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An Integral Perspective on Depression

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The integral approach to therapy proposes to accommodate all the etiological factors of unipolar depression in its theory, as well as to make use of all existing therapies, both pharmacological and psychological, in the treatment of unipolar depression. Integral Therapy is compared to cognitive therapy to find evidence for its superiority over the cognitive approach. It appears that the cognitive therapy is more cost-effective than Integral Therapy as an individual approach in the treatment of depression, but that the integral perspective accounts better for etiological factors.

Introduction

Depression is the most widespread mental disorder, and in 1999 as many as 1 in 20 Americans were severely depressed (Satcher, 1999). Every year, about 6 million people suffer from depression in the U.S., with a cost of more than 16 billion dollars; 60% of suicides have their roots in major depression, and 15% of patients admitted for depression to a psychiatric hospital kill themselves (Nierenberg, 2001). The recovery rate from major depressive disorder (MDD) is as follows: 50% of those who had a major depressive episode and recovered will never experience a new episode; while 40% will have MDD recurrence in the future, and 10% will never recover and will experience a chronic depression (Passer & Smith, 2001).

Depression is perhaps the most researched mental disorder. Street et al. (1999) list more than 27 theories of depression and 99 factors that contribute to its onset and maintenance. Of the 27 theories, none is able to accommodate all these factors. The classical ones have concentrated only on some of them, often getting in conflict with other theories that emphasised other factors, and thus giving rise to an unfortunate competition for the "truth."

Today we see in the U.S. a real battle between pharmacotherapy and psychotherapy in claiming full rights in the treatment of MDD. The psychotherapy quarter seems to be losing ground because of the problem of funding research, while the pharmacology quarter is obviously supported by large grants from the pharmaceutical industry. The double-blind pharmacology studies on MDD have all been criticised, because they are not really double-blind, since during the trials the subjects come to realize whether they have placebo or not. Because of the pressure from medical insurance companies, psychotherapies have been urged to develop short-duration therapies that can be quantified, and today the field has developed a new approach, the so-called evidence-validated therapies (EVT), proposing that only those therapies that have a research-based evidence should be considered. However, the benefits of EVT over the other therapies have been questioned (Lampropoulos, 2000; Henry, 1998; Garfield, 1996).

For the time being, there are only two therapies that are recommended by the American Psychiatric Association (APA) for the treatment of MDD based on research evidence: namely, cognitive therapy (CT) and interpersonal therapy (IPT) (American Psychiatric Association, 1993). The question which remains is what shall be the fate of the 200 or more existing psychotherapies (Bohart et al., 1998; Chambless et al., 1998) that may work as well as CT and IPT, but for the time being don't seem to have the "credentials" from research. Some of them, such as psychoanalysis and some humanistic psychotherapies, may prove impossible to quantify using a research setting, and in the end they may prove "too long and expensive" for the health insurance companies.

Given this growing problem for today's psychotherapies, it is indeed "unreasonable" to propose a new therapy, which may prove even longer in achieving results and even more difficult to be tested in an experimental setting. And it is a problem for the present paper, meant to introduce a new form of therapy for MDD, Integral Therapy (IT).

Psychotherapy integration has long been an ideal

for many psychotherapists dreaming of an overall framework with a theory endorsing specific therapy techniques. Efforts for an integration of different theories were first made in 1936 by trying to combine psychoanalytic and behavioral approaches, in order "to combine the vitality of psychoanalysis, the rigor of the natural science laboratory, and the facts of culture" (Wachtel & Messer, 1998, p. 231). Surveys have found that between 30% and 65% of interviewed psychotherapists identified themselves as eclectic (Norcross & Goldfried, 1992). But there are big differences. Whereas the eclectic perspective is just borrowing freely from the classical schools and just chooses from the existing therapies, the integral perspective tries to create an umbrella that may accommodate all existing factors and therapies, as well as combine different therapies (Jensen et al., 1990). The integral approach tries to create something new, unifying the parts, while the eclectic approach is just applying the parts of what there is.

Today there are three popular pathways toward the integration of psychotherapies: technical eclecticism, theoretical integration, and common factors. The main aim is to increase therapeutic efficacy and efficiency by looking beyond the boundaries of single theories and restricted techniques.

Technical eclecticism seeks to select the best treatment for the person and the problem. It draws its techniques from a large number of different systems of psychotherapy, which may be epistemologically or ontologically incompatible.

Theoretical integration seeks to integrate two or more therapies, hoping that the resulting therapy may be better than each constituent therapy alone. The emergent theory is more than the sum of its parts. There are several examples of efforts meant to integrate two therapies: psychoanalysis and behavior therapy (Wachtel, 1997), humanistic and behavioral therapies (Wandersman et al., 1976), family/systems therapies, biological and individual therapies (Pinsof, 1995), incorporating interpersonal factors in cognitive therapy (Safran & Segal, 1990), or integrating multiple therapies such as the integrative psychodynamic therapy which combines psychodynamic, behavioral, and family systems theory (Wachtel & McKinney, 1992), and the transtheoretical approach, which integrates the major therapy systems (Prochaska & DiClemente, 1992).

The ***common-factors approach*** seeks to identify similarities and core ingredients of different therapies, and to propose a more parsimonious and more efficacious therapy. The common factors present in all genuine psychotherapies are: a positive therapeutic alliance, a supportive relationship, genuine interest in the client's problem, authenticity, warmth, empathy, openness, unconditional love, arousing hope and positive expectations in the client, the client's emotional involvement in the therapy, encouraging new ways in the client to understand oneself and one's problems, and generating new patterns of activity outside the therapy session (Norcross & Goldfried, 1992).

A common-factors therapy for depression has been proposed by Arkowitz (1992), emphasising one basic factor, lack of social support, as the main cause of depression. He argues that there have been no significant differences between different treatments for depression (Robinson et al., 1990, Elkin et al., 1989), and that common factors are responsible for the outcome of the treatment. Lambert et al. (1986) found that the common factors are responsible for some 40% of the therapy outcome, specific techniques for only about 15%, expectancy (placebo effects) for another 15%, and extratherapeutic change for maybe 30%.

We also have an integrative therapy that combines pharmacotherapy and psychotherapy (Beitman & Klerman, 1991).

Finally, the last development on the integrative front is Integral Psychology (IP) as proposed by Ken Wilber (2000a), which sets out a master template theory that can accommodate 100 psychological models, using freely all possible therapeutic interventions and weighing their strength according to the master template theory.

The aim of the present study is to compare the theoretical and therapeutic virtues of Integral Therapy (IT) and cognitive therapy (CT) (Beck et al., 1979).

