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Bruno Trindade

Emptiness as Symptom,
Emptiness as Healing:
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Between Buddhist and
Psychodynamic Perspectives
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ABSTRACT

Despite growing usage of meditation in Western psychotherapeutic practice, there is a divergence in the meaning of empty self-experience between psychodynamic psychotherapy and the Buddhist source of these meditative practices. In this theoretical study I propose that empty self-experience is manifold, including both beneficial and pathogenic forms, specifically the experience most prized in Buddhism as *sunyata*, and those most dreaded in personality disorders. By studying these through the theories of control-mastery and Buddhist *Abhidhamma*, I demonstrate how similar psychological processes are involved in overcoming pathogenic emptiness, on one hand, and in the achievement of *sunyata*, on the other. The findings suggest an approach to pathogenic emptiness that views it as comprised of pathogenic beliefs and employs meditation as a powerful adjunct to disconfirming these beliefs. Future research is suggested through which outcomes are compared between groups involved in control-mastery interventions for pathogenic emptiness, with the experimental group engaged in meditation.

EMPTINESS AS SYMPTOM, EMPTINESS AS HEALING:

EXAMINING THE INTERSECTIONS BETWEEN BUDDHIST AND PSYCHODYNAMIC PERSPECTVES ON NO-SELF

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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2013

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I. INTRODUCTION

"I do not teach theory. I analyze." – Buddha

The word "emptiness," when referring to an experience or a feeling, conjures up the notions of depletion, insubstantiality, hollowness, deadness, or incompleteness. A "glass half empty" is never considered a good thing even if in essence it is the exact same thing as a "glass half full." To those of us who hail from Western culture—those cultures heavily influenced by the traditions of the Renaissance, Protestant Reformation, and the Enlightenment movement of Europe and America—feeling empty is a sign that something has gone awry and we are not well. When severe, we may feel that we are empty of our very essence, our self, in conflict with the expectation that we should feel solid and substantial; it is better to be "full of one's self" than empty.

On the other side of the Earth there are those who strive for emptiness. To them, having a sense of a fixed self, solid and essential, is the primary source of suffering. Embracing transience and a relativistic view without grasping to an illusory core is the way to find true contentment and optimal psychological functioning. Rather than feeling hollow or dead, this experience makes one feel more alive and part of the world. Those who follow this line of thinking draw from any number of long traditions of Buddhist practice dating back to the 6th century BCE. The method of practice they engage in to cultivate this experience is meditation.

Meditation has become a solid fixture in many psychotherapy practices in the Western world. Thanks mostly to research on mindfulness meditation, evidence-based approaches like dialectical behavior therapy (DBT) and acceptance and commitment therapy (ACT) have rapidly become mainstream, and are widely practiced in clinical settings (Linehan, 2001; Semple & Hatt, 2012). The style of meditation referred to as "mindfulness" comes from Buddhism, and the

practice is inextricably located within a larger context that includes metaphysical, religious, cultural, and psychological frameworks and is one part of a complementary set of practices used to achieve greater and greater levels of psychological and spiritual health.

This psychological framework of Buddhism is described in some of its earliest documents collectively called the *Abhidhamma* (Aylward, 2007; Bodhi, 2000; Olendzki, 2008; Thera, 1998). This framework describes in great detail various mental states including those that are adaptive and those that are maladaptive or pathogenic. In it, the capacity for and practice of meditation is woven into the very fabric of the healthier mental states, appearing as the presence and strength of various "mental factors." It also carefully elucidates the purpose of meditation as a means of cultivating progressively healthier mental states towards an ultimate goal of complete liberation from suffering.

This goal sounds lofty and practically unattainable to the ear of one who is steeped in Western psychotherapy traditions. Even so, these traditions use the physically and emotionally calming and centering effects of mindfulness meditation as an adjunct to other psychotherapeutic techniques. The goal of these techniques is to attain an acceptable level of functioning, embracing a view that "complete liberation from suffering" is not possible. But to achieve even an average level of happiness, a strong, rooted sense of self is essential. On the surface, then, it appears that mindfulness meditation as a therapeutic technique is being used towards an opposite goal than that of its original context in Buddhism; it is a tool to save one from emptiness that leads to suffering, rather than a tool to achieve emptiness that leads to salvation. This is a startling difference between the Western and Buddhist traditions, and it gets to the very definition of mental health. It is striking that each of them employs similar techniques to what seem to be vastly different ends.

For Buddhism, the self exists, but not in a fixed and abiding way. In this way it is said to lack *inherent* existence, while it does exist *relatively*. Indeed, this is the keystone of Buddhist psychology (Huntington, 1989; Komito, 1987). This notion is referred to by the term "emptiness" (*sunyata*), and while it applies to all phenomena, its key psychological implications appear in relation to the self. In this sense, a narcissistic attachment to a fixed image of self as either *something* or *nothing* causes suffering. As Rank (1978) described it, our basic suffering is rooted in a kind of original separation anxiety, which he called a "fear of life" (p. 124). We fear what has already irrevocably happened—separation from the greater whole—and yet we also come to fear the loss, in death, of this precious individuality (Rank, 1978). Mindfulness meditation is the primary tool to ameliorate this, as espoused by the Buddha in the Satipatthana Sutta: "Monks, this is the one-way path for… the surmounting of sorrow and lamentation, for the passing away of pain and dejection, for the attainment of the true way… namely, the four establishments of mindfulness," (Bodhi, 2005, p. 281). Hence, meditation's essential position within the Fourth Noble Truth—"the means of ending suffering." Its main purpose is to cultivate the lived experience of *sunyata*, allowing one to experience the self in its relativistic and transient reality. According to Epstein (1995a), "the Buddha's teachings might be read as an attempt to establish this *reality principle* with regard to the appearing self. Just as we distort the true nature of pleasurable sensory experiences, so we also consistently distort the self-feeling, inflating or deflating it in a perpetual attempt to fix an acceptable image of self in mind" (p. 61).

By contrast, Western psychology has historically associated a strong sense of self as a hallmark of mental health. It is the natural product of the healthy functioning of the ego. Furthermore, the experience of "emptiness" is often cited as a troubling sign of emotional disturbance and is considered diagnostic of some disorders such as borderline personality

disorder (BPD). Meditation in psychotherapy is therefore primarily used in ego-supportive roles for benefits such as relaxation and managing intense affect. On the one hand, within Buddhism the primary goal of meditation is to alter self-experience (by achieving *sunyata*). On the other hand, an altered self-experience is a common therapeutic achievement. Overcoming pathogenic emptiness, for example, would involve a shift to a new self-experience. Despite this, altering one's self-experience is not the explicit goal of meditation practice within psychotherapy as it is in Buddhism.

The psychoanalyst and Buddhist scholar Jack Engler (1983) has succinctly summarized these positions: "The two great developmental achievements in the all-important line of object relations according to ego psychology—identity and object constancy—are seen by Buddhist analysis as the root of mental suffering" (p. 35). Here we see two starkly different takes on emptiness as it applies to self-experience: one of ultimate health and the other of pathology. And in each context, the same technique is being used to alleviate suffering. In other words, the same technique is used by one group to help achieve the experience of emptiness, and by the other to treat those for whom an empty self-experience is seen as pathogenic. Even more puzzling: there is evidence for improved psychological health in *both* cases (Grenard, 2008; Linehan, 2001; Shelton, Sampl, Kesten, Zhang, & Trestman, 2009).

Pathogenic emptiness is a prominent feature of many disorders, including depression and many of the personality disorders: borderline, narcissistic, and schizoid (Jorgensen, 2010; Kernberg, 1975; Singer, 1977). The high correlation between identity disturbance and suicidal ideation (Muehlenkamp, Ertelt, Miller, & Claes, 2011) makes it an especially important issue for social workers to consider in the context of psychotherapy. It is of great interest, therefore, that some techniques using Buddhist meditation have been developed specifically with some of these

disorders in mind. For example, DBT was developed with the intent of reducing suicidality in those with borderline personality organization (Clarkin, Lenzenweger, Levy, & Kernberg, 2007; Linehan, 1993). The correlation between identity disturbance and suicidality on the one hand, and the centrality of emptiness (*sunyata*) in Buddhist practice on the other warrants a close examination of the differences in between the empty self-experiences of pathological conditions (disorders) and those that result from Buddhist practice.

In this study, I examine empty self-experiences, both adaptive and maladaptive. Given the strong association in the psychological literature between identity disturbance and suicide (Singer, 1977), understanding the differences between the two is all the more crucial for clinical social workers treating clients vulnerable to pathogenic self-experiences of emptiness. If Buddhist practice is to be used to help those with these forms of psychopathology, we can begin to address the question of the different types of empty self-experience by conceptualizing pathogenic emptiness within the framework of classical Buddhist psychology. This will allow us to place pathogenic emptiness adjacently to *sunyata* and to understand the former in terms of the conceptual framework that defines the latter.

Similarly, emptiness will be examined through the lens of control-mastery theory, a psychoanalytic approach that derives from ego psychology (Silberschatz, 2005; Weiss, 1993; Weiss & Sampson 1986). Control-mastery theory (Weiss, 1993) holds the empirically-validated claim that a vast range of pathology results from pathogenic beliefs which are, in essence, the individual's attempt at adaptation. The individual is continually "testing" the veracity of these beliefs and reevaluating them. Using control-mastery theory (CMT) allows an approach to emptiness as a pathogenic belief as well as a legitimate attempt at adaptation to their relationship, surroundings, and the world in an existential sense.

It is with these theoretical lenses that I examine the vicissitudes of empty self-experience. In Chapter II, I provide a more in-depth discussion of the theoretical orientation and methodology of the study. Following that, in Chapter III, I describe and discuss various forms of emptiness, including some aspects of their psychodynamics, and provide case examples. Chapters IV and V elaborate in further detail Buddhist *Abhidhamma* and the theories of ego psychology and CMT, respectively. The final chapter, Chapter VI, examines both modes of emptiness using these theoretical frameworks and discusses the implications of my findings for social work practice and further research.

II. METHODOLOGY

"How can one know anything at all about people?" – Anna Freud

The interest of this study is in the therapeutic implications of experiences of emptiness. There are a number of reasons why an empirical approach to this is difficult. For example, conducting a controlled experiment would be unethical without understanding the risks involved in introducing intensive Buddhist mediation to subjects suffering from severe pathological emptiness. We may understand these risks better by conceptualizing both healthy and pathogenic forms of emptiness within a single framework that may be used in further studies. Such conceptualization is essential to any empirical study for collecting relevant data. A thorough conceptualization of emptiness within a theoretical framework that could be used as the basis of empirical (qualitative or quantitative) research is all but absent (Aylward, 2007). For this reason, this study takes a theoretical approach over an empirical one. In doing so, it may perhaps begin to address this gap and provide justification for further research.

The theories selected are control-mastery theory—including concepts from ego psychology with which it is closely related—and classical Buddhist psychology. Control-mastery theory (CMT) is a psychodynamic theory with a history of empirical research, making it one of the few psychodynamic therapies that may be considered evidence-based (Weiss & Sampson, 1986). It developed out of ego psychology, including and expanding upon its understanding of ego functioning and defenses. Theorists of ego psychology have done some considerable work on the condition of pathogenic emptiness. And while some notable writing has been done on non-pathogenic, healthy, emptiness from an ego psychological point of view, it is all but absent from control-mastery theory and remains mostly the purview of Buddhist thought. Buddhist psychology and practice, on the other hand, is almost entirely organized

around the experience of emptiness (*sunyata*). Although the therapeutic practices for each of these theories differ (with some striking similarities to be discussed further on), they each have a systematic, structural metapsychology that provide this study with a rich "grammar" for framing the ego functioning involved in experiences of emptiness.

Below I provide a brief discussion of terminology. Following that is an overview of the relevant aspects of the two theories mentioned above, including the way they are used to examine the phenomenon of emptiness. Finally, I discuss potential biases and strengths or weaknesses of this study.

Definitions

Self-experience. The way one experiences one's own being. It is informed by one's own past experiences, and one's understandings and assumptions. In turn, it also constitutes a framework organizing one's experience of self-in-world.

Emptiness. Emptiness may refer to wide range of subjective experience. As the focus of this study, it is meant to refer to empty *self-experience*. Although it may include a feeling or mood that may be characterized by the same term, it refers more specifically to the felt quality of one's identity or being. I use the term *emptiness* in referring to both beneficial and pathogenic forms. When necessary, I use *pathogenic emptiness* to differentiate emptiness related to intense states of suffering, such as those experienced by those with depression or some character disorders. Empty self-experiences that are not considered pathogenic in most contexts are simply referred to as *non-pathogenic emptiness*, and this category includes the more specific Buddhist concept of *sunyata*.

Sunyata. This is the Pali word for "emptiness" (lit. "nothingness" or "voidness") used in Buddhist doctrine, and this refers to the experience cultivated in Buddhist meditation which is

the antidote narcissistically-rooted suffering. Although the concept of *sunyata* applies to all existent phenomena, I use the term to refer specifically to self-experience apart from any ontological claims about *sunyata* within Buddhist doctrine. In Buddhism, the ontological emptiness of the self is referred to by the term *anatta* ("no-self"), but for simplicity this term is used only when it must be distinguished from *sunyata*.

Buddhism. Buddhism is a rich and complex tradition with many, sometimes quite divergent, paths. Although the perception in the West is that Buddhism is a meditative or contemplative tradition, there are a minority of branches that are devotional in nature (Japanese Jodo Shinshu is one example). In the present context, *Buddhism* refers to the first sort. Further, because of the central role of psychology in the contemplative forms of Buddhism we refer to, *Buddhism* is also used as shorthand for Buddhist psychology. When necessary, I distinguish Buddhism as a religion from Buddhism as a psychology.

Abhidhamma. The "higher teaching" of Buddhism is a collection of canonical texts that deal with the nature of consciousness by applying a highly methodical and detailed metapsychology. Occasionally the term may be used in adjectival form as *abhidhammic* to indicate that the accompanying term should be understood within this context.

Meditation. There are two types of meditation common to most types of Buddhism. Although distinct, the techniques are similar and they are practiced together. Even in tantric traditions that employ a great variety of techniques such as visualization practices, the two basic forms of concentration (*samatha*) and insight (*vipassana*) meditation are still a foundational practice (Hayward, 1998). The generic term "meditation" encompasses both of these types, and may also refer to non-Buddhist techniques in context. The phrase "mindfulness meditation" connotes the sense of "mindfulness" invoked by the *Abhidhamma* as a mental factor that is

honed in both types of meditation is. The phrase “mindfulness meditation” therefore refers to Buddhist meditation in general (Olendzki, 2011). When necessary, I distinguish between concentration and insight meditation in their particular roles in the experience of emptiness.

