

PSYCHOGRAPH AS MAP, MATRIX, AND MIRROR

An Integral Psychograph Assessment

Vipassana Esbjörn-Hargens

ABSTRACT This article introduces integrally informed clinicians and their patients to an Integral Psychograph Assessment (IPA). The IPA I employ is a clinical assessment process developed for psychotherapists to be used with their patients in the therapeutic context to evaluate levels of an individual across 10 lines of development. In this article, the integral psychograph is first situated within the Integral model and then within a larger historical discussion of multiple lines of development. The components of the IPA—the map, matrix, and mirror—which utilize third-, second-, and first-person clinical assessment methodologies are then introduced and described. Clinical considerations, with an emphasis on the impact of the assessment process on therapy, are woven into the discussion of the six procedural steps of the IPA. To illustrate the assessment process, I present clinical vignettes in which the IPA was administered in the context of long-term (five year) psychoanalytically oriented integral psychotherapy with an adult patient. I conclude with a discussion of clinical implications to be considered when using an IPA in the context of psychotherapy.

KEY WORDS clinical assessment; Integral Theory; psychoanalytic; psychograph; psychotherapy

For people inhabit a world that consists, in the first place, not of things but of lines. After all, what is a thing, or indeed a person, if not a tying together of the lines—the paths of growth and movement—of all the many constituents gathered there? Originally, ‘thing’ meant a gathering of people, and a place where they would meet to resolve their affairs. As the derivation of the word suggests, *every thing is a parliament of lines*. ... to study both people and things is to study the lines they are made of.

– Tim Ingold (2007, p. 5)

The theoretical concept of the integral psychograph was developed by Ken Wilber and first formally introduced in his book *The Eye of Spirit* (1997) and then later in *Integral Psychology* (2000). Since then, it has become a popular informal assessment tool among students and practitioners of the Integral model, appreciated widely for its capacity to visually and elegantly convey levels of development across multiple psychological and interior dimensions in an individual. As a tool for clinicians, the integral psychograph has the potential to serve as a valuable methodological framework for inquiring into, capturing, and tracking facets of development in an individual.¹ This article is aimed at advancing the integral psychograph from an informal reflective process into a clinical assessment instrument with a clear methodology.²

The integral psychograph is based on the notion that human beings have multiple distinct interior capacities (e.g., cognitive, interpersonal, moral, spiritual, emotional) and that each of these capacities develops at various rates through a holarchical landscape of complexity and depth.³ For example, a person could be average or mid-range in her interpersonal development, highly advanced spiritually, while quite low in her somatic development. The integral psychograph attempts to capture these distinct levels of development across various dimensions or lines of development in a person (e.g., Gardner, 1983).⁴ These capacities or lines

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of development are distinguished from personality traits in an important way: unlike personality traits (e.g., extroverted, introverted, optimistic, melancholy), a line develops vertically over time through discrete stages of development that unfold sequentially (Wilber, 2000).

A typical integral psychograph is a chart that includes a horizontal axis displaying lines of development that might include: cognitive, interpersonal, spiritual, orders of consciousness, self-identity, moral, values, needs, aesthetic, psychosexual, emotional, kinesthetic, and somatic lines. The levels or stages of development, also referred to in the Integral Theory lexicon as altitude (Wilber, 2006), run along the vertical axis and include: the broad levels of preconventional, conventional, postconventional, and post-postconventional; or first tier, second tier, and third tier (Marquis, 2008, p. 120). While some integral psychographs will simply use levels of low, medium, and high, many will use the altitudes that Wilber (2006) has outlined with their corresponding colors (see Fig. 1). Psychographs can also be depicted as lines or spirals moving through concentric circles from the middle outward (see Marquis, 2008, pp. 118-119). A broad sweep of the altitudes from low to high can be understood as egocentric, ethnocentric, sociocentric, worldcentric, and Kosmocentric. In terms of altitude, we have the following correlations: magenta to red is egocentric or preconventional; amber is ethnocentric, or conventional; orange is sociocentric or early postconventional; green to turquoise is worldcentric or postconventional; and lastly, indigo and above is considered post-postconventional or Kosmocentric (Marquis, 2008; Wilber, 2006).

An aspect of the integral psychograph that is especially appealing to integral practitioners is the fact that it can be used in different ways in a variety of contexts (e.g., psychotherapy, coaching, education, and business). However, at the same time, this panoply of ways people seem to be using the psychograph across various disciplines can also be quite frustrating to those interested in learning how to apply the integral psychograph to their particular discipline. That is, there appears to be minimal agreement and understanding as to *what* exactly each line is assessing (e.g., what are we really talking about when we refer to the interpersonal line), *what* each line at every level truly looks and feels like in a person’s daily embodied life, and *how* to go about assessing each line (i.e., a distinct methodology). Without this mutual understanding among practitioners, it is difficult to implement and advance the use of the integral psychograph as an assessment tool. For example, some people use low, medium, and high to describe levels of development, without necessarily having a clear structural definition/map or a thick description as to the distinguishing factors that differentiate

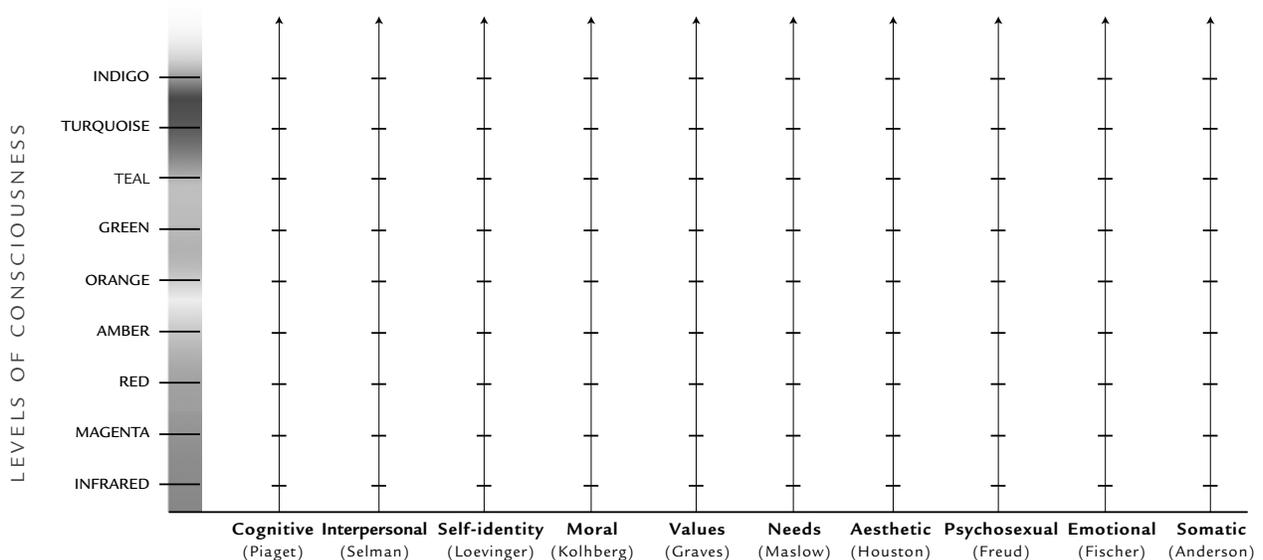


Figure 1. Ten lines of development used in the Integral Psychograph Assessment.

low from medium, or medium from high, in any given line. A key task for integral clinicians will be to develop clear notions of, for example, a “worldcentric somatic line” and to do so in a way that can be applicable to non-integral audiences. In addition, others are using the altitudes proposed by Wilber (2006) by drawing on a variety of different descriptions of the various levels, or even simply using one’s own knowledge of the Integral model to infer what various levels of each line actually look and feel like. There is also the issue that different lines that comprise a psychograph will be more relevant in some contexts and less in others. For example, the lines most useful for a psychotherapy context are not necessarily the same ones most useful for a life or executive coaching context.

Integral practitioners may assume that all of the information delineating the various levels of each line exists in print, even if buried deep within various articles and books; while in actuality, if one were to compile all of this published information, there would still be significant blank spots in the map. For instance, a few years ago integral scholar Barrett Brown (2007) took on the project of compiling level descriptions for six major lines (cognition, self-identity, order of consciousness, values, morals, and faith) from the primary sources associated with each particular line. The resulting 200-page document is an immense resource for the integral community. While Brown’s document is clearly valuable, some levels for certain lines still remain completely or largely undescribed by the central theorist. For example, Lawrence Kohlberg proposes a tentative “universal spiritual” seventh stage but refers to it as a “soft hypothetical” stage. As integral practitioners, we do not thus far have a comprehensive map with descriptions and concrete examples that illustrate the various levels of development for each line in an integral psychograph. And even if we did have such maps, at this time we do not have many methods that can address the relationships between levels and lines, content and structure in any systematic way.⁵

Part 1: Context

The IPA: A Clinical Approach to the Psychograph

In this article, I will present the Integral Psychograph Assessment (IPA), a clinical psychograph assessment process. I will explain the three dimensions of the assessment—the *map* (third-person), the *matrix* (second-person), and the *mirror* (first-person)—as well as the six procedural steps of the assessment.⁶ To illustrate the assessment process, I will draw on clinical vignettes in which the IPA was administered over 16 months by myself in the context of long-term (five year) psychoanalytically oriented integral psychotherapy with an adult patient.⁷ In addition, I will also refer to the Integral Psychograph Index (IPI), a structural meta-map and guidebook I am developing, which aims to provide clinicians and patients with concrete examples and thick phenomenological descriptions to illuminate each level of every line included in the index.⁸

While I will not go into great detail regarding the specifics of the IPI in this article, I will, however, describe the IPI with a few broad strokes. The IPI includes 10 lines of development, a definition of each line of development, and a key question that corresponds with each line that is used to guide a patient’s inquiry.⁹ The central feature of the IPI is structural descriptions with phenomenological examples for each line at every level, generally from magenta to turquoise altitudes, and sometimes through indigo altitude. Also included in the IPI are relevant theorists and texts for each line, assessment instruments associated with each line, and a bibliography of relevant sources. While I am developing the IPI, I encourage other therapists to consider what such an index might include. Clearly, there is little value in having dozens of other therapists each developing their own unique IPI without integrative metatheoretical work being done. Thus, what I am advocating here is that building a useful IPI will in some ways be an endeavor of the community of the adequate. This will likely involve other interested and qualified therapists building on what I have done, doing their own versions, and engaging in conversations with each other—working toward an integrated metatheoretical map and process. Over time, the integral psychotherapy community will need to come together and compile such a resource

itself. I hope that mine might be a contribution toward that meta-map. I realize that a process like this is only as good as the meta-model being used. What I want to contribute in this article is an overview of the kind of process I engaged in as a possible template for other integral psychotherapists to use as a psychograph in their own clinical work.

As depicted in Table 1, the IPI includes the following lines of development, each with their corresponding question: cognitive (“What am I aware of?”); interpersonal (“How should we interact?”); self-identity (“Who am I?”); moral (“What should I do?”); values (“What is significant to me?”); needs (“What do I need?”); aesthetic (“What is attractive to me?”); psychosexual (“How do I experience Eros?”); emotional (“What do I feel?”); and somatic (“How do I experience my body?”). Each inquiry question serves to orient the patient to the developmental terrain of their own Being. Table 1 presents these lines, their questions, a key researcher associated with the line, and one or two of the key psychometric tests that has been developed to assess the line.¹⁰

By presenting the IPA, my hope is that this article may serve integral practitioners in several ways. First, the IPA may begin to lay down a framework, a consistent methodology with specific procedural steps for clinicians to draw on who are interested in utilizing the integral psychograph as part of their treatment plan.¹¹ Second, patients who are interested in completing an IPA might bring this article to an integrally informed psychotherapist, one that can help guide the patient-therapist dyad through the assessment process. Third, I hope to illuminate the potentially profound significance—both the benefits and the possible pitfalls—of the impact of a psychograph assessment on the therapeutic process. In other words, I believe that something is gained and something is potentially compromised by attempting to implement the IPA in the context of psychoanalytically oriented integral psychotherapy. Lastly, by presenting a psychograph assessment geared toward the psychotherapeutic context, my hope is that this might inspire integral practitioners in other disciplines to develop methods of using the integral psychograph in their respective fields.

Varieties of Psychographs

In addition to the absence of a comprehensive structural map, clinicians using the integral psychograph

Developmental Line	Key Inquiry Question	Key Researcher	Key Psychometric
Cognitive	What am I aware of?	Piaget	Science Reasoning Tasks & Arlin Test of Formal Reasoning
Interpersonal	How should we interact?	Selman	Sociomoral dilemmas
Self-identity	Who am I?	Loevinger	WU- Sentence Completion Test
Moral	What should I do?	Kohlberg	Standard Issue Scoring System
Values	What is significant to me?	Graves	None developed
Needs	What do I need?	Maslow	The Personal Orientation Inventory & The Short Index of Self-Actualization
Aesthetic	What is attractive to me?	Housen	Aesthetic Development Interview
Psychosexual	How do I experience Eros?	Freud	The Dynamic Personality Inventory
Emotional	What do I feel?	Fischer	Nice/Mean Interaction Scale
Somatic	How do I experience my body?	Anderson	Body Intelligence Scale

Table 1. Ten lines of the Integral Psychograph Assessment, key questions, researchers, and psychometrics.¹²

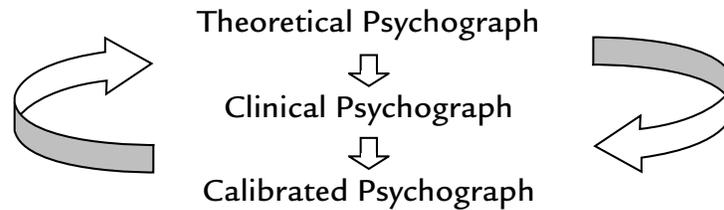


Figure 2. Phases of psychograph development.

are also in need of a procedural methodology. In their recent book *Integral Psychotherapy*, Elliott Ingersoll and David Zeitler (2010) distinguish between three types of psychographs: empirical (i.e., the current zone 2 research on specific lines to date), clinical (i.e., the use of “lines” to support the therapeutic encounter), and theoretical (i.e., Wilber’s concept of multiple developmental lines representing an individual’s psychological capacity). These three types of psychographs can influence each other in a number of ways. For example, an empirical map could inform which clinical methods one uses in a therapeutic context, which could in turn enact refined theoretical maps. Clearly, zone 2 methods enact structural maps, but here I am highlighting how such research-based maps can then be used to inform a procedural method of enacting integral psychotherapy, which would generate experiences that help to create maps attuned to the actual territory of transformation.

