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Integral Yoga Psychology: Clinical Correlations

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This article provides an overview of Sri Aurobindo's Integral Yoga Psychology (IYP), with a focus on relevance to clinical practice. After summarizing recent developments in integrative medicine that have brought transpersonal themes into the mainstream of contemporary healthcare, the transformational paradigm of IYP is used to articulate a spiritually-informed approach to psychology and psychiatry. Topics covered include the soul (psychic being), reincarnation, the chakra system, psychodynamic therapy, ego defenses, positive psychology, CBT, AA, parapsychology, and mind-body medicine. The possession model of illness is addressed in detail, using both case material and the author's own experience, and is compared to Jung's method of working with the shadow. Finally, a range of real-world issues are discussed, including cross-cultural considerations, the structure of healthcare systems, the stigma of mental illness, and psychopharmacology.

Keywords: yoga psychology, transpersonal, spirituality, ego, psychodynamic, cognitive-behavioral, parapsychology, possession, reincarnation, mind-body, Buddhist, integrative

When transpersonal psychology was founded in the late 1960s, mainstream psychology viewed the field's interest in spirituality, mysticism, and psychedelics as eccentric and speculative. However, in the last two decades a sea change in healthcare has brought transpersonal themes into the mainstream of clinical practice. Integrative or "whole person" medicine, which includes spirituality in its purview, is now accepted in many ways within mainstream healthcare. Mindfulness-based stress reduction (MBSR) is widely accepted by both patients and providers, and a large amount of research shows that meditation is helpful for a wide range of medical and mental health problems (Gotink et al., 2015). The public devotes significant out of pocket expenditures to complementary and integrative treatments, and the practice of yoga is increasing in the United States (U. S. Department of Health and Human Services, National Institutes of Health [NIH], National Center for Complementary and Integrative Health [NCCIH], 2012). Chaplains have become key members of multidisciplinary teams (www.healthcarechaplaincy.org), clinicians routinely refer patients to faith-based 12-step programs for help with addictions, and hospice and palliative care clinicians discuss spirituality with patients on a daily basis (Markowitz & McPhee, 2006). Ethics committees are interested in diversity and respecting patients' worldviews, and psychopharmacological research is showing renewed interest in psychedelics (Tupper et al., 2015; Ross et al., 2016; Griffiths et al., 2016; Multidisciplinary Association for Psychedelic Studies at www.maps.org).

Today, the literature on integrative medicine has become so large that it is impossible to summarize it quickly here. Some key sources include the World Health Organization (2013) "Traditional Medicine Strategy 2014–2023," which documents the aforementioned trends at a global level, and makes recommendations about how to incorporate traditional and complementary medicine into mainstream practice. In the United States, the NIH now has a National Center for Complementary and Integrative Health (NCCIH), which sponsors research on the clinical effects of spirituality and meditation (www.nccih.nih.gov). In India, the National Institute of Mental Health and Neurosciences (NIMHANS) is also studying

yoga and meditation, both clinically and in terms of neuroscience (www.nimhans.ac.in). Other important organizations include the Bravewell Collaborative, which promotes the diffusion of integrative medicine through a broad range of initiatives (www.bravewell.org).

Historically, transpersonal psychology contributed to the rise of integrative medicine, at least indirectly via cultural evolution if not directly via citations, and in turn Sri Aurobindo's work has influenced the development of transpersonal psychology from the very beginning. Michael Murphy, founder of Esalen, visited the Sri Aurobindo Ashram for 16 months from 1956–1957, and this early experience was likely an influence, among others, on his subsequent interest in the spiritual potential of the human body (Taylor, 1999, pp. 238–246; Murphy, 1992). Haridas Chaudhuri, a direct disciple of Sri Aurobindo, founded the California Institute of Asian Studies in the 1960s, which went on to become the California Institute of Integral Studies (CIIS). Wilber acknowledges Sri Aurobindo as an important thinker in the field of integral studies, and Cortright's (1997, 2007) work on integral psychotherapy is openly Aurobindonian. While many authors have already made comparative studies of Sri Aurobindo's thought and Western psychology in terms of theory, the developments outlined above warrant a fresh look at what Sri Aurobindo's insights have to offer the mental health provider in clinical practice.

This article focuses on clinical correlations drawn from several of the author's prior essays on IYP (Miovic, 2004b, 2008, 2011). In framing this topic, it is important to note that IYP is primarily an approach to spiritual and transpersonal development, not a method of treatment. IYP has not invented any specific therapy or treatment modality for either mental or physical health problems, and there are no systematic studies that have reported demographic, epidemiological, or clinical data directly related to IYP. Thus, the views set forth here are opinions based on the author's experience and interpretation of Sri Aurobindo's philosophy.

As I have explained in prior work, there are three large categories of worldview—theistic, atheistic, and agnostic—and neither science nor philosophy is able to determine which is correct (Miovic, 2004a). As result, there is ample room to interpret psychology and psychiatry from a variety of perspectives. This paper makes no claim on "ultimate truths"—its purpose is simply to illustrate how Sri Aurobindo's worldview has wide-ranging implications for clinical practice.

The Psychic Being and Reincarnation

For practical purposes, the essence of Sri Aurobindo's approach to psychology is nicely summarized in the following letter, which serves as a useful starting point:

> There are, we might say, two beings in us, one on the surface, our ordinary exterior mind, life, body consciousness, another behind the veil, an inner mind, an inner life, an inner physical consciousness constituting another or inner self. This inner self once awake opens in its turn to our true real eternal self. It opens inwardly to the soul, called in the language of this Yoga the psychic being which supports our successive births and at each birth assumes a new mind, life and body. It opens above to the Self or spirit which is unborn and by conscious recovery of it we transcend the changing personality and achieve freedom and full mastery over our nature. (Aurobindo, 2014, Vol. 30, p. 257)

For spiritual development, the central process of IYP is cultivating experiential contact with the true soul, which Sri Aurobindo calls the "psychic being." His emphasis on the role of the psychic being in transpersonal growth is one of the key ways in which IYP differs from those schools of Buddhist psycho-spiritual practice that do not recognize the existence of a true soul (see Epstein, 1995). Subjectively, the psychic being is often felt as residing deep within the center of the chest, *behind* the heart chakra, with which it may be confused. Opening to the psychic being brings feelings of spiritual devotion, surrender to the Divine, gratitude, sweetness, quiet joy, love of all that is good and beautiful and harmonious, and a spontaneous recoil from all that is false, evil, dishonest, selfish, or discordant (Aurobindo,

2012, Vol. 28, pp. 102–124; Aurobindo, 2014, Vol. 30, pp. 337–366). Note that the intuitive tact or guidance of the psychic being is quite different from the intuitions of "psychics" in the West, which usually arise from various parts and levels of the inner being and are far more prone to error.

A topic of perennial interest that involves the psychic being is the process of reincarnation, which Sri Aurobindo accepts as a fact of life. However, he clarifies that it is not the outer personality that reincarnates, but rather the psychic being, whose aim is to grow through the process of evolution. In a letter to a disciple, Sri Aurobindo commented on this in a somewhat humorous vein:

> You must avoid a common popular blunder about reincarnation. The popular idea is that Titus Balbus is reborn again as John Smith, a man with the same personality, character, attainments as he had in his former life with the sole difference that he wears coat and trousers instead of a toga and speaks cockney English instead of popular Latin. That is not the case. What would be the earthly use of repeating the same personality or character a million times from the beginning of time till its end? The soul comes into birth for experience, for growth, for evolution till it can bring the Divine into Matter. It is the central being that incarnates, not the outer personality—the personality is simply a mould that it creates for its figures of experience in that one life. In another birth it will create for itself a different personality, different capacities, a different life and career. (Aurobindo, 2012, Vol. 28, p. 543)

Psychologically, an important corollary of IYP's view of evolution is that the future is more important than the past, because the whole mission of the psychic being is to grow towards a supramental manifestation on Earth. Consequently, Sri Aurobindo and the Mother did not advocate past-life regression as a therapeutic method (which is not to say that past-life memories cannot be healing in some instances), and also warned that people's purported past-life memories are easily distorted by imagination and auto-suggestion. Only the psychic being's memory of the past is veridical, and even when one has the true psychic memory, that fact alone does not solve the problem of what to do with one's present and future lives (for comparative views, see Weiss, 1992; Jue, 1996). As Sri Aurobindo noted succinctly:

> Too much importance must not be given to the past lives. For the purpose of this yoga one is what one is and, still more, what one will be. What one was has a minor importance. (Aurobindo, 2012, Vol. 28, p. 553)

Applied in the clinical setting, a discussion of this focus on the future can help prepare clients who are considering visiting a "psychic" to get a past-life reading, or who are interested in past-life regression therapy. By setting realistic expectations as to what can be achieved with such consultations, and by maintaining focus on current choices and future development, the therapist can help the client maintain a growth-orientation that is both emotionally and spiritually healthy. This approach also tends to reduce the use of spirituality to defend against or bypass psychological issues (see Battista, 1996; Cortright, 1997, 2007). For example, I once consulted on a case in which the client developed an erotic transference to the therapist that was both defensive *and* based on a real past-life relationship as determined by a psychic. In this situation, acknowledging both the spiritual and psychological components of the transference allowed the therapy to proceed productively, because the client felt genuinely understood.