Defense mechanisms. The concept of defense mechanisms (or simply “defenses”) was originally introduced in Sigmund Freud’s structural model (Freud, 1920), and later emphasized and expanded upon by ego psychology (Freud, 1937), and plays an important role in control-mastery theory (Silberschatz, 2005). Defenses protect an individual from four kinds of psychological “danger” arising from id/ego/superego conflicts, interpersonal conflict, conflict with social norms or institutions, and disruption of psychological equilibrium due to trauma (Schamess & Shilkret, 2008). The anxiety produced from these conflicts is classified into four types according to the developmental level with which they are associated. From developmentally early to mature, these are: annihilation anxiety, fear of the loss of the object, fear of the loss of the object's love, and what's still sometimes referred to as “castration anxiety” (Freud, 1924). Correspondingly, the defenses used to combat these anxieties are classified along a developmental continuum. McWilliams (1994) classifies defenses into primary (or primitive) and secondary (higher-order) defense mechanisms. The primary defenses, while effective at reducing anxiety, often involve more gross distortions of reality and hence interfere with an individual's overall level of functioning. Secondary defenses are more adaptive, often more transient, and cause less dysfunction. Even someone who has successfully developed higher-order defenses may still have recourse to earlier defenses when faced with significant stressors.

Pathogenic belief. This is a term from control-mastery theory referring to the (usually) unconscious beliefs one has about oneself and others. These beliefs are formed in response to traumatic experience and represent distortions in the understanding of self, others, and the

relationships between the two. They may once have been adaptive, but in their present form they cause dysfunction and suffering to the individual who holds them, and often to the people in that person's life.

Testing. "Testing" is another term from control-mastery theory. CMT holds that everyone is naturally inclined to mastery, and one way this manifests is that one will test the validity of a pathogenic belief within present relationships in the hopes of disconfirming it. According to CMT, the therapeutic project is for the therapist to anticipate these tests and "pass" them, enabling the patient to disconfirm their underlying pathogenic beliefs.

Theory: Buddhism

The main concern of Buddhist psychology is exactly the same concern of Western psychotherapy: understanding and alleviating psychological suffering. This is nowhere more plainly stated than in Buddhism's most basic tenets, the Four Noble Truths:

1. That suffering is endemic to life.
2. The cause of this suffering is known.
3. Since the cause is known, it can be cured (or alleviated).
4. The Eightfold Path: the technique to alleviate suffering.

The first truth asserts that suffering suffuses our daily lives. The reason our experiences cause psychological suffering is due to the three forces of *ignorance, craving, and aversion*. *Ignorance* refers to the attribution of solidity or permanence to phenomena that are inherently transient (empty). Having attributed this solidity, in the mind there is now some "thing" which is judged to be desirable or undesirable, to be attained or denied (Aylward, 2007). *Craving* refers to the attachment to this mental image that one believes to be real (solid, permanent). This is sometimes called "desire" in the literature, but the term "craving" carries the sense of discomfort

as well as some level of unattainability of the desired object, both of which are central to the Buddhist understanding of this force (Epstein, 1989). *Aversion* is in the literal sense the opposite of craving, yet it is also in response to the misapprehended object. Both attachment and aversion lead to suffering. Aversion is self-evidently a form of suffering, while attachment leads to suffering since the object desired can never be fully attained since it does not exist in the way it is perceived. Moreover, its ephemeral nature inevitably leads to the experience of loss or disappointment. This formulation may be applied to the self-experience: the fixed image of self leads to suffering because of the mutable, impermanent nature of the self. One can be attached to a particular image of the self and averse to another, and neither is of enduring substance.

Knowing that suffering comes from craving, aversion, and ignorance, it logically follows that if we are able to mitigate these three forces, it would alleviate our suffering. The Eightfold Path is the way in which Buddhists undertake this. It is Buddhism's "psychotherapy." It can be roughly divided into three branches: *ethical conduct, mental development, and wisdom. Ethical conduct* is thought to form a foundation for the other two branches (Aylward, 2007). (There are numerous reasons for this, some metaphysical, and some practical for the monastic life that was central to classical Buddhism.) Mindfulness and concentration practices are referred to in the second branch, *mental development*, and correct understanding with correct intention (*wisdom*) the third. Correct understanding refers to, among other things, the (intellectual) acceptance that all things including mind and body are impermanent or empty. These branches are inextricably linked, and it's important to note that meditation, for example, is not pursued without correct understanding.

The practice of meditation (mindfulness and concentration—the second branch of the Eightfold Path) is the method through which the experience of *sunyata* is cultivated. But

concentration practices pre-date Buddhism, and one can take many things as the subject of concentration. This is the reason for the importance of the third branch, that meditation is undertaken with at least a conceptual understanding of emptiness, and with the purpose of deepening that understanding and experiencing its reality. This way the practitioner's attention is on the self, and eventually begins to experience its emptiness. Through years of practice, these fleeting insights become more frequent and long-lasting, and are cultivated into a cognitive framework that influences one's perceptions in an ongoing manner in daily life, allowing one to live (ideally) free from psychological suffering (Komito, 1987). In fact, an orientation around *sunyata* can be seen in all the of the Eightfold Path; for example, accepting the truth of emptiness of one's self means that one should act selflessly (ethical conduct).

In Chapter IV, the phenomenology of this transformation is discussed in more detail. It is understood through the components of consciousness as described in the canonical texts of Buddhist psychology collectively known as the *Abhidhamma*, or "higher teaching." These components are metapsychological structures used to describe both ordinary and meditative states of consciousness. This study uses these structures in conceptualizing the experience of *sunyata*, and then attempt to apply these structures to specific cases of pathogenic emptiness. Pathogenic emptiness is more readily identified in the Western psychological literature, having received much less treatment from a Buddhist perspective. One form of it in Buddhist literature comes from the discussion of the contrast between *sunyata* and nihilism; Buddhism considers the latter an experience of emptiness based on the delusional reification of voidness as an enduring “nothing.” This is referred to as the craving for "being" and the craving for "non-being"; a “narcissistic craving” for a fixed image of self as being either something or nothing:

When that [craving] occurs with the eternalist view, 'Lasting, eternal', as basis, that is

> called craving for being, for it is the lust accompanying the eternalist view that is called craving for being. And when that [craving] occurs with the annihilationist view, 'Breaking up, perishable', as basis, that is called craving for non-being, for it is the lust accompanying the annihilationist view that is called craving for non-being. (Buddhaghosa, 1976, pp. 567-568)

Theory: Control-Mastery

According to most Western psychological theories with roots in ego psychology, a strong, cohesive self is a sign that the mind and its various components are functioning well and in harmony (Singer, 1977a, 1977b). These components perform a variety of functions including testing and modifying one's understanding of the world and others, and leveraging of defenses against psychic conflict (defense mechanisms). The healthy and harmonious functioning of these components produce an integrated and cohesive sense of self. It's therefore inferred that should some of these components "malfunction," it may lead to a disturbing sense of emptiness from the lack of a cohesive sense of self.

In the clinic, the founders and proponents of control-mastery theory observed that the "malfunctioning" of ego components is correlated with unconscious pathogenic beliefs—distorted beliefs about reality and relationships causing one to engage in self-defeating behavior and leverage painful defenses against the psychic conflict caused by them. One can think of pathogenic beliefs as a sort of "pragmatic misunderstanding" of reality. They are pragmatic in the sense that these distortions occur in response to early trauma, broadly defined as painful interactions with one's caregivers or significant others. They are a way of adapting to a difficult environment. Over time their pernicious nature begins to take a toll due to their misrepresentation of others and the world at large; they do not apply to the broader context,

hence leading to maladaptive behavior and more suffering.

Although pathogenic beliefs are persistent, control-mastery theory holds that human beings have an innate drive to master them. We are constantly testing the validity these beliefs with others. Given the right environment, these tests are "passed," and pathogenic beliefs are weakened or disconfirmed. The task of the CMT therapist is to create such an environment and pass these tests, allowing the client to establish more adaptive beliefs about themselves and the world around them which, of course, alleviates their suffering.

Chapter V describes this theory in more detail, and in the final chapter the concepts of pathogenic beliefs and testing from CMT is be used to examine pathogenic emptiness as well as *sunyata*. I do so by describing the ego functioning involved in pathogenic emptiness described in the literature, then doing the same for *sunyata*. Framing eternalist or annihilationist views of self—the poles of "narcissistic craving" (Epstein, 1989)—in light of pathogenic beliefs makes available the explanatory power of testing and defensive processes from within a Buddhist framework which understands those views of self as delusional or “pathogenic” as well.

Biases

The theories I use to examine emptiness have been selected in part due to their “structural” approach to describing psychological processes. This approach is useful in grounding the discussion of the experience emptiness—an abstruse subject, especially in its transcendental forms—with tangible concepts. However, such structural approaches lend themselves to reductionism; a common criticism of Western philosophy and science (Pope, 1982) which has occasionally been leveled against the works of the *Abhidhamma* (Thera, 1989). These approaches should therefore be “held loosely” as tools for understanding, keeping in mind that the phenomena being described transcend the sometimes mechanistic language of these

theories.

Buddhism is a religion as well as a psychology. As such, its psychology is ensconced in a web of metaphysical assertions including rebirth, deities, and *karma*. Since my primary concern is in the use of Buddhist practice in Western psychotherapy, I am excluding much of its metaphysical and ontological assertions. In this I run the risk of omitting context in the same fashion that has been done in appropriating meditation to Western psychotherapy. My hope is that because focusing on experience and phenomenology is in line with much of Buddhist literature (including the *Abhidhamma*), this is an acceptable scope within the Buddhist tradition that is not antithetical to that tradition as a whole.

Some of the more rigid systemization in the *Abhidhamma* can also present some challenges in applying the system to Western scientific understandings of psychopathology. For example, the "unwholesome universal" mental factors always occur together in any so-called unwholesome state of mind. One of these mental factors is *restlessness*, which co-occurs with *suspension of conscience* and *suspension of respect*, among others (Olendzki, 2011). This suggests that one cannot be calm and relaxed while committing misconduct that involves a lack of conscience. However, in current Western understanding, it appears that many individuals who may be classified as psychopaths are able to do just that; recent scientific studies on psychopathy appear to even show a correlation between low anxiety and the willingness to endorse personal harm (Koenigs, Kruepke, Zeier, & Newman, 2011).

One can speak neither of psychoanalysis nor Buddhism without considering the role of gender. Each has its roots in patriarchal worldviews, and each has attempted to reconcile with it in different ways as it has grown and changed with modernity. Control-mastery theory was developed in the 1960s and 1970s (Schamess & Shilkret, 2008, p. 89), occurring within a period

of psychodynamic theorizing about gender consisting of what Berzoff (2008) terms as a "difference" perspective (p. 232). This perspective assumed that boys and girls assimilated to rigid gender roles from within the context of an unequal nuclear family where the mother is the primary caregiver—the "stay-at-home mom"—and the father was the "bread-winner." As a result, boys "developed their gender identities by first separating and individuating from their primary love objects, their mothers" and as a result the boy's sense of self depends upon becoming "more boundaried, more differentiated, and more autonomous than that of girls" (Berzoff, 2008, p. 234). By contrast, a girl develops a sense of self "in the context of a continuous relationship with her mother," resulting in "more permeable ego boundaries with greater capacities for empathy than do boys" (Berzoff, 2008, p. 234). The selfless, empathic, submissive role of women in this society is seen as a result of oppression from patriarchal social order. Individuation and independence being the prized developmental achievement in psychoanalytic thought, the relational and empathic aspects of women's roles were pathologized. This view was critiqued by some feminists of the time who reframed the capacity for connectedness and empathy as virtues and positive adaptations. Additional postmodern critiques of this view according to Berzoff (2008) is that it takes the privileged, white, hetero-normative position as the norm without accounting for the varieties of gender experiences and parenting including situations where there is a single parent, where both parents work outside of the home, gay couples, and people of color, for example.

CMT emerged from the psychoanalytic climate of that era and may be subject to some of the same biases. Its almost exclusive focus on pathogenic beliefs and testing allows CMT, makes it simplistic and practical enough that these issues may remain in the background. Additionally, like other psychoanalytic theories of the era, CMT holds separation and

individuation as paramount developmental achievements, and many of its formulations of pathogenic beliefs center around reasons, such as survivor guilt (Weiss, 1986), that this step has not been taken or is incomplete.

Buddhism was founded as a monastic tradition dominated by male monks or *bhikkhus*. Traditional sources speak of the Buddha's reluctance to establish an order of female monastics. When eventually he did do so, it was done with an additional 84 rules of conduct (311 for *bhikkhunis* versus 227 for *bhikkhus*) which persist in many Buddhists sects to this day. It was also more difficult for females to be ordained and subordinate to monks (Harvey, 2000). There have been many modern efforts to rectify this situation, notably in Tibetan and American traditions. Despite this, the texts and ideas from which I draw come from some of the earliest traditions of Buddhism, and therefore almost certainly were the product of an oral tradition created by men, recorded in writing also by men, and influenced by a very specific patriarchal worldview.

Race and class, too, play roles in the worldview in each of these theories. Since its inception, psychoanalysis has been mostly dominated by white and privileged men. For this reason, psychoanalysis has dealt primarily with neuroses typical for their situation in life by, for example, focusing more on childhood psychosexual development rather than the psychological impact of racial discrimination and of economic struggle. It must be noted, however, that Freud and many of his colleagues were Jewish ethnic minorities suffering persecution from the Nazi regime in the early 1930's, which undoubtedly influenced the early works of psychoanalysis and, some argue, Freud's general pessimism about human nature (Mitchell & Black, 1995).

Buddhism, on the other hand, arose among the underclass of Indian society. By emphasizing personal liberation from the rounds of rebirth, it subverted the caste system within

which there was no upward mobility; each was expected to live up to the expectations of one's own caste in order to obtain a more prosperous existence in the next life. Only after being reborn in the highest caste, that of the Brahmin, could one hope for spiritual liberation. Because Buddhism held that each individual is capable of liberation regardless of caste, it gained widespread adoption among the lower castes, many of which consisted of the darker-skinned races originally inhabiting the southern parts of India and Sri Lanka (de Bary, 1969).

As to the differing definitions of mental health in each of the theories being used, I take the stance that they are both "right," instead of entertaining the possibility that one may be "wrong" or "less right" than the other. In other words, the paper assumes that their ideals for optimal mental functioning are both accurate, and therefore compatible. While this stance is supported by evidence (Emavardhana & Tori, 1997), it is far from settled (Engler, 1983, 2003).