The approach I describe in this article uses the *theoretical* psychograph as a foundation to focus on the *clinical* psychograph, with an eye toward using the clinical setting to help refine the *theoretical* psychograph so that a more accurate empirical or *calibrated* psychograph can be developed (see Fig. 2). Regarding terminology, I understand Zeitler’s (2010) use of the word “empirical” to be referring to zone 2, but I feel that “empirical” is a confusing word choice in this context. That is, Integral Theory uses empirical in a broad sense to include both qualitative and quantitative (or first-, second-, and third-person) research. For this reason, I want to avoid reducing empirical to simply zone 2 measures, as even clinical assessments are empirical in that they are collecting and analyzing original data. Thus I have chosen to refer to his “empirical psychograph” as a “calibrated psychograph.” I am choosing “calibrated” in order to highlight the empirical validity associated with zone 2 psychometrics.

Reflecting on Zeitler’s three types of psychographs, it appears that the theoretical psychograph has been initially established (Wilber, 2000) but its clinical application has yet to be developed. There is an emerging possibility of a calibrated psychograph. But to date there are only a few lines that have accessible zone 2 assessments. Thus it will take significant time and funding to develop the specific zone 2 psychometrics to address the additional lines. What we do have now is the possibility to develop clinical psychographs that make use of and include the zone 2 assessments currently available (for a few specific lines). These clinical psychographs, such as the IPA I am proposing, combine personal inquiry, clinical judgment, and psychometric assessment, using first-, second-, and third-person perspectives to triangulate the psychograph assessment.¹³ Arguably, for now and the foreseeable future such an integral clinical psychograph is perhaps the most viable way of operationalizing the construct of the psychograph. Additionally, the clinical psychograph helps identify which lines could most benefit from a newly developed zone 2 assessment.

Zeitler (personal communication, September 7, 2010) has helped me clarify that while I am emphasizing the clinical context in this article, I am proposing and developing a methodology for producing an “integral psychograph,” which is a dynamic-process that includes all three (first-, second-, and third-person-based psychographs). In other words, while the clinical psychograph is highlighted in this discussion, I am presenting a vision for an integral psychograph that combines theoretical, clinical, and calibrated psychographs. Although Zeitler and I may differ on the terminology, I think we share a vision of an integral psychograph that transcends and includes theoretical, clinical, and empirical/calibrated psychographs.¹⁴

To date, Zachary Stein and Katie Heikkinen (2008) are among the few practitioners to begin to outline a methodology to help organize and frame assessments associated with a zone 2 psychometric: the Lectical Assessment System (LAS).¹⁵ Developmental Testing Services, the non-profit organization that supports the development of the LAS, currently offers calibrated, online assessments in decision-making, ethical reasoning, leadership reasoning, reflective judgment, and self-understanding, and is involved in research to develop additional assessments (e.g., reasoning about the Integral model).¹⁶

Various versions of the integral psychograph appear to be used among integral practitioners across disciplines—from psychotherapists (Ingersoll & Zietler, 2010), to educators (S. Esbjörn-Hargens, 2007), to coaches (Divine, 2009; Hunt, 2009), to consultants. While much has been written on Integral Psychotherapy (e.g., Forman, 2010; Ingersoll & Zeitler, 2010; Marquis, 2008; Sehrbrock, 2007) and some have included a discussion of the psychograph, none have specifically focused on the integral psychograph in terms of an applied methodology of assessment in a psychotherapeutic context. One notable exception is the appendix in Ingersoll and Zeitler (2010), which does present a case study that includes a discussion of the client's lines.

While most integral authors have not yet delved extensively into the application of the integral psychograph, a number of recently published integral psychotherapy textbooks are important to examine in some detail. First, Andre Marquis' *The Integral Intake* (2008) devotes chapter 5 to "Developmental Lines and the Integral Psychograph." In this chapter, Marquis provides a solid overview of 10 common lines used by integral psychotherapists (nine of which I use in the IPA—where Marquis includes the spiritual line, I include the psychosexual). This is a valuable chapter, although it only devotes two pages of text to the integral psychograph. Therefore, the chapter serves as a tour of some major lines for consideration in a psychograph assessment more than as a guide for clinical application. Additionally, Marquis raises some important issues to consider in the clinical setting.

More recently, Mark Forman's *A Guide to Integral Psychotherapy* (2010) also devotes his chapter 5 to "Lines of Development in Practice." In this chapter, Forman focuses on a three-line model (i.e., cognition, self-system, and maturity) based on the work of psychologist G.G. Noam. This is a refreshing and noteworthy approach, given how complex it could be for clinicians to work with 10 lines. After describing each of these three lines in detail, Forman offers up some reflections on the more differentiated 10-line version of the psychograph. He raises three key issues that any clinician using a psychograph such as the one I present here should be aware of: first, "clients rarely present themselves in psychotherapy in the highly differentiated way that the model would suggest" (p. 86); second, "different lines emerge in their most distinct forms when pushed by context or environment" (p. 86). By this, Forman is highlighting that therapy typically provides the clinician with a single context from which to assess their client, which might not be the most revealing for accurate assessment; and third, "often when people discuss lines... there is an assumption that being 'lower' in a line is a sign of a problem" (p. 87). Forman (2010, p. 88) also raises the issue of spending valuable time, money, and resources on a lengthy process that might not have clear therapeutic import.

These are valuable issues Forman is raising, and it is important to understand these kinds of critiques of the psychograph, as they likely have contributed to the dearth of research on its application. I will briefly respond to Forman's critique in the context of my own work with the IPA. I will address each concern in order. First, because I worked with my patient over a five-year period and implemented the IPA over a 1½-year period, I found there was adequate material to be able to differentiate the lines sufficiently, even though they often presented themselves in an overlapping, "messy" way. Second, while I did not witness my patient in other contexts than my office, the IPA includes second-person assessments from the patient's peers, colleagues, and family members—precisely those individuals who have seen him or her in various contexts. As a result, the IPA is able to include a multiple-context assessment of each line. Third, the patient I worked with did not tend to view a lower assessment in any given line as problematic but rather as a source of inquiry and curiosity. As for the issue of spending valuable time and money on the IPA, this was an important topic

that my patient and I reflected on, particularly relative to the time spent on the psychograph assessment. For my patient, the value of a clinical psychograph assessment reportedly felt well worth the time and financial resources that were devoted to such an endeavor. In short, Forman's (2010) chapter provides essential reflections to be considered for a clinician utilizing the integral psychograph.

Ingersoll and Zeitler devote chapter 4 (authored solely by Zeitler) of *Integral Psychotherapy* (2010) to "Lines and Levels of Development." This is an extensive chapter that devotes most of its 35 pages to the notion of an integral psychograph. As noted above, these authors introduce three kinds of psychographs (theoretical, clinical, and empirical) and they do an excellent job of discussing all three of them and their relationships to one another. There are many important points made throughout this chapter, and I highly recommend it to anyone who is considering using the psychograph construct in a clinical setting.¹⁷

One of the interesting contributions made in this chapter is that Zeitler (2010) provides three tables (4.3, 4.4, 4.5) that identify which lines have empirical evidence, anecdotal evidence, and are lacking evidence but show promise. This kind of framing is an important step for clarifying which lines in a possible psychograph are substantiated. Zeitler does an excellent job (as does Forman, 2010) of raising crucial issues around the empirical viability of lines of development both as a construct and as a clinical tool. Building on Zeitler's tables, it would be helpful to create another table that presents lines having a psychometric that clinicians could either refer a patient to or administer themselves. Toward this end, I offer an initial table based on the 10 lines of the IPA (see Table 1).¹⁸ This is important because, as Stein and Heikkinen (2009) point out, there is an important difference between developmental models and developmental metrics. And then within metrics, some are publicly available (e.g., Cook-Greuter's SCTi) while others are primarily found in academic research contexts (e.g., Selman's "practice-based dilemmas"). Of the ten lines in the IPA, eight of them are found in Zeitler's list of lines with empirical evidence, although I would add that the aesthetic line, which I use, could be added to this list based on the research of Abigail Housen (1983, 2002) as well as the other line I use, the somatic line, based on the work of Rosemarie Anderson (2006, 2008, 2010).¹⁹

Both Ingersoll and Zeitler (2010) and Forman (2010) are concerned about the ways in which some scholar-practitioners in the integral community overly focus on the unevenness of lines within an individual psychograph. Their concern is that such a focus displaces the role that regression in service of transformation and integration has in the developmental process. This is a particularly relevant issue for practicing integral psychotherapists. I know for myself, I have observed intrapsychic variability that at times feels like regression and at other times feels like an issue of uneven lines. Teasing apart these dynamics and exploring their complimentary nature is part of the important work that lies ahead for the field.²⁰

In this article, I focus on the application of the psychograph within the context of clinical application in contrast to an extensive theoretical critique. For a theoretical critique of the integral psychograph, see Ingersoll and Zeitler (2010). In the discussion section of this article I will, however, raise some crucial issues surrounding the application of the psychograph construct in the context of clinical application.²¹ Before I focus on my own work with the integral psychograph, I will first situate the psychograph within its historical context. Given how little has been written about the integral psychograph, I feel it is important to provide a historical overview that highlights some key figures in the rich and colorful history of the concept of psychographs. In doing so, I hope to inspire other integral practitioners to begin to explore the many pioneers who have something to offer our future efforts at developing the integral psychograph.

History of the Psychograph

The father of psychoanalysis, Sigmund Freud, had a daughter named Anna who also became a highly respected psychoanalyst in her own right. Anna Freud (1963) was among the first to introduce the concept of "lines of development"—that is, the notion that humans have a number of different psychological capacities and that these develop relatively independent of one another.²² In fact, in this article Freud outlines a number

of distinct lines including a basic one that she calls a “prototype of a developmental line” (p. 247). This basic prototypical line runs from dependency (biological unity between mother and infant) to emotional self-reliance (where object constancy is mastered), to adult object relationships. Additional lines proposed by Anna Freud include: a cluster of developmental lines associated with body independence; a line from egocentricity to companionship; and a line that moves from an infant’s pleasure in the body to pleasure in toys, and then from play to work. Her interest in lines of development occurred in the later part of her career and can be seen in one of her last major books: *Normality and Pathology in Childhood* (1965). She even developed what she called a “developmental profile,” which served as a prototypical psychograph in that it provided a diagnostic schema and assessment of development and where it was fixated or regressed.

Discovering that Anna Freud helped pioneer the concept of lines and used a prototypical psychograph was quite meaningful to me as a psychoanalytically oriented integral psychologist. I have often felt an inner tension between my deep appreciation for Integral Theory and my love of psychoanalytic thought, not always sure how to bring them together in a mutually enhancing encounter. Anna Freud’s early work on developmental lines provided me with an important bridge for my own professional process as a practicing psychoanalytically oriented integral psychotherapist. In this light, and for the historical context it provides, I feel it is worth quoting Anna Freud (1963) at length from a section entitled “Correspondence Between Developmental Lines”:

If we examine our notions of average normality in detail, we find that we expect a fairly close correspondence between growth on the individual developmental lines. In clinical terms this means that, to be a harmonious personality, a child who has reached a specific stage in the sequence toward emotional maturity (for example object constancy), should have attained also corresponding levels in his growth toward bodily independence (such as bladder and bowel control, loosening of the tie between food and mother), in the lines toward companionship, constructive play, etc. We maintain this expectation of a norm even though reality presents us with many examples to the contrary. There are numerous children, undoubtedly, who show a very irregular pattern in their growth. They may stand high on some levels (such as maturity of emotional relations, bodily independence, etc.) while lagging behind in others (such as play where they continue to cling to transitional objects, cuddly toys, or development of companionship where they persist in treating contemporaries as disturbances or inanimate objects)... Such imbalance between developmental lines causes sufficient friction in childhood to justify a closer inquiry into the circumstances which give rise to it, especially into the question how far is it determined by innate and how far by environmental reasons... The disequilibrium between developmental lines which is created in this manner is not pathological as such, though it becomes a pathogenic agent where the imbalance is excessive. Moderate disharmony does no more than produce the many *variations of normality* with which we have to count. (pp. 262-263; 264)²³

Freud points to the interaction between id–ego–superego as the driver of development. Additionally, Anna Freud’s concept of lines has been used to explore developmental lines in achievement (Smith & Lau, 1974), gender identity and role (Tyson, 1982), and marital therapy (Lucente, 1994). In writing this article part of my hope is that it would serve as an invitation to the integral community to further engage with the rich tradition of psychoanalysis.

It has been exciting to learn from Wilber (personal communication, August 31, 2010) how deeply he

was steeped in reading psychoanalytic thought during his twenties and how the psychoanalytic tradition therefore helped shape some of his early thinking in Integral Theory. Some of the authors and books Wilber was reading at the time included Freud's *Collected Works* (1953-1974), Otto Fenichel's *The Psychoanalytic Theory of Neurosis* (1946), and the work of Alfred Adler and Sandor Ferenczi. He was also reading Norman O. Brown's *Loves, Body* (1966) and *Life Against Death: The Psychoanalytical Meaning of History* (1959). In fact, part of Wilber's inspiration for the term *Atman Project* came from Brown's notion of the Oedipal Project. When Brown died, Wilber contacted his widow and then published his unpublished manuscripts in an early issue of *ReVision!* The fulcrum notion in general also originated from reading Gertrude Blanck and Rubin Blanck (1974, 1979). Through writing this article, I want to explore how the emerging field of integral psychotherapy might explicitly and more prominently include more insights from psychoanalysis.

