WHITE PAPER 1.1 · JULY 2026

A Four-Quadrant Model of Illness and Healthcare

An Integral Framework for Diagnosis, Treatment, and Healing

Stephanie MoDavis
awakeninghealthcare.com

ABSTRACT

Biomedicine treats an illness as an event located entirely in the body, evidenced by a mutation, a lab value, a biopsy result. This paper proposes a fuller reading, using Integral Theory's four-quadrant model as a holistic framework that views illness across multiple domains of human reality. Through this framework we see that a patient's experience of an illness unfolds simultaneously across four irreducible dimensions — the biological, the psychological, the relational-cultural, and the social-institutional. It helps us see that healing modalities which address only the first of these, the biological, remain structurally partial. This framework is illustrated through the author's own journey with systemic lupus erythematosus and two kidney transplants. The paper closes by asking the reader to imagine how a truly holistic, or "Integral," standard of care could significantly enhance and evolve the current biomedical model without replacing it.

PREFACE

This paper is written through the lens of direct experience, not clinical authority. It does not claim scientific proof for its central hypothesis. Its purpose is to hold illness, diagnosis, and the experience of being treated within a wider frame than biomedicine alone currently offers. This paper also exemplifies the holistic approach that we take at Awakening Healthcare regarding illness and healing.

> *"An illness is never only a biological event. It is deeply related to one's psychology, their relationships and cultural attitudes, and the structural functions of modern medicine."*

But these relations are outside the current biomedical model. When only the biological channel receives sustained attention, the influences from these related domains keep expressing themselves in patients' lives — sometimes for years, and often for life.

Our suggestions are offered as a hypothesis and a way of seeing holistically, not a replacement for the clinical disciplines — nephrology, rheumatology, transplant immunology — or the biomedical procedures in general that kept the author alive. It is a complement to them: an attempt to see what the biomedical model, by its own design, is not built to see.

PART ONE

The Framework — Ken Wilber's Four Quadrants (AQAL)

Ken Wilber’s Integral model proposes that any human phenomenon can be viewed through four irreducible dimensions, arranged as a 2×2 grid crossing interior/exterior with individual/collective:

	INTERIOR	EXTERIOR
INDIVIDUAL	INDIVIDUAL · INTERIOR · UL **Mind & Meaning** Subjective: thoughts, feelings, beliefs, meaning, psyche.	INDIVIDUAL · EXTERIOR · UR **Body & Behavior** Objective: biology, behavior, physiology, measurable data.
COLLECTIVE	COLLECTIVE · INTERIOR · LL **Relationship & Culture** Intersubjective: shared culture, relationships, attitudes, values, worldview.	COLLECTIVE · EXTERIOR · LR **System & Environment** Interobjective: systems, institutions, economics, medical protocols.

Wilber’s core claim is that none of these four is reducible to the others, and that a mature response to any complex human condition — illness included — has to include all four domains, or it will be structurally partial. Modern medicine, as an institution, is built almost entirely in the Upper Right. It is highly advanced in that quadrant: surgical techniques, imaging, biopsy grading, medication protocols. What it is not built to do, and largely does not attempt to do, is ask what is happening in the other three quadrants and how they might be causally related to an illness.

The remainder of this paper applies the four quadrants to a single, specific case: the author’s own twenty-year experience with systemic lupus erythematosus, two kidney transplants, and the founding of Awakening Healthcare.

PART TWO

The Four Quadrants Applied to My Own Diagnosis and Transplant

UPPER RIGHT · UR

The Objective Biological Quadrant

WHAT THE MEDICAL RECORD SHOWS

The biological facts are these. A mystery illness went unresolved for roughly a year until a diagnosis was finally reached: systemic lupus erythematosus (SLE), an autoimmune disease in which the body's own immune system attacks its tissues — in this case, eventually the kidneys. The condition progressed far enough to require a kidney transplant, and years later, a second.

This is the quadrant medicine is built for, and it is the reason the author is alive. This paper does not diminish any of it. But taken alone, it is also incomplete: it describes what happened to a kidney without describing what happened to a whole person.

UPPER LEFT · UL

The Subjective Psychological Quadrant

TEN YEARS OF INTERNAL DEVELOPMENT

The biological timeline above took roughly a decade, start to second transplant. The psychological timeline did not end when the surgeries did. For ten more years afterward, an ongoing, low-grade crisis ran underneath an outwardly functioning life. Why did this happen to me? Who am I now? How long will I live? How will I live? These questions did not arrive once and resolve. They resurfaced at each anniversary, each lab result, each reminder that the body now depended on immunosuppression and vigilance for the rest of its life.

What made this quadrant particularly strange to live inside was the setting it happened in. During these same years, the author was running several yoga and inner-work healing centers — spaces explicitly built to help other people process exactly the kind of crisis she was privately still working through. She was, in effect, teaching integration to others while still mid-integration herself, and this disconnect was not always visible to her or to others from the outside. This is worth naming as its own pattern: caregivers and healers are not exempt from the Upper Left psychological quadrant simply because their profession is built around it. If anything, professional fluency can make private, unresolved material easier to hide, including from oneself.

LOWER LEFT · LL

The Relational and Cultural Quadrant

INHERITED BELIEFS AROUND ILLNESS AND HEALING

A significant part of the author's own healing turned out to live in this quadrant, just as much as the other two. It required deliberately reverse-engineering beliefs about her own family's patterns around illness, care, and worth — asking where those beliefs had actually come from, whether they were hers or inherited, and whether they were still true. None of this shows up on a lab panel. All of it shaped how she experienced two transplants.

This is the quadrant most consistently absent from clinical care — not because it is unimportant, but because it is intersubjective rather than objectively measurable, and modern medicine's tools are built to find and treat what can be objectively measured.

