be. The basic idea is that we are most likely to optimize our health and well-being if we exercise, nourish, and cultivate as many aspects of our being as possible. Thus, we can assist our client's choice of a practice or two from each domain of body (ideally one physical and one more feeling-oriented), mind, and spirit and encourage them to engage those practices consistently. Although we need additional research

to more specifically ascertain which domains (such as body, mind, spirit, as well as ethics, interpersonal relationships, shadow work, etc.) are most transformative for which specific types of people to exercise, available research suggests that when we engage practices addressing many dimensions of our being simultaneously, their positive influence increases synergistically (Murphy, 1995; Leonard & Murphy, 1995).

Analogous to exercising each dimension of body, mind, and spirit, paying attention to each client's "quadratic balance" is also important. For example, someone who is excessively preoccupied with himself (UL) will be self-absorbed or what laypeople call narcissistic. Such an individual will often benefit by devoting time, energy, and attention to more collective endeavors, whether that is a systemic activity (LR) such as engaging in civic action or working to reduce environmental pollution or a cultural activity (LL) such as empathically listening to others or helping someone in need of assistance. Conversely, someone who is inordinately concerned about her "we," or her place within various groups/collectives (LL), is likely to be excessively conformist. This person may benefit from spending more time alone, whether in nature, meditating, exercising, or engaging in some form of art, music, reading, or any other solitary activity that provides enjoyment and meaning to the individual. Finally, excessive focus on, or preoccupation with, solely the exterior, or the more objective, dimensions of life (UR and LR) can produce dissociation from oneself or from one's groups. Such a person would be served by interventions from the UL or LL quadrants: Eugene Gendlin's focusing; dialogues with parts of self or others; personal journaling; or cultivating better relationships by practicing empathy and compassion for friends, family, etc. To summarize, as integral therapists, we scan which quadratic dimensions each client tends to ignore, avoid, or devalue, and then select specific interventions from the ignored, avoided, or devalued quadrant(s) that fit optimally for that individual's type, or way, of being-in-the-world.

A Few Clarifications

What most clients describe as their "problems" are situations or feelings that, in one way or another, knock them from their center of balance. Thus, it is helpful to teach and encourage the practice of centering skills throughout the duration of therapy. Life will always throw us curve balls, and rest assured, we *will,* even if only temporarily, lose our balance. If we have cultivated our capacities to regain our own balance and center, those moments of distress will be fewer, or at least briefer. This applies not only to our clients, but to ourselves as well. I am here reminded of Wilber's comment that we should not strive to rid the ocean of life of its waves; rather, we should to learn to surf, which requires considerable balance indeed! Consistently practicing basic centering skills is as vital for therapists as it is for clients.

Although I personally react against the hegemony that cognitive-behavioral approaches are currently enjoying due to problematic and/or misguided conceptual, methodological, and political dimensions of EST research protocols (Marquis & Douthit, 2006), I also recognize therapeutic value in both cognitive and behavioral methods. Regarding cognitive restructuring: the basic notion is that much of what we experience is mental and much of our mental activity, especially in the form of thoughts and images, influences how we feel and act. Moreover, what we tell ourselves (self-talk) is critical to our processes of change and our awareness of what *is*. The success of cognitive-restructuring interventions depends in large measure upon creating and strengthening patterns of thinking that serve the individual's welfare. "Maladaptive" thought patterns are thus to be replaced with more adaptive ones. However, before individuals can replace dysfunctional thoughts with functional ones, they must be aware of those thought processes. Thus, training in introspection or other attention processes is an essential component to cognitive methods; after all, you cannot change negative self-talk

and catastrophizing imagery if you are not first aware of them. This is corroborated by research by Zindel Segal and colleagues (2002), who demonstrated that integrating mindfulness meditation with cognitive therapy increases the latter's efficacy, particularly its long-term effectiveness and the prevention of relapse.