Historically, other prominent psychologists such as James Mark Baldwin (1894) worked early on with concepts similar to lines. More recently, Jane Loevinger (1976) also discussed different lines and their possible relationships to one another:

[Kohlberg (1971) and Selman (1971)] believe that there are several related lines of development, cognitive, interpersonal, and moral at a minimum, and that they stand in asymmetrical relation to each other. A given stage of cognitive development is a necessary but not sufficient condition for the corresponding stage of interpersonal development, and the latter stands in the same relationship to moral development. (p. 188)

The idea of multiple intelligences was widely introduced by Howard Gardner in his book *Frames of Mind: The Theory of Multiple Intelligences* (1983). Gardner outlines seven distinct intelligences—linguistic, logical-mathematical, spatial, musical, bodily-kinesthetic, interpersonal, intrapersonal—and then later tentatively suggests there may be two more lines, naturalistic and existential intelligence (Gardner, 1999).²⁴ The integral psychograph draws, in part, on Gardner's research on multiple intelligences. However, Wilber reflects on Gardner's terminology: "His 7 or 9 multiple intelligences just don't cover all of the developmental lines. Equating developmental lines with multiple intelligences really gets us off the mark, it's confusing. He's really describing talent lines." Wilber goes on to say:

The psychograph is really all of the fundamentally important characteristics of human beings that develop in stages but at relatively different rates from one another but are important to know about. This is different from Blanck and Gardner. It includes all of the previous factors that need to be included. The integral psychograph is the first psychograph in history that is *actually* integral (personal communication, August 31, 2010).

Wilber built his concept of the psychograph on these pioneers; however, the notion of a psychograph actually extends back beyond any of the well-known theorists outlined above. In fact, the term *psychograph* has a colorful history. It has sometimes been used with a slight variation in spelling: *psycograph* (the h being absent from psych).²⁵ In 1796, Dr. Franz Joseph Gall founded a new field of psychology. Gall subdivided the brain into 26 areas and designated corresponding regions on the skull, as he believed that the contours of the skull would reflect the development of the brain beneath. The study of these 26 areas on the skull and their corresponding various mental capacities or "faculties" became the field of Phrenology (Simpson, 2005). Then in 1905, Henry Lavery patented the *psycograph machine*, which included a metal helmet with 32 feelers that measured the contours of a person's skull in order to identify the development of these 26 mental capacities

Prior to Murray’s usage, another Harvard psychologist, A.A. Roback, was also using the term. In his book *The Psychology of Character* (1927), Roback includes a section titled “Psychography,” wherein he states:

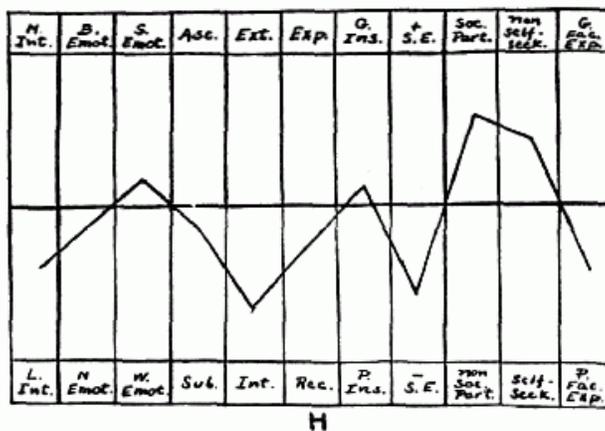
Psychography is a step in advance of pathography in that it records a person’s *total* reactions (moral, temperamental, physical and intellectual) under all sorts of conditions. The examination upon which the psychogram is based extends over a period of weeks and sometimes even months; and specially devised tests are often introduced for the purpose of the examination.

The Psychographic Chart. Rough psychography may be divided into two separate divisions, with a third as a combination of the original two types. Toulouse, Binet, and also Ostwald have adopted a literary form in which to pursue the method. On the other hand we have the psychographic chart of G. W. Allport which is reproduced below. Stern’s approach is purely descriptive, and while making much of quantitative facts, it does not treat qualities by means of graphic curves.

The chart does not purport to deal with a multitude of separate traits. It consists of a selection of fundamental personality components and represents a neat profile of one’s whole makeup, assuming that we approve of the selection and the order of arrangement. (p. 426)

On the next page, Roback provides a picture of one of Gordon Allport’s charts, which Allport (another Harvard professor) called a “psychograph” and included 14 polarities (e.g., social participation vs. lack of social participation) across a number of categories such as “factors of physique,” “factors of intelligence,” “factors of temperament,” “self expression,” “attitudes toward self,” and “sociality.” Beginning in the early 1920s, Allport (1921, 1937) began to devise a number of different ways to graphically represent and “plot” personality and development (see Fig. 4 for one example). These “psychographs” played a formative role in the development of Individual Differences Psychology, or what is also called Differential Psychology.

Nearly 100 years after Lavery’s technical debut of the “psychograph,” it independently reemerged within the context of Integral Theory. As noted above, it appears that Wilber first formally introduced the term “psychograph” in *The Eye of Spirit* (1997) to provide a visual map of a person’s development across multiples lines of development. However, nearly two decades prior to this, Wilber began to formulate the



GRAPH III.

Figure 4. An original Allport psychograph.

notion of lines in his book *The Atman Project* (1980), where he organizes aspects of development into discrete areas. For example, he presents the level specific expression of developmental areas such as *cognitive style*, *affective elements*, *motivational factors*, and *mode of self*. Then in *Transformations of Consciousness* (1986), Wilber discusses three aspects of the self-stages: self-needs (Maslow, 1971), self-sense (Loevinger, 1976), and moral sense (Kohlberg, 1981). Apparently, Wilber came up with the idea of a psychograph while watching an episode of *Star Trek* (S. Esbjörn-Hargens, personal communication, May 10, 2008). As the story goes, one of the *Star Trek* characters was lying on a table being examined by Dr. McCoy, while there was an electronic machine in the background that was measuring interior qualities of this fellow on the table and displaying them in a bar-graph style. Who would have guessed that the ever-popular crew aboard the Starship Enterprise would have a hand in inspiring one of the central features of Integral Theory? In fact, the seeds of this concept had even been planted much earlier: a significant inspiration for Wilber's notion of a psychograph came from two books by Gertrude Blanck and Rubin Blanck (1974, 1979) on psychoanalytic developmental ego psychology. One of these books included a chart that was close to what we now recognize as a visual psychograph. Then the *Star Trek* episode later jogged Wilber's memory of Blanck and Blanck's (1974) Figures 1-3 (Wilber, personal communication, August 31, 2010). Informed by Wilber's notion of the integral psychograph, I have been interested for years in how the psychograph might be operationalized in a clinical setting, which led me to the development of the IPA.²⁸

Part 2: Content

The Integral Psychograph Assessment: Overview

The terms *map*, *matrix*, and *mirror* refer to and describe the integral psychograph from three perspectives: the third-person map, the second-person matrix, and the first-person mirror. These three components comprise the IPA.

- The *third-person map* consists of the IPA process itself serving as a procedural representation and guide; it also includes the IPI, which serves as a meta-map, illustrating what each stage of development *looks* and *feels* like within each distinct line. In addition to the IPI, the third-person map also includes the results of any psychometric tests a patient takes that measures level of development in a particular line (e.g., using the Sentence Completion Test for assessing ego-identity development).
- Next, the *second-person matrix* consists of the clinician's assessment of the patient. This includes the intersubjective dialogue and dialectical inquiry that takes place between the patient and therapist, to help illuminate the patient's development. The second-person assessment also includes the reflective dialogue between the patient and his or her family, colleagues, and peers, regarding their levels of development in various lines.
- Finally, the *first-person mirror* includes a patient's own self-assessment, using the IPI as a tool for self-reflection. The self-reflective dimension of the psychograph assessment process invites a patient to reflect honestly in the spirit of William Torbert's (2004) "critical subjectivity" on their own level of development. They do this through techniques such as phenomenological inquiry that includes the embodied reading of the IPI as well as supplemental literature, attention to dreams and reveries, contemplation, meditation—and asks them to then give their genuine appraisal as to what they see reflected back at them.²⁹

INTEGRAL PSYCHOGRAPH

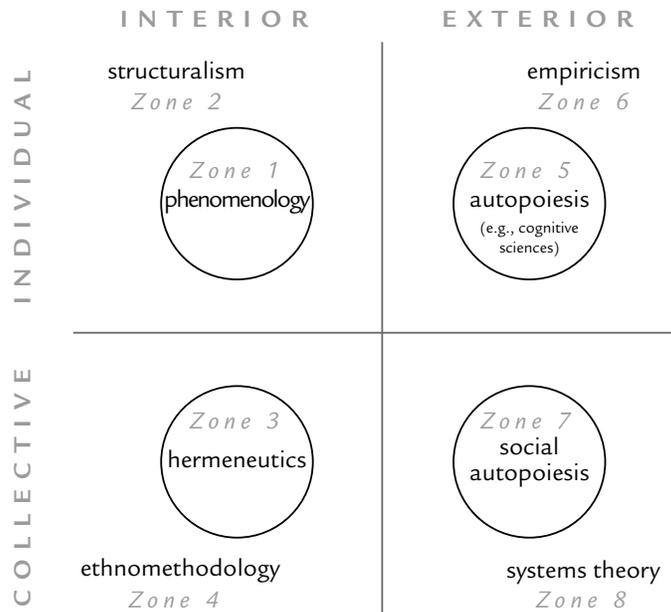


Figure 5. The eight zones of Integral Methodological Pluralism.

Using the zones of Integral Methodological Pluralism (Wilber 2006), technically this assessment process draws heavily on zone 1 (phenomenology); zone 2 (structuralism); and zone 3 (hermeneutics) (see Fig. 5). The role of zone 3 in this context is really in service of zones 1 and 2 because the patient and therapist are largely investigating the patient’s interior. That is, the dialogical matrix between patient and therapist (zone 3) is being explored, yet generally this intersubjective matrix is placed in service of the patient’s experience and understanding of their own interior (zone 1) and structures (zone 2).

The structure of the IPA uses first-, second-, and third-person perspectives (i.e., 1-2-3 and 3-2-1) to create two arcs of inquiry. The arc *in* is a 3-2-1 process and comprises phase 1. The arc *out* is a 1-2-3 process and comprises phase 2. Thus, each of these movements represents an integral arc in the assessment process. I have chosen this structure because in my experience this is a thorough and skillful sequence through which to guide a patient’s IPA process.³⁰ Because there are a number of steps in each of the integral arcs, I will provide a diagram (see Fig. 6) that can serve as a reference point as you read the subsequent sections. The details of each of the six steps are presented interspersed with clinical vignettes and theoretical musings. The vignettes are used to illustrate some of the steps and anchor the discussion that follows. In some cases, the vignettes provide a direct example of what has just been presented and in other cases they are used more indirectly to provide a window into the IPA clinical process. The vignettes are italicized to make their identification easy. Now that I have set the context, I will take you through the IPA from commencement to completion.

Phase 1 (3-2-1 arc)

IPA Commencement: Interest

Either a patient or therapist may initiate a conversation suggesting interest in using the IPA in the present therapeutic context. At this point, either party may provide the patient-therapist dyad each with a copy of this article and any other supportive material.

Lance came to me for psychotherapy as a longtime student of Integral Theory. He was interested in

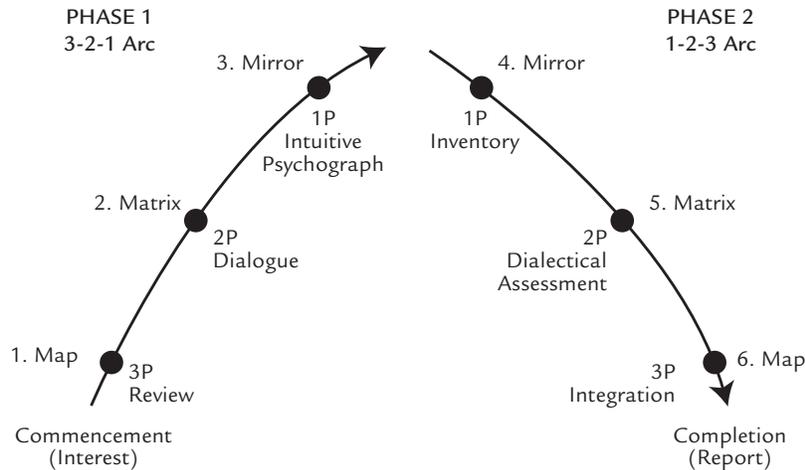


Figure 6. The Integral Psychograph Assessment process.

doing psychological work on himself as he pursued graduate studies at a private university in Berkeley, California.³¹ When Lance entered therapy with me, he was 25 years old and we then worked together for the next 5 years. When he started therapy, Lance had been meditating daily for a few years as a serious student of an emergent contemporary spiritual tradition that draws on various wisdom traditions as well as on Western psychology. His interior life was rich and meaningful, and he appeared to have already gained a certain wisdom and compassion as a result of the spiritual practices he undertook with rigor and discipline. After growing up in the Rocky Mountains near Boulder, Colorado, Lance studied environmentalism in his undergraduate years at a small progressive college on the east coast. He had a love for the wilderness and an aptitude for adventure sports; by the time he came to see me, he had already started somewhat giving these up in order to devote more time and energy to his interior explorations. Lance identified as a 7 on the Enneagram (Riso & Hudson, 1999)—he was optimistic, filled with a spark for life, and often talked about a background anxiety that was just out of reach. Lance embodied what appeared to be genuine love and joy much of the time. He had a strong impulse to manifest his purpose and potential in life so that he could serve humanity most optimally. Lance was tall and slender with a healthy glow about him.

Capable of taking multiple perspectives, Lance had a robust capacity for self-reflection and enjoyed being challenged in our therapeutic work.³² He came from a supportive and close-knit family, one that spent holidays and long-weekends together—traveling, skiing, and generally enjoying each other’s company. He had a history of mostly stable intimate relationships, suggesting the capacity for secure attachment (Wallin, 2007). Lance reported having a wide range of friends and various forms of social connections. When Lance gave up some of his adventure sports, he took up yoga (among other body practices) and appeared agile and generally comfortable in his skin.

