Towards an integrative model for understanding and managing trauma: *integral psychology* as a comprehensive framework

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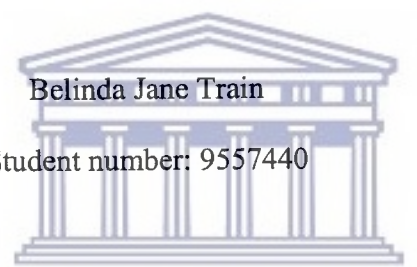

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Keywords

integrative, eclectic, integral psychology, trauma, post-traumatic stress disorder, trauma management, differences in reaction to trauma, resilience, mind-body, social, cultural

Abstract

This is a theoretical study that draws on existing literature to provoke further development in the area of integrative theoretical paradigms of trauma. The main thesis of this study is that an integrative model of trauma, based on Ken Wilber's theory of integral psychology, would facilitate an understanding of individual differences in reaction to trauma and assist in identifying suitable interventions.

The following pertinent concepts were identified from Wilber's theory: the four quadrants of experience, including individual subjective, individual objective, social interobjective and cultural intersubjective, the self-system, and the fulcrums of development. These concepts were then compared with theories and empirical studies of trauma to assess their validity for trauma. The theory was found consistent with existing theories and findings from empirical studies of trauma. This was deemed sufficient basis for developing a preliminary integrative model of trauma based on Wilber's theory.

This study indicates that a model of trauma based on Wilber's framework facilitates theorising around differences in individual reactions to trauma and targeting appropriate interventions. Individual reactions are based on the interaction between the severity of the traumatic event and the individual's experiences in each of the four quadrants. The model requires comprehensive clinical reflection and empirical testing to further establish its validity.

Declaration

I declare that *Towards an integrative model of trauma for exploring individual differences in reaction to trauma and targeting interventions* is my own work, that it has not been submitted for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged by complete references.

Full name: Belinda Jane Train Date: 6 September 2002

Signed: B. Train

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Chapter 1: Introduction

Theoretical paradigms exploring individual differences in the nature and extent of reactions to traumatic events (Horowitz, 1992; Joseph, Williams & Yule, 1997; Nightingale & Williams, 2000) and targeting interventions and goals in relation to these differences are severely limited. Though there has been considerable interest in the varying responses of individuals to traumatic events (Horowitz, 1992; Joseph, et al., 1997; van der Kolk, McFarlane, & Weisaeth, 1996) and in the outcomes of various treatment approaches to post-traumatic stress disorder (Sherman, 1998), treatment approaches studied have not been targeted in relation to individual differences in reaction.[1] Furthermore, findings from a number of studies of treatment outcomes have been conflictual, indicating a range of negative to positive outcomes.[2] These limitations in the theory and the empirical studies that have been conducted, as well as the conflicting findings around treatment outcomes, are likely to be a result of the multiple factors that are involved in traumatic responses.

Clinicians working with trauma need a range of therapeutic options available that can be used according to the specific needs of individuals (Turner, McFarlane, & van der Kolk, 1996). Most clinicians use an eclectic approach in actual practice and it is critical that they constantly reevaluate what is being accomplished (van der Kolk, et al., 1996). Whilst the clinician's sensitivity to the unique aspects of each individual and the intuitive use of treatment approaches to trauma (Turner, et al., 1996) is imperative, the lack of a broad

theoretical framework limits the knowledge base from which clinicians can reflect on treatment.

The main thesis of this paper is that a theoretical paradigm of trauma based on Ken Wilber's integrative framework (2000a) would facilitate theorising around differences in individual reactions to trauma and would assist in identifying whether treatment is required, what treatment approaches are indicated and what is contra-indicated. The comprehensive nature of his framework and its capacity to organise various theoretical approaches would serve this purpose.

I begin this chapter by defining the background and rationale of this study, including the main practical, theoretical and empirical factors that determined the choice of topic. Following this, I briefly trace the development of theory in the fields of trauma and integrative theory and therapies, noting developments in each field and efforts towards an integration of both. I refer to the influence of preliminary reading in these areas in clarifying the research problem. Then I state the overall aims and goals of the study and the research methodology used. Finally, I outline the structure of this study.

Background and rationale

I have chosen this topic for a number of reasons. Firstly, given the widespread experience of trauma generally, and in the South African context particularly, it is likely that most psychologists will at some point work with individuals who have experienced trauma. Secondly, vast amounts of empirical evidence

point to the significant but varied impact trauma can have. Thirdly, studies explaining trauma are fragmented in terms of the aspects of trauma with which they deal. Finally, numerous healing systems are available and it is often not clear which is the most suitable. I explore each of these issues briefly below.

There has been a significant increase in international interest in the impact of trauma over the last two decades (Allen, 2000).[3] This has coincided with an interest in trauma in the South African context, where experience of trauma has been extremely widespread (Hajiyiannis & Robertson, 1999; Lewis, 1999; Straker, 1994).[4] Studies of the prevalence of post-traumatic stress disorder in at-risk individuals across a wide variety of traumatic experiences yield results of between 3 and 50 percent (American Psychiatric Association, 1994). Studies of the prevalence of post-traumatic stress disorder in individuals involved in motor vehicle accidents yield results of between 20 and 30 percent (Nightingale & Williams, 2000). One study of a community sample of former prisoners of war found that less than 10 percent of the sample was free of symptoms, and the authors concluded that post-traumatic stress disorder is a normative and persistent result of exposure to severe trauma (Engdahl, Dikel, Eberly & Blank, 1997). These figures do not include responses to trauma that are classified in other diagnostic categories.

Numerous empirical studies have recorded links between exposure to traumatic events and traumatic responses. Acute- and post-traumatic stress disorders (Engdahl, et al., 1997; Murray, 1993), high levels of dissociation and the

dissociative disorders (Becker-Lausen, Sanders & Chinsky, 1995; Irwin, 1994; Mulder, Beautrais, Joyce & Fergusson, 1998; Murray, 1993; Sanders & Giolas, 1991; Waldinger, Swett, Frank & Miller, 1994), depression (Becker-Lausen, et al., 1995; Hyer, Stanger & Boudewyns, 1999), borderline personality disorder (Murray, 1993; Shearer, Peters, Quayton & Ogden, 1990; Zanarini, 1997), eating disorders (Shearer, et al., 1990), and somatic disorders (Rodin, de Groot, & Spivak, 1998; van der Kolk, Pelcovitz, Roth, Mandel, McFarlane & Herman, 1996) have been linked to exposure to traumatic events. Such empirical studies confirm the varied impact of trauma. More recently, complex traumatic stress syndrome has been defined as the result of exposure to long-term trauma and abuse and many of the more severe psychopathologies above have been associated with complex traumatic stress (Herman, 1992).

For a significant number of people, the experience of trauma results in a process of fragmentation, shattering, disconnection or dissociation, which is seen most commonly in the intrusion and avoidance symptoms of post-traumatic stress disorder (Herman, 1992). Experiences of trauma need to be examined and responded to in terms of the self (Brothers, 1995; Herman, 1992), the psyche-soma relationship (Herman, 1992; Rodin, et al., 1998), relationships with social, political and economic structures (Kleinman, 1995; Swartz, 1998) and the cultural realm of creating meaning in community (Kleinman, 1995; van der Kolk, et al., 1996). A variety of authors have raised one or more of these aspects in terms of how interventions can be approached.

There are numerous healing systems available that can be used to respond to trauma. In professional practice, the approaches that are used generally arise from Western disciplines and include various forms of psychotherapy and psychopharmacology. The so-called alternative therapies include African, Eastern and other practices and are becoming increasingly popular amongst the general population (Kaplan & Sadock, 1998). The studies I made reference to in the introductory paragraph of this chapter explored the effectiveness of certain Western disciplines in treating trauma. Although these studies have significant limitations, they highlight the importance of thorough analysis of treatment approaches and their effectiveness. Alternative medicines need to be tested in terms of their efficacy in working with trauma and, as is the case with the mainstream therapies referred to, could benefit from testing that targets specific therapies in relation to individual reactions to trauma. Furthermore, the trend towards the medicalisation of suffering (Kleinman, 1995; Summerfield, 1999) and importation of Western treatment approaches to all populations who have experienced trauma needs to be examined carefully.

Psychological literature on trauma during the last century has, to a large extent, mirrored the fragmentation experienced by survivors of trauma (Herman, 1992). This can be observed in two ways. Firstly, in trauma's periodic appearance in and disappearance from psychological literature (Allen, 2000; van der Kolk, et al., 1996). Secondly, in the multitude of psychological theories for understanding trauma and their implications for trauma management. There is frequent recognition that no single theoretical or

treatment approach is adequate as a response to trauma (Eagle, 1998). However, there is limited theory incorporating the broad range of theory and treatment approaches that exist. Integration of the traumatic event is one of the key goals of recovery in many approaches to trauma (Herman, 1992). It may well be time for theoretical paradigms and approaches to treatment to mirror this goal.

Preliminary reading

In an initial review of the literature, I explored theories of trauma and the related treatment modalities, including integrative theories and therapies. I engaged with Wilber's integrative framework and also considered it in relation to the trauma literature and integrative theories and therapies more generally. These areas will be outlined briefly in this section.

Preliminary reading in the field of trauma showed the following theoretical understandings. Classical psychoanalytic theory explains traumatic reactions as the reactivation of a previously dormant but unresolved conflict (Herman, 1992). Self psychology explores infantile trauma as a failure of empathy (Rachman, 1989) and traumatic responses as a failure in self-trust (Brothers, 1995). Behavioural theory believes classical conditioning is involved because people with post-traumatic stress disorder often avoid or react strongly to conditions that were present at the time of the trauma (Kilpatrick, Veronen & Best, 1985). From a cognitive standpoint, traumatic reactions are theorised in terms of an inability to process incoming information related to the trauma

based on inconsistency of this information with pre-existing schemas that organise and process information (Horowitz, 1992; Resick & Schnicke, 1993). Cognitive theory also understands such reactions as an inability to rationalise the trauma that precipitated the event (Kaplan & Sadock, 1998). Each of these theories appear to have something to offer in terms of understanding trauma, but when each theory stands alone, it provides partial insights. Furthermore, none of them adequately explains differences in severity of response to trauma and each assumes treatment based on the particular theory. Empirical studies and clinical experience point to each of them having value in terms of treatment.

Individual differences in severity of reaction to traumatic events have been noted (Herman, 1992; Horowitz, 1992; Joseph, et al., 1997) but have been largely ignored by trauma theory (Joseph, et al., 1997). In a study that focuses on post-traumatic stress disorder, Joseph, et al., (1997) develop an integrative model of adjustment. They suggest that personality factors (including previous mental illness), cognitive and emotional state factors and sociocultural factors all interact with the severity of the event to determine the likelihood of developing post-traumatic stress disorder. Their theory provides one of the few approaches to understanding resilience and the severity of traumatic response. However, although it provides a useful understanding of cognitive styles that mediate the experience of traumatic events it does not in any way explain how these cognitive styles develop.

Some inconsistency is evident in the degree to which integrative approaches to understanding and managing trauma explore the etiology of trauma and the extent to which this informs therapeutic approaches. Prout and Swartz (1991) identify common features of post-traumatic stress treatment approaches as the basis for an integrative perspective, preferring an integrative approach to 'a myopic lens which limits etiologic understanding and constrains treatment methods' (p. 122). Joseph, et al. (1997) suggest a psychosocial care model that uses direct exposure therapies and cognitive-behavioural therapies, and encourages activity and social support based on their understanding of trauma outlined briefly above. Peltzer (1999) proposes a process model of ethnocultural counselling for African survivors of organised violence which includes social comparison, cognitive undoing, relaxation techniques, ritualistic, cognitive and supportive techniques, and principles of education and advice. Ablack (2000), Eckberg (1998) and Levine (1997) describe body psychotherapies for working with trauma because of the impact trauma has on the body. An integrated psychodyamic and cognitive-behavioural model is recommended by Eagle (1998) as an ideal treatment for psychological trauma because dysfunction in post-traumatic stress occurs at the interface of internal and external psychological functioning. Knight (1998) and van der Kolk, et al. (1996) explore various etiological factors, including social factors, personal factors such as stage of life, psychological factors, biological factors, and comorbidity with other psychiatric disorders. In addition, they report empirical studies on the efficacy of various treatment approaches. Van der Kolk, et al.

(1996) offer an extremely comprehensive view of the etiology of trauma and considerations regarding management; however, their work comes from an empirical-eclectic basis rather than an integrative theoretical framework.

Ken Wilber's *Integral psychology* (2000a) offers a comprehensive framework for integration.[5] It is a theory of consciousness that identifies different levels of development – fulcrums of development – and different types of pathology that may develop if an individual does not move satisfactorily through all aspects of each level. He also identifies four quadrants – individual subjective, individual objective, social interobjective, and cultural intersubjective – which he considers essential to any understanding of human experience. Wilber (2000a) identifies Gustav Fechner (1801–1887), William James (1842–1910), James Mark Baldwin (1861–1934), Jurgen Habermas (born 1929) and Abraham Maslow (1908–1970) as some of the pioneers in an 'all-quadrant, all-level' integral approach (2000a). He does not engage deeply with psychotherapeutic issues but suggests different therapeutic approaches may be appropriate for treating pathology that could develop in relation to each of these aspects of experience. Wilber (2000c) suggests the clinician's role should be to identify treatment approaches that are suitable for an individual and refer where necessary.

In a discussion that focuses on integrative psychotherapeutic approaches, Carrere-Comes (1999a) notes the need for a map that coherently organises basic therapeutic needs and the range of responses to them. He suggests '...a

good map can help in orienting empirical research, [and] in turn can help in constructing better maps' (Carrere-Comes, 1999a, p. 1). The map he suggests engages with the dialectic between psychological remaking, which deals with defect-driven disorders, and philosophical uncovering, which deals with conflict-driven problems (Carrere-Comes, 1999a). The first of these could be likened to Wilber's first two fulcrums of development and the latter would probably incorporate all the later fulcrums Wilber identifies (these fulcrums are outlined in Chapter 2). Carrere-Comes (1999a; 1999b) provides deeper discussion on the therapeutic issues that arise from the map that he outlines whilst Wilber provides a more comprehensive map.