Chakras and the Inner Being

In the process of trying to contact one's own psychic being, people often experience some aspect of their inner being, which stands between the psychic being and the outer personality (ego). In the terminology of IYP, the inner being consists of the subtle bodies or sheaths of consciousness (inner mental, vital, and physical), the *chakras* of classical Indian yoga, and an individual element of the subconscious. The correspondences among the traditional yogic descriptions of the chakras and Sri Aurobindo's elucidation of their psycho-spiritual functions are interesting, and are listed in Table 1. Sri Aurobindo viewed the chakras as subtle (i.e., non-

material) organs of perception and action that put the individual consciousness into relation with the larger universe of forces and beings that operate on each of the non-material planes of consciousness described previously. Note that IYP views most non-local phenomenon studied in parapsychology as arising from the inner being (for instance, precognition and telepathy involve the *inner mental,* astral travel the *inner vital,* and spontaneous remission or "miraculous" healing the *inner physical*).

Also, Sri Aurobindo identified junctional layers of consciousness that help translate the subtle energies of chakras into the active psychological content of the outer being. Some

Chakra	Sri Aurobindo's Description
Sahasradala Thousand-petalled lotus; top of head; blue with gold light	***Higher Mind, Illumined Mind*** Commands the higher thinking mind (buddhi) and the illumined mind, and opens upwards towards the intuitive mind and Overmind.
Anna Forehead; two petals; white	***Dynamic Mind*** Commands thought, will, vision, inner mental formation. "Third eye."
Visuddha Throat region; sixteen petals; grey	***Externalizing Mind*** Commands expression and externalization of all mental movements and forces; also called physical mind when it gives a mental order to external things and deals with them practically.
Hrtpadma or Anahata Sternal region; twelve petals; golden pink	***Emotional Mind and Higher Vital*** Perceived as more external; seat of various feelings, such as love, joy, sorrow, hatred, affection, etc. The "heart" chakra.
Chaitya purusha [not a chakra per se and not emphasized in older yogas]	***Inner Heart (Psychic Being)*** Perceived as deep inside center of chest; the evolving soul that grows from life to life and is the seat of true individual identity.
Nabhipadma or Manipura Region from heart to navel; ten petals, violet	***Central Vital*** Seat of the stronger vital longings and reactions, e.g., ambition, pride, fear, love of fame, attractions and repulsions, desires and passions, life-forces and life-energies.
Svadhisthana Between the navel and base of spine; six petals; deep purple red	***Lower Vital*** Connects all centers above with the physical consciousness below, and is concerned with small desires, such as for food and sex, as well as small likings and dislikings, such as vanity, quarrels, love of praise, anger at blame, little wishes.
Muladhara Base of spine; four petals; red	***Physical Consciousness*** Governs the physical being down to the subconscious. The physical consciousness, when not transformed, is prone to inertia, ignorance, repetition of habits, slowness, resistance to spiritual consciousness. The subconscious has no organized chakra, but arises from below the feet.

Table 1. The Chakras (based on Aurobindo, 2012, Vol. 28, pp. 229-247)

clinical correlations that arise from this include the *physical mind* (related to the throat chakra) which is responsible for problems with stuttering, self-assertiveness, and translating ideas into effective action; and the mechanical mind (related to the physical or root chakra), which is involved in the repetitive thoughts and behaviors of obsessive-compulsive disorder. Likewise the *mental vital* gives mental expression to vital movements such as emotion, desire, passion, and nervous sensations, and through this avenue vital movements can rise up and cloud or distort reasoning (as in the defense of rationalization). The *vital mind* is a vital layer of the mind that is involved in day dreaming, imagining, planning for the future, and fantasies of narcissistic grandeur (Aurobindo, 2012, Vol. 28, pp. 177–225).

With regard to other aspects of classical Tantra, it is important to note that Sri Aurobindo did not recommend raising the *kundalini shakti* (force or power) from below, because doing so can lead to a variety of psychological disturbances acknowledged by transpersonal psychology (Scotton, Chinen, & Battista, 1996, pp. 261–270). Instead, IYP proceeds by bringing forward the psychic being from behind the heart chakra and opening to a higher consciousness that descends from above the head. The advantage of this method is that it slowly and gently opens the chakras and releases the kundalini power without danger of inducing what transpersonal psychologists now call "spiritual emergencies" (Aurobindo, 2013, Vol. 29, pp. 460–464; Aurobindo, 2014, Vol. 30, pp. 420–422).

The Subconscious and Inconscient

The *Inconscient* refers to a densely unconscious inversion of the *Sacchidananda* in which all being and existence seem to disappear. From this arises the subatomic and atomic consciousness of matter, as well as the molecular organization of matter into intracellular machinery. In yogic experience, the Inconscient can be felt externally as extending through all material substance (e.g., even rocks have a consciousness according to Sri Aurobindo), and internally as supporting the consciousness of the body's cells. The Mother's statements about her *cellular yoga* in the latter part of her life afford extraordinary glimpses into the spiritual transformation of the Inconscient (Van Vrekhem, 1995/1998, 2000). However, this goes well beyond the current purview of clinical practice, and transpersonal therapists should not confuse the emotional memories clients frequently have during bodywork with the true cellular consciousness of supramental yoga.

Psychologically, a much more common clinical phenomenon is the interfusion of the vital plane with the physical consciousness of the body, leading to a variety of ways in which emotion can be somatized. This is how and why body-oriented therapies (massage, acupuncture, myofascial release, therapeutic touch, etc.) can be helpful in expanding the range of consciously experienced emotion, and in resolving somatized psychological distress (Basu, 2000). Alternatively or simultaneously, repressed emotion can be pushed down and back from frontal awareness into what Sri Aurobindo calls the *subconscious*. This plane of consciousness accounts for the "unconscious" of Western psychology, as well as chronic or recurrent physical illnesses and habits:

> The subconscient is universal as well as individual like all the other main parts of the Nature . . . It contains the potentiality of all the primitive reactions to life which struggle out to the surface from the dull and inert strands of Matter and form by a constant development a slowly evolving and self-formulating consciousness; it contains them not as ideas, perceptions or conscious reactions but as the fluid substance of these things. But also all that is consciously experienced sinks down into the subconscient, not as precise though submerged memories but as obscure yet obstinate impressions of experience, and these can come up at any time as dreams, as mechanical repetitions of past thought, feelings, action, etc., as 'complexes' exploding into action and event, etc., etc. The subconscient is the main cause why all things repeat themselves and nothing ever gets changed except in appearance. It is the cause why people say character cannot be changed,

> the cause also of the constant return of things one hoped to have got rid of for ever. All seeds are there and all Sanskaras [fixed patterns] of the mind, vital, body—it is the main support of death and disease and the last fortress (seemingly impregnable) of the Ignorance. All too that is suppressed without being wholly got rid of sinks down there and remains as seed ready to surge up or sprout up at any moment. (Aurobindo, 2012, Vol. 28, pp. 225–226)

Sri Aurobindo is careful to differentiate the subconscious from the inner being (*subtle physical*, inner vital, and inner mental), which he also calls the "subliminal being." From the perspective of IYP, Jung's memoirs reveal a rich and detailed subliminal awareness (Jung, 1961), and his notion of the collective unconscious reflects an interaction between the subliminal being and portions of the subconscious. Also, note that Jung did not definitively settle on the immortality of the soul until the end of his life (McLynn, 1996), so it is debatable to what degree specific passages from his writings do or do not reflect the influence of the psychic being on human psychology.

For readers interested in further exposition of IYP, Dalal (2001a, 2001b, 2007) has written several excellent collections of essays that compare Sri Aurobindo's system and Western psychology. Basu (2000), a psychiatrist, has developed an integral model of health based on Sri Aurobindo's work, which importantly gives due credit to scientific biomedicine and moves beyond the current model of integrative medicine to a fully consciousness-based model. He is currently finalizing a major work on consciousness-based psychology and Sri Aurobindo's transformational paradigm (Basu, in press). Salmon and Maslow (2007) gave a detailed explanation of the planes of consciousness and parts of the being, which incorporates a wide range of current scientific findings and cultural developments. Their book is the most thoroughly researched and vividly documented work on IYP to date, and it is easy to read. They also have a website that highlights clinically useful MBSR practices (remember-to-breathe.org).

Soul and Ego Development

This section introduces a heuristic model of psycho-spiritual development that recognizes the presence of both soul and ego in the process of psychotherapy. This is only an introduction to the topic intended for routine treatment, in cases where the clinician simply needs to validate the authenticity of a client's spiritual life while focusing on the presenting problems. For a full discussion of transpersonal therapy in the light of IYP, see Cortright (2007), who addressed depth psychotherapy, attachment theory, opening the heart chakra, spiritual bypassing, body work, as well as the complex spectrum of issues currently lumped under the rubric of spiritual emergencies (Lukoff, 1996). The focus here is limited to showing how IYP interprets mainstream literature on ego development, psychodynamic therapy, positive psychology, MBSR, AA, and mind-body medicine.