The Study's Questions

In this paper we shall look more closely at the virtues of IT in the understanding and accommodation of multifactorial causes for unipolar depression. Further, we shall look at the capacity of IT to use freely, in an integral perspective, from all existing therapies, either alone or in combination, to better serve the particular needs of the client in prevention and treatment, and against recurrence of major depressive episodes. IT will then be compared to an established, empirically validated therapy, cognitive therapy (CT), in order to

identify its strengths and weaknesses. To this effect, we have formulated two separate questions: (1) Does IT provide a better understanding than CT of the multifactorial causes of unipolar depression, accommodating all the factors into a coherent theory of depression? (2) Does IT provide a better therapeutic offer than CT for preventing the first onset of the MDD, treating, and preventing recurrence? In order to answer these questions a literature search has been undertaken.

Nature of the Disorder

Depression is primarily a disorder of mood, characterized by cognitive, motivational, and somatic (physical) symptoms. Emotional symptoms include sadness, hopelessness, misery, loss of pleasure, dysphoric mood, affective emptiness, and depersonalisation. Cognitive symptoms can be briefly described as negative cognitions about self, the world, and the future. More specifically, cognitive symptoms are the following: thoughts focused toward the past, followed by intense regret; feelings of worthlessness; poor concentration; intense rumination; diminished locus of control; magnification; minimisation; absolutistic thinking; confirmatory biases; and the utilisation of the availability heuristic (Clark et al., 1999). Common motivational symptoms are loss of interest, loss of interest in others and social relationships, lack of drive, and difficulty starting anything. Somatic symptoms are loss of appetite, lack of energy, sleep difficulties, weight loss or gain, somatic preoccupation, and psychomotor retardation with fatigue.

Unipolar depression is a kind of depression where the individual experiences only the above symptoms, without mania, distinguishing it from bipolar depression. To diagnose MDD, according to DSM-IV-TR, the subject must report five of the following nine symptoms in the last two weeks: depressed mood and feeling sad; markedly diminished interest or pleasure in almost all activities; significant weight loss or weight gain; insomnia or hypersomnia; psychomotor agitation or retardation; fatigue or loss of energy; feelings of worthlessness or excessive or inappropriate guilt; diminished ability to think and concentrate, or indecisiveness and recurrent thoughts of death or recurrent suicidal ideation (APA, 2000).

Etiology

Several causes have been proposed as the origin of depression, such as: personality and intrapsychical causes (Millon, 1996; Bowlby, 2000), personal vulnerability (Vrasti & Eisemann, 1995), genetic causes (Barondes, 1999), sex differences (Nolen-Hoeksema, 1990), interpersonal causes (Joiner & Coyne, 1999; Brown & Harris, 1979; Hammen,1991), avoidant coping strategies (Chan, 1995; DeLongis, 2000), culture (Manson, 1994; Culbertson, 1997), learned helplessness (Seligman & Isaacowitz, 2000), and environmental causes (Nezlek et al., 2000; Tseng et al., 1990).

Different therapies have considered only some of the possible etiologies, because of limitations of the theory or out of ideological reasons, leaving unaddressed all the rest. There are theories emphasising some factors while ignoring others: biological psychology emphasises brain structures and chemical imbalances in the brain; behavioural theories emphasise inappropriate behaviours (Wolpe, 1982); cognitive theories emphasise maladaptive cognitive processes (Kovaks & Beck, 1978); social psychology emphasises the importance of relationships, life events and chronic stressors (Brown & Harris, 1979); self-psychology emphasises personal needs and desires (Arieti & Bemporad, 1980); psychoanalysis believes in early negative experiences as the origin of maladaptive coping mechanisms (early loss giving rise to anger directed inward) (Freud, 1959); attachment theory emphasises early interpersonal conflicts (Bowlby, 1977); attributional style theory emphasises the role of making wrong attributions about the outcome of events; and, finally, the helplessness theory emphasises the role of learning helplessness throughout one's life (Alloy et al., 1988).

One of the best models to date proposes that personal vulnerability to depression is determined by a combination of biological, psychological, and social variables (Eisemann & Vrasti, 1995), but it fails to include the developmental levels and lines of the patient (Wilber, 2000b).

Notable efforts have been made by Street et al. (1999), who tried to integrate 27 theories of depression. They found 99 psychological factors that can cause the onset of depression, leaving out other theoretical approaches such as biological and sociopolitical ones. They proposed that an individual vulnerable to depression might interact with the environment in certain maladaptive ways, resulting in the formation of a

negative view of the self, the environment and the future, and in the occurrence of the depressive symptomatology.

Four fundamental dimensions have been identified, each designated by a cluster of factors.

The ***cognitive-bias dimension*** proposes that information is processed selectively by the individual, thus contributing to the creation of a negative view of self and negative self-schemata. These two are involved in the etiology and maintenance of depression.

The second dimension is *the* ***lack of positive reinforcement for the self,*** resulting from the individual's maladaptive social behaviours and pursuit of unrealistic social goals.

Lack of social support and interaction is the third dimension, which has two aspects, a cognitive one and a behavioural one: for the cognitive one, the individuals are unable to express their own thoughts and feelings and to monitor those of others; for the behavioural one, individuals behaving in socially undesirable ways have deficits in social skills and lack social relationships and/or a network of contacts and support.

The fourth dimension proposes the importance of ***goal pursuit and achievement*** and indicates that a failure to achieve goals affects self-esteem, which may give rise to depression. It is also stressed that inappropriate or unachievable goals may have the same impact on self-esteem. Finally, four negative beliefs have been found that contribute to the onset of depression: negative self-view, worthlessness, loneliness, and failure.

In the effort better to serve the needs of those who do not benefit from one therapy alone, an eclectic and integral perspective has developed. IT has come into being to address all the different factors of depression and accommodate them in a comprehensive theory to be used in the process of choosing a treatment.

Prevention and Treatment

Unfortunately, very little research in preventing the onset of depression has been done, showing the current widespread interest in treating rather than preventing (Munoz et al., 1996). One researcher found several measures that may prevent the onset of depression: prevention of childhood abuse and racism, relief from economic hardships, early diagnosis, and safe, effective treatment (Poslusny, 2000).