A number of other theorists focus on integrating specific therapeutic approaches. In the general literature on integrative therapies, these include combined psychodynamic and cognitive-behavioural therapy (Jacobs, 2000), symptom- and person-oriented therapy (Omer, 1993), and transactional analysis and gestalt therapy (Erskine & Moursund, 1988), and, in South Africa, the integration of African and Western healing practices (Straker, 1994). Each of these integrative approaches offers a deepening of understanding of issues that arise from integration of therapeutic approaches but do not provide any more clarity as to why one would choose one approach over another. As with the single-theory therapies it is likely that the therapist's own theoretical bias will determine usage.

A preliminary review of the literature highlights multiple views of and treatment approaches to trauma that have value for understanding and managing trauma. These include integrative approaches to trauma. There is, however, minimal theorising about the relationship between these approaches and little guidance as to what would determine the use of one or another. One of the roles of an integrative framework is organisational: it should allow for disparate theories, clinical observations and empirical data to be considered in an organised manner that can allow for the clarification of relationships. Further, it should provide a paradigm for making more specific interventions and for guiding future research. For this purpose, Wilber's integrative framework provides a comprehensive theoretical base.

Aims and goals of this study

This study aims to add to the development of an integrative theoretical model for understanding and managing trauma based on Wilber's (2000a) theory of integral psychology. I propose that Wilber's theory provides a comprehensive basis for integration that assists in organising multiple variables relevant to trauma and facilitates the clarification of relationships between them. An analysis of an individual's experience in each of the four quadrants, and how each quadrant has impacted on the individual's current state, will be useful in exploring individual differences in the nature and extent of reactions to traumatic events. Further, the recognition of where an individual's self-structure is located in Wilber's fulcrums of development and whether this has

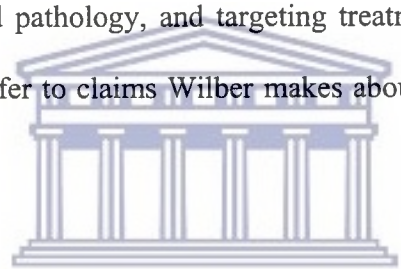
been significantly impacted on by traumatic experience would enable more strategic therapeutic responses that enhance trauma management.

Outline

Chapter 2 outlines pertinent aspects of Wilber's integrative framework. This includes his formulation of the self-system, the fulcrums of development and the four quadrants. In Chapter 3, I explore the validity of Wilber's framework for understanding trauma in terms of its consistency with theoretical constructs and empirical evidence in the trauma literature. Chapter 4 attempts to integrate Wilber's theory with the trauma literature as an integrative model for understanding and further researching trauma. Chapter 5 examines the manner in which this model might influence treatment. Chapter 6 concludes the study with a summary of findings and implications for further research.

Chapter 2: Theoretical framework

This chapter presents a brief overview of aspects of Wilber's framework that are pertinent to this study. Initially, I delineate the four quadrants as a base from which to examine the relationship between the internal experience of individuals, their physiological responses, the social structures in which they exist, and the way in which they create meaning in their communities. Then I describe the self-system and how it negotiates experience. Following this, I detail the fulcrums of development as a framework for understanding individual development and pathology, and targeting treatment responses. In concluding the chapter, I refer to claims Wilber makes about the relevance of his theory.

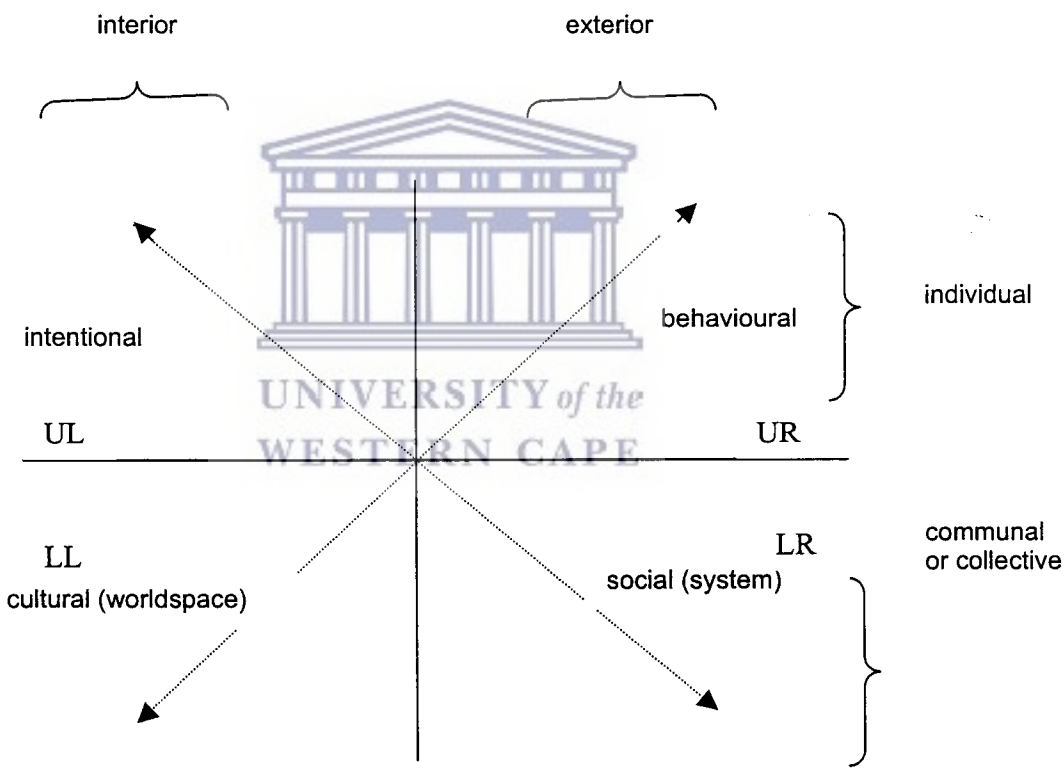


The four quadrants of experience

The concept of four quadrants of experience developed by Wilber (2000b) provides a framework for examining interior and exterior aspects of experience. In this section, I define the four quadrants that Wilber has identified and their relationship to each other. I then outline each of these quadrants and the aspects of experience that each is able to contain. I go on to explore how this four-quadrant approach may be useful in exploring the mind-body relationship. The section is concluded with a brief overview of the relationship between the self-system, the fulcrums of development and the four quadrants.

The four quadrants of experience Wilber identified are the individual, subjective, intentional (upper-left quadrant), the individual, objective, behavioural (upper-right quadrant), the social, interobjective (lower-right quadrant), and the cultural and intersubjective (lower-left quadrant) (Wilber, 2001a).

The diagram below illustrates these four quadrants.



The four quadrants (Wilber, 2001a, p. 65)

According to Wilber 'The four quadrants are mutually arising and mutually determining. It is not just that the individual mind and consciousness (upper-

left) interacts with the individual body-brain organism (upper-right), but that they both equally and mutually interact with the collective cultural mind (lower-left) and collective social body (lower-right)' (Wilber, 2000a, p. 234). The two left-hand quadrants are related to interiors or subjective worlds (e.g. the individual's internal experience and the internal experience of communities or the way that groups of people create meaning together). These can only be understood by talking to people and cannot simply be observed. The two right-hand quadrants are related to exteriors or objective worlds (e.g. objective systems of structures and functions that can be seen with the senses or their extensions). These can be studied empirically (Wilber, 2000a). Much of the trauma literature conflates these interiors and exteriors when describing the mind-body response or broaching society's role in the etiology or management of traumatic responses.

The diagonal lines in each quadrant can be used to mark out milestones of development (both ontogenetic and phylogenetic) in each quadrant. For example, the upper-right quadrant could map out the neural cord, the reptilian brain stem, the limbic system, the neocortex, the complex neocortex and the more developed correlates of brain physiology. These could be correlated with perception, impulse, emotion, symbols, concepts, concrete operations, formal operations and vision logic in the upper-left quadrant. The lower-right quadrant could indicate milestones in the social systems of societies with division of labour, groups or families, tribes, tribal villages, the early state or empire, the nation state, and the planetary system. The lower-right quadrant includes the

exterior of social aspects of human interaction, including forces and modes of production, legal codes, and so forth. The lower-left quadrant might identify worldviews such as archaic, magical, mythical, rational, centauric, etc. It would also include interpretive meanings, cultural meanings in general, collective and group identities, and so on (Wilber, 2000a; 2000b; 2001a).

The four quadrants provide a useful basis for clarifying the mind-body relationship. Wilber states that much of the mind-body problem is not the differentiation of mind and body, but the dissociation of mind and body as has happened in the modern world. Modernism explains the mind purely in right-hand terms by considering only the body and the brain. Consciousness, feeling, thought, awareness and other aspects of the left-hand domains can't be explained in these terms. This results in two apparently absolute but contradictory truths where immediate experience points to the existence of consciousness and science points to the existence of a world that consists of arrangements of fundamental units that possess no consciousness. As long as these units are seen as exteriors only, no amount of reorganising will result in an explanation for mind (Wilber, 2000a).

Wilber considers various definitions of body and mind. Firstly, he suggests that 'body' can mean the biological organism, including the brain (the neocortex, the limbic system, reptilian stem, etc.). From this perspective, the brain is in the 'body', which is the commonly accepted scientific view and describes the contents of the upper-right quadrant in Wilber's four-quadrant

framework (Wilber, 2000a). Secondly, 'body' can also mean the subjective feelings, emotions, and sensations of the felt body and this is how the term is commonly used. This usage refers to some of the contents of the upper-left quadrant where 'body' means the low levels of an individual's interior (Wilber, 2000a). Wilber describes this graphically in the following statement: 'When the average person says, "My mind is fighting my body", he does not mean that his neocortex is fighting his limbic system. By "mind" he means the upper levels of his own interior, the upper levels of the upper-left quadrant ... in other words, his rational will is fighting his feelings or desires ... The mind is described in first-person phenomenal accounts and I-language, whereas the brain is described in third-person objective accounts and it-language.' (2000a, p. 178).

Wilber identifies three dilemmas involved in the mind-body problem: '(1) how to relate mind (interiors) and body (exteriors, including brain); (2) how to relate mind (interior conceptual consciousness) and body (interior feelings); and (3) how to see the final relation of mind and body (subject and object)' (2000a, p. 276). He approaches these dilemmas in the following way: '(1) acknowledge that every exterior has an interior which binds mind and body; (2) acknowledge that there are interior stages of consciousness development which bind mind and body; and (3) acknowledge that there are higher levels of consciousness development, which finally unite mind and body (thus preventing any form of dualism)' (2000a, pp. 276-282).

The four quadrants provide a valuable framework for recognising the multiple factors that may be implicated in an individual's response to trauma and the concepts included here do not in any way contradict each other. The upper-left quadrant includes a structure for recognition of the self-system and the fulcrum of development it is functioning in and how this may be resulting in a traumatic response. The lower-left quadrant provides a framework for examining the way that the self is creating meaning in intersubjective experience and for analysing whether this space is implicated in the traumatic response or is supporting recovery. Analysis of an individual's experience in the upper-right quadrant would recognise the physiological implications of trauma and the lower-right quadrant would acknowledge the role that political, economic and social systems are playing in the traumatic response and in supporting recovery. In Chapter 3, I will explore the consistency of Wilber's four quadrants with the trauma literature.

The self-system

I will begin this section by outlining Wilber's definition of the self or self-system, followed by an explanation of the difference between the proximate and the distal self. A brief explanation of the streams of development and other elements of the self and their relationship to the self-system will follow. Then I will examine the functions of the self, the process of development, and how the self navigates this process.

The self-system plays a pivotal role in negotiating all aspects of experience. This includes negotiating different aspects of the self, development through the fulcrums, and balancing the four quadrants as the individual interacts with them (Wilber, 2001b, p. 203). The overall self consists of the proximate self, the distal self, and all other elements of the self being negotiated by an individual (Wilber, 2001b, p. 351). Definitions of these aspects of the self are critical in understanding the self-system.

The proximate self and distal self are fundamental components of the overall self. The proximate self is the aspect that is so close to the self that it identifies totally with the self. The distal self has some distance and so is able to reflect on self-experience. This differentiation is significant because as the self navigates development, what was the proximate self of one stage of development becomes the distal self of the next stage. For example, a baby identifies the self completely with the body and is not able to stand back and reflect on the experience of the body. However, as the mental self develops, a young child is able to reflect on the body more objectively. Therefore the body becomes the object of the subject, which is now the mental self. As the individual moves through the stages of development, the subject of the earlier stage becomes the object of the next stage (Wilber, 2000a). The proximate self is the aspect of the self associated with self-sense or self-identity that is frequently referred to as ego development (Wilber, 2001b). The names Wilber frequently uses for the different stages of this aspect of development are the

bodyego, persona, ego, centaur and soul (Wilber, 2000a, p. 91).[1] The proximate self and the distal self play crucial roles in the functions of the self.

The overall self is composed of the proximate self and the distal self, as described above, and any other elements the self-system may be juggling. These other elements may include other streams of development such as affective, moral, interpersonal, and cognitive development, worldview (Wilber, 2000a) and so forth, and unconscious material that has not been integrated at any stage of development.[2] This unconscious material may be dissociated or repressed sensations, impulses, affects, personae, thoughts, talents and such like (Wilber, 2001b). Strongly dissociated material that is not accessible to the conscious self may sabotage further growth and development and may be context-triggered (Wilber, 2000a). Elements of the streams of consciousness may represent internal resources that the self-system can draw on for, or propel itself towards, growth, or they may represent aspects of pathological development (Wilber, 2000a). I will now examine the self's functions which include the process of healthy and pathological development.