WHAT "NO FAMILY HISTORY" ACTUALLY MEANT

This pattern showed up literally, not only metaphorically, in the author's own family history. For years, whenever a physician asked the standard intake question — does this run in your family? — the honest answer was: I'm the only one. It was only later, after going back and actually asking around, that a different picture emerged. Multiple aunts, uncles, and cousins on her mother's side had lived with their own variations of autoimmune disease, under different names, in different organs — never diagnosed as connected, and never discussed among the family as a pattern.

The genetic predisposition itself sits in the Upper Right biological quadrant: it is heritable and, in principle, measurable. But the family's unconscious "expectation" of generational illness, and all of the relational and social caretaking and bonding summoned by illness, is stored and expressed as implicit patterning in the intersubjective familial psyche.

The family was collectively unconscious of the connectivity of illness across generations. They had no framework for noticing that a cousin's thyroid condition, an aunt's rheumatoid arthritis, and the author's own lupus might be the same underlying proclivity wearing different faces. Not only did they not see the Upper Right genetic component — they had even less awareness of the Lower Left way in which the family organized, and even unconsciously thrived on, the implications of illness within it. These connections stayed invisible, not just to her doctors, but to her, until she went looking for them herself.

LOWER RIGHT · LR

The Institutional Quadrant

DISCOVERING BLIND SPOTS IN THE SYSTEM

A physician invited the author to join a care team supporting another patient — not as a patient herself, but as someone with lived experience to contribute. What she learned inside that collaboration became the seed of Awakening Healthcare. The patient in front of them had significant, structural gaps in her care. But so did the physicians around her — not in dedication or intelligence, but in training. Their medical education had prepared them exceptionally well for the Upper Right biological quadrant, but had given them almost no structured preparation for the other three. This was not a failure of any individual clinician. It was a gap built into the shape of medical education itself — one that is increasingly being discovered and documented.

A national survey of U.S. physicians found that only a minority (25%) reported their formal training was helpful in addressing the psychosocial domain, while 44% rated it as not helpful; additional barriers included low self-efficacy and systemic constraints (Astin et al., 2006).

That experience reframed everything that came before it. The decade of “why did this happen to me” was not only a personal crisis to move through privately. It was evidence of systemic blind spots that other patients, and their physicians, were also standing inside — largely without language for it.

The Lower Left family-history gap described above is a small but concrete example of these systemic blind spots. A standard intake question — “does this run in your family?” — is aimed at locating a genetic predisposition, but its usefulness depends on a family culture that has actually tracked and discussed its own illness history. It entirely misses that illness is also closely related to intersubjective family dynamics, which are also heritable. When that familial work hasn’t happened, the protocol returns a technically honest but practically misleading answer — and the medical professionals asking it have no way of knowing that.

PART THREE

The Founding Insight of Awakening Healthcare

Held only in the Upper Right biological quadrant, this case is a successful outcome: diagnosis reached, two transplants performed, one rejection episode managed, kidney function sustained. Held across all four quadrants, a different picture appears — one in which the biological success ran parallel to a decade of unaddressed psychological crisis, an unexamined inheritance of family belief, and a systemic gap in how the physicians involved had been trained to see any of it.

Awakening Healthcare exists because that gap is not unique to lupus, or to kidneys, or to any one person. It is structural, and it is what a purely biomedical model will keep reproducing until the other three quadrants are treated as clinically relevant rather than optional.

PART FOUR

Toward Truly Holistic Care

Our perceived issue with current care is not that biomedicine is wrong. It is that it is partial, and it is currently the dominant cultural view for those with institutional power, funding, and voice regarding how care is designed and delivered. A truly holistic, or Integral, approach to any diagnosis requires us to ask foundational questions about the ways we frame illness and its treatment:

UR · OBJECTIVE BIOLOGICAL

Where does our biomedical framework work well, and where does it fall short due to its focus on a single-quadrant view of the human condition?

UL · SUBJECTIVE PSYCHOLOGICAL

What is a patient's relationship to their diagnosis, their sense of identity, and their own capacity for psychological stress and meaning-making? Is there psycho-spiritual support to help them internally manage and integrate their experience?

LL · INTERSUBJECTIVE, FAMILIAL & CULTURAL

What family and cultural inheritance around illness, care, and worth is this person carrying, and is there space, beyond the clinical encounter, to examine it? Could intake processes be redesigned to actively surface family patterns?

LR · INTEROBJECTIVE, SYSTEMIC

How can medical education itself close the training gap documented in the chronic-care literature, so that physicians are as prepared for the other three quadrants as they are for the Upper Right? How can healthcare become teamwork between professionals who specialize in the other three quadrants? How might caregivers be trained to view patients and illness holistically, across all four quadrants of human experience?

Integral Theory's four-quadrant heuristic makes clear that human beings experience life across four dimensions of reality — the biological, the psychological, the intersubjective-cultural, and the social-institutional. But there is another overarching principle implicit in the model: each of these perspectives is a view of one thing, the human being. And being is a verb, not a noun. We are far more than bodies having a biological experience. We are holistic beings, and all of the quadrants of experience covered here overlap, combine, and link into one another. We cannot be human outside of this holistic reality, and we do not heal ourselves of any illness in any one quadrant alone. We experience life holistically, we break down holistically, and we can only heal holistically.

> *"How would our healthcare model look, and how much better would it function, if we viewed patients as whole human beings?"*

In this paper, we have tried to make clear that our current, biomedical-heavy approach is in many ways extremely advanced and effective — but in other ways, just as important, it falls short. We have attempted to be constructive in this presentation, and not dredge up the countless examples of the darker side of modern healthcare, recognizing that the reader is likely well aware of these already. We invite the reader to ask: how would our healthcare model look, and how much better would it function, if we viewed patients as whole human beings?

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