Strengths and Limitations

Drawing from psychoanalytic traditions that derive from Freud's lineage, there is an inherent assumption of unconscious processes. This is absent from Buddhist psychology; in this view, there are no mental processes that are not observable by consciousness. This means that any unconscious process, such as an ego defense, would be assumed to be accessible to meditative observation in the Buddhist context. Control-mastery theory comes a bit closer to this in its assertion that defenses may be lifted by the ego in response to assessments of safety. But there is still the assumption of this process occurring without the individual's explicit (conscious) awareness.

On the other hand, by drawing from *Abhidhamma* and ego psychology, psychoanalytic and Buddhist thinking are brought closer by taking a structural view of the psyche. This not only offers a unique approach to the discussion of emptiness, but it also increases the likelihood of

finding compatibility and complementarity that may enhance our visualization of the human mind, and enrich our language for describing it.

Whereas *Abhidhamma* provides a deeply detailed metapsychology with well-defined components and rules governing mental processes, CMT has a very simplistic metapsychology consisting of a handful of general concepts, and focuses on the implementation of these concepts in a therapeutic setting rather than in elaborating the niceties of these ideas in exhaustive detail. In one sense, this could imply a complementarity in using both of these lenses together. Alternatively, there is the risk that imposing a more elaborate metapsychology onto CMT involves a good deal of conjecture and assumption. This poses a weakness inherent in the approach of this paper of applying these two particular theories together.

As a Buddhist practitioner, my own experiences and beliefs have undoubtedly influenced my very decision to use Buddhism as one of the theories with which to study emptiness. I have done my best to keep my enthusiasm for the practice from influencing my application of its principles to the subject at hand. In this application of these principles, however, my years of practice and study help to ensure their accuracy and fidelity to acceptable interpretations of Buddhist teaching.

In a similar vein, my experience as a social worker in a psychotherapy setting has exclusively involved CMT-based interventions and supervision. This is simultaneously a weakness and a strength. I may have, in places, applied it with too broad a stroke and glossed over some subtleties which may be better illuminated through different clinical approaches. On the other hand, this experience lends at least a modicum of credibility in applying concepts of CMT to a phenomenon that has not explicitly been dealt with in the CMT literature.

III. PHENOMENON

"Some may feel that all things become empty, or may see the void nature of the world; others experience all things as devoid of self-entity, or that both body and mind are non-existent; while yet others really understand the truth of Sunyata." – Mahamudra

In this chapter, I discuss emptiness in its broad division between healthy and pathogenic forms. Each form of emptiness refers to a collection of different types of experience and psychological states, with some overlapping characteristics. Depending on context, emptiness commonly refers to many different experiences of the self: an emotion, a symptom, a defense, an existential state, or a desirable spiritual goal (Peteet, 2011). As a self-experience, it spans several of these references; it is a gestalt of affective experience and core identifications that comprise a cognitive schema.

What I mean by cognitive schema or cognitive paradigm is not merely a conceptual understanding of what one is, but something that is experienced as an existential reality. For example, those with schizoid personality structure

> may experience emptiness as an innate quality that makes them different from other people; in contrast to others, they cannot feel anything... An internal sense of drifting, of subjective unreality, and of a soothing quality derived from this very unreality. (Kernberg, 1975, p. 215)

In this example, experiencing emptiness as an "innate quality" is the cognitive paradigm, whereas the "internal sense of drifting" and "soothing quality" are some of the affective components of this self-experience. In contrast, a Buddhist practitioner experiencing *sunyata* might "[know] herself as *nothing but* those feelings," (Epstein, 1995a, p. 126). In this case, the paradigm is that there is no "experiencer" of the feelings separate from the momentary

conditions that are giving rise to these feelings. The affective component is a "raw" experiencing of the feelings as they come and go, without secondary feelings becoming the predominant experience. "Secondary feelings" refer to reactions, such as anger or anxiety, that arise due to aversion or attraction to the original experience; for example, becoming frustrated with oneself for feeling sad.

Emptiness in Western Thought

Emptiness, as it has been known in its various forms to mainstream Western psychological tradition, is an experience causing subjective distress or psychological dysfunction; in other words, pathogenic. Pathogenic emptiness involves the experience of some type of loss. It may be the void felt when something that was experienced to be there is now missing; or it may be the converse of this—something not existing that ought to—invoked by the words of Winnicott: "nothing happening when something might profitably have happened," (1974, p. 106). Pathogenic emptiness is often expressed in the synonyms of hollowness, deadness, numbness, nothingness, an inner void, or "something's missing" (Singer, 1977a). Kernberg (1975) relates an experience of emptiness he shared with a patient:

> One patient with strong schizoid features said in one session … that she was unable to have any feelings... The patient then started to talk about how tiring it was to have to attend that social event with her cousin and to make an effort to appear involved, engaged, interested, when in fact she felt miles away and would have loved to simply be at work, carrying out mechanical tasks without any effort to respond internally... Again, I discovered that I had become distracted and lost the connections of what she was saying. At the same time, I was aware of the sun shining into the office, the lines and shadows of the furniture, and realized with a shock that the patient sitting in front of me seemed an

> almost inanimate object, or, rather, that for me she had at that moment become impersonal, strange, and mechanical. In other words, she just induced in me the sense of emptiness and irrelevance that she had described in her interactions with her cousin and the other people. (pp. 216-217)

In this case, Kernberg discusses the type of emptiness typical of the experience of someone some level of schizoid character organization. When we speak of emptiness as a symptom of a disorder or character organization, the quality of the experience of emptiness is closely tied with the condition it is a symptom of. Epstein (1989) tells us it may at times refer to

> …the confusing numbness of the psychotic, the 'despairing incompleteness' of the personality disorders, the depersonalized state in which one aspect of the self is repudiated while the observing ego becomes hyperaware, identity diffusion, in which the self seeps out and fuses with whatever surrounds it, existential meaninglessness. (p. 61)

This statement illustrates the difficulty in describing the experience of emptiness without referring to the psychodynamics that form the condition we refer to as a disorder. Therefore, while leaving a more detailed discussion of the theory to the chapters below, I refer to some of these concepts as I describe the emptiness of these disorders.

Psychopathology and Emptiness

There is a group of four conditions for which emptiness is thought to be a typical symptom: depression, borderline personality disorder, narcissistic personality disorder, and schizoid personality disorder (Epstein, 1989; Kernberg, 1975; Levy, 1984; Singer, 1977a, 1977b). The quality and pervasiveness of pathogenic empty self-experience differs for each of these disorders. Emptiness in depression is excruciating but experienced intermittently. For those with more severe character pathology, emptiness is a more chronic and fixed self-

experience (Kernberg, 1975; Singer, 1979). Those who have severe forms of the personality disorders in this group lack an integrated self, experiencing a disruption of normal relations of the self with integrated internal objects. How deeply emptiness is experienced by these individuals is relative to the severity of the disturbance in self-cohesiveness, "not only in quantity, but in the extent that it encroaches on the entire range of mind and body self experiences," (Singer, 1979, p. 491).

Depression. In those with chronic neurotic depressions or depressive personality structure, the experience of emptiness is intermittent, and in sharp contrast to the rest of their experience. Emptiness in these cases is seen as related to, but more severe than, loneliness. Whereas mere loneliness "implies elements of longing and the sense that there are others who are needed, and whose love is needed, who seem unavailable now" (Kernberg, 1975, p. 214), the depressive person is under attack by their superego's maintenance of the internal fantasies that "because of their badness they have destroyed their inner objects and are therefore left alone in a world now devoid of love" (Kernberg, 1975, p. 215). In other words, the loved object is both missed and longed for, and there is "an internal void and a feeling of an incapacity for love... the depressed person comes to feel that they do not deserve to be loved or appreciated" (Epstein, 1989, p. 69).

Borderline personality disorder. Otto Kernberg is widely known for his writings on borderline and narcissistic personality disorders, and in them has often addressed the borderline individual's problem with maintaining self-representations. His 1967 paper, *Borderline personality organization*, is seen as a pivotal work on the subject, and he is almost invariably cited by subsequent writers on the subject of borderline experience of emptiness (Singer, 1979; Epstein, 1989; Jorgensen, 2010; Jennings, 2007; Fuchs 2006). He stressed the central role of the

defense-mechanism of splitting in borderline experiences of emptiness (Kernberg, 1967, 1975). Splitting is the defense by which positive and negative aspects of introjections and identifications are kept apart (Flanagan, 2008). In the individual with borderline personality disorder, splitting leads to "a psychological structure characterized by the fragmentation rather than integration of the representations of the self and others that are internalized in the course of development" (Yeomans, Clarkin, & Kernberg, 2002, p. 8). This fragmentation results in the fluctuations of self-image and causes a subjective sense of incoherence and discontinuity. Because they are not integrated, the self-states are mutually dissociated and experienced in isolation from each other. The individual with borderline character organization abruptly shifts from identification with one self-state to another, without reference to previous states (Ryle, 1997). This results in a disruption of the experience of one's self as relatively stable and enduring over time; a "fragmentation of the narrative self" (Fuchs, 2007). Being fully identified with each successive state, as one state supplants another, the emptiness in this case is the experience of radical discontinuity in one's life, of incoherence or inauthenticity—of not being who one "really is." On the level of object relations, one is successively identifying with split off, mutually dissociated self images manifesting in "nonreflective, contradictory, and chaotic descriptions of self and others, and in the striking inability to become aware of these contradictions" (Clarkin, et al., 2007). Beneath this tenuous, fluctuating grasp on a sense of selfhood lies the terror of descending into an even more "regressed" level of emptiness involving the total loss of any self experience (Singer, 1979, p. 490). This terror is captured in the words of one client, who indicates that it is worse than the fear of biological death:

> It felt like I was going to fall apart and disintegrate into nothing. I would dissociate while driving and run red lights. I could have died on many occasions because I

> accidentally ran a red light in a dissociative state of mind. I never was suicidal, but I resented being alive and wanted to be dead. (Kreger, 2011, para. 2)

Narcissistic personality disorder. Of the four conditions being discussed presently, emptiness is the most prevalent and pervasive in those narcissistic personality structures (Kernberg, 1982). Emptiness in the individuals with this condition is a result of the poverty of their internalized object relations that comes from constant devaluation of others (Kernberg, 1982), and the fusion of their ideal ego with what Kernberg calls a *pathological grandiose self*. Their diminished capacity for empathizing in depth with others makes it difficult for them to experience wholeness through intimacy. Instead, it is through being "filled up" with admiration and respect for being a superior person (Kreger, 2011) that drives them to organize their social life around "opportunities to obtain confirmation in reality or fantasy of their needs to be admired, and offers them direct instinctual gratifications, [providing] them with an immediate sense of meaningfulness" (Kernberg, 1975, p. 218). This attitude often invokes the opposite response from others, and the narcissist becomes deflated and empty. Kernberg (1975) continues:

> 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 (p. 218).

In other words, if one were "full of oneself," one is now "empty of oneself." This emptiness is expressed as a flat boredom and restlessness. This boredom is a product of the lack of a sense of connection with the world or others through meaningful relationships. One individual describes her own experience with this as follows:

> No faith, no love coming in to me, nothing to believe in, work towards, or even be excited about or look forward to. I am surrounded by things I can't have, as well as people I can't have, and can no longer take them. (Kreger, 2011, para. 6)

The restlessness is driven by the constant need for affirmation from the outside world of their gravely distorted self-images. This inevitably results in disappointment given their unrealistic nature, and those disappointments ignite an even more vigorous effort for affirmation becoming a vicious cycle.

Schizoid personality disorder. Emptiness in one with schizoid traits has been touched on above. In these individuals, the splitting process may lead to "a defensive dispersal and fragmentation of affects as well as of internal and external relationships involving the self and significant objects, present strong feelings of emptiness" (Kernberg, 1975, p. 220). Clark (1996) identifies four components of the schizoid person's inner world:

> (1) the conviction that loving or needing people leads to control and the loss of autonomy; (2) the conviction that attempts at psychological separation lead to vulnerability and destruction of the self owing to the individual's inability to take care of himself/herself; (3) the conviction that the subsequent reluctance to experience both states, leading to the vacillation between them, both feels bad in and of itself and is disapproved of others; (4) the conviction that empty, seeming unconflicted, undemanding behaviors both feel good and are approved of by others. (p. 155)

The schizoid stance is a defense against longing for "emotional supplies from a good object" (Stewart, 1985) on the one hand, as receiving those threatens the individual with being "swallowed" or consumed by the other, and on the other hand against the threat of consuming or

destroying the other with their own feelings of love. In Clark's (1996) words, “schizoid people believe that their feelings of love destroy the other and/or lead to their own destruction” (p. 153).

In each of the four types of pathology discussed above, emptiness is a painful, frightening, and destabilizing experience. We now turn to emptiness in Buddhism, known as *sunyata*, which, rather than the hollowness and disintegration felt in pathogenic emptiness, is an experience of wholeness, connectedness, and authenticity.

Emptiness in Buddhist Thought

In contrast to Western psychological thought, Buddhism formulates emptiness (as *sunyata*) primarily as a vehicle for mental health. Additionally, there are other forms of emptiness that may also be thought of as healthy or non-pathogenic emptiness besides *sunyata*. Like pathogenic emptiness, all of these may also involve the experience of loss since it involves an abandoning of what for most is the conventional way of experiencing oneself. However, it is often an experience of loss and gain together; a loss without *lacking* or the feeling that something is “missing.” It is better seen as a shift in perspective in which what was thought to exist absolutely is now perceived as existing in a relative sense, as part of something else or as a process emerging from interdependent conditions. Paradoxically, it leads to a sense of wholeness instead of hollowness, of being fully alive rather than “dead inside.”

Many examples of non-pathogenic emptiness are associated with some form of spiritual tradition or practice. One such example is the mystical union sought by followers of Advaita Vedanta (Hinduism) whereupon the personal self or psyche is dissolved into the greater Self of the universe (Brahman). Others may experience the emptiness of the universal principle as a Cosmic Void (Grof, 1998) and through the dissolution of ego boundaries, experience a merger with it. Grof (1998) also refers to this as the “pregnant Void” because of its creative potential

and the simultaneous subjective experience of emptiness and wholeness. Although these experiences may be beneficial or at least experienced as such—increasing a sense of understanding and relatedness to the world—within the frame of Buddhist psychology these types of emptiness are not the same as *sunyata* would still be considered, at best, distractions from the ultimate Buddhist aim of liberation from suffering. This is because in these cases, emptiness is still experienced as independently existing, having an enduring substance as either *some*thing or *no*thing. According to Buddhism, grasping upon a sense of substantial nature of any kind is a root cause of suffering. Therefore, experiencing emptiness as a "thing," whether it is the dissolution into Brahma of Advaita, the Cosmic Void, or nihilistic nothingness as the antithesis of being, fundamentally misses the mark even if the individual can be said to have benefited from such experience. These are examples of pathogenic emptiness found in Buddhist thought.