For IYP, the development of the psychic being (true soul) across multiple lives, and the outer personality (ego, self) in one life, are two distinct yet interacting dimensions of growth. Thus, children with immature ego structures can have well-developed souls, accomplished adults with well-developed ego structures can have paltry spiritual development, and—as I have noticed in my own clinical experience—a surprising number of low functioning schizophrenics have more psychic sweetness than some of the professionals who treat them. In geriatric psychiatry, this intertwining of soul and ego leads to what I have termed "the conundrum of Zen masters vs. Zen monsters", that is, patients with dementia who are living totally "in the moment" due to neurodegeneration, but for whom the quality of that moment is highly variable. Some may exude psychic peace, while others can become violently agitated, and the relative balance of states can shift in a given patient based on a variety of environmental and medical factors.

In psychotherapy, patients present with widely varying levels of development in the various parts of the being, and the clinician needs to meet them where they are. This is an art not a science, and of course depends upon the clinician's own intuitions, capacities, interests, experiences, and state of personal and professional development.

Regarding contemporary literature, there are two large streams that inform mainstream practice of spiritually informed therapy: Buddhist and Judeo-Christian. Not surprisingly, the Western literature on Buddhist psychology adopts a pragmatic and non-theistic approach to psycho-spiritual development, much as did the historical Buddha (Michalon, 2001; Molino, 1998; Twemlow, 2001). Meditation and mindfulness practices are empirically noted to improve spiritual, mental, emotional, and even physical well-being (e.g., Carlson & Garland, 2005; Kabat-Zinn, Lipworth, & Burney, 1985; Kabat-Zinn et al., 1992; Kaplan, Goldenberg, & Galvin-Nadeau, 1993; Miller, Fletcher, & Kabat-Zinn, 1995). The fascinating neurophysiological basis of meditation is being elucidated as well (e.g., Cahn & Polich, 2006; Lazar et al., 2005; Newberg & d'Aquili, 1998, 2001). Also, psychotherapists report that engaging in non-judgmental awareness of the moment during therapy sessions improves their effectiveness as therapists and facilitates the resolution of emotional suffering in clients, which is the main work of psychotherapy (Epstein, 1995; Finn & Rubin, 2000; Germer, Siegel, & Fulton, 2005). However, the question of whether or not the soul actually exists, and whether clients might at times be having experiences or perceptions of such, is almost entirely avoided in this line of literature, again because Buddhist philosophy is largely agnostic.

On the other hand, psychotherapists writing from the Judeo-Christian perspective have grappled more with the issue of spiritual faith and the existence of the soul. This line of inquiry began with Jung's work on archetypes and the phenomenon of a psychological "God-image" (McLynn, 1996), although his views had little direct effect on mainstream psychoanalytic thinking because of the historic split between Freud and Jung. However, in his nuanced re-visioning of the psychoanalytic theory of mysticism, Parsons (1999) traced out how Winnicott's notion of *transitional objects* was used to re-interpret what Freud called the "illusion" of religion, and to see religious phenomena as transitional and therefore potentially adaptive and creative (pp. 156–165). The most successful of these efforts was by Rizzuto (1979), who showed how the development of intra-psychic structures of God-representation parallels the development of other object relations, and may complete an integrated sense of self. Rizzuto stopped short of asserting that God is actually real, but Meissner (2000) proceeded further along this trajectory by exploring how faith can be understood simultaneously in psychodynamic terms and as referring to a real Christ, a real God, and a real sacrament. Still, he remained cautious about the following step in the sequence, Spero's (1992) introduction of an ontologically real God as a factor both in the God-representation and in the therapy process. Meissner was concerned about the dangers of therapists wrongly presuming to know the Divine's will in the therapy process, but others have gone on to address these legitimate concerns and articulate appropriate ways to conduct faith-based psychotherapy (e.g., Richards & Bergin, 1997, 2000).

IYP accepts both Buddhist and Judeo-Christian lines of literature as statements of experience, and offers some useful insights about how to understand the interaction of soul and ego in clinical work. In psychodynamic therapy, the whole aim is to strengthen the ego by repairing deficits (giving "corrective emotional experience") and making unconscious conflicts conscious. In the vernacular of spiritual practice, on the other hand, people are enjoined not to have "big egos" and to "be humble" before God. How does one resolve this apparent antithesis? The key is that the vernacular big ego in psychotherapeutic terms refers to *narcissistic vulnerability*, an ego deficit well described by Kohut's self psychology, which is compensated with narcissistic defenses of grandiosity (Mitchell & Black, 1995, pp. 149–169). Sri Aurobindo touches on the neurotic issues of narcissistic grandiosity vs. a punishing superego in the following letter to a disciple:

> Humility is needful, but constant self-depreciation does not help; excessive self-esteem and self-depreciation are both wrong attitudes. To recognise any defects without exaggerating them is useful but, once recognised, it is no good dwelling on them always; you must have

> the confidence that the Divine Force can change everything and you must let the Force work. (Aurobindo, 2012, Vol. 28, p. 429)

The stable confidence that Sri Aurobindo prescribes here requires a well-integrated ego that allows for what Rizzuto and Meissner would call a mature object-relationship with God. Therefore, in clinical work what is really meant by "transcending the ego" is not to regress to earlier stages of ego development, but to complete the growth of the ego by adding to it another source of sustenance—the awareness of the soul. In Sri Aurobindo's words:

> There is individuality in the psychic being, but not egoism. Egoism goes when the individual unites himself with the Divine or is entirely surrendered to the Divine . . . . On the higher spiritual planes there is no ego, because the oneness of the Divine is felt, but there may be the sense of one's true person or individuality—not ego, but a portion of the Divine. (Aurobindo, 2012, Vol. 28, p. 124)

This distinction between soul and ego is the foundation for spiritually informed psychotherapy. Sri Aurobindo acknowledged that childhood and adolescence are critical periods for ego development, and on that basis usually did not recommend taking up a serious spiritual practice until adulthood. He encouraged families and schools to accept that children do often have spontaneous contact with their souls (a phenomenon mostly overlooked by Western psychology), but he did not advise undertaking conscious efforts at ego-transformation until later.

When people are developmentally ready, however, he described the process of transforming the ego as follows:

> Everybody has the ego and it is impossible to get rid of it altogether except by two things—the opening of the psychic within and the descent of a wider ego-free consciousness from above. The psychic being opening does not get rid of the ego at once but purifies it and offers it and all the movements to the Divine, so that one becomes unegoistic through self-giving and surrender . . . but it cannot happen in so short a time. (Aurobindo, 2014, Vol. 31, p. 236)

While both psychosis and neurosis (to a lesser degree) increase fear and decrease the capacity for intimacy and generative love, spirituality as Sri Aurobindo defines it decreases fear and increases the ability to see reality as it is and love others as they are, because one is psychologically fulfilled in the Divine. Erikson (1997) showed that as the ego matures across the lifespan, it naturally broadens its scope of concerns to include more and more people, culminating in the healthy generativity of adulthood. IYP would interpret this natural trend towards un-selfishness and individuation, which connects rather than separates one from the others, as due to the influence of the soul (psychic being) on ego development. This interaction effect also accounts for the stages of faith development identified by Fowler (1981).

A related clinical concern is how to distinguish the psychological qualities and characteristics of the soul from those of the ego. According to Sri Aurobindo, the psychic being is subjectively felt to reside deep within the "heart centre," behind the heart chakra of classical yoga. The essential characteristic of the psychic being is spontaneous opening and self-giving to the Divine, which produces subtle feelings of love and devotion without demand for return, while ego-based emotions and drives are characterized by selfishness and strong demand for return (Aurobindo 2014, Vol. 30, pp. 340–366). According to Sri Aurobindo, the foundation of his method of yoga is to "bring forward" the psychic being and use its conscious influence to transform all the "movements" of the ego (thoughts, feelings, actions, sensations) into spiritualized movements that can receive and express the Divine consciousness (Aurobindo, 2014, Vol 30., pp. 367–388). Cultivating contact with the psychic being creates a range of beneficial qualities including sincerity, honesty, compassion, joy, love (in the sense of *agape*), forgiveness, patience, humility, courage, devotion, gratitude and the appreciation of beauty. As previously noted, many people find touches of the psychic consciousness in the joyful innocence of children.

