

Mindfulness and Feelings of Emptiness

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“Nothing is as unbearable for man as to be completely at rest, without passion, without business, without distraction, without application to something.”

In such a state of rest man becomes aware of “his nothingness, his forsakenness, his insufficiency, his dependence, his impotence, his emptiness.”

Incontinently there springs from the depth of his soul “the ennui, the blackness, the tristesse, the chagrin, the spite, the despair.”

Blaise Pascal

Introduction

The feeling of emptiness is a common symptom or phenomenological experience found in clinical practice with several kinds of disorders. What is, however, more difficult is finding two patients who describe this experience in the same way. Patients report different experiences: “I feel an emptiness inside,” “everything seems empty,” “I feel like I’m falling into a great emptiness,” “nothing makes sense because of the emptiness,” and many others. Though at first sight they may appear to be very similar, some specific and distinctive characteristics surface on closer observation. The diagnoses that comprise these manifestations can be multiple and are recurrent in relation to a series of disorders: from common depressive episodes to personality disorders, even in comorbidity with other pathologies.

This phenomenon seems to be a universal human experience and might not always seem directly linked to a pathology. All of us, at some moment in our lives, can experience a “feeling of emptiness,” without suffering from a mental disorder. Like many other nonspecific symptoms, the feeling of emptiness is neither a necessary nor a sufficient reason for a frank diagnosis although it has become one of the inclusion/exclusion nosological criteria of borderline personality disorder (BPD) in the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*, American Psychiatric Association, 2000).

The experience of emptiness has aroused the interest of well-known scholars and has become the main subject of their writings. Unfortunately, few thorough or rigorous studies have focused specifically on emptiness. This may be because of the many methodological problems involved in this type of study. For example, what do we mean by experience of emptiness? Does this feeling of emptiness always present itself in the same way? Does it vary

according to the disorder diagnosed? Although we will try to answer these questions, at least in part, in this chapter, the main aim is to take the reader through a theoretical reflection on the possible clinical use of mindfulness, to alleviate, reduce, or eliminate the suffering caused by the experience of emptiness as a pathological symptom.

Psychology and Emptiness

He who has a why to live, can bear almost any how
Nietzsche

The experience of emptiness has not been studied only by psychologists. Various categories of scholars, including philosophers and theologians, have been and still are interested in this phenomenon of human experience. However, if we focus specifically on psychology, we can highlight some epistemological approaches that, more than others, have tried to explain this psychological experience. Cognitive-behavioral theory (Linehan, 1993; Young, 1987), existential psychology (Frankl, 1975, 1963; May, 1950, 1953), and psychoanalysis (Kernberg, 1975; Kohut, 1971, 1977) are some of the theoretical perspectives that have provided important contributions to the understanding of the experience of emptiness. These contributions will be discussed in detail below.

Cognitive-Behavioral Theory and Feelings of Emptiness

Several cognitive-behavioral authors have suggested that the experience of emptiness can be a sort of dysfunctional avoidance strategy in a situation of deep subjective suffering (Beck, Freeman et al., 1990; Linehan, 1993; Young, 1987). Linehan (1993) bases her therapeutic model on the idea that the inability to regulate and modulate painful emotions is an essential element in explaining the behavioral difficulties of patients with BPD. These patients present a sort of intolerance to negative emotions: “Many borderline patients try to control their emotions simply by forcing themselves *not to feel* what they are experiencing” (Linehan, 1993). Other researchers, such as Fiore and Semerari (2003), speak of a state of *emotional anesthesia* to avoid any suffering by which patients detach themselves from everything and everyone.

Young, Klosko, and Weishaar (2003) have identified various *modes*, meaning the specific emotions, cognitions, and behavior active in a person in the here and now. Among these, the *detached protector mode* aims at isolating the person from his needs and feelings, creating a sort of detachment with a protection purpose. The main symptoms of this mode include depersonalization, self-harm, boredom, and feelings of emptiness. These theories can be associated with Hayes, Wilson, Gifford, Follette, and Strosahl’s (1996) assertions on *experiential avoidance*.

Experiential avoidance is a putative pathological process recognized by a wide number of theoretical orientations. Experiential avoidance is the phenomenon that occurs when a person is unwilling to remain in contact with particular private experiences (e.g., bodily sensations, emotions, thoughts, memories, and behavioral predispositions) and takes steps to alter the form or frequency of these events and the contexts that occasion them. We occasionally use terms such as *emotional avoidance* or *cognitive avoidance*

rather than the more generic *experiential avoidance* when it is clear that these are the relevant aspects of experience that the person seeks to escape, avoid, or modify. We recognize that thoughts, memories, and emotions are richly intermingled and do not mean to imply any necessary rigid distinction among them (although distinctions might be drawn by some theoretical perspectives without threat to the underlying principle of experiential avoidance) (Hayes et al., 1996).

The question, then, is what can a patient do if, as has been hypothesized by the aforementioned authors, the feared stimulus is one's own emotions? How can a person avoid something that is not outside, but part of his or her natural and theoretically adaptive response to the outside world? Certainly, a possibility is to try *not to feel*, as was said above. Experiencing this "emptiness" creates a detachment leading to actions aimed at distancing the subject from the stimulus situation, that is, the negative emotions, replacing them with physical pain (self-harm), numbness (alcohol or substance abuse), euphoria (acting out dangerous behaviors), or physical gratification (sexual promiscuity, bulimic crises), all manageable situations from the subject's point of view.

Referring to the BPD, Linehan (1993) claims that exposure to an invalidating environment, where inadequate and unforeseeable answers follow the manifestation of a person's inner experiences, leads to the *non-recognition* or *inhibition* of negative emotions. This continuous inhibition of negative emotions leads to emotional avoidance. The paradigm, the author claims, is similar to learning flight behavior to avoid painful stimuli. In this case, the emotions, meaning the complex response of the body (activation of the central nervous system accompanied on a neurovegetative, behavioral, and cognitive level by specific modifications), seem to be conditioned. This conditioning may have been caused by a repeated process of aversive association stimuli such as those previously described by Linehan regarding an invalidating environment. If we add this to specific circumstances, increases in fear not caused by events experienced by the subject but rather by the simple repeated presentation of discriminative and conditioned stimuli, connected to such events (Sanavio, 1991), we find that even simple physical sensations, previously associated with a negative emotion, can produce a phenomenon known as *incubation of fear*. The sense of emptiness could be triggered by the simple arising of one of these discriminative stimuli, preceding the activation of the negative emotions, which the subject avoids and sometimes fails to recognize.

Existential Psychology

Viktor Frankl coined the term "existential vacuum" (1963; 1973), and aspects of the meaning of this term come close in meaning to the term "emptiness" as described in this chapter. Frankl posits that humans have a "will to meaning," which is as basic to them as the will to power or the will to pleasure. The frustration of the will to meaning results, in Frankl's estimation, in a "noogenic neurosis" – an abyss experience (Hazell, 2003). If meaning is what you desire, then meaninglessness is a hole, an emptiness, in our lives. Whenever you have a vacuum, of course, things rush in to fill it. Frankl (1963) suggests that one of the most conspicuous signs of existential vacuum in our society is boredom. He points out how often people, when they finally

have the time to do what they want, don't seem to want to do anything, for example, people go into a tailspin when they retire, students get drunk every weekend, and people submerge themselves in passive entertainment every evening. He calls this the "Sunday neurosis" and defines it as "that kind of depression which afflicts those who become aware of the lack of content in their lives when the rush of the busy week is over and the void within themselves becomes manifest" (Frankl, 1963, p. 169). The result of this is an attempt to fill our existential vacuums with "stuff" that, because it provides some satisfaction, we hope will provide ultimate satisfaction as well; for example, we might try to fill our lives with pleasure, eating beyond all necessity, having promiscuous sex, living "the high life;" we might seek power, especially the power represented by monetary success; we might fill our lives with "busyness," conformity, and conventionality; or we might fill the vacuum with anger and hatred and spend our days attempting to destroy what we think is hurting us. We might also fill our lives with certain neurotic "vicious cycles," such as obsession with germs and cleanliness, or fear-driven obsession with a phobic object. The defining quality of these vicious cycles is that, whatever we do, it is never enough.

