AN INTEGRAL APPROACH FOR TEACHING AND PRACTICING DIAGNOSIS

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ABSTRACT: Psychologists and other students training to be mental health professionals are required to learn how to use the Diagnostic and Statistical Manual of the American Psychiatric Association. Needed, however, are approaches to the instruction and practice of diagnosis that incorporate the transpersonal domain as well as a holistic perspective of clients. This paper describes an approach to supplement the standard 5-axis DSM diagnosis using Ken Wilber’s Integral Model.

As more psychologists and masters’ level mental health practitioners are sanctioned by law to diagnose and treat mental/emotional disorders, they are trained in using the Diagnostic and Statistical Manual of the American Psychiatric Association, 4th edition, Text Revised (DSM-IV-TR, hereafter referred to as DSM) (American Psychiatric Association, 2000). Educators teaching students how to use the DSM are faced with the tasks of imparting a basic understanding of the manual, facilitating skill development in diagnostic interviewing, and heightening students’ awareness of the politics of DSM. This paper outlines an approach for DSM training utilizing Ken Wilber’s (1995) Integral Model. Wilber has stressed in his writings that the Integral Model honors the partial truths of different approaches to pursuing truth and draws them together in a complementary way. Inspired by Wilber’s work, this integral approach to diagnosis honors the partial truths of the medical model while also allowing for other truths (including the transpersonal) that may be relevant to the client’s case.

THE DISEASE MODEL IN DSM

According to the American Psychiatric Association (APA) (2000) the five axis diagnoses of DSM are supposed to facilitate “comprehensive and systematic evaluation” (p. 27), capture “the complexity of clinical situations,” and “promote the application of the biopsychosocial model in clinical, educational, and research settings” (p. 27). Engel (1977, 1997) proposed the biopsychosocial paradigm as a holistic alternative to the medical model that focused disproportionately on the physical aspects of illness. This latter model was derived from allopathy, the mainstream approach to medicine that commonly practices what is called the “disease model.” This allopathic model treats disease with agents that produce effects different from the disease process with the hope of ameliorating it. For example, if psychotic symptoms are believed correlated with dopamine activity in the brain’s mesolimbic dopamine tract, one standard allopathic approach is to
administer medications that decrease dopamine activity in that brain area with the hope of reducing symptoms.

Engel contended that all branches of medicine (including psychiatry) should be taught so clinicians consider biological, psychological, and social variables when dealing with patients’ symptoms. Many psychiatrists lament that Engel’s call was not heeded in any branch of medicine and in psychiatry, the allopathic approach, or disease model, has won the political day (Cohen, 1993; Victor, 1996).

The disease model got a real boost when the psychiatric nosology moved into a descriptive format with DSM III (American Psychiatric Association, 1980). Up to that point, psychiatric practice and the labeling of disorders had a more dimensional quality to it. The dimensions were varied and may have related to severity of symptoms or the client’s manifestation of diverse symptom sets that seemed to go together (like symptoms of both anxiety and depression). Much of the dimensional quality of the first two DSMs relied on psychodynamic concepts. Critics of the approach thought the reliance too heavy since psychodynamic approaches relied on the client’s reported subjective experience. These critics turned to researchers of mental disorders who used more objective statistical techniques to conclude that certain symptoms occur together and can be organized as syndromes. As Dilts (2001) noted, the syndromes are described by the symptoms that compose them thus the approach is called “descriptive” as opposed to dimensional. Dilts added that the descriptive model does not capture everything about a particular disease state or client. He proposed a more rigorous use of the biopsychosocial approach. Again, his recommendation has not been followed. Currently many psychiatrists are challenging the descriptive model and urging an integration of the dimensional model in the upcoming DSM-V (Helzer & Hudziak, 2002).

