THE DEVELOPMENTAL SPECTRUM
AND PSYCHOPATHOLOGY:
PART II, TREATMENT MODALITIES

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In Part I of this paper (Wilber, 1984), I have attempted to show how qualitatively different pathologies are associated with qualitatively different levels of self-organization and self-development. It might be expected, then, that a specific level of pathology would best respond to a specific type of psychotherapeutic intervention. In this section I would like to discuss those treatment modalities that seem best tailored to each type or level of self-pathology. Some of these treatment modalities were, in fact, specifically designed to treat a particular class of psychopathologies, and are often contraindicated for other syndromes.

Fulcrum I (Psychoses); Physiological Intervention

Most forms of severe or process psychoses do not respond well (or at all) to psychoanalytic therapy, psychotherapy, analytic psychology, family therapy, etc. (Greist et al., 1982)--despite repeated and pioneering efforts in this area (Laing, 1967). These disturbances seem to occur on such a primitive level of organization (sensoriperceptual and physiological) that only intervention at an equally primitive level is effective--namely, pharmacological or physiological (which does not rule out psychotherapy as an adjunct treatment [Arieti, 1967; Greist, et al.; 1982]).

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The central problem in the narcissistic and borderline syndromes is not that the individual is repressing certain impulses or emotions of the self, but that he or she does not yet possess a separated-individuated self in the first place (Blanck & Blanck, 1979). In a sense, there is not yet a repressed unconscious (or a "repression barrier") (Gedo, 1981). All the various thoughts and emotions are present and largely conscious, but there is considerable confusion as to who these belong to—there is, in other words, a fusion, confusion, or splitting of self and object representations. The self is not yet strong enough or structured enough to "push" contents into the unconscious, and so instead simply rearranges the surface furniture. The boundaries between self and other are either blurred (narcissism) or very tenuous (borderline), and the self shuffles its feelings and thoughts indiscriminately between self and other, or groups all its good feelings on one object (the "ali-good part-object") and all its bad feelings on another (the "all-bad part-object") (Masterson, 1981).

Accordingly, the aim of therapy on this level is not so much to uncover unconscious drives or impulses, but to build structure. In fact, it is often said that the aim of therapy in these less-than-neurotically structured clients is to enable them to reach the level of neurosis, repression, and resistance (Blanck & Blanck, 1979). Therapy on the Fulcrum 2 level thus involves the so-called "structure-building techniques," as contrasted with the "uncovering techniques" used to deal with repression and the psychoneuroses (Gedo, 1979, 1981; Blanck & Blanck, 1974, 1979).

The aim of the structure-building techniques, very simply, is to help the individual re-engage and complete the separation-individuation process (Fulcrum 2) (Masterson, 1981). That involves an understanding (and undermining) of the two central defenses that the individual uses to prevent separation-individuation from occurring: projective identification (or fusion of self and object representations) and splitting (Kernberg, 1976; Rinsley, 1977). In projective identification (or merger defense), the self fuses its own thoughts and feelings (and particularly self-representations) with those of the other. Notice that the thoughts and feelings remain more or less conscious; they are not repressed, but simply tend to be fused or confused with those of the other. This inability to differentiate self and other leads to the self engulfing the world (narcissistic disorders) or the world invading and threatening to engulf the self (borderline disorders). In splitting, the particular thoughts
and feelings also remain largely conscious, but they are divided up or compartmentalized in a rather primitive fashion. Splitting apparently begins in this way: During the first six months or so of life, if the mothering-one soothes the infant, it forms an image of the "good mother"; if she disturbs it, an image of the "bad mother" forms. At this early stage, however, the self does not have the cognitive capacity to realize that the "good images" and the "bad images" are simply two different aspects of the same person (or "whole object"), namely, the real mother. As development continues, however, the infant must learn to integrate the "all-good part-object" and the "all-bad part-object" into a whole image of the object, which is sometimes good and sometimes bad. This is thought to be a crucially important task, because if there is excessive rage at the "all-bad part-object," the infant will not integrate it with the loving "all-good part-object" for fear it will harm the latter. In less technical language, the infant does not want to realize that the person it hates is also the person it loves, because the murderous rage at the former might destroy the latter. The infant therefore continues to hold apart, or split, its object world into ali-good pieces and all-bad pieces (and thus over-react to situations as if they were a dramatic life and death concern, "ali-good" or "all-bad") (Spitz, 1965; Jacobson, 1964; Kernberg, 1976).

In short, the F-2 pathologies result because there is not enough structure to differentiate self and object representations, and to integrate their part-images into a whole-self image and a whole-object world. The structure-building techniques aim at exactly that differentiation-and-integration.

It is very difficult to describe, in a paragraph, what these techniques involve. Briefly, we may say this: the therapist, keeping in mind the subphases of F-2 development, gently rewards all thrusts towards separation-individuation, and benignly confronts or explains all moves towards de-differentiating and splitting. At the same time, any distortions of reality-caused by projective identification or splitting-are pointed out and challenged wherever feasible (this is known variously as "optimal disillusionment," "confrontation," etc.). A few typical therapist comments, paraphrased from the literature, illustrate this level of therapy: "Have you noticed how sensitive you are to even the slightest remark? It's as if you want the world to perfectly mirror everything you do, and if it doesn't, you become hurt and angry" (narcissistic mirror transference). "So far you haven't said a single bad thing about your father. Was he really all that good?" (splitting). "What if your husband leaves you! Would it really kill you?" (fear of separation abandonment). "Perhaps you have avoided a really
uncovering and re-integrating

"serious" pathology up through the oedipal phase

intimate sexual relationship because you're afraid you will be swallowed up or smothered?" (fear of engulfment).

A common feature of the structure-building techniques is to help clients realize that they can activate themselves, or engage separation-individuation, and it will not destroy them or the ones they love. Sources on these techniques include Blanck & Blanck (1974, 1979), Masterson (1981), Kernberg (1976), and Stone (1980).

**Fulcrum 3 (Psychoneuroses): The Uncovering Techniques**

Once a strong-enough self-structure has formed (but not before), it can repress, dissociate, or alienate aspects of its own being. The uncovering techniques are designed specifically to bring these unconscious aspects back into awareness, where they can be re-integrated with the central self. Readers may be familiar enough with these techniques, which include psychoanalysis proper (Greenson, 1967), much of Gestalt therapy (Perls, 1971), and the integrating-the-shadow aspect of Jungian therapy (Jung, 1971).