The lack of "thingness"—as neither something nor nothing—makes *sunyata* difficult to describe. In the Buddhist view, there is a sense that pathological states of self-experience are a product of narcissistic craving for *either* existence or nonexistence; the image of the self is clung to as either something or nothing. These are

> the two poles of the false self: namely, the grandiose self developed in compliance with the parents' demands and in constant need of admiration, and the empty self, alone and impoverished, alienated and insecure, aware only of the love that was never given. (Epstein, 1995a, p. 64)

There is a powerful tendency in human beings to impute absolute meaning or to impute none. *Sunyata* is a "middle way" (*madhyamaka*) that neither reifies nor denies the self, protecting from the extremes "of left and right (of grandiosity or despair), and when we are in danger of being

overtaken by our own reactions to things, we can suddenly catch ourselves," (Epstein, 1995a, p.100). Apropos of this description, one Buddhist practitioner shared his experience of emptiness while struggling with a visceral encounter with the polarity of existence and nonexistence, a diagnosis of cancer:

> My own reactions have sunk further into a kind of stillness or darkness, as if a wind is blowing out of the depths. I was driving along looking for a vacuum cleaner store. I noticed a guy tailgating me and then stopped noticing him. I slowed, found the store, turned, and parked. Then a man drove up toward me in a Subaru. He and his dog were both looking at me. I turned the ignition back on and wound down the window. He yelled at me for driving like an old lady and some other stranger beings. He had driven round the block to do this. I didn't go through the operation I sometimes do of explaining him to myself. I felt happy and simple, as if honey had been poured over me. "Thank you," I said, smiling radiantly. "Thank you." He paused. He rolled up his window and drove away. (Tarrant, 2007, p. 212)

This vignette illustrates a number of features of this type of emptiness. The author describes a completely different sense of agency, of his actions "blowing out from the depths." This invokes a sense of effortlessness, his actions flowing forth with neither obstruction nor undue effort from his ego. His interaction with the irate driver demonstrates a fearlessness of being destroyed or controlled by someone else's feelings, indicating that this situation would normally require him to explain this man to himself (in psychodynamic terms, use the defense of *rationalization*) to stave off his anxiety. And he is able still to demonstrate warmth and kindness to the man (albeit in a rather abrupt way). All of this is the opposite of the case of the schizoid, whose emptiness is driven by fears of being controlled, consumed, and consuming or destroying the other.

In all four psychopathologies described above, including schizoid personality disorder, emptiness is a symptom of ego dysfunction. By contrast, *sunyata* in Buddhism is a quality to be cultivated, and this process—meditation—assumes a relatively intact ego and structured sense of self to start with (Engler, 2003). *Ego* is defined here as "a collective term designating regulatory and integrative functions," (Engler, 2003, p. 36). *Sunyata* is not to be confused with the concept of "transcending the ego" popular in some variations of new age thinking and most transpersonal theories. The ego remains intact and essential and is in fact strengthened in meditative practice (Epstein, 1989; Epstein, 1990a, 1990b). Instead, the cultivation of the experience of *sunyata* destroys "the idea of a persisting individual nature," (Guenther, 1974, p. 207) referring to the unconscious propensity to view oneself as concrete and "inherently existing" independent being. Through the acceptance of the self's constructed nature, the self-referential parts of the ego are altered to embrace a more complete picture of the transiency and relativity of self-identifications:

> Although [the self] can be deceptive because it is not exactly what it appears to be, it is nevertheless efficacious, valuable, and not at all problematic for one who recognizes its exclusively pragmatic nature. (Huntington, 1989, p. 56)

The self is not annihilated; the self is seen to exist "in the sense that this particular configuration that is 'me' has a momentary reality of its own in the ongoing flux of change and transformation" (Engler, 2003, p. 76). It is not disavowed through dissociation, numbness or unreality; it is not the "emptiness" of being nothing, dead, gone, or missing. Instead, those who experience *sunyata* describe feeling just the opposite: more alive, more real, more present; "the absence of grasping for that essential core that unleashes the flood of affect that makes us feel most real" (Epstein, 1995a, p. 72). *Sunyata* is the relinquishing of a fixed image of the self as *either something or nothing*. Experiencing emptiness as something "real in itself" or a "vacuity

of nothingness" (Epstein, 1989, p. 64) is another form of pathogenic emptiness within the Buddhist frame. Quoting Nagarjuna, the founder of one of the most influential forms of Mahayana Buddhism, "Emptiness has been said... to be the relinquishment of view, but... those who hold to the view of emptiness are incurable" (Cleary, 1986, p.19). And despite the philosophical implications of *sunyata*, it is not cultivated with the intention to decide a philosophical or metaphysical issue about reality, but to "liberate oneself from what today we would call pathogenic beliefs or dysfunctional cognitions" (Engler, 2003, p. 88). The result is a healthier and more flexible self-experience. The cultivation of *sunyata* through years of practice eventually molds the perceptual frame and gradually becomes a habitual mode of functioning.

Conclusion

Emptiness as a phenomenon exists as part of the inner experience of a person. It can be described in terms of one's affective or sensory experience, as "the confusing numbness of the psychotic, the 'despairing incompleteness' of the personality disorders" (Epstein, 1989, p. 61) as well as various feelings of warm contentment, joy, and bliss experienced by Buddhist practitioners. But emptiness in terms of self-experience cannot be understood solely from this perspective. It is also an integral part of a person's cognitive and perceptual framework, both conscious and unconscious, that informs and influences almost every aspect of one's mental life (Kernberg, 1975). Being inextricable from a person's psychology, one may attempt to understand emptiness as one does other aspects of one's psychology by framing it within conceptual frameworks. By applying ego psychology and control-mastery theory on one hand, and Buddhist psychology and *Abhidhamma* on the other, a more complete understanding of emptiness may be developed and the role it plays in mental health and illness.

IV. BUDDHIST PSYCHOLOGY

The purpose of this chapter is to describe Buddhist psychology according to *Abhidhamma*, a collection of texts that make up a part of the canon of classical Buddhism (called Theravada Buddhism). This psychology presents a view of the mind as constantly in flux, its components impermanent and interdependent. The theoretical constructs and assertions made about the mind are the product of direct observation of moment-to-moment consciousness through the practice of meditation (Bodhi, 2000; Olendzki, 2008; Thera, 1998). Through close scrutiny, what appears to be the uninterrupted flow of continuous lived experience is revealed to be "a series of discreet sensory and mental events that arise and pass away in rapid succession, while the sense of continuity and narrative coherence is something supplied by higher level imaginative capabilities" (Olendzki, 2011, p. 56). It is to this microscopic level of experience that the theoretical constructs of the *Abhidhamma* are applied. In this chapter, I describe these constructs in detail so that I may use them to create a picture of emptiness from a Buddhist perspective. Since meditation is of essential importance to classical (and most other forms) of Buddhism, I also discuss its influence on consciousness as represented by these constructs.

History

Buddhism began in what's now northeastern India around the 5th century B.C.E. This was a time of rapid material and intellectual development, and the shift from a rural society based in agriculture to an urban one based on a market economy (cf. de Bary, 1969). The pervasive, mainstream religious views during this period were based on the Upanishadic tradition for which the caste system was of central importance as a reflection of a greater cosmic order. But this time of development and transition was also reflected in the emergence of several heterodox traditions, many which appealed to those disenfranchised by these modern

developments: the lower castes and those who relied on agriculture for their livelihood. The two most prominent of these to survive are Jainism and Buddhism.

Buddhism shares some common ideas with Upanishadic philosophy. Primary among these is the idea that individuals are subject to endless rounds of birth, death, and rebirth, and that *kamma*[1] is the moral causative force governing the nature of one's rebirth. Both also hold as the supreme goal of spiritual life the liberation from this endless cycle. But as to the method and nature of that liberation, and the nature of the person who is to be liberated, the traditions differ distinctly.

According to Upanishadic philosophy, *atman*, the essence or soul of a person, is the transcendental "true self" of all beings. It is a singular collective Soul underlying and unifying all people and phenomena (Sharma, 1972). *Atman*, the "true self," is covered up by a "false self" that is individual consciousness and personality. A metaphor often used is that individual existence is a wave and the *atman* is the ocean—the wave's individual existence is illusory as it is not truly separate from the ocean. Failure to recognize and unify with this universal essence is what leads to endless rounds of birth, death, and rebirth into the various castes in the phenomenal world. The particular caste one inherits is based on the ethical conduct in previous lives, and ethical conduct was thought of in terms of performing the duties appropriate to the person's (current) caste. When one is finally reborn into the highest order, that of a *brahmin*, one may dedicate oneself to attaining the highest spiritual knowledge, and ultimately liberation (de Bary, 1969; Sharma, 1972).

Likewise, Buddhism accepts that a distinct, individual self is illusory. However, it rejects the belief in *atman* as an immutable, transcendental self to be realized or unified with (Safran,

[1] Sanskrit: *karma*

2003). To return to the ocean metaphor, according to Buddhism the ocean is as illusory as the wave. Accordingly, the system of liberation described above—obtaining better rebirths by performing one's caste-defined duties—is seen as perpetuating the rounds of rebirth rather than leading to liberation. Instead, it is through recognition of the impermanence of reality and letting go of self-centered craving that leads to liberation. Whereas the Upanishadic view was to merge or relinquish the embodied "false self" into the universal "true self," Buddhism holds that no self exists separate from the aggregates of form and psychological experience (cf. Olendzki, 2011, p. 68). Therefore, there is no view in Buddhism of an eternal true self that is at odds with a mundane self that is subject to the pains and fluxes of everyday life. What the Upanishads view as the mundane self, transient and fluctuating, is indeed all there is. The goal of Buddhism is therefore not the transcendence of worldly experience, but finding a better way of living in it (Safran, 2003).

Buddhist psychology is founded upon this understanding of the self. It is based not only on philosophical underpinnings, but also direct observation through meditation (Bodhi 2000; Olendzki, 2008, 2011; Thera, 1998). By combining deep concentration with insight practices, the Buddhist practitioner comes to experience their mental existence as the arising and passing of various mental and physical phenomena in each subsequent, infinitesimal moment; much like a film creates the illusion of seamless movement through the rapid succession of static images.

Key Concepts

It is this type of observation that has been systematized in *Abhidhamma*—the "higher teaching" of the Theravadin Buddhist canon. It contains a deliberate and highly methodical systematization of the phenomenology of consciousness and the interplay between consciousness and the material world. In it, the "static images" referred to in the analogy above, are called

cittas, translated as “mind-moment”. These, in turn, consist of a grouping of psychological components referred to as *cetasika*, “mental factors”. The rapid succession of these mind-moments are themselves grouped into a larger unit of a moment of cognition, or cognitive process, where a physical or mental object is sensed, observed, recognized, and cognized. Together these units, with their mutual influence and interdependence, comprise the flow of consciousness that includes mental illness, wellness, and everything between (Bodhi, 2000; Olendzki, 2011).

Since the duration of a mind-moment is said to be so small that “in the time it takes for lightening to flash or the eyes to blink, billions of mind-moments can elapse,” it is difficult to compare to the categories in Western psychology (Bodhi, 2000, p. 156). This level of analysis is much finer, whereas categories of the latter apply to referents with much longer duration (Goleman, 1976). Even so, the two models are not at odds, and may even be complementary. For example, when repetitive patterns of mind-moments occur with enough consistency over time so as to adopt some level of apparent stability, there emerges those observable categories that may include symptoms, syndromes, or even those more enduring traits of personality and personality disturbances. With this in mind, I turn to more detailed descriptions of these basic concepts of *Abhidhamma*.

Mind-moments and mental factors. Mind-moments are the most microscopic slice of experience dealt with in *Abhidhamma* (Olendzki, 2008; Thera, 1998). All of our experience can be broken down into a succession of mind-moments, whose particular qualities determine the nature of that experience. They are divided into two broad categories of *mundane* mind-moments—those moments comprising our everyday consciousness—and *supramundane*—which refers to those mind-moments that comprise the consciousness of one who is on the path to

awakening (liberation from suffering). The majority of mind-moments (81 of 89) fall into the former category, and it includes states of deep meditative absorption, including very advanced stages of such. The supramundane states (8 of 89) consist of "path" and "fruit" *cittas* each of *stream-enterer*, *once-returner*, *non-returner*, and *arahant* or "worthy one" (Bodhi, 2000). The roles of these mind-moments, and the method of their attainment, are discussed in greater detail below.

Awareness according to *Abhidhamma* always has an object. In other words, awareness always arises interdependently with a stimulus for that awareness. Where there is no stimulus, there is no consciousness (A. Olendzki, personal communication, January 19, 2010). To put it colloquially, one never simply thinks without thinking *about* something.

> Consciousness is what happens when an organism encounters an environment. If an eye is struck by light reflected off a colored shape, then visual consciousness occurs. But as soon as the object passes out of the field of vision or one shuts one's eyes, that consciousness ceases. This is true of every kind of consciousness. "Just as fire," Gotama explained to Sati, "is reckoned by the particular condition dependent on which it burns—a log fire, a dung fire and so on—so too, consciousness is reckoned by the particular condition on which it arises." Consciousness is an emergent, contingent, and impermanent phenomenon. It has no magical capacity to break free from the field of events out of which it springs. (Batchelor, 2011, p. 180)

The object of consciousness can be external and perceived through the "five doors" of perception, or an internal object where products of the mind—affects, previous cognitions, prior *cittas*—are perceived through the "mind-door." This is an example of the fundamental Buddhist notion of interdependence: seeing arises in dependence on a sense organ, an object with visual

properties, and a mind in which the visual representation is created. If any one of these is absent, the mind-moment related to seeing does cannot occur. This relationship becomes apparent when we examine the constituents of a single mind-moment: the mental factors.

A mind-moment is composed of *cetasikas* or *mental factors*. They represent the various qualities of that mind-moment. They should not be thought of as fundamentally existent, indivisible "psychic atoms" that make up consciousness. Instead, they are phenomenological units that are simply not reducible by further analysis to any substantial bearers of qualities (Thera, 1998). There is a group of mental factors that appear in every mind-moment, called the "universals," and together they illustrate the interdependent nature of the various faculties that arise in a single mind-moment. The universal mental factors are as follows:

1. Contact—The factor by which consciousness "touches" the object, initiating the entire cognitive event.
2. Feeling—The bare affective quality in which the object is experienced. Rather than complex emotions, this refers simply to the quality of being pleasant or painful to varying intensities, or neutral.
3. Perception—Apprehension of the qualities of an object.
4. Volition—Organizes the associated mental factors in acting upon the object.
5. One-pointedness—The "unification" of the mind on its object.
6. (Mental) Life faculty—Vitalizes the associated mental states.
7. Attention—Responsible for advertence of the mind to the object, by virtue of which the object is made present to consciousness. (Bodhi, 2000).