We had been working together for 1½ years when Lance approached me with a request to create a psychograph as part of our clinical work.

Step 1: Review (IPA Map 1)

The patient and therapist then each review this article in order to familiarize themselves with the contours of the IPA process. In addition to reviewing the IPA, this step of the assessment process also includes an initial review of the IPI, which the therapist provides. As stated previously, this could be a document created by the clinician, or in the future there will likely be a standard IPI available to integral practitioners. This

review of the third-person map—the IPA procedural map and the IPI meta-lines map—ideally provides both the patient and therapist with enough information to have an informed dialogue (Step 2) as to the clinical appropriateness of undertaking the IPA in the present therapeutic context. This initial review of the IPA and the IPI might take one to two sessions, depending on how much reading and review takes place between sessions. These sessions could occur sequentially or could take place over many months, emerging in therapy and then receding again while more pressing therapeutic issues are attended to in the foreground of therapy.

Because we did not have a template for a psychograph assessment process, Lance and I spent several sessions talking about what a psychograph assessment (process and content) might look like.

Step 2: Dialogue (IPA Matrix 1)

After reviewing the procedural steps of the IPA and the IPI, should the patient wish to proceed with the assessment process, a dialogue then takes place between the patient and therapist. It is in this second-person therapeutic matrix that it is decided whether or not to undertake the IPA (and which lines to include and how many sessions to devote to it). Clinical considerations such as the patient's ego strength, longevity of the therapeutic relationship, regularity of meetings, degree of safety and trust in the therapeutic container, and competing issues in therapy are all taken into account by the patient-therapist dyad in assessing whether to proceed. While the patient's input and desire to do the assessment is taken into serious consideration, ultimately the responsibility as to the clinical appropriateness of the IPA lies with the therapist. In the discussion section of this article, I explore a number of clinical issues that I mention in passing throughout the IPA procedural steps below.

Considering all of the above clinical factors, including the depth of analysis that is required for the therapist to evaluate the patient during the second-person phase of the IPA, I recommend that an IPA be started no sooner than three months into treatment. Ideally, the IPA would begin after a patient and therapist have worked together, meeting weekly for about six months. I suggest this timeline because rich informed assessments and meaningful dialogue could be more readily available when knowledge of the patient's history is gathered, trust in the therapeutic relationship is established, and mutual understanding is developed over time.

As Lance and I dialogued about the psychograph process, we considered a number of factors before proceeding with the assessment. Some of the clinical considerations that impacted my decision to move forward with the assessment were Lance's robust ego strength, the longevity of our work given that we had been meeting weekly for 1½ years, the regularity and consistency of our meetings, and the sense I had of our therapeutic container being a strong one of safety and trust. I had a sense of Lance's development and capacity to have a meaningful encounter with the psychograph process. It also seemed to me that in our therapeutic process thus far we had established access to the subterranean layer of Lance's experience. I trusted that if the assessment process began to obscure our access to this subterranean layer of Being, that we would attend to such an obscuration. Together we discussed a number of these factors. Before proceeding with the psychograph assessment, I also considered my own resonance, knowledge, and ease with Integral Theory. I felt I had a solid understanding of Integral Theory, enough to facilitate the assessment process and I was an experienced and skilled clinician. I felt confident that I would do research and seek consultation along the way, should theoretical questions emerge throughout the process. Ultimately we decided to proceed with the psychograph process, which emerged over time into the IPA.

This phase of considering the clinical appropriateness of the IPA with one's patient might take around one to two sessions, though it could take longer, particularly if there is a difference in opinion as to whether it is prudent to take on the assessment. In such cases, this is a rich opportunity in the therapeutic matrix to explore interpersonal and perhaps even primitive and unconscious material that could get stirred should the therapist suggest it is not appropriate to proceed with an IPA for any number of factors described above. For example, if there is a severe fragility in ego-strength it would likely not be clinically appropriate to undertake

an IPA, and conveying that decision clearly and sensitively to one's patient could bring up material to be attended to and explored within the therapeutic dyad. If it is determined that an IPA would be clinically appropriate and potentially beneficial to the patient, the IPA process then *formally* begins with the review and signing of an IPA Consent Form.³³ When complete, a copy of this form becomes part of the IPA packet. After the consent form is signed, the clinician then reviews the stages of the assessment process with the patient and begins to instruct them on the contours of first-person phenomenological inquiry.

After 1½ years of working together, Lance and I then spent the second year and a half completing his IPA (the entire process took about 16 months), with many sessions entirely devoted to the IPA process. However, during many other sessions we explored the current themes in Lance's life—intimate relationships, early family dynamics, professional considerations, spirituality, anxiety, and the vicissitudes of daily life—while the IPA process receded into the background.

Step 3: Intuitive Psychograph (IPA Mirror 1)

If the process continues to move forward, the patient then begins their first-person self-assessment, an intuitive psychograph. This process is fairly quick, using the broad levels of low, medium, and high delineated in the IPI to describe one's current understanding and felt sense as to where one's development falls within each line. This is analogous to an oil painter's first charcoal sketch on newsprint. The general contours of one's development across various lines are captured, without a great deal of time, detail, or extensive inquiry given to the process at this juncture. In this phase, the IPI can be used as a reference, but more importantly the task is to capture the patient's intuitive felt sense of development (in terms of low, medium, or high) across various lines *before* a thorough investigation has unfolded. This process typically occurs through an informal interview in the therapeutic context (the clinician interviewing the patient).

As I interviewed Lance for his intuitive psychograph, I presented questions to him: "As we begin to consider your emotional line of development, sense into your body, your heart, your mind, and ask the question, 'What do I feel?' Without thinking too much about it, what is your sense of your emotional development—how you feel, what you feel, your awareness of what you feel, your capacity to feel—in terms of low, medium, or high?"

It is entirely appropriate for the therapist and patient to refer to the IPI throughout the initial interview and assessment process. The therapist is available to answer any simple clarifying questions the patient may have, although the intent at this point is to gather the patient's own initial self-reflections. This initial first-person self-assessment is reported to and documented by the clinician in the Intuitive Psychograph. When complete, a copy of this form becomes part of the IPA packet. I recommend clinicians take detailed notes throughout the IPA process, as I have found them invaluable to return to, especially when the assessment process extends out over many months or even years with some patients.

This phase of the initial first-person self-assessment might take three to four sessions to complete (assuming an IPA with 10 lines), though it could take longer as other material is also being attended to in the therapeutic hour (i.e., 50 minutes). Patients will come in with a wide range of knowledge and exposure to Integral Theory and this could also impact the amount of time it takes to complete this initial self-assessment phase. Longtime students of Integral Theory may move quickly through the intuitive psychograph due to their familiarity with the model and previous reflection they have done around their lines. However, understanding the nuances of Integral Theory does not necessarily mean that a person has a great capacity for self-understanding and self-inquiry. These capacities draw on at least two different skill sets, or lines of development. In other words, the capacity to *know* and *see* the various levels of each line (generally a cognitive line capacity) is distinct from the ability to *self-reflect* and accurately *self-assess* one's strengths and weaknesses (generally an aspect of the self-identity line). Additionally, one might find that it is the experts in Integral Theory who are particularly vulnerable to getting caught in the web of technical clarifications and who may have a difficult

time roughing out their initial charcoal sketch—a quick intuitive psychograph.

This completes Phase 1 and the 3-2-1 arc. This phase is characterized by an introduction to the IPA and IPI map (step 1), a dialogue in the therapeutic matrix (step 2), and an intuitive look in the developmental mirror (step 3). Spiraling in from an objective view, to an intersubjective dialogue, to a subjective self-reflective process, provides multiple perspectives on one's development. If the patient-therapist dyad moves at the general pace I outline above, Phase 1 (including commencement) might take from six to nine sessions to complete. Below I present Phase 2 and its 1-2-3 arc. This phase is characterized by a self-reflective inventory (step 4), then a dialectical assessment (step 5), and finally an integration of all the results including any third-person developmental test results (step 6). The IPA process ends with a final report. The movement begins in the first-person perspective, which is where Phase 1 just landed. So from this first-person place we begin to spiral out. If the IPA process moves at the general pace I outline below, Phase 2 (including completion) might take from eight to eleven sessions to complete. The entire IPA process then, from commencement to completion, should take a minimum of 14 to 20 sessions, or 3½ to 5 months of weekly therapy to complete. I recognize that this timeframe may seem daunting to some. While I recommend this general framework to glean the richness that the IPA is intended to reveal, I also know that this may be an ideal to strive toward and not realistic for some. In the discussion section I present a short description of some possible briefer adaptations that one could employ in an IPA.

Lance generated an Intuitive Psychograph pretty quickly. During this process I was creating the Integral Psychograph Index, so many of the descriptions I gave Lance for each level in a line were initially in verbal form. I was continuing to revise and refine the IPI throughout the IPA process, drawing both on our clinical work and my own scholarly research of the literature. As I interviewed Lance on his level of development in each line (in terms of low, medium, and high), during this first pass I encouraged him to not think too much about each line and level but instead to give me his “intuitive hit.” He did so and then upon returning the following week, he adjusted and refined some of his responses.

Phase 2 (1-2-3 arc)

Step 4: Inventory (IPA Mirror 2)

Next, with an Integral Psychograph Index in hand, a deeper and more thorough first-person phenomenological inquiry takes place. This phase of the IPA process asks a patient to engage the IPI through embodied reading, using the guiding question for each line.³⁴ One might use the IPI in this phase of the assessment in the same way a person first reads an Enneagram book and its various descriptions of each personality type, as they try to discern in which type they see themselves.³⁵ Patients are encouraged to be open to a variety of avenues for gleaning information about themselves during their self-assessment process. Embodied reading, dreams, reveries, journaling, body-awareness exploration, contemplation, and meditation are all aspects of this first-person phenomenological inquiry. Wilber (personal communication, August 31, 2010) points out that not only is the assessment valuable in terms of the results gleaned, but it has enormous secondary benefits in terms of a self-exploratory process. Self-exploration is supported in that a therapist may not even be aware of these 10 different lines/dimensions, as they may work in only one or two areas primarily. During this self-assessment phase, patients may do the inquiry both at home and in session. The therapist then interviews the patient and documents the patient's reflections in the Integral Psychograph Inventory, a record of the patient's self-assessment. When complete, a copy of this form becomes part of the IPA packet.

At this point, the therapist might also describe some of the unconscious (shadow) dynamics that may arise during the self-assessment phase of the IPA such as the common tendency for over-estimating or in some cases underestimating one's level of development.³⁶ One factor that may contribute to a patient over or under-estimating their development is what Kegan (1998) refers to as the “principle of origination” that is,

individuals often have difficulty seeing their structures objectively because they are subjectively embedded within them. Another factor that might contribute to a person's inaccurate assessment of their development is simply that there may be a lack of understanding as to what each level actually looks and feels like. An inaccurate assessment may also be due, in part, to the fact that it generally takes a certain degree of ego-strength and stable sense of self to be able to tolerate seeing where one actually is developmentally, which includes both one's strengths *and* weaknesses.

An important issue raised by Thomas Jordan (personal communication, September 11, 2010) highlights that the IPI places a lot of “mental demands” (à la Kegan) on a patient engaged with this process. To read stage descriptions for 10 lines of development and self-reflect on them is a fairly complex task and may not be possible or appropriate for some people. Jordan makes the excellent suggestion that perhaps in these cases the IPI may be more of a resource for the therapist, a map that helps the therapist guide the patient through the reflective inquiry process. How and whether to implement the IPA with certain lower functioning patients is an essential consideration. While it is beyond the scope of this article to outline precisely what an adapted IPA process might look like when working with various specific populations, I hope this area will be explored in future psychograph work by myself and other integral clinicians.

As a person engages the IPI, first they are gaining familiarity with each level of each line. As the inquiry deepens, one will likely end up seeing themselves represented in or characterized by primarily two or possibly even three levels of most lines. This is due to the fact that we are never just in one level of development but typically “spread across” two or three with a center of gravity in one. In the IPA process we are looking for a patient's center of gravity, which is where they will land in their final assessment. A person's center of gravity is the level a person embodies about 50% of the time. This means that *in principle* roughly 25% of the time the individual will be operating just above that level and around 25% of the time they will be operating at the level just below one's center of gravity. It is important to remember that Integral Theory sees these levels as probability clouds, not rungs on a ladder. Because of this, it makes sense that many patients will see aspects of themselves in two or three different levels for each line. Some lines will be easier to assess than others. Some lines will be clearer and others more obscure and this will vary for each person. All of this provides ample opportunity for inquiry, reflection, and therapeutic work. In addition, working with the IPI in this way can be psychoactive in that the mere engagement with developmental maps and models can be a stimulus for actual growth and transformation.

Much of this self-reflective phase of the assessment can occur outside of the therapeutic hour, as a patient reflects, journals, and contemplates their development with the help of the IPI as a resource and guide. On the other hand, a person may prefer to use session time to investigate each line, with the clinician assisting the self-inquiry process. If this is the case, the psychograph process *at any phase* can easily (and appropriately) move into “tangential” territory that may appear not directly related to the assessment process. While working on an IPA, during these “tangential associations,” I hold in my awareness the patient's intention for completing the IPA. Yet at the same time, I typically yield to the intelligence of the unconscious revealing itself (i.e., through following the associations) rather than closely adhering to the IPA dialogue, as I believe this is an essential ingredient in transformative therapy. Therefore, I generally believe the therapeutic process should be privileged over the assessment process if one is committed to maintaining the integrity of sound therapy throughout the IPA.

This self-assessment inventory might take around two to three sessions. The timeline could vary depending on how much of the self-assessment a patient completes outside of the therapeutic hour, and how much of the therapeutic hour is devoted directly to the IPA.