It is worth emphasizing here the importance of a more or less accurate, initial diagnosis of the level of pathology involved, in each case, before intensive therapy begins (see Gedo, 1981; Masterson, 1981). It is of little use, for instance, to try to integrate the shadow with the ego-self if there is insufficient ego-self to begin with. The types of treatment modalities are characteristically different and often functionally opposed. In F-3 pathologies, for example, resistance is usually confronted and interpreted (as a sign of repression), but in the F-2 pathologies, it is often encouraged and assisted (as a sign of separation-individuation). Sources for such differential diagnosis include Kernberg (1975, 1976), Masterson (1981), Gedo (1981), and Blanck & Blanck (1974, 1979).

**Fulcrum 4 (Script Pathology): Cognitive-Script Analysis**

Most conventional psychodynamic theorists tend to end their accounts of "serious" pathology at F-3, that is, at the oedipal phase and its resolution (or lack therof) (see, for example, Greenson, 1967). This is perhaps understandable; after all, the classic psychopathologies (from psychosis to hysteria) do seem to have their most disturbing etiologies in the first three fulcrums of self-development (see Abend et. al., 1983; Kernberg, 1976). But this by no means exhausts the spectrum of pathologies. not even the spectrum of "serious" or "profound"
pathologies. Accordingly, researchers increasingly have begun to look at higher or post-oedipal stages of development and their correlative vulnerabilities and diseases.

Take, for example, the notion of "role confusion." The capacity for genuine role taking is a decisively post-oedipal development. The capacity to take the role of other does not emerge, in any sophisticated fashion, until around age 7-8 years (Piaget, 1977; Loevinger, 1976), whereas the typical age of oedipal resolution is 6 years. Thus, one could theoretically resolve the oedipal conflict in a completely normal and healthy fashion, only to run aground on role confusion and identity confusion, for reasons totally unrelated to oedipal conflicts or concerns. We are here dealing with different levels (not just lines) of development, with different conflicts and vulnerabilities. These conflicts are much more cognitive than psychodynamic in nature and origin, because at this point the self increasingly is evolving from bodily to mental levels of the spectrum.

One of Berne's (1972) contributions was the investigation of this crucial level of the self—the text self or script self—on its own terms, without reducing it to merely psychoneurotic or libidinal dimensions. He began with the tripartite ego (P-A-C), which shows that he was starting at the F-3 level (and not F-1 or F-2), and then phenomenologically examined how this self took on more complex and intersubjective roles in an extended series of object relations. Similar but more sophisticated types of investigations have been carried out by cognitive role theorists (Selman & Byrne, 1974), social learning theorists (Bandura, 1971), family therapists (Haley & Hoffman, 1968), and communications psychologists (Watzlawick et al., 1967). These closely related techniques, of whatever school, are referred to here as "cognitive-script analysis."

Probably the most prevalent or common pathologies are cognitive-script pathologies. These pathologies—and their treatment modalities—seem to break down into two very general classes, one involving the roles a person is playing, and one involving the rules the person is following. Though closely related, these two classes may be discussed separately:

J. Role pathology—This has been typically investigated by Transactional Analysis (Berne, 1972), family therapists (Nichols, 1984), and cognitive-role psychologists (Branden, 1971). The individual involved in role pathology is sending multi-level communicative messages, one level of which denies, contradicts, or circumvents another level. The individual thus possesses all sorts of hidden agendas, crossed messages, confused
roles, duplicitous transactions, and so on. It is the job of the script analyst to help separate, untangle, clarify, and integrate the various communicative strands involved in role-self pathology. The interior splitting of the text-self into overt vs. covert communicative engagements (or into dissociated sub-texts) is thus confronted, interpreted, and, if successful, integrated (a new and higher level of differentiation-integration).

2. Rule pathology-One of the central tenets of cognitive therapy is that "an individual's affect and behavior are largely determined by the way in which he structures the world," and therefore "alterations in the content of the person's underlying cognitive structures affect his or her affective state and behavioral pattern" (Beck et al., 1979). In other words, an individual's cognitive schemas, configurations, or rules are a major determinant of his or her feelings and actions. Confused, distorted, or self-limiting rules and beliefs can be manifested in clinical symptoms; conversely, "through psychological therapy a patient can become aware of his distortions," and "corrections of these faulty dysfunctional constructs can lead to clinical improvement" (Beck et al., 1979). Similar cognitive approaches can also be found in such theorists as George Kelley (1955) and Albert Ellis (1973).

I do not mean to imply that cognitive-script therapy applies solely to F-4 pathology (it appears to have significant applications in the F-4, F-5, and F-6 range). It is simply that F-4 is the first major stage that cognitive-script concerns fully develop and begin to differentiate themselves from the more psychodynamic concerns of the previous fulcrums, and, as in any developmental sequence, such early stages are particularly vulnerable to pathological distortions. Just as adult sexual dysfunctions can often be traced back to early phallic Oedipal conflicts, many of the cognitive-script pathologies seem to have their genesis in the early (and possibly distorted or limited) rules and roles one learned when the mind first became capable of extended mental operations i.e., during Fulcrum 4). Thus, in addition to uncovering techniques, the pathogenic cognitive-script should ideally be attacked on its own level and in its own terms.

Fulcrum 5 (Identity Neurosis): Introspection

The hierarchic model of pathology and treatment presented thus far is in substantial agreement with mainstream, conventional psychiatry. To cite one example, as far back as 1973, Gedo & Goldberg presented a hierarchic model composed of, as they word it, "five subphases and fivetherapeutic modalities.
Each modality was tailored to deal with the principal problem characterizing a different subphase: introspection [formal-reflection] for the difficulties expectable in adult life, interpretation for the intrapsychic conflicts [psychoneuroses], 'optimal disillusionment' for archaic idealizations of others or self-aggrandizement [narcissistic mirroring], 'unification' for any failure to integrate one coherent set of personal goals [borderline splitting], and 'pacification' [pharmacological (custodial] for traumatic states.

With the exception of cognitive-script pathology and analysis, Gedo & Goldberg's model is, within general limits, exactly compatible with the one I have thus far presented i.e.,F-1 to F-5). Pacification, either custodial or pharmacological, refers to F-I pathology. "Optimal disillusionment" is a structure-building technique for the narcissistic disorders, and involves benign ways of letting the narcissistic self realize that it is not as grandiose or omnipotent as it thought or feared. "Unification" is a structure-building technique to overcome splitting, which is thought to centrally characterize F-2 pathology. "Interpretation" refers specifically to interpreting the resistances (repressions) and transferences manifested in the treatment of the F-3 pathologies (the psychoneuroses). And introspection, in this context, refers to the techniques used in dealing with the difficulties or problems that arise from F-5 development: the formal-reflexive-introspective self and its turmoils.