Although the universal mental factors are present in every mind-moment, the relative strength of a particular mental factor depends on the particular mind-moment in which it arises,

or on the phase within the cognitive process in which the mind-moment occurs (Olendzki, 2011). This is true about any two mind-moments that would otherwise seem identical: depending on the context, there could be great variation in the strength or prominence of individual factors. Three examples come to mind. In the *determining* phase of a cognitive process the universal factor of *perception* comes to prominence in any mind-moment that occurs. In the *javana* phase, however, it is *volition* that comes to prominence (Bodhi, 2000). Perhaps the most important example is the universal factor of *one-pointedness*. This *cetasika* is the essential ingredient for meditative achievement—in the mind-moments of deep, meditative absorption it comes to utmost prominence and is referred to as a "*jhana* factor." However, its weaker presence is in *every* mind-moment of consciousness, demonstrating "that the germ of that capacity for mental unification is present in all types of consciousness, even the most rudimentary" (Bodhi, 2000, p. 80). Therefore, meditation involves at least in part the active cultivation of these cognitive states marked by the progressive strengthening of this mental factor.

Kamma (karma). Mind-moments may also have an ethical quality of being either wholesome or unwholesome, though some may also be neutral. This is a psychological context for the workings of *kamma*, the Pali word for the more familiar Sanskrit term *karma*. Just as *kamma* has implications on rebirth from one life to another, it is also seen as a force influencing and connecting one's various mental states over time in one's present life.

The word *kamma* literally translates to "deed" or "action." In Buddhism it denotes the law of ethical causality—actions are inextricably linked to a reaction or consequence (Thera, 1998). The ethical component is in whether the action is rooted in one of the three unwholesome roots. These are often coarsely translated as *greed*, *hatred*, and *delusion* (Bodhi, 2005), but the meanings of "greed" and "hatred" are more aptly translated as *desire* or *clinging* for greed and

aversion for hatred (Epstein, 2007). Delusion (Pali: *moha*) also carries the sense of "bewilderment." The exact opposite of these terms comprise the "wholesome roots." Actions rooted in any of these roots have the effect of increasing or decreasing suffering for oneself or others (Harvey, 2000). Although most translations of *Abhidhamma* render the positive and negative types of *kamma* as "wholesome" or "unwholesome" (Bodhi, 2000), they may also be rendered as "healthy" or "unhealthy" in the context of psychology (Goleman, 1976).

When a person is actively adapting (consciously or unconsciously) to the object of a mind-moment, there is the potential for producing *kamma*. The attempts may be adaptive, resulting in decreased suffering, or maladaptive, increasing it. The *kamma* produced by these actions influence future mind-moments (called *resultant* mind-moments), which become wholesome or unwholesome depending on the *kamma* of the originating mind-moments (Bodhi, 2000) These are often referred to as the "fruit" of *kamma* (Bodhi, 2005, p. 161).

The cognitive process. Mind-moments occur in a fixed sequence that comprises a single moment of cognition, referred to as *cittavitthi* or "cognitive process." Since consciousness requires an object of perception to exist, cognitive processes are categorized by the type of object in question. The first type of cognitive process is the product of sensory stimulus, perceived through one of the "five-doors" corresponding to the five senses. The second is a product of the mind and perceived through the "mind-door."

The five-door process arises in response to external (material) stimulus experienced as sight, sound, taste, touch, or scent. It consists of 14 mind-moments arising with the sense object: (1) adverting, (2) sensing, (3) receiving, (4) investigating, (5) determining, (6-12) *javanas*, (13-14) registration (Bodhi, 2000).

The mind-door process takes as its object the products of the mind itself, for example

memories, feelings, or any other psychic event. It consists of 10 of the 14 mind-moments in the five-door process; the four that are absent this case are only involved with processing sensation: (1) adverting, (2-8) *javanas*, (9-10) registration (Bodhi, 2000).

The first mind-moment to arise in either process is *adverting*. This mind-moment "bends" the consciousness toward the stimulus. The next few mind-moments differ between the two types. Whereas the mind-door process proceeds directly to the series of *javana* mind-moments, the five-door process has four additional mind-moments before the *javanas* begin. These are *sensing*, *receiving*, *investigating*, and *determining*. *Sensing* refers to the raw sensory input that is experienced. *Receiving* is the stage where this data is assembled into coherence as an object, while *investigating* cognizes the object's qualities.

Determining is the process through which the object is identified or recognized and attached to concepts (even if it is recognized as "unknown"). In actuality, this is precisely the same mind-moment that is called *adverting* in the mind-door process (Bodhi, 2000). This somewhat confusing nomenclature actually illustrates the process through which the sense object becomes a mental object after it has been "investigated"; it is essentially a second adverting process adverting this time to the mental representation of the external stimulus that was originally adverted to (Olendzki, personal communication, January 20, 2010).

The seven *javanas* are identical mind-moments in terms of their qualities and the mental factors that comprise them, except that each subsequent *javana* increases in intensity (Bodhi, 2000). It is within the *javanas* that the individual take adaptive measures to the object, with the possibility of generating *kamma*.

If the impact of the object is great enough, the *javana* states are followed by two *registration* mind-moments. This phase of the cognitive process is reminiscent of the

psychodynamic process of *internalization*. After the object has been discerned, interpreted, and acted upon (adapted to) in the *javana* processes, a mental representation is formed (Aylward, 2007).

Whereas the *javana* process is the place where an individual may generate *kamma* the receiving, investigation, and registration processes may consist of *resultant* mind-moments: the "fruit" of past *kamma*. This is highly significant. That receiving and investigation mind-moments are influenced by the fruition of *kamma* illustrates how actions of the past may influence one's perception in the present. The two registration mind-moments are also *resultant* mind-moments (Bodhi, 2000), implying that the process of internalizing objects is also subject to influence from the *kamma* of past thoughts and actions.

Pathology

The focus of Buddhist practice is not to apply a blunt instrument in treating those larger patterns of behavior described in Western psychotherapy as disorders or mental illness. Rather, it applies the very fine instrument of moment-to-moment awareness in gaining control over our mental processes in those moments, the *javanas*, where there is opportunity to intervene (Epstein, 1995a). Pathology in Buddhist psychology is therefore attributable to cognitive processes consisting of mind-moments that are maladaptive (unwholesome *kamma*). Yet there is a sense in which even healthy, wholesome, consciousness is still considered maladaptive insofar as it still occurs within the spheres of the *mundane*. It is perhaps due to this that only half of *sense-sphere* wholesome mind-moments are accompanied by the feeling of joy, and half of those are *dissociated from knowledge*, lacking insight into the true nature of the object of consciousness (Bodhi, 2000). If the goal of Buddhist practice were to merely cultivate the wholesome states of consciousness, this would be comparable to Freud's notion that the goal of

psychotherapy is to transform "hysterical misery into common unhappiness" (Breuer & Freud, 2000, p. 305). In fact, in Buddhism even joyful states are seen as subject to the “three marks” of existence which are impermanence, suffering, and non-self. These states are temporary, they are not “me” in any abiding way, and through their passing cause suffering. For this reason, I have been referring to the action of *kamma* as increasing or decreasing suffering, rather than eliminating it.

How does suffering, or pathology, relate to emptiness in Buddhist thought? Attachment to a fixed image of the self is thought to be at the root of suffering. The three marks of existence—suffering, impermanence, and non-self—directly point to the relationship between suffering and attachment to a self perceived as permanent, solid, and “mine.” But Buddhism elaborates further in that attachment to a self perceived as empty, where emptiness is felt to be something real as if existing in space and time, is also a source of suffering (Epstein, 1989). This is clearly observable in clinical expressions of emptiness, for example, in those disorders mentioned in the previous chapter. In those cases, an individual experiences herself as nothing, as incomplete, fractured, or missing “pieces” of herself. That pathogenic emptiness is explicitly addressed in Buddhist writing affirms that both of these theories, one steeped in Western culture and the other from the East, identify a very real and problematic self-experience. The main difference lies in where Western psychotherapy advocates an escape to the opposite pole—of affirming a solid and cohesive sense of self—Buddhism advocates a “middle path” experience of *sunyata*, that advocates a viewing both existence and non-existence with skepticism; in other words, the emptiness of emptiness itself (Huntington, 1989). Without this experience one continues to suffer from painful self-related experiences like narcissistic injury or humiliation (Epstein, 1998).

Whereas Freud seemed resigned to the notion that the best outcome of psychotherapy is "common unhappiness," Buddhism holds that the total emancipation from suffering—*nibbana*—should be the ultimate goal and that this should be reachable. For this, there is another class of mind-moments called *supramundane*, and these are grouped into *path* and *fruition* consciousness, referring to mind-moments that advance one forward through the successive stages of *stream-enterer*, *once-returner*, *non-returner*, and *arahant*, and the fruition of that progress which are the resultant states (Bodhi, 2005). Unlike mundane mind-moments, where even very high meditative states may be followed by unwholesome ones, once a person has "changed lineage" (Bodhi, 2000, p.345) to the supramundane, that person moves inexorably forward to awakening. The key to these achievements lies in the Buddhist practice of meditation.

Meditation

The meditative practice of classical Buddhism consists of two complementary aspects. These are *samatha* (calm or concentration) and *vipassana* (insight) (Buddhaghosa, 1976; Olendzki, 2008). *Samatha* is a concentration practice that involves placing sustained attention on a particular object. This has the effect of bringing one's attention to the present moment without distraction by thoughts or other stimulus, and facilitates progression into deeper levels of meditative absorption, called *jhanas.* As meditation is developed, these absorptions may be sustained for successively longer periods of time by the practitioner (Aylward, 2007; Olendzki, 2011), hence the idea of achieving a lasting quality or change implied by the word *jhana*, meaning, literally, "limb."

The practice of *samatha* involves focusing on a single object as one's concentration intensifies, taking the practitioner through the successive levels of *jhana*. When the breath is

taken as the object of focus in *samatha*, this practice is what is often referred to in the West as "mindfulness meditation," (Epstein 1995a) and may also go by the term *anapanasati* in Buddhist scripture. The mental factor of one-pointedness is the essential quality that is being refined (Olendzki, 2011). The 4 or 5 *jhanas* are considered essential aspects of the supramundane mind-moments. However, they also occur in mundane mind-moments such as the so-called "fine-material" and "immaterial" spheres. This illustrates that *samatha* meditation is a necessary, but not sufficient, condition for awakening (Olendzki, 2008). The supramundane states may only be reached by combining *samatha* practice with *vipassana* (Aylward, 2007; Olendzki, 2008; Olendzki 2011).

Vipassana translates as "insight" and refers to the practice of contemplation of experience providing insight into *sunyata* defined by the "three marks" mentioned above—suffering, impermanence, and non-self. The *Abhidhamma* and Buddhaghosa's important treatise, the *Visuddhimagga*, describe the process in detail as a series of seven "purifications" that, taken in sequence, lead one into the supramundane paths. Of these, the second one is purification of mind and refers to access or absorption meditation—*samatha*. It is only between the sixth and the seventh purifications that the "change of lineage" occurs whereby one has achieved the level of "stream-entry." The aspect of insight is represented by the mental factor of wisdom.

> Wisdom, understood as seeing things as they really are, is the crucial transformative principle in the Buddhist tradition. Just as you can practice meditation without manifesting mindfulness, so also you can practice mindfulness all you want, but if it is not conjoined with insight (another word for wisdom) it will not in itself bring about a significant change in your understanding. Real transformation comes from uprooting the deeply embedded reflex of projecting ownership upon experience ("this is me, this is

> mine, this is what I am") and seeing it instead as an impermanent, impersonal, interdependent arising of phenomena. (Olendzki, 2008, Cultivation of Mindfulness section, para. 5)

When this is developed along the path of purification, upon entering supramundane mind-moments, elements of the eightfold path pertaining to ethical conduct manifest as mental factors; namely, Right Speech, Right Action, Right Livelihood (Buddhaghosa, 1976). It may appear odd that apparently external volitional activities appear as mental factors in the supramundane mind-moments. But this signifies the fruits of insight practice; that one has "internalized" the path to the point where they manifest "automatically" in the consciousness of one who has progressed to this level (Bodhi, 2000). In other words, it no longer requires effort to conduct oneself in a wholesome manner. The other elements of the eightfold path that fall under the categories of mental development and wisdom are already accounted for in the mental factors that correspond with the *jhanas*, called *jhana* factors, and the mental factor of wisdom. According to Bodhi's (2000) commentary, in one "who has reached the experience of stream-entry, the path factors [of the eightfold path] become fixed in destiny, and flow like a stream leading to Nibbana," (p. 67).

In the practice of *vipassana*, one is said to go through several successive stages, called *purifications*. Of these, the first refers to ethical conduct, and the concentration practice of *samatha* occupies the second purification. However, it is only towards the end of the sixth stage of purification that the full experience of *sunyata* is crystallized, and the "idea of a persisting individual nature" (Epstein, 1989, p. 14) is finally relinquished (Buddhaghosa, 1976; Bodhi, 2000;). This demonstrates that acquiring the skill of *samatha* practice is not equivalent to spiritual or psychological awakening in the Buddhist tradition.

Summary

Buddhist psychology of the *Abhidhamma* envisions the mind in terms of minute units of experience. It looks to these units to explain pathology, and its primary therapeutic practice of meditation, by focusing the mind on the present moment, intervenes at this level. Despite how this differs from traditional Western ways of thinking about pathology, our familiar diagnostic categories may also be seen as larger interacting patterns of these mind-moments. Rather than being at odds with this familiar diagnostic system, it offers a complementary view focusing on the same phenomena at a different scale. This level of magnification has for centuries been applied in the context of *sunyata*. In the present study it is also used to examine the phenomena of pathogenic emptiness and break them down into the microscopic level, determining what mind-moments are involved in the experiences and how they are connected and influence each other to establish a pattern over time that one may recognize as symptom, defense, or personality trait.

V. CONTROL-MASTERY THEORY

The purpose of this chapter is to describe control-mastery theory (CMT), a psychodynamic theory that grew out of contemporary ego psychology. Contemporary ego psychology is the school of thought that evolved from the initial efforts of Anna Freud and Heinz Hartmann. It marks a shift in focus from the unconscious instinctual drives, which is the primary concern of Freud's drive theory, to the executive and synthesizing functions of the ego. As the theorists continued to focus on the ego, it increasingly revealed itself to be an elaborate structure with highly nuanced and complex functions that scale well beyond Freud's initial conception of it as primarily a mediator between the demands of the drives, the superego, and external reality. Eventually it was observed that the traditional drives of aggression and sexuality could not account for the full range of human behavior. It was therefore proposed that *mastery* is also a primary motivating force driving us to overcome problems in ourselves and in our environment, and to make sense out of the world. CMT marks a further shift by placing the drive to mastery at the heart of the psychotherapy process, overshadowing, if not completely eradicating, treatment based on analyzing the traditional instinctual drives. Furthermore, CMT proposes that individuals have unconscious *control* over some of the ego functions of ego psychology, particularly defenses; they may lift or activate defenses in response to assessments of safety and danger.