Many also experience openings to the soul when appreciating great music, literature, or art, or when communing with nature (Aurobindo, 2004, Vol. 27). Flowers, for example, are especially full of psychic beauty, and the Mother of the Sri Aurobindo Ashram developed a new branch of yoga based on the consciousness of flowers (the Mother, 2000). For psychotherapy, the most important quality of the psychic being is that it is inherently joyful and free of ambivalence or conflict:

> Let the sweetness and the happy feeling increase, for they are the strongest sign of the soul, the psychic being awake and in touch with us. Let not mistakes of thought or speech or action disturb you—put them away from you as something superficial which the Power and the Light will deal with and remove. Keep to the one central thing—your soul and these higher realities it brings with it. (Aurobindo, 2014, Vol. 30, p. 344)

Significantly, the list of psychic (soul) qualities identified by Sri Aurobindo matches closely with emotions and character traits now studied by positive psychology, which has highlighted the adaptive value of gratitude, forgiveness, joy, love, courage, the appreciation of beauty, hope, curiosity, team-spirit, and so on (Seligman & Csikszentmihalyi, 2000; see also Fredrickson, 2004, Snyder & Lopez, 2002). Research in this field is beginning to empirically validate interventions that foster positive emotions (Seligman, Steen, Park, & Peterson, 2005). Research has also found that such feelings often arise during "flow" states in which the consciousness of the agent becomes one with the activity, as can happen sometimes during satisfying work, play, sports, prayer, meditation, or artistic expression (Csikszentmihalyi, 1990). From the perspective of IYP, all of the feelings and traits aimed at in positive psychology are due ultimately to contact with the psychic being (soul), although one should note that for many people the feelings experienced are actually a mix of higher vital (heart-chakra) movements with touches of the psychic from behind.

On the other hand, clinicians are well aware of the existence of psychological ambivalence and defenses, and the futility of telling people to be more happy and positive, especially when they are grieving. Practicing therapists have seen countless instances of false or inauthentic positive emotion, such as altruism that hides unconscious anger, faithfulness that avoids loneliness and fear, hypomanic happiness that distracts a client from grief, forgiveness motivated by guilt, etc. What does Sri Aurobindo have to say about such instances in which apparently positive emotions are being used to defend against the awareness of hidden, negative ones?

This is a good question, and it leads to the heart of a useful framework for spiritually informed psychotherapy. The concept of defense mechanisms is the single most enduring piece of wisdom developed by the psychoanalytic tradition. In his research following a cohort of Harvard graduates over several decades, Vaillant (1993, 2000) studied the interaction between defensive styles and Eriksonian stages of adult development across the life span. He found that, in general, people tend to grow towards using more mature defense mechanisms as they age, and that those who were stuck in earlier stages were unhappy and fared poorly. The basic defense mechanisms cluster into four groups: psychotic, immature (borderline), intermediate (neurotic) and mature (see Table 2). In the terms of IYP, what Vaillant has demonstrated is an evolution of consciousness, a growth out of the darkness and turbulence of the inchoate (*tāmasic*) ego to the relative stability and self-mastery of the well-formed ego (*sātvic)*.

Sri Aurobindo also recognized the existence of defense mechanisms, but understood them within the larger context of the evolution of consciousness on Earth:

> The vital started in its evolution with obedience to impulse and no reason— as for strategy, the only strategy it understands is some tactics by which it can compass its desires. It does not like the voice of knowledge and wisdom—but curiously enough by the necessity which has grown up in man of justifying action by reason, the vital mind has developed a strategy of its own which is to get the reason to find

> out reasons for justifying its own feelings and impulses. (Aurobindo, 2014, Vol. 31, p. 103)

This passage clearly conveys Freud's idea of the id (although the Aurobindonian concept of the "vital" is broader than that of the id), implies the existence of the unconscious, and cites the defense of rationalization. Sri Aurobindo did not explicitly catalogue the other defense mechanisms listed in Table 2, although he alluded to some in other letters, but it is clear from this and other statements (including the discussion of the subconscious, previously cited) that he understood that the psyche contains many parts of which people may not be aware, and which the ego does not control (Aurobindo, 2012, Vol. 28, pp. 79–80).

Now, if the psychic being (soul) is real and can actually transform ego function, then it must have processes or modes of operation that are distinct from the defense mechanisms listed in Table 2. Sri Aurobindo explained that such psycho-spiritual functions do indeed exist, and he named and defined the psychic movements of ego-transformation as follows: *Aspiration* is an inner invocation of and yearning to feel the presence of the Divine and to manifest its spiritual qualities in one's life. By *surrender* he means to open oneself entirely to that higher power and to it alone, and to let oneself be a vehicle for its dictates. *Rejection* he defines as using the psychic being's discriminative tact to evaluate the source and quality of thoughts, feelings, and behaviors, and to discard or transform all that is false, weak, divisive, harmful, ego-centric, or simply not conscious of the Divine (Aurobindo, 2012, Vol. 32, pp. 3–26).

Clinically, for both clients and therapists it is important not to confuse these psychic movements with ego conflicts and deficits, or unconscious drives and wishes (desires). Aurobindo's *surrender* means surrender to the inner Divine as mediated via one's own psychic being (soul), not to any absolute human authority or the vulnerabilities of one's own ego. True spiritual practice also requires the application of correct understanding (insight), good judgment, willpower, and appropriate boundaries—all of which ensue from the movement of *rejection*. Such rejection proceeds directly from the soul, unlike suppression, which is a psychological defense that involves trying to control emotions with mental willpower (Miovic, 2011).

Against this background, we can now expand the hierarchy of ego development (Table 2) by extending it vertically to add on ego-transformational processes. Whereas ego defense

I. Ego defense mechanisms
(adapted from Vaillant, 1993)

Psychotic
- Delusional projection
- Denial
- Distortion

Immature
- Projection
- Fantasy
- Hypochondriasis
- Passive aggression
- Acting out
- Dissociation

Intermediate (Neurotic)
- Displacement
- Isolation/Intellectualization
- Repression
- Reaction formation

Mature
- Altruism
- Sublimation
- Suppression
- Anticipation
- Humor

II. Ego transformational processes

Therapeutic movements
- Observing ego
(e.g. witnessing, listening, going into, understanding)

Psychic (soul) movements
- Aspiration
- Surrender
- Rejection

Table 2. Hierarchy of Ego Functioning

mechanisms deny, disguise, or distort negative/painful/frightening psychological content so as to make it more bearable, transformational processes accept such content openly and work to transmute it. In order to integrate Sri Aurobindo's description of the three psychic movements of transformation with the existing knowledge of psychotherapy, I have created a bridging category dubbed "therapeutic processes". These are the cognitive skills of affect regulation developed in CBT and DBT, which are essentially synonymous with psychoanalytic concept of the observing ego. These functions are classified here as transformational processes because they are not defense mechanisms per se, but rather adaptive capacities of the ego that derive ultimately from the soul's covert influence on the ego (Miovic, 2004b). Although one does not have to be conscious of one's soul in order to have a good observing ego, if the soul is entirely dormant (as in antisocial personality disorder), there will be a weak or absent observing ego.

In terms of definitions here, to *witness* means to detach from and observe the flow of thoughts and feelings without interfering, controlling, or altering them. IYP notes that one can witness from many planes and parts of the being, but in a general sense *vipāssanā* and other meditation techniques aim to use the inner mind to witness the outer mind. Such witnessing of the outer mind is used extensively in CBT to identify negative automatic thoughts and cascades of catastrophic thinking. One can also interpret Freud's method of free association as a type of witnessing, in as much as patients were encouraged to observe and report whatever came into their minds without making any effort to screen out or select thoughts (Mitchell & Black, 1995, p. 6). On the other hand, *listening* means to turn one's awareness towards arising content so as to study and learn from it, while *going into* means to consciously experience a thought/feeling as much as possible, particularly if the experience is painful or difficult. Finally, *understanding* is the balanced process of practicing witnessing, listening and going into over time, the result of which is that liberating awareness that analysts call "curative insight," and which Buddhists call "mindfulness."

Prototypically, in psychotherapy periods of witnessing allow painful content to arise, which can then be listened to and later gone into, so as to arrive eventually at directly experienced understanding. This cycle is repeated in miniature within each therapy session, and on a larger scale over time across many visits. Also, clients often initially delegate the transitional capacities of ego-transformation to the therapist, and it becomes the therapist's role to gradually help clients learn and internalize these capacities over time (Miovic, 2011).

Some readers may know that in the 1930s, Sri Aurobindo opined that a disciple's pursuit of psychoanalysis interfered with his spiritual practice, as evidenced in the following letter. However, it must be understood that these comments were directed against the classical psychoanalytic method of Oedipal interpretations, which is no longer done in clinical practice:

> If one wishes to purify and transform the nature, it is the power of these higher ranges to which one must open and raise to them and change by them both the subliminal and the surface being . . . But to begin by opening up the lower subconscious, risking to raise up all that is foul or obscure in it, is to go out of one's way to invite trouble. First, one should make the higher mind and vital strong and firm and full of light and peace from above; afterwards one can open up or even dive into the subconscious with more safety and some chance of a rapid and successful change. (Aurobindo, 2014, Vol. 31, pp. 612–613)

Today, psychodynamic practice has become much more relational than during Freud's time, such that now extensive attention is given to attachment issues and the quality of current relationships, and to developing "ego strength" before delving into the subconscious. Also, much time is devoted to understanding the emotional effects of insufficient parental empathy and nurturing, and to the negative psychological impacts of real events such as abuse, neglect, and other losses and traumas (Mitchell & Black, 1995, pp. 206–254). Overall, this means that psychoanalysis and psychodynamic

therapy have evolved away from the fantasy-based phenomenon of Oedipal wishes towards a more reality-based model, precisely as Sri Aurobindo recommended. Many contemporary therapies (such as CBT, DBT, interpersonal and short-term models) avoid the subconscious entirely, or work at the pre-conscious level and allow issues to emerge from the subconscious at their own pace. Finally, many clinicians now use a spiritual worldview to frame psychotherapy, and this emphasizes the importance of moral development, faith, and spiritual beliefs and practices (Josephson & Peteet, 2004; Koenig, 1998; Peteet, 2004; Richards & Bergin, 1997, 2000; Shafranske, 1996).