According to Gedo (1981), "The mode that reflects postedoipal phases of mental organization permits the analysand to apprehend his internal life through introspection, i.e., without the interpretation of defensive operations. In such circumstances, the role of the analyst is optimally confined to lending his presence to the procedure as an empathic witness." That is, the central and defining problems of F-5 development involve neither psychoneurotic repression nor immersion in pathogenic scripts, but the emergence and engagement of the formal-reflexive mind and its correlative, introspective self-sense (with its particular vulnerabilities and distresses). No amount of uncovering techniques or script analysis will suffice to handle these problems, precisely because these problems involve structures that transcend those lower levels of organization and thus present entirely new features, functions, and pathologies of their own.

This is not to say, of course, that pathology has no relation to the developments (or lack of them) at the previous four fulcrums. As we will see in a subsequent discussion of COEX systems, any previous subphase deficiencies, if not enough to arrest development entirely at a lower level, can and will invade

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upper development in specific and disturbing ways (see Blanck & Blanck, 1979; Mahler et al., 1975). In this case, for example, an individual with only partial F-2 (or separation-individuation) resolution may be very reluctant to engage the formal-reflexive mind, with its demanding call to individual principles of moral reasoning and conscience. The attempted engagement of the formal-reflexive mind might trigger abandonment depression or separation anxiety.

Introspection may be considered simply another term for philosophizing, and it is philosophizing, by any other name, that seems to be the treatment modality of this level. However, I do not agree with Gedo that the therapist's job at this level is simply to be a silent empathic witness to the client's emergent philosophizing. To be merely silent at this point is to be absent, i.e., worthless. Gedo's psychoanalytic orientation may have instilled in him unwarranted fears of "contaminating" the client with countertransference material. But by Gedo's own definitions, if that occurs, it could only involve the interpretive modality, not the introspective. If the client is clearly in the introspective (not interpretive) modality, there is nothing to be lost, and much to be gained, by the therapist taking a more active role, becoming, in a sense, a co-educator or co-philosopher.

It is exactly at this level, then, that the therapist can engage the client in a Socratic dialogue, which engages, simultaneously, the client's formal-reflexive mind (if, in this dialogue, lower-level residues surface, the therapist can revert to interpretation, structure-building, script analysis, etc.). As with any Socratic dialogue, the particular content is not as important as the fact that it engages, activates, draws out, and exercises the client's reflexive-introspective mind and its correlative self-sense (e.g., Loevinger's conscientious and individualistic). The therapist, then, need not overly worry about "contaminating" the client with his or her own philosophy; once engaged, the formal-mind, by definition, will gravitate towards its own views, the birth of which the therapist may Socratically assist.

Fulcrum 6 (Existential Pathology); Existential Therapy

As introspection and philosophizing are engaged and matured, the basic, fundamental, or existential concerns of being-in-the-world come increasingly to the fore (see Maslow, 1968; May et al. 1958). Existential pathology occurs if these concerns begin to overwhelm the newly formed centauric self and freeze its functioning (Wilber, 1980). These pathologies include, as we
have seen, existential depression, angst, inauthentieity, a flight from finitude and death, etc.

How these existential pathologies are handled varies considerably from system to system; for some, it is a simple continuing and qualitative deepening of the introspective mode. But a central therapeutic commonality seems to be this: the clearer or more transparent the self becomes (via concernful reflection), or the more it can empty itself of egocentric, power-based, or inauthentic modes, the more it comes to an autonomous or authentic stance or grounding (Zimmerman, 1981). And it is this grounding in authenticity and autonomy that itself provides a courage to be in the face of "sickness unto death" (Tillich, 1952; May, 1977). Authentic being, in other words, carries intrinsic (not extrinsic) meaning; it is precisely the search for extrinsic or merely external meaning that constitutes inauthenticity (and thus existential despair). Analysis of, and confrontation of, one's various inauthentic modes—particularly extrinsically-oriented, non-autonomous, or death-denying—seems to be the key therapeutic technique on this level (Koestenbaum, 1976; Yalom, 1980; May et al., 1958; Boss, 1963).

This emphasis on intrinsic meaning (or a new and higher level of interiorization) and the engagement of autonomy (or a new and higher level of self-responsibility) seem to be the two central features emphasized by all genuine schools of humanistic-existential therapy. Further, their claim that this constitutes a higher level of development has substantial clinical and empirical research support—this is, for example, Loevinger's (1976) integrated-autonomous stage (as opposed to the previous conscientious-individualistic).

I should point out that when existential therapists speak of the self becoming a clearing or opening for the "Being" of phenomena, they do not mean that the self has access to, or opens to, any genuinely transcendental or timeless and spaceless modes of being. The self is an opening to Being, but that opening is strictly finite, individual and mortal. As far as they go, I agree with the existentialists; there is nothing timeless or eternal about the centauric self, and an acceptance of that fact is part of the very definition of authenticity. But to say this is the whole picture is to say the centauric self is the highest self, whereas, according to the philosophia perennis, there lie above it the entire realms of the superconscient. If this is correct, then at this point a denial of the possibility of spiritual transcendence would constitute a preeminent defense mechanism. It is my own belief that what the existentialists call autonomy is simply
a higher interiorization of consciousness (see subsequent dis-
cussion); if this interiorization continues, it easily discloses
psychic and subtle developments. The self is then no longer an
opening to Being; it starts to identify with, and as, Being itself.

Fulcrum 7 (Psychic Pathology): The Path of Yogis

Da Free John (1977) has divided the world's great esoteric
traditions into three major levels: the Path of Yogis, which
predominantly aims for the psychic level; the Path of Saints,
which predominantly aims for the subtle level; and the Path of
Sages, which predominantly aims for the causal. That termin-
ology will be used in the following sections, as I am in
substantial agreement with his writings on these topics.

However, since these terms tend to have several different
connotations, many not intended by Free John nor the author,
one may also refer to these levels with more neutral terms, such
as beginning, intermediate, and advanced; or ground, path,
and fruition. I have tried to represent the various contemplative
traditions evenly, but if it appears that my own preferences and
biases are coloring any of the following discussions, I invite the
reader to re-interpret them according to the terms, practices,
and philosophies of his or her own particular path. My central
point, no matter how it might be finally worded, is that
contemplative development in general possesses three broad
levels or stages (beginning, intermediate, and advanced); that
different tasks and capacities emerge at each level; that different
distortions, pathologies, or disorders may therefore occur at
each level; and that these distortions or pathologies may best be
treated by different types of "spiritual" therapy (some of which
may also benefit from adjunct conventional therapies).

The following discussion of psychic (F-7) pathology parallels
that of Part I, which outlined three general types—spontan-
eous, psychotic-like, and beginners.