In this section, I provide a brief history of the development of CMT. Then, I describe the main theoretical constructs of CMT, including pathogenic beliefs, unconscious plans for mastery, and testing.

History

In 1923, Freud introduced his Structural Model of the psyche in *The Ego and the Id.* The

model describes the id, ego, and superego as locked into an ongoing struggle between competing interests: the id interested only in gratifying infantile wishes, while the superego's sole purpose is to stop this from happening, with the ego attempting to mediate between each of these aims and the external world (Freud, 1923). The ego accomplishes this through an unconscious process called *compromise-formation*. This compromise allows the id some gratification by channeling it through a system of *defenses*. This way the id's impulses are controlled and disguised, allowing them to escape the gavel of the superego and social censure. It is due to these compromise-formations that neurotic symptoms emerge, and these symptoms serve as "inherent punishment" that satisfy the demands of the superego (Mitchell & Black, 1995, p. 25).

Starting with this structural model, Anna Freud pioneered the beginnings of modern ego psychology. She focused most of her study to the role of unconscious defenses, and felt it was part of the analyst's task to bring those unconscious defenses (beyond merely id impulses) to light. Through her study, she cataloged the various defenses commonly observed, and located them along a developmental continuum ranging from psychotic, to immature, to neurotic, to mature (Freud, 1936). The use of more primitive defenses by an adult signals disturbances in developmentally earlier phases of childhood. Furthermore, Anna Freud noted that the defenses are not only called into activity in response to internally arising conflict, but may also be prompted by displeasure with its source in the external world (Mitchell & Black, 1995, p. 30). Thanks to her contributions, the focus of analysis shifted away from concentrating mostly on underlying id impulses to giving equal due to the unconscious processes of the ego and superego as well. It also expanded the application of psychoanalytic ideas from symptoms to character style as it relates to the stable, idiosyncratic, repetitive pattern of ego organization (Schamess & Shilkret, 2008, p. 65).

Despite this shift in emphasis in the practice of psychoanalysis, the fundamental view remained of the ego as entrenched in the conflicts between id, superego, and the demands of reality. It wasn't until Heinz Hartmann (1958) began to study closely the ego's role in adaptation that many of the ego's functions are autonomous, operating in a "conflict-free sphere." According to this view, humans, like other animals, have evolved to adapt to their environment. As such, humans are born with "built-in ego potentials" flourish in what he called the *average expectable environment*—in other words, an environment free from extremes of duress and with basic supports and nurturing in place (Hartman, 1958). These ego functions concerned with adaptation are generally uninvolved with and free from the effects of intrapsychic conflict. The must, therefore, derive their energy, or motivation, from something other than sexuality or aggression. Hartmann speculated that this energy could be derived through a process of *neutralization* – where the ego strips the drives of their sexual and aggressive qualities (Mitchell & Black, 1995; White, 1959). This is different than the ego defense of *sublimation*, where id impulses are redirected into valuable and socially acceptable behaviors while maintaining, in "subliminal" form, their sexual or aggressive qualities. This way, Hartmann maintained a connection to Freud's drive theory, keeping ego psychology within the realm of psychoanalysis while also broadening the theory with a more complex view of the ego that brought it closer to the field of psychology.

To many, neutralization was an unsatisfactory explanation, and as a more complex vision of the ego emerged there grew objections to the conception that "so vital and versatile a part of the personality could be developed solely by libidinal and aggressive energies" (White, 1959, p. 307). A solution was eventually proposed that, rather than through neutralization of the drives, the energy for autonomous (conflict-free) ego functions is provided by a third primary source:

the innate drive toward *competence.* White (1959) made a compelling argument a motivation for competence that "cannot be wholly derived from sources of energy currently conceptualized as drives or instincts" (p. 297). He observed that from the time of birth, there appears to be an innate motivation to undertake actions that are not directly related to need states. A great number of activities may be classified under this including exploration, play, search for novelty, and active learning. Moreover, such activities are done more effectively in the *absence* of strong motivating influences of the drives (White, 1959, p. 327). This turn in ego psychology completely freed it from the need to account for ego activity by way of drive theory, though veering from Freudian orthodoxy.

The final development in ego psychology to be presently discussed builds on this notion of mastery as a primary motivating force. It is called control-mastery theory (CMT), and, as in White's (1959) conceptualization of mastery, it maintains the notion that people are intrinsically motivated to achieve greater degrees of competency; it's the *adaptive imperative* that predisposes all animals to adapt to their environment (Silberschatz, 2005). This extends not only to the external environment and various developmental tasks, but also to overcoming traumas and conflicts (Schamess & Shilkret, 2008). As part of the task of adaptation, a person establishes unconscious beliefs about how the world works, especially interpersonal relations. People form, and test, hypothesis about the world around them in order to establish a reliable conception of reality: the world, their relationships, and themselves. According to Joseph Weiss, one of the founders of CMT, psychopathology results when these beliefs are maladaptive, providing an inaccurate picture of reality. For these he coined the term *pathogenic beliefs* (Weiss, 1993).

"Control" in CMT refers to the assumption that people are able to exercise unconscious control over their ego defenses, usually in response to assessments of safety and danger. This

presents another diverging view from drive theory. On of the goal of the therapist is therefore to "understand what the patient is afraid of, what the patient is defending against, and to help the patient feel safe from these dangers" (Rappoport, 2002, p. 1). Creating safety allows the client to lower the defenses and thereby become more open, relaxed, expressive, and insightful. From there, the client may begin unconsciously testing pathogenic beliefs with the therapist in an attempt to form a more reliable model of reality.

Key Concepts

The concepts from control-mastery theory relevant to the present undertaking will now be described in detail. Concepts from ego psychology are also discussed insofar as they are relevant to CMT.

Ego functions. The ego itself is generally not seen as consisting of various "parts", with or without corresponding biological mechanisms. Similar to the mental factors of *Abhidhamma,* the ego functions are interrelated and interdependent, and the ego as a whole is more than a sum of its parts (Schamess & Shilkret, 2008). In fact, it is precisely the cohesive structure of the ego that gives rise to the experience of a stable, independently existing self: "When ego successfully accomplishes its organizing and synthetic functions, individual experiences himself as coherent, functional human being with an *enduring sense of personal identity* [emphasis added]" (Schamess & Shilkret, 2008, p. 65). Even so, discerning its various functions as discrete entities has proven helpful modeling mental activity, and they are often used in the context of assessment tools in mental health clinics. The two ego functions of particular significance to CMT are *mastery* and *ego defenses.*

Mastery is the ego function that seeks to achieve competence. Greater levels of ego organization are achieved as the individual masters successive developmental challenges. As

discussed above, mastery plays a central role in contemporary ego psychology (through the thought of Hartmann (Mitchell & Black, 1995) followed by White (1959)) and control-mastery theory as a primary motivating force alongside the biologically-based sexual and aggressive drives. Especially in the case of CMT, this function plays a central role in the theory and practice of psychotherapy, supplanting the importance of drives in classical psychoanalysis. In CMT, mastery drives the process of psychotherapy, motivating the client to seek more adaptive ways to understand and interact with the world through testing these beliefs with the therapist.

Understanding *ego defenses* provides insight into the psychotherapeutic process since they play a large role in the interaction between client and therapist. As McWilliams (1994) notes, almost any psychological process may be used defensively, therefore there is no such thing as an exhaustive list of defenses. The ones listed in her own text are the ones most commonly referred to in the clinical literature, and are relevant to the discussion of emptiness in particular, due to their roles in character patterns (McWilliams, 1994, p. 117); since character patterns are an important part of self-experience, it is logical to assume they influence empty self-experiences as well. What follows are some examples of defenses relevant to this discussion, paraphrased from McWilliams (1994) text:

- Primitive withdrawal—This type of withdrawal represents entering a different state of consciousness. It is a psychological escape from reality that can be seen even in infants who fall asleep in response to being overstimulated or distressed.
- Denial—This defense in its most archaic form is a type of magical thinking that holds that if something painful or unpleasant is not acknowledged, it isn't really happening. This is typical, and normal, in the egocentric thinking of young children. In adults, this type of defense can be very dysfunctional, for example when alcoholics deny their

drinking problem even after great personal losses due to it (loss of a job or important personal relationships, for example).

- Omnipotent control—In an infant's experience of reality, she is in complete control of the world. This state of primary grandiosity gives way to a "secondary" omnipotence, where it is believed that the child's primary caregivers are all-powerful. Eventually, as the child matures, she comes to accept the reality that no one has unlimited power over reality while ideally maintaining a sense of agency. This may be seen as a defense in an adult when they interpret experiences as "resulting from their own unfettered power," (McWilliams, 1994, p. 104).
- Projection and introjection—In these defenses, there is a lack of psychological boundary between the self and the world. In projection, what is inside is misperceived as coming from outside. While being a basis for empathy, it may also be pathological when it is a blatant denial of a person's own deficiency, perceived instead as a deficiency in another. Introjection is the inverse of the above, and can take the form of benign identification with significant others, or it can be more problematic such as in the case of "identification with the aggressor" in victims of severe interpersonal trauma.
- Splitting—Splitting is the process of segregating positive from negative, good from bad. This process, while effective in staving off anxiety, can result in unintegrated object-representations where bad aspects of an object are completely disconnected from good aspects.

Unconscious pathogenic beliefs. The main focus of CMT is to work with a client's *unconscious pathogenic beliefs*, or just *pathogenic beliefs*, for short. People form unconscious beliefs about the world, about others, about themselves, and about the relationships between all three. When

these beliefs provide an inaccurate “map” of reality, the individual to acts in maladaptive ways. These beliefs are often the result of traumatic childhood experiences and begin as an effort at adaptation. The traumatizing circumstances of the child's environment, or in Hartmann's (1958) terms, lacking an *average expectable environment*, leads one to form beliefs that allow one to function *within that environment*. These beliefs, however, are not generalizable outside that environment with those particular relationships, and therefore maladaptive. Silberschatz (2005) provides a common example:

> Individuals who experience physical or emotional abuse in childhood often develop a pathogenic belief readily familiar to most therapists, regardless of their theoretical orientation. The abuse victim typically believes that he or she was “bad” and deserved the treatment he or she received at the hand of his or her abuser. Like all pathogenic beliefs, this belief begins as an effort at adaptation. In order to survive, the abused child needs his parents, even if they are hurting him. Consequently, he would prefer to see himself as bad or flawed rather than see his parents as being flawed … However, this irrationally self-blaming belief ultimately leads to psychopathology because a person who believes (consciously or unconsciously) that he or she is flawed and deserves to be mistreated frequently becomes involved in abusive or destructive relationships and suffers from depression, severe anxiety, self-destructive behavior patterns, and/or personality disorders. (pp. 5-6)

While everyone lives with a number of pathogenic beliefs, people often seek treatment when these are severe and persistent enough to interfere with normal developmental goals. The therapeutic environment is one in which the client may (and, as proponents of CMT would emphasize, *will*) test their pathogenic beliefs with their therapist. Through testing, the client is

actually attempting to *disconfirm* the pathogenic belief, replacing it with a more adaptive one. This implies that on some level, they are aware that the pathogenic belief is causing them to suffer, and enter therapy with a plan (often unconscious) to overcome them (Silberschatz, 2005, p. 8).

Testing. Testing, as the definition of the word implies, is a trial action that is undertaken in order to assess the results of that action. By testing the therapist, the client is seeking "corrective emotional experiences" (Alexander & French, 1946)—experiences that will allow the client to gradually work through early traumas, disconfirming pathogenic beliefs and replacing them with more adaptive ones. Testing may occur in one of two forms (or sometimes a combination of both): *transference* tests, and *passive-into-active* tests (Weiss, 1996; Weiss & Sampson, 1983). Transference testing refers to the same phenomenon of transference recognized by most other schools of psychoanalysis. In it, the client "experiences himself or herself in the historical role he or she had as child and experiences the therapist as a parent or other significant authority figure," (Rappoport, 2002, p. 2). As a method of testing, the client unconsciously hopes that the therapist will react differently (the opposite) from the way the original person in the client's life did.

> He may hope, for example, that he will not, by his sexuality, provoke the therapist to punish him, or by his contentment provoke the therapist to charge him with complacency, or by his independence cause the therapist to feel rejected. (Weiss, 1993, p.14)

In passive-into-active testing, the roles are reversed with the client behaving towards the therapist in the traumatic ways that the significant other behaved towards them. This mode of testing is more adversarial; the client assumes the role of the traumatizing parent and attempts to induce the same distressing emotions in the therapist that the client had experienced as a child.

Therefore, the therapist may experience a high level of emotional strain. The client hopes the therapist will respond assertively in the face of this mistreatment, thereby "modeling" this behavior for the client, who then feels safer to exercise more assertiveness in future interactions.

Conclusion and Summary

Control-mastery theory is a natural framework to apply to the phenomenon of emptiness. Emptiness involves a cognitive schema that defines how one experiences one's self. This, in turn, influences one's way of viewing and being in the world and interacting with others. At least part of this cognitive schema is unconscious as it comprises the lens through which we view reality. CMT is directly concerned with this lens when it negatively affects one's life. It is this type of schema that is referred to as a pathogenic belief.

CMT has developed from a lineage that gradually refocused the work of psychotherapy away from the id and its drives and toward the intricate workings of the ego. Along with this development came a greatly expanded role for the ego function of mastery as a powerful force in human psychology. As the name implies, mastery is foundational to control-mastery theory as the entire therapeutic technique derives from the notion that the client is constantly working towards mastering their problems in and out of the therapy clinic.

The concepts of ego functions and defense mechanisms are some of the greatest contributions of ego psychology. These provide a helpful assessment tool in clinical situations, and provides a language with which to discuss the dynamics involved in experiences of emptiness and in the therapeutic process. The concept of pathogenic beliefs and testing that are central to control-mastery theory provide a conceptually clear way to model both pathogenic experiences of emptiness and the way one works to overcome those beliefs. The applicability to self-experience comes primarily from the observation that pathogenic beliefs predominantly

manifest as conceptions and definitions about the self. Pathogenic self-experiences may thus be profitably viewed as resulting from unconscious pathogenic beliefs about the self. Along with this, the phenomena of testing and mastery (as a primary motivating force) provide useful parallels to the practice and process of Buddhist meditation in transforming self-experience.