The essence of cognitive restructuring involves the following four steps:

1. Pay attention and observe your feelings, particularly when your feelings change. This requires a certain degree of skill in moment-to-moment awareness, or mindfulness. The ability to notice that you are becoming anxious or angry *as that feeling is emerging* is a skill that most clients do not possess upon entering therapy. More often, they are likely to become pre-reflexively absorbed in, and by, the anxiety or anger and it may be minutes or hours before they are aware that they are upset. Thus, encourage clients to train their attention!
2. As soon as you become aware of your feelings (especially when they have just changed, either positively or negatively), notice what was passing through your mind in the form of thoughts or images.
3. Evaluate those thoughts and images: do they make sense? What do they mean or imply? Would you want someone you love to hold onto such thoughts and images?
4. If your feelings are distressing or are headed in that direction, can you imagine alternative ways of thinking about your situation/self? Can you imagine and truly entertain counterarguments to your manner of thinking/imagining? Can you come up with more functional options that you will systematically attempt to replace the dysfunctional ones with? Until a client can imagine constructive alternatives, change is unlikely. A useful way of determining if a client can imagine her life without her problem(s) is Alfred Adler's "miracle question": "What would your life be like (what would you *specifically* observe and experience) if a miracle occurred during your sleep and you woke up without your problem?" Some clients organize their lives around problems and crises to such a degree that they either fail to conceive of such a possibility or they find the idea (of being without their problems) intensely distressing (adapted from Mahoney, 2003).

Some key behavioral points to teach clients include: *be actively engaged*; *pay attention to the consequences* of your actions/behaviors and "control" your behavior with a much greater percentage of rewards than punishments; *small steps* are more likely to be maintained than dramatic changes; *practice those small steps* as consistently as possible (consistency and regularity create habits). Homework assignments are a useful way to encourage clients' consistent practicing of what they are learning in therapy. Moreover, we not only adapt ourselves to our environments, we also shape our environments to meet our needs and preferences. It is important to explore how aware clients are of how their environment influences them. Clients are more likely to succeed in a new behavioral regiment if they can anticipate environmental "hazards." For example, with a client trying to eat healthier and lose weight, it is helpful to have healthy, low-calorie foods readily visible in the cupboards or refrigerator. The more salient and within reach the junk food is, the more likely he will consume it. Also, teach clients about how much of our behavior is a function of our associating two events, even if we are often unaware of those associative processes. For example, if a client observes that he is usu-

ally watching television when he binges on junk food, he may want to try minimizing television viewing and find another activity that provides a similar function for him, or he may want to begin consciously eating only healthy, smaller portions of food while he is watching television.

You may wonder what is therapeutic about writing one's epitaph/personal epilogue or "deeply pondering" existential givens such as death and isolation. Perhaps it seems morose to meditate on death. However, deeply understanding death can free our hearts, illuminating the futility of our false projects that function to console, distract, and delude ourselves. Thus, deeply contemplating our mortality can be an ideal way to realize and will what is most important to us. These interventions, however, are contraindicated for clients who are depressed, psychotic, or struggling to maintain or develop an integrated self-sense.

An important caveat for the therapist who works with clients' suprapersonal issues is that she needs to know not only suprapersonal theories (which are a more philosophically- and empirically-informed subset of transpersonal theories), interventions, and diagnostic issues and to practice these under supervision; she must also be engaged in her own inner work: "For transpersonal therapists, undergoing their own in-depth, transpersonally oriented psychotherapy and long-term practice of transpersonal disciplines such as yoga or meditation are invaluable… part of a lifetime practice" (Walsh & Vaughan, 1993, p. 154). In fact, the therapist's being, presence, empathy, compassion, and acceptance may be as helpful as any other therapeutic elements, and these are primarily a matter of the therapist's own spiritual work (Epstein, 1995): "To whatever degree my personal practice keeps *me* loving, keeps *me* compassionate and empathic, to that degree therapy proceeds most effectively" (Boorstein, 1997, p. xvi).

Although integral therapists will focus on the specific problems of clients and also work within the constraints of managed care, we are, in general, more *awareness-focused* and *development-focused* than problem-focused. With many clients, simply identifying and removing the obstructions to growth and development is sufficient to help them lead more healthy, fulfilling lives. We are also highly cognizant of how the constraints of different clients bear on the services we provide. For example, we work in a much more direct, solution-focused manner with clients who have the resources for only a few sessions than those who have the time, money, and personal investment of many months or years of counseling.