Treatment for MDD currently uses drugs, drugs in combination with psychotherapy, electroconvulsive therapy (ECT) (Rey & Walter, 1997; Petit et al., 2001), vagus nerve stimulation, or with transcranial magnetic stimulation (TMS) (Boutros et al. 2001, Wassermann & Evans 2001). Treatment of depression either with drugs or with psychotherapy (DeRubeis et al., 1999; Hollon, 1996) has been the subject of a hard dispute between the biological and the psychological perspective. But now, any such ideologically motivated perspectives no longer have a place in choosing the right therapy for any given individual (Weismann, 2001).

What are the best therapies for MDD? Antidepressants are effective in approximately 70% of cases with MDD and there are today more than two dozen drugs with seven distinct mechanisms of action (Manning & Frances, 1990). Both pharmacotherapy and psychotherapy are available to treat MDD, and often the treatment is a combination of the two (Blatt et al., 2000). In Norway, at a Consensus Conference in 1999, American publications on the effects of drugs were criticised as being biased by selective publishing and by the economic interests of the big drug companies. The general consensus was that there appeared to be very little effect from recommended drugs such as TCA, SSRI, MAO and RIMA, and that psychotherapies like CT, cognitive-behavioral therapy (CTB), and interpersonal therapy (IPT) were recommended for treating MDD.

Cognitive Therapy for Depression

Today we have a couple of dozen cognitive therapies, but in this paper we shall consider in depth only Beck's cognitive therapy (CT) (Beck, 1967), while mentioning Ellis's rational-emotive therapy (Ellis & Dryden, 1987), covering the two most important figures in cognitive therapy. Both Beck and Ellis consider the person as a biosocial organism and the basic unit for analysis and therapeutic interventions. They believe in individual differences in biological functioning, proposing that psychopathology is a result of innate vulnerabilities or biological tendencies to either over- or under-react to environmental influences. In their view, depression is seen as the result of predisposing factors, such as heredity and physical disease leading to neurochemical abnormalities, and of precipitating factors, such as physical disease and chronic or acute stress. Cognitive therapy emphasises psychological functioning as the main area of interest,

saying that human functioning is organised and regulated primarily by cognitive processes. Beck and Ellis see healthy people as good scientists who gather rational empirical data, formulate hypotheses, and test them. In contrast, malfunctioning people deviate from these principles, are irrational, illogical, distorted, overgeneralised, and absolutistic, and display inadequate reality testing for their beliefs.

Beck proposes that negative beliefs and dysfunctional, maladaptive processing of information are at the origins of depression. The latter sets in when negative self-schemata are activated by current circumstances. Self-schemata are cognitive structures that can be viewed as sets of rules, standard strategies that individuals use subconsciously to evaluate and control their behaviours. Negative schemata are developed in childhood due to repeated negative experiences of deprivation, loss, or death of a loved one. Circumstances analogous to those when the schema was created can activate negative schemata, which are usually inactive. The activation of a negative schema causes dysfunctional, biased processing of information toward schema-consistent information and systematic cognitive errors. Negative self-schemata manifest in consciousness as automatic thoughts, which can take the form of the depressive cognitive triad: negative opinions about oneself, about the ongoing experience, and about the future.

Negative automatic thoughts result from processing errors through which perceptions and interpretations are distorted. They include many errors in logic, such as overgeneralisation (making judgements based on a single experience), selective abstraction (attending only negative aspects of the experience), dichotomous reasoning (thinking in extremes), personalisation (taking personal responsibility for events), arbitrary inference (jumping to conclusions on the basis of inadequate evidence), magnification (exaggerating personal small faults), and minimisation (reducing the importance of personal successes).

In addition to errors in logic, depressed people also make six depressogenic assumptions on which they base their life:

1) In order to be happy, I must be successful in everything I do.
2) To be happy, I must be accepted by all people at all times.
3) If I make a mistake it means I am inept.
4) I can't live without love.
5) If somebody disagrees with me, it means he or she doesn't like me.
6) My value as a person depends on what others think of me.

Depression is also seen as being caused by a depressive attributional style and learned helplessness (Seligman, 1975). Depressed people interpret success and positive events as due to external factors, while attributing failure and negative events to internal ones. Failing to take credit for success and blaming themselves for failure and feeling guilty and worthless, they lower their self-esteem, thus maintaining their depression. Three dimensions of causal attributions have been proposed: internal-external, stable-unstable, and global-specific.

Depression is also seen as the result of making internal, stable, and global attributions for negative events (Abramson et al., 1978). Learned helplessness theory proposes that, due to earlier repeated experiences involving bad events that one could do nothing to prevent or escape, one learned that nothing can be done, and thus feels helpless, hopeless, and finally depressed (Seligman, 1975; Seligman & Isakowitz, 2000).

The goal of cognitive therapy (CT) is to identify automatic thoughts and modify or restructure them in order to help the client to develop and use more functional patterns of thought, emotion, and behaviour. The therapist teaches clients to revise dysfunctional schemata and faulty information-processing by reality testing of automatic thoughts, reattribution training, and changing depressogenic assumptions. Reattribution training implies teaching the client to change the attribution for failure from internal, stable, and global to external, unstable, and specific explanations (Ellis & Dryden, 1987).

In CT, the therapist is seen as having much of a teacher role, teaching his or her client to identify, challenge and test the automatic thoughts and depressogenic assumptions. The therapist may use different techniques, such as verbal challenging of the negative thoughts and dysfunctional assumptions, or assigning behavioural experiments for a reality test of these thoughts and beliefs. CT is a time-limited therapy, usually not extending beyond 20 sessions for treating MDD, and today there is a solid evidence for its effects from a number of studies. Some 28 metaanalytic studies for unipolar depression showed CT to be better than pharmacotherapy, behaviour therapy, and other therapies, as well as the wait-list condition (Dobson,

1989). Research has shown differential relapse following CT and pharmacotherapy for depression, with the greater relapse being after pharmacotherapy (Evans et al., 1992). The problem of matching patients to cognitive and interpersonal therapies in research programs has been an important factor for the outcome of the therapy (Barber & Muenz, 1996).

The CT field is in continuous expansion and one of the latest developments is the cognitive-interpersonal approach (Safran & Segal, 1990), which criticizes Beck's view as too reliant on an informational processing model. Safran and Segal stress the need to study people from an ecological perspective, pointing out that cognitive structures develop in relation to other people. They propose interpersonal schemata to be added to self-schemata for a thorough understanding of the person. Interpersonal schemata are cognitive representations of interpersonal events created by the person out of the need of relatedness to significant others in order to maintain these relationships. The interpersonal schemata have a functional utility and include cognitive, affective, and interpersonal components. Some authors regard this new development as an integration of CT with interpersonal therapy (Norcross & Goldfried, 1992).