Challenges to a Psychiatric Disease Model

The disease model that underlies the DSM has been called into question on many counts. Critics like Colbert (2000) and Fisher and Greenberg (1997) have asserted that psychological disorders are over determined and very different from allopathic disorders. In their view there is a world of difference between a streptococcus infection and depression. While the former can clearly be conceptualized and treated through the allopathic approach, the latter may or may not respond to allopathic approaches and may require hermeneutic therapies. Other critics have challenged the validity of DSM categories of disorders. For example, Healy (1997) has documented how the concept of depression was “sold” by the medical community and the pharmaceutical industry through the descriptive (DSM) model. The correlation of certain symptoms occurring together was first labeled “depression.” Then the construct was “sold” via DSM. After the concept of depression was “bought” by the medical establishment, antidepressants were marketed as a treatment for the disorder and, as Healy has pointed out, you must have a disorder before people will be interested in purchasing a cure for it. Healy has also documented how, in the United States, Food and Drug Administration (FDA) regulations reinforce the descriptive model of psychiatry because potential drugs must show efficacy for the
treatment of some disease. Without the *DSM* categories there are no diseases on which drugs may be shown to have an effect.

Whatever the validity and reliability of particular *DSM* diagnoses, axis I diagnoses tend to be the primary focus of third-party reimbursers and this bias is reflected in psychology and other mental health training. Such dynamics have likely fueled the negative reaction many therapists have to the topic of diagnosis. As Hohenshil (1994) has noted, many clinicians question the necessity of diagnosis and feel it is an unproductive labeling process based on oversimplified categories to describe complex human dynamics. Ginter and Glauser (2001) have written that diagnostic outcomes depend more on how the diagnosis informs treatment than with the process of making it.

Training in using the *DSM* requires an approach that acknowledges the spirit of the biopsychosocial model advocated by Engel but that goes beyond it to include the full spectrum of the human condition. The integral approach to diagnosis described in this paper fulfills these criteria.

**Wellness Versus Pathology?**

Most of the mental health professions have wrestled with the “wellness versus pathology” issue and many professionals are still engaged in that debate. Turner, Lukoff, Barnhouse, and Lu (1995) have led efforts to normalize the religious and spiritual dimensions of life with their creation of the *DSM V*-code for religious or spiritual problems. Sprinthall (1990) outlined the issue for the practice of counseling psychology, which he predicted would lose its distinctiveness compared to clinical psychology if it continued to teach the categorical *DSM* model. Counseling students experience dissonance about the disease model of *DSM* because their training model emphasizes a wellness orientation. In such cases students may receive the message that the DSM is a “necessary evil” on the path to third party payment. They can be taught that the *DSM* is a tool like any other that can reflect “truth” but only partial truth. To encompass other types of truth in diagnosing clients, the standard *DSM 5*-axis diagnosis can be complemented by an Integral Diagnosis [named for Wilber’s (1995) integral model].

The approach to integral diagnosis outlined in this paper is one I have been working with in my psychopathology and differential diagnosis courses for the past five years. I became aware of the limits of traditional diagnoses while doing my post-doctoral work in various nursing home facilities. All clients receiving any type of psychotropic medication had to receive psychological evaluations and, if necessary, counseling services. Medicare and other third-party payers required *DSM* diagnoses when appropriate. One of the greatest challenges was differentiating depression, dementia, and mood symptoms due to medical conditions. While this work could be done with flow charts or decision trees related to DSM (e.g. First, Frances, & Pincus, 1995) even successful differentiation of these conditions did not address cultural, social, and profound phenomenological variables like awareness of imminent death.

One case particularly (the case of Alice documented in Ingersoll, 2000) demonstrated the shortcomings of the *DSM 5*-axis diagnosis. Alice met the *DSM*
criteria for Major Depressive Disorder, was recovering from a broken hip, and had recently been diagnosed with pancreatic cancer. Alice struggled with belief that those who suffered were being punished by God. For a good part of her life this belief was reinforced by a religious community with which she eventually severed ties. She worried that her treatment was causing economic hardship for family members helping with the cost. In addition, Alice had an out-of-body experience (OOB) and deathbed visions of a beloved uncle. Phenomenologically, these latter experiences were comforting and ego-syntonic for Alice but she did go through a period where she feared they meant she was losing her mind. Staff at the facility seemed unusually eager to explain these non-ordinary experiences as side effects of the cancer (even though she was in minimal pain and the cancer had not spread to her nervous system). While her financial concerns could easily be noted on axis IV (psychosocial stressors) the notation did not convey the complexity of her concerns nor was an axis IV notation adequate to describe her struggle with the religious belief system that was becoming too narrow in interpretation for her.