The self-system has several important functions. The most significant is the task of integrating and balancing the components of the self and its experience, and negotiating development. Other functions are self-identification, making choices that are free within the constraints and limitations of its present level, mobilising defenses, and metabolising experience (Wilber, 2000a).

The overall self does not move mechanically through clearly sequenced stages of development (Wilber, 2000a). However, the proximate self-sense unfolds in a developmental sequence of relatively unchanging stages (Wilber, 2000a; 2001b). Because the overall self is composed of the proximate and the distal self and the other aspects of self outlined above, it may spiral, regress, and return and may experience temporary states of consciousness in the transpersonal realms (Wilber, 2000a). None the less, the overall self 'tends to hover around one basic level of consciousness at any one time' (Wilber, 2000a, p. 35) and this is what Wilber loosely refers to as the 'centre of gravity' of consciousness (Wilber, 2001b, p. 351).

The proximate self navigates by using the capacity to identify with each fulcrum of development, become competent at that level, and then differentiate from it and integrate it in order to move to the next higher and wider fulcrum and identify with it. When the proximate self moves forward on its developmental path, it can do so relatively healthily or relatively pathologically. When there is healthy development, the self is able to identify with the new level, then achieve a sufficient level of differentiation from that with which it has been fused, followed by integration of what is experienced at that level. In pathological development, there may be a failure in the process of identification, differentiation or integration. The individual then remains fused, fixated or arrested in that aspect of development, or aspects of experience are repressed, alienated or fragmented (Wilber, 2000a, 2000b, 2001a, 2001b).[3]

Successful and pathological movement through each fulcrum will be described in greater detail below.

Wilber's formulation of the self-system offers a valuable framework for understanding the complexity of the psyche. The significance of the self has been explored in texts on understanding and managing trauma (Brothers, 1995; Herman, 1992; Meares, 1992) but there is either a focus on one aspect of self-experience or insufficient definition of the self and the role it plays. Wilber develops a detailed definition of the self and the roles it plays using concepts that are consistent with each other. In the following chapter, I explore the consistency of Wilber's concept of the self with theoretical constructs of the self that have developed in relation to trauma. The following section outlines the fulcrums of development that the self moves through.

The fulcrums of development

In describing the process of development, Wilber outlines nine or ten fulcrums of development. [4] In this section, I present each of these fulcrums, including the main tasks, the defences operating, pathological development, and the role different psychological theories play in explaining each. In my conclusion to this section, I will consider the relationship between the fulcrums of development and the four quadrants.

Wilber (2000a) notes that a major breakthrough in depth psychology in the last several decades has been the recognition of a continuum of pathology from

neurotic to borderline to psychotic.[5] He acknowledges the critical role played by psychodynamic theory in developing insight into the defences and self-structures of the early levels of development. These levels are encapsulated in his first three fulcrums.

In fulcrum-1, the self is initially fused with the sensorimotor world and is in a state of primary narcissism. It is not able to recognise where its own body begins and ends and the self has an archaic worldview (Wilber, 2000a, 2001a). This primary indissociation is resolved during the first year of life when the individual differentiates the physical self from the physical environment.[6] During this phase, it will have started to recognise that when it bites its own body it feels it and when it bites something else it doesn't, and thus there is the differentiation between matter and body (Wilber, 2001a). This stage is consolidated with physical object constancy at around 18 months at which point fulcrum-2 is already well under way (Wilber, 2000b). The defences operational at fulcrum-1 are distortion, hallucination, delusional projection and wish fulfillment (Wilber 2000a). The pathology associated with this fulcrum is psychosis, where there is severe reality distortion, the incapacity to establish even the physical boundaries of the self, narcissistic delusions of reference, and thoughts that confuse self and others (Wilber, 2001a).

The self is largely identified with the emotional-feeling body in fulcrum-2. It has established the boundaries of its physical self in fulcrum-1 but moves into a fusion of the emotional-feeling boundaries of self and others, especially the

mother. It is now able to identify itself physically from the environment but is unable to differentiate its emotional experience from that of others. This is still an extremely narcissistic state – because it is unable to differentiate itself from the emotional world of others, it treats others purely as an extension of itself. The worldview of this fulcrum is initially archaic magical, and it develops into magical, where the ego is seen to be the locus of magical power (Wilber, 2000a). The defences of this fulcrum are selfobject fusion, projection, and splitting. In describing the development of pathology at this stage, Wilber (2001a, p. 152) states 'if things go poorly at this fulcrum – that is, worse than the normal mess this fulcrum is anyway – then the self either remains in *fusion* at this emotionally narcissistic stage (the so-called narcissistic personality disorders), or the differentiation process begins but is *not* [sufficiently] *resolved* and there is some sort of *dissociation* (the so-called borderline disorders)'.[7] At this stage, the self can't repress its emotions but is completely overwhelmed by them. It is here that structure-building therapy helps the fragile self to differentiate, stabilise and build boundaries (Wilber, 2001a).

Fulcrum-3 brings about the beginning of the self's identification with the mental or conceptual self. The representational mind consists of images, which emerge at about seven months, symbols, which emerge during the second year with the use of language, and concepts, which dominate awareness from four to seven years. It is with the emergence of concepts that the self begins to identify with the mental self. The self is no longer just a collection of sensations, impulses and emotions, it is also a set of symbols and concepts.

The self now has thought and language and can begin to control its bodily functions and think about the past and plan for the future. The ability to anticipate the future can result in worry and anxiety and to think about the past can result in guilt, remorse and regret. Precisely because it is able to transcend the body, the self is able to repress and dissociate and deny those aspects of experience, resulting in neuroses. Healthy development would differentiate from the body and emotional experience and integrate these aspects of experience. The worldview that is evident at this stage is initially magical and as the self progresses through this fulcrum, it becomes magic-mythical where the ego-omnipotence is transferred to the gods or the superhuman other (Wilber, 2000a, 2000b). The defences that are utilised are isolation, repression, reaction formation and displacement (Wilber, 2000a). Therapy working with this stage would focus on uncovering and relaxing repression in order to recontact impulses, emotions and felt sense that the stronger self of this fulcrum has repressed (Wilber, 2001a).[8]

In fulcrums-4, -5, and –6, the self is identified with aspects of mental experience. Fulcrum-4 arises at approximately six to seven years and continues to approximately eleven to fourteen. In this fulcrum, the capacity to form mental rules, take mental roles and take the role of the other arises (Wilber, 2001a). The worldview changes to mythic rational where the mythic structures are rationalised (Wilber, 2000a). In this stage, the child's moral stance changes from an egocentric and preconventional stance to a sociocentric, conventional and often highly conformist stance. The critical task becomes how to fit in with

learned social roles and rules and the scripts that are expected by the broader social group. Most of these scripts are useful and draw the individual into intersubjective cultural experience, but where something goes wrong with these scripts, the pathology of this stage can arise in what Wilber terms script pathology (Wilber, 2000a, 20001a).[9] This would take the form of the self-defeating or self-harming scripts that are worked with in cognitive therapy, transactional analysis and narrative therapy (Wilber, 2001a).[10]

In fulcrum-5, the capacity to think about thought develops. The individual can start to judge the rules and roles that they previously accepted without question. The moral stance moves from conventional to post-conventional where the individual can reflect on and choose to agree with or disagree with the norms of their society. In this fulcrum, the individual can begin to question the appropriateness of the sociocentric perspectives that were simply adopted in the previous stage and can begin to recognise other sociocultural perspectives. Wilber describes this as a worldcentric stance – '... a world that is decentred from the me and the mine, a world that demands care and concern and compassion and conviction ...' (Wilber, 2001a, p. 171). The worldview of this stance is rational. In defining rational, Wilber considers critiques of this view that suggest it is Eurocentric. He broadly defines rational as the capacity to take the perspective of another person (Wilber, 2000b, 20001a). The pathology that Wilber identifies in this fulcrum is role-confusion. Individuals are either successful in establishing a self-identity that doesn't depend on conforming to social norms or they struggle to identify who they are when they

no longer have society to make decisions for them. Introspection is an important aspect of treatment at this level.

The central task of fulcrum-6 is integration of the self, including the body and the mind. The self begins to transcend the body and the mind and becomes aware of both the body and the mind. It is then able to hold the mind and body as components of an integrated self. The worldview is that of holistic integralism (Wilber, 2000a), where the individual is able to co-ordinate different perspectives that include both interior and exterior experience (Wilber, 2001a).[11] This integrated individual would be able to enact a global perspective. The pathology of this level is existential and existential therapy is recommended (Wilber, 2000a, 2001a). The defenses are inauthenticity, deadening, aborted self-actualisation and bad faith (Wilber, 2000a). Further, taking all perspectives into account can become very disorientating.[12]

Fulcrums-7 to -9 are the transpersonal domains, moving from psychic to subtle to causal (Wilber, 2000a), with their own developmental difficulties and pathologies. These are less relevant to traumatic responses and therefore won't be dealt with in this study. Most people have their centre of gravity located between fulcrums-3 and -5 and are dealing with issues of getting in touch with feelings (fulcrum-3), the need to belong (fulcrum-4), self-esteem (fulcrum-5) and self-actualisation (fulcrum-6). They may have peak experiences of the transrational realms which they require assistance with for integrating, and it is

important that this experience doesn't get confused with prerational magical and mythical structures (Wilber, 2000a).[13]

Wilber's fulcrums of development are generally consistent in outlining levels of development that don't contradict each other. One area of possible inconsistency that overlaps with the four quadrants is his positioning of cognitive therapies as appropriate to fulcrum-4 in the upper-left quadrant (2000a). In a later text, he suggests that cognitive therapies would be based in the upper-right quadrant because they don't deal with interiors (2001b) (see endnote 10 of this chapter for a fuller discussion of this issue). Recognition of where an individual's self-structure is located in terms of the fulcrums of development and whether this has been significantly impacted on by the experience of trauma may be useful in determining the most appropriate therapeutic response. In Chapter 3, I will explore the consistency of Wilber's fulcrums of development with theoretical constructs for understanding traumatic responses. Chapter 5 considers how assessing the self's development through the fulcrums may be useful in determining what interventions are indicated and contra-indicated.

Summary

Wilber suggests that any attempt to understand consciousness needs to be 'all-level, all-quadrant' (2000a, p. 193). However, he also suggests that his work is applicable to most endeavours because the four quadrants cover a multitude of ordinary events. 'You do not have to include, or even believe in, the higher and

transpersonal levels of each quadrant in order to find the quadrants themselves useful' (Wilber, 2000c, p. 235). Integral therapy should engage all these aspects of experience to renormalise the mind-body experience of people looking for help. Where individuals are seeking postformal development, integral therapy can be devised for this purpose (Wilber, 2001b). Although Wilber's framework is more broadly defined, I have outlined the above concepts because these are the most relevant to my study. In the next chapter I use the literature on trauma to examine the validity and consistency of this framework as a basis for theorising about trauma. I will then attempt to outline an integrative model of trauma and consider implications for trauma interventions.

Chapter 3: Validity of Wilber's framework

This chapter explores the validity of Wilber's framework as the basis for a theoretical paradigm of trauma by considering whether the central concepts are consistent with theoretical constructs and empirical evidence in trauma literature. I will outline definitions of trauma as a point from which to proceed. Then I will review the literature to assess whether Wilber's four quadrants are consistent with trauma literature. Following this is a look at theoretical constructs of the self that appear in theories of trauma and a comparison of them to Wilber's construction of the self-system. Finally, I examine theoretical constructs and empirical studies that inquire into individual differences in the nature and extent of reactions to traumatic events, and investigate the consistency of Wilber's fulcrums of development with them.

Definitions of trauma

Krystal (1997) differentiates between adult experience of trauma, which can result in regression, and infantile psychic trauma, which can result in developmental arrest. Kleinman (1995) and Summerfield (1999) express concern about the medicalisation of human suffering, especially in circumstances such as political violence and war. I will take each of these into account in the definitions of trauma outlined in this section.

Adult reactions to trauma are most commonly associated with the diagnosis of post-traumatic stress disorder, though many other diagnoses are associated

with traumatic experiences as was detailed in Chapter 1. Psychological trauma only received official diagnostic recognition in 1980 when post-traumatic stress disorder first appeared as a category in the third edition of the *Diagnostic Manual of the American Psychiatric Association* (DSM III). The clinical features of this disorder were congruent with the formulations of Janet in the late nineteenth century and Kardiner fifty years later. The essential feature of this disorder is the breakdown of the human system of self-defense as a result of becoming overwhelmed and disorganised by exposure to traumatic events. Physiological states, emotions, cognition and memories – functions that are normally integrated – may become severed from each other. The symptoms of post-traumatic stress disorder can be organised into three main categories: hyperarousal, intrusion and constriction. Hyperarousal refers to the state of being permanently alert because of the continued expectation of danger. Intrusion reflects the re-experiencing of trauma as though it was occurring in the present. Constriction refers to the freezing or shutting down of responses and shifting into an altered state of consciousness or a dissociated state (Herman, 1992).

Aspects of normal human experience that cause complexity in the psyche's development have been described as traumatic. Although they aren't associated with post-traumatic stress disorder, their impact on development may be significant enough to cause developmental arrest (Krystal, 1997) or increase susceptibility to traumatic reactions at a later stage in development. Freud highlighted the essentially traumatic nature of human sexuality (in McDougal,

1974).[1] Klein (in McDougall, 1974) and Mahler (in Shane & Shane, 1989) have highlighted the earlier traumata inherent in the processes of physical and emotional separation. Kohut (in Rachman, 1989) emphasised empathic failure in early relationships as traumatic and Ogden (1985) suggests that repeated environmental impingements that are developmentally inappropriate can be seen as cumulative trauma. Ogden (1985) differentiates this from other forms of disruption in the early unity of the infant and caregiver such as constitutional hypersensitivity, physical illness of the infant, and illness or death of a parent or sibling. Wilber seldom uses the term trauma, but where he does, he uses it broadly to refer to anything that can go wrong in the developmental process. He states '…trauma at *any* of the fulcrums can form a pathological complex which "infects" all subsequent development … the self can take a bad step at any of the nine or so fulcrums, and the type of pathology that results depends upon the [fulcrum and stage within the fulcrum] where the accident occurred' (Wilber, 2001a, p. 146).