In self-assessing the emotional line of development, it became apparent early on that the full spectrum of emotions—one that included fear, anxiety, grief, anger, lust, embarrassment, terror, as well as the more familiar joy, contentment, bliss, pleasure—was difficult for Lance to access and give voice to. The explora-

tion of developing the capacity for, first, recognizing subtle and nuanced emotional realities and then, second, articulating them, became a substantial theme we explored in our work. In general, accessing certain aspects of emotional material such as grief, anxiety, terror, dread, rage, deep pain—what Wilfred Bion (1970) refers to as negative capacity—was less available in the therapeutic space. Thus Lance at times lacked the capacity to feel, contain, process, and ultimately make meaning out of the more primitive and darker material of the unconscious.³⁷ Negative capacity became particularly significant in exploring and assessing the emotional line of development in the IPA. These kinds of considerations were reflected upon during Lance's Psychograph Inventory. Reflecting upon the nuances of Lance's emotional line over time helped me as a clinician to track development and change in this dimension of Lance's experience, while it appeared to support Lance in becoming aware of the emotional terrain of his Being.

Step 5: Dialectical Assessment (IPA Matrix 2)

After completing the Integral Psychograph Inventory outlined above, the therapist then brings forward her own professional assessment of the patient. This second-person assessment primarily rises out of the therapeutic matrix made up of patient and therapist. In addition to the therapist providing a second-person assessment during this phase, the patient is also seeking second-person assessments from select friends, family, or colleagues. This step can happen informally through a dialogue where the patient verbally conveys his self-assessment with members of his community to gain their feedback and reflections. A patient might also solicit feedback from others on some capacity such as interpersonal skill without revealing his own assessment. Using the Community Assessment Form with recommended guiding questions can be a helpful tool for facilitating this feedback.³⁸ This step can also be guided more formally by the patient sharing in whole or part his Integral Psychograph Inventory with friends and family as a way of facilitating dialogue and gaining feedback from others. During this phase, I recommend a patient seek feedback on each of the lines being assessed from a minimum of two people in their community. If the person has a longtime romantic partner or spouse, ideally this would be one of those persons.³⁹

In the therapeutic matrix, the therapist is now beginning a second-person evaluation of the patient based on their work together thus far. Using one's own clinical knowledge and judgment alongside the IPI as a resource and map, the therapist evaluates the patient using specific altitudes across the 10 lines of development included in the IPI. It is useful for the therapist to have an understanding and felt sense as to the qualities present in the therapeutic matrix as this is the ground and context for this stage of the assessment.

The intersubjective therapy matrix made up of Lance and myself grew increasingly rich with aliveness and intimacy over our many years of working together. I reflected on Lance's capacity for interpersonal contact and this impacted my assessment of his interpersonal line.

I often had the experience of moving into a shared meditative state with Lance, especially at the beginning of our sessions while we were first making contact. I also noticed at times I would have a hard time staying in my body during these extended silent moments, as my awareness wanted to rise up and out of my head. In my own private reveries, I reflected on this dynamic in myself for a long time and wondered to myself how much of this experience reflected my own tendency, historically, for my awareness to float up and out of my body in meditative states. This was a subtle form of dissociation from my body with a habitual preference for the movement of ascension in my meditation practice. Additionally, I wondered to what degree I was picking up on an experience that was being had by Lance. Lance reported a related experience of a certain historical momentum toward and preference for ascension in his interior world. Upon exploring this dynamic together with Lance over several years, we came to see Lance's tendency to habitually privilege the movement of ascension. One of his growing edges was to descend and ground down through the heart and lower body, including feeling awake in his physical body, in particular his lower body, and being attuned to his emotional body. This territory became especially relevant as we explored the somatic and emotional lines of

development and as I assessed Lance in these areas.

I often inquired into Lance's dreamlife more than I do with many patients, in an attempt to access the raw unconscious material of his dreams. From time to time, significant dreams of his revealed dark and morbid, lustful, or violent images that we then attempted to unravel for their meaning and interpretation. These seemed especially significant due to the stark contrast they had relative to his conscious, waking self. These dreams became important as I assessed Lance's self-identity line, because it appeared that his primitive aspects were not yet integrated into a coherent sense of self. These dreams were also relevant to his emotional line as such raw and primitive feelings were strikingly unusual in his emotional expression.

Once the therapist's initial IPA of the patient is complete, this evaluation is documented and presented to the patient. To support claims and provide concrete illustrations for the patient in this initial assessment, the therapist includes examples from the patient's life and from the therapeutic context, specifically within each line. In the written assessment, after the body of text I include a section called "Growing Edge." Here, I make suggestions for what might be needed to optimally integrate or further development. As a reference, I have included Lance's initial IPA as it was written in its entirety, for the self-identity line (Appendix B). In addition, the patient is presented with an initial integral psychograph that visually details their center of gravity on all 10 lines.

The assessment that the therapist creates for the patient is not necessarily going to be consistent with the patient's self-assessment. Therefore, this highlights the importance of the patient's ego-strength, should the therapist assess the patient at a lower altitude than what the patient has assessed himself. Should such differences in perspective arise during this phase of the assessment procedure, therapeutic issues such as trust in the therapeutic relationship, potential empathic breaks, or a patient's sense of being confronted by a lower assessment may arise and demand careful attention. As in the larger therapeutic endeavor, these potential empathic breaks can ultimately be opportunities for healing in the patient and a deepening in intimacy and aliveness in the therapeutic dyad (Ogden, 1994). In some cases, the assessment might be higher too, which can be ego dystonic.

The patient's self assessment and the clinician's initial assessment of the patient are then explored in depth in this second-person therapeutic context. This is a dialectical inquiry between patient and therapist that takes place in the intersubjective field of analysis (psychotherapy). This intersubjective matrix is sometimes referred to in psychoanalytic theory as the *analytic* or *subjugating third* (Ogden, 1994, 1997), the *intersubjective third subject of analysis* (Ogden, 1994), *transitional space* (Winnicott, 1951) or *potential space* (Winnicott, 1971), and the *container-contained* (Bion, 1962). The analytic third is a distinct ontological entity that exists between patient and therapist. It is neither the patient's subjectivity nor the therapist's subjectivity, but rather it is the co-mingling of both subjectivities.⁴⁰ As Wilber notes, "Another way to look at the therapeutic container is to look at the *therapeutic we*. Then all the richness in what we understand about the we can come to the container. The therapeutic we is a third" (personal communication, August 31, 2010).

The second-person assessment utilizes the intersubjective matrix between patient and therapist, as well as the matrix between patient and his or her community to assess one's level of development. While the therapist is looking for concrete examples from the patient's life and from the therapeutic matrix to help assess the patient's level of development, he is also available and interested in his own unconscious material revealing itself through dreams (Freud, 1953) and reveries (Ogden, 1997) that might help illuminate the patient's development. As a result of this second-person dialogical exploration, clarifications, adjustments, or modifications may be made by the therapist or patient regarding their initial assessment.

As is the case in any psychoanalytic or psychodynamic therapy, as part of the therapeutic matrix, it is also important to attend to transference-countertransference dynamics prior to beginning the assessment process and throughout the IPA. Understanding some of the transference-countertransference currents that are alive in the room will help determine the clinical appropriateness of taking on the IPA together.⁴¹

*As I tracked the transference-countertransference that was in the room, some themes became apparent.⁴² In terms of countertransference, it is not too common for my patients to show up in my dream life. In over 10 years of working as a therapist, patients have appeared in my dreams maybe a dozen times. When my patients have appeared in my dreams, the dreams have typically come in clusters. There was a phase of our work together where Lance showed up in several of my dreams, usually in the context of us hanging out as friends, typically doing something such as going to a movie together on a Saturday afternoon. When I reflected on these dreams, it seems that they captured a sense of *simpatico* that was present in the therapeutic space. Even if the boundaries of our therapeutic relationship did not allow for us to hang out on Saturday afternoons, the spirit of friendship was alive in the room. Additionally, I reflected on these “friendship dreams” and wondered if they were giving me information regarding Lance and his process and development. Perhaps aspects of my experience of Lance were being illuminated in my dreams—his orientation toward easy-going friendliness and positivity such that he had virtually never expressed anger directed at me in five years of therapy. I considered how this might be relevant to his self-identity, interpersonal, and emotional lines of development. Considering my countertransference, I wondered if I had pulled for a certain friendliness to be extended toward me in our therapeutic relationship and if this could be contributing to the absence of more raw and primitive material arising in our relationship.*

I also noticed at times I felt waves of grief and anger in the therapeutic space that—after my own inquiry—did not always feel like they belonged to me. This was a place of exploration for us to examine, where was this coming from: was it Lance’s unfelt or intolerable emotion I was feeling, or maybe my own? Anxiety also showed up in the matrix. Knowing that I tend to feel a fair amount of anxiety, when there was anxiety in the room sometimes it was harder for me to discern to whom it primarily belonged. This would become a point of inquiry particularly as it related to the emotional line of development as Lance reported more and more contact with his own grief and anxiety as the years progressed.

*In terms of Lance’s transference onto me, one significant image that appeared with frequency throughout the years was an image of me that would appear in his mind’s eye. Typically at the beginning of our session, after we had sat together for a while and usually in silence, Lance would sit with his eyes closed and report seeing an illuminated silhouette of me. We explored this image over the years and inquired into its meaning. Lance reported associations such as love and radiance, and at times early on in our work it seems this image was sometimes imbued with a maternal quality, though this seemed to shift over time. These associations would then be folded back into our inquiry for exploration and interpretation. What these dynamics evoked in me was the recognition that there was a deep and at times maternal love and fondness that I developed in relation to Lance, one that deepened with time. This maternal love was captured, I believe, one day when Lance was turning 30. We had worked together for 5 years, journeying together through his young adult years into his emergence as a mature man. We stood at the door to say goodbye, while mutually recognizing the significance of this milestone in his life and development, and he said, “Thank you for helping raise me.” This love served as a ground and container for the IPA process, one that was deep and wide enough to contain anything that emerged in our field. Love is the container for the developmental process across these many lines. *Agape* is expressed in this context through my embrace of the many facets of Lance. *Eros* is expressed in this context through my love of Lance’s own rich and mysterious developmental process. The strength and depth of our therapeutic matrix supported a richly honest and evocative psychograph assessment process.*

This second-person phase of the assessment might take around four to five sessions. The time it takes for this phase to be completed depends on a number of factors including how long it takes the therapist to complete her assessment of the patient, how long it takes for the patient to gather reflections from his community members, and then how the assessment dialogue unfolds in the patient-therapist dyad and to what degree this is the focus of the therapeutic hour.

Step 6: Integration (IPA Map 2)

At this point, the therapist and patient each have their initial assessment of the patient in all 10 lines, and the patient now also has evaluations from others in his or her life. Next, the patient may bring in for consideration any third-person psychometric test results he or she has taken. These test results are then explored and evaluated in light of the patient’s first- and various second-person assessments. Next, patient and therapist engage in cycles of hermeneutic inquiry clarifying, honing, spiraling toward what is becoming the patient’s final IPA that has co-arisen out of the intersubjective analytic third, the space between patient and therapist. Finally, by taking into consideration and exploring all of the first-, second-, and third-person assessments, the therapist creates a final IPA. The result is an integral map produced from informal and formal mixed methods. It is more accurate than simply a third-person zone 2 map in that it transcends and includes such results through a triangulation process. As a reference, I am including Lance’s final IPA (Fig. 7).

The IPA highlights the contrast between a third-person zone 2 test versus a first-, second-, third-person enactment. Many of us fall into thinking that a third-person psychological test captures the best or the most accurate picture of who we are. People often assume such “objective” results are more valuable than first- or second-person psychological assessments. Rather than being a third-person assessment instrument that can sometimes feel like something done *to* you, the IPA is an actual embodied co-enactment. In the end, the IPA very much includes third-person test results, but it does so in the context of finding the synthetic ground between first-, second-, and third-person forms of assessment. For example, it is possible for third-person test results to be superceded by the first- and second-person assessment in the IPA process. In other words, zone 2 assessments do not always override zone 1 and zone 3 assessments.

The final IPA is not a product of consensus or a postmodern process approach. The therapist takes into serious consideration the patient’s own assessment of himself, his community members’ assessment of him, and any psychometric test results he has taken. All of these factors, including the therapist’s expertise and judgment, determine her best appraisal of the patient’s final altitudes in the IPA. This is all the more reason it is essential that the therapist has done her own psychograph work, preferably including a formal evaluation, so that this information (i.e., the therapist’s strengths and limitations in perspective and capacities) is all taken into account. I will elaborate on this point in the discussion section. The final IPA conveys the patient’s specific developmental level, as defined by the therapist at that particular time, for each of the 10 lines included in the

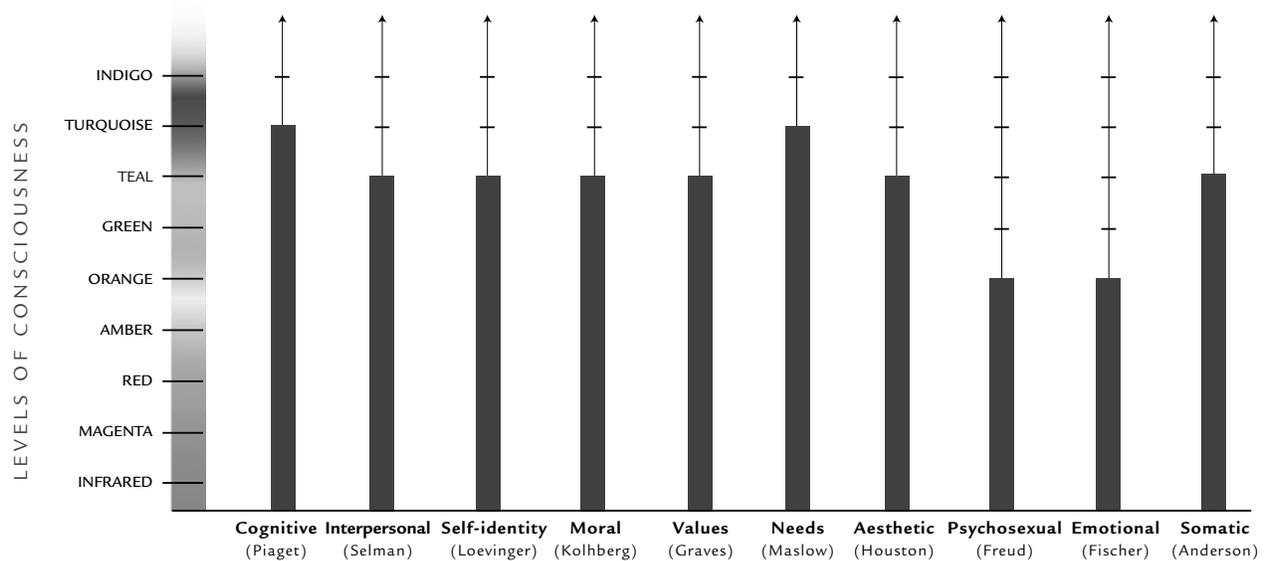


Figure 7. Lance’s final integral psychograph.