Shortly after the death of this client I had finished my first reading of *Sex, Ecology, Spirituality: The spirit of evolution* (Wilber, 1995) that introduced Wilber’s Integral Model. It was clear to me that aspects of Wilber’s Integral Model would have greatly expanded the diagnostic information relevant to Alice’s case. I came to conclude that an integral approach to diagnosis could complement the 5-axis DSM diagnosis in a manner that would better capture the complexity in a client’s life and decrease the risk of reducing that life to a monological, diagnostic label. In addition, I found that the Integral Model was a useful organizing framework for my psychopathology and differential diagnosis courses at the university.

**The Integral Model**

Wilber’s (1995) Integral model is dedicated to integrating body, mind, soul, and spirit in self, culture, and nature. The integral model tries to honor and integrate research from numerous disciplines including the natural sciences (physics, chemistry, biology, neurology, ecology), art, ethics, religion, psychology, politics, business, sociology, and spirituality (Shambhala, 2002). Wilber has stated that piecemeal approaches to solving problems or even exploring phenomena are inadequate particularly where human beings are involved (as they are in diagnosing psychopathology). Whether trying to understand human beings, the universe, or psychopathology, Wilber recommends using the integral model. He noted that, ideally, an integral exploration considers multiple levels of reality, multiple perspectives (represented by four quadrants), and multiple lines of development. The summary of the model for this paper is necessarily brief and incomplete and the interested reader is referred to Wilber (1995) for a deeper understanding of the model.

*The Integral Model and Levels of Reality*

The Integral Model is based in an evolutionary theory sometimes referred to as a “great chain of being theory.” In this portion of his theory, Wilber defined four
levels of reality (Physiosphere, Biosphere, Noosphere, Theosphere). In the order presented, each level builds on its predecessor as organisms of increasing depth unfold at each level. The physiosphere is referred to as the basic building blocks for physical matter—the mineral kingdom being an example. The biosphere encompasses the physiosphere and goes beyond it as physical matter that contains life like a plant or mammal. The noosphere encompasses the biosphere and physiosphere and goes beyond them as a life system that is aware of itself (like a human being). The theosphere is the realm of the ultimate source of life. This level is difficult to describe but encompasses and animates the previous three levels and goes further beyond them to include a transpersonal awareness of connection to the source of life. Wilber (1996) has noted that these levels of reality can be known through “three eyes.” The three “eyes” are metaphors for epistemological tools that we can “look through” to gather knowledge about clients. The “eye of flesh” is the eye that looks at the objective, measurable physiosphere and biosphere of the client. In looking at the case of Alice with the eye of flesh, we see a 79-year-old woman with fairly advanced pancreatic cancer, a broken hip, and the vegetative signs of depression. While the cancer would preclude a total “cure” for these conditions, they were being treated allopathically with medication.

The “eye of mind” is the eye that examines the hermeneutic meaning of the individual and the groups with which the individual identifies. Elements from the eye of mind require dialogue and cannot be discerned through simple observation. In engaging Alice with the eye of mind, I learned pertinent aspects of her history and the shared beliefs of the religious culture that became too narrow in interpretation for her. I also learned from her how the “culture” of the nursing home she resided in impacted her, as well as the morbid, fatalistic “culture” of the residents. These certainly appeared to contribute to her depression.

The “eye of spirit” is one of the more difficult concepts in Wilber’s model. He also refers to it as the eye of contemplation (Wilber, 1997) and as an epistemological tool, this “eye” allows us to experience transcendental knowledge. While one cannot use words as a boundary to define the knowledge this eye discloses, one can say that this knowledge is related to experiences of ultimate meaning and the client’s relationship to the source of life. In the case of Alice, her non-ordinary states (the OOB and the deathbed visions of her uncle) seemed to open this “eye” for her.