Frankl conducted many studies where he interviewed people on "existential emptiness" (1975). At the Policlinic Hospital in Vienna, he found that 55% of patients had experienced a loss in the meaning of life, and a statistical survey showed that 25% of European and 50% of American students had had this experience. In Frankl's thinking, the experience of emptiness is made up of two feelings: a feeling that life is meaningless and a feeling of inner emptiness. This bifactorial quality in the experience of existential vacuum is sometimes undifferentiated from other concepts such as boredom and depression: "The existential vacuum manifests itself mainly in a state of boredom" (Frankl, 1963, p. 169). Another important representative of existential psychology, Rollo May (1950, 1953), has illustrated some useful ideas on the concept of the experience of emptiness. In his earlier work, May (1950) connects the experience of anxiety with the threat of nonbeing, that is, anxiety is the experience of being affirming itself against nonbeing: "Emptiness and loneliness, are thus the two phases of the basic experience of anxiety". In 1953 (p. 14), he wrote: "... the chief problem of problem in the mid-decade of the twentieth century is emptiness. By that I mean that not only do people not know what they want; they often do not have any clear idea of what they feel ... they have no definite experience of their desires or wants." May relates the experience of emptiness with turning to drug use or to the use of sex in a mechanical way: "... the most common problem now is not social taboos on sexual activity or guilt feelings about sex itself, but the fact that sex for most people is an empty, mechanical and vacuous experience" (May, 1953, p. 15). This behavior, which is found rather frequently in some types of disorders such as BPD, is often traced back by the same patients to their own experience of emptiness. Other interesting reflections by the author refer to the relationship between the experiences of emptiness, helplessness, and powerlessness (May, 1953). The experience of emptiness rather generally comes from people's feeling that they are powerless to do anything effective about their lives or the world they live in. Inner vacuousness is the long-term accumulated result of a person's particular conviction toward himself, namely, that he or she cannot act as an entity in directing his or her own life,

and since what he or she wants and what he or she feels can make no real difference, he or she gives up wanting and feeling. Apathy and lack of feeling are also defenses against anxiety (May, 1953, p. 22).

Psychoanalysis and Emptiness

As far as psychoanalysis is concerned, let us take a look at Otto Kernberg's work (1975) on the experience of emptiness. Kernberg used psychodynamics and object-relations theory as a means of explaining the various forms the experience might take. For him, the experience of emptiness arises when there is a loss of what Jacobson (1964) calls "self feeling". Kernberg points out that although there are several forms of the experience of emptiness, there are two broad reactions to the experience: that of "acting out" in a forced attempt to regain a sense of internal aliveness and that of submitting to the experience and going through one's daily activities in a split-off, mechanical fashion (Hazell, 2003).

Kernberg (1975) also highlights the difference between the two concepts of emptiness and loneliness, which at times can be confused in a clinical context: "loneliness implies elements of longing and the sense that there are others that are needed, and whose love is needed and who seem unavailable now." If this longing were present, the individual would not feel empty. Emptiness is the lack of others without the realization of the lack or the longing to fill the lack (Hazell, 2003). In general, Kernberg (1975, p. 220) posits that: "The experience of emptiness represents a temporary or permanent loss of the normal relationship of self with the object relations, that is, with the world of inner objects that fixates intrapsychically the significant experiences with others and constitutes a basic ingredient of ego-identity Therefore, all patients with the syndrome of identity diffusion (but not with identity crises) present the potential for developing experiences of emptiness." The author hypothesizes that the experience of emptiness could be different depending on the personality experiencing it, and he describes the feeling of emptiness as it may occur in four personality types (depressive, schizoid, narcissistic, and borderline), arguing that its form, intensity, and etiology will differ for each type. While Kernberg interprets the experience largely in terms of object relations, Heinz Kohut (1977, p. 243) uses the framework of "self psychology" to explain this experience: "The psychology of the self is needed to explain the pathology of the fragmented self and of the depleted self (empty depression, i.e., the world of unmirrored ambitions, the world devoid of ideals)." He argues that the experience of emptiness is a symptom of narcissistic personality disorders (NPDs). The self-structure matures gradually in response to optimal failures in mirroring and idealized figures. If the failures are sub-optimal, the self-structure becomes friable and labile. One of the experiential outcroppings of this is the experience of emptiness, especially in the face of criticism or lack of warmth or acclaim from the environment. Kohut argues that very often, in response to early traumatic environmental failures, reactions develop, very often in the way of a soothing mechanism, to cope with, and alleviate the pain of the inner emptiness (Hazell, 2003). On occasion, a person will develop "a psychic surface that is out of contact with an active nuclear self" (Kohut, 1977, p. 49). This concept sounds extremely close to the concept of "false self

system” proposed by Winnicott (1965a,b) and developed by Laing (1969). The false self is like a mask or set of clothes, donned to adapt to society but cut off from the individual’s real self that lies hidden, even to the individuals themselves. This psychological state can lead to frequent experiences of emptiness: When the person attempts to discover his or her “true feelings,” he or she is so alienated from them through habit that he or she draws a blank and feels empty (Hazell, 2003).

Among the symptomatic responses to the experience of emptiness, Kohut cites the following: an excessive interest in words, pseudovitality, compulsive sexuality, addictions, and delinquency. Each of these is a reaction to the inner experience of emptiness and is employed as a means of counteracting the experience in some way. Kohut also posits that young adulthood and middle age are the critical testing grounds for the cohesiveness of the sense of self, and there are thus times when the individual is especially prone to experiences of emptiness.

Subtle variants of these psychodynamic explanations for the experience of emptiness, basically growing out of “object relations theory,” can be found in a number of other works. Bowlby (1980) follows the thought of Winnicott in that he connects feeling of emptiness with the experience of loss. “Numbness” and “emptiness” are, in Bowlby’s model, the first phases of the human being’s reaction to a loss. For Bowlby this loss is confined to a loss through death. He argues, however, that a small loss may act as a trigger for a prior, more serious loss. Bowlby also offers a hint at an explanation for the feeling of emptiness or numbness although he does not propose it as such. He cites the disruption of habitual responses that occur to the person who has recently experienced a loss. This, in turn, leads to a vague sense of disorientation, much akin to the disorientation Bowlby mentions in his earlier works on attachment and separation (Bowlby, 1980, p. 94).

Feelings of Emptiness and Essential Needs

Other valuable hypotheses have been suggested by Almaas (1987) and Trobe-Krishnananda (1999). Almaas (1987), in the chapter called “The Theory of Holes,” describes how energetic holes develop inside when an essential need is not met as a child. A hole is a feeling of emptiness inside in relation to some aspect of our being that was not nourished and therefore not developed. According to Trobe-Krishnananda (1999), because it is frightening and uncomfortable to feel these holes, we spend much of our time and energy in our daily life unconsciously trying to fill them. Much of our behavior is directed at getting others to fill them. There may be many reasons that these holes exist; many of them can be difficult to explain, but they are probably directly related to basic needs that remain unfulfilled. Although there is really only one hole inside, the author makes distinctions to help with clarity. Those of us who did not receive the support we needed to find out who we were may develop a *support hole*. When we did not get the recognition we needed, we have a *recognition hole*. We can have a *worthiness hole* when we feel that we are not good enough as a person or when we don’t feel special or respected. In this latter case, we then hunger for someone to validate us with the hope that the hole can be filled. We may develop holes related to being perfectionists and self-critical or to having deep fears of survival; we

may have holes connected to feeling unwanted and abandoned or to getting warmth, touch, and closeness; in this case, we become dependent on someone to provide that for us. We may also have a hole related to trust when we feel that opening up and being vulnerable exposes us to mistreatment, control, or manipulation by another.