Thus, we can now state that psychodynamic theory and practice support a spiritually-informed approach to psychotherapy, which is consonant with the central tenants of transpersonal psychology. The fact that psychodynamic therapy often developed in antagonism to, or in ignorance of, transpersonal psychology is regrettable.

Cognitive Behavioral Therapy and Buddhism

Cognitive behavior therapy (CBT), which historically was the rival of psychodynamic theory, can also be used to support a spiritually-informed approach to psychotherapy. For example, following is one of my favorite passages from Sri Aurobindo's letters, in which he uses cognitive techniques to help a disciple who was moody and pessimistic to gain greater emotional equilibrium. Here, Sri Aurobindo uses ironic humor due to the nature of their friendship, but the underlying strategy is to replace catastrophic, self-critical thoughts with more balanced and reasonable ones (disciple's letter in italics, Sri Aurobindo's annotated replies in Roman script):

> *You will see from J's letter what has happened. I am absolutely moribund and gasping; don't see the way. Cursing myself every minute.*
> All that is rather excessive. It would be better to stop dying, gasping and cursing.
> *What have all these to do with Yoga?*
> It has nothing to do with Yoga. Usual human tangles, sir.
> *The Yoga of oblation, sacrifice and severe austerities would be better.*
> There is no such Yoga.
> *–No hankering for fame, name or meddling with others' affairs.*
> That also is not Yoga.
> *I have lost all faith, confidence, hope, and if all that is gone, what else remains for me to do here?*
> Good God! What a shipwreck in a teacup! Kindly cultivate a sense of proportion. Learn the lessons of experience, ponder them in silence and do better next time—that would be more sensible. (Nirodbaran, 1983, p. 376)

From the perspective of IYP, one can make a plausible argument that the Buddha was the greatest cognitive-behaviorial therapist in the history of the world. Although the Buddha's teachings had a larger existential scope than the more limited concerns of CBT, still there is nothing in CBT that the Buddha had not already formulated in essence when he set forth right understanding (cognition) and right action (behavior) as the basis for achieving liberation from suffering. Furthermore, contemporary therapies with cognitive components related to CBT, such as dialectical-behavior therapy (DBT) and MBSR, openly acknowledge borrowing from Buddhism. Sri Aurobindo commented on Buddhist philosophy in the following letter, which accurately describes the Buddha's pragmatic and psychological approach:

> His conception of Nirvana was of something transcendent of the universe, but he did not define what it was because he was not concerned with any abstract metaphysical speculations about the Reality; he must have thought them unnecessary and irrelevant and any indulgence in them likely to divert from the true object. His explanation of things was psychological and not metaphysical and his methods were all psychological,—the breaking up of the false associations of consciousness which cause the continuance of desire and suffering, so getting rid of the stream of birth and death in a purely phenomenal (not unreal)

> world; the method of life by which this liberation could be effected was also a psychological method, the eightfold path developing right understanding and right action. His object was pragmatic and severely practical and so were his methods; metaphysical speculation would only draw the mind away from the one thing needful. (Aurobindo, 2013, Vol. 29, pp. 429–430)

Alcoholic's Anonymous (AA)

A fascinating—and unexpected—illustration of the transformational processes listed in Table 2 are the principles embedded within the 12-step method of Alcoholics Anonymous (AA), a faith-based, non-denominational, self-help organization that addresses problem drinking. While the effectiveness of AA is debated and skeptics maintain that the "Higher Power" invoked in AA is just a useful fiction for eliciting a placebo response, on the other hand Vaillant (2005) has noted that the individual and group spirituality of AA probably taps into some of the same pleasure and reward circuits in the brain that addictions do, and he has argued convincingly that AA is neither a cult nor a religion. Certainly, AA is no panacea and it is not appropriate for people who dislike its faith-based approach, but it can help some people, sometimes. Reviews that weigh the evidence for and against AA in a thoughtful fashion do conclude that AA helps some participants reduce problem drinking (Kaskutas, 2009). However, AA is not the only effective intervention for alcohol addiction, as other secular models of self-help exist (e.g., Rational Recovery and HAMS: Harm Reduction for Alcohol), and professional guidelines recommend a collaborative relationship between mental health professionals and AA, especially for patients with severe mental illnesses (Brooks & Penn, 2003).

With these qualifications duly acknowledged, from the IYP perspective it is significant to note that the language of AA's "Big Book" is sometimes quite beautiful, and the sincerity and lucidity of its thought substance reveals a psychic inspiration. Appreciate, for instance, the penetrating transparency of the last of the 12 traditions: "Anonymity is the spiritual foundation of all our Traditions, ever reminding us to place principles before personalities" (Alcoholics Anonymous, 2001, p. 562). Likewise, consider the 12 steps themselves, which on paper read almost like yoga *sūtras* that teach the soul movements of aspiration, surrender and rejection (Alcoholics Anonymous, 2001, pp. 59–60). Step 1 begins with understanding, or the observing ego's ability to hold a painful truth without enlisting defenses to alter or distort perception, and then Step 2 proceeds upwards with an *aspiration* to the Divine for transformation:

> 1. We admitted we were powerless over alcohol —that our lives had become unmanageable.
> 2. Came to believe that a Power greater than ourselves could restore us to sanity. (Alcoholics Anonymous, 2001, p. 59)

Steps 3 through 7 focus on *surrender*, with aspiration and rejection in the background:

> 3. Made a decision to turn our will and our lives over to the care of *God as we understood Him*.
> 4. Made a searching and fearless moral inventory of ourselves.
> 5. Admitted to God, ourselves, and to another human being the exact nature of our wrongs.
> 6. Were entirely ready to have God remove all these defects of character.
> 7. Humbly asked Him to remove our shortcomings. (Alcoholics Anonymous, 2001, p. 59)

Steps 8 through 10 focus on *rejection*, or the psychic being's conscious will to transform the faults of the outer personality. In this working-through process, the functions of the observing ego are enlisted and applied interpersonally:

> 8. Made a list of all persons we had harmed, and became willing to make amends to them all.
> 9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
> 10. Continued to take personal inventory and when we were wrong promptly admitted it.
> (Alcoholics Anonymous, 2001, p. 59)

Finally, Steps 11 and 12 consolidate the work and provide a prescription for spiritual living based on the continued application of aspiration, surrender and rejection in all activities:

> 11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry it out.
> 12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs. (Alcoholics Anonymous, 2001, p. 60)

These last two steps, minus the passing reference to alcoholics, are as concise a definition of yoga as any written, and integrate the three main approaches to the Divine described in the *Bhagavad Gītā* and reaffirmed by Sri Aurobindo (1999) in his *Synthesis of Yoga* (Vols. 23–24): *bhakti,* encompassing devotion and prayer; *jñāna,* encompassing knowledge and meditation; and *karma,* encompassing action and work. Obviously, in real life AA is full of fallible human beings who do not live up to the high ideals of the 12-step method. However, these shortfalls in implementing the 12-step method do not discount the merits of the method itself.

Parapsychology

A host of studies on telepathy and other forms of psi phenomenon have corroborated the central tenant of IYP, which is that consciousness is non-local, meaning not solely limited to the operations of the brain. While it is true that early parapsychology research had flaws, contemporary studies have resolved these problems. The high methodological quality of this research (see Radin, 1997; Radin & Schlitz, 2005; Rao, 2002) is evidenced in studies by Braud (2000) and Standish, Johnson, Kozak, and Richards (2003). Likewise there have been extensive case studies of re-incarnation (Tucker, 2005) and near-death experiences (NDEs; see iands.org) that further support the conclusion that consciousness is non-local. In my opinion, the main reasons why mainstream psychology and psychiatry do not teach parapsychology to graduate students are: 1) cultural bias; 2) philosophical ignorance about the unproven assumptions of materialism; and 3) because this field has not yet yielded a major application. For instance, quantum mechanics and theoretical physics are every bit as "spooky" as parapsychology, to use Einstein's famous term, but are widely accepted because they have technological applications, especially military ones. As things stand, non-local effects are still so small and variable among test subjects that mainstream academia views these phenomenon as questionable.

Nonetheless, there are points of clinical relevance. For instance, seasoned hospice nurses and physicians have all met patients and families who have had uncanny experiences around death, including NDEs, premonitions of death, and communications from the deceased in dreams or via intutions. As a clinician who has worked in this area, I can confirm that when one encounters such moments of expanded consciousness, the only appropriate model of psychology is the transpersonal one. There is no other way to honor the patient and his or her family than to acknowledge that death is, indeed, not the end but the beginning of another life or plane of existence. Certainly, it is inappropriate to foist one's personal beliefs on others—but when the patient or family spontaneously present the clinician with spiritual experiences surrounding death, then it is appropriate to respond discreetly in a spiritual way. Indeed, simple human decency requires it.