For a more commonplace example of how these levels may relate to a case, consider a client who suffers from Bipolar I disorder. This client constitutes a life system (biosphere) made up of elements from the physiosphere. Even though we have no laboratory evidence confirming that his symptoms derive from the physiosphere, by introducing other physiospheric elements (like lithium) into his bloodstream, we may have some success in reducing the symptoms of Bipolar I disorder. Certainly consideration of the client’s problem from one level is important but what of the other two levels? At the level of mind (noosphere) we must address how what goes on in the client’s mind may affect his symptom profile. As Wilber (1991) pointed out, we must examine how each level contributes to illness while recognizing there may be influences across levels. The client with Bipolar I Disorder may have a pervasive “eye of flesh” component predominantly responsible for his mood symptoms. That being said however, “eye of mind” variables like stressors,
difficulty in meaning-making, and resistance to regular sleep/wake patterns can significantly affect the manifestation of symptoms.

One view of the client’s situation from the “eye of spirit” addresses the ultimate meaning that may be experienced from life when one is dependent on rather severe medical interventions to maintain emotional balance. What implication does this have for the client’s development particularly for traversing the fulcrums between ego and trans-ego levels of development? Thus Wilber’s emphasis on levels of reality provides us with an expanded cartography for conceptualizing the client’s symptoms and not merely describing the symptoms that fit a diagnostic label.

**The Integral Model’s Four Quadrants or Perspectives**

Another aspect of Wilber’s work is a four-quadrant model that encompasses these levels of reality and provides different perspectives or types of information. This section of the paper is paraphrased from Wilber (1995, 1996, 1997, 2000a, 2000b). The four quadrants are summarized in Figure 1.

The four quadrants provide a more integral view of whatever is being examined. The right hand quadrants are more concerned with objective measurement, reflect the biosphere and physiosphere, and answer questions like “what does it do?” The left hand quadrants deal with interiors that, where human beings are concerned, require
dialogue and interpretation and reflect the noosphere and aspects of the theosphere. The left hand quadrants answer questions like “what does this mean to me/us?” The summary below elaborates on each quadrant and how each would relate to a hypothetical client.

**Upper Right Quadrant: The Objective Self Quadrant.** This quadrant uses they eye of flesh and “it” language (“what does it do?”) to examine the objective, measurable aspects of the individual (e.g. brain functions). This quadrant best represents the disease model in its search for objective facts related to the individual. This quadrant relies more on behavioral and physiological measures that can be gathered from a client through observation without the client ever saying a word (although it could include self-report measures). Examples of data gathered in this quadrant would be client’s blood pressure, non-verbal behaviors, levels of serotonin metabolites, and the amount of electrical activity in areas of the brain as shown on a brain scan.

**Upper Left Quadrant: The Subjective Self Quadrant.** This quadrant uses the eyes of mind and spirit and deals with the “insides” or subjective aspects of the individual. It uses “I” language to reflect the realm of the client’s subjective experience (e.g. “How do I feel, what do I mean?”). You can only learn about this subjective experience if the client shares with you and you, in turn, interpret accurately what the client shares. Material from this quadrant is the focus of most “talk therapies” and as Wilber (2000b) referred to it [summarizing Guntrip (1969)], it is the locus of personal meaning and values that are explored in counseling or psychotherapy. Examples of data gathered in this quadrant would be what it feels like to live the client’s life, how the client experiences life events and emotions, how the client views herself or himself.

**Lower Right Quadrant: The Objective Social Quadrant.** This quadrant uses the eye of flesh and “it” language (“what does it do?”) to examine the measurable, objective elements of groups (e.g. “society”) that impact the individual. This would include social systems like the criminal justice system, techno-economic modes of production and distribution (pharmaceuticals and who can afford them), and linguistic structures of a society. In turn, this quadrant outlines the objective aspects of the society into which the individual must “fit,” however it cannot examine the value of those aspects (whether they are “worth” fitting into).