The intensity and effects of these holes and the degree to which they can affect the development and life of an individual may depend on the particular way in which he or she is able to deal with this experience. In some cases, these holes create a *co-dependency* in which individuals continually push other people away while longing for closeness at the same time. Our holes create deep anxiety and our life becomes a constant unconscious compulsion to fill them. Every hole creates a dependency on the outside in some way, either by desiring another or a situation to fill it or by avoiding a person or situation because of the hole. Our holes have a powerful effect on the type of people and situations we attract. We have a compulsion to create situations that provoke our holes because that is often the only way we become aware that they are there. This is the way that we can learn about and develop what is missing inside. We need the challenge to grow (Trobe-Krishnananda, 1999).

When we don't have awareness or understanding of our holes and the way they are affecting our lives, we naturally feel that something on the outside has to change for us to be happy. This is one of the cardinal beliefs of what the Trobe-Krishnananda has called "emotional child" - an inner experience of self, derived from the childhood wounds and negative experiences full of fear, shame, and mistrust and covered with compulsive behavior. For example, people can find themselves repeating the same painful patterns in their relationships without understanding why; they can become lost in addictive behavior, or they may have repetitive accidents or illnesses or sabotage their life repeatedly (Trobe-Krishnananda, 1999). Because of the emptiness inside, when individuals are identified with the *emotional child*, they experience themselves as needy. It is not real, but it leads to their believing that life or others have to fill the hole. People have to start treating us better or give us more recognition, love, space, attention, and so on. Another reaction is that individuals try to fill the holes with things that make them feel better such as drugs, objects, or entertainment. It can be very difficult to find other ways to end the discomfort, pain, anxiety, and fear that holes cause, without filling them from the outside. People can realize that the efforts to fill the holes from the outside never work - it only creates deeper frustration. What does work is beginning to understand our holes - what they are, where they come from, and how we can fill them. To do this, it could be helpful to have a look at what the author calls "the essential needs".

As a child, we each have essential needs (see also Bowlby, 1980). When these needs are not met, we could live in a constant state of deprivation. That deprivation is the hole inside, longing to be filled. While the degree and types of deprivation vary, we all share a common experience of deprivation in some form. From our deprivation, we unconsciously project our unmet needs onto our lovers, children, close friends, and those we work with - in fact, on anyone with whom we relate. The closer the connection, the deeper the projection. The experience of being deprived is universal, and it is an important rite of passage. People usually start out in a state of

denial, in which they are not even aware that they were deprived of certain essential needs or how. Trobe-Krishnananda (1999) highlighted some of individuals' *essential needs*: the need to feel wanted and to feel special and respected; the need to have our emotions, thoughts, and perceptions validated (see also Chapter 11 in this volume); the need to be encouraged to discover and explore our unique aptitudes and turns, sexuality, resourcefulness, creativity, joy, silence, and solitude; the need to feel secure, protected, and supported; the need to be physically touched with loving presence; the need to be inspired and motivated to learn; the need to know that it is right to make mistakes and to learn from them; the need to witness love and intimacy; the need to be encouraged and supported to separate; and the need to be given firm and loving limits and boundaries. This list is where an individual's deprivation comes from, and it is ever present. It is interesting to notice that when one starts a relationship with another person, very often he or she is unconsciously experiencing these unmet needs. When there is no awareness, the individual automatically moves into one of five behavioral patterns of the emotional child: reaction and control, expectation and entitlement, compromise, addictiveness, or magical thinking (Trobe-Krishnananda, 1999). For this author, the starting point for overcoming these holes, and feelings of emptiness, is recognizing how automatically people try to fill them from the outside. This process of watching and understanding releases energy to break the automatic behavior and just be with the experience of emptiness when it is provoked. This means feeling it and letting it be there without trying to fix or change anything. Mindfulness, as we will see in the last part of this chapter, can be the core strategy to developing this non-reactive attitude.

Mindfulness and Emptiness: The “Paradox” of Meditation

If you say you are somebody, you are attached to name and form,
so I will hit you thirty times.

If you say you are nobody, you are attached to emptiness,
so I will hit you thirty times.

What can you do?

Soen Sa Nim (Cited in J. Kabat-Zinn, *Coming to Our Senses*)

As we mentioned in the introductory paragraph, the aim of this chapter is to theorize a possible clinical use of mindfulness to treat the pathological feeling of emptiness. To be able to speak about the relationship between mindfulness and emptiness, it is essential to know how it is conceived within the psychological and philosophical approaches and traditions that have given origin to meditative practice.

The concept of emptiness in Eastern psychology and culture is totally unrelated to that of the West, especially considering the negative value that is commonly ascribed to it in the West. An analysis of the classical texts of Taoism or Chinese Buddhism is enough to conclude that the Christian-Western concepts are basically opposite of those illustrated in Eastern thought.

The majority of Buddhist schools share a series of basic common principles. What interests us is called *Sunyata* (Sanskrit), generally translated into English as “emptiness” or “voidness.” This is a concept of central importance in the teaching of Buddha since a direct realization of *Sunyata* is a

requirement for achieving liberation from the cycle of existence (*samsara*) and full enlightenment. Widely misconceived as a doctrine of nihilism, the teaching on the emptiness of people and phenomena is unique to Buddhism, constituting an important metaphysical critique of theism with profound implications for epistemology and phenomenology.

Sunyata means that everything one encounters in life is empty of absolute identity, permanence, or “self.” This is because everything is interrelated and mutually dependent – never wholly self-sufficient or independent. All things are in a state of constant flux where energy and information are forever flowing throughout the natural world giving rise to themselves undergoing major transformations with the passage of time. This teaching never connotes nihilism – nihilism is, in fact, a belief or point of view that Buddha explicitly taught was incorrect – a delusion, just as the view of materialism, is a delusion. In the English language, the word emptiness suggests the absence of spiritual meaning or a personal feeling of alienation, but in Buddhism the emptiness of phenomena enables liberation from the limitations of form in the cycle of uncontrolled rebirth. Kabat-Zinn (2005, p. 180) explains the concept:

People can get scared even hearing such a thing, and may think that it is nihilistic. But it is not nihilistic at all; emptiness means empty of inherent self-existence, in other words that nothing, no person, no business, no nation or atom exists in and of itself as an enduring entity, isolated, absolute, independent of everything else. Nothing! Everything emerges out of the complex play of particular causes and conditions that are themselves always changing. This is a tremendous insight into the nature of reality.”

Further he posits that “Emptiness is intimately related to fullness. Emptiness doesn’t mean a meaningless void [...] emptiness is fullness, [...] is the invisible, intangible “space” within which discrete events can emerge and unfold. No emptiness, no fullness.”

Rawson (1991) states that “One potent metaphor for the Void, often used in Tibetan art, is the sky. As the sky is the emptiness that offers clouds to our perception, so the Void is the ‘space’ in which objects appear to us in response to our attachments and longings.” The Japanese use of the Chinese character signifying *Sunyata* is also used to connote sky or air.