IPI. The clinician documents the complete IPA, again with detailed examples and illustrations to support the final assessment of each line. A visual integral psychograph accompanied by a written narrative detailing the assessment of each line is then presented to the patient (see Fig. 7). This final phase of the assessment might take one to two sessions, although it definitely could take longer.

To summarize, Lance completed an intuitive psychograph (step 3) using the broad stages of low, medium, and high at this early juncture. Next, he completed his psychograph inventory (step 4), which put him at one or two specific altitudes for every line. I then created my initial IPA for Lance (step 5). And finally, after all the test results and input from the community was in, and the dialectical inquiry between us was complete, Lance's final IPA was finished (step 6 beginning). Lance then took psychometric tests that were relevant to certain lines, which he then brought back into our psychograph process for further reflection and possible revision. He also brought these results again to certain community members for their feedback. Generally, the final assessment tends to be an average of the multiple perspectives we have for each line.⁴³ When Lance took the Sentence Completion Test as part of the assessment for the self-identity line, he scored lower than either he or I had assessed him. So in that case, we then took an average of his first-person self-assessment, my second-person assessment, the feedback he got from people who knew him, and the third-person test results. After much dialogue and inquiry over the next five months, Lance's final IPA was complete (step 6 finished), which meant that we both agreed on what specific altitude he was for all of the 10 lines assessed.

As noted previously, it is important to keep in mind the difference between clinical and calibrated assessments within a psychograph. There are strengths and limits to both kinds of assessments. I arrived at my assessments of Lance (e.g., at Strategist in the self-identity line) via an integrated process that included my clinical assessment combined with the results of Lance's own inquiry process and the results of psychometric tests he took. Clearly, second-person clinical assessments should be differentiated from third-person calibrated tests—each revealing an important dimension of the integral psychograph assessment process. It is interesting to note that there is some suggestive research being done by both Ingersoll (in the context of the SCT) and Stein (in the context of the LAS) on how individuals are able to approximate levels of development within others with some remarkable accuracy. Nevertheless, a clinical assessment should not be seen as equal to a calibrated assessment (and vice versa).

IPA Completion (Report)

When the Integral Psychograph Assessment is concluded, the therapist gives her patient a completed IPA packet that includes the following documents:

- Integral Psychograph Index
- Integral Psychograph Assessment Consent
- Intuitive Psychograph
- Integral Psychograph Inventory
- Initial Integral Psychograph (visual graph) and Initial Integral Psychograph Assessment (write-up)
- Final Integral Psychograph (visual graph) (see Fig. 7)
- Final Integral Psychograph Assessment (write-up).

The resulting final report is approximately 100-150 pages.

The entire IPA process can take anywhere from a few months (I recommend a minimum of three) to in some cases years, depending on the variety of factors stated above. It is a good idea to set up a general timeframe with your patient at the start of the IPA process as a way of setting a mutual intention. At the same time, however, it is important to remain flexible within that timeframe, always keeping in mind the integrity

of the therapeutic process.

I gave Lance a final 125-page Integral Psychograph Assessment and I kept a copy of this report in his file. We agreed that it would be meaningful to revisit the IPA again at a later point in therapy.

A year later, Lance and I revisited the self-identity line of development. He had retested with the SCT and scored higher than the first time, which put him solidly in Strategist/teal altitude. Then I did my assessment with him and we had a conversation about that and confirmed that it did indeed feel like he was no longer straddling between Individualist and Strategist. He also had second-person conversations with people in his life to learn what their perspectives were. His evaluation, the SCT, my evaluation, and the people in his life generally agreed he was at the Strategist level (i.e., teal altitude).

As a map to help guide the IPA process, Appendix A outlines a summary of the six procedural steps of the IPA presented above with short descriptions of each step, the associated documents that are relevant to each stage of the assessment, and the minimal number of sessions suggested for each step.

Part 3: Considerations

There are a number of considerations for psychotherapists to keep in mind as they use the IPA in their clinical work. Here, I present a few issues to be considered by a therapist interested in facilitating an IPA with his patients. This exploration of clinical considerations is by no means meant to be exhaustive. I am presenting these issues as a starting point and I look forward to furthering the dialogue with integral practitioners regarding these and other relevant topics.

How an IPA Can Inform the Course of Treatment

There are a variety of ways in which the results from the IPA can inform the course of psychotherapy treatment. One way to think about how I used the IPA results after the assessment was complete is to look at how it can support the patient's vertical development and horizontal integration. Wilber has observed:

The IPA is not just a theoretical head-trip, an elaborate test. It is a first-, and second-, and third-person evaluation in 10 dimensions of a person. Many times they are not even aware that they have these dimensions. Many therapists are not aware that they have these dimensions. The shadow can hide in any one of those 10 dimensions. So [there is great value in] pulling it forward, feeling it, touching it, tasting it, checking it out with your friends, colleagues, spouses, coming back and discussing it with your therapist. (personal communication, August 31, 2010)

In terms of vertical development, Lance and I worked extensively on the emotional line and self-identity line after the assessment was complete. Where he assessed in these two lines informed the course of treatment, as we examined specific issues in his life that were relevant to each line. His emotional line was the lowest line in his assessment (along with the psychosexual line), so we did a lot of work to expand his capacity to hold in his awareness and embody a full spectrum of emotion—from ecstatic joy to dark anger. In terms of the self-identity line, Lance was straddling two levels—green and teal altitudes. We often talked about the characteristics of each of those levels of self-identity. Through this reflective inquiry and the subsequent psychotherapeutic work, patients have the potential to expand into their emerging level of development.

The IPA also informs integrative work and by its process is integrating in and of itself. For Lance, the process of identifying distinct aspects of himself and working with them actively opened up a lot of subject-into-object work. He was in a practice of making many aspects of himself that were subject into object, including interpersonal skills, emotional capacities, self-identity dynamics, and somatic tendencies. All of these

were being made into object both for him personally, and in terms of the therapeutic context where the two of us could reflect on those dimensions of him.

Also, as a clinician the importance is less about how high each level is and perhaps there is even greater relevance in the altitude of each line relative to one another. For example, Lance is by and large quite developed in most lines, but the gestalt that emerges when viewing his entire IPA graph is that his center of gravity is teal altitude (with six lines being at teal). Two of his lines are at turquoise altitude, and two of his lines are at orange altitude. As a result, some of the focus of our clinical work repeatedly explored the two lower lines.

What optimally could be gained through the IPA process is a deeper and wider degree of self-knowledge, and with this a greater capacity to self-reflect with coherency and meaning. The IPA process also facilitates awareness by helping to make what is subject into object. It supports both vertical growth and horizontal integration, and it may help to identify key areas to focus on in the clinical work—for example, emotional obstacles, relational patterns, or underdeveloped capacities, to name just a few. The IPA process makes these 10 dimensions or lines of development available in our awareness.

The Compatibility of an IPA within Psychoanalytic Integral Therapy

For the purposes of this article, I have illustrated what an IPA might look like implemented in psychoanalytically oriented integral psychotherapy. However, within integral psychotherapy there is room for various streams of therapy: cognitive behavioral integral therapy, attachment oriented integral therapy, psychoanalytic or psychodynamic integral therapy, existential-humanistic integral therapy, to name just a few. Each of these orientations within integral psychotherapy is going to bring up their own set of issues when implementing an IPA. Some of these issues will be overlapping across orientations while others will be specific to a particular orientation to integral psychotherapy. In this process, I have attempted to illustrate which issues might be relevant to psychoanalytically oriented integral therapy. My hope is that as integral clinicians we will gain insight over time into which particulars to keep in mind throughout an IPA process, within each of the various streams of integral psychotherapy.

While these are not fixed categories, I generally liken the overall IPA process to a more cognitive behavioral model of therapy, drawing largely on the conscious self. That is, the IPA draws on a conscious reflective appraisal of one's development by self and others. Psychoanalytically oriented therapy, on the other hand, draws largely on the unconscious or subterranean layer of Being. For instance, in psychoanalytic therapy, free associations are followed and explored as a window into the self and soul, and the transference-countertransference in the room is attended to with consistency and depth. These differences between an integral assessment and psychoanalytic therapy have created an ongoing tension in me. Throughout this process, I have attempted to maintain the integrity of depth-oriented therapy, while at the same time following the trajectory of the IPA through its completion. In my conversation with Wilber about this article, I was struck by the similarities between, and deep mark that psychoanalytic thought has made on the formation of, Integral Theory. This was helpful for me to hear because I have always felt torn between the two in some ways and at the same time sensed a compatibility between them.

Given this ongoing tension, I am committed to exploring and including the unconscious material that is revealed throughout the IPA. At each turn in the assessment process, the psychoanalytically oriented integral therapist is invited to explore with her patient what the results of each step is stirring within the patient and within the therapeutic dyad (patient and therapist). The material that is evoked is then folded back into the therapeutic exploration. These associations, if handled with care and sensitivity, do not need to create a breach in the therapeutic container but rather can provide the unearthing of rich material which can inform the therapy and the IPA process itself. This material is potentially a gain for the IPA and ultimately for the therapy itself.

The Impact of an IPA on the Therapeutic Container

The importance of therapeutic containment is such that I feel it is imperative to consider the impact of the assessment process on the therapeutic container. It is essential to consider how this sort of assessment process, especially the clinician's assessment of the patient's level of development across multiple lines, will impact the trust and safety of the therapeutic container.

To understand the notion of a therapeutic container, it may be useful to recall C.G. Jung's (1944) notion of an alchemical vessel. In the context of psychological and spiritual inner work, Jung talks about the importance of an alchemical process—one that turns something common into something precious. The alchemical vessel needs to be sealed for the alchemical process to occur. From a psychoanalytic or psychodynamic perspective, a primary though not exclusive area of focus is the *sub rosa*, the area that is “beneath the skin,” that which is hidden or subterranean. Therefore, in psychoanalytically oriented therapy, it is essential for the patient to first feel safe enough within the therapeutic matrix, the alchemical vessel, in order to *see* and eventually *feel* this subterranean layer of one's experience. And then second, a patient must feel safe enough for this hidden material to *emerge* in the intersubjective container. A significant consideration in the IPA process, particularly for clinicians who are psychoanalytically or psychodynamically oriented, is the impact of the assessment process on the therapeutic matrix or container.⁴⁴

A potential drawback to the IPA process is a compromise to the alchemical vessel (the therapeutic container) that is ideally sealed to best facilitate and protect the heat of transformation. Upon receiving the therapist's assessment, a patient may feel hurt, betrayed, misunderstood, and no longer safe to reveal their primitive, more “ugly” aspects. There is a need for a commitment on the therapist's part to address the impact of the assessment process with the patient along the way. Still, a major loss to the therapy could be a break in the therapeutic container. That is, at some point in the IPA process a patient may no longer feel the safety of the therapeutic vessel that is necessary to do effective psychotherapy. Then again, ruptures in therapy can sometimes, though not always, be repaired. The process of repairing an empathic break can actually be quite valuable and even transformative when handled with courage, care, and understanding as to the value of the process.

The Importance of the Therapist's IPA

In order to effectively assess a patient using this clinical assessment tool, I strongly recommend the therapist first go through the IPA process herself. The therapist ought to include at least one other person's perspective on her in addition to the self-assessment. This process of taking the time to deeply reflect and create one's own integral psychograph is important because this material will show up in the therapeutic space as patients explore their own psychograph, especially in the lines in which the therapist is least developed.

Prior to beginning the IPA, I created my own integral psychograph. While I did not have the IPA procedure formally documented at that time, I generally followed the procedural steps outlined above. To do this, first I created an intuitive psychograph much in the same way that is outlined in the IPA. I used the levels of low, medium, and high to assess myself in each of the 10 lines included in the IPI (cognitive, interpersonal, self-identity, moral, values, needs, aesthetic, psychosexual, emotional, and somatic). I then took a sharper and more sustained look at each of these lines of development, and meditated on their corresponding question (see Table 1). Meanwhile, I steeped myself in the literature relevant to the various lines. Then, I created a more specific psychograph, an integral inventory that reflected one or two altitudes for each line. Once my self-assessment process was complete, I then brought it to my husband—who happens to be an Integral Theory expert—to get his evaluation. In our relational matrix, we then had many fruitful dialogues over several weeks regarding my development, and development in general. The outcome of this dialectical assessment was an integral psychograph that reflected my altitude in 10 lines of development. This served as a backdrop

for my facilitation of the IPA with Lance.

Keep in mind, each patient-therapist dyad will co-enact together certain lines more fully than others, and this will likely change for a clinician with each patient, and perhaps with the clinician's own development across various lines. Part of my own process of self-reflection included exploring how my own Lower-Left quadrant orientation (Divine, 2009), Enneagram type 4 (Riso & Hudson, 1999), and personal integral psychograph enacted the clinical space and my assessment of Lance.

A Brief Approach to the IPA

As an integral psychoanalytic therapist, beginning the assessment process around 3 to 6 months into treatment seems appropriate. As I have already explored, if the assessment process is started too soon into treatment, the developing therapeutic container could be disrupted, a risk that is present throughout the IPA process but seems more likely in the early stage of therapy.