There have been some criticisms about Beck's description of schemata, because its vagueness and imprecision make it inadequate for testing and verification (Mahoney, 1995). Cognitive theory says little about developmental issues and the impact of environment on individual development. Now some efforts have been made to address the role of affect and interpersonal relations in the negative self-schema (Safran & Greenberg, 1991).

A new development in CT is its combination with mindfulness, namely the Mindfulness-based Cognitive therapy, that is used mostly as a cost-efficient group preventive program for major depressive disorders (MDD) (Teasdale, 1999).

Overall, CT is very effective in treating depression (Blackburn et al., 1986) and it is one of the two evidence-validated therapies recommended by the American Psychiatric Association (1993) for the treatment of MDD.

Integral Psychology

Integral Psychology (IP) is a vigorous attempt to change the memetic perspective (Price 1999) of current psychology by proposing a new meme of looking at psychopathology and treatment. Integral psychology has risen to unify many of the existing psychological, biological, social, and environmental theories, from both East and West, into a master theoretical template that may serve as a sound basis for research and treatment in the new millennium.

The IP theory has been created by Ken Wilber, an American seen by some as the Einstein of consciousness (Ingram, 1987), because of his integration of more than 100 psychological models, East and West (Wilber, 2000a). Wilber is the only psychologist who has his collected works published while alive. Currently he is leading his private Integral Institute with more than 300 respected scientists working together in a new, integral way of doing research.

Integral Therapy (IT) is both a perspective for looking at causes and treatments of mental problems and a particular therapy, which tries to address "all quadrants, all levels, all lines" (4 dimensions of the Kosmos, 10 levels of development, and 30 lines of development) of the person. Today we know too much from so many sciences to ignore all the factors that may contribute to the MDD, and it is IT that has the capacity of integrating all of them into a master template. IT is not an eclectic approach either in theory or in practice, but is in its own right both a theory and a therapy that integrates all existing therapies, following a careful logic based on the perspective of treating the whole person, "all quadrants, all levels, all lines." IP can be seen as an ecological psychology, which takes into consideration the person-in-context, as its primary unit of analysis. This approach contrasts with cognitive therapy, which concentrates mostly on the psychological side of the person, while considering the importance of biological and social factors.

The Four Dimensions of the Individual

The human being is seen in Integral Therapy as a bio-psycho-social system that has an individual existence; and also is part of a collective existence. Any individual has two dimensions: an interior and an exterior existence, or better said, a subjective life open to introspection and phenomenological research, and

an objective life open to scientific investigation. The collective also has two dimensions: an interior domain created by the intersubjective contact between individuals, and an exterior domain that consists of the interobjective relations between the material entities. Wilber (1999) has named these four dimensions that define any person the four dimensions or quadrants of the Kosmos. Kosmos contains the physical and the spiritual dimension of the universe.

The Kosmos is made by holons, which are organised in hierarchies, so that higher holons enfold and include the previous ones. All holons have a quasi-independent life, living their own life while at the same time being an integrated part of a higher holon. Finally, every holon has its own four quadrants that evolve together with it. A short description of the four quadrants follows.

The ***Upper Left Quadrant*** is the individual's interior dimension, involving the psychic dimension, soul and Spirit. The right investigation method here is a phenomenology that may describe qualitatively the subjective experiences of the person.

The ***Upper Right Quadrant*** is the individual's exterior dimension, composed by the body with its brain. The right investigation method here is the scientific method, which may describe quantitatively the physical changes of the body and brain. Between these two dimensions there is a close relationship, so that any change in one dimension produces an effect on the other, for example any thought involves an accompanying emotion and a specific brain wave.

The ***Lower Left Quadrant*** is the collective interior dimension; it is characterized by intersubjective relations between people and nations, and is the public domain of culture.

The ***Lower Right Quadrant*** is the collective external dimension; it is characterized by interobjective relations between physical objects, and is the home of nature and the environment, with its political structures.

Any modification in any of the four quadrants gives a reaction in the other three, so the causes of pathology and the treatment of depression must consider all the quadrants equally. Any change in any of the individual, collective, biological, psychological, social, or environmental dimensions has a direct influence on the other parts of the system, setting the coping skills of the person to trial.

Cognitive theory considers only the first two quadrants as important in understanding and treating depression; interpersonal theory stretches out to cover also the third quadrant, stressing the importance of relations between people, while integral theory covers all the four quadrants.

The Notion of Self in Integral Therapy

The self concept is a key one in Integral Psychology, where it is not seen as a monolithic entity but rather as a collection of lesser selves, composed by various subpersonalities and different modules of development—cognitive, emotional, social, spiritual, moral, and so forth (Rowan 1993). A subpersonality may develop when, following a childhood trauma, a part of the existing self has defensively split off, with which consciousness remains identified. The subpersonality endures over time and maintains all the characteristics of the personality at the moment the split occurred, usually characterized by specific age needs, desires and impulses. The subpersonality does not develop further and lives its own life, at a conscious, subconscious, or unconscious level of awareness.

The feeling of a unique self is given by the integrative function of the overall self who tries to unite all the subpersonalities and different cognitive modules in a cohesive entity.

The self is seen to also have several other functions, such as cognition, will, caring for others, justice in relationships with others, aesthetic apprehension, metabolism (metabolizing the experience to build structures), integration (integrating the function, needs, states, waves and streams of consciousness) (Wilber, 2000b).

The self also evolves through identification with higher levels of the Kosmos, following a Piagetian stage–like development of a constant process of embedding in the proximal level and then disembedding, and transcending that level for further development.

The development of self can be stopped by childhood trauma, such as depression produced by the loss of a loved one in the early stages of development, the preconventional stages, which may create a split in the self. This creates a subpersonality that is characterized by preconventional impulses and needs, impulsivity, narcissism, egocentricity, moral stage one, and an archaic worldview. While the subpersonality stops its development and endures over time as a distinct entity,

the main part of the self continues to develop. This split in development between the subpersonality and the main self creates tensions in the integrative function of the overall self, which may result in psychopathology.

The psychopathology of the self is then this internal conflict between the main part of the self-system and the subpersonalities, which are at different levels of development (each with its own needs, wishes, worldviews, morals, and so forth). The goal of therapy of the self-system is to end these internal conflicts and achieve a horizontal as well as vertical integration of the various self structures. IT acknowledges the existence of defenses of the self, and for therapy it is important to identify the level of defenses, so that if these are not adequate for the present level of development, they may be changed, allowing the self to release the internal tensions caused by the incompatibility of the level of defenses with the level of self-development (Wilber 2000a).