Sunyata is a key theme of the *heart sutra* (one of the Mahayana Perfection of Wisdom Sutras), which is commonly chanted by Mahayana Buddhists worldwide. The *heart sutra* declares that the skandhas, which constitute our mental and physical existence, are empty of any such nature or essence. However, it also states that this emptiness is the same as form (which connotes fullness), that this is an emptiness which is at the same time not different from the kind of reality which we normally ascribe to events, and that it is not a nihilistic emptiness that undermines our world, but a “positive” emptiness that defines it.

The inability to experience emptiness (*Sunyata*), considered as the true nature of reality, would represent a sort of primordial ignorance of the human being (*avidya*). When this happens, it is called *nirvana* (the awakening) in Buddhism. This concept is a central part of all the Buddhist psychology, so much so that the teachings of Buddhism on the nature of reality develop in order to help understand this vacuity. Mark Medweth (2007) explains

this notion of emptiness in Buddhism: “Emptiness has been a term used to describe many psychological states in the West, including the confusing numbness of the psychotic, incomplete feelings of the personality disorders, identity diffusion and existential meaninglessness (Epstein, 1989). Buddhists, however, refer to emptiness as the ultimate reality. Emptiness assumes a defining role in the notion of ‘self’; it is the experience of emptiness that destroys the idea of a continuous, independent individual nature. Unlike many Western misconceptions, emptiness is not an end in itself nor is emptiness considered real in a concrete sense but merely a specific negative of inherent existence (Epstein, 1988). While the ordinary consciousness perceives things as permanent and independent, Buddhists would counter that perceived phenomena are interdependent and thus empty of permanence and without an identity based on their own assumed nature (Komito, 1984). In relation to the sense-of-self, in Buddhism, emptiness does not imply (as Westerners have often interpreted) the abandonment or annihilation of the ego, ‘self,’ or ‘I’ but simply a recognition that this ‘self’ actually never existed at all (Epstein, 1989). Buddhism is not an escape from the world but simply a refusal to extend or exaggerate the importance of conventional reality. In so doing, the mind becomes empty of struggle, allowing us to see things as they are in an ultimate sense. Thus, in Buddhist psychology, the empty quality of the mind is regarded as the true nature of a person.” Therefore, a translation of this mental and experiential state in Western terms is what we called “*mindemptiness*”.

The Feeling of Emptiness as an Indicator of Psychopathology

There are many psychological disorders in which the feeling of emptiness generally presents itself as a transitory symptom (e.g., eating disorders, obsessive compulsive disorders, PTSD, schizophrenia) or as a rather stable phenomenological condition (personality disorders). Describing all these disorders is beyond the scope of this chapter, so we will limit the following discussion to pathologies where the feeling of emptiness often appears to be a central and recurrent experience of the pathology.

Personality Disorders and Emptiness

All clinicians who have worked with personality disorders are familiar with the relationship between this type of disorder and the experience, often reported by patients during sessions, of the feeling of emptiness. The descriptions, the hypothesized causes, and the consequences of experiencing these sensations vary greatly even within the different disorders in Axis II (DSM-IV, 1994). We will now try to discuss what “emptiness” means when we come across a patient with a specific personality disorder.

Borderline Personality Disorder

The main characteristics of BPD, as reported in the DSM-IV (APA, 2000), are a pervasive instability condition of interpersonal relations, self-esteem, and mood and a marked impulsiveness, with onset in early adult age and occurring in several contexts. Among all the diagnostic criteria of the disorder,

criterion 7 specifies, “These individuals can be affected by chronic feelings of emptiness. They are easily bored, they are continuously searching for something to do.” This state, as well as anger, has been a specific characteristic of this disorder since its first formalized empirical descriptions (Fiore & Semerari, 2003). Kernberg (1975), in his descriptive analysis, considers it a minor criterion. Other important authors like Gunderson and Singer (1975) or Spitzer (1975) consider this diagnostic criterion a discriminating feature of this disorder.

As previously pointed out, several authors in the field of cognitive-behavioral therapy think that the experience of emptiness in BPD can be a sort of dysfunctional avoidance strategy in situations of clear subjective suffering and associated with a major risk of abuse or injuries to self and others (Beck, Freeman et al., 1990; Linehan, 1993; Young, 1987). According to Fiore and Semerari (2003), the perception, in this type of patient, of the “unworthy self” and the “vulnerable self” can expose them to intolerable pressure. At times, patients succeed in escaping this pressure, detaching themselves from everybody and everything and entering into a state of numbness. This is the condition where frequent suicide attempts and self-injuries occur more frequently, representing a state of complete detachment from the world or a way to evoke such detachment. Other times, according to these authors, the emptiness can be perceived as “a painful sense of lack of purpose.” In these cases, patients tend to react by raising their level of arousal, for example, seeking promiscuous sexual relationships, dangerous acting out, and alcohol or substance abuse to the point of no return or bulimic crises.

From a psychodynamic perspective, Pazzagli and Monti (2000) for research purposes consider that two of the criteria listed in the DSM-IV for BPD diagnosis, chronic feelings of emptiness and efforts to avoid abandonment, can be appropriately grouped together in the concepts of “solitude and emptiness.” According to the authors, the borderline person functions via osmosis: He is empty but, at the same time, intolerant of a solitude in which he keeps looking for objects to fill this inner sense of emptiness. The solitude of the BPD patient is actually an intolerance of true solitude, the solitude of being able to be alone. It is a solitude dominated by emptiness: a void in the outside world, made up of inadequate objects, sporadic, stormy, and superficial relationships prone to sudden break-ups, and a void in the inner world, always subject to the threat of rupturing and the loss of limits.

In a research study conducted by Rogers, Widiger, and Krupp (1995) aimed at identifying the qualitative differences of depression diagnosed in patients with BPD and others, the most frequent aspects associated with depression were found to be self-condemnation, emptiness, abandonment fears, self-destructiveness, and hopelessness. The authors conclude that the depression associated with borderline pathology is unique in certain aspects. The implications of the study outline the importance of considering the phenomenological aspects of depression, among which is the experience of emptiness, in the BPD. Leichsenring (2004) reports the following in another study: “Clinical observations suggest that depressive experiences in patients with borderline personality disorder have a specific quality. These experiences are characterized by emptiness and anger (‘angry depression’).” In this study, this observation was tested empirically. Westen et al. (1992) found an interpersonally focused “borderline depression” that was phenomenologically

characterized by emptiness, loneliness, despair, and an unstable negative affectivity. The quality of the depression may also have consequences for pharmacotherapy (Westen et al., 1992, p. 391). The qualitative experience of depression (e.g., emptiness or anger) may influence a patient's reaction to drugs more strongly than the diagnosis (depression).

Narcissistic Personality Disorder

The essential characteristic of NPD is a pervasive picture of grandiosity, necessity of admiration, and lack of empathy, with onset in early adult age and present in a variety of contexts (DSM-IV, APA, 2000). On the whole, we can say that the authors studying the disorder can be divided into those who describe some subtypes (Gabbard, 1989; Millon, 1999) and those who lean more to a Horowitz-type interpretation assuming that a subject experiences a set of multiple distinct mental states. These authors observe how the narcissists oscillate between states of grandiosity, emptiness, shame, anguished depression, and dysregulated affect with acting-out tendencies (Horowitz, 1989; Young & Flanagan, 1998; Dimaggio et al., 2002). A substantial agreement exists between the various authors: It is most probable that the narcissist experiences on the whole mental states described in the literature and that the diagnosed subtype is characterized by the most important and manifest of mental states. Dimaggio et al. (2002) have identified in their work four mental states: grandiosity, transition, frightening depression, and devitalized emptiness. In this state of devitalized emptiness, the emotional experience is completely shut down; not only are feelings of weakness and fragility "sco-tomized" (obscured, clouded), but also feelings overall are. Subjects feel cold, detached, distanced from others and from their own inner experience, and they perceive an almost unreal world; their body is annoyingly far away and they are anhedonic. The experience is not at all intensely unpleasant; for a long time narcissists dwell in this state where they are untouchable, not subject to self-esteem fluctuations and to the complex, annoying, and incomprehensible demands of others.