An Integral Algorithm for Classifying Therapeutic Interventions

I anticipate that a reaction of some readers may involve disagreement, or perhaps even some confusion, regarding the placement of the various interventions in the ITTI. Thus, this section attempts to clarify how I classified the interventions. Regarding the quadratic placements, recall that the four quadrants represent the interiors and exteriors of both individuals and systems. Although many therapeutic interventions clearly involve more than one quadrant (such as empty chair work), most of them emphasize or focus on a dimension-perspective characterized by a single quadrant. For example, take the first intervention in the UL quadrant (see Fig. 3). Gendlin's method of focusing involves a client directing her attention internally to her inner "felt-sense." Hopefully, this is a good example of this "integral algorithm": the focus is on an *individual* (as opposed to a family system, relationship, culture, or society) and the therapeutic work of the individual is done *internally*, with her sensations and feelings (as opposed to her experimenting with a new behavior, which could be observed from the exterior, and thus would be one of the more objective, Right-Hand quadrants). To explicate the difficulty of placing empty chair work in a single quadrant, which I classified in the UL quadrant,

consider that such an intervention *can* be analyzed from the exterior; the intervention could be captured with a video camera. (The client sits in one chair and speaks to an empty chair in which the client imagines a sub-personality of his or another person with whom he has unfinished business.) However, I consider this more of an *internal* intervention because the power, meaning, and therapeutic value of empty chair work depends primarily on the client's ability to enter certain psychological (internal) spaces in which his sub-personality or other person is vividly imagined to occupy that chair, as well as the emotional courage to dialogue about what is most important to the client. Why, you might ask, if the person is "talking to another person" is this not a collective quadrant? Because the other with whom the client is dialoguing is "there" only to the extent that the client is holding the other within his own psyche; thus my placement in the UL quadrant.

Another counter-intuitive placement involved classifying cognitive interventions in the UR quadrant. Are not cognitions "inside" the individual and therefore belong in the UL quadrant? The reasoning behind my placing them in the UR involves a primary thrust that has characterized the cognitive therapy approach, which is its striving to be as empirical and objective as possible, and a concomitant belief that information processing can be reduced to the associations of sensations, which is another quintessential characteristic of empirical/externally observable, as opposed to rational/internal, ways of acquiring data (Anchin, 2005). As Wilber has stated, orthodox cognitive theorists have usually defined cognitions as internal (mental) acts upon external objects; thus essentially reducing cognition to sensori-motor objects (personal communication, February, 3, 2007). Moreover, Aaron Beck modeled his approach after—and teaches his clients to practice on themselves—the scientific method: clients "are taught to treat their beliefs as hypotheses and to gather additional information and conduct behavioral experiments to test their accuracy" (Hollon & Beck, 2004, p. 448). All of the above characteristics signify "gaining distance from" one's thoughts—as *from the exterior* looking in—so that one is not so involved with the matter that they cannot see their thoughts as they "really are," which is what objectivity is all about. Kenneth Gergen (1985) highlighted an irony that characterizes cognitive approaches to psychology and therapy: by privileging approaches that are objective—in an experimental manner that is valid independent of subjective appraisal—cognitive researchers devalue the very processes that they ultimately propose are most significant in our understanding of human nature.

Many of the interventions are difficult to classify solely in one quadrant because their placement is often a function of how the intervention is viewed or conceptualized. Take, for example, relaxation training. Literally hundreds of studies have documented the physiological changes and benefits of practicing various forms of meditation and/or relaxation. To the extent that those changes are measured externally (whether via blood pressure, galvanic skin response, EEG, or frequency of fidgeting), we can place such interventions in the UR quadrant. However, if we endeavor to illuminate the phenomenological experience of relaxation and other altered states of consciousness, those same interventions are more accurately placed in the UL quadrant. Thus, some of the confusion and apparent contradictions stem from the goals with which a specific intervention is used and/or evaluated. Again, noting that much of this is a matter of emphasis rather than strict placement, and also highlighting Wilber's notion of how the quadrants "tetra-mesh", a society (LR) that encourages meditation or other contemplative practices will increase the percentage of its members who engage in such practices (UR), which will likely lead them to have certain phenomenological experiences (UL) that will tend to play out in how they relate and understand one another (LL), which in turn can have an externally observable impact on that society's structures (LR), and on and on. Thus, the quadrants not only co-arise with one another; they mutually-constitute one another.