VI. DISCUSSION

Emptiness is not one single phenomenon. It is a gestalt of affective experiences and core identifications that are part of a cognitive schema that consciously and unconsciously influences the way one experiences everyday life. Moreover, the experience of emptiness may range from deeply disturbing to centering, joyful, and even blissful. Hence there is emptiness that is detrimental, causing distress and suffering—pathogenic emptiness—and there is emptiness that is beneficial and leads to adaptive functioning.

The forms of emptiness that have been known to Western clinical practice are concomitant with psychopathology. The experience of being empty is considered a symptom of distress, not a sign of health. This is primarily due to its emphasis on individual identity and object constancy; accordingly, emptiness in its pathogenic form is the converse of these ideals of mental health. It is a source of intense suffering and often at the very core of psychopathology, especially in the case of personality disorders. It can be experienced as emotional destitution, incompleteness, depersonalization or dissociation, or meaninglessness. There are four mainstream diagnoses that have this type of emptiness as a symptom: depression, borderline personality disorder, narcissistic personality disorder, and schizoid personality disorder.

On the other hand, Buddhist practice is organized around achieving the experience of emptiness. Emptiness, *sunyata*, is integral to one's well-being, so much so that in Buddhism most, if not all, of psychological suffering is attributed to not having achieved and integrated this form of self-experience. Rather than an experience of lacking or incompleteness, it is an experience of wholeness, feeling more alive, more real, more present for having relinquished an absolutist attachment to self as “either something or nothing” in favor of a relative view of self which is felt to exist “in the sense that this particular configuration that is 'me' has a momentary

reality of its own in the ongoing flux of change and transformation" (Engler, 2003, p. 76).

With this understanding of emptiness in mind, as well as our more extensive description of it in Chapter III, I now discuss the findings that came from applying the two theoretical lenses described in Chapters IV and V. Applying the coarser lens of control-mastery theory allows me to frame the phenomenon in terms of pathogenic beliefs and the observable behavior that comes from them, including testing. Then "zooming in" with the lens of Buddhist psychology (*Abhidhamma*) provides insight into the potential inner workings of pathogenic emptiness, which should simultaneously allow us to compare this with *sunyata*, which is already a part of this Buddhist framework. To illustrate and underscore these findings, I apply them to a case vignette of pathogenic emptiness taken from the literature. Implications relevant for clinical social work or psychotherapy are highlighted and discussed, as are recommendations for future research.

Case Vignette

To illustrate the discussion of pathogenic emptiness I use a case vignette taken from Clark's (1996) article. The example follows the case of a woman, Ellen, who is described by the author as possessing a schizoid disorder of the self. Ellen was the eldest of two children. Her father is described as cruel, controlling, narcissistic, physically abusive and sexually seductive. Her mother was an alcoholic who neglected and ignored Ellen. Despite this, Ellen describes how at an early age she adored her mother. She recalled "clinging to her physically and crying because she loved her so much" (Clark, 1996, p. 159). At times when she felt lonely and empty, she would sit quietly beside her preoccupied mother attempting to receive some comfort from her physical proximity. Her father forced her to care for her mother when she was drunk, and generally treated her as a kind of servant. He demanded her companionship at night where she was expected to sit silently and unobtrusively while he read the newspaper or watched television

and forbade her to engage in any activity of her own. She survived this by emptying herself of her own needs and sense of selfhood, becoming a "featureless and emotionless doll" which resulted in a sense of inner deadness, loneliness, and invisibility (Clark, 1996, p. 159). When this became unbearable, she would provoke her father into attacking her in order to feel seen. When those attacks became intolerable, she once again became empty.

In her adult relationships, Ellen continued this pattern of oscillating between empty and provocative states. This was also noticeable in her presentation in therapy; Ellen's demeanor was very detached, wooden, and muted. It would occasionally give way to more provocative behavior:

> …she had so successfully hidden any evidence that she was a living, breathing person that she resembled a windup doll far more than a woman. However, across the seemingly perfect emptiness of her demeanor from time to time, tiny glimpses of aspects of her hidden personality flitted… at times she would appear frightened, timid, shallow, in a low level dither, and falling all over herself to obey orders. At other times, just for a moment, she would appear cold, supercilious, aloof, superior, and vain… with a hint of cruelty and contempt. (Clark, 1996, p. 158)

She had little capacity for intimacy, yet also had difficulty managing alone. To her therapist she reported no particular interests, activities, or hobbies. Her career as a secretary put her in a position where she was required to put the needs of others ahead of her own. As for her family life, she claimed to have no particular liking for her husband, and seemed to have married him in part due to an accidental pregnancy. Clark (1996) describes Ellen's relationship to her children as "alternately intrusive and neglectful, and cruel" (p. 160).

Treatment. Clark (1996) describes how in the initial course of treatment, Ellen "reacted

to almost anything I said as if it were an order, rushing out of the office to follow it, but in such a way as resoundingly to sabotage the results" (p. 160). She understood this as a method of provoking that allowed Ellen to express her anger without owning it, and to be simultaneously involved and not involved with the therapist. Over time, as the therapist interpreted this to her, she began to acknowledge how she kept "one foot in and one foot out" of numerous relationships in her life. Clark (1996) terms this position the "neutral zone" (p. 159).

Leaving this neutral zone through the desire to know and express herself brought up intense anxiety about being controlled, enslaved, or abused. Ellen likened the experience to feeling like she is with "Big Brother" and reported feelings of impending disaster if she speaks up. Clark (1996) observes that Ellen dealt with this anxiety by "pushing onto" her therapist part of her experience. The author writes:

> I was fascinated by the strength of my reactions to this seemingly innocuous person. On all too many days, simply seeing her in the waiting room elicited in me a powerful urge to sadistically attack her; alternately, I would feel controlled by her and, in response, helpless and impotently enraged. (Clark, 1996, p. 161)

Clark (1996) sees this dynamic as the defensive process of *projective identification*. In projective identification an unwanted or threatening aspect of the self is projected unto another, and that person is experienced as having those traits. Additionally, the person who is projected upon may experience the projected qualities as if they are coming from herself. In Ellen's case, the therapist's role in the projective identification dynamic alternated between being felt to be sadistic and tyrannical and impotent and helpless.

As Ellen progressed, she became more outspoken about her feelings and needs and this was seen as a positive sign. She was becoming more independent and autonomous.

Correspondingly, feelings of abandonment by a bored, indifferent and unresponsive mother came to the foreground. Clark (1996) notes that at this point she, as her therapist, began to experience incredible boredom and sleepiness during their sessions, and it was challenging to combat this and stay awake and present for Ellen. At these times when Ellen was asked how she was feeling, she responded by saying she felt lonely and alone, as though the therapist was not with her, and that she felt "terrifyingly" invisible (Clark, 1996, p. 162). This aloneness and invisibility would prompt her to return to her provocative behaviors. She would then become annoyed and distance herself from her therapist. After providing some momentary relief, the distancing would cause her to feel alone and invisible again. With neither closeness nor distance tolerable, she would once again become empty in the sense of an "emotionless, detached doll" (Clark, 1996, p. 162). But with her growing awareness of herself, this state provided little solace and she would earnestly turn to her therapist for help. This would again invoke her fear of being controlled, thus perpetuating the cycle.

As time went on Ellen gradually began viewing this engagement of projective identification as a process with roots within herself rather than as a real product of her relationship with her therapist. Her awareness of her shifting experiences of the therapist became sharper, and this increased her anxiety with respect to being controlled or ignored by her therapist. To combat this, she began "regressively idealizing" the therapist (Clark, 1996, p. 164), just as she had tried to idealize her mother as a child. This developed into an adoring attitude toward the therapist that became counterproductive; her emotional expression once again became restricted by becoming "shallow" and her progress in identifying her needs and feelings and acting on her own behalf was fading. Ellen was deemphasizing herself in relation to the therapist. After multiple interpretations along this line, Ellen identified her anxiety as stemming

from the feeling that she was defying her parents by placing herself "in the middle of her own psychological universe" by being independent and aware of her own needs (Clark, 1996, p. 163). In Clark's (1996) words, she became aware of the "basis of her fear of acknowledging the very existence of a self" (p. 163). Emptiness in the form of effacing or repudiating her self was the price of belonging in the "sick system" (Clark, 1996, p. 163) of her family of origin.

It began to emerge that emptiness set in during therapy when Ellen experienced shifting, contrary attitudes, feelings, or impulses. The vacillations produced intense shame, and to avoid this she became empty—the "hollow doll." Her parents held negative attitudes about having contradictory feelings and wishes, and exploring these types of feelings and wishes in therapy caused her to feel separate from her family and alone. The emptiness of disavowal of her self was her way of remaining close to her parents. More generally, by receiving the nurturance and support for the emergence of her separate self in therapy, it became all more painfully evident that this would never be provided by her own parents. This separation from her internal images of her parents led to a different type of emptiness that consisted of a despairing loneliness. The repudiation of her self, as it did when she was a child, allowed her to connect with her parental images in a way that exchanged this pain for numbness. Ellen came to recognize the importance of experiencing her shifting, contrary wants and needs as a pathway to separation/individuation, and her "correct experience of that perception as the doorway to her dawning recognition of the nature of her real self," (Clark, 1996, p. 164). Ellen expresses this in her own words:

> There are a lot of different feelings in me, and I am beginning to accept it. I am beginning to enjoy the day, maybe not even a day, maybe a moment when I feel joy, knowing that there may be utter turmoil in the next moment, because I can accept the turmoil. Because of this, I feel a bit more spontaneous, more social, more relaxed.

(Clark, 1996, p. 165)

Pathogenic Emptiness as Pathogenic Belief

Pathogenic emptiness as we have described in Chapter III involves a cognitive framework through which a person experiences herself as incomplete or non-existent (Epstein, 1989). To a therapist whose practice is based in CMT this has the traits of a pathogenic belief; pathogenic beliefs are themselves a cognitive framework or schema (Silberschatz, 2005) that influence an individual's perception of the world and her self. Such a therapist would then hope to eventually reveal the traumatic events from the client's past that led to such a maladaptation.

The identification of pathogenic emptiness as a pathogenic belief is also supported *a priori* by Buddhist psychology. As I have discussed above, in Buddhist thought attachment to self as either something or nothing is the source of suffering. This comes from the fact that both of these extremes of self-experience are subject to the three marks of existence—impermanence, suffering, and no-self. In other words, neither of them are real and therefore attachment to them, i.e. *believing* in one or the other, is *pathogenic*. It follows that experiencing the self as nothing, incomplete, or missing pieces is based on a pathogenic belief, maladaptive in that it is not an accurate model of reality. For Buddhism, it exemplifies the attachment to self as nothing. One can even phrase it in the converse as the attachment to the self as *something*—an independently existing whole—the individual could be or achieve (but isn't or hasn't).

The one thing that isn't obviously addressed in this formulation is how such a pathogenic belief comes to be. For CMT, all pathogenic beliefs are formed at least in part as a response to traumatic experience. It is evident in the case example of Ellen that traumatic experiences precipitated pathogenic beliefs about her empty self, and one can see the ways in which these beliefs influenced her self-experience and behavior.

Ellen's childhood was marred by traumatic relationships with her abusive and neglectful parents. Her experiences of emptiness formed as a result of these early experiences and became an embedded part of her way of experiencing and relating to the world. Her emptiness manifests as both a deficiency in the development of her sense of self and an active suppression of a sense of self. From her narcissistic father and "deserting but desirable" (Guntrip, 1971, p. 28) mother, she received no nurturance or support for her emerging self as a child. This situation causes a disruption in the development of self and object representations resulting in "an 'emptying of the self' with concordant fears of being swallowed, extinguished, imprisoned, absorbed or lost in a 'vacuum of experience'" (Epstein, 1989, p. 63). Ellen's own poignant description of her subjective experience echoes this, likening it to "shouting into space, her voice echoing out and out with never a response to beam it back to her and help her to feel real" (Clark, 1996, p. 162). This aligns with Singer's (1977a) *deficiency* model of emptiness.

Her emptiness was also a defensive suppression of a sense of self, outwardly visible in the way Ellen related with her therapist. Clark (1996) likens it to an "empty doll, [hiding] any evidence that she was a living, breathing person," (p. 158). This denial of her self was also a consequence of Ellen's relationship to her parents as a child. Her parents did not tolerate Ellen's expressions of her self, and responded in ways that actively suppressed her or neglected and abandoned her emotionally. Ambivalence was especially frowned upon by her parents, who expressed "negative attitudes about her contradictory feelings and wishes and their approval of self-effacing, doll-like behavior," (Clark, 1996, p. 164). In the case of her father, Ellen was required to be physically near him, while at the same time unobtrusive and vacant of her own needs and feelings. Her own agency about whether or not to be there and any expression of herself risked violent retribution by him. Ties to her father were thus completely on his terms,

and conditional upon her simultaneous presence (at his whim) and emptiness. As for her mother, Ellen was essentially invisible to her. She was required to take care of her, for example, when she was drunk essentially being a mother to her, and not receiving any mothering *from* her. Ellen had to be selfless, in both the colloquial sense of the term and in the literal sense of being self-less. It was only through selflessness that she could maintain ties with her parents.

Ellen's traumatic treatment by her parents in response to expressions of a self led to a dilemma. On the one hand, her survival as a child depended on people perceived to be too dangerous to be close to because of their "potential to control [her] and squash [her] autonomy," (Clark, 1996, p. 154). On the other hand, her basic need for her caretakers remains strong as leaving them would leave her terribly alone and vulnerable. As a result, Ellen tries to preserve an attachment with her parents while simultaneously avoiding the terrible feelings triggered by turning toward the relationship or away from it. She accomplishes this by emptying herself so that she does not feel her emotions nor identify needs, and in so doing she becomes increasingly unable to experience herself as real and authentic. This empty, inauthentic self is accepted and reinforced by her parents, and therefore becomes "a positive alternative to the more authentic feelings of turmoil and vacillation in attitudes about the relationship to the caretakers: it provides a way of relating in and of itself," (Clark, 1996, p. 155).

This dynamic follows the pattern of a pathogenic belief. A pathogenic belief involves an observation of a traumatic event, assumptions about that observation, an attempt to adapt to the environment based on those assumptions, then the assessment of whether the adaptation was successful. In Ellen's case, she observes that expressions of having her own needs and feelings put her in danger of being attacked or ignored and abandoned. Since it appeared to her that having a self of her own was a source of suffering, she responded by emptying herself. She then

observed the accepting response from her parents, leading to the assessment that being empty allows her to avoid the miserable pain of rejection or abuse and to maintain ties to her caregivers.