The fantasy of success and almightiness can fill up mental life even though these subjects lack the triumphant echoes overwhelming the state of grandiosity. The aims are mostly inactive. This state largely coincides with the clinical descriptions of Modell (1984), which describes patients as being closed up as if in a "cocoon." In the long run, this state becomes ego-dystonic: The subject perceives life as empty and boring, the emotional coldness touches him, and his need for relationships surfaces unconfessed (Dimaggio, Petrilli, Fiore, & Mancioffi, 2003).

The sense of emptiness as an important and distinctive experience in NPD has been indicated by a large number of authors. Forman (1975) made a summary of the characteristics that emerge from the descriptions of Kohut (1971). The most important are low self-esteem, a tendency to have hypochondriac episodes, and a feeling of emptiness or a deficiency of vital force. Millon (1996) gives us the following description of the narcissistic prototype at a biopsychological level in clinical settings: "the narcissistic personality presents a general indifference, unflappability, and fake tranquility. . . except when his narcissistic confidence is threatened, where brief demonstrations of anger, shame or feelings of emptiness appear." Millon identifies rationalization as a mechanism of defense in NPD; if the rationalization fails, these

individuals often feel rejected and embarrassed, and experience feelings of emptiness. Kernberg (1975) explains how the experience of emptiness in narcissists is characterized by the addition of strong feelings of boredom and restlessness: “Patients with depressive personality and even schizoid patients, are able to empathize deeply with human feelings and experiences involving other people, and may feel painfully excluded from and yet able to empathize with love and emotion involving others. . . patients with narcissistic personalities, on the other hand, do not have that capacity for empathizing with human experience in depth. Their social life, which gives them opportunities to obtain confirmation in reality or fantasy of their needs to be admired, and offers them direct instinctual gratifications, may provide them with an immediate sense of meaningfulness, but this is temporary. When such gratifications are not forthcoming, their sense of emptiness, restlessness and boredom take over. Now their world becomes a prison from which only new excitement, admiration, or experiences implying control, triumph or incorporation of supplies, are an escape. Deep emotional reactions to art, the investment in value systems or in creativity beyond gratification of their narcissistic aims, is often unavailable and indeed strange to them” (1975, p. 218)

Schizoid Personality Disorder

The essential characteristics of schizoid personality disorder are a pervasive condition of detachment from social relations and a restricted range of emotional experiences and expressions in interpersonal contexts. The onset of this condition is in early adult age, and it is present in a variety of contexts (DSM-IV, APA, 2000).

Kernberg (1975), as previously indicated, thinks that the experience of emptiness varies in form, intensity, and etiology in relation to the type of personality disorder affecting the patient. Even in schizoid disorders, specific characteristics of emptiness are obviously present. According to the author, these individuals can experience the emptiness as an inborn quality that makes them different from others: “in contrast to others, they cannot feel anything and they may feel guilty because they do not have feelings of love, hatred, tenderness, longing or mourning which they observe and understand in other people, but feel they cannot count on to experience themselves” (1975, p. 215). For these schizoid patients, the experience of emptiness can be less painful than for the depressed because the contrast between the periods when they feel empty and those when they would like to have emotional relations with others is less violent. A feeling of inner fluctuation, of subjective unreality, and the appeasement derived from this same unreality make the vacuous experience more acceptable to schizoids, allowing them to fill in time with the awareness of external reality opposed to their subjective experience.

Depression and Emptiness

Many people who come to therapy complain about having a senseless life. Their words express the idea of deep and anguishing “emptiness” leading them to wish for death as a liberation from this state. These patients often suffer from depression, and what has been described is only the manifestation

of one of the many emotional, cognitive, and physical symptoms marking the disease.

Maureta Reyes (2007) defines this existential emptiness as:

the feeling of a lack of a sense in life, of tediousness, of not knowing the reason for living, leading to isolation and impoverishment of the relation with family and society [...] patients with this problem, usually experience moments of strong tension and anxiety attacks without a valid reason, they worry about everything, but nothing seriously, they have lost the motivation and interest for everything and this makes them think that living is the worst thing that can happen to them. When this situation is prolonged, becoming more intense, it can lead to suicide.

This type of experience, described as such, appears more frequently in certain periods of life, for example, during old age, retirement, or the course of a terminal illness, or in the so-called empty-nest syndrome when adult children abandon the family home. In the latter case, women, seeing their role as mothers ending – their children having little need for them and their husbands busy at work, spending little time with them – are more prone to feeling depressive symptoms and a sense of emptiness. Old age, though, is surely a period where this type of feeling of emptiness becomes more present. Faced with fears associated with becoming old, such as isolation, solitude, physical decline, no longer being desired, uselessness, the loss of every role in society or in the family, and illness, it is easy to imagine how the lack of one's own sense of life leads to experiencing emptiness.

The feeling of emptiness in depression is often associated with significant experiences of loss (see also Bowlby, 1980), above all in conjunction with a first depressive episode (see also Chapter 12). In some cases, the feeling of emptiness is connected not only to what is no longer there, but also to what will no longer be there in the future.

In the following case example, a 41-year-old depressed patient describes her deep sense of emptiness derived from the loss of her 15-year-old son who died tragically in a car accident:

I would never have thought that, from one day to another, life could change so violently and destructively. With N's death, I find myself having to reinvent everything, fighting against this harsh reality, with all its emotions and feelings. It is unthinkable that he is no longer here with me and that he has left this immense emptiness just in this moment: a life yet to start, come to a sudden end by such an unfair destiny.

The pain is so great that with its presence, it is actually physical every time I think of the things N. liked and loved to spend his time on, his determination and will to live. It's like suddenly opening a door without expecting to find someone there: an icy wave, a shock which rises up from my feet and leaves me momentarily incredulous that all this belongs to me. A great weakness is left behind and a loss of feeling pervades my arms and hands. I get a tingling which becomes all one with a pain in my stomach as if it were knotted. These are very hard moments that make me realize that I'll never have him near me again. This great emptiness that I perceive projects itself not so much in my past memories which are alive, but based on the fact that I will never experience some situations or

share them with him. There is only emptiness when I think I'll never be able to listen to his secrets, there won't be any requests of advice, I won't be able to see him growing up, becoming a man. I won't be able to get excited about his first love, a disappointment, a defeat or a victory. There will only be the lack of a relationship based on participation, bonding, joining of forces that was just starting and I was really waiting for. Why has all this been denied me? Everything has become null and void when I think of all that has been left suspended: it's like an abnormal condition in my life that I don't know how long will last. It's as if, while I'm watching a TV programme, this suddenly changes and I'm left here waiting in vain for everything to go back to normal, to the previous programme.

In this patient, like in other individuals suffering from major depression, the deep and overwhelming feeling of emptiness was determined on the one hand by what was no longer in her life, but on the other hand by the loss of what there would not be in the future and that never more will be, that is, the ineluctable interruption of a plan, a *loss in the future*.

How Mindfulness Can Help to Deal with and Overcome the Feeling of Emptiness

There is nothing greater than anything else

Plutarco, *Adversus Colotem*

Mindfulness as an Anti-avoidance Strategy

If we hypothesize the feeling of emptiness as a sort of emotional avoidance of a phobic stimulus situation (negative emotion), it is then right to think that the treatment should include the exposure to the stimulus provoking fear in the absence of the feared consequences. During this exposure, the patient is asked to pay attention to the stimuli that he or she usually systematically avoids in a controlled way, showing him or her with the same stimuli (imaginatively or in vivo), thereby hampering avoidance so that the patient can experience the harmlessness of the stimulus.