Another potentially controversial placement involves assigning structure-building approaches to the UL quadrant. Intersubjective field theorists such as Stolorow and colleagues (2002) would argue that because psychic structures (ego, self) never develop independently of an intersubjective matrix of object relations, such approaches belong in the LL quadrant. Wilber agrees that human psychology emerges within intersubjective contexts and thus all of our psychological dimensions are powerfully influenced by intersubjective and other cultural dynamics. Wilber's point—regarding why structure-building approaches are placed in the UL quadrant—is that a given psychic structure exists not within a collective, but rather within the interior of an individual, hence the UL quadrant placement (personal communication, February 9, 2006).

A final quadratic issue involves placing behavioral methods in the UR quadrant. One could argue that the LR quadrant is a more appropriate placement because most behaviorists have stressed that behaviors are not creatively initiated from within the organism, but rather are either elicited by environmental (systemic) stimuli and/or reinforced or extinguished by their environmental consequences. Wilber, however, suggests the UR quadrant placement because behavioral methods have as their goal a change of (externally observable) behaviors *in the individual*; the goal of behaviorists is usually not simply to change the environment (personal communication, February, 9, 2006).

My decisions regarding developmental placements were even more difficult and less clear-cut, primarily because many interventions can influence or work upon different dimensions of being. In general, I classified interventions according to which dimension of body, mind, or spirit they target or aim to impact the most. For example, it will hopefully be generally agreed that catharsis, pharmacotherapy, distress-tolerance skills, and behavioral methods primarily target the level of body (which includes feelings, because feelings are typically felt within one's body). Likewise, consciousness raising, cognitive restructuring, and narrative reconstructions primarily target dimensions of mind. Finally, contemplative prayer; cultivating love, compassion, and forgiveness; serving others and working for their social liberation are dimensions that most therapists would categorize as spiritual.

Prime examples of interventions that impact multiple dimensions of being and development are meditation and yoga. Although these two practices are probably most strongly associated with spirit, in contrast to body or mind, they both positively influence all levels of our being. Different types of yoga or meditation may emphasize bodily postures and energies, others will emphasize mental processes, while others focus on spiritual dimensions.[5] I have chosen to place these interventions in more than one developmental category because, although they are not panaceas, they do often have extraordinary positive outcomes for people who practice them appropriately and ardently (often under a competent teacher's guidance). Nonetheless, although meditation has been shown to affect the brain's physical structure (Schwartz & Begley, 2002), and although meditation also clearly influences our mental states, I do believe that the most powerful and unique contributions of meditation are directed toward states of consciousness and levels of development that are best described as spiritual.

Regarding my classification of silence as a therapeutic intervention, I can think of the use of therapeutic silence as also involving all three levels of body, mind, and spirit. During silence, awareness of felt-experience may be heightened (body); thoughts may be further processed (mind); or a mental quietude may open to a deeper realization of spiritual presence (spirit). Frequently, the most powerful therapeutic moments are those

of silence—not awkward, dead, or paralyzing silences—but healing silences pregnant with meaning and possibilities. "This healing silence, which is an untouched natural resource for the practice of psychotherapy…" (Epstein, 1995, p. 187) is possible only when the therapist can be with a client without an agenda, simply being present to the intersubjective field arising between therapist and client. This capacity is greatly augmented by the therapist's own meditative or contemplative practice. I chose to place it at the level of mind in the LL quadrant because, in psychotherapy, silence is always occurring only between two or more people, and in my experience as a therapist, the most frequent dimension that clients discuss after silences are mental (insightfully making connections or realizing patterns in their lives), though often emotional as well. Aware that many readers may feel strongly that, for example, silence more frequently elicits bodily or emotional reactions, I titled Figure 3 a *preliminary* ITTI, as opposed to a *final* ITTI. I welcome reactions to, and feedback regarding, this taxonomy.