Kleinman notes that when trauma is situated in individual rather than social dynamics, the interpersonal and community-wide effects of violence are missed and it is seen as 'medical *pathology* [rather] than of religious or moral happenings' (1995, p. 177). Furthermore, the diagnostic criteria for post-traumatic stress disorder rule out the possibility of normal responses to trauma and suggest that suffering is not something that can or should be endured. Yet the examples of traumatic experiences that are given – natural disasters, accidents, violent death, and experience of atrocities – are the most typical

representations of human suffering and in the major religious traditions are seen as defining the human existential condition (Kleinman, 1995).

The term trauma is used to refer to a broad range of experiences. These include a single overwhelming event, prolonged exposure to overwhelming events, and aspects of normal human experience that were particularly complex due to disturbances in relationships or the environment at particularly significant points in development. These various definitions, along with reservations about trauma being rooted in individual rather than social dynamics, are pertinent in considering the validity of Wilber's framework to trauma.

The four quadrants as they appear in trauma literature

Van der Kolk, et al. (1996, p. xi) note the importance of seeing post-traumatic stress disorder as '... the result of a complex interrelationship among psychological, biological, and social processes – one that varies, depending on the maturational level of the victim, as well as the length of time for which the person was exposed to the trauma.' The trauma literature will be examined in this section to assess the external consistency of Wilber's four quadrants as concepts relevant to trauma. Initially, the issues of the upper-left quadrant and the individual interiors are only dealt with so far as they relate to the other quadrants. The following sections in this chapter will deal with psychological factors and issues related to maturation level and more specifically related to Wilber's upper-left quadrant. This section will also discuss biological factors and social processes in relation to Wilber's four quadrants, whereby biological

factors fit into the upper-right quadrant and social processes can be investigated in terms of the interiors of the lower-left quadrant and the social systems of the lower-right quadrant.

Eagle (1999) proposes an integrated psychodynamic and cognitive-behavioural treatment modality that addresses the interface between the externally and internally based psychopathology of trauma. The psychodynamic aspect of such an intervention is seen to deal with the internal phenomena and the cognitive-behavioural aspect is seen to deal with the external stimuli. This modality recognises the importance of individual interior and exterior experience. Wilber's framework, with its emphasis on interiors and exteriors, is consistent with Eagle's model (see endnote 10, Chapter 2, for further discussion on this issue).

Numerous theorists note the complex mind-body response evoked by traumatic experiences (Eckberg, 1998; Herman, 1992; Krystal, 1997; Mitchell, 2000; Levine, 1997; van der Kolk, et al., 1996). Van der Kolk (in van der Kolk, et al., 1996) refers to the complex relationship between the three interdependent subanalysers of the brain: the brainstem or hypothalamus, the limbic system, and the neocortex. These control a number of complicated functions of the mind or brain through multiple layers of interconnected clusters of neurons with specialised functions. Trauma seems to affect people on multiple levels of biological functioning. Levine (1997) emphasises the mind-body relationship in traumatic responses through his study of the 'immobility response'

experienced at the time of the traumatic event. He suggests that talking about the experience cannot release the immense charge of energy that builds up in the nervous system at the time of the traumatic event and that a physical therapy is required for this release to occur.

It is well recognised that traumatic stress requires that clinicians and researchers approach the subject with an awareness of the socio-political contexts in which trauma is embedded (Herman, 1992; Kleinman, 1995; Swartz, 1998; van der Kolk, et al., 1996). Herman (1992) recognises the important context of a political movement in advancing the study of psychological trauma. She also notes the importance of transforming the meaning of personal tragedy by making it the basis for social action (Herman, 1992, p. 207). The major role legal systems have played in defining how societies acknowledge the association between traumatic events and psychiatric symptomatology has been noted by Scrignar (1996) and Van der Kolk (1996).

Connecting with community is also recognised as an important factor in both resilience against traumatic stress and in recovery from traumatic stress (Herman, 1992; Hollander, 1997; van der Kolk et al., 1996). This may refer to distress caused by not being able to share experiences (Hollander, 1997). Herman (1992) also indicates that sharing one's story of trauma creates social as well as personal meaning. Van der Kolk (in van der Kolk et al., 1996) notes that the cultural context of trauma is important because the meaning of trauma

is often culturally specific, and the social and religious rituals surrounding loss and disaster have an important healing role in both individual and community trauma.

The literature on trauma confirms the relevance of Wilber's four quadrants as playing a critical role in both understanding the etiology of traumatic responses and in the successful management of trauma. Wilber's framework would be advantageous as a basis for furthering research in the relationship between these aspects of experience and understanding the role each of them plays in various situations because of the tendency to conflate and confuse aspects of what he describes.

The self in theories of trauma

Meares (1999) notes that the self is often ignored in attempts to understand the psychological impact of trauma. In this section, I will examine literature that *does* refer to the self in relation to trauma and consider whether Wilber's construction of the self-system is consistent with this theory.

Meares (1999) defines the self as double, involving not only mental life but also reflection on it. His definition depends on the concepts of Hughlings Jackson (in Meares, 1999), where the self is made up of subject and object poles, and William James (in Meares, 1999), who saw the cardinal feature of the self as an awareness of the streams of consciousness which occurred with the poles of subject unconsciousness or 'I' and object consciousness or 'me'.

Meares (1991) suggests that trauma is caused by an uncoupling or dedoubling of these two poles of consciousness whereby the subject-object distinction in psychic life is diminished.[2] The concepts Meares uses in defining the self could be likened to Wilber's concepts of the proximate and distal self where the distal self is able to reflect on experience.

Horowitz (1992) does not specify the meaning of the self in his attempt to integrate psychodynamic and cognitive theories of trauma. However, he refers to person schemas which he suggests are organised meaning or knowledge structures providing an overall gestalt of one's self or of another person.[3] He depicts these person schemas as including the traits, roles, attributes, and characteristics of oneself and others. Complex schemas might include the potential transactions and communications of relationships. Horowitz's model assumes that each person may have a repertoire of self-schemas and role-relationship models, any of which could be activated by a traumatic event. Horowitz uses schemas to define aspects of the self that could be likened to what Wilber describes as conscious or unconscious streams of development such as worldview, affective, moral, interpersonal and cognitive development, including dissociated and repressed aspects of experience from any fulcrum.

Herman (1992) pays attention to the damaged and shattered sense of self. Though she doesn't define her understanding of the self explicitly, her use of it implies the psychological structures of an individual that are formed in relation to others. The sense of self appears to be that which negotiates and resolves

developmental conflicts such as autonomy, initiative, competence, identity and intimacy. It is related to self-image, self-esteem, and trust in self and others. Herman's use of the self is similar to Wilber's definition of the functions of the self, including integration and negotiating the fulcrums of development.

Self psychology has offered some explorations into the role of self in traumatic reactions. Rodin (1991) traces the development of the self-concept in self psychology, starting with Kohut's deliberately vague definition of the self because he believed the self was not 'knowable in its essence'. Later self psychologists, Atwood and Stolorow (in Rodin, 1991), defined the self as that which acquires cohesion and continuity. Stern (in Rodin, 1991) noted that the body is the core around which the self develops and Rodin (1991) states that with stress-induced regressions in adult life, the self may be experienced primarily as somatic. Grotstein (1997) refers to the disownership of the self as an important consequence of trauma whereby the self disconnects from the body both in terms of physical experience in the world and as a visible and vulnerable aspect of experience. In a slightly different direction, Brothers (1995) has developed a theory based on traumatic experience leading to a breakdown of trust in self and others. Wilber's framework is once again compatible with these notions of self, reflecting the role of the self in integrating and balancing all aspects of experience and negotiating development. Wilber's belief that identification with the body occurs in the first fulcrum of development is also consistent with the recognition of the body as the core around which the self develops. Whilst Rodin's and Brother's views

are not directly dealt with by Wilber, his framework in no way contradicts these views.

Wilber's framework of the self-system appears to be congruent with references to the self in psychological literature on trauma. Each of the theories examined offers a partial view of Wilber's more comprehensive framework. This is not really surprising, because Wilber claims to be integrating a wide variety of theoretical approaches in psychology more generally. Theories of trauma are derived from those theories and therefore we can expect a degree of consistency. The value of Wilber's theory over any one of the theories mentioned above is the more comprehensive and clearly defined framework it offers. Conceptualisation of the self in the literature is based largely on clinical experience rather than empirical studies. Wilber's overall framework of the self requires the validation of a broad base of clinical experience and empirical studies.

The fulcrums of development

If Wilber's fulcrums of development are to be valid for understanding trauma, we would expect to find different responses to trauma that could be understood in terms of them. In this section, I will examine theoretical constructs and empirical studies that emerge from the literature and take individual differences in reaction to trauma into account, considering them in relation to Wilber's fulcrums of development.

A continuum of disorders, which are consistent with the pathologies identified in Wilber's first three fulcrums of development, has arisen from the psychodynamic literature. Broad groupings of psychotic, borderline and neurotic pathology emerge from the psychodynamic literature as categories differentiated from each other by a detailed focus on ego functioning (Goldstein, 1995). Psychosis is generally not associated with trauma and therefore won't be dealt with further in this paper.[4] Zanarini (1997) identifies several different theories of borderline personality disorder, all of which are consistent with Wilber's framework where the bodyego is engaged in fusing with, differentiating from and integrating impulses and emotions in the second fulcrum of development. Complexities in this fulcrum could result in failure to differentiate from impulses or affects or varying degrees of dissociation of these important aspects of experience. Theories Zanarini (1997) identifies are: borderline personality disorder as an affective spectrum disorder; as an impulse spectrum disorder; and as a trauma spectrum disorder related to post-traumatic stress disorder and dissociative disorders, including dissociative identity disorder. Zanarini (1997) cautions against the trend to see sexual abuse as the main etiological factor in almost all disorders common in women and argues that empirical evidence suggests that for some borderline patients, childhood sexual abuse is not an issue, for some it is a significant factor in their subjective pain and objective pathology, and for others it may be the defining factor. She identifies the need for future research to explore models implicating a complex, multidimensional etiology. Empirical studies confirming a link

between borderline pathology and childhood abuse (Brodsky, Cloitre & Dulit, 1995; Bryer, Nelson, Miller & Krol, 1987; Cahill, Llewelyn & Pearson, 1991; Herman, Perry & van der Kolk, 1989) highlight the importance of paying attention to borderline pathology in a comprehensive theory of trauma. However, as Zanarini notes, a large number of factors need to be considered. Wilber's framework provides a structured and comprehensive model for examining these multiple factors.

Dissociation, somatisation and affect dysregulation have frequently been associated with trauma (Mitchell, 2000; Rodin, et al., 1998; Ross, 1994; Sanders & Giolas, 1991; van der Kolk, et al., 1996). Rodin (1984) notes that somatisation or the development of physical symptoms is common in response to emotional distress. Taylor (1987) documents a significant association between physical illness and object losses from clinical observations. He attributes this to withdrawal of biological and behavioural regulatory processes that the primary caregiver supplies during early infancy. This may affect an individual's self-regulatory processes and thereby influence susceptibility to disease later in life when confronted with losses. After a comprehensive review of the literature and conducting research into these issues, Ross (1994) concludes that psychosomatic symptoms in all body systems are often dissociative in nature and related to chronic childhood trauma. Rodin, et al. (1998) hypothesise that dissociation and somatisation reflect a relative failure in the development of the capacity for affect integration, which usually results from parental failures in responsiveness to emotional experience. Dissociation

has been described as the 'unlinking [of] aspects of the self from the sensory apparatus as a protection against potential or actual trauma' (Bromberg, 1998, p. 204), the 'defensive withdrawal of mind from sensory experience' (Goldberg, 1995, p. 506) and as an indicator of the incomplete emotional processing of trauma (Foa & Hearst-Ikeda, 1996). Dissociative identify disorder is the most extreme form of dissociation in which the psychic numbing and intrusion of traumatic material become personified and structured in part-selves in defense against trauma and its related affects of terror, rage, dread, annihilation, anxiety and grief (Schwartz, 1994). Significant interest in these aspects of experience associated with trauma has developed, and most particularly in dissociation. Tillman, Nash and Lerner (1994) observe that there is insufficient attention paid to the occurrence of dissociation in the absence of trauma and situations where trauma has occurred without dissociation resulting. Nash, Hulsey, Sexton, Harralson and Lambert (1993) found abuse to be associated with a greater use of dissociation, but their study identified that this effect was accounted for by family pathology. Though Wilber does not deal with these specific issues, his focus on the physical body and emotional experience in the early fulcrums of development is consistent with theory and findings around dissociation, somatisation and affect regulation related to trauma. Furthermore, his concepts of the four quadrants provide a framework for considering a broad range of factors that might be implicated in such responses to trauma.

Studies have indicated that post-traumatic stress disorder is closely correlated with depression: between one and two thirds of people diagnosed with post-traumatic stress disorder are also diagnosed with a major depressive disorder at some point (Blanchard, Buckley, Hickling & Taylor, 1998; Erickson, Wolfe, King, King & Sharkansky, 2001; Hyer, et al., 1999). This is a complex bidirectional relationship where depression could be a risk factor for post-traumatic stress disorder and vice versa. The bidirectional nature of this relationship has been confirmed by one study although initial post-traumatic symptoms were found to be more strongly predictive of later depression than vice versa (Erickson, et al., 2001). The authors of the study hypothesised that the specific causal mechanisms through which this risk occurs could be neurochemical, behavioural, cognitive or a combination of the three. The hypothesis offered by the study could be seen to be located in Wilber's upper-right quadrant with some aspects of the cognitive understanding possibly being related to his upper-left quadrant. This does not contradict Wilber's framework, but Wilber's framework would encourage the consideration of further hypotheses such as the possibility that a person who experiences depression has unresolved fulcrum-3 conflicts that have been triggered.