It is assumed that exposure causes habituation to the stimulus or a process of extinction of the avoided reactions, favoring the emotional coping, that is, preparing the subject to face the emotions resulting from feared situations. Baer (2003) affirms that among the mechanisms explaining the clinical effectiveness of mindfulness, one of the most important is experimenting through exercises a form of "exposure" to various types of information (exteroceptive and interoceptive) that are usually avoided and/or suppressed. Kabat-Zinn (1982) used mindfulness on patients affected by chronic pain. The author has stated that guiding patients to develop a non-judgmental attitude with respect to their own feelings of pain, and helping them to curiously observe them without reacting impatiently or intolerantly, resulted in a significant reduction in suffering, not related to the sensory perception of pain but to their own emotional reactivity (aversion) toward the perceived feelings. This can be considered an extended exposure associated with an

attitude of acceptance of physical pain. The result would be an increase in tolerance toward the suffering and a reduction in the reactive emotionality.

Linehan (1993) starts from the theoretical assumption that BPD emotional distress is mainly derived from secondary responses (e.g., deep shame, anxiety, anger, or guilt) to the primary emotions that often, instead, would be adaptive and context appropriate. A reduction in this secondary stress requires exposure to primary emotions in non-judgmental circumstances. In a similar context, awareness and non-judgmental attention toward one's own emotional responses can be considered a technical exposure. The basic concept is that exposure to intense or painful emotions, without associating negative consequences, will extinguish their ability to stimulate negative secondary affects. If a patient judges negative emotions as "bad" or "wrong," it is obvious that every time he or she experiences them, he or she will have feelings of guilt, anger, and/or anxiety. Adding these feelings to an already negative situation will only increase the patient's distress and will only make it more difficult to put up with the anguish. Mindfulness is the ability to ensure or the set of skills capable of ensuring that the patient enacts this form of perception, taking advantage of all the assumptions needed for it to be effective. During the practice of mindfulness, we can keep frequency and duration of the exposure under control. The exercises can be guided so that they will be clearly specified and last long enough. Intensity can also be managed by leading patients to set their non-judgmental attention and awareness on elements outside themselves and far from anxiety-producing stimuli: As they progress in the process, they bring themselves closer to their physical sensations, thoughts and, lastly, to their negative emotions. The validating environment, during mindfulness training, accepts any experience originating from practice, informing patients that accepting reality does not necessarily mean approving it.

Exposure is probably not the only active factor in the process of mindfulness clinical effectiveness that could refer to the experience of emptiness. The mechanisms implementing these effects are in our opinion closely related to the development and initiation of meta-cognitive processes regarding the aforementioned experience.

Detachment and Decentering

One of the more important processes in the state of mindfulness is detachment (*detached mindfulness*; Wells, 1997, 2000, 2006; see also Chapters 5 and 11). According to the author, this attitude would be characterized by meta-awareness (a form of objective conscience of thoughts), cognitive decentering (acquired consciousness that thoughts are just thoughts, not facts), attentive flexibility (self-regulation of attention including both *sustained attention* and *skills in switching*, and meta-attention; see also next paragraph and Chapter 11 of this volume), low levels of conceptual processing (low levels of inner dialogue), and a low level of coping behaviors aimed at the avoidance or reduction of the threat. This is the equivalent of affirming that the patient becomes aware of his or her feelings mainly due to the ability to observe them, implementing a decentering from them, and developing a better understanding of his or her own cognitive functioning.

Self-Regulation of Attention

Bishop et al. (2004) consider self-regulation of attention to be central among the main cognitive processes that lead to mindfulness (see also Chapters 5 and 11 of this volume). Wallace and Shapiro (2006) also say that there are two types of attentive ability: One deals with the ability to continuously support voluntary attention on a familiar object without forgetfulness or distractions; the other, called “meta-attention,” refers to the ability to monitor the quality of the attention, quickly recognizing if he or she has yielded to sluggishness or excitement. The concept of self-regulation of attention would then include three sub-functions: the ability to shift attention from one content to another, the ability to stay focused on a single object, and the meta-attentive ability leading to recognizing the moments where the attention has shifted toward other mental objects. In the process of dynamics, the self-regulation of attention constantly interacts with two other factors: the unconditioned openness of behavior toward the tried experience (acceptance equanimity) and the continual consideration given to the functional objectives of the momentary task (intention). The self-regulation of attention becomes extremely useful in helping subjects to focus on the components of the experience of emptiness, overcoming the difficulties that are often present in deciphering their own emotional and cognitive state.

Acceptance

Acceptance, another basic component of the state of mindfulness, has an essential role in allowing the patient to stay in touch with his or her own experience of emptiness, thus allowing the exposure to painful stimuli, whichever they are. Acceptance allows the patient, in a state of psychological openness and willingness, and through a gentle curiosity to approach various sources of aversive stimulation that has till that moment caused the person behavioral patterns of escape, refusal, or avoidance. For Hayes (1994), acceptance is a position relative to which previously intrinsically problematic or painful events become an opportunity of personal growth and development. Donaldson (2003) and Wells (2002) consider it a meta-cognitive process operating at a higher level than that of immediate experience, a “meta” level implying the direct perception of thoughts, feelings, or intentions of purpose.

Accepting is receiving, welcoming the experience of the moment, staying fully in touch with one’s own thoughts, emotions and physical feelings, without reacting to and developing a decentered ability to observe them. Acceptance gives us the possibility to see our experience in the moment as it really is. However, accepting does not actually mean appreciating what we accept. The experience of emptiness could for a certain period of time be admitted and accepted. This would give the patient the opportunity to observe the consequences of this contact without negatively labeling it through judgment.

In a state of acceptance, the person recognizes that some aspects of the experience cannot be changed while he succeeds in realizing the elements that can. The patient will, therefore, channel his or her energies toward these

latter ones, trying to *respond*, where possible, through a thoughtful action, rather than *reacting* (with automatic and impulsive actions) to the distressing experience in order to reduce, and often cancel out, the aversive psychological component of the experience. All the signs that accompany the experience of emptiness are usually submitted to meta-evaluation (a meta-cognitive process) by the subject; that is, they are affected by a negative meaning considered highly disagreeable or unbearable, leading the individual to various attempts of suppression or avoidance. Unconditioned acceptance would be a different way to relate to the experience that would reduce cognitive avoidance, thereby eliminating one of the factors responsible for the suffering (Didonna, 2007).

Letting Go

Letting go is the ability directly connected to acceptance that can fail to be immediately experienced when the patient comes into contact with certain disagreeable thoughts or feelings. Kabat-Zinn (1990) states that in the practice of meditation, we deliberately put aside that part of the mind clinging to certain aspects of our experience and reject others. The non-attachment, the letting go, is a form of acceptance of the things as they are. This ability allows patients to give the same attention to all stimuli, regardless of his or her need to hold on to or distance him/herself from those aspects of the experience of emptiness that cause suffering, or “entrapping” them in a certain mental state.

Not Striving

Not striving is the attitude where the patient does not pursue any precise aim during the practice of mindfulness. There is nothing that he or she should or should not do. Nothing has to be reached. It is enough “to be” and to remain in the present, bringing his or her own attention to himself/herself. We need to ask patients not to want to attain any changes or expect to modify their own experience of emptiness. The only thing they are to do is to remain there and observe. The change, if it happens, will paradoxically be the result of not having sought it out.