1. Spontaneous-i-For pathology resulting from spontaneous
and unsought awakening of spiritual-psychic energies or in-
sights, there seem to be only two general treatment modalities:
the individual must either "ride it out," sometimes under the
care of a conventional psychiatrist who may interpret it as a
borderline or psychotic break and prescribe medication, which
often freezes the process in mid-course and prevents any
further reparative developments (Grof, 1975); or the individual
can consciously engage this process by taking up a contem-
plative discipline. If the spontaneous awakening is of the
kundalini itself, the Path of Yogis is most appropriate (raja
yoga, kriya yoga, charya yoga, kundalini yoga, siddha yoga, hatha-ashtanga yoga, etc.), and for a specific reason: the Path of Saints and the Path of Sages, which aim for the higher subtle and causal realms, contain very little explicit teachings on the stages of psychic-kundalini awakening \textit{ie.g.,} one will look in vain through the texts of Zen, Eckhart, St. John of the Cross, etc., for any mention or understanding of kundalini. If at all possible, the individual should be put in touch with a qualified yogic adept, who can work. if desired, in conjunction with a more conventional therapist (see, for example, Avalon, 1974; Krishna, 1972; Mookerjee, 1982; Taimni, 1975; Da Free John, 1977; White, 1979).

2. Psychotic-like-For genuinely psychotic or psychotic-like episodes with periodic but distorted spiritual components, Jungian therapy may be suggested (see Grof, 1975; White, 1979). A contemplative discipline, whether yogic, saintly, or sagely, is usually contraindicated; these disciplines demand a sturdy ego or centaur level self, which the psychotic or borderline does not possess (Engler, 1984). After a sufficient period of structure-building (which most Jungians are aware of), the individual may wish to engage in the less strenuous contemplative paths (\textit{e.g.,} mantrayana); see section on "Meditation and Psychotherapy."

3. Beginning Practitioner-a) Psychic inflation-This confusion of higher or transpersonal realms with the individual ego or centaur can often be handled with a subtler version of "optimal disillusionment," a continual separation of psychic fact from narcissistic fantasies (see Jung, 1971). If this repeatedly fails, it is usually because a psychic insight has reactivated a narcissistic-borderline or even psychotic residue. At that point, meditation should usually be stopped immediately and, if necessary, structure-building engaged (either psychoanalytic or Jungian). If the individual responds to these, and eventually can understand the how and why of his psychic inflation, meditation can usually be resumed.

b)Structural imbalance (due to faulty practice of the spiritual technique);- The individual should verify this with the meditation teacher; these imbalances, which are not uncommon, point up how extremely important it is to undertake contemplative disciplines only under guidance of a qualified master (see Aurobindo, n.d.; Khetsun, 1982).

c) Dark Night of the Soul-Reading accounts of how others have weathered this phase can be very helpful (see especially John of the Cross, 1959; Underhill, 1955; Kapleau, 1965). In periods of profound despair, the soul may break into petition-
Dark Night agony

ary, as opposed to contemplative, prayer (to Jesus, Mary, Kwannon, Allah, etc.); this need not be discouraged—i.e., prayer to one's own higher Archetype (see Hixon, 1978; Kapleau, 1965). It might be noted that no matter how profound the depression or agony of the Dark Night might be, the literature contains virtually no cases of it leading to suicide (in sharp contrast to existential or borderline depressions, for example). It is as if the depression of the Dark Night had a "higher" or "purgatorial" or "intelligent" purpose—and this, of course, is exactly the claim of contemplatives (see, for example, John of the Cross, 1959).

d) Split-life goals—It is important (particularly in our society, and particularly at this point in evolution) that one's spiritual practice be integrated into daily life and work (as a bodhisattvic endeavor). If one's path is of exclusion and withdrawal, perhaps one ought to consider another path. In my opinion, the path of ascetic withdrawal all too often introduces a profound split between the upper and lower dimensions of existence, and, in general, confuses suppression of earthly life with transcendence of earthly life.

e) Pseudo-duhkha—is Although the details of the treatment modality for this disorder may be worked out with the meditation teacher, the teacher is sometimes the worst person to consult in these particular cases. Spiritual teachers generally have no knowledge of the dynamics of borderline or psychoneurotic disorders, and their advice may be, "Intensify your effort!", which is precisely what triggered the problem in the first place. In most cases, the meditator should cease all meditation for a few months. If moderate-to-severe depression/anxiety persists, a borderline or psychoneurotic COEX (see subsequent discussion) might have been reactivated, and appropriate structure-building or uncovering therapies might be engaged. It seems inadvisable for such an individual to continue intensive meditation until the particular subphase deficiencies have received appropriate attention.

f) Pranic disorders—These disorders are notorious for inducing hysterical-like conversion symptoms which, if left untreated, may induce genuine psychosomatic disease (see Da Free John, 1978; Chang, 1974; Evans-Wentz, 1971). They are best handled in conjunction with the yogic meditation teacher (and a physician if needed). Specifically suggested: Kriya Yoga, Charya Yoga, Raja Yoga and (more advanced) Anu Yoga (Khetsun, 1982; Rieker, 1971; Chang, 1974). Also, acupuncture performed by qualified practitioners may be effective (Clifford, 1984).
g) Yogic illness-> The best "cure" is also the best prevention: strengthening and purifying the physical-emotional body: exercise, lactovegetarian diet, restricted intake of caffeine, sugar, nicotine, and social drugs (Aurobindo, n.d.; Da Free John, 1978).

Fulcrum 8 (Subtle Pathology); The Path of Saints

1. Integration-Identification Failure - The author is not aware of any treatment modality for this pathology except to engage (or intensify) the path of subtle-level contemplation (the Path of Saints), which, at this point, usually begins to involve some form of inquiry, overt or covert, into the contraction that constitutes the separate-self sense (Da Free John, 1978; Ramana Maharshi, 1972; Suzuki, 1970). It is said to be an actual seeing of that contraction, which is blocking subtle or archetypal awareness, and not a direct attempt to identify with archetypal awareness itself, that constitutes the therapeutic treatment for this particular disorder (much as, in psychoanalysis, one has to deal with the resistance first, then the content).

According to some traditions (e.g., Aurobindo, Christian mysticism, Hinduism), if this contraction or subtle-level resistance is not relaxed to a sufficient degree (it is not totally dismantled until the causal level is realized), the consolidation and stabilization of the archetypal self will not be achieved, and the individual may then be inundated and overwhelmed by the tremendously powerful energies and dynamics released in the subtle realm - some Tantric texts speak of being "destroyed by luminosity" (e.g., Evans-Wentz, 1971); in Christian mystical terms, the soul damages itself by denying (resisting) God's love (or archetypal presence).