The Dark Side

No discussion of transpersonal psychology would be complete without addressing the potential dangers of transpersonal practices, as well as the possession model of illness. In addition to the risks of cult dynamics and inducing premature *kundalini* awakenings (see Scotton et al., 1996, pp. 261–270, 316–326), some people and cultures believe in the spiritual reality of possession. Sri Aurobindo always warned about the existence of hostile beings and forces whose aim is to destroy life and oppose the evolution of consciousness (*asuras* and *rakshasas*). Although he affirms that there is no Evil in an absolute sense, for ultimately all is the

Divine, he also notes that hostile beings and forces are as relatively real as any other manifestation of phenomenal existence (Aurobindo, 2014, Vol. 31, pp. 765–810). According to IYP, not only can these forces invade individuals, but they can also influence groups and even whole nations. For instance, biographical accounts of how Sri Aurobindo and the Mother reported using yogic powers to fight the hostile forces behind Hitler's Nazi regime offer thought-provoking insights into the possible inner workings of world history (Nirodbaran, 1972, pp. 128–169).

Mainstream Western psychology is most uncomfortable with the notion of hostile influence and possession. Western medical anthropologists have long been interested in the frequent use of possession models of illness in traditional societies, but for the most part this literature deals with possession as a cultural construct rather than as a spiritual reality. For example, studies have found that the traditional possession model of mental illness is now giving way to more modernized idioms of psychological "tension" and "depression" in Kerala (Halliburton, 2005). Outside of India, some have attempted to correlate the phenomenology of possession with psychiatric models of dissociative states (Ferracuti, Sacco, & Lazzari, 1996), while others have studied descriptively the frequency of possession attributions across both psychotic and non-psychotic diagnostic categories (Pfeifer, 1999). Progressive thinkers have even recommended that mental health professionals work with rather than against beliefs about possession and exorcism (such as allowing patients to engage in combined treatment), so as to improve compliance and outcomes (Vlachos et al., 1997). The most informative study of the possession model of illness that I have read to date is Tobert's (2014) work on transpersonal approaches to psychiatry in India, which documents both patient and clinician perspectives on a range of paranormal phenomenon including possession, reincarnation, astrology, and the healing powers of temples and other sacred sites.

The main barrier to examining the issue of possession more deeply in academic literature is the history of conflict between religion and science in the West, which has lead to polarization and politicization of discourse on spiritual psychology. Scientific writers frequently assume that the presence of a physical mechanism of disease (seizure focus, brain tumor, identifiable psychiatric syndrome, viral or bacterial infection, etc.), or an obvious source of psychosocial distress, followed by the reduction of possession symptoms after biopsychosocial intervention, thereby disproves the existence of hostile forces. Yet there is an error in logic here, for correlation does not imply causation and science cannot prove that matter is the only reality, nor that supra-physical planes of consciousness do not exist. Due to philosophical ignorance on the part of some scientists, materialism is constantly put forward as a scientific fact when actually it is an unproven and unprovable hypothesis, because it cannot be subjected to experimental testing (Miovic, 2004a). Issues of worldview are therefore decided by human beings, not experiments. Thus, from the perspective of IYP, physical and psychosocial mechanisms of disease are simply the *gateways* through which hostile forces enter people and then exert their negative influence (Aurobindo, 2014, pp. 765–781). Conversely, in this worldview biopsychosocial interventions can also have occult spiritual effects due to the consciousness of those who deliver the help.

For example, Sri Aurobindo interpreted many cases of psychosis and epilepsy as due to the *interaction* among hostile vital beings who invade or possess the individual, psychological issues that invite such attacks (such as borderline, narcissistic and histrionic tendencies), and underlying physical brain defects that permit and perpetuate the condition(s). However, he recognized that the medical condition of delirium is purely physical, which is an astute observation for someone writing in the 1930s who was not trained in clinical medicine (Aurobindo, 2014, Vol. 31, pp. 801–810). He also warned about a range of potentially dangerous phenomenon that can transpire when people first open to the non-physical planes of consciousness, which he called the "intermediate zone" (Aurobindo, 2014, Vol. 30, pp. 303–304). Cortright (2007) has discussed

this intermediate zone further with reference to the wide range of psychological disturbances that are currently grouped together under the rubric of spiritual emergencies in transpersonal psychology.

Sri Aurobindo observed that vital beings and other hostile forces are polymorphic in nature and can manifest themselves in various forms, according to the mental schema of different times and cultures. Although he did not specifically discuss alien abduction, my interpretation of IYP is that he would have viewed the demons of old and the inimical space aliens of today as related phenomenon that involve the same adverse forces that have been plaguing humanity since its beginning. Mack (1994) entertained this possibility in his work on alien abduction, but his discussion would have benefited from IYP's consciousness perspective. Likewise his materialist critics would do well to consider how a consciousness perspective could move the debate beyond arguments about lack of physical proof that aliens exist, to more comprehensive formulations about the phenomenon of alien abduction. For instance, the following cases from my own practice in the United States illustrate how the worldview of IYP can lead to a richer and more nuanced understanding of the possession model of illness.

Case 1

First is the case of a Haitian patient with schizoaffective disorder who presented with vivid descriptions of being attacked and possessed by a voodoo spirit. I attempted to treat her with antidepressants, antipsychotics, and psychotherapy, with limited success. Suffering and frustrated, she returned to Haiti for a voodoo healing ceremony, which led to a dramatic remission of all symptoms for 3 months. Subsequently she returned to the United States, relapsed into psychotic depression, became suicidal, and so I had to hospitalize her involuntarily for her own safety. After discharge, she told me about an experience on the psychiatry ward during group therapy in which her "soul" was "sucked up" into a large, rotating disc that was hovering over the building. While inside this "disc," frightening little "beings" stuck needles into her ovaries and extracted eggs. The experience was terrifying and painful, and when it was over her "soul" was put back into her body.

Notably, she never used the word "UFO" or "alien" in describing her experience, and I asked no leading questions. The only question I asked, several times, was whether her experience was physical or "out of the body", and she consistently maintained that her body remained *in the hospital* while her "soul" (subtle or astral body in IYP terms) was sucked out. She clearly had no idea what UFOs nor aliens are, as she was raised in Haiti and was not exposed to those terms and cultural constructs. Her interpretation of the event was that it was some sort of "evil spirit", but she did not connect it with the voodoo spirit that had previously attacked her.

My interpretation of this incident was that this patient experienced hostile beings that stand behind the phenomenon of alien abduction, but because of her cultural acceptance of voodoo spirits as a reality, she did not need to translate this powerful subtle experience into solely physical terms. In contrast, because many contemporary Euro-Americans lack non-materialist explanatory models of the world, they are compelled to translate supra-physical events into purely physical terms. Thus, both camps in the alien abduction debate are right, and both are wrong: there *are* such things as inimical aliens, but they are *not* physical.

Case 2

The second case involved a man with schizophrenia who was suffering extremely violent paranoid delusions and needed to be placed in a locked cell for several months. I went in to interview him one day and was struck by the dark, demonic force that clouded his consciousness. Chills ran down my spine, fear gripped my heart, and I felt like fleeing the room. I had no doubt that I was in the presence of an evil force that had possessed the man. The next day I rotated onto another clinical service and had no further contact with the patient until a year later, when I happened to meet him again at an outpatient day treatment program. At that point he was on clozapine (a powerful antipsychotic medication) and was participating in a day hospital program that employed highly skilled social workers, psychiatrists, nurses, and support staff. I was surprised to find that the formerly possessed man had become one of the most tender and gentle patients I have ever seen.

The darkness in his aura was mostly gone, pushed far into the background as a potential that could return but was now effectively held in check, and the man had a lovely psychic sweetness about him, even though his cognitive capacity remained quite confused due to chronic schizophrenia.

Since this man did not receive any exorcism or shamanistic intervention that his team was aware of, I concluded that the *positive consciousness of the mental health system itself* had repelled the hostile attack on him. That is, the goodwill of the staff who cared for him, the science involved in making and managing his medication, and the humanistic values of the society that supported his treatment, were altogether unpalatable to the hostile being that wished to destroy him. So the demon withdrew, perhaps to wait for a lapse in treatment to attack again, or to go in search of some other place where the practice of medical ethics and knowledge was less robust.

Both of these cases show how IYP can be used to frame a more subtle discussion about the possession model of illness—including the non-local effects of standard treatments that are not considered to be "spiritual" and yet in fact are. In my experience and that of colleagues in IYP, such a synthetic approach to the subject is also useful in understanding a common pattern we see in clinical practice, where we observe cyclical relationships among psychological trauma, substance abuse, family dynamics, and hostile forces. To help clients extricate themselves from this negative cycle, psychotherapists may need to bring a spiritual understanding of the problem into treatment, and they may need at times to avail of spiritual guidance and protection both for themselves and for their clients (Curtiss, personal communication, August 20, 2015). The exact form this spiritual help will take depends on the personal beliefs and cultural context of the client and therapist, respectively.