**Lower Left Quadrant: The Subjective Social Quadrant.** This quadrant uses the eyes of mind and spirit and “we” language (“what do we value, what do we mean?”) to examine the shared worldviews, values, and meanings of the group. This is the quadrant that encompasses and examines culture in all its diverse phenomenological aspects. This would include shared communication, values, meaning, sense of purpose, etc. Where the Objective Social Quadrant measured the parameters of how individuals fit into the larger social structure, this quadrant examines whether or not a given structure is worth fitting into.

**Preventing Category Errors**

The importance of the four quadrants is that they preclude category errors (Wilber, 1995). A category error basically occurs when someone tries to explain all four
quadrants with only one. Examples include advocates of biological psychiatry who claim all things human (including meaning, values, and character) boil down to brain chemistry (the Objective Self Quadrant) or multiculturalists who insist that all things human boil down to culture (the Subjective Social Quadrant). This is not to say that these perspectives are wrong; just that they are partial. The biggest category error related to diagnosing mental and emotional disorders occurs when, framed by the perspective of the disease model, one tries to use the quadrant of the objective self to account for all aspects of the self. Wilber (2000b) has summarized how category errors are possible because each element in each quadrant has corresponding elements in the other three quadrants. For example a thought or feeling (Subjective Self Quadrant) registers a brain change in an EEG test (Objective Self Quadrant). While factually valid, the EEG cannot tell you what the thought or feeling was, how it relates to a client’s cultural worldview, or even if it was “caused by” the brain change. Wilber (1995; 2000b) has noted that trying to reduce the left hand quadrants to the right hand quadrants is meaningless because each quadrant discloses different types of truth that cannot be reduced to the others.

The Integral Approach: Lines of Development

A final component of the integral diagnostic approach is the notion that an integral view of a client considers the client’s various developmental levels. This means that of the myriad lines of human development, an integral view tries to include as many as possible. Wilber (2000a) noted that Western psychology has often over-emphasized cognitive development to the detriment of other lines of development of which he wrote that there are at least two dozen if not more (for example sexual, artistic, moral, spiritual, affective, ego, interpersonal, etc.). Although space does not permit a full treatment of this aspect of the model, the reader is referred to Wilber (1997). The following case illustrates what I am calling the “Integral Approach,” an application of Wilber’s Integral Model to the diagnostic process.

CASE EXAMPLE OF AN INTEGRAL DIAGNOSIS

Katie is a 29-year-old, Caucasian, mother of three children (ages 3, 4, and 6). She identifies as an Evangelical Christian (meaning a belief in the historicity and general inerrancy of scripture, the exclusive Divinity of Jesus of Nazareth and a Calvinist emphasis on personal conversion). This client was originally seen at an agency for financial counseling and was subsequently referred for personal counseling. She stated that she had been “wrestling with strong demons” and said she had been meeting with her pastor about them. The “demons” were feelings of fear about the future, her children’s welfare, and her husband’s drinking problem. Her husband had been drinking heavily (for him) every night and becoming sullen and distant. Katie thought he was drinking because of their financial problems but also feared he drinks because she is not as good a wife as she should be. Her husband had snapped at her verbally several times a week—also uncharacteristic of him.

Katie discussed times when she felt “attacked” and was beset with heart palpitations, sweating, chest pain and nausea, and a frightening feeling that she was
going crazy. She had four such attacks in the 3 months prior the evaluation. She said she constantly worried about having these attacks and that they were going to really cause her to go crazy. When they occurred, she said she felt as if the devil had her in his grip and was crushing her chest. As a result of the attacks she started seeing her pastor for counseling and had tripled her prayer time. She was dismayed that she still had the attacks despite her prayer and was growing increasingly despondent because she was starting to doubt her religious convictions since her prayer time had not resulted in any appreciable lessening of symptoms. In her religious faith community, traditional gender roles were the norm and she felt that her husband’s behavior may have been her fault.