Developmental Lines or Streams of the Self

Psychological development is seen in IP as a parallel development of several lines, which may develop independently but nevertheless are held together by the integrative function of the self. Because of the quasi-independent characteristics of the developmental streams, disjunctions and tensions occur, causing possible psychopathology. Wilber (2000d) identified around 30 lines of human development, the most important being sense-identity, defense mechanisms, interpersonal development, affects/emotions, needs, morals, and worldviews.

Developmental lines included in the Upper Left Quadrant (subjective components) are self-identity, affects/emotions, needs (Maslow's hierarchy of needs), and the like; those in the Lower Left Quadrant (intersubjective components) are worldviews, linguistics, aesthetics; those of the Upper Right Quadrant (objective components) are exterior cognition and scientific cognition; and those of the Lower Right Quadrant (inter-objective components) are sociopolitical and environmental structures.

The most important lines or streams responsible for vulnerability to depression may be the undeveloped or arrested lines of development in the Upper Left Quadrant, such as cognition, morals, self-identity, psychosexuality, self-integration, religious faith, affects/emotions, needs, worldviews, gender identity, and defense mechanisms. Some of the Lower Left Quadrant–oriented developmental lines or streams, such as socioemotional capacity, communicative competence, interpersonal capacity, role taking, and empathy, if they have an arrested development, may be responsible for vulnerability to depression. These modules or streams tend to develop in a relatively independent fashion and each needs a careful development if the self is to function to its fullest capacity and to avoid the onset of depression.

Different societies have emphasised different developmental lines, and we may find a huge variation even within the same society, so that we may not yet have a clear consensus about which are the most important and desirable lines of development. Howard Gardner (1985) has demonstrated the existence of multiple intelligences, which has ended the monopoly of the IQ as the only measure of human intelligence. For example, a person may have a high IQ, but be underdeveloped emotionally, morally, spiritually, and interpersonally.

None of these developmental streams can finally be separated from the others, but each tends to be oriented toward a particular quadrant. Cognitive therapy is concentrated mostly on the cognitive modules from the Upper Left and Upper Right Quadrant, giving little importance to the affective, social relationship, and communication modules.

Developmental Levels or Waves of the Self

Integral Psychology is a whole-spectrum psychology, which unites Freud's depth psychology of the unconscious with the height psychology of the superconscious of Eastern psychologies (Wilber, 1977). It covers ten levels of development, from the most basic material level to the highest spiritual level. Human development is seen as a rising of consciousness from the unconscious to conscious and further to the superconscious (Alexander & Langer, 1990). This development may also be called the development of the self, whose gravity centre rises its through ten fulcrums of development, trying to balance the different lines or streams of development in each level or wave. Wilber follows the Piagetian scheme of cognitive development, but identifies higher levels, such as post and

post-post formal levels of development, calling them "second and third tier" (Wilber, 2000c). Self-development is seen more like a spiral than as neat levels on a ladder, but nevertheless, in order to move to one developmental wave, the preceding level must have been conquered. Wilber emphasises that no wave can be skipped in favour of a higher one, and every wave has an equal importance for the overall spiral. The main point is that each wave is equally important and any jump is dangerous and ultimately impossible, so that the mission of the therapist is not to help people to move to higher waves, but to help clients to accommodate and integrate the waves where they are in the present moment.

The sense of self ("ego") develops from the egocentric level, when it is dominated by its narcissistic needs, moral stage 1, and animistic worldview, to the sociocentric level, when it identifies with its family needs, moral stages 2 to 3, and mythic worldview. Then the self develops to the world-centric level, when it identifies with needs of the whole world, is at moral stages 4 to 5, and holds a pluralistic postconventional worldview. Further, development can still proceed to the transpersonal level, when the ego is transcended and what remains is a total identification with the Kosmos, a post-post conventional worldview, or One Taste, and a moral stage defined by Jesus by His commandment: "Love your neighbour like yourself!." Table 1 shows a graphical representation of all the levels of development correlated with memes, worldviews, psychopathologies and treatments (Wilber, 2000a).

Why is it important to know the levels of develop-

Table 1. Structures, levels, memes, worldviews, pathologies and therapies according to Wilber

Basic Structures	Levels	Memes	Worldviews	Disorders	Treatments
Transpersonal					
Nondual	Spirit		Transpersonal/ Post-postconventional	Perfect Health	
Causal		White		Causal Pathology	Formless Mysticism
Subtle	Soul	Coral		Subtle Pathology	Deity Mysticism
Psychic		Turquoise		Psychic Disorders	Nature Mysticism
Personal					
Vision Logic	Mind	Yellow	Integral; pluralistic/ postconventional (worldcentric)	Existential Pathology	Existential Therapy
Formal		Green		Identity Neuroses	Introspection
Rule/Role		Orange	Formal/ conventional	Script Pathology	Script Analysis
Prepersonal					
Rep-mind	Body	Blue	Mythic/ Conventional Ethnocentric	Psychoneuroses	Uncovering Techniques
Phantasmic-emotional		Red	Magic (animistic)/ Preconventional (egocentric)	Narcissistic-Borderline Disorders	Structure Building Techniques
Sensorimotor		Purple		Psychoses	Physiological/ Pacificaton
Undifferentiated/ Primary Matrix	Matter	Beige	Unconscious	Perinatal Pathology	Intense Regressive Therapies

ment of the client for the treatment of depression? It is because IT assigns the adequate therapy for depression based on the persons' current level of overall development, which may facilitate and accelerate the healing process (Wilber, 2000a; Wilber et al., 1986). Cognitive therapy is not concerned with the levels of development of the client, although it works faster with clients who are verbally developed (Wachtel & Messer, 1998).

Causes of Depression in IT

The person is seen in IT as a holon integrated into higher holons, each characterised in a quadruple perspective forming the four aspects or quadrants of the Kosmos. A person is seen as a physical entity with a material brain in the Upper Right Quadrant, while the person's thoughts or psychological existence are seen in the Upper Left Quadrant, and interpersonal relations and their part in a social culture are seen in the Lower Right Quadrant. All four quadrants define a person and his or her place in the Kosmos, and every dimension of the Kosmos directly influences the person, who must constantly adapt to its internal and external changes. From this quadruple perspective, the individual's psychopathology is an all-quadrant affair, and respectively, recovery is also an all-quadrant endeavor. In order to find out the causes of MDD, IT proposes that all four dimensions of the person must be searched for etiology, first independently and then together for a search for possible multiple causes. For example, in the Upper Left Quadrant the etiology of MDD may originate from the psychopathology of the self. The self is seen to develop through a series of stages or waves, so any arrest or failure at a particular stage would manifest as a particular type of psycho-pathology, ranging from psychoses, borderline disorders, and personality disorders, to existential, psychic, subtle, and causal pathology. The type of psychopathology depends upon both the level of consciousness in the fulcrum where it occurs and the phase within the fulcrum when the miscarriage occurs. Each fulcrum has three basic subphases, namely: fusion, transcendence, and integration. These give us a typology of 27 major self-pathologies, which range from psychotic through borderline, neurotic, and existential, to transpersonal, with depression being possible at any level, but of a different kind, and requiring different treatment.