The common treatment modality for these disorders seems to include a seeing and then understanding of the subtle contraction or resistance to a larger archetypal awareness, a contraction that at bottom involves an inability to accept the death of the previous (or mental! psychic) self-sense and its attachments and case of morbid fixation/arrest at the psychic level (which prevents transformation to the subtle; see, for example, Aurobindo, n.d.; Da Free John, 1978; Trungpa, 1976; Khetsun, 1982).

According to Hinduism and Buddhism, it is at this point, too, that one begins to encounter and understand the "deep-seated defilements" (root klesas and vasanas) that not only obscure the next and higher stage of formless or unmanifest awareness,
but ultimately give rise to all forms of human suffering and pathology, high or low (Deutsche, 1969; Feuerstein, 1975; Gard, 1962; Longchenpa, 1977).

2. Pseudo-nirvana- This mistaking of subtle illuminations and archetypal forms for ultimate enlightenment can only be handled by moving beyond these luminous forms to unmanifest or formless cessation; that is, by moving from subtle to causal level development. Many of the most sophisticated contemplative traditions have numerous "checking routines" that help the practitioner review the ecstatic, luminous, blissful, and "tempting" subtle experiences and thus eventually gain a distancing or nonattached stance towards this archetypal level (after, that is, it has been stably achieved in the first place) (Goleman, 1977; Da Free John, 1978; Khetsun, 1982; Trungpa, 1976).

3. Pseudo-realization-Unlike pseudo-duhkha, which usually demands a halting of meditation, there is usually no cure for pseudo-realization except more meditation. The only thing more painful than continuing meditation is failing to continue meditation. Zen refers to this particular type of "Zen sickness" as being like "swallowing a red-hot iron ball" (Suzuki, 1970); it is apparently one of the few disorders for which one can therapeutically say, "Intensify your efforts!"

With most subtle-level pathologies, it apparently is not too late for adjunct psychotherapy, if, and only if, the therapist is sympathetic towards, and reasonably knowledgeable about, transcendental or spiritual concerns. The psychotherapeutic freeing of repressed emotional energies, for example, might be the crucial boost needed to negotiate subtle level integration. The structure-building techniques, while not without use, become increasingly less applicable at this stage, because most individuals with significant borderline deficiencies rarely develop to this stage.

\textit{Fulcrum 9 (Causal Pathology): The Path of Sages}

L Failure to Differentiate-According to Teachings as diverse as Zen, Free John, and Vajrayana, this final differentiation or detachment (i.e., from all manifest form) involves a subtle but momentous collaboration on the part of the student and the teacher, which may be briefly (and inadequately) described as follows: The teacher, at this point, resides within the "Heart" (or causal unmanifest realm) of the student, and exerts a special "pull"; the student, in the final and root form of the separate-self sense (archetypal self), is still standing in a subtly
contracted form "outside" the Heart ii.e., resisting the final and total dissolution of the separate-sense. The student and teacher "together," through an "effortless effort," release this stance, and the separate-self "falls" into the Heart. This "fall" into formless, unmanifest cessation or emptiness breaks all exclusive attachment to manifest forms and destinies, and Consciousness as Such (or Absolute Subjectivity) differentiates itself from all objects, high or low, and from all archetypal tendencies or root contractions (klesas, vasanas, etc.). Repetition of this "fall" or repeated "movement" from manifest to unmanifest and back again "burns" the root inclinations and desires for contracted and separated modes of self existence. This fall is the "entrance" to the stages of enlightenment (conceived by Buddhism as ground, path, and fruition enlightenment, which may be thought of as the three subphases of the enlightened or "perfectly ordinary" estate).

2. Failure to Integrate-This "ultimate pathology"-a failure to integrate the manifest and unmanifest realms-results when the root klesas and vasanas (or archetypal forms and inclinations) are seen only as defilements and not also as the means of expression or manifestation of unobstructed Wisdom (absolute Spirit or Being). The overcoming of this disjunction and the reunion or re-integration of emptiness-form and wisdom, is the "supreme path," the path of "ordinary mind" (Maha Ati), "open eyes" (Free John), and "everyday mind" (Ch'an)-wherein all phenomena, high or low, exactly as they find themselves, are seen as already perfect expressions and seals of the naturally enlightened mind.

Fig. 9 is a schematic summary of the basic structures of consciousness, the corresponding fulcrums of self-development, their characteristic pathologies, and the correlative treatment modalities.

RELATED TOPICS

In this section I would like to comment on differential diagnosis, connections to Grof's COEX systems theory, narcissism, dreams, and meditation/psychotherapy, in light of the full spectrum of development and pathology.

Differential Diagnosis

It is important to emphasize again the great care that should ideally be given to differential diagnosis, particularly in light of the full spectrum of human growth and development. For
example, psychic anxiety, existential anxiety, psychoneurotic anxiety, and borderline anxiety are apparently very different phenomena with very different treatment modalities, and thus any effective and appropriate therapeutic intervention depends significantly on an accurate, initial diagnosis. This, in turn, rests upon a skilled understanding of the entire spectrum of consciousness—a comprehensive understanding of the overall levels of self-structuralization and the particular types of needs, motivations, cognitions, object relations, defense mechanisms, and pathologies that are specific and characteristic for each stage of structural development and organization.

Currently, models less comprehensive than the one proposed here are being used to diagnose and treat clients, with an apparent collapse of what seem to very different diagnostic and treatment categories. For example, Kohut's (1971, 1977) two major diagnostic categories are Tragic Man (borderline) and Guilty Man (neurotic). His theory does not address spiritual pathologies, and therefore must reduce them all to lower-level concerns. Likewise, his conceptualization apparently requires the reduction of existential pathologies to borderline "Tragic

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**FIGURE 9**

CORRELATION OF STRUCTURES, FULCRUMS, PSYCHOPATHOLOGIES, TREATMENTS

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Man,” as if the only existential tragedy in the cosmos is separation of child from mother.

A major therapeutic confusion among various theorists stems from what I have called the "pre/trans fallacy" (Wilber, 1983), which is a confusing of pre-rational structures with trans-rational structures simply because both are non-rational. This confusion runs in both directions: pre-rational structures (phantasmic, magic, mythic) are elevated to trans-rational status (e.g., lung), or trans-rational structures are reduced to pre-rational infantilisms (e.g., Freud). It is particularly common to reduce samadhi (subtle or causal subject-object identity) to autistic, symbiotic, or narcissistic-oceanic states. Likewise, Atman, the one universal Self, is confused with the monadic-autistic F-I self. Alexander (1931) even called Zen a training in catatonic schizophrenia. In my opinion, such theoretical (and therapeutic) confusions will continue to abound until the phenomenological validity of the full spectrum of human growth and development receives more recognition and study.