Unlike briefer forms of therapy such as cognitive behavioral therapy, in psychoanalytic therapy the first year of therapy could easily be considered the early phase of treatment. I recognize that this sort of timeline may not be applicable for the many valuable forms of shorter-term therapy, such as insurance-based therapy that may only reimburse for a minimal number of sessions per year. The IPA I present could be adapted to fit the needs of patients who only have a limited number of sessions due to insurance benefits or general time and money constraints. A briefer version could work with just a few central lines—perhaps the cognitive, interpersonal, self-identity, and moral lines—and cycle through them in shorter intervals. Or, the patient may wish to explore one or two select lines—perhaps the emotional and psychosexual lines—that are most relevant to the work they are doing in psychotherapy. Each psychotherapist can identify the appropriate time lengths for their respective clinical situation and patients. I look forward to this abbreviated IPA being utilized and expanded in the future by myself or other integral clinicians so that a wider population may be served.⁴⁵

Conclusion

Implementing an Integral Psychograph Assessment in the context of depth-oriented psychotherapy asks a great deal of the therapist. As depth-oriented clinicians, not only are we attempting to do subtle and transformative work on the deepest layers of self and soul for our patients, we are also undertaking a thorough integral process of assessment, the IPA. All the while, we are doing our best to attend to our alchemical vessel (the therapeutic container) so that it may stay as hermetically sealed as possible to protect the precious transformation that is occurring within the vessel. As integrally informed clinicians, we are also asked to have a certain knowledge and working understanding of Integral Theory, such that we may guide the assessment process in a meaningful way. If we have devoted our professional life to becoming a sound and expert clinician, though integrally informed, we may not know all of the complex and subtle nuances of Integral Theory. We are asked to be humble in our willingness to not know what is next, in theory or application of the IPA. We are also asked to have self-knowledge, to be willing to take the time and do our self-reflection, our own integral psychograph, in order to better serve those with whom we work. We are invited to open ourselves to be impacted and changed by the *therapeutic we*. Finally, we are asked to attend to the impact of the assessment process on the therapy. Ideally, both insights and any wounds that might emerge as a result of the assessment process will be attended to in the therapeutic vessel.

During the IPA process and in therapy in general, if I am willing to tolerate not knowing, I often feel I am swimming in the unknown, uncertain as to where to go next. Any clinician who recognizes this territory knows that this can be quite a scary place to navigate with your patient, not knowing what will happen from one moment to the next. Yet this is also quite enlivening, if one can relax into not knowing. In those moments when I feel lost as I am swimming in the unknown of the therapeutic matrix, I take refuge in the great psycho-

analyst Wilfred Bion's (1990) statement: "In every consulting room there ought to be two rather frightened people: the patient and the psychoanalyst" (p. 5). Perhaps if we are willing to be frightened and confused as we navigate the IPA process with our patients, something unexpected and potentially transformative might emerge in the therapeutic matrix. In addition, the insight, self-knowledge, coherence, and integration that are possible with the IPA process can have a calming and healing effect on one's Being.

Bion (1970) talked about the deep and formless infinite that is available to us in the consulting room when we are willing to leave memory and desire at the door and swim in the waters of the unknown together. Bion's student, James Grotstein (2000), calls this the *transcendent position*. Grotstein writes: "Transcendence means having the ability to transcend our defensiveness, our pettiness, our guilt, our shame, our narcissism, our need for certainty, our strictures in order to become 'one with O,' [O is Bion's symbol for ultimate Truth], which I interpret as becoming one with our aliveness, or with our very being-ness our *Dasein*" (p. 300). With our patients, and with ourselves, if we are willing to leave memory and desire at the door and to *not know*, we have the possibility of touching the deep and formless infinite, the transcendent position that is alive with living inquiry and intimacy. This deep and formless infinite can feel overwhelming and scary; I sometimes feel I cannot contain that much unknown. Yet this is the place where transformative, integrative healing happens—in the vast container of the deep and formless infinite, a place where the contractions around one's Being loosen, relax, and eventually can dissolve and one's divinity can shine through. As Wilber (2000) eloquently reminds us: "Through these general waves in the great River, some two dozen different developmental streams flow, all navigated by the self on its extraordinary journey from dust to Deity" (p. 27). May we as integral psychotherapists, regardless of the integrative frameworks we use, never lose sight of what such frameworks are on behalf of—the deep and formless infinite.

Acknowledgments

I offer immense gratitude to my patient Lance, for in many ways the development of the Integral Psychograph Assessment and the Integral Psychograph Index would not have happened in the way that it did, had he not been such a dedicated student of Integral Theory and a human being capable of rich and complex self-reflection and inquiry. He made significant contributions to the formation of this process, and for that I am very thankful. In addition, the courage, intimacy, and aliveness that was often palpable in the consulting room (our matrix) during our work together moved me in profound ways. I am grateful to those who read earlier versions of this article and provided valuable feedback—meaningful challenge and robust support. In particular, thanks to Sean Esbjörn-Hargens for his support every step of the way and for encouraging me to see this through to completion; to Bob Walters for inspiring me to believe in the transformative power of "O" in the therapeutic context; to Steve Sulmeyer for engaging me in mind and heart, thinking and feeling, over all these years of collaborative inquiry and for his careful read and detailed feedback on this article; to Andre Marquis for his helpful written feedback as well as his loving support during the original presentation of this work; to David Zeitler for his stimulating dialogue surrounding theoretical considerations and for the passion that he brings to the psychograph; to Elliott Ingersoll for his engaging and challenging feedback that most certainly made this a stronger and hopefully more accessible article; to Mark Forman for generously sharing with me his deep integration of clinical expertise and integral knowledge; to Thomas Jordan for his discriminating and careful read of this paper and his offering of such important clinical considerations and knowledge of relevant literature; and to the excellent editorial comments offered by JITP peer reviewers, as well as the fine stewardship Lynwood Lord provided throughout this process. I offer a deep bow and thanks to Bert Parlee who supervised me as a budding clinician in integral psychotherapy and who first invited me into the exciting world of Integral Institute during its inception in 2000. Finally, I offer a heartfelt thanks and deep bow to Ken Wilber for his profound generosity of spirit in sharing his work with the world and his kind and discriminating personal engagement with this piece of work.

Appendix A

Summary: Integral Psychograph Assessment Steps and Forms

IPA Commencement (1 session)

- Patient expresses initial interest in Integral Psychograph Assessment (IPA)

Phase 1 (3-2-1 arc) (1-2 sessions)

1. *IPA: Review*
 - Patient familiarizes themselves with the IPA and Integral Psychograph Index (IPI)
 - *Relevant forms:* This article; IPI
2. *IPA: Dialogue (1-2 sessions)*
 - Patient and therapist dialogue and decide whether or not to undertake the IPA
 - *Relevant form:* Integral Psychograph Assessment Consent
3. *IPA: Intuitive Psychograph (3-4 sessions)*
 - Patient completes initial psychograph self-assessment sketch (low, medium, high)
 - *Relevant form:* Intuitive Psychograph

Phase 2 (1-2-3 arc) (2-3 sessions)

4. *IPA: Inventory*
 - Patient completes integral psychograph self-assessment.
 - *Relevant form:* Integral Psychograph Inventory
5. *IPA: Dialectical Assessment (4-5 sessions)*
 - Therapist completes initial IPA for patient using integral altitudes and presents to patient. The patient's self-assessment and the clinician's initial assessment are explored through dialogical inquiry in the therapeutic matrix. Also during this phase, patient seeks feedback regarding self-assessment from a select few community members
 - *Relevant forms:* Community Assessment, Initial Integral Psychograph (visual graph), and Initial Integral Psychograph Assessment (write-up)
6. *IPA: Integration (1-2 sessions)*
 - Therapist and patient together review the following assessments: patient's first-person Intuitive Psychograph; patient's first-person Integral Psychograph Inventory; therapist's first-person Initial Integral Psychograph Assessment; second-person reflections from patient's community; any third-person psychometric test results patient has taken. Taking all of these first-, second-, and third-person assessments into account, therapist completes a final IPA accompanied by a written narrative, and a visual Integral Psychograph and presents to patient
 - *Relevant forms:* Final Integral Psychograph (visual graph) and Final Integral Psychograph Assessment (write-up)

IPA Completion (1 session)

- A completed IPA packet that includes all of the above-mentioned forms is presented to the patient and a copy of this packet is kept in the patient's file

Appendix B

Initial Written Assessment for Lance's Self-Identity Line

Self-Identity Line: “*Who am I?*”

Teal Altitude

Autonomous (The Strategist)

Lance demonstrates a capacity to navigate conflicting needs and expectations from self and others ongoingly in a variety of contexts. Lance is deeply committed to asking himself, “Who am I” and has displayed a long standing relationship to this question in a reflective and curious way. He is aware of the social construction of reality and how he participates in this both in terms of his perception of himself and others’ perception of the world. Lance’s life is guided by higher principles, often drawing on a spiritual tradition as a way of serving humanity and the planet. His life’s work is guided by fulfilling his life’s purpose as he understands it, and he is committed to becoming the most he can be. Natural to this stage of development is the assumption that higher development is preferred and should be encouraged in self and others. Lance is aware of this subtle privileging of vertical development and is actively seeking to focus on his own horizontal growth and integration. He has demonstrated growth, for example, in allowing others to develop at their own pace, as is evidenced in Lance’s increasing tolerance for his father’s apparent disinterest in certain aspects of health and wellness. Lance is able to hold paradox in a personal way. He is generally able to hold contradictions in reality, as he is aware of the enacted nature of phenomena. Not only is Lance open to feedback but he actively seeks it out from friends, colleagues, teachers, and consistently in our therapeutic relationship. As a result of Lance’s advanced self-identity, he is a leader among friends and colleagues. For example, in his role within his spiritual tradition, he is both student as well as facilitator. For some time now, Lance has served as counselor/consultant within the tradition as guide to individuals seeking spiritual and psychological assistance in their growth process. He genuinely is committed to serving others in their own transformative process.

Growing Edge

Natural to this stage of development, Lance sometimes feels constrained by the ordinary aspects of life, that is, the concrete limitations on time and the financial necessities of making a living. Also natural to this stage is Lance’s ongoing attempt to keep one’s act together and to generally appear balanced and mature. I would like to see Lance continue to open to the ordinary constraints of life as well as allowing for further inclusivity and openness to both sides of reality—good and evil, beauty and ugliness, life and death. Also, I would like to see Lance continue to develop his capacity to express his less reasonable and mature self and opt for experimenting with a more spontaneous and raw response to life. Lastly, I would like to see Lance practice tolerating ambiguity more and this could be experimented with in the therapeutic setting. While cognitive understanding is an important dimension of integrating insight and experience, sometimes Lance’s desire to understand the theoretical underpinning of a suggestion or intervention can foreclose a learning that leads with direct experience and is only *then* augmented by theoretical understanding.

NOTES

¹ In Excerpt D, Wilber (2002) introduces a sociograph to track facets of development in collectives.

² Stein and Heikkinen (2009) provide a valuable overview of how clinical assessments are similar and yet different than psychological models of development or psychometrics. Given the importance of these kinds of distinctions for developing a more sophisticated discourse around clinical psychographs, I quote them at length:

Closely related to models and to metrics—but belonging strictly in neither category—are *clinical assessments*. This important area of developmental psychology is the province of trained professionals, from therapists to teachers and consultants. Clinical assessments are complex judgments about individuals rendered in uncertain real-life conditions, such as during the practice of psychotherapy (Sullivan, 1964). They are based on models of development endorsed by professionals and they function like metrics insofar as they classify and discriminate between persons. However, they are not as explicit and codified as true metrics; they must remain flexible and facile in the hands of the professionals who make them. Moreover, the value of different types of clinical assessments hinges in large part upon the quality of the professional practices that surround it. This also sets them apart from metrics, which are deemed valuable in terms of specific psychometric quality control parameters. (p. 9)

Therefore, the Integral Psychograph Assessment does not provide a calibrated measure of a patient's level of development (i.e., a psychometrically calibrated designation that is stable across persons and conditions) but rather provides a rich and nuanced clinical assessment of the patient as experienced and assessed by the clinician within a specific context and a particular time. As a result, the IPA may provide a more intimate and detailed assessment than most psychometrics. However, the clinician is enacting a different level than the kinds of levels enacted by calibrated measures even if they overlap in terms of their ontological focus.

³ There appears to be at least three kinds of relationships between lines of development: first, a relationship that is *necessary but not sufficient* where the growth in one line must precede the growth in another (e.g., cognitive line precedes interpersonal line); second, capacities that develop *relatively independent* of one another (e.g., somatic line and emotional line); and third, *autonomous* such as talent lines, which may or may not be activated in a person's lifetime (e.g., aesthetic line). David Zeitler (personal communication, September 7, 2010) has pointed out that a key issue for the psychograph in this context is whether these capacities (i.e., "lines") are to be operationalized or left as "colloquial shared understandings (LL)." I agree this will be an important area for integral clinicians to explore.

⁴ For the purposes of this article, I am using "lines of development" and "capacities" interchangeably. I recognize that "lines" are still not clearly defined in the psychology literature. A close examination of the differences between "lines" and "capacities" (and even Gardner's use of "multiple intelligences") is an important piece of work to be done, yet this undertaking is beyond the scope of this article.

⁵ One pioneering effort in this context is the Lectical Assessment System developed by Theo Dawson (e.g., Dawson & Wilson, 2004).

⁶ The Integral Psychograph Assessment that I present here has been used with three patients to date and as such it is still evolving as a clinical assessment process. I imagine that aspects of what I present here will be refined as I work with a larger sample size of patients. Nevertheless, due to the lack of clinical descriptions of the psychograph, I feel it is important to share my initial results with the integral psychotherapy community so that a much-needed discourse concerning the use of psychographs in therapeutic work can take place.

⁷ I am a licensed clinical psychologist (PSY 20879) in private practice in Sebastopol, California, working within *The Center for Integral Human Being*. My theoretical orientation is largely informed by contemporary psychoanalytic thought and Integral Theory.