Identifying the Precocious Signs of Emptiness

Another important mechanism of change of mindfulness for the experience of emptiness could be the precious aid given to the ability to identify the feelings, thoughts, or situations leading to the feeling of emptiness early. Mindfulness allows patients to gather these signs, which differ depending on each patient’s own experience, from the onset, helping to identify the suitable moment in order to use appropriate coping strategies and not to remain “entrapped” in the emptiness that leads to having to resort to dysfunctional solutions. Baer (2003) suggests that mindfulness training may promote recognition of early signs of a problem, at a time when application of previously learned skills will be most likely to be effective in preventing the problem.

Clinical Application of Mindfulness to the Experience of Emptiness

Practical Issues

A mindfulness-based intervention with patients affected from a pathological “feeling of emptiness” should be carried out by an expert therapist in the practice of meditation. In addition, the therapist should have good clinical competence with respect to all the psychological problems of the patient toward which the intervention is directed. The therapist should be ready to effectively deal with the eventual intense reactions that could be activated during the sessions, including dissociative crises and intense states of anxiety or escape.

Many patients who feel emptiness have a long history in invalidating environments where their emotions, feelings, and needs have been denied recurrently, and the only remaining inner criteria is the one labeling their own inner experience of the moment as unreliable or dangerous. It is therefore useful and important to help the patient trust and believe what he or she is feeling, in his or her own cognitive, emotional, and sensory experience, learning to listen to herself/himself. Furthermore, a regular practice of mindfulness by the patient outside of the therapeutic setting is necessary. It is vital that he/she has the possibility to find a small amount of time to dedicate to meditative practice every day (even 10–15 minutes). This intervention could be integrated in a structured mindfulness-based program (e.g., MBSR, MBCT) or form a specific independent intervention that could be implemented in an individual or group setting.

The final goal of this training is to lead the patient to explore and confront his or her own emotions, mainly anxiety, which, as we have hypothesized above, appears to be strictly related to the emptiness experienced in certain types of disorders. As suggested by Trobe-Krishnananda (1996), the objective is to penetrate the fear in depth, but with awareness, compassion, and understanding, giving value to these feelings and creating an inner space to allow patients to feel, observe, and accept.

Venturing into this layer of vulnerability is not an easy task for the patient affected by feelings of pathological emptiness. As we have previously explained, these people are used to activating a set of avoidance strategies and mechanisms in order not to feel the suffering. This “shell” keeps psychological fear and pain away, even at the cost of developing alexithymia or turning psychological suffering into a physical one, sometimes putting the patient’s life at risk.

In our opinion, approaching the emotional sphere should take place in a gradual way, with the utmost caution. The activation of emotions at a neurovegetative level is often undifferentiated and can be the same for different emotions. Any element of this activation can lead the patient back to a state of emptiness, given the strong evocative potential for emotions associated thereto. Every session, in such a structured intervention, should include a gradual increase in the level of difficulty, that is, taking the patient a little closer to the stimuli, situations, and feelings connected to emptiness. Everything has to take place in a completely acceptable and non-judgmental framework. In order to do this, we suggest starting the intervention by teaching

patients to initially focus attention on exteroceptive stimuli, which are usually less anxiety inducing, doing exercises like mindful seeing or hearing, or mindful walking (see Appendix A). Only at a later stage, during the course of the program, are they conscientiously drawn closer to their inner feelings and, therefore, to the interoceptive experiences; some exercises such as body scan or sitting meditation (see Appendix A) would be suitable for this purpose (Didonna, 2007, paper submitted for publication).

Once these abilities have been consolidated, for example, “letting go,” not passing judgment on their own experience, or “trusting” their own perceptions (see also Chapter 11), patients should be in a position to be in contact with thoughts, feelings, and negative mindsets without enacting avoidance behaviors. Moreover, during the course of the treatment, patients have the opportunity to observe their own state of emptiness, to become aware of its components, and above all, to perceive how secondary emotions and the increase in emotional reactivity in those situations have decreased, reducing the level of suffering of this experience. The patient should no longer judge or blame himself/herself for feeling what he or she feels.

Staying in Touch with the Feeling of Emptiness

At a certain point in the therapeutic program, the patient should directly face the experience of emptiness. Specific exercises can be developed to help the patient to voluntarily enter into such a state. The fear of feeling pain can keep patients distanced from their own feelings. A particular atmosphere of acceptance, presenting them with a gentle invitation to get in touch with what they fear, is required. There must be no pressure or judgment. In order to recreate this state, it might be sufficient to ask patients to remember the last time they felt this way, or the time when the feeling was so strong that they did something particular in order not to feel it. Being “with themselves” in those moments was not a pleasant feeling.

These experiences can be explored with the guidance of the therapist, helping patients to focus their attention on certain aspects in order not to let themselves go, thereby avoiding passing judgment on themselves. The most important thing is to learn to recognize what is happening, intimately bonding with what was previously avoided. The instructions could invite the patient to focus their own attention on those aspects, for example, allowing them to remain inside their experience, preventing the activation of the escape behavior, or observing how the sense of threat is perceived, or simply examining when and which type of impulses occur during the session. This could help, in some cases, to identify even the nature of their own fear connected with the feeling of emptiness (abandonment, failure, violence, judgment, and the thought that the fear will never end) more easily recognized observing the contents of thoughts in this state.

It is natural for these patients to fear being overwhelmed by the feeling of emptiness they encounter. The idea of being in contact and remaining with the feeling is terrifying. For this reason, the method used needs to be well consolidated, offering a “safe base” made up of previously acquired experiences and abilities, which are needed to deal with stimuli with greater aversive potential. The approach has to happen gradually, with the maximum sensitivity and without haste, but with the knowledge that with mindfulness

meditation, the individual needs to go through the feeling of emptiness if he or she wants to be free.

Some possible instructions that can be used in order to allow patients to better understand and stay in touch with the feeling of emptiness, in a mindful way, are the following (adapted from Trobe-Krishnananda, 1999):

1. Look over your childhood essential needs. Ask yourself: "Do I have a hole related to this need?"
 2. Then focusing on this particular hole, ask yourself: "How does this hole affect the way I relate to myself?" and "How does this hole affect the way I relate to people and life?"
 3. Staying with this hole, ask yourself: "How do I feel this hole inside?" and "Which sensations do I feel right now and where in the body?" Allow yourself to notice your feelings in this moment and realize how they are, however, different from you, they aren't you. . .breathe with them. Try to observe them, without judging them, carrying a sense of gentle curiosity toward that experience. You can approach or recede from these feelings, and finally try to let them go.
 4. Explore your needs: "What thoughts and feelings arise when you consider your needs?" (e.g., "I am weak or needy if I want this" or "I don't feel I have the right to want or need this"). Let's grant them the possibility and the necessary time to cross our mind . . .; "We accept and are compassionate toward these thoughts, realizing that when they were formed, they certainly made sense and had a function even though we have now lost them. . .let's try to think how much they need us to exist, without us they don't have strength or meaning. . .let's allow ourselves to observe and understand them without judging . . ."; "Let's give ourselves permission to immerse ourselves in our inner experience even though it hurts and causes pain, breathing together, crossing it and letting it envelop us in order to reemerge at a certain point. . .let's try to observe what happens, what changes. . .trusting our experience."
- We may also ask the patient to write down, if possible, what beliefs he or she holds inside about having or expressing these needs.
 - And eventually may ask: "What were you taught as a child about having and expressing your needs?" (e.g., "It is selfish to have needs and wants" and "Men should not have needs and wants"). "Be kind and do not judge yourself and your own thoughts. There is nothing that you need to do or not do in this moment. Just stay with yourself and your breath now, moment by moment . . .".