COEX Systems

Stanislav Grof (1975) has coined the term "COEX systems" to refer to "systems of condensed experience," which are developmentally layered or onion-like complexes in the psyche. This is an important concept and, although similar ideas abound in the literature, Grot has given the notion one of its clearest articulations.

Pathological COEX systems, as I see them, are simply the sum of the associated and condensed aspects of unmetabolized experiences or subphase deficiencies that result at any particular fulcrum of self-structuralization (see Guntrip, 1971; Kernberg, 1975). Starting at Fulcrum I, any particular subphase deficiency (provided it is not severe enough to derail development entirely at that point) is taken up as a dissociated pocket in the self-structure during the ongoing march of self-structuralization. At the next fulcrum, any subphase deficiencies or malformations likewise become split off and lodged in the self-structure, where-and this was pointed out by both Grof and Jung-they become condensed and associated with similar, previous, subphase malformations. Not only do present-level malformations condense with previous ones, they tend to invade and contaminate the subsequent or higher-level fulcrums, skewing their development toward similar pathological malformations (quite apart from the malformations that might develop entirely due to their own subphase deficiencies).
grain of sand lodged in a pearl during its early formation, each subsequent layer tends to reproduce the defect on its own level. The result is a pathological COEX system, a multi-layered unit of associated and condensed subphase malformations, built up, fulcrum by fulcrum, and lodged, as split or dissociated sub-units (or pockets of "unconscious, undigested experience") in the overall self-structure itself.

A presenting symptom, therefore, may be merely the tip of a more or less extensive pathological COEX system. The particular COEX might be compounded of residues from, say, F-5, F-3, and F-2 subphase deficiencies. One of the aims of psychotherapy in general is to re-contact and re-experience the particular undigested subphase residues, layer by layer if necessary, and thus help repair structural malformations, allow those aspects of the self-system, previously lodged and stuck in various lower subphase pockets, to be released or "freed-up" to rejoin the ongoing march of structural organization and development.

Narcissism

"Narcissism" is probably the most confused and confusing topic in the technical therapeutic literature. It has been given literally dozens of different and sometimes contradictory definitions; there are vague references to levels of narcissism (primary, secondary, tertiary, etc.); and finally, there is said to be normal narcissism and pathological narcissism. What are we to make of all this?

Most of these confusions can be cleared up if we 1) explicitly define the levels or stages of narcissism, and 2) recognize that each stage of narcissism has both normal and pathological dimensions.

To begin with, the term "narcissism," as it is used in the Literature, has several major and quite different meanings. In a neutral or non-pejorative sense, "narcissism" is used to mean "self." "Narcissistic development," for instance, simply means "self development." No negative connotations of egocentricity, grandiosity, or arrogance are implied. To say there are levels of narcissism or levels of narcissistic development means, in this usage, nothing more than that there are levels of self or levels of self-development. In this paper, for instance, we have outlined nine major stages (each with three subphases) of "narcissism."

"Narcissism" is also used to mean "selfeentric," or an incapacity to take sufficient awareness of others. This, however, is not
necessarily a pathological or morbid condition; in fact, it is usual to distinguish between "normal narcissism" and "pathological narcissism," Normal narcissism refers to the amount of selfcentrism that is structurally inevitable or normal at each stage of development. Thus, for example, primary narcissism (or incapacity to even recognize an object world) is inevitable or normal at the autistic stage. The grandiose-exhibitionistic self-object fusion is normal at the practicing subphase. Although this is often called "the narcissistic stage," as a matter of convention, it is universally recognized that the amount of narcissism (selfcentricism) at this stage is actually less than in the previous stage, because there is at least an awareness of objects, which the previous or primary narcissism lacked entirely.

The rep-mind stage is even less narcissistic or selfcentric than the grandiose stage, but it still possesses a substantial degree of selfcentrism (or narcissism), as Piaget demonstrated, simply because it cannot yet take the role of others. This narcissism decreases with the rule/role mind, since the role of others is now recognized, and decreases even further with the emergence of the formal-mind, which can increasingly escape its own subjectivism by reflection on alternative viewpoints.

But at this point a certain amount of selfcentrism still remains, according to the contemplative traditions, simply because a certain amount of the separate-self sense still remains. Even into the subtle realm, according to Da Free John, "Narcissus" (which is his term) is still present (though highly reduced) because there is still a subtle contraction inward on self and consequent "recoil from relationship" (Da Free John, 1977).

So here is the first point: there are nine or so major levels of narcissism, each of which is less narcissistic (less selfcentric) than its predecessors. Narcissism (selfcentricism) starts out at its peak in the autistic stage (primary narcissism); each subsequent fulcrum of development results in a reduction of narcissism, simply because at each higher stage the self transcends its previous and more limited viewpoints and expands its horizons increasingly beyond its own subjectivisms, a process that continues until narcissism (selfcentricism) finally disappears entirely in the causal realm (simply because the separate-self sense finally disappears).

Now, at each stage of this lessening-narcissistic development, there is not only the normal or healthy amount of structurally inevitable narcissism, there is the possibility of an abnormal, pathological, or morbid narcissism on that level. This pathological narcissism is always a defensive measure; the self-
The structure of that level is over-valued and the self-objects of that level correspondingly devalued, in order to avoid a painful confrontation with those self-objects *i.e.*, on the mental level: "So what if they disagree with me! Who are they anyway? I know what's going on here; they're all really a bunch of clowns," *etc.*. The result is an amount of narcissism (or selfcentrism) quite beyond what would be structurally inevitable and expectable *at that stage*. Theorists such as Mahler maintain that pathological narcissism may occur even at the earliest stages of self-development *i.e.*, F-I and F-2).

In short, the "narcissistic defense" can theoretically occur at any stage of self-development (except the extreme end points), and involves an over-valuation of the self-structure of that stage and a commensurate devaluation of the self-objects of that stage, as a defense against being abandoned, humiliated, hurt, or disapproved of by those objects. The narcissistic defense is not indicated merely by a high self-esteem; if there is an equally high regard for self-objects, this is not narcissistic defense or pathology. It is the imbalance, the overestimation of self as measured against the devaluing of others, that marks the narcissistic defense.

It would be technically correct, then, and much less confusing, to define "narcissistic disorders" as the result of the narcissistic defense at any level of self-development. Thus, there is the normal narcissism of F-I, and the pathological (defensive) narcissism of F-I; there is a similar potential for normal and pathological narcissism at F-2, F-3, and so on, all the way up to and including the subtle fulcrum.