MDD can appear at any wave of self-development, so understanding the developmental nature of human consciousness (e.g., its structures, waves, streams, dynamics) is indispensable to both diagnosis and treatment (Wilber et al., 1986). Wilber identifies a self-pathology originating in the personality organisation and ego functioning, which may produce structural deficits in the function of the whole self, object representations, and lack of a cohesive, integrated sense of self (Wilber, 2000a).

Here are some examples of etiology as may appear in the different quadrants. In the Upper Left Quadrant, the etiology of MDD can be any failure in the capacity of differentiation and integration of the self at each stage of development; in the Upper Right Quadrant, it can be any imbalance of brain physiology, neurotransmitter imbalance, or poor diet; in the Lower Left Quadrant, it can be any cultural pathologies, communication snarls, or double-meaning communication; and in the Lower Right Quadrant, it can be any economic stress, environmental toxins, or social oppression that may put pressure on the person's coping mechanisms causing them to break down. The etiology of MDD from the Upper Left (self pathology factors) and the Upper Right Quadrant (brain pathology factors) must be integrated with the Lower Left (cultural pathology factors) and the Lower Right Quadrant (social pathology factors), in order to have a complete understanding of the causes of MDD.

We have now several studies that identify the causes of MDD in the Lower Left and Lower Right Quadrant, such as levels of social support (La-Roche, 1999; Lin & Lai, 1999); adverse living environment (Cheung et al., 1998; Lizardi et al., 1995); environmental stressors (Lin & Lai, 1995; Lin et al., 1999; Pahkala et al,. 1991; Richter, 1995); poor social skills (Gable & Shean, 2000); poor interpersonal relationships (Zlotnick et al., 2000); communication problems (Segrin, 1997); distressing interpersonal context (Whifen & Aube, 1999); and other social factors (Stroebe, 1997). We identified only some studies pointing to a combination of factors from two quadrants, Upper Right + Lower Right, that is, genetic liability to stressful environment (Kendler, 1998; Kendler et al., 1997), and only one study emphasising multiple causes from three quadrants, Upper Left + Lower Left + Lower Right, namely, negative thinking patterns, social relationships, and social stresses (Barry et al., 2000).

Cognitive therapy is mostly concerned with the

self-pathology from the first five fulcrums, in the Upper Left Quadrant, while other factors from other quadrants are overlooked. From this point of view CT is reductionistic in its etiological views, and only later new changes have occurred to include also factors from the Lower Left Quadrant, that is, interpersonal and affective factors.

Integral Therapy is also concerned with higher developmental fulcrums, the transpersonal levels consisting in soul and Spirit. MDD can be caused by transpersonal causes, and it is important to mention here the Kundalini phenomena (Shannella, 1992; Greenwell, 1990; White, 1990; Krishna, 1989, 1993; Yang, 1992; Satyananda, 1993), the Dark Night of the Soul (St. John of the Cross, 1988; Tweedie, 1993; Roberts, 1993; Segal, 1996), and spiritual emergencies (Grof & Grof, 1990; Bragdon, 1990, 1993),which are the most common causes of psychopathology in the higher fulcrums. Kundalini awakenings can cause MDD and the integral therapist must consider this possibility.

Treatment of Depression in IT

IT is not a particular psychotherapy in itself, but rather a therapeutic approach, which makes use of the existing therapies on the market in an integrated way, in order to cover all four domains that define a client. Treatment of MDD in IT implies treating each client as a unique individual, with a specific developmental history and particular bio-psycho-social competencies. Even if the cause of MDD is the same in two individuals, the treatment of MD in each of them may be different, based on the personal developmental history and the competencies in the four quadrants that have been assessed in the Integral Psychograph (Wilber, 2000c). Treatment can ideally be seen as an all-four-quadrants endeavour—"all quadrants, all levels, all lines"—just as psychopathology can be seen as caused by all four quadrants.

Prevention of depression is one of the main concerns of IT, and studies have shown that this effort must be both personal, by engaging in an integral transformative practice (ITP), and political, in order to prevent rather than cure depression (Dadds, 2001).

IT makes use of clinical interview, using the ICD-10/DSM-IV-TR, in assessing the MDD together with a specific assessment of some of the major lines/streams of development (cognitive, moral, interpersonal, affective/emotional, spiritual) and levels/waves of development using individual tests. The test results may be shown on an Integral Psychograph as the psychological profile of the client (Wilber, 2000a; 2000c). The Integral Psychograph shows levels of each developmental line, vertical and horizontal type of self development (ego development) (Descamps et al., 1990), level of basic pathology, predominant needs (motivations), moral stage, spiritual development, level of object relations, and so forth. This profile can be interpreted to prevent and discover psychopathology.

In order to find the best therapy for MDD, the integral therapist needs to identify its possible causes from each of the four quadrants using a battery of psychological tests: Psychological Map, Form A, The Values Test (the first two tests have been developed by Spiral Dynamics), Dimensions of Self Concept, Defense Mechanisms Inventory [Revised], Bessell Measurement of Emotional Maturity Scales, Social Adjustment Scale, Social-Emotional Dimension Scale, Quality of Life Questionnaire, and Kundalini Experiences Inventory. Based on the Integral Psychograph an IT should be suggested.

Cognitive therapy rarely makes use of tests and gives a standard treatment for any type of client, while IT acknowledges the uniqueness of the individual clients and their complexity and diversity, calling for a tailor-made treatment for each individual. This characteristic also makes the randomisation of treatment, as practised in other therapies, inappropriate. IT proposes a detailed identification of the causes of MDD, and based on this first assessment, there may be given one or a combination of therapies for treating MDD, covering "all quadrants, all levels, all lines." The quality of IT is that it can integrate apparently different psychotherapies, seen as complementary rather than mutually exclusive.