Jungian Therapy

This section touches on the similarities and differences between the Jungian and yogic views of the "dark side." For most of his career, Jung viewed parapsychological phenomena, whether positive or negative, as stemming from the collective unconscious rather than supra-physical planes of consciousness that exist independent of the human psyche. Jung therefore treated possession states and related dark phenomenon as projections from a shadow side of self that needs to be integrated psychologically (McLynn, 1996). IYP, in contrast, views adverse forces and the Inconscient as spiritual realities, and therefore places more emphasis on volitional efforts to reject or transform them, rather than trying to interpret them as split-off aspects of a Jungian "shadow" that needs to be worked through psychologically.

Evidently, both views have their relative merits, depending on the individual and exact nature of the phenomenon in question, and the two views are not mutually exclusive. From the perspective of IYP, the personal shadow studied by Jung is simply a local manifestation of the Inconscient in the individual, and it can contain both psychological and parapsychological elements. For example, consider my personal experience with transforming the "darkness" in myself, described next. As you read this, note that a Jungian would interpret the process as reflecting fruitful archetypal work with my shadow, while IYP would interpret it as a fruitful albeit slow transformation of consciousness. Both interpretations are valid, and both show why it is important for clinicians to engage in their own psycho-spiritual process sincerely:

Case 3 (the author)

For the last decade, I have been diligently meditating on opening an area of darkness centered around the back of my head, neck, and shoulders to the transforming infusion of a higher Light. I can see both the light and the darkness in my inner vision, and the muscles and fascia of the region are tight, which indicates that a problem in consciousness has been somatized. In the beginning of this psycho-spiritual inquiry, I experienced the darkness lodged in my body with demonic imagery and a sense of intrusion by an inimical "other," which I interpreted as due to a hostile attack on me during early adolescence that scarred my emotional and social development via a constellation of outer events. However, as I worked through this possession imagery in meditation, it gave way to a deeper, older, and more pervasive

darkness ultimately connected with the evolution of life dating back to the very beginning of the Earth.

This underlying darkness is what Sri Aurobindo calls the Inconscient, and as I entered this layer of the work the sense of fear in the face of a demonic "other" resolved. I now recognize how this darkness of the Inconscient actually stimulates me to grow by seeking for a higher consciousness that can overcome it, and as a result I am no longer frightened by perceiving darkness in others. I now relate to "darkness" as an impersonal force, like gravity, that is part of the fabric of daily life and has both benefits (stimulates the growth of consciousness) and side effects (illness and death). I am also learning that the more conscious I become of the darkness in myself, the more I am able to engage productively with darkness in others. In fact, because the darkness in me resonates with the darkness in others, the very act of my perceiving darkness in another makes both of us part of a single field of consciousness that is being worked upon by the higher consciousness. In this way, pursuing my own transformation actually helps others seek theirs.

Clinicians who are less than comfortable broadcasting associations with shamanism, occultism, and other explicitly spiritual interventions might consider that one does not need to change one's clinical practice outwardly to gain these palliative effects: rather, *consciousness itself* does the work. One need not discuss perceptions of darkness or subtle operations of consciousness with others as the experience is unfolding; in fact, doing so can often do more harm than good.

Mind-Body Medicine

Another area where IYP can deepen the discussion is on the topic of mind-body effects. There has been a long-standing debate as to whether meditation, other mind-body practices, and psychosocial interventions can improve "hard" outcomes in medical practice, such as prolonging survival. For instance, while early studies in the 1970s and 1980s suggested that participation in support groups might prolong survival in patients with breast cancer, later studies that were better controlled found that psychosocial interventions do not prolong survival but do improve quality of life (Smedslund & Ringdal, 2004). The most recent meta-analysis reopens the question in a very limited way, suggesting it is possible that psychosocial interventions might prolong survival up to 1-2 years after cancer treatment, but not after that point (Fu et al., 2016). Since IYP accepts the scientific method as a tool for sorting out the difference between cause and correlation, it accepts this skeptical outlook on prolonged survival. However, there may be mind-body effects that are real but do not prolong survival—such as recent evidence that correlates MBSR practice with telomere length in both breast cancer survivors (Carlson et al., 2015) and patients without cancer (Schotte & Malouf, 2014).

At the same time, a growing body of literature is elucidating the many components of placebo effects, both psychosocial and biological (Finniss, Kaptchuk, Miller, & Benedetti, 2010), including some of the neurophysiological circuits involved, such as the endogenous opioid and dopamine systems (Benedetti, Mayberg, Wager, Stohler, & Zubieta, 2005). Interestingly, recent research shows that placebo effects can occur even when patients are explicitly told they are receiving placebos, and this is probably mediated, at least in part, via the supportive quality of the client-clinician relationship (Kaptchuk et al., 2010). Even though the American Medical Association still defines the use of placebos as unethical (because it involves deceiving patients and thus undermines autonomy), doctors clearly understand the potentially positive effects of placebos and about 50% of physicians recommend treatments—such as vitamins and over the counter pain killers—that they know are probably working via placebo effects (Tilburt et al., 2008).

What IYP has to add to this debate about "mind-body" effects is that there are many planes of consciousness above, between, around, and below what people commonly call the "mind" and the "body." Long before George Lucas imagined Jedi using "the Force" on the silver screen, Sri Aurobindo was studying and describing a range of different spiritual "forces" that exist. He was well

aware of the power of suggestion and expectations (Aurobindo, 2014, Vol. 31, pp. 559–562), but also maintained that consciousness can produce phenomenon beyond such ordinary effects. In the following letter, he lucidly discussed the problem of rationally determining whether interventions using spiritual force actually work, and hinted at the range of outcomes he observed in his own practice of yoga:

> In a case of cure of illness, someone is lying ill for two days, weak, suffering from pains and fever; he takes no medicine but finally asks for cure from his Guru; the next morning he rises well, strong and energetic. He has at least some justification for thinking that a force has been used on him and put into him and that it was a spiritual power that acted. But in another case medicines may be used, while at the same time the invisible force may be called for to aid the material means, for it is a known fact that medicines may or may not succeed—there is no certitude. Here for the reason of an outside observer (one who is neither the user of the force nor the doctor nor the patient) it remains uncertain whether the patient was cured by the medicines only or by the spiritual force with the medicines as an instrument. Either is possible, and it cannot be said that because medicines were used, therefore the working of a spiritual force is per se incredible and demonstrably false. On the other hand it is possible for the doctor to have felt a force working in him and guiding him or he may see the patient improving with a rapidity which, according to medical science, is incredible. The patient may feel the force working in himself bringing health, energy, rapid cure. The user of the force may watch the results, see the symptoms he works on diminishing, those he did not work upon increasing till he does work on them and then immediately diminishing, the doctor working according to his unspoken suggestions, etc. etc. until the cure is done. (On the other hand he may see forces working against the cure and conclude that the spiritual force has to be contented with a withdrawal or an imperfect success.) In all that the doctor, the patient or the user of force is justified in believing that the cure is at least partly or even fundamentally due to the spiritual force. Their experience is valid of course for themselves only, not for the outside rationalizing observer. But the latter is not logically entitled to say that their experience is incredible and must be false. Another point. It does not follow that a spiritual force must either succeed in all cases or, if it does not, that proves its nonexistence. Of no force can that be said. (Aurobindo, 2013, Vol. 29, pp. 180–181)

Sri Aurobindo had no training in modern medical science and wrote this letter in the 1930's, at a time when medical practice itself was not evidence-based. Nevertheless, he managed to analyze the matter in such a nuanced fashion that we can still learn from his thinking today. He saw no problem with combining spiritual "force" and medications or medical procedures, nor any essential contradiction between doing science and practicing yoga. In another letter, he discussed the complex interplay of the many planes of consciousness and parts of the being that can be involved in so-called "mind-body" effects. Scientifically, it is impossible to study these subtle phenomenon because controlled trials depend upon standardized interventions delivered to patients with the same condition, while in terms of consciousness every patient is unique and each intervention depends upon the consciousness of the person who delivers it:

> Always the same rigid mind that turns everything into a statement of miraculous absoluteness! It is my experience and the Mother's that all illnesses pass through the nervous or vital physical sheath of the subtle consciousness and subtle body before they enter the physical. If one is conscious of the subtle body or with the subtle consciousness, one can stop an illness on its way and prevent it from entering the physical body. But it may have come without one's noticing, or when one is asleep or through the subconscient, or in

> a sudden rush when one is off one's guard; then there is nothing to do but to fight it out from a hold already gained on the body. Let us suppose however that I am always on guard, always conscious, even in sleep—that does not mean that I am immunised in my very nature from all illness. It only means a power of self-defence against it when it tries to come. Self-defence by these inner means may become so strong that the body becomes practically immune as many Yogis are. Still this "practically" does not mean "absolutely" for all time. The absolute immunity can only come with the supramental change. For below the supramental it is the result of an action of a Force among many forces and can be disturbed by a disruption of the equilibrium established—in the supramental it is a law of the nature; in a supramentalised body immunity from illness would be automatic, inherent in its new nature.
>
> There is a difference between Yogic Force on the mental and inferior planes and Supramental Nature. What is acquired and held by the Yoga Force in the mind and body consciousness is in the supramental inherent and exists not by achievement but by nature—it is self-existent and absolute. (Aurobindo, 2014, Vol. 31, pp. 563–564)

In terms of clinical correlates, the passage above highlights that the "mind" is not a unitary phenomenon, and that there are many non-physical planes of consciousness and parts of the being involved in healing. From the perspective of IYP, simplistic notions of the mind having a direct effect on the body are naive and potentially harmful. For instance, one must be careful when discussing mind-body effects with patients so that they do not wrongly attribute the existence of illness, disease progression, or lack of healing to their own thoughts and emotions. This can happen in the context of any illness, but it is a common problem in my field, psycho-oncology, where patients can experience guilt and self-blame related to such interpretations, and families may discourage patients from expressing doubts and fears due to concern that the result of not "staying positive" will be hastened death. There is a big difference between imagining cells via mental imagery and directly experiencing the consciousness of cells, as the Mother reported experiencing in the later phase of her life and work (Van Vrekham, 1998, 2000)—a difference practitioners of visualization and guided imagery who are interested in cellular healing should understand.