She agreed to let the therapist speak with her pastor and he noted that Katie’s life was stressful and he hoped that their sessions gave her comfort and some ways to access the power of the Spirit to help her. He noted that she didn’t seem to feel any better in the two months since she has been seeing him. He stated that he was glad she was seeking additional help. Katie was relieved that her pastor supported her work in counseling as she felt that her anxiety was interfering with her ability to perform daily tasks. Because of increasingly pervasive religious doubts, she was also ambiguous about her pastor’s ability to help her with her problems. Katie had no history of mental health interventions, and her physician had confirmed that she also suffered from Irritable Bowel Syndrome. She had no medical disorders that would mimic anxiety and there was no evidence of any drug use/abuse. In the third session with Katie she revealed an experience late one night when she was up worrying about the family’s problems. She said she was suddenly “overwhelmed” by a sense of peace. For about an hour she said she felt on the one hand as if she were merely watching her fears like they were someone else’s but that she didn’t feel “numb” to them. She said she thought it might be a state of grace but had no sense of Jesus or God or herself for that matter. While one counselor suggested she was dissociating due to stress, Katie felt there was something more to the experience. It has not repeated yet.

**Standard DSM Diagnosis of Katie**

The standard five-axis diagnosis for Katie was:

- **Axis I:** 300.01 Panic Disorder Without Agoraphobia  
  R/O V62.89 Religious or Spiritual Problem
- **Axis II:** V71.09 No Diagnosis on Axis II
- **Axis III:** 564.1 Irritable Bowel Syndrome
- **Axis IV:** husband’s drinking problem
- **Axis V:** 58

**Complementary Integral Diagnosis Related to the Quadrants**

*Objective Self Quadrant.* Katie is clearly suffering from many physiological symptoms of anxiety given the confirmation from her physician that she is otherwise healthy. Her behavior of increasing her prayer time is a logical response given her
worldview which, however, may cause distress depending upon her expectations and subsequent results. She also has the diagnosis of an irritable bowel syndrome. One important aspect of the treatment must be to decrease the frequency and intensity of the panic attacks and objectively measure these to assess the effectiveness of treatment as it progresses.

Subjective Self Quadrant. Katie feels like she is being persecuted by demons – a construct that makes sense and generates more anxiety in her worldview. She harbors some apprehension about secular counseling. She fears that she is losing her mind and her faith all at once. She also is questioning her worth as a woman related to her husband’s alcohol problem. Katie must use the therapeutic dialogue to explore new understandings of herself, her values, and her sense of the resources she will need to cope with her life circumstances. The one night when Katie describes the experience of being “at peace” has qualities that sound like a breakthrough to what Wilber (2000a, 2000b) has referred to as the psychic level of development. This experience should be explored more fully in relationship to Katie’s relevant developmental levels.

Subjective Social Quadrant. Katie has grown up with an Evangelical Christian worldview and has derived support from her faith and faith community. Her faith tradition has, however, supported her sense of the primacy of family and the current problems with her family have religious as well as interpersonal significance for her. Further, developmentally Katie may have grown beyond aspects of her literalistic understanding of her faith tradition (e.g., the righteous are rewarded, the wicked are punished) and that may require some attention from her pastor and maybe the counselor working with her.

Objective Social Quadrant. The church and the fiscal institutions of society are impinging on Katie the most right now. She is beset with phone calls from collection agencies and feels shame in response to these interactions. While she understands there are bankruptcy laws in place that may offer one solution to her family’s debt, her shared worldview from the Subjective Social Quadrant does not affirm the use of them. She seeks comfort and control through the rituals of her church but has not experienced that control. She feels dissonance about her place in her church community and is not sure how she fits in that community right now. One might also say the institutions that support traditional gender roles are impinging on Katie if only indirectly. Katie must develop strategies that help her cope with the pressure of her creditors as well as make a decision about where she fits in her faith community.