For interventions in the Upper Left Quadrant, the integral therapist can choose from a number of self-psychotherapies, such as psychodynamic, cognitive, humanistic, or transpersonal. In the Upper Right Quadrant, he or she can choose between various drugs, CTS, ECT, vagus nerve stimulation, or acupuncture (Allen et al., 1998). In the Lower Left Quadrant, the therapist may choose different therapies, such as transactional analysis (Berne, 1975), relational therapy (Magnavita, 2000), and volunteer community work therapy. In the Lower Right Quadrant, he or she can

assess the socioeconomic and environmental factors that may be a pathogenic source. The remedies here may be political, economic, and environmental support, education, and skills training (Nezu et al., 2000).

For multiple-etiology MDD, a more complete IT may be given, working on several quadrants either sequentially or in parallel. For a double-cause MDD, say intrapsychical and interpsychical problems, Upper Left Quadrant + Lower Left Quadrant, CT may be given for correcting negative thoughts, or helplessness, and afterwards or in parallel one may also give IPT for correcting interpersonal relationship skills. For a triple-cause MDD, say intrapsychical, interpsychical and interobjective problems (economic problems), Upper Left + Lower Left + Lower Right Quadrant, one may prescribe CT, IPT, and a social skill training.

IT for MDD is concerned with a quick reduction of symptoms and recovery without relapse. In order to prevent relapse, a maintenance therapy may be given, either individually or in group. The integral therapist may give the client an integral transformative practice (ITP) that is expected to be carried out for the whole life, as a means of preventing the recurrence, enhancing the quality of life, and raising the level of consciousness for the benefit of the individual as well as society.

Today a few studies on MDD treatment acknowledge the efficacy of addressing multiple quadrants in combination: Upper Left (psychotherapy) + Upper Right Quadrant (pharmacotherapy) is more efficient than one form alone (Nierenberg, 2001; Beitan & Klerman, 1991; Thase et al., 1997). The decision to use combined medication and psychotherapy in the treatment of MDD (Petit et al., 2001) must be based on severity of symptoms, quality of depression, duration of disability, and response to previous treatments, and not on ideological views favoring one treatment over the other. Some researchers have found that medication does not interfere with the patient's capacity to participate in psychotherapy, and because of the reduction of the symptoms, the patient's capacity to make use of social learning is increased (Klerman & Weissman, 1993).

Based on existing research, IT may propose, for the treatment of MDD caused by factors from the Upper Left + Upper Right Quadrant a double intervention, a combination of CT with pharmacotherapy (Rush & Hollon, 1991; Blackburn et al., 1986; Kupfer & Frank, 2001; Savard et al., 1998).

For an etiology of the Upper Right + Lower Left Quadrant, a double combination of IPT with pharmacotherapy (Klerman & Weissman, 1993; Weissman et al., 2000; Frank et. al., 2000; Reynolds et al., 1992, 1999) may be given. Unfortunately we don't have today any research on a treatment for MD that covers three or four quadrants together—maybe with a few exceptions (Pinsof, 1995; Lazarus, 1995).

The main point of IT is that it is an "all-quadrant, all-level, all-lines" therapy, engaging the intentional (Upper Left), behavioural (Upper Right), cultural (Lower Left) and social (Lower Right) in all relevant dimensions. The weakness of cognitive therapy as well as other therapies is that they don't recognise that the various levels of interior consciousness have correlates in the other quadrants. Wilber says, "Human beings have different levels: body, mind, soul and spirit, and each of these levels has four aspects: intentional, behavioural, cultural and social."

So far we have discussed treatment of MDD at the first five fulcrums, but there are also higher levels of consciousness development, and now we shall introduce therapies that are concerned with these higher fulcrums. These are the transpersonal therapies, and address the levels of soul and Spirit. IT acknowledges all transpersonal therapies, adding the "all-quadrants, all-levels, all-streams" healing perspective that may be pursued by the transpersonal therapist. Until the publication of Wilber's book "*Sex, Ecology and Spirituality,*" transpersonal therapists were not considering the integral perspective, being mostly concerned with only one or two quadrants. The four quadrants are present until the last fulcrum, when the Kosmos becomes "One Taste" and division loses all meaning, but until the last fulcrum it is important to practice transpersonal therapy from an integral perspective. Today, there are very few evaluated transpersonal therapies, so there must be caution in recommending and using such approaches. Many Western transpersonal theorists have proposed different therapies for different fulcrums, based on their private experience with clients, but there is no agreement among them, and their proposals are of an exploratory nature (Boorstein, 1991, 1997; Scotton et al., 1996; Rowan, 1993; Boggio Gilot, 1995, 1996; Weil, 1988; Wilber et al., 1987; Descamps et al., 1990; Leloup & de Smedt, 1986; Claxton, 1996).

Therapies that can successfully address a sixth fulcrum MDD may be mentioned: Jungian therapy (Jung, 1957; Singer, 1995), psychosynthesis (Assagioli,

1993; Ferrucci, 1995), Gestalt therapy (Perls, 1994), and logotherapy (Frankl, 1985; Fabry, 1981).

The traditional transpersonal therapies that can successfully address MDD generated by a transpersonal cause at the seventh fulcrum are mainly from the East and include Kundalini yoga (Swami Satyananda, 1993a, 1993b; Swami Sivananda, 1985), Yoga (Swami Rama, Ballentine & Swami Ajaya, 1993), and Chi Kung (Chia & Chia, 1993; Yang, 1992; Lu, 1991). The few Western transpersonal therapies that address this level are: Hara therapy (Dürckheim, 1988), biogenetics (Katchmer, 1993), neo-Reichian therapy (Reich, 1993) and the holotropic breathwork of Stanislav Grof (Grof, 1985; Grof & Bennett, 1993).

The eighth-fulcrum therapies that can address an eighth-fulcrum MDD are mostly found in the traditional mystical traditions of both East and West, such as Christianity (St. Nikodimos & St. Makarios, 1981; St. Teresa of Avila, 1988), Theravada Buddhism (Buddhaghosa, 1975; Narada, 1975; Surangama Sutra, 1978), and Tibetan Buddhism (Cozort, 1986).

The last fulcrum that may cause MDD is the ninth, which is the domain of Spirit and causal reality. At this level there are few traditional therapies: Mahamudra (Namgyal, 1986), Dzogchen (Clemente, 1996), Advaita Vedanta (Godman, 1985), and Zen (Buswell, 1992; Kapleau, 1989; Hirai, 1989). Recently, a new generation of enlightened Westerners has arisen who may have something of value to offer (Tolle, 1999; Kornfield, 1993; Segal, 1996; Packer, 1999; Ardaugh, 1999; Parsons, 2000; Lumiere & Lumiere-Wins, 2000; Parker, 2000). Reaching the end of human development, the fear of death or annihilation may give rise to MDD, and here some bibliotherapy may ease the anguish (Sogyal Rimpoche, 1992; Da Avabhasa, 1991; Blackman, 1997).