A Cautionary Appeal

In my experience as an educator and supervisor of therapists, it is common for mental health professionals to fall prey to the "tyranny of technique," and too often, what we think is a therapeutic "groove" is more a mechanically-employed, technical rut: "The art of human helping will not be found in specific words or meticulously repeated rituals, unless those words and rituals reflect something deeper than their own surface structure" (Mahoney, 2003, p. 168). Similarly, Frankl wrote that, "What matters is not the technique applied but the doctor who applies it, or more specifically, the spirit in which he [sic] applies it" (1967, p. 81). Thus, integral psychotherapy is not defined by the specific interventions that are used, but rather by 1) the perspective from which, and within which, clients are viewed and therapy is practiced; 2) basing one's practice—as much as is feasibly possible—upon research grounded *not* in reductionistic "EST" research, but rather research deriving from Integral Methodological Pluralism; 3) the therapist's *being* and her capacity to *be-with* those who are suffering; and 4) the therapist's own emerging suprapersonal awareness and her corresponding capacity to recognize their clients' deeper self. Regarding the significance of the therapist's personhood (UL, spirit), it is common to find this or similar ideas posited in most books on psychotherapy practice, and it is well addressed by Yalom (2002), who stated that the therapist's most valuable instrument is herself and that it follows, therefore, that:

> Personal psychotherapy is, by far, the most important part of psychotherapy training…therapists must show the way to patients by personal modeling. We must demonstrate our willingness to enter into a deep intimacy with our patient, a process that requires us to be adept at mining the best source of reliable data about our patient—our own feelings…I believe there is no better way to learn about a psychotherapy approach than to enter into it as a patient. (pp. 40-41)

In a similar vein, Ronald Miller states boldly that the therapist is "the primary therapeutic tool in any therapeutic encounter" (2004, p. 254). I further agree with Perls when he wrote that, in and of itself, "A technique is a gimmick…We've got enough people running around collecting gimmicks, more gimmicks and abusing them" (1977, p. 1). Kegan echoed this sentiment when he stated, "Like any technique, it can only stop being a technique when it is embodied by a person with a specific set of ideas and hopes which he is himself trying to bring to life through the medium of 'technique'" (1982, pp. 277-278).

Conclusion

I have argued that integral theory is a prime candidate for lending order to the multitude of therapeutic interventions, and that the ITTI is merely one example of Integral Psychotherapy's clinical utility. Regardless of your guiding theory, the ITTI provides a fairly comprehensive classification of therapeutic treatment practices and hopefully a conceptual aid in your process of choosing among the many therapeutic interventions. You and your clients may be served by your consulting the ITTI and considering whether or not some of the interventions from different quadratic or developmental dimensions might be more appropriate to your client's specific struggles.

A primary point of this ITTI is that our clients are tremendously multidimensional and complex, that they have *at least* these 12 dimensions, and that suffering and/or dysfunction can arise within any of these 12 dimensions. An indexing system such as this ITTI is not meant to be used to pigeonhole, oppress, or marginalize any system of psychotherapy or any client; it is meant to continually remind us of the richness, fullness, and wholeness of human beings everywhere. This ITTI also affirms that many therapists have *already* created interventions to address problems in each of these 12 dimensions of people.

Integral theory and this ITTI are both *complexifying* (in that they reveal, incorporate and integrate more of reality than most approaches) and *simplifying* (in that they bring order to the cacophony of disparate dimensions of humans with great parsimony). This ITTI reminds us of—and hopefully helps us hold in both heart and mind—the rich fullness of what it is to be human. An AQAL approach and this ITTI are enjoinders to look for all of the important dimensions of each client and not to reduce anyone to just an id, ego, superego, information processor, passive product of reinforcements and punishments, merely the product of social systems, and so on.

As most of us continue laboring to improve our ability to serve our clients, let us not forget the paramount priority of therapist self-care. What might an inability to be understanding, gentle, and compassionate with ourselves imply about our capacity to care for others? And how might that influence our work with clients? This is particularly critical in light of recent reports on "therapist impairment" (Rollins, 2005). Furthermore, to what degree are we, as therapists, willing to be vulnerable to the unforeseen consequences of practicing "the dangerous recruitability" that Kegan stresses is inherent in optimal counseling? And to what extent are we practicing a *life-wisdom*, as opposed to merely accumulating information and mechanically repeating interventions? Deeply pondering such questions is a vital element of professional helping. As such, an integral approach to psychotherapy rests upon *phronesis*, the practical wisdom of the therapist's being, more than *techne*, the type of knowledge involved with machinery, crafts, and production. In sum, the notion of counseling practice based upon a tyranny of technique is misguided and potentially harmful (Mahoney & Marquis, 2002).