We could also speak of a "narcissistic disorder" if the normal narcissism of one stage is not outgrown at the next stage. In this case, narcissistic disorder would mean a developmental arrest at the normal narcissism of a particular lower level, and all we would have to do is specify which lower level is involved.

Unfortunately, however, the "narcissistic disorders"-and this is part of the extraordinary confusion surrounding this topic-have been solely defined as a developmental arrest at the normal narcissism of F-2. There is no way to reverse this general usage, and so I have followed it in the first part of this presentation; I will continue to use "narcissistic disorder" in the narrow sense to mean a pathological arrest fixation at the normal narcissism of F-2.

To summarize: There are nine or so levels of narcissism, each of which is less narcissistic (less selfcentric) than its predeces-
sorts); each of which has a normal or structurally inevitable amount of narcissism (normal or healthy narcissism), and each of which can develop, as a defensive pathology, a morbid, overblown, or pathological narcissism. The "narcissistic disorders," in the broadest sense, refer to 1) the pathological narcissism that may develop on any level, and 2) a pathological arrest/fixation to the normal narcissism of any lower level. In the narrowest sense—that of most present-day theory—a "narcissistic disorder" means an arrest/fixation at the normal narcissism of F-2.

**Dreams and Psychotherapy**

Dreams have long been held to be the "royal road to the unconscious," i.e., of great help in both the diagnosis and treatment of psychopathology. But given the nine or so levels of psychopathology, how might dreams best be used?

The practical theory of dream work that I have developed suggests the following: the manifest dream can be the latent carrier of pathology (or simply benign messages) from any or all levels, and perhaps the best way to work with the dream is to begin its interpretation at the lowest levels and progressively work upward. The same dream symbol in a single dream sequence could carry equally important material (pathological or healthy) from several different levels, and it is necessary to seek interpretations from all levels and see which ones elicit a responsive recognition in the individual. The therapist or analyst starts at the lowest levels—F-1 and F-2—and interprets significant dream symbols according to the meanings they might have on those levels. He/she watches for those interpretations that resonate with the client (usually by being emotionally charged), and then works through the charge surrounding each symbol. The dream is thus decathected or relieved of its emotional charge at that level (we "get its message"), and the interpretation then moves to the next level, re-interpreting each significant symbol according to its possible meanings on this new level (and so on up the spectrum).

Obviously in practice every single dream symbol cannot be interpreted from every single level—it would take hours or even days to do so. Rather, working from a general knowledge of the individual's overall self-structure and level of overall development, the therapist selects a few key symbols for each of, say, three or four most-suspected levels, and focuses on those. The more developed a person is, the higher the level of interpretation that is likely to also strike a responsive chord. Although even the most highly developed individuals are by no means
An example of multi-level dream interpretation

immune from lower-level messages (and frequently just the contrary—the lower levels are sometimes ones they have tended to ignore in their otherwise admirable ascent, a deficiency that dreams will not let them forget).

The only way to indicate the apparent richness of this approach would be to present several cases with parallel interpretations across the various levels. Since that is beyond the scope of this short section, the following simple example may suffice to indicate the general thrust of this spectrum approach. A middle-aged woman presents a dream which contains a highly charged scenario composed of these central images: she is in a cave (associations: "hell," "death"); there is a silver-luminous pole leading from the cave to the sky ("heaven," "home"); she meets her son in the cave, and together they climb the pole ("release," "safety," "eternity").

What, for example, does the pole represent? From an F-J/F-2 level, it might represent a denial of the "all-bad" mother and a fusion or "umbilicus" to the safety of the symbiotic "all-good" mother (splitting). From an F-3 level, it might represent phallic/incestuous wishes. From an F-4 level, it might symbolize the means of more closely communicating with her son. From F-6, an escape or avoidance of existential death. And from F-7, the silver-lined kundalini sushuma (which is said to be the central channel in the spine leading from the first chakra of the physical-hell realms to the seventh chakra of liberation and release in the transcendental Self).

My point is that the pole might have simultaneously represented all of these. The dream symbol, being plastic, is apparently invaded and informed by any pressing issue or level of insistent pathology. Thus the way one might best deal with dreams is to start at the bottom and work up, resonating with the dream at each significant level. (We start at the bottom to insure that we don't take an unrealistic or "elevationist" stance, overlooking the unpleasant lower-level messages that might be involved; we don't stop with the lower levels, however, because we also want to avoid the "reductionist" stance, which violates the existential and spiritual dimensions of the human condition.)

Meditation and Psychotherapy

Meditation, in my opinion, is not a means of digging back into the lower and repressed structures of the submergent-unconscious; it is a way of facilitating the emergence, growth, and development of the higher structures of consciousness. To
confuse the two is to foster the reductionist notion, quite prevalent, that meditation is (at best) a regression in service of ego, whereas by design and practice it is a progression in transcendence of ego.

However, when a person begins intensive meditation, submergent-unconscious material (e.g., the shadow) frequently begins to reemerge or occasionally even erupt into consciousness. It is this "derepression of the shadow" that has contributed to the notion that meditation is an uncovering technique and a regression in service of ego. I believe this derepression does in fact frequently occur, but for a very different reason (possessing very different dynamics): meditation, because it aims at developing or moving consciousness into higher levels or dimensions of structural organization, must break or disrupt the exclusive identification with the present level of development (usually mental-egoic). Since it is the exclusiveness of the identification that constitutes the repression barrier, its disruption, in whole or part, may release previously repressed material—hence the derepression. This happens very often in the initial stages of meditation, but it definitely seems to be a secondary by-product of the practice, not its goal, and certainly not its definition. (For a detailed discussion of this topic, see Wilber, 1983.)

Can or should meditation be used in conjunction with psychoanalysis or psychotherapy? I believe that this depends largely on the type of meditation and on the level of pathology being treated by the particular therapy.

In general, meditation seems contraindicated in F-1 and F-2 pathologies. There simply isn't enough self-structure to engage the intense experiences that meditation practices occasionally involve. Not only does meditation not seem to help in these cases, it apparently can be detrimental, because it tends to dismantle what little structure the borderline or psychotic might possess. Meditation, in other words, tends to undo those intermediate-level self-structures that the borderline or psychotic is in need of creating and strengthening in the first place. Ironically, many individuals with F-2 pathologies are, according to Jack Engler (1983), actually drawn to meditation, particularly its Buddhist forms, as a rationalization for their "no-ego" states. With Engler, I believe meditation is usually contraindicated in such cases.