Complementary Integral Diagnosis Related to the Three Eyes

From the Eye of Flesh, ruling out medical conditions that may mimic anxiety was the most important consideration here but understanding the physical symptoms is important. The objective signs tell us that Katie’s predominant “style” of anxiety symptom is physical and this informs the shape the intervention will take. Understanding the effects of alcohol on her husband (likely negative effects on his mood and behavior) figure indirectly. The irritable bowel syndrome is probably
not unrelated as it may be exacerbated by the stress and anxiety the client is experiencing.

From the Eye of Mind, Katie’s reported distress is remarkable. She is experiencing self-defeating and other irrational thoughts that may be targeted in cognitive therapy. She is also experiencing doubts about her faith that are having a strong emotional impact on her (in addition to her other worries). These may in fact be adding to her anxiety response. It was also important to explore the moment of “peace” Katie reported, as mentioned in the Subjective Self Quadrant. If it was a breakthrough to the psychic level, it is important to know how (if at all) this may have been the result of her prayer practice.

Eye of Spirit: There are clearly religious elements that may be described under “eye of mind;” however, there is a transcendent worldview that may be used to assist the client—if only in the existential sense—to make meaning and persevere through treatment. The client’s pastor assessed her prayer ritual and worked with the client to deepen her understanding of prayer (beyond the petitionary) to a more contemplative style that aided in decreasing her anxiety. The pastor understood some of the history of mystical practice in the Christian tradition and was very encouraging about prayer practices that went beyond the petitionary.

**Complementary Integral Diagnosis Related to Developmental Lines**

The type of developmental assessment recommended by Wilber (1997) would summarize Katie’s level of cognitive, moral, and psychosexual development. More importantly would be to assess her religious or faith development in deciding whether or not to rule out a Religious or Spiritual Problem. Fowler’s (1981) stages of faith development could be an appropriate tool for this task. In addition, Wilber (1984) outlined the transitive versus transformational dimensions of religion. Whereas the transitive dimension helps a person as a separate ego make sense of the world, the transformational dimension helps the person transcend (and include) the ego and go to the next level of translation and, ultimately, to the experience of the world from the perspective of the non-dual one. Katie’s problems with her current mode of translation (her religion) may also be beckoning for a transformation to the next level for her.

**SUMMARY: THE INTEGRAL APPROACH AS TEACHING TOOL**

For some therapists with a transpersonal orientation and years of experience in complementing the standard DSM diagnosis, this exercise in integral diagnosis may be redundant. However, with students just learning the DSM, the integral diagnosis helps them keep the whole client in their awareness and avoid the temptation of committing the category error of reducing every aspect of the client to a narrow and inadequate medical model. In addition, using the model with students in internship reminds them of the responsibility the counselor has to derive as full an understanding as possible of their clients and their potential in the spectrum of human development.
In addition to using the integral model to supplement conventional diagnosis, the model can be used to help students think critically about DSM. For example, the four quadrants provide four different views of mental health professional associations like the American Psychiatric Association (APA) that publishes DSM (MacCluskie & Ingersoll, 2001). From the Objective Social Quadrant students will note how much money APA makes through the DSM. From the Subjective Social Quadrant students can study the power that groups in our society, via their shared worldview, attribute to psychiatry and medicine in general. From the Subjective Self Quadrant, students can study how different diagnosing professionals feel about the DSM in general. Finally from the Objective Self Quadrant, students can study how diagnostic labels are applied differentially in ways that correlate with client demographics. All of these enrich the student’s understanding of what DSM can and cannot offer.

The lobbying power of medical groups and the tremendous influence of the DSM (deserved or not) make it likely that the format of the DSM, and the underlying medical model of mental and emotional disorders, will be with us for a long while. As long as clinicians remember that the “truths” of the DSM and the medical model are only partial truths, clients will be better served. Complementary systems of diagnosis, like this Integral Approach, can help clinicians in training and practice think more globally about cases. In thinking globally, truths are honored from different domains increasing the usefulness of the diagnosis and the clinical interventions.

REFERENCES


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