With its mission to embody a counseling approach that integrates compassionate recruitability with the most current, sound, scientific psychotherapy outcome and process research, Integral Psychotherapy attempts to marry not only the heart and mind, but also the client's experience and capacity to choose (UL); biomedical perspectives and the individual's behavior (UR); culture and our meaning-making systems (LL); and the social systems in which we find ourselves (LR). May this ITTI help therapists honor and nurture each person's body, mind, and spirit as each unfolds in self, culture, and nature.

Notes

[1] I would agree with a critic that points out that there are few, if any, psychological constructs that are properly understood as being completely objective. I recognize that even neurological measures such as PET scans and fMRI are not completely objective; that those methods are social practices that have emerged within socially constructed traditions that are subject to the dynamics of power and privilege (see Gergen, 1985). Nonetheless, in comparison to the quality of lived, felt experience (UL), the amount of blood in a specific region of the brain, or the number of times someone washes his hands (UR) is relatively objective—by which I really mean externally observable. Thus, *relatively objective* is a phrase that I have used numerous times. I also stress in this article that "the four quadrants represent the interiors and exteriors of both individuals and systems"; that is more accurate than saying the "subjective and objective views of both individuals and systems." Importantly, the same *relatively* applies to all four quadrants.

[2] See Esbjörn-Hargens and Zimmerman (2009) for another example of a four-quadrant x three-level matrix in the context of ecology. They refer to the resulting 12 dimensions as the "12 niches" and use it to help organize 200 distinct perspectives on the natural world and their respective techniques. It is interesting to note that in both cases the resulting matrix is used to organize 200 techniques.

[3] As I wrote this sentence, I was reminded of a humorous phrase attributed to Schopenhauer: "There are two kinds of people in the world: those who believe that there are two kinds of people in the world, and those who do not."

[4] Integral theory does not suggest that a person's internal experiences or external behaviors homogenously derive from a single, stable developmental structure. Because healthy development involves integrating previous stages into one's current developmental stage, individuals have access to not only their current stage but also their previous ones, and thus may function, perceive, and exist from several different altitudes or perspectives, even within the same day. Nonetheless, most people will *tend* to spontaneously act from the most developed meaning-making system or perspective that they have mastered. According to integral practitioners, this preferred perspective—or "central tendency" from which individuals make meaning—is called their developmental *center of gravity* (see Cook-Greuter & Soulen, 2007, p. 183; Marquis, 2008, chapter 4).

[5] For the sake of simplicity, I subsume many different types of yoga under a single category when, actually, there are distinct types of yoga that specifically address physical, mental, or spiritual dimensions. Interested readers can consult *The Shambhala Encyclopedia of Yoga* (Feurestein, 1997).

References

American Counseling Association. (2005). *Code of ethics of the American Counseling Association*. Alexandria, VA: American Counseling Association.

American Psychological Association. (2002). *Ethical principles of psychologists and code of conduct.* Washington, DC: American Psychological Association.

American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorders*, fourth edition, text rev. Washington, DC: American Psychiatric Association.

Anchin, J. C. (2005). Introduction to the special section on philosophy and psychotherapy integration and to the inaugural focus on moral philosophy. *Journal of Psychotherapy Integration, 15*(3), 284-298.

Asay, T. P., & Lambert, M. J. (2003). The empirical case for the common factors in therapy: Quantitative findings. In M. A. Hubble, B. L. Duncan, & S. D. Miller (Eds.), *The heart and soul of change.* Washington, DC: American Psychological Association.

Boorstein, S. (1997). *Clinical studies in transpersonal psychotherapy.* Albany, NY: State University of New York.

Cook-Greuter, S., & Soulen, J. (2007). The devel-

opmental perspective in integral counseling. *Counseling and Values, 51*, 180-192.

Corey, G. (2001). *Theory and practice of counseling and psychotherapy,* sixth edition. Belmont, CA: Brooks Cole.

Corsini, R. J., & Wedding, D. (Eds.). (1995). *Current psychotherapies,* fifth edition. Itasca, IL: F. E. Peacock Publishers.

Epstein, M. (1995). *Thoughts without a thinker: Psychotherapy from a Buddhist perspective.* New York, NY: Basic.