Horowitz (1992) doesn't differentiate the responses to trauma he refers to in any clearly defined continuum. He does, however, identify that a traumatic event always combines with pre-existing personality styles, dispositions, conflicts, personality pathology or premorbid functioning to determine the nature of traumatic response. He notes that a person may go through phases of

intrusion and denial in an adaptive way, where memories of the event are integrated with the individual's previous experience of the world. He also speaks of a continuation of the symptoms of traumatic response to the point where it becomes clear that the individual is not working through the traumatic event and suggests that characterological limitations may represent avoidance of a reaction to the event. Horowitz notes self-schemas such as views of the self as weak or strong, good or bad, or self-centred or protective towards others. He implies that these schemas would not be unconscious but may be memories or fantasies associated with the traumatic event. He also refers to self-schemas that may be activated by trauma, such as primitive rage and the wish to harm others, along with the belief in the magical properties of such wishes. Horowitz refers to the extreme nature of such cases and thus appears to recognise the primitive nature of such schemas. Horowitz's description of the individual who goes through intrusive and avoidance symptoms in an adaptive manner would be consistent with what would be expected of an individual functioning in fulcrum-5, where the mature ego would have the capacity for introspection and could thus integrate experience in this manner. The individual who is avoidant is typical of what would be expected in fulcrum-3, where it may be a neurotic avoidance, or fulcrum-4, where the self that is identified with social roles is unable to explore the meaning of the trauma. The conscious self-schemas Horowitz focuses on would be consistent with what would be expected if a person was functioning with their centre of gravity in fulcrum-4, and the unconscious schemas he refers to would be consistent with

Wilber's fulcrum-2. Further, this is consistent with Wilber's theory where one's centre of gravity can be based in any of the higher fulcrums but there may be dissociated or repressed material related to any of the earlier fulcrums.

Subclinical responses to trauma which may not be significant enough for clinical treatment but which none the less impact on the individual's quality of life have been noted. The individual's state may deteriorate at a later point when, for whatever reason, including aging, capacities for repression start to deteriorate (van der Kolk, et al., 1996). Such a response can be seen as consistent with Wilber's framework and is likely to represent someone whose functioning is in fulcrums-3 to -5 where they have intact defense mechanisms. However, they are not able to experience the related physical responses, thoughts and feelings and thus don't have the capacity to integrate all experience as one would in fulcrum-6.

Numerous writers on the topic of trauma identify the critical question of what the natural mechanisms are that allow some individuals to face severe traumas and to go on (Joseph, Williams & Yule, 1997; van der Kolk et al., 1996). In general, this capacity to cope is termed resilience. Resilience may refer to individuals who face severe trauma but never have a reaction that requires clinical care. However, it may have a significant impact on their experience of life none the less, as in the situation described above. I would like to use the term resilience in this paper to refer to either the adaptive behaviour Horowitz refers to, or the capacity to experience the physical and emotional responses

and the thoughts that arise in response to traumatic experiences without even experiencing intrusion and denial. I would liken this experience to Ogden's description of 'I-ness', where 'experience is subtly endowed with the quality that one is thinking one's thoughts and feeling one's feelings as opposed to living in a state of reflexive reactivity' (1985, p. 131). This is consistent with Wilber's fulcrum-6 centaur, where there is the ability to integrate experiences of the mind and body. Ogden (2001) contrasts this experience with mindedness that is disconnected from experiences in the body, and suggests that disconnection results when early childhood experience leads the individual to create a pathological mindedness. He suggests that this may be precipitated by the infant's constitutional hypersensitivity, by inadequate maternal provision or by trauma.

Wilber's fulcrums of development do not contradict either the theoretical constructs developed for understanding different reactions to trauma, nor the empirical evidence that arises from trauma studies. Furthermore, I believe his framework assists in organising and observing relationships between multiple theories and large amounts of empirical data. None the less, in order for this framework to have external consistency, prospective studies would need to be conducted that test an individual's functioning in relation to the fulcrums and ascertain their predictive capacities in response to traumatic events. This kind of study would be difficult to set up as obviously one cannot do the testing and then ensure a traumatic event. However, a similar design to that used by Nightingale and Williams (2000), whereby attitudes to emotional expression

were assessed within a week of a motor vehicle accident and were used to predict post-traumatic disorder six weeks after the accident, could be utilised.

Summary and main conclusions of findings

A review of the trauma literature indicates significant moves towards integration consistent with Wilber's integrative framework. Whilst van der Kolk, et al. (1996) approach trauma from an eclectic standpoint rather than from an integrative theory, their material is by far the most comprehensive text on trauma I have discovered. Wilber's framework is consistent with all the issues they discuss. Other material is also consistent with Wilber's framework, however, it often focuses on one or two aspects only. There may be a focus on the relationship between mind and body, the individual and society, or the mind, body and society where the interior and exterior aspects of society are conflated. Integration of psychotherapeutic approaches may deal with a variety of theories that deal with the individual only. Evidently there is a process of integration of theory and practice already in progress, but there are weaknesses that need to be addressed. In my opinion, Wilber's theory of integral psychology provides a map that would facilitate this process. This would help to avoid some of the gaps and inconsistencies that are evident in aspects of integration. Further empirical studies are required with a specific focus on Wilber's integrative framework to further assess the external consistency of his framework for understanding and working with trauma.

Chapter 4: An integrative model of trauma

In this chapter, I will attempt to integrate Wilber's theory with the trauma literature in order to develop an integrative model for understanding, managing and further researching trauma. I begin by reflecting on why it is useful to theorise an integrative model of trauma. Then I consider the relationship between traumatic reactions and the four quadrants, how the self-system negotiates trauma, and the relationship between trauma and pathology in the various fulcrums of development.

Why theorise an integrative model of trauma?

In this section, I explore reasons for theorising an integrative model of trauma. In brief, these reasons are that no single theory fully explains traumatic reactions, eclecticism does not allow for reflection into practice based on theory, and a clinician's understanding of traumatic response is likely to inform the treatment approach adopted. Also, the goals for treatment and the capacity to reflect on success or failure in terms of meeting these goals will be determined by theoretical understanding. Finally, a theoretical model allows a therapist greater flexibility in taking a therapeutic stance between the poles of knowing and not knowing. I will explore each of these issues briefly.

An examination of the local and international literature on trauma indicates widespread recognition that no single psychological theory or therapeutic approach is adequate for developing a full understanding of trauma and trauma

management (Eagle, 1999; Hajiyiannis & Robertson, 1999; Herman, 1992; Horowitz, 1992; Knight, 1998; O'Brien, 1998; Scrignar, 1996; van der Kolk, et al., 1996). This raises questions as to what theories and therapeutic modalities one includes in approaching trauma. Further, how do a number of theories and management approaches come together? Does one work eclectically, drawing on what seems appropriate at any one time, or develop a theoretical base from which to consider a variety of approaches?

John Norcross (in Dryden, 1992) makes a distinction between integration and technical eclecticism – the former refers to a conceptual or theoretical scheme that provides a coherent and evolving framework and the latter is relatively atheoretical, pragmatic and empirical. Several approaches to therapeutic integration were referred to in Chapter 1. Whilst these integrative therapeutic approaches have not all been theorised with a specific focus on trauma, it is likely that at times they are all used to respond to trauma. Technical eclectic and empirical texts on trauma may refer to one or more psychotherapeutic approaches. They also frequently refer to the significance of physiology, cultural, social, political and economic factors in the etiology and management of traumatic responses. A conceptual framework providing a theoretical base that can incorporate an integrated understanding of etiology and appropriate therapeutic responses, including the integrative approaches listed above and other psychotherapeutic approaches, would be valuable in the field of trauma for the purpose of reflecting on and developing theory and practice.

One's understanding of traumatic response is likely to influence the therapeutic approach adopted. If traumatic reactions are understood as being the result of unresolved internal conflicts that have been triggered, a psychodynamic approach will appear to be the most suitable response. If these reactions are seen to be due to cognitive schemas being disrupted, a cognitive therapy will seem the most appropriate. Clinicians who firmly locate their practice in one approach only are likely to always respond from that approach. Empirical studies clearly indicate that a wider number of factors that may include both unresolved internal conflicts and disrupted schemas are involved in the etiology of traumatic responses. Such an understanding should then lead to therapeutic responses that incorporate this wider understanding.

The theoretical stance of a clinician is also likely to influence the goals set for a therapeutic intervention and the way in which successes or failures in terms of meeting these goals will be understood. In terms of the above-mentioned approaches, this may mean that the therapy is considered successful when the core conflict has been uncovered or when problematic cognitive schemas have been modified. If these goals are not successful, the psychodynamic therapist may understand it in terms of resistance and the cognitive therapist may understand it as a lack of motivation. Frequently, considering Wilber's view that most people have their centre of gravity located between fulcrum-3 and -5, these may be appropriate responses and relevant explanations. However, at times these may be inappropriate or incomplete goals. For example, let us consider a person who is fairly stably located in fulcrum-6 and dealing with

existential issues. They may need to do uncovering work in fulcrum-3, but may be resistant because a therapist who only focuses on fulcrum-3 is unable to engage them with the existential issues that are also pertinent. The opposite scenario may be a therapist based in an existential perspective working with a person whose centre of gravity is located in fulcrum-3. This therapist may have unrealistic goals about the nature of meaning that the person can make out of a traumatic incident. A broad integrative theoretical framework based on Wilber's theory may allow for a wider scope of vision to recognise different aspects of a person's development and from there identify appropriate treatment responses and goals for a therapeutic intervention. This may, however, raise the question of whether suggestions for such a framework are attempts at creating the infallible therapist who knows and sees all things.

Carrere-Comos (1999a) makes the important point that a comprehensive theoretical model allows the therapist greater flexibility in taking a therapeutic stance between the poles of knowing and not knowing. The most significant role of a comprehensive theoretical framework would be negated if it became the point of safety for a therapist to feel that they have understood everything. Rather, it needs to be used as a map that signposts important things that might be otherwise missed and it gives the therapist and client more freedom to move into the space of not knowing.

The expansion of integrative therapies has been identified as one of the most important trends in contemporary psychotherapy (Omer, 1993) and is predicted

to expand most in the new century (Jacobs, 2000). This recognition is itself sufficient basis for theorising integrative therapies because it is only through theorising and testing different theories that progression in this field will occur. And with trauma being a significant area of concern in current psychological literature, the time is ripe to develop the broadest possible integrative theory of trauma. These reasons, along with those already discussed in this section, provide sufficient explanation for the value of theorising an integrative approach to understanding and managing trauma.

Traumatic experience and the four quadrants

In this section, I explore the exteriors – the upper-right and lower-right quadrants – and the interiors of sociocultural experience and how all four quadrants arise together and interact with each other in the expression of traumatic responses. In the following two sections, I will describe the self-system and the fulcrums of development in terms of how they might be affected by or implicated in traumatic responses. Both of these aspects would fit into Wilber's upper-left quadrant of subjective, interior experience.

The impact of trauma is clearly experienced in the physical body. This can be understood in terms of the physical sensations and emotional responses experienced by an individual in the interior aspect of experience as will be described in more detail later. It can also be understood in terms of reactions in the central nervous system and parts of the brain such as the reptilian brain, which controls our instinctual reactions, the mammalian or limbic brain, which

controls our emotional responses, and the human brain or neo-cortex, which controls rational behaviour. Traumatic experiences involve both the reptilian and mammalian aspects of the brain. Trauma may also impact on the capacity to reflect on experience as a result of cerebral disruption. This physiological experience impacts on the self's capacity to co-ordinate experience. This physiological experience and an individual's understanding of it may impact on their sense of self, their functioning in various social systems and the way in which they make meaning with other people. If they experience total helplessness in relation to their own body's functioning, it is likely to impact on all areas of experience. Recognition of this aspect of trauma is imperative for the effective treatment of traumatic reactions.

The functioning of various social systems and the individual's role in them also impacts on the manner in which an individual experiences traumatic events. Access to basic needs such as food, a safe environment and legal resources are very important when an individual has experienced trauma. Furthermore, development of the self and the way communities make meaning together will have been impacted on by roles given to the self and others in family and social systems. If these systems do not function in a way that allows for developmentally appropriate experiences, the individual's self-development will be impacted on. The systems should function in a way that allows dependency in early infancy and physical and emotional separation leading to increasing autonomy and expression of self in all its aspects. Pathology in any of these systems – whether family, social, political or economic – will impact

on all quadrants of experience, including the capacity of the self to integrate all aspects of experience as it moves through the fulcrums of development and the sociocultural realms of creating intersubjective meaning. An example of pathology in systems may be the Victorian family and social system that attempted to fulfill the function of social cohesion by strict discipline and restrictions on emotional and sexual expression. This would have impacted on the self's potential to integrate early libidinal and emotional experiences, and the 'stiff upper lip' required in interactions with other people would have prevented making meaning with others around these aspects of experience. Another example of pathology in systems is the apartheid system, where racist social, political and economic structures excluded the majority of the population from exercising basic human rights and used repressive measures to silence people's resistance. Social systems and an individual's functions in these systems is a significant factor in understanding trauma and needs to be considered in appropriate and effective trauma management.

The interior experience or manner in which meaning is made in a person's sociocultural group is significant in the experience of trauma and is a very important factor in assessing the appropriateness of interventions. This is particularly important when a group of people have been affected by traumatic experience on a collective basis, such as in the case of war or natural disasters. On an individual level, early experience, and the degree to which caregivers acknowledge and respond to physical and emotional experience and then assist in the process of symbolising this experience by providing language for it, will

support either the process of integration of this experience or repression and dissociation from it. Where intense affects are aroused by abuse or neglect and there is no opportunity for facilitation of these intense affects, there will be greater investment in the repression or dissociation of these affects. This will impact on the self's development and may result in developmental arrest or pockets of repressed and dissociated material. The degree to which the social environment facilitates and supports a person in making meaning of traumatic experiences and their reactions later in development is likely to have a significant impact on the individual's capacity to integrate the experience. Very few, if any, people will have the sense of self to experience the physical and emotional reactions that are a normal response to trauma if their sociocultural context denies the validity of their responses.