While the term *client* is more customary among integral practitioners, including psychotherapists, I am instead consciously using the term *patient* to refer to the individual seeking psychotherapeutic treatment. The reason for this

is because the origin of the word patient is generally defined as a person who suffers, while client typically refers to a person or customer seeking benefits or services. I believe we do a disservice to those with whom we are in a healing relationship when we privilege the business aspect of the relationship through the use of the term client, and under-emphasize the component of suffering that brings a person in for psychotherapy. Here, I am using the term *suffering* to point to the vast spectrum of suffering that I see and work with in my patients, from debilitating psychological dysfunction to the subtle but no less painful existential suffering, one that is felt as a separation from God or the ground of Being. It is unfortunate that the term patient has come to be associated with a traditional medical model—one that in its less-than-integrated forms has tended to be reductionistic with an overemphasis on pathology. Additionally, I prefer the term *patient* over *client* because it honors the lineage of psychoanalytic thought that comes down from Freud (1953, 1961), a tradition of inquiry and healing in the human soul (Bettelheim, 1983)—one that has shaped my thinking and my clinical work enormously. Within the psychoanalytic tradition, my clinical work is especially inspired by relational psychoanalysis (e.g., Mitchell & Aron, 1999) and most notably, the work of W.R. Bion (1962, 1970) as well as his close colleagues and students. See also the recent book by Dan Merkur, *Explorations of the Psychoanalytic Mystics* (2010), for a discussion on the interface between mysticism and psychoanalysis and in particular, his commentary on Hans Loewald, Wilfred Bion, James Grotstein, and Michael Eigen.

⁸ The Integral Psychograph Index is a written document that was first developed by me in 2007 within the context of my clinical practice as part of the Integral Psychograph Assessment. Over the subsequent years, with feedback from both patients and colleagues, I have continued to revise the IPI so that it may best serve the IPA process. At this time, the IPI is still in unpublished form. While the IPI is useful for supporting the IPA, it is important that such guidebooks or compiled maps are never seen as a replacement for the extensive training that typically goes into learning how to score various linguistic expressions and nonverbal performances associated with psychometric assessment. For a clinician to become skilled in assessing—even in a clinical context—5 to 10 distinct levels within 10 lines requires a lot of time and energy and is not suited for all integral psychotherapists. This is why using three lines (Forman, 2010, Chapter 5) or six lines with three levels (Divine, 2009) might be more appropriate for some clinicians. In short, a successful IPA will be heavily dependent on the quality of the IPI (e.g., using empirically validated lines with clear structural-phenomenological descriptions for each level) and the training of the clinician (e.g., how many lines and levels therein are they professionally and personally capable of resonating with and recognizing).

⁹ I have taken Wilber's lead in using most of the key questions he has suggested. However, some lines do not have a corresponding question (e.g., the somatic line). For those, I have created a question. In a few instances (e.g., the aesthetic line), I have modified the question Wilber came up with in order to better serve a patient's inquiry process.

¹⁰ Table 1 obviously raises a number of questions that will need to be fleshed out further by myself or other integral psychotherapists. In particular, what is the actual stage content of each of these 10 lines and why might we align them with one researcher's findings over another's? There are also a host of epistemological issues relating to stage models in the context of therapeutic intervention. Part of my excitement over writing this article is to identify and stimulate a conversation around these crucial issues.

¹¹ While my discussion is tailored toward psychotherapists applying the integral psychograph to the clinical setting, professionals in other disciplines (e.g., education, coaching, business) may find this framework useful as well and may choose to adapt certain aspects of the assessment to best suit their context.

¹² Additional psychometric tests relevant to an IPA include the Lectical Assessment System (Dawson) and the Subject-Object Interview (Kegan).

¹³ Ingersoll and Zeitler (2010) point out that the scores of calibrated tests are most useful in a dialogical context. Having patients take these tests (third-person), and then work with their results in the therapeutic container, allows meaning-making to occur around the tests in an important way. Ingersoll clarifies that “an applied, dialogical approach is most resourceful and precludes the error of reifying the metric” (personal communication, September 21, 2010).

¹⁴ I am grateful for the time David Zeitler has taken to dialogue with me on these fine distinctions and for his articulation of a psychograph that transcends and includes the three types outlined in this section.

¹⁵ In contrast to the LAS, which can be viewed as primarily a zone 2 structural assessment (though it does contain zone 3 elements in its thick thematic coding and has strong zone 5 and 6 research supporting its claims), the IPA is an integral methodology that combines first-, second-, and third-person methods, which can include third-person psychometric assessments such as the LAS as part of the integral mixed methods approach of the IPA. For an overview of Integral Research, see S. Esbjörn-Hargens (2007) and Hedlund (2010).

¹⁶ Each of these areas tested with the LAS can be viewed as a line of development (see Stein & Heikkinen, 2008).

¹⁷ Note that these last two volumes (Forman, 2010; Ingersoll & Zeitler, 2010) were published after I submitted this article for publication. As evidenced in the text, however, I have been able to revise my initial submission to draw on their insights to help frame aspects of the IPA process. Hopefully, the fact that these two volumes as well as my article are all being published in the same year is an indicator that the integral community is going to engage more actively in the exploration of the integral psychograph in the context of Integral Psychotherapy.

¹⁸ It is important to note that the researchers listed in Table 1 are not the only ones associated with these lines. Likewise, the psychometrics I have listed are not necessarily the only ones that measure their respective lines. There is also a range of validity associated with each of these measures. The central point here is that we as integral psychotherapists need to become more familiar with the actual psychometrics associated with various lines and which have appropriate levels of validity.

¹⁹ Another point for integral clinicians using the IPA to keep in mind is the fact that many of the lines are not theoretically fully developed and transforming our understanding of these lines from theory to application is a gradual and collective process. For instance, the developmental line of emotion does not yet fully exist. Robert Kegan's Subject Object Interview (SOI) includes emotions in a significant way in the assessment of one's order of consciousness, although the SOI is not primarily an assessment of emotional development. In spite of all the professional literature on emotional intelligence (e.g., Mayer & Salovey, 1997; Goleman, 1995), a structural assessment (zone 2 holarchy of growth) of emotional development is not yet fully established. One exception is some of the work of Kurt Fischer, which provides a promising start (see e.g., Ayoub et al., 2006; Fisher et al., 1990; Mascolo & Fisher, 2006, 2010). Also see Joanne Rubin (2010) and Kirk Leslie (2010), both in this issue, for interesting presentations on the emotional line.

²⁰ See also Wilber (2000) for his discussion of the self-system.

²¹ There are a couple of additional important articles and books that integral psychotherapists should be aware of when considering an IPA. These books take up the task of really exploring the application of developmental theory (zone 2) to the psychotherapeutic process (zones 1 and 3). For example, see Michael Basseches' chapter in the book *Transformation in Clinical and Developmental Psychology* (1989). Among other issues, Basseches takes up with dialectical reflectivity, he explores stage conceptions within the context of psychotherapy. He also delves into the relationship between the psychoanalytic tradition and constructive-developmental theory. See also the new book by Basseches and Mascolo, *Psychotherapy as a Developmental Process* (2010). Another researcher for integral psychotherapists to be aware of is that of Otto Laske (2006, 2009). Within the context of coaching, Laske has made incredible efforts toward developing a framework that draws on and integrates various lines of development. These kinds of pioneering efforts are extremely valuable for the further development of the psychograph and help to address some of the issues I have raised around how to bring developmental theory more fully into the clinical setting. I am very grateful to Thomas Jordan for bringing to my attention this important literature.

²² Wilber (personal communication, August 31, 2010) reflected that he first learned of lines of development from Anna Freud. During his early twenties, from *Atman Project* (1980) to the publication of *Transformations of Consciousness* (1986), Wilber steeped himself in psychoanalytic work.

²³ In discussing the "sloppy" nature of development, Ingersoll and Zeitler (2010, p. 129-130) not surprisingly (given the striking resonance with Integral Theory) also cite this quote, though their source is different than mine and was published two years later than the source I used.

²⁴ For a helpful discussion of the relationship between Gardner's multiple intelligence theory and the integral psychograph, see Ingersoll and Zeitler (2010, pp. 134-137).

²⁵ A contemporary definition for the word *psychograph* from a medical online dictionary reads: “A graphic representation or chart of the personality traits of an individual or group” (<http://dictionary.reference.com/browse/psychograph>). A key distinction between this definition and how integral practitioners use the term is that in the above stated definition it is being used to describe *personality traits* rather than distinct developmental capacities or *lines of development*.

²⁶ This device is now appropriately found in the Questionable Medical Devices exhibit within a science museum in St. Paul, Minnesota.

²⁷ See Robinson’s *An Intellectual History of Psychology* (1995).

²⁸ I am grateful to Sean Esbjörn-Hargens, my friend, colleague, and beloved husband, for our many conversations and his editorial support in the writing of this article, especially regarding the theoretical and historical dimensions of the narrative.

²⁹ Also note how both the patient and the clinician could use a 1-2-3 process to explore the patient’s various lines. That is, the patient directs their 1-2-3 inquiry at their own subjectivity through first-person introspection, second-person solicitation of feedback from friends and family, and third-person reflection on the structural descriptions of each level in relationship to their own developmental history. The clinician directs their 1-2-3 inquiry at the patients’ subjectivity through first-person introspection using her own embodied subjectivity as a phenomenological sounding board to understand the patient’s interior landscape, second-person resonance with the patient during clinical sessions, and third-person clinical assessments of the patterns of awareness and action that the patient demonstrates in the therapeutic encounter.

³⁰ I am indebted to my mentor and friend, Rosemarie Anderson (2004), for the creation of the Intuitive Inquiry research method and I acknowledge the mark that Intuitive Inquiry research has made on me in terms of how I think about Integral Research. Intuitive Inquiry continues to inform how I think and feel as a researcher (Esbjörn-Hargens & Anderson, 2006) and the method clearly informs the spiraling 3-2-1 and 1-2-3 inquiry arcs of the IPA.

³¹ Lance is a pseudonym for my patient, and I have also changed some identifying information to protect anonymity.

³² There were a number of ways in which I felt I was able to assess Lance as being capable of taking multiple perspectives. For example, during sessions he was often able to hold paradox—honoring the truth of both sides even when each side negated the other. When making a big decision, such as attending a graduate program he was considering, Lance demonstrated an ability to consider multiple points of view and situate those within a long-term time frame, seeing the ways different choices played themselves out over multiple years. Also, when describing conflict with others he consistently considered the value and vantage point of various perspectives in addition to his own, even when those perspectives were challenging or confrontational to his own perspective.

³³ I am happy to provide a packet of relevant IPA forms to clinicians interested in facilitating an IPA. Contact me at vipassanaesbjorn@yahoo.com for such a packet.

³⁴ Embodied reading is an integral practice developed by Sean Esbjörn-Hargens (2007) in the context of John F. Kennedy University’s Integral Psychology program and is outlined in his article on integral education. Briefly, embodied reading instructs one to read with your entire body, being attentive to somatic states that arise or somatic reactions that one has. A practitioner is instructed to notice their desire to read more or to skim pages while noticing the body’s involvement and one’s need to stop taking in new material.

³⁵ Patients may also choose to consult the primary sources from which the IPI is based in order to read more extensive descriptions of the various levels. A list of primary sources applicable to each line is included in the IPI.

³⁶ While *shadow* is a popular and familiar term within integral circles, in keeping in line with psychoanalytic thought, I prefer the term *unconscious* to describe the primitive subterranean material that is just out of an individual’s reach but can make itself known through avenues such as phenomenological and somatic inquiry, dreams, reveries, and free association.

³⁷ The notion of *negative capacity* was originally put forth by the poet John Keats and then later picked up by W.R. Bion (1970). A student of Bion, Michael Eigen (1993), and then later James Grotstein (1990), further brought this term into the psychoanalytic community.

³⁸ The process of gathering feedback from others is important. One has to keep in mind that friends and family members may know little if anything about developmental levels, Integral Theory, or the basic tenets of psychological health. Therefore, guiding questions can be helpful and important.

³⁹ Keep in mind that a spouse or romantic partner will often see the lower end of one's development, given the nature of primitive material that typically shows up in intimate relationship and the object relations that often play out in this form of relationship unlike in any other relationship (except perhaps, with one's parents).

⁴⁰ I am indebted to my mentor and friend Bob Walters and colleague and friend Steve Sulmeyer for the many years of collaborative inquiry and thoughtful consideration regarding notions such as the analytic third.

⁴¹ Wilber (personal communication, August 31, 2010) explained how he has thought a lot about transference-countertransference dynamics throughout the years. He has formulated a spectrum of transference-countertransference from the lowest to the highest. The lowest level of transference being libidinal and he has looked at transference from the student to guru, transference of true Self being shuttled onto the guru. Wilber observes that the guru who is sophisticated in these matters can differentiate from a lower developmental level of transference. He points out that this whole area needs to be explored in the transference-countertransference domain: the spectrum from lowest to highest levels of transference and the dynamics and issues that come with each level. The true Self is ever-present and one can help a patient see how they might be transferring the ever-present Self onto their therapist.

⁴² It is important to note that I am using the terms *transference* and *countertransference* in line with contemporary psychoanalytic thought (e.g., Loewald, 1989). That is, these terms are not meant to point to some pathological dynamics between patient and therapist but rather the inevitable thoughts and feelings that arise in relationship to one another that may have familiar contours from past, perhaps familial and other relationships.

⁴³ While Lance was able to demonstrate cross-paradigmatic reasoning (e.g., able to think in and across multiple paradigms of reality construction) in the cognitive line, keep in mind that his self-identity line was assessed at a lower altitude. Following Wilber (2006, Fig. 2.4), I have used names from Francis Richards and Michael Common's (1984) Model of Hierarchical Complexity for some of the postconventional levels within the cognitive line.

⁴⁴ I am grateful for my conversations throughout the writing of this article with Bob Walters regarding the importance of therapeutic containment. His knowledge and depth of experience regarding such psychoanalytic considerations greatly informs my thinking and feeling about these matters. Throughout the course of our discussions he continued to caution me, however, on the overall compatibility of an IPA within psychoanalytic therapy.

⁴⁵ Andre Marquis was instrumental in pointing out the need for a brief IPA. I am grateful for his feedback on this point.

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