It is also worth noting that future alterations to the human brain and body through robotics, artificial intelligence, microbiomes, and/or genetic engineering need not be taken as contradicting Sri Aurobindo's proposition of a supramental evolution, but can rather be understood as routes through which such an evolution could potentially proceed.

Real-World Reflections

The theory of IYP is presented in its own context as a universal description of human nature and spiritual potential. However, in the world of healthcare, how the theory is translated into practice depends upon the individuals and social contexts involved, including the specific legal, administrative, and financial structures of healthcare systems.

For example, one may consider how my practice in the United States differs from that of my colleague in Kolkota, Dr. Basu. He sees 80–100 patients per day in his private practice, usually sees the patient with the whole family present, writes limited to no progress notes, does not deal with insurance as there is none for mental health treatment in India, nor is he concerned with the threat of medical malpractice claims. He has a huge picture of Sri Aurobindo and the Mother on the wall in his waiting room, and his clients feel comfortable with this even though most of them ascribe to other faith backgrounds ranging from various Hindu affiliations to Muslims, Christians, and atheists. Basu works extensively with local occultists (spiritual healers) who work in the possession model of illness, and together they determine the degree to which any given case of is due to possession vs. mania or psychosis (Tobert, 2014). The answer ranges on a scale from 0 to 100% in either direction, and the respective clinicians will adjust their impressions and interventions over time. Also, since the laws

on involuntary treatment are weak in India, there is no social security, and poor families cannot afford inpatient psychiatric treatment, thus sometimes Basu (personal communication, Nov. 7, 2016) has to instruct a desperate housewife on how to hide psychotropics in curry in order to stabilize her mentally ill husband. If not, the husband could lose his job and the whole family starve to death.

In contrast, in the United States where the laws on life-saving involuntary treatment are strong and people have medical insurance and social security, it is illegal and unethical for me to medicate patients without informed consent. As a hospital-based psychiatrist in Minneapolis, I see 8–12 patients per day on average, usually see patients in private or have to get permission to involve family, spend a third or more of my time on documentation, deal constantly with insurance issues and the potential for a malpractice claim, and have to be discreet about my spiritual beliefs. I would never think of putting a picture of Sri Aurobindo and the Mother in my office, lest my mostly Judeo-Christian or atheist patients think I am involved in a cult. Sometimes I have perceptions of patients' auras as they relate to the medical or psychiatric problem at hand, but I never discuss these perceptions directly. I may discuss the patient's spiritual state in a general way, but I am careful to let the patient lead the discussion, while I mirror their preferred terminology. I am more open with a few chaplains with whom I have occasional hushed but frank hallway conversations about direct transpersonal experiences, but I would not discuss possession in a public forum at the hospital as the topic is still taboo in general practice.

Thus, Dr. Basu and I share the same theory of IYP but our practices are quite different. Although one might dream of combining the best of both worlds, in real life this is not possible. Dr. Basu works in a highly unstructured healthcare system that allows maximum creative freedom to both the patient and clinician in terms of expressing their spiritual worldviews, while I work on the opposite end of the spectrum—and there are pros and cons to both systems. In India, the government clinics are overwhelmed, there are limited consequences for fraud and abuse, and quality control is lax to the extreme. As a result, it is difficult to ensure that patient rights and informed consent are implemented and protected. On the other hand, all of the regulation, standardization, and constant evaluation of healthcare in the United States leads to much higher quality control but it saps creative freedom. What is lost is the unique, individual expression of spiritual inspiration, which necessarily is unpredictable, unquantifiable, and uncontrollable. As a result, the most frankly transpersonal and/or spiritual therapies in the United States are now happening in private practice, pastoral counseling, and faith-based communities. By going off insurance and out of clinics and hospitals, patients and clinicians can explore a range of spiritual and integrative approaches to treatment that are unproven but creative and sometimes even helpful.

In between these two poles of total creative freedom and total quality control, patients and clinicians are confronted with a series of trade-offs: at each step of the continuum something is gained and something is lost. The closest one can come to a "solution" is to allow patients to go everywhere and try whatever they wish. Tobert (2014) has documented how patients do this in India, blending together a range of traditional, spiritual, integrative, and allopathic treatment modalities. In the United States, this is done through out-of-pocket expenditures on a range of complementary and integrative treatments up to and including psychics, medical intuitives, and indigenous American and other spiritual healers. Thus, the patient of means goes to Memorial Sloan Kettering for the latest cancer clinical trial, flies off to John of God in Brazil for psychic surgery, and perhaps visits a guru or ashram in India as well. However, medical insurance will not pay for John of God and the trip to India, so the middle class and poor miss out on these options. The attempted solution to this is to import integrative treatments into hospitals. However, as soon as one does this, necessarily one has to start licensing, supervising, and otherwise regulating these practitioners, which inevitably leads to dilution of the creative consciousness. Thus we end up with music therapy, healing touch, non-denominational chaplaincy, mindfulness and mind-body programs, etc. These professionals

certainly add a positive dimension to healthcare, but they are not full-fledged psychics, shamans, gurus, or other faith-based healers.

Other real-world problems to contend with are the stigma of mental illness, ambivalent feelings about diagnosis and psychotropic medications, and the increased frequency of phenomenon from the "intermediate zone" in people who have immature defenses (i.e., borderline and other personality disorders). The first two issues are general to all mental health treatment, not specific to transpersonal work, but all three sets of issues bear a similarity in that they can engender strong negative feelings in patients about mental health care, and/or put clinicians in opposition to the wishes of patients and families. Few people like to be diagnosed as psychotic, much less to be told that they have a personality disorder. Many people irrationally fear psychotropics in a way they do not mistrust other classes of pharmaceuticals, and no one likes to be informed that their version of spirituality may be dysfunctional or even dangerous. One should be empathic and respectful in exploring these issues with patients and families, and sometimes this works. However, even the most sensitive clinician will at times need to take a stand that patients dislike or even interpret as disrespectful. Such conflicts arise in all fields of medical practice, but in mental health they are endemic because we have few objective measures (such as blood tests and brain scans) with which to justify our assertions to skeptical clients—and we have less cultural legitimacy than, say, surgeons or oncologists.

Regarding pharmacology, from the perspective of IYP medications have a sort of consciousness, just like the crystals and flower essences used in complementary therapies (Vandana, 1998). For instance, I have noticed that citalopram tends to create a yellow hue in patients' auras, while fluoxetine has a more clear or diamond-hued light. The feeling of lorazepam is light and dispersing, while that of clonazepam is dense and subduing. Presumably all other psychotropics have a specific aura or consciousness as well. What this means for treatment selection I do not yet know—but there is a whole field of study waiting to be born.

Finally, in my opinion the most fundamental real-world problem we all face as human beings is that our outer minds define problems in one way, while our inner beings may see things from a different perspective. We all want our "problem" symptoms, behaviors, and health conditions to go away, and often conventional treatments and/or transpersonal practices achieve that. However, there are times when our problems persist despite all efforts, and in some of these situations the soul is actually using these problems to stimulate the growth of consciousness in ways that the outer mind simply cannot foresee or understand. The wisdom art of clinical practice, therefore, is to find the right balance between fixing problems and growing from them—and that balance is a constantly moving target.

Conclusion

This article has given a broad overview of IYP as it relates to transpersonal psychology, with an emphasis on clinical relevance to psychotherapy, psychiatry, and mind-body medicine. In summary, IYP agrees with the general model of transpersonal psychology, but expands and deepens current understandings in a few areas. The most important of these are differentiating the planes of consciousness and parts of the being, and understanding that the integrating element in integral psychology is the psychic being, not the mind or emotions. The main limitation of IYP is that its worldview is founded upon spiritual perceptions of non-physical planes of consciousness that cannot be scientifically proven or disproven. However, since the assumption that matter is the only reality also cannot be experimentally tested, and many human beings report spiritual experiences that are felt to be non-material, in the author's opinion Sri Aurobindo does clinical practice a great service by refusing to let reductionistic materialism monopolize discourse on healing. The rise of integrative medicine proves that many patients and providers view spirituality as a key part of healthcare, and transpersonal psychology is to be congratulated for having championed this perspective from the very beginning.

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