Esbjörn-Hargens, S., & Zimmerman, M. E. (2009). *Integral ecology: Uniting multiple perspectives on the natural world*. New York, NY: Random House/Integral Books.

Fall, K., Holden, J. M., & Marquis, A. (2004). *Theoretical models of counseling and psychotherapy*. New York, NY: Brunner-Routledge.

Feurestein, G. (1997). *The Shambhala encyclopedia of yoga*. Boston, MA: Shambhala.

Flanagan, E. H., & Blashfield, R. K. (2002). Psychiatric classification through the lens of ethnobiology. In L. E. Beutler and M. L. Malik (Eds.), *Rethinking the DSM: A psychological perspective* (pp. 121-145). Washington, DC: American Psychological Association.

Foucault, M. (1973). *The order of things*. New York, NY: Random House.

Frank, J. D. (1961). *Persuasion and healing*. Baltimore, MD: Johns Hopkins University Press.

Frankl, V. E. (1967). *Psychotherapy and existentialism: Selected papers on Logotherapy.* NewYork, NY: Simon and Schuster.

Garfield, S. L. (2000). Eclecticism and integration: A personal retrospective view. *Journal of Psychotherapy Integration*, *10*(4), 341-355.

Gergen, K. J. (1985). The social constructionist movement in modern psychology. *American Psychologist, 40*(3), 266-275.

Gold, J. R. (1993). The therapeutic interaction in psychotherapy integration. In G. Stricker & J. R. Gold (Eds.), *Comprehensive handbook of psychotherapy integration* (pp. 525-531). New York, NY: Plenum.

Gold, J. R. (1980). *A retrospective study of the behavior therapy experience*. Unpublished doctoral dissertation. Garden City, NY: Adelphi University.

Hollon, S. D., & Beck, A. T. (2004). Cognitive and cognitive behavioral therapies. In M. J. Lambert (Ed.) *Bergin and Garfield's handbook of psychotherapy and behavior change,* fifth edition. New York, NY: John Wiley & Sons.

Hubble, M. A., Duncan, B. L., & Miller, S. D. (1999). The heart and soul of change: What works in therapy. Washington, DC: American Psychological Association.

Ingersoll, R. E., & Cook-Greuter, S. (2007). The self system in integral counseling. *Journal of Counseling and Values 51*(3), 193-208.

Ingersoll, R. E., & Rak, C. F. (2006). *Psychopharmacology for helping professionals: An integral exploration*. Belmont, CA: Wadsworth.

Ivey, A. E. (1986). *Developmental therapy*. San Francisco, CA: Jossey-Bass.

Jensen, J. P., Bergin, A. E., & Greaves, D. W. (1990). The meaning of eclecticism: New survey and analysis of components. *Professional Psychology: Research and Practice*, *21*, 124-130.

Kegan, R. (1982). *The evolving self: Problem and process in human development.* Cambridge, MA: Harvard University.

Kernberg, O., & Aronson, J. (1980). *Internal world and external reality: Object relations theory applied.* New York, NY: Jason Aronson.

Kohut, H. (1977). *The restoration of the self.* New York, NY: International Universities Press.

Kohut, H. (1984). *How does analysis cure?* Chicago, IL: The University of Chicago Press.

Kuhn, T. S. (1977). *The essential tension: Selected studies in scientific tradition and change.* Chicago, IL: The University of Chicago Press.

Lambert, M. J. (Ed.). (2004). *Bergin and Garfield's handbook of psychotherapy and behavior change,* fifth edition. New York, NY: Wiley.

Lampropoulos, G. K. (2001). Bridging technical eclecticism and theoretical integration: Assimilative integration. *Journal of Psychotherapy Integration, 11*(1), 5-18.

Leonard, G., & Murphy, M. (1995). *The life we are given: A long-term program for realizing the potential of body, mind, heart, and soul*. New York, NY: G.P. Putnam's Sons.

Mahoney, M. J. (1991). *Human change processes*. New York, NY: Basic Books.

Mahoney, M. J. (2003). *Constructive psychotherapy*. New York, NY: The Guilford Press.

Mahoney, M. J., & Marquis, A. (2002). Integral constructivism and dynamic systems in psychotherapy processes. *Psychoanalytic Inquiry*, *22*(5), 794-813.