Most forms of F-3 pathology, on the other hand, can apparently receive auxiliary benefit from meditation practice (see Carrington & Ephron, 1975). I believe vipassana meditation, however, should be used with caution in cases of moderate-to-severe depression, due to the tendency to link psychoneurotic
use of meditation at F-3 level

Meditation may also be used with most forms of F-4 and F-5 pathologies, but there is a specific complication: someone caught in role-confusion or role-conformist pathology, or who is having a difficult time establishing formal self-identity, is particularly vulnerable to using meditation, as well as various meditation groups, in a cultic fashion, pledging allegiance to the particular meditative “in-group” as an acting out of unresolved identity neuroses. The resulting "cultic mentality" is extremely difficult to deal with therapeutically, because allegedly "universal-spiritual truths" are being used as an otherwise airtight rationalization for simple acting out.

Most forms of F-6 or existential pathologies, in my experience, usually show a positive response to meditation. Existential anxiety, unlike psychoneurotic anxiety, does not seem to be a contradiction for even the more strenuous meditation practices such as koan (see Kapleau, 1965); with existential depression, however, the duhkha-intensifying meditations, such as vipasana, might be used with caution. Further, individuals with existential pathologies or persistent existential dilemmas usually find the whole philosophy behind contemplative endeavors to be salutory, pointing to a genuine and transcendental meaning to life's enterprise. Notice I said existential pathology; individuals at the normal existential level itself are frequently uninterested in (and suspicious of) meditation/transcendence tend to view it as a form of death denial.

In sum: meditation is not a structure-building technique, nor an uncovering technique, nor a script-analysis technique, nor a Socratic-dialoguing technique. It cannot substitute for those techniques, nor should it be used as a way to "spiritually bypass" any major work needed on those levels. In conjunction with analysis or therapy, however, it apparently can be very useful in most forms of F-3, F-4, F-5, and F-6 pathology, both because of its own intrinsic merits and benefits, and because it tends to "loosen" the psyche and facilitate derepression on the
lower levels, thus contributing in an auxiliary fashion to the therapeutic procedures on those levels.

**Meditation and Interiorization**

The charge has been circulating, for quite some time now, in both psychoanalytic and popular literature, that meditation is a narcissistic withdrawal (Alexander, 1931; Lasch, 1979; Marin, 1975). I would in this section like to challenge that claim, using the definitions and findings of psychoanalysis itself.

In this paper we have been discussing the development or evolution of consciousness. How, then, does psychoanalytic ego psychology define evolution? "Evolution, to [Heinz] Hartmann [the founder of psychoanalytic developmental psychology], is a process of progressive 'internalization', for, in the development of the species, the organism achieves increased independence from its environment, the result of which is that '. . . reactions which originally occurred in relation to the external world are increasingly displaced into the interior of the organism.' The more independent the organism becomes, the greater its independence from the stimulation of the immediate environment" (Blanck & Blanck, 1974). Increasing development, for such psychoanalysts, is defined as increasing interiorization.

It does not follow, then, that such a theoretical orientation should applaud the increasing interiorization from body to ego-mind, but stand back aghast at the increasing interiorization from ego-mind to subtle-soul to causal-spirit (or meditation in general); but this is exactly what appears to happen with certain psychoanalytically oriented theorists (e.g., Alexander, 1931; Lasch, 1979) and with some popularly oriented writers who claim modern psychiatric support (e.g., Marin, 1975). This apparently occurs because, half way up the Great Chain of increasing interiorization, these theorists begin to apply the term "narcissism." But we have seen that each higher level of development is marked by less narcissism. In other words, a perfectly acceptable psychoanalytic definition is: increasing development = increasing interiorization = decreasing narcissism. From which it follows that meditation, as an increasing development of interiorization, is probably the single strongest tool we have for decreasing narcissism.

This may sound paradoxical if one does not distinguish between two very different sorts of "inside-ness" or "internalness." Let us call these two sorts of internalness by the names "inside" and "interior." The first point is that each higher
level of consciousness is experienced as being "interior" to its lower or preceding level, but not as being "inside" it. To give an example: the mind is experienced as being interior to the body, but not inside the body; if I eat some food, the food feels inside the body; or if I have a physical ache, that also feels inside the body; but there is no inside physical feeling, sensation, twitch or twinge to which I can point and say, that's my mind. My mind, in other words, is not specifically felt as inside my body (as I am using the term), but is, somehow, felt to be rather vaguely "internal" to the body—and that feeling I call "interior." The difference is simply that each level of consciousness has its own boundaries, with an inside and an outside; but a higher level is experienced as interior to the lower, not as literally inside it. These boundaries should not be equated, because they exist on different levels entirely. For example, the boundaries of my mind and the boundaries of my body are not the same. Thoughts can come into and go out of my mind without ever crossing the physical boundaries of my body.

Notice that because my mind is interior to my body, it can go beyond or escape the insides of the body. In my mind I can identify with a country, a political party, a school of thought; in intersubjective reflection I can take the role of others, assume their views, empathize with them, and so on. I could never do this if my mind were only and actually inside my body. Being interior to it, however, it can escape it, go beyond it, transcend it. This is why interiorization means less narcissism—one level, being interior to another, can go beyond it, which it could never do if it were really and solely inside it.

Likewise, the soul is interior to the mind; it is not inside the mind—the only thing inside the mind is thoughts, which is why introspecting the mind never reveals the soul. As thoughts quiet down, however, the soul emerges interiorly vis-a-vis the mind, and therefore can transcend the mind, see beyond it, escape it. And likewise, spirit is not inside the soul, it is interior to the soul, transcending its limitations and forms.

Apparently, then, theorists who claim that meditation is narcissistic imagine that meditators are going inside the mind; but they are rather going interior to it, and thus beyond it: less narcissistic, less subjectivistic, less selfcentric, more universal, more encompassing, and thus ultimately more compassionate.

CONCLUSION

I would like to be very clear about what this presentation has attempted to do. It has not offered a fixed, conclusive, unalter-
able model. Although I have at every point attempted to ground it in the theoretical and phenomenological reports of reputable researchers and practitioners, the overall project is obviously meta theoretical and suggestive, and is offered in that spirit. But once one begins to look at the full spectrum of human growth and development, an extraordinarily rich array of material becomes available for metatheoretical work; a variety of connections suggest themselves which were not apparent before; and a wealth of hypotheses for future research become immediately available. Moreover, different analytical, psychological, and spiritual systems, which before seemed largely incompatible or even contradictory, appear closer to the possibility of a mutually enriching synthesis or reconciliation.

This presentation has offered one such full-spectrum approach, more to show the strong possibilities than the final conclusions; if this type of model is useful in reaching better ones, it will have served its purpose. My point, actually, is that given the state of knowledge already available to us, it seems ungenerous to the human condition to present any models less comprehensive—by which I mean, models that do not take into account both conventional and contemplative realms of human growth and development.

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