The aspects of experience that arise in each of the four quadrants interact with each other in every individual's experience of trauma. One or other quadrant may be more significant for each person or at a particular point in an intervention. It is imperative that all these aspects of experience be considered when assessing an individual's reactions to trauma and that management responds to what is most significant in each quadrant.

How the self-system negotiates trauma

The self-system is the part of the psyche that attempts to negotiate traumatic experience. Firstly, I will describe the interaction of the severity of trauma with the functions of the self-system and its central task of integrating and balancing

whatever is present. Secondly, I will explore the significance of where the centre of gravity is located in an individual prior to and following the experience of trauma. I will examine these issues briefly in this section before moving on to a more detailed account of the fulcrums of development.

The success of the self-system in negotiating trauma will depend on the interaction of the severity of trauma, what is occurring in relation to the other three quadrants of experience, and the functions of the self-system in its central task of integrating and balancing whatever is present. Traumatic experiences always demand an element of physical and emotional response and thus tap into any material that remained fused, repressed or dissociated in early development. If later development was not sufficiently metabolised, or if the traumatic experience is very severe, individuals may not be able to integrate traumatic experience. The experience may throw into question their sense of identity and whether the self identifies with the material self, bodyego, emotional self, persona, ego, or centaur. It may also throw into question whether they identify with self, friends and family, ethnic group, nation or all beings – especially where traumatic incidents have been caused by people from another racial or sociocultural group. Individuals functioning with certain mature defences could find themselves using earlier immature defences. Individuals may also develop the belief that they are no longer free to make the choices they previously were able to. Experience of trauma may interfere with the functions of the self-system, especially where location in a particular fulcrum has not been fully metabolised. The intrusive and constrictive

symptoms of trauma may well be the self's attempt to metabolise and integrate the experience of trauma. The manner in which this is achieved and the extent to which it is successful will depend on where the individual's centre of gravity is located, how stably it has been metabolised, and the extent and nature of material from previous fulcrums that remains fused, dissociated or repressed. The functioning of individuals in the social systems in which they exist and the extent to which they are able to make meaning in their sociocultural environment will interact with the self's functioning in this process.

The functions of the self-system are integrally tied up with the location of the centre of gravity in an individual prior to and following the experience of trauma. Development through the fulcrums can be arrested at the stage of fusion, differentiation or integration in any one of the fulcrums. This may be so severe that it results in developmental arrest or there may be pockets of arrest that have differing degrees of severity. Whilst these pockets of arrest may not have prevented movement of the centre of gravity into higher fulcrums, they remain as undifferentiated or unintegrated aspects of experience. Traumatic experience may trigger these pockets of arrest resulting in regression to material that now demands integration or continued pathology. Someone whose centre of gravity is located in a higher fulcrum may experience regression to fulcrum-1, -2 or -3. However, treatment of such a person would be very different to treatment of someone located in those earlier fulcrums prior to the experience of trauma. It is likely that the individual who was functioning in a higher fulcrum prior to the trauma will move more easily

through an integration of whatever is required (if the therapist can recognise this and assist them with it or ensure that the social environment allows it). It would be important to recognise what the level of functioning was prior to the experience of trauma and how it had been impacted on in order to assess what it is that the self-system needs to integrate and balance and what type of intervention is required for this.

The experience of trauma interferes with the self-system's function of defending against previously unintegrated material. The extent of pathology and the successful resolution of it will depend on the fulcrum of development the self had metabolised in prior to the traumatic experience, how stably it had metabolised in that fulcrum, and the degree to which material from previous fulcrums has been integrated. This occurs in interaction with the other three quadrants, which may have varying degrees of significance in the severity of an individual's reaction to traumatic experience and in the process of integrating the experience.

Trauma and pathology in the various fulcrums

In this section, I examine the relationship between trauma and responses to trauma in the various fulcrums. I describe the reaction to traumatic experience one might expect of people functioning stably in each of the fulcrums and the shifts that might be seen when regression occurs. I also consider the role of the fulcrums of development in setting realistic goals.

It is likely that most people who appear in clinical settings as a result of trauma have their centre of gravity located in one of the first three fulcrums or are experiencing difficulty integrating material related to the first three fulcrums. A person's centre of gravity may shift temporarily in response to traumatic experience or their centre of gravity may remain located in the same fulcrum as it was prior to the traumatic event but unintegrated material from earlier levels of development becomes problematic.

A person who is actually resilient to trauma rather than using very effective defense mechanisms will experience some kind of physical reaction to the experience of trauma such as shaking, and emotional reactions such as anger, grief and guilt. They will also develop cognitive understanding of how and why the event occurred. However, though they may continue experiencing some of these reactions, they will not be experienced as their sole sense of identity and will not be incongruent with their self-identity. Such a person is likely to have their centre of gravity in one of the higher fulcrums and a high degree of integration of the early fulcrums, therefore being able to allow such responses to be experienced freely.

A person who appears resilient but does not experience any kind of physical or emotional response is likely to be functioning in fulcrum-4 or above. However, it is likely that they have repressed or dissociated aspects of their physical and emotional experience. It may be that they never experience a traumatic response or it may be delayed. This could assist in explaining why some

elderly people experience traumatic responses later in life when they had subclinical responses following the actual trauma. As their cognitive faculties become less acute with age, their defenses may become less effective. It is possible that acute stress disorder, where there is short-term experiencing of avoidance and re-experiencing of symptoms, would be a fairly normal response to trauma in a person functioning in fulcrum-4 and above who hasn't integrated physical and emotional responses. The experience of avoidance and re-experiencing of the event is possibly an attempt by the self-system at metabolising the experience of trauma. For the experience to be deeply metabolised the individual would need to reach a point of being able to allow and be present to a free flow of physical and emotional responses. It is possible that in some instances, the symptoms allow for sufficient integration to re-establish a stable enough centre of gravity in the previously functioning fulcrum. In other instances, it may be that a period of time was required for previously utilised defenses to become fully effective again.

A fairly straightforward post-traumatic stress disorder that resolves itself over time may be a result of a similar process that requires more time to reach a state of equilibrium, either because the individual took more time to allow a free flow of physical and emotional responses or because it took longer for them to get their defenses functioning effectively again.

Complex post-traumatic stress disorder that does not resolve easily over time is often comorbid with depression, suggesting that the individual's centre of

gravity is located in fulcrum-3. It may be that they were functioning unstably in a higher fulcrum prior to the traumatic experience and the anxiety or depression (or other psychoneurosis) as well as the post-traumatic stress disorder was triggered by the traumatic experience. Otherwise their centre of gravity may have been located in fulcrum-3 and the post-traumatic stress disorder was superimposed on already existing psychoneurotic pathology.

Individuals functioning in fulcrum-2 may be experiencing some kind of borderline or narcissistic pathology. It is likely that in these instances, when trauma is experienced it is superimposed on already existing pathology or may be one of the contributing factors towards the long-term development of the pathology. Dissociative identity disorder may fall into this category. Other severe dissociative experiences could also be experienced by individuals whose self-system is located in fulcrum-2. However, in these instances it likely that they were previously functioning unstably in a higher fulcrum and are experiencing regression to fulcrum-2.

Recognition of the fulcrum in which a person's centre of gravity is located prior to and following trauma is important for setting realistic goals. It will not be helpful to the clinician or the client to, for example, set goals for a patient that include making meaning in the manner someone in fulcrum-6 might make meaning if the patient's centre of gravity is located in fulcrum-2. This kind of scenario might occur when, for example, a therapist is him or herself located in a higher fulcrum of development and they are hoping for the client to make

meaning in a similar way to what they would expect for themselves. Inappropriate goal setting will result in both the therapist and client feeling that the treatment has been unsuccessful and also feeling unable to identify why they consider it unsuccessful. Whilst this is a fairly extreme example, it is possible for a discrepancy to occur between a client's experience and the goals set for treatment. Identification of what each individual is most needing to integrate in relation to their current functioning will be most helpful for them to move forward in their development.

The severity of traumatic response a person experiences is likely to be a result of the interaction between the severity of the trauma experienced, the fulcrum of development in which they have been functioning, and the degree to which they have integrated material from early fulcrums of development. The facilitation they receive will be the most beneficial if it recognises where their self-system is located and responds and sets goals accordingly. Furthermore, the interaction of the self-system with experience in the other four quadrants is likely to have varying significance for each person but is critical in understanding the severity of a person's reaction to trauma and to selecting an appropriate management strategy.

Summary and main conclusions

Joseph, et al. (1997) observe that a traumatic event is clearly the necessary etiological factor for the onset of traumatic reactions but suggest it is not sufficient and that we need to be aware of other factors that contribute to

symptoms. They hypothesise that personality variables, emotional and coping responses, characteristics of different emotional states, the responses of others and the social context interact to affect an individual's response to trauma. On a similar note, Horowitz (1992) identifies from intensive case studies that a traumatic event joins with pre-existing meaning structures to produce consequences. Whilst each of these explanations appear useful, they lack a framework that organises the material meaningfully and assists in looking at the relationship between the multiple factors. Furthermore, Joseph, et al. fail to explain how these coping mechanisms and personality variables develop. In integrating Wilber's theory with the trauma literature, I have attempted to provide a framework that can organise apparently disparate information in a manner that facilitates recognition of the relationships.

Assessing the relationship between traumatic reactions, the self-system and experience in each of the four quadrants seems a valuable framework from which to approach individual reactions to trauma. An understanding of the role of the self-system in negotiating trauma and of different fulcrums of development appears useful in understanding an individual's reactions, assessing their needs and deciding on appropriate goals to work towards.

Chapter 5: Integrative interventions

This chapter focuses on an integrative approach to intervention. I first discuss issues around working within an integrative framework, including the goal of interventions, assessment of individuals who have experienced trauma, principles of selecting appropriate interventions, and having a range of therapeutic approaches at one's disposal. Then I explore a spectrum of treatment modalities for trauma management.

The goal of interventions

Important in identifying the goals of working with trauma is the recognition that physical, emotional and mental responses that may be painful and confusing are a normal part of traumatic experience. Integration of these aspects of experience and stabilising the mind-body functioning are central goals in trauma work. In this section, I briefly examine these factors.

Integration means the capacity to be present to all aspects of traumatic experience in order to release energy tied up in avoiding the painful responses and be freed to be present to continuing life experience. This will mean continuing to be present to physical, emotional and mental responses as and when they arise and not expecting them to disappear over time. Ultimately this will mean awareness of experience and an allowing of these aspects of experience with a high degree of self-reflection and lack of reactivity. Where there is an overwhelming physical and emotional response, there may be the

goal of developing cognitions that contain these responses and assist the individual in enduring the pain of the trauma at the same time as making interior meaning of the experiences. For the individual who is emotionally constricted, the goal may be to develop an understanding of the fear of the physical and emotional realms and to begin establishing a greater connection with them. Facilitation of a process of integration of aspects of experience from each of the fulcrums will be appropriate for individuals with their centre of gravity located in fulcrum-3 or above. Individuals with their centre of gravity in fulcrum-2 will have significant groundwork to do related to separating their sense of self from others before this process of integration can take place – and in some instances it is questionable whether they will reach the point of integration being appropriate. In setting goals, it is crucial to establish the extent to which the individual's environment may be able to support the processes of integration required and to set goals for developing this support in each of the quadrants.

The process of goal setting needs to be closely related to the assessment process and is likely to shift as the intervention proceeds. Early goals may have an emphasis on the right-hand quadrants and focus on establishing safety in the individual's environment and assisting them with meeting their basic physical needs for sleep and nutrition. Later goals may shift towards making meaning in the left-hand quadrants.

Assessment and principles of selecting interventions

A thorough assessment needs to be conducted initially and then continually updated in determining interventions. Initially, I consider how assessment that is specific to this integrative model would occur, including assessment of experience in each of the four quadrants. Then I make suggestions for principles that would determine interventions from an integrative framework based on such an assessment. Finally, I discuss psychoeducation about the nature of traumatic experience and any interventions suggested.

The process of assessment and goal setting would involve the usual clinical assessment process along with establishing experience in each of the four quadrants. Wilber (2001b) suggests that a DSM-IV diagnosis would be accompanied by a 'psychograph', which maps out these issues. The individual's self-structure and where their centre of gravity is located, what the impact of traumatic experience has been, and what they need to integrate would be established. The relationship between the self's interior experience and the other three quadrants would also need to be established.

The basic principle of choosing interventions from an integrative framework would be to respond to all quadrants and all levels that are appropriate to an individual's fulcrum of development. In the early stages following a traumatic event, it is likely to be most appropriate to ensure that basic physiological needs are met and that social systems are functioning to normalise experience as far as possible, thus responding to experience in the right-hand quadrants.

At a later stage, it is likely that making meaning will become more important, thus bringing into play the left-hand quadrants. The fulcrum of development that an individual's centre of gravity is located in should guide choices of therapeutic interventions with the basic guideline that the lower the fulcrum of development an individual is based in, the more the modality should focus on structure-building. This would pertain to all modalities including individual psychotherapy, body therapies, meditation or group therapy. If an individual is functioning relatively well and has a sociocultural network that can support their efforts to make meaning of what has occurred, it may be that an intervention is not required at all or that some psychoeducation may be useful as the only intervention. If a community has experienced trauma such as in the case of war or a natural disaster, it may be that the most suitable intervention is to identify whether the community is able to rebuild its sociocultural networks and sense of community, assess strengths and weaknesses in the social system, and reinforce local capacities (Summerfield, 1999).

Assessment would best be drawn up in conjunction with the person, indicating to them at all times what is being suggested and why. In this way, assessment would play the dual function of psychoeducation. This would be for the purpose of establishing their sense of involvement in the process and to avoid developing or reinforcing the helplessness that is often prevalent in survivors of trauma. It would also be a part of ensuring that the treatment process develops at the pace the individual is ready to deal with and would allow him

or her to make choices about treatment with the advantage of the clinicians informed recommendations.