Finally, there are yet untested integral approaches to treat MDD from this perspective, but the best we can offer is Ken Wilber's recommendations for treatment in a case with existential depression and in one with a life-goal apathy and depression:

> A client with existential depression, postconventional morality, suppression and sublimation defence mechanisms, self-actualization needs and a centauric self-sense, might be given: existential analysis, dream therapy, a team sport (e.g., volleyball, basketball), bibliotherapy, t'ai chi chuan (or prana circulating therapy), community service and kundalini yoga....A client who has been practicing zen meditation for several years, but suffers life-goal apathy and depression, deadening of affect, postconventional morality, postformal cognition, self-transcendence needs, and psychic self-sense, might be given: uncovering therapy, combination weight training and jogging, tantric deity yoga (visualization meditation), tonglen (compassion training), and community service. (Wilber, 1998, p. 252).

Finally, IT is an "all-quadrant, all-levels, all-lines" therapy, which addresses equally the intrapsychic (Upper Left Quadrant), behavioural (Upper Right), cultural (Lower Left) and social (Lower Right) in all their dimensions.

Discussion

The most comprehensive view for studying humans is from an "all-quadrant, all-level, all-lines" perspective. The multiple factors of the etiology of depression are better integrated by integral theory than cognitive theory, or any other theory for that matter. CT has searched for MDD etiology only in the Upper Left, and lately also in the Lower Left, while IT has taken into account all quadrants, and all the interactions between them. IT proposes that the causes for MDD can be multiple and their accumulative effect account for the intensity of the symptoms. There are today some efforts toward psychotherapy integration (Glass et al., 1998), but though valuable, this is still far from a comprehensive research on "all quadrants, all levels, all lines." The answer to the first question of this study is clear: integral theory is more accommodating for the etiology of MDD than cognitive theory.

Integral Therapy can be more efficient in the treatment of depression than other therapies, if the synergy ensured from the combination of multiple therapies makes a difference, but today we have no studies to support this. Further, the public seems not to be really open to a combination of treatments (e.g., combining psychotherapy and pharmacotherapy), and the first choice is psychotherapy alone (Hall & Robertson, 1998). CT has a very good record of efficiency and as a single therapy it may be the therapy of choice even from an integral perspective. The answer to our second question is that CT is better than IT in treating episodes of MDD, but has no clear advantages for preventing recurrence.

Finding empirical support for IT is difficult today, because the existing meme in psychological research

on MDD tends to acknowledge only one, two, or three quadrants, mostly independently rather than together. Further, today's research effort on MDD is much dictated by funding provided by the drug companies which are mainly interested in research on the Upper Right Quadrant, so as to sell more drugs and make more profit. This is a serious problem, and IT research using a quadruple perspective may prove too expensive and wide to be funded; this may change if we make the case for IT well known.

The weakness of IT is that it is highly specialised, that it requires therapists qualified in more than one therapy, as well as higher levels of personal development, at the second tier and beyond. The assessment process in IT may take too long but the costs may prove little in the long run, both for the individual and society. The Integral Transformative Practice that may be given to a client in order to prevent future MDD episodes may prove difficult, needing to cover 31 streams of consciousness at 17 levels in 4 quadrants, hence 2108 consciousness variables to develop (de Quincey, 2000). IT has already got critics who complain about Wilber's limited description of Upper Right (Combs, 2001) or Lower Left Quadrant (de Quincey, 2000), but even critics acknowledge the importance of IT in opening a new perspective in treatment. Anecdotal criticism has been raised on the length of training: if an integral therapist should qualify as a Ph.D. in each of the four quadrants, education would take some 7x4=28 years! Clearly, IT needs highly qualified therapists who are familiar with both phenomenological approaches and quantitative research methods. But the most important qualification must be Spiritual Awakening, if the integral therapist is to counsel clients on transpersonal levels. Enlightenment must come first in any IT curriculum, and only then can the development of the streams and waves be engaged in a gradual manner, from an awakened perspective on the Kosmos, following the recommendations of Zen Master Chinul (Buswell, 1992). Once, the author of this paper asked Ken Wilber (2000e) how can the self be developed after enlightenment. It is believed that after enlightenment there is nobody left to identify with the body, and no self to do any integral practice. Here is Wilber's answer:

> How to function with the Unborn is indeed the question. Yet how simple that ultimately is, for notice: Right now, you are spontaneously and effortlessly aware of the clouds floating by in the sky, feelings floating by in the body, thoughts floating by in the mind. There is a consciousness that is already noticing all that, and is spontaneously and effortlessly present. All of those things—clouds, feelings, thoughts—all drift by in your own vast consciousness, right here, right now. But what about that consciousness itself? what color is that? where is it located? where is your mind right now? does it have a shape or size or color? In fact, your own consciousness right now is without shape or form, but it beholds all the shapes and forms floating by. Your own consciousness right now is without color, yet it beholds all the glorious colors passing by. It is without taste, yet can taste all the flavors that arise moment to moment. Your own consciousness, in other words, is without taste or color or shape or form. Your own consciousness—right now at this very moment, and just as it already is—is in fact the great formless Unborn. Even your own body and feelings and thoughts and mind arise in the vast openness of your own ever-present awareness, and that present awareness is none other than Spirit itself. In short, you are aware of yourself existing now. That of which you are aware is your individual self; that which is aware of your individual self, right now, is God.
>
> And you, as pure witness, are that God, that Goddess. You, as pure witness, are the Divine itself, right here and right now; whereas you, as an object of that Self, are the mortal, finite, limited thing you are used to calling yourself ("dinu" or "tom" or "ken" or "amy"). It is not impossible, or even hard, to rest as the great empty Witness, the great Unborn, and simultaneously exercise any object that arises in this great open awareness—such as your body, your ego, your psyche, or anything else that arises.
>
> The integral view, then, embraces both absolute (Unborn and empty Consciousness) and relative (any and all Forms that arise in that vast infinite space that you are). May this infinite great Unborn, which you always already are, tacitly announce itself to you when you aren't looking, and slowly begin to reorganize your entire being along lines that can never be whispered. (Wilber, 2000e)

We need a new therapy for the new millennium, and the IT may prove to be the quantum leap therapy, helping the field to make the shift, from the present-day meme (Wilber, 2002) to the second tier.

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