Marquis, A. (2007). What is integral theory? *Counseling and Values*, *51*(3), 164-179.

Marquis, A. (2008). *The integral intake: A guide to comprehensive idiographic assessment in integral psychotherapy.* New York, NY: Brunner-Routledge.

Marquis, A., & Douthit, K. Z. (2006). The hegemony of "empirically supported treatment": Validating or violating? *Constructivism in the Human Sciences, 11*(2), 108-141.

Marquis, A., & Wilber, K. (2008). Unification beyond eclecticism and integration: Integral psychotherapy. *Journal of Psychotherapy-Integration*, *18*(3), 350-358.

Maslow, A. H. (1971). *The farther reaches of human nature.* New York, NY: The Viking Press.

Miller, R. B. (2004). *Facing human suffering: Psychology and psychotherapy as moral engagement*. Washington, DC: American Psychological Association.

Murphy, M. (1995). *The future of the body: Explorations into the further evolution of human nature*. Los Angeles, CA: Jeremy P. Tarcher, Inc.

Perls, F., Hefferline, R., & Goodman, P. (1977). Gestalt therapy: Excitement and growth in the human personality. Goulsboro, ME: Gestalt Journal Press.

Prochaska, J. O., & Norcross, J. C. (2003). *Systems of psychotherapy: A transtheoretical analysis,* fifth edition. Pacific Grove, CA: Brooks Cole.

Rogers, C. R. (1980). *A way of being.* Boston, MA: Houghton Mifflin.

Rogers, C. R. (1986). A client-centered/person-centered approach to therapy. In I. Kutash & A. Wolf (Eds.), *Psychotherapist's casebook* (pp. 197-208). San Francisco, CA: Jossey-Bass.

Rollins, J. (2005). A campaign for therapist wellness. *Counseling Today*, October, 2005.

Schneider, K. J., & May, R. (1995). *The psychology of existence: An integrative, clinical perspective*. New York, NY: McGraw-Hill, Inc.

Schwartz, J. M., & Begley, S. (2002). *The mind and the brain: Neuroplasticity and the power of mental force*. New York, NY: Regan Books.

Segal, Z. V., Williams, J. M. G., & Teasdale, J. D. (2002). *Mindfulness-based cognitive therapy for depression: A new approach to preventing relapse*. New York, NY: Guilford.

Sloan, R. B., Staples, F. R., Cristol, A. H., Yorkston, N. J., & Whipple, K. (1975). *Psychotherapy vs. behavior therapy*. Cambridge, MA: Harvard University Press.

Sollod, R. N. (1993). Integrating spiritual healing approaches and techniques into psychotherapy. In G. Stricker & J. R. Gold (Eds.), *Comprehensive Handbook of Psychotherapy Integration* (pp. 237-248). New York, NY: Plenum.

Stolorow, R. D., Atwood, G. E., & Orange, D. M. (2002). *Worlds of experience: Interviewing philosophical and clinical dimensions.* New York, NY: Basic Books.

Stricker, G. (1993). The current status of psychotherapy integration. In G. Stricker & J. R. Gold (Eds.), *Comprehensive Handbook of Psychotherapy Integration* (pp. 533-545). New York, NY: Plenum.

Walsh, R,. & Vaughan, F. (1993). Introduction

to the quest for wholeness: Transpersonal therapies. In R. Walsh & F. Vaughan (Eds.), *Paths beyond ego: The transpersonal vision* (pp. 153-155). Los Angeles, CA: Jeremy P. Tarcher.

Wilber, K. (1999). *The collected works of Ken Wilber* (vol. 1-4). Boston, MA: Shambhala.

Wilber, K. (2000a). *The collected works of Ken Wilber* (vol. 5-8). Boston, MA: Shambhala.

Wilber, K. (2000b). *Integral psychology: Consciousness, spirit, psychology, therapy.* Boston, MA: Shambhala.

Wilber, K. (2006). *Integral spirituality: A startling new role for religion in the modern and postmodern world.* Boston, MA: Integral Books.

Yalom, I. D. (2002). *The gift of therapy: An open letter to a new generation of therapists and their patients.* New York, NY: Harper Collins Publishers.Stryker, S. (2008). *Transgender history*. Berkeley, CA: Seal Press.

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