Use of an integrative model such as this for assessment will reduce the risk of ignoring a significant aspect of an individual's experience. It could also assist in ensuring that interventions are focused on understanding and responding to the specifics of an individual's experience and needs in these significant areas.

Drawing on a range of interventions

Wilber (1993) notes that the different major fields of Western psychotherapy are concerned with different levels or aspects of functioning and suggests that a truly integrated approach should make use of the complementary insights offered by each school of thought. Murphy (1993) notes that different practices and therapies are one-sided in a manner that reflects their founders' biases. In this section, I suggest two basic approaches to integrating a broad range of therapeutic practices. The first is what I refer to as the blending of modalities and working with modalities that span two or more quadrants. The second is having basic knowledge of a broad range of modalities for purposes of referral.

Blending of approaches is the integration of more than one therapeutic approach into a single therapeutic modality. Eagle's contribution (1998) of an integrative psychodynamic and cognitive approach describes the use of these two approaches in a single model of trauma. This method integrates a modality that is based in the upper-left quadrant with one that is based in the upper-right

quadrant. Another such model, developed by Levine (1997), is somatic experiencing as a therapeutic approach for dealing with trauma. This model combines development of awareness of the felt sense and the body with visualisation of a traumatic event, and has an emphasis on releasing energy built up in the nervous system through the physical body. Though neither of these models have empirical studies to support their effectiveness, the writers refer to significant clinical experience in which their approaches have been used effectively.

The second method of integration, which can be inclusive of the blending discussed above, is the recognition of a multitude of therapeutic modalities in the upper-left and all the other quadrants and the use of one or other as the need arises. This would include being skilled in more than one therapeutic modality that could be used when deemed appropriate and having the knowledge of various modalities for which referrals could be made. The most obvious and well-used application of this is the psychologist who may treat an individual with psychodynamic or cognitive-behavioural therapy and refer to a psychiatrist for psychopharmacology. It could, however, go much broader than this and this is what I would like to suggest here.

A spectrum of treatment modalities

It is well recognised that the multidimensional nature of traumatic reactions often requires a combination of several different approaches (van der Kolk, et al., 1996). I will not attempt to include all possible modalities in this section as

there are a large number of possibilities available and many of them are likely to have some value in certain situations. Instead, I will consider some of the main modalities one might work with in each quadrant, including mainstream approaches and some of the so-called alternative approaches. I will also consider some issues related to integration of African traditional healing.

Therapeutic approaches for working with internal subjective experience include psychodynamic approaches of structure-building and uncovering therapies, gestalt therapy, transactional analysis, narrative therapy and existential therapy. Critical to each of these therapies is the interpretation and recognition of internal meaning created through working with the mind. Each of these approaches works with integrating experience of the body and the emotions in the manner most appropriate to individuals functioning in the fulcrums each approach was related to in Chapter 2. One could use each of these therapies for an individual with their centre of gravity based in any of the fulcrums but it is likely to be less effective than targeting the therapeutic approach at the fulcrum their self is largely centred in.

There is a range of different types of meditation that can also be used for developing and integrating interior subjective awareness. These range from concentration on a particular focus of attention in the mind, to meditations focused on bringing awareness of the sensations in the body, to breath meditation where there is a focus on awareness of the breath, to mindfulness meditation where one focuses on the movement of the mind and becoming

aware of what triggers certain thoughts, to meditations focused on compassion. Whilst a person functioning in a higher fulcrum of development may use all these types of meditation to integrate traumatic experience, it would not be wise for an individual with a borderline disorder to use awareness-training meditations. Such meditations tend to dismantle subjective structures and therefore require a healthy, strong ego, which the borderline is still needing to develop (Wilber, 2001b). Concentration-type meditation would be appropriate for borderline patients. Other practices for developing interior awareness and integrating mind and body include yoga and tai chi. A more structured and disciplined yoga such as Iyengar yoga may be appropriate for individuals with their self-system located in earlier fulcrums of development.

Interventions that are useful for trauma management in the upper-right quadrant include pharmacotherapy and establishing conditions for stability. This may be ensuring an individual's basic physical needs are being met, such as personal safety, the establishment of regular day and night rhythms, and appropriate self-care including food and rest and structuring of daily activities (Turner, et al., 1996). Cognitive therapies that work with automatic thoughts and behavioural therapies such as imaginal exposure and eye-movement desensitisation and reintegration are also useful approaches to working with the symptoms of trauma. General exercise programmes such as running, walking, weightlifting or team sports can also be useful tools in integrating the experiences of trauma. Wilber (2000b) suggests that exercise that is done alone is most appropriate for individuals centred in the early fulcrums whilst team

sports can assist those in higher fulcrums. Massage is another therapy that can assist in the process of integrating traumatic experience.

Working with the lower levels of the upper-left quadrant engages an overlap with the upper-right quadrant because of the nature of the mind-body relationship described in Chapter 2. Hence the importance of cognitive-behavioural therapies, and body therapies generally, when working with trauma. This may also offer a part explanation for the success of these approaches evident in empirical studies. However, on their own these therapies do not offer any interpretation or way of making meaning of traumatic events and are thus preferably used along with an interpretive upper-left quadrant therapy appropriate to the level of functioning of an individual.

In the lower-right quadrant, one might include legal support, political action towards social and economic change, family systems therapy and such like. Accurate identification of an individual's functions in relation to the functions of others in social systems, including the family system, the work environment and political system as is relevant, and the function of the traumatic response will be important. Changes in these systems may be necessary to facilitate healing.

In the lower-left quadrant, one might include support groups, group therapy and rituals that assist in making meaning. It is important to assess whether the individual can be encouraged to find meaning in the environment they live in

or whether they need to find another environment that will be more supportive, such as support groups or group therapy. Family therapy that focuses on creating meaning rather than an individual's functions in the system would also be relevant in this quadrant.

A healing modality that engages two or more quadrants is African traditional healing, as it engages aspects of the individual and collective. A large number of African people who seek treatment in Western-style contexts may also be consulting a traditional healer, though many patients will keep this secret because they believe it will be frowned upon. There has been much debate about the role of traditional healers and whether they are engaged in magical practices or whether there is a rational element to their practice (Swartz, 1998). In terms of Wilber's framework, further investigation would be useful in terms of whether traditional healers are involved in transrational or prerational practice. I would speculate that at least some of the practice is based on experience in the psychic realms of fulcrum-7 – whether as peak experiences or stable functioning in these realms – however, I don't think this is what is significant when working with individuals seeing traditional healers. What is significant is the integration of therapeutic responses that would include traditional healing as an important modality. The clinician's capacity to integrate and see the role of different healing modalities is critical if the individual is to utilise whatever therapies they need to the best advantage. I believe the worldview of the individual who sees the traditional healer is more important in terms of this paper than that of the traditional healer. I suggest this

may be varied. They may be coming from the mythical worldview that some higher being can solve all their problems. If this is the worldview projected onto the traditional healer, it is likely they will also project it onto the Western-trained therapist or doctor. Or it may be that they have seen that at times people are healed when they see Western practitioners and at other times are healed by traditional healers and therefore they are making the rational choice to see both in order to increase their chances of healing. Furthermore, they may value all traditions and thus make use of them, thus as an expression of an aspect of vision-logic. It is not helpful to the person if they are coming from a rational perspective for the therapist to imply that they are wasting their resources in magical or mythical thinking. It is also not useful for the individual who may be engaged in magical or mythical thinking to simply get the message that it is wasteful of their resources to see a traditional healer. Far more useful is likely to be the accurate interpretation made at an appropriate time of the wish to be able to get revenge or sort out problems by one's own magical thought or for some higher being to do this as in the case of mythical thought. Whether the individual's hope for the fulfillment of this wish is through the Western-trained practitioner or the traditional healer is immaterial. It is likely that if they are thinking magically or mythically, it will be in relation to both healers. They will not be using rational thought in relation to the one healer and magical or mythical thinking in relation to the other.

I have presented a wide range of healing modalities that might be used in trauma management based on the different quadrants they relate to and

consideration of fulcrums of development. The use of these modalities is recommended with some very basic guidelines for selection based largely on theoretical understanding. Appropriate targeting of modalities requires further reflection based on clinical experience and thorough empirical testing.

Summary and conclusions

An integrative model of trauma based on Wilber's framework provides a sound basis for assessing an individual's experience in relation to trauma. Assessment of an individual's self-system and whether there has been a shift in the primary fulcrum of functioning and the interaction between this upper-left quadrant and the other three quadrants of experience will facilitate a comprehensive view of the person's situation. This would assist in setting goals and targeting interventions.

To practise from an integrative framework, a therapist would require knowledge about a broad range of interventions in order to select modalities appropriately. This may be either through modalities they have skills in themselves or through referral.

This chapter has provided some initial thoughts about targeting interventions in relation to an individual's specific needs. Clinical experience and reflection, comprehensive testing and further development of these guidelines is required.

Chapter 6: Conclusion

This study set out to investigate Wilber's integrative framework as the basis for a theoretical paradigm that would allow for systematic exploration of individual differences in the nature and extent of reactions to traumatic events, and assist in identifying treatment approaches that are indicated or contra-indicated. This chapter begins with a summary of my argument and findings and an interpretation of how these relate to the literature and theory in the domains of integrative psychology and trauma. I then discuss the limitations of my study and close by considering the significance and relevance of my study and suggesting areas that require further research.

Argument and findings

The main argument of my paper is that Wilber's integrative framework (2000a) provides a comprehensive basis for a broad theoretical paradigm of trauma that facilitates an understanding of differences in individual reactions to traumatic events and assists in targeting treatment approaches and goals in relation to these differences. My preliminary review of the literature in Chapter 1 outlined how this argument crystallised. In Chapter 2, I detailed relevant concepts from Wilber's integrative framework. I explored the validity of these concepts for the trauma literature in Chapter 3, attempted to outline an integrative model of trauma in Chapter 4 and considered an integrative approach to treatment based on this framework in Chapter 5. I will summarise and discuss the salient points from each chapter in this section.

My preliminary review of the literature highlighted theoretical views of and treatment approaches to trauma – both single-theory and integrative approaches – that have significant value for understanding and managing trauma. However, the relationship between these approaches and what would determine the use of one or another was unclear. Wilber's theory does not offer the depth of understanding into specifics that each of these appoaches may offer and does not provide detailed insights into therapeutic issues. However, he does provide a broad and comprehensive integrative framework that allows for disparate theories, clinical observations and empirical data to be considered in an organised manner that can allow for the clarification of relationships. This could guide choice of interventions and offer a theoretical base for future research.

The concepts of Wilber's framework that I put forward as useful for developing an integrative theoretical paradigm of trauma are the self-system, the fulcrums of development and the four quadrants of experience. The self-system is that aspect of the psyche that negotiates experience and plays the primary function of integrating and balancing experience. The fulcrums describe the self's development and pathologies that might arise where problems occur. The four quadrants of experience that Wilber defines are the individual, subjective, intentional; the individual, objective, behavioural; the social interobjective; and the cultural and intersubjective. I found his theory as an integrative framework to be comprehensive and internally consistent.

My review of the trauma literature, including both theoretical and empirical studies, indicated that the essence of each of Wilber's concepts was at some point raised as significant in the experience of trauma. Furthermore, all aspects of what was referred to as significant in the trauma literature I reviewed could be incorporated in Wilber's theoretical framework. While this is perhaps not sufficient to validate Wilber's framework as a basis for trauma, the lack of contradiction between Wilber's framework, already existing theories of trauma, and empirical observations suggests a high degree of validity.

My attempt to outline an integrative model of trauma indicates that Wilber's theory is useful as a framework for mapping a large number of factors pertinent to trauma in relation to each other and elucidating greater clarity regarding their relationship to each other. I have merely depicted some issues that would be relevant with broad brushstrokes rather than attempting to include everything that would be relevant in the detail and depth it would require.

I have made some broad generalisations for using an integrative theory of trauma to identify treatment approaches that are indicated or contra-indicated for specific reactions to trauma. These are offered as a basic starting point for developing practice which allows for more informed targeting of treatment approaches and setting of therapeutic goals. These suggestions are based

largely on theoretical understanding and would require the experience of clinical practice and comprehensive empirical testing to assess their validity.

The large number of factors involved in traumatic reactions and the interrelationship between them is very complex and has limited the capacity of theoretical paradigms in their exploration of individual differences in traumatic reactions. This has inevitably limited the possibility of being specific in targeting treatment approaches in response to individual variations in reaction to trauma. Furthermore, this has limited the capacity of empirical research in testing the suitability of different treatment responses for different variations in traumatic response. Wilber's concepts of the self-system, the fulcrums of development and the four quadrants provide a framework for systematically investigating the multiple factors, exploring the relationship between them and assessing which is most significant in an individual's reactions. This would then assist the process of targeting treatment approaches.

Limitations of this study

In this section, I describe some of the limitations of this study. Initially, I pay attention to limitations of theory building in relation to practical utility. Then I refer to the epistemological concerns that arise from integration that have not dealt been with in this study. Finally, I consider shortcomings in the scope, depth and detail of the study.

The main focus of this study has been on theory building rather than reality and its diversity. Theoretically it is possible to conceptualise a broad and comprehensive framework that organises the vast number of factors involved in trauma, to consider the relationship between them and to assess intervention on the basis of them. The practical utility of such theorising can only be assessed in practice. I believe that this theory can guide one type of integrative practice and provide a basis for reflection on such practice. Inevitably that practice will assess the theory's practical utility, and refine or discard that which is not of value. None the less, theorising and revision of theory is critical in the development of practice.