What Can the Instructor Do

- **Consider that sense of pathological emptiness is only the manifestation of a wider range of psychological difficulties of the patient.** According to Teasdale (2004), it is necessary to keep in mind the specificity of emotional disorders examined as well as some specific interventions likely to help the patient in the effort to modify the processes (apart from the contents) of his or her own modes of mind. Mindfulness must be used in an overall therapeutic strategy within a framework of clear understanding of the emotional problems of the patient.

- **Share with the patient a new conceptualization/formulation of his problem**, helping him or her to formulate an alternative vision of the feeling of emptiness through a cognitive-behavioral model of understanding the functioning of his or her problem. Some mindfulness-based training, like MBSR, MBCT, or ACT, use homework (ABC, self-monitoring form, diary, etc.) as a vehicle for explaining the various cognitive processes at the basis of the disorder and of their functioning modes when they occur.
- **Welcome the difficulties of the method reported by patients from the onset**. We need to use the difficulties from the beginning as an opportunity to teach new attitudes for facing the problems. Relating to the difficulties with curiosity and interest, trying to accept them rather than reject them, defines the bases for a mindfulness approach to thoughts and negative emotions, especially those deriving from experiences of emptiness.
- **Share one's own experience during the meditative practice, inviting patients to do the same**. Segal, Willians, and Teasdale (2002, p. 55) talk about the approach and attitude of the instructors observed in the MBSR mindfulness program: "the stance of the instructor was itself 'invitational'. In addition, there was always the assumption of 'continuity' between the experience of instructor and the participants (...)". The assumption was simple: Different minds work in a similar way, and there is no reason to discriminate between the mind of the person asking for help and of the person offering it.

Conti and Semerari (2003) describe *sharing* in a therapeutic context as a set of explicit interventions where it is stressed that some aspects of the patient's experience are shared or shareable by the therapist himself/herself. Sharing interventions include elements of both validation and self-disclosure. With this technique, in fact, the therapist implicitly validates the patients' experience through the acceptance and recognition of the shared dimension and, in so doing, reveals one's own mental state. However, this does in no way imply that the patients should feel forced to report their own experience. It must be clear that it is a free choice that does not affect the practice. It is enough to be present and to listen in order to take part in this intervention.

- **Eliminate any type of judgment during the practice or the sharing, and invite patients to do the same**. Often, especially at the beginning, patients tend to judge the "success" of the practice sessions, the positive or negative changes, their own feelings at the time, or their mental contents. Following the examples and instructions of the leader, they initially learn not to pass judgment on the experience of others; as the practice slowly goes ahead, they will acquire the ability not to judge themselves and their own experience, which is much more complex.
- **Communicate clearly that meditating implies the unconditioned acceptance of anything arising moment by moment**. The first thing that we can suggest to a patient is to note and record (without judging himself/herself) during the early experiences with the practice of mindfulness the moments when he or she would tend to react (or actually reacts) to the disturbing experience, noticing the type of evaluations that lead to the non-acceptance and to the dysfunctional reactions as well.

- **Refrain from offering solutions or answers.** At any time during the individual or group intervention, patients are simply asked to become aware of their difficulties and remain in contact with them. The aim is to promote acceptance, “being” and not “doing”, suggesting the detachment from a reactive way, aiming at getting results and answers to any problem.
- **Validate the patient’s emptiness experience together with all the elements connected thereto:** Validation, according to Linehan (1993), is a therapeutic strategy consisting in giving value to the subjective experience of a patient. In particular, it is needed when the individual finds himself/herself in a *self-invalidating state*, a mental state where he or she negatively judges or tries to suppress any aspect of his or her own experience, considering it dishonorable, wrong, horrible, or unacceptable by others. In this condition, totally aimed at judging or denying, rather than at understanding one’s own mental states, the patient is not in a position to reflect on it in a constructive way. The simple fact of succeeding in sharing one’s own perceptions of the feelings of emptiness, being able to feel that they are accepted, not receiving any type of judgment while they are reported, and not feeling pressured to modify or find a solution to them validates the experience as of itself.

Possible Usefulness and Effects of the Intervention

Clinical observation suggests that a mindfulness-based intervention may help a patient deal with his/her experience of emptiness in many ways. This approach might make it possible to

- identify the prodromes or the early signs of emptiness before it starts, as well as at-risk situations;
- succeed in identifying the components of one’s own “emptiness”: thoughts, physical feelings, emotional states and impulses, acquiring awareness;
- neutralize the tendency to self-invalidate one’s own experience, developing the ability to cross one’s own inner state;
- become able to remain in that state without exasperating it by activating *secondary emotions* (guilt, shame, anger) or with an escalation of anxiety;
- accept being in contact with the experience of emptiness without enacting dysfunctional behavior in order to escape it, also thanks to the awareness of its transience;
- lower the intensity of suffering experienced in the feeling of emptiness and its frequency;
- succeed in sharing what patient feels with others and accept their support.

Summary and Future Directions

The feeling of emptiness may be one of the most difficult psychological phenomena to explain and describe, but it is also not an unusual symptom to find in both normal and pathological human experience. In this chapter, the authors have tried to illustrate the state of the art present in the literature with respect to the clinical problem of emptiness and show how the concept

of emptiness is utilized in radically antithetical ways in Western psychology compared to its meaning in Eastern psychology.

The authors have proposed some hypotheses to explain the possible mechanisms of actions of mindfulness with regard to the clinical experience of emptiness. The potential clinical effectiveness of mindfulness with respect to feelings of emptiness should mostly be due to exposure to the different stimuli configuring the aversive experience, usually avoided or suppressed, most often dysfunctionally. Surely there are also other possible mechanisms of change in the potential clinical relevance of mindfulness on the feeling of emptiness. Different meta-cognitive processes are developed and strengthened during its use of mindfulness such as detachment or the self-regulation of attention. Becoming aware of what one really feels inside an experience of emptiness; identifying emotions, thoughts, and feelings related thereto; managing to observe everything by decentering; and reflecting on one's own cognitive functioning and on the consequences of the dysfunctional behavior actually mean improving the meta-cognitive functions implying controlling and regulating of one's own mental states.

Some treatment guidelines have been proposed on pathological emptiness, but it is important to stress that these interventions are never a substitute for an overall psychological therapy for the pathology that is at the root of the feeling of emptiness. Furthermore, we believe that this type of intervention must be carried out by therapists expert in the disorder presenting emptiness as a symptom and with a long and regular mindfulness practice. At the moment there are few studies that have investigated the phenomenological experience of emptiness and there are even fewer that have certified the effectiveness of the treatments carried out thereon.

Future research is needed to more thoroughly study this clinical phenomenon since it is common to numerous nosographic frames that are extremely different from one another. The importance of methodologically sound research in this area cannot be overstated as this could lead to a better understanding of the activating and maintenance mechanisms of the phenomenon, as well as how therapeutic intervention like mindfulness-based training, used for the pathology presenting these symptoms, modify and improve this challenging and disabling experience.

I am tired of being bedridden with the feeling that something must happen.

I don't understand what is happening to me. I have never been afraid of the dark: but maybe mine is not fear of the dark. I have exchanged day for night. At night I open the shutters and I always keep the light on. . .during the day I close everything in order to isolate myself from the thought that everyone is working or doing something. Lately I have started to go to bed dressed and putting the pillow on top of the blankets for thickness.

Maybe it is just a habit, I cannot look for a meaning in everything I do. In so doing, I miss out on so many things that could make me feel alive. . .Well, all these thoughts are partly a defense against those feelings of emptiness that otherwise I would experience. In other words, the truth is that inventing all these small manias and fears or choosing to live the depression is a more acceptable way of saying that you do not know what to do with yourself and your life.

Angela, a 21-year-old depressed patient

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