I realise there are different accepted ways of combining methods and concepts in psychotherapy integration, and I believe these also apply more broadly to integration of psychological theory. In Chapter 4, I touched very briefly on theoretical integration and technical eclecticism. Integration as opposed to technical eclecticism is believed to throw up numerous problems because of the contradictions created by the different knowledge bases of various theories. I have not dealt with this issue in this paper and recognise it is an important issue to be examined in relation to Wilber's integrative framework. I believe, however, that Wilber's framework may provide a useful way forward in exploring this issue because it provides a base from which to look at the *relationship between* different theoretical perspectives, the *different role* each one plays and the *different value* each has to offer within a broad framework of experience. This approach requires further investigation but possibly avoids

some of the difficulties that arise when attempting to synthesise varied approaches towards one purpose.

Wilber's framework was identified because of its comprehensive scope and because I believed it could play a valuable role in organising the multiple factors involved in trauma and clarifying relationships between them. The framework does not provide the detail of each of the theories it draws on and depends on literature in these areas to flesh it out. Further theorising is required in clarifying the relationships between them.

My attempt to outline an integrative model identifies a large number of factors pertinent to trauma and maps them in relation to each other. Each of the factors I have identified has been glossed over and not given the detail or depth it would deserve in a fully developed model. This would clearly be an enormous task beyond the scope of this study and requiring expertise in a range of disciplines beyond my scope of knowledge or capacity.

Significance and relevance of this study

It was not within the scope of this paper to develop a fully fleshed out theory of trauma based on this framework. However, the findings of this paper are sufficient to suggest that further investigation into Wilber's framework and the fleshing out of a theoretical paradigm of trauma based on this framework would be a worthwhile endeavour. Further development of theory in this manner may provide a useful basis for reflection on integrative practice.

Reflection on practice should in turn lead to clinical data that confirms or disconfirms whether the suggested modalities for specific situations are appropriate. It would also be important that empirical studies be conducted on the relevance of the fulcrums of development in understanding individual differences in reaction to trauma. Furthermore, the success of treatment approaches that are developed in response to individual differences using this framework needs to be empirically researched.

Endnotes

Chapter 1

[1] Studies that have been carried out may be limited to looking at one type of treatment for post-traumatic stress disorder in response to a specific experience of trauma (Taylor, Koch, Fecteau, Fedoroff, Thordarson, & Nicki, 2001; Wolfsdorf & Zlotnick, 2001) though it is well recognised that the nature of a traumatic event is less significant in the severity of the response than other individual factors. Other studies have compared the outcomes of different types of treatment, such as cognitive therapy and imaginal exposure therapy (Tarrier & Humphreys, 2000; Tarrier, Pilgrim, Sommerfield, Faragher, Reynolds, Graham & Barrowclough, 1999) or trauma desensitisation, hypnotherapy, and psychodynamic therapy (Brom, Kleber and Defares in Sherman, 1998).

[2] One study of a treatment programme that incorporated behavioural, cognitive and social interventions (Solomon, Bleich, Shoham, Nardi, & Kotler, in van der Kolk, McFarlane, & van der Hart, 1996) identified both short-term and long-term negative effects. Another study of various treatment modalities concluded that the results were often limited and remission was rare (Shalev, Bonne, & Eth, in Sherman, 1998). In a review of studies of critical incident stress debriefing, Hamling (2000) notes that numerous studies show no effect and in some studies a negative effect was noted. Sherman (1998) reviewed and quantitatively synthesised results of psychotherapeutic treatment modalities and concluded that such treatment reduces post-traumatic stress disorder and these effects are maintained even after termination of treatment.

[3] It is not clear whether this has been the result of increased exposure to traumatic events or whether other factors have been responsible. Factors such as the peace movement's response to the Vietnam war and its focus on the implications of war, and the introduction of the diagnostic classification of post-traumatic stress disorder in the *Diagnositic and statistical manual of mental Disorders* in 1980 may be significant. In addition, the feminist movement's focus on women abuse and childhood sexual abuse, and an increasing social awareness of the occurrence of childhood physical abuse may have further highlighted the issue (Herman, 1992). This increased interest in the effects of traumatic experience and recognition of its prevalence has resulted in a growing awareness of the impact of trauma and the need for effective treatment responses.

[4] Civil protest against apartheid in the 1970s and 1980s was met with state brutality, resulting in a large number of psychological casualties (Straker, 1994). In the last decade there have been increasing levels of random criminal violence (Hajiyiannis & Robertson, 1999; Lewis, 1999). Further, South Africa has recorded extremely high levels of child abuse (Lewis, 1999).

[5] Thomas Jordan (2000) examines dimensions of consciousness development and further explores some of the concepts presented by Wilber in *Integral psychology*. He refers to nomotheitical approaches to knowledge which attempt to build and refine a valid and universal theoretical system resulting in striving for a 'Grand Theory' that gives a coherent explanation of a field of knowledge and implies criticism of his own and Wilber's work on this basis. He suggests a preference for idiographical approaches that look for tools that may be helpful in explaining the particular rather than hoping that reality can be meaningfully represented by an abstraction. This very same criticism may be valid of my attempt to integrate Wilber's framework with the trauma literature. I believe both perspectives are valid and that, regarding trauma, there is such a vast amount of literature, much of which is based on explaining the particular, that developing a broad overview is useful for organising theory and data and considering relations. Furthermore, I think Wilber's recognition of interiors (which he states one can never know about a person, you have to enter their depths which can only be done by introspection and interpretation) and exteriors (that which we can see), which will be described in Chapter 2, spans both these types of knowledge.

Chapter 2

[1] Wilber (2000a) refers to confusion that has arisen out of questions of whether the ego exists in higher transpersonal stages of development. He suggests this depends on one's definition of the ego. If it is defined as exclusive identification with the separate self, then it is mostly lost. But if it is defined to mean the functional self that relates to the conventional wold, it is definitely retained. And if it is used to describe the psyche's capacity for integration as it is used in ego psychology, then it is retained and strengthened.

[2] Wilber uses the concept of subpersonalities such as the parent ego state, child ego state, adult ego state, false self, authentic self, and so on to describe aspects of the self, and he refers to the work of Rowan, and Watkins and Watkins for development of the concept. He believes that each subpersonality lives on as a subconscious or unconscious aspect of the proximate self that was defensively split off at some time during development. The nature of each subpersonality will depend on the level of development at which it was split off. These are all parts of the self that remained fused or differentiated but unintegrated and have not been turned into objects of the distal self.

[3] At each fulcrum of development, Wilber (2000a, 2001a) identifies three subphases in which something can go wrong. The self can remain in fusion in which case there is a fixation. The self can fail to differentiate sufficiently in which case it fails to establish a responsible boundary. Or it can fail in the process of integration in which case it doesn't integrate and include that aspect of experience but rather dissociates or represses it. Such failures influence all later development and can occur at any fulcrum.

[4] Wilber (2000b) acknowledges Blanck and Blanck as the authors that introduced the term *fulcrum of development* to refer to the separation-individuation process in Margaret Mahler's work. He suggests that each of the fulcrums he outlines establishes a different and important self-boundary. He usually outlines nine or ten fulcrums as he believes these to be the most important; however, he recognises that one could identify many more fulcrums. Wilber's nine or ten fulcrums of development (1991, 2000a, 2000b, 2001a, 2001b), which are described later in this chapter, identify pathologies that differ at each of these levels. Wilber believes a great problem with many psychological theories is that they recognise one basic boundary: that between self and other. He has termed this the single-boundary fallacy. He suggests that such theories fail to note the different types of boundaries that arise in different stages of development. These would include the differentiation of the physical self from the physical other, the emotional self from the emotional other, the conceptual self from the conceptual other, the cultural role-self from the role-other, and such like (2000b).

[5] This continuum arose from the historical development of the term borderline in the psychoanalytic literature where patients who came to be defined as borderline were initially viewed as having a mild form of schizophrenia or were described as having an 'as if' personality that was operating psychopathologically on a level between neurosis and psychosis (Goldstein, 1995).

[6] Mahler, Klein and Winnicott are some of the theorists who have provided insight into development in this early fulcrums. Kleinian theory is based on the belief that there is both a basic ego and a primitive instinctual life in existence at birth. The infant's instincts drive its ego toward objects with which it makes primitive relationships from the very beginning of life; a point at which the infant's ability to distinguish the internal world from the external world is very limited. The infant moves from this very early paranoid-schizoid position into the depressive position when it is able to distinguish its mother and thus begins to recognise itself as separate (St Clair, 1986). Winnicott (1972) recognises that integration in development takes many forms, of which one is the psyche-soma relationship. He studied interactions between mothers and infants interacting naturally together to identify that the basis of a self forms in the existence of the body which is alive, has shape, and functions. Further, Winnicott (1958) stated that the developing psyche-soma that initially needs to be protected from environmental impingements, requires developmentally appropriate impingements according to developing mental capacity, thus recognising the earliest basis of self being in the body.

Mahler describes the process of 'hatching' in the first six to ten months of infants' lives, at which point infants begin the process of differentiating and developing a sense of body image (Shane & Shane, 1989).

[7] The borderline patients developmental arrest has been consistently understood to occur during Mahler's rapprochement subphase of separation-individuation (Klein, 1989). There is some debate in the literature as to whether the arrest of narcissistic patients occurs before this, because they do not seem to experience the rapprochement crisis. Masterson experiences this as a quandary because object relations theory holds the basic tenet that ego functioning matures in parallel with intrapsychic structure (Klein, 1989). Wilber places the arrest of narcissistic disorders at this earlier point, whereby he ascribes it to arrest with the fusion subphase of fulcrum-2 (2001a). Wilber's view that these aspects of the self don't necessarily mature in parallel with each other ensures that this view is consistent in his overall framework.

[8] The psychoneuroses of classical psychoanalytic theory are relevant at this stage.

[9] I would like to add the possibility that there may be a failure to fuse with or differentiate satisfactorily from the conventional and sociocentric stance of fulcrum-4 if significant aspects of an individual's experience are based in a variety of sociocultural settings that have conflicting norms.

[10] In *Integral psychology* (2000a) and *A brief history of everything* (2001a), Wilber recommends cognitive therapy as a therapy for working in the upper-left quadrant (this quadrant is defined later in the chapter but basically refers to that which involves the self-system and interior experience). In *The eye of spirit* (2001b), he describes cognitive therapy as being largely located in the upper-right quadrant that is related to exterior objective experience of individuals. His reasoning is that it is not so much an interior exploration of depths but a manipulation of 'sentences one uses to objectively describe oneself' (p. 286) and works with adjusting the premises to match objective evidence. This later perspective creates a greater level of internal and external inconsistency in his theoretical framework. His later view makes more sense because cognitive therapies are evidently successful with people who are, for example, functioning in fulcrum-2. However, it is also likely that many therapists who work from a cognitive framework do not do this in a rigid manner where they only examine the thoughts and beliefs. It is likely that there a degree to which meaning is made of these false concepts and why they are held.

[11] Wilber (2001b) makes it clear that he doesn't mean one has to be engaging on a complex philosophical level in order to have vision-logic. He suggests that even in the earliest foraging societies it is probable that chieftains would have been able to take multiple perspectives for the purpose of co-ordinating them.

[12] Wilber (2001a) notes that because vision-logic no longer automatically privileges any one perspective over another, all perspectives become relative and interdependent. He cautions that this can throw one into a paralysis of will and judgement and offers the reminder that because all perspectives are relative does not mean they are all equal. The worldcentric view of this level is better than the ethnocentric view of the previous fulcrums, which is better than the egocentric view of the early fulcrums.

[13] Wilber refers to the pre/trans fallacy, which he identified and wrote about in the late 1970s in relation to his own early work, and observes in numerous other theories (Wilber, 20001b). Because pre- and post-rational experiences are both non-rational, there is a tendency to confuse them. He highlights the tendency to inflate prerational magical and mythical experiences to transrational experience in theories that liken the 'oneness' of early infancy to genuine transpersonal experience (Wilber, 2000b). He notes that peak experiences and spiritual illuminations need to be differentiated from magical and mythical structures (2000a).

Chapter 3

[1] Freud's abandonment of the seduction hypothesis in favour of the Oedipus complex led to a significant shift in psychoanalytic thinking, resulting in an emphasis on intrapsychic processes rather than interpersonal processes. As a consequence, the actual incidence of sexual encounters between children and parents (or other adults) became seriously neglected

(Herman, 1992; Rachman, 1989). Ferenczi (in Rachman, 1989) challenged this and called for a recognition of actual child abuse and its pathological effect on adult functioning, as well as noting emotional abuse as trauma.

[2] Meares (1999) proposes that the effect of this is a change in the form of consciousness during trauma to a focus on immediate stimuli. The traumatic memory is then recorded in the nonepisodic memory system where it lacks a reflective component. This impairs the interpretation of the meaning of the traumatic event whereby its construction is determined by affect. Meares' exploration of the impact of trauma on the self is largely in relation to physiological functioning and could thus also be described in Wilber's upper-right quadrant. This theory of traumatic reactions highlights the 'mutually arising and mutually determining' (Wilber, 2000a, p. 234) relationship between the four quadrants Wilber defines.

[3] Horowitz's use of the term schemas could imply that his understanding of the self is in terms of schemas that need to be manipulated and adjusted in order to meet objective reality. This could lack the interior aspects of depth and making meaning that the psychodynamic theory he is integrating cognitive theory with emphasises. Drawing the links between what would be located in Wilber's theory in the upper-right and upper-left quadrants of exteriors and interior meaning is valuable in the process of integrating interiors and exteriors. And whilst the use of terminology that may be better placed in relation to exteriors does not necessarily mean the loss of the interiors, it would be important to guard explicitly against it.

[4] Although psychosis is not significantly associated with trauma and thus won't be discussed here, it is worth noting that both Freud and Winnicott's views of psychosis are consistent with Wilber's theory. Freud believed that psychosis could be viewed as a conflict between the individual and the external world in which reality is disavowed and remodelled (Kaplan & Sadock, 1998). Winnicott (1958) theorised psychosis as an environmental deficiency disease whereby the individual does not receive good enough mothering and has to care for the self at a premature stage of development. This puts a strain on mental functioning before it is developed and results in the individual's desire to return to the dependent psyche-soma where it can function 'without mind'.

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