While this conclusion is essentially true for that particular dysfunctional relationship, the problem comes when it is generalized to her other relationships, hence becoming a pathogenic belief. Having its genesis in distorted, traumatic childhood environments, these beliefs lead to dysfunction and suffering in adulthood. Ellen's tendency to engage in self-negating behavior in her life, including with her therapist, is an example of this over-generalization. One of Ellen's pathogenic beliefs about her self could be phrased in the following way: "Having a self is dangerous. In order to be safe I must suppress and get rid of my self." While the actual emptying of herself may be seen as a defense, it is based on this pathogenic belief (a belief that, of course, was true of living with her parents). Furthermore, as this emptying becomes a more ingrained part of her, she experiences herself *as* empty, having no particular interests, needs or desires, being incapable of giving or receiving love, etc. This may also be seen as a pathogenic belief that denies the existence of these capacities: "I have no interests, I cannot love," and so forth.

Having established pathogenic emptiness as a form of pathogenic belief, pathogenic emptiness can now be segmented into four rough stages of a pathogenic belief: formation, reinforcement, and disconfirmation. Given these basic stages, it is now possible to "zoom in" using the finer-grained formulations of *Abhidhamma*: mind-moments and their mental factors, and the cognitive processes they belong to.

Pathogenic beliefs are complex phenomena, and represent patterns of thought and behavior that span a long period of time (years) in someone's life. On the contrary, the basic unit of a mind-moment is thought to last less than the duration of a blink of an eye. Since mind-

moments occur in such an infinitesimal span of time (Bodhi, 2000), it is when these mind-moments emerge in larger patterns that create observable behavior that we may call "symptoms"; when someone has pervasive patterns of unwholesome mind-moments, they constitute mental illness. Conversely, when they're wholesome mind-moments, they constitute mental wellness. This is similar to how, in a pointillist painting, tiny points of individual colors construct and influence an overall shade to the subject. Therefore, it is justified to restrict our discussion to those key mind-moments within the cognitive processes that play the most significant roles in belief formation, reinforcement, and disconfirmation.

Mind-Moments and the Formation of Pathogenic Emptiness

In the formation of pathogenic beliefs, the most significant mind-moments will have "unwholesome roots," referring to the type of *kamma* that is involved. This is indicated by the mere fact that pathogenic beliefs are just that—pathogenic, literally "suffering-causing." Since according to *Abhidhamma* all suffering is attributable to mind-moments with unwholesome roots (Bodhi, 2000), it follows that mind-moments involved in pathogenic beliefs also have their basis in unwholesome roots (desire, aversion, and delusion/bewilderment).

Recall from Chapter IV that mind-moments with such ethical valence come in two forms: *kamma*-producing and *kamma*-resultant mind-moments. These refer to cause and effect relationships between mind-moments. *Kamma*-producing mind-moments play a large role in the formation of pathogenic beliefs. They represent the volitional response of the individual to the object of cognition. Since according to CMT pathogenic beliefs begin with traumatic experiences, we can model the belief as a volitional response to an external object, the traumatic experience. Even though the *Abhidhamma* does not speak specifically of trauma, it is clear that the object of cognition causing the trauma, at least in the present context of pathogenic beliefs, is

an external one experienced through the five senses. This indicates the presence of the five-door cognitive process, with its object being a trauma that is seen, heard, felt, or otherwise perceived through the five senses. To recap, the mind-moments of the five-door cognitive process are, in sequence: (1) adverting, (2) sensing, (3) receiving, (4) investigating, (5) determining, (6-12) *javanas*, (13-14) registration (Bodhi, 2000). However, as we shall see, in this model the initial stimulus is not inherently traumatic but it is through the cognitive process, and the *kammic* actions within it, that create the psychological effects of trauma.

According to *Abhidhamma*, in the phases prior to *investigating*, the object is not yet experienced as trauma. The only types of mind-moments that these phases may consist of are the so-called "functional" mind-moments. These are described as being "accompanied by" either equanimity or "smile-producing" consciousness rather than by pain or displeasure. This points to the fact that in Buddhism, the experience itself does not inherently cause suffering, but it is in later mind-moments, through the influence of *kamma* and our own volitional processes, that suffering is experienced.

In the *investigating* and *determining* phases, our perception of the (otherwise neutral) object is now subject to the effects of *kamma* and is potentially influenced by the forces of desire, aversion, or delusion. It is here that physical pain becomes psychic suffering, for example by the strong aversion to pain and wish for it to be gone, or a child's desperate clinging or longing for a caregiver who is in the act of rejecting or abusing her. One must be careful not to apply what has become the "pop culture" understanding of *karma* here as "good" or "bad." It is not morally bad, and in fact it is natural and generally adaptive for a child to have a very strong and idealizing attachment to her caregivers. But her action is influenced by forces deemed by Buddhism to lead to suffering. These forces are intrinsic to our existence even from

birth into this world[2]—from birth, a child will be influenced by the unwholesome root of ignorance (delusion) until she has gained wisdom and knowledge from learning and experience. Until then, many of her actions will be done with some lack of understanding of the world.

During the volitional (*javana*) phases of the five-door cognitive process, the individual engages in some sort of response to the stimulus. When a response is rooted in desire, aversion, or delusion the unwholesome *kamma* impacts future mind-moments with suffering. This is the case when someone forms a pathogenic belief. Since pathogenic beliefs are often an attempt by a child to maintain ties to her caregivers in a dysfunctional relationship, one may say that these volitional moments are subject to unwholesome *kamma* rooted in desire (or clinging). The child's response seems drastic in that it modifies their very perception of the situation, for example shifting blame from the caregiver to herself.

In the cognitive processes involved with the formation of a pathogenic belief about emptiness, having responded in the *javana* phase in a way that negates the self, the resulting *kamma* would manifest in future *investigating* phase that precedes the *determining* phase. This *resultant* mind-moment would influence an individual's perception of new events. This influence is a distortion from viewing the event "as-is." The individual is interpreting the present in light of past responses, and as such it is influenced by the unwholesome root of delusion. Therefore, in the *javana* phases one is attempting to adapt to one's *interpretation* of the object rather than the object itself. This cyclical application of a distorted response is the adaptation and, in effect, represents the formation of a pathogenic belief.

Ellen's pathogenic emptiness, like most pathogenic beliefs, is also formed in response to traumatic experiences with her caregivers. Ellen's experience of her mother's emotional

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[2] See Bodhi's 2006 discussion of dependent origination, pp. 312-316.

abandonment and her father's abuse would have been experienced through 5-door cognitive processes. Her adaptation in the *javanas* was at times out of her desire to maintain ties, and this "unwholesome" root influenced the psychological response of "emptying" herself. At other times, the adaptation was to avoid pain or survive (even in a psychological sense). This represents another unwholesome root of aversion.

Let us follow this process in more detail. One may assume that as a child Ellen was subject to the common and developmentally-linked "distortion" of omnipotent control. This may be said to be a *kammic* influence in the *investigating* and *determining* phases. In the moments when Ellen's expressing of an individual self provokes her father to attack her, she may therefore conclude that she it is her fault due to having and expressing a self. This would occur in the *determining* phase where the object is recognized and attached to concepts, and a conclusion is drawn concerning the object or what is happening. During the following *javana* phases, she responds in a way that protects her from her father, or maintains a sense of closeness with her mother, but also generates future suffering: she suppresses her self and becomes empty. Ellen's trauma, then, is the experience of pain from her parents, which she *determines* to be her fault. She perceives the presence of her self to be the problem, and all of this is based on her developmental imperative to maintain bonds with her parents and also her developmentally-appropriate but unwholesome-*kamma*-producing delusion of omnipotent responsibility. She responds by emptying herself in order to maintain those bonds. As a result, she does not feel her emotions nor identify needs, and in so doing she becomes increasingly unable to experience herself as real and authentic. This empty, inauthentic self is accepted and reinforced by her parents, and therefore becomes "a positive alternative to the more authentic feelings of turmoil and vacillation in attitudes about the relationship to the caretakers: it provides a way of relating

in and of itself" (Clark, 1996, p. 155). So while maintaining bonds with her parents is crucial for survival and therefore adaptive, the method through which this happens is influenced by unwholesome roots and will cause future suffering.

Mind-Moments and the Reinforcement of Pathogenic Emptiness

Kamma-producing mind-moments are the active moments where suffering is either produced or cut off. Therefore, they are responsible for the formation of pathogenic beliefs. On the other hand, *kamma*-resultant mind-moments are influenced by the unwholesome roots and feel the effects of suffering. Therefore, these are where the influence of pathogenic beliefs is expressed. Reinforcement of pathogenic emptiness occurs through a mutual feedback loop that occurs between *kamma*-producing and resultant mind-moments repeated over long spans of time.

It has already been noted that resultant mind-moments have a distorting effect on the *investigating* phase of the five-door process. This also explains the effect of pathogenic beliefs; they influence through *kamma* the resultant mind-moment of the *investigating* phase, causing the individual to view the object of perception through a lens distorted by this belief. Resultant mind-moments do not themselves produce *kamma*, they are only the result of *kamma* produced previously. Therefore they are called "rootless." The three mental factors at play besides the universals (listed in Chapter IV) are *initial application*, *sustained application*, and *decision*. Initial application and sustained application refer to the mind's focus on the object, and decision characterizes the actual act of investigating, i.e. "deciding" what it is that is being experienced. Given the distorting effect of the pathogenic belief on the investigating mind-moment, it is likely that, having misperceived the object of perception in this way, this person will respond during the *javanas* in ways that are influenced by the pathogenic belief. Therefore, mind-moments that produce unwholesome *kamma* are rooted in delusion, with that delusion *being the pathogenic*

belief. The *kamma* produced by these mind-moments in turn will influence future resultant mind-moments, continuing the cycle and reinforcing the pathogenic belief.

The strength of the object of consciousness is also a factor in this reinforcement. Recall that a strong stimulus results in two *registration* mind-moments following the *javanas*. Interpersonal experiences resulting in trauma would most certainly be considered a strong object. According to *Abhidhamma*, registration mind-moments have the same *kamma* as the investigating mind-moment, i.e. the moment influenced by the pathogenic belief. Therefore, if the object being experienced is traumatic (strong), those registration mind-moments will serve to further solidify the pathogenic belief. In other words, the investigation and registration mind-moments are all influenced by the pathogenic belief, the first affecting the person's perception of an object, the last affecting that person's internalization of the object. The lasting impact of trauma is almost universally accepted, and the presence of these final two mind-moments attests to this. That impact is felt when the fruition of that *kamma* emerges in future, resultant, mind-moments—the pathogenic belief becomes stronger when the individual continues to experience trauma that re-confirms it.

In Ellen's case, she forms the belief that she must be devoid of a self in order to be safe. She then interprets future relationships in the light of this pathogenic belief; if she somehow triggers her father's wrath, for example, she may attribute it to some emerging need or something else attributable to the presence of a self. This reaffirms the belief that having a self is dangerous and she must empty herself. But I also noted earlier that this belief, as it becomes entrenched, transforms into an experience of herself *as* empty, having no interests, needs, desires, incapable of love, etc. This translates into another pathogenic belief that she *is* empty or *has* emptied herself. This appears to be an instance of a pathogenic belief being generated from another,

indicating that in the mind-moments involved in developing this secondary belief, the object of cognition originates in the mind. This is a case of the mind-door cognitive process. The object of this cognitive process is the pathogenic belief that she must be empty to be safe. From examining this belief, she concludes that she has therefore become empty, setting in motion the *kammic* sequence described above for the generation of a new pathogenic belief (or a transformation of the original). This process plays a very important role in the disconfirmation of pathogenic beliefs, and I discuss it in more detail in the following section.

Disconfirmation of Pathogenic Emptiness

According CMT, an individual works to disconfirm their pathogenic beliefs through testing. Developing, as it has, out of the view that *mastery* is a fundamental drive, people are constantly working to overcome pathogenic beliefs that are causing them suffering. This implies that at least on an unconscious level, they are aware of their pathogenic beliefs and understand that their suffering is caused by them. Testing is the means through which they "study" their pathogenic beliefs by in various ways replaying the traumatic situations that lead to their formation, at times assuming their original roles in transference tests, and at other times assuming the role of those whom they felt traumatized by in passive-into-active tests.

Mind-moments of testing. How can this testing be understood in light of the mind-moments and cognitive processes described above? To begin with, that testing is a form of "investigation" of pathogenic beliefs, and that some, even if unconscious, awareness of the pathogenic beliefs is implied points to the involvement of the mind-door process. Instead of taking an external sensory experience as its object, the mind-door process takes mental constructs as its object. One can then conclude that mind-door processes would, by necessity, play a significant role in any moment when testing is happening.

The mind-door process is distinct from the five-door process in that there is only one phase, *adverting*, that precedes the *javana* phases. To recap, the mind-moments of the mind-door cognitive process are, in sequence: (1) adverting, (2-8) *javanas*, (9-10) registration (Bodhi, 2000). Adverting belongs to a class of mind-moments referred to as *functional*, meaning it is neither directly impacted by *kamma* nor does it create *kamma* (wholesome nor unwholesome). Therefore the *kammic* action occurring in the *javana* is unencumbered by distortion. This is especially significant as it implies that when one examines, say, one's own pathogenic beliefs, by definition one cannot at the same time be distorted by that belief (at least not in that same cognitive process). Therefore the actions taken in the *javana* are a response to the "thing-in-itself" of the mental representation.

Since the *javana* phases are where volitional actions take place, it is in these phases of the mind-door cognitive process where testing would originate. The pathogenic belief is taken as the object of cognition in the adverting phase, then, in the *javanas* the decision is made to question the belief and validate it in the external world (for example, with the therapist). This leads to the actual execution of the test by the individual. Following this, the five-door cognitive process once again comes to the fore in order to process the responses of the other person(s) to the test—observing facial expressions, body language, listening to verbal responses, etc. Then once again, in the *javana* phases of this process, the individual takes "action" on that input and the pathogenic belief is either weakened or reinforced.

Just as with the five-door process, in the mind-door process two registration mind-moments occur when the stimulus is strong. In the mind-door process, the registration mind-moments are instances of *investigating* mind-moments. These are influenced by *kamma* and this represents the difficulty of internalizing our insights into particularly wounded or pernicious

parts of ourselves without, for example, framing them within our pathogenic beliefs.

Mind-moments involved with testing would mostly be wholesome, since they derive from the individual's drive for mastery over their suffering. Many of the mental factors in wholesome mind-moments seem to play an important role in mastery: 1) mindfulness—the individual is paying attention to what she wishes to master, 2) non-aversion—aversion would be antithetical to mastery, and 3) the *path* factor of *right action*—taking beneficial action that moves one toward the cessation of suffering (Bodhi, 2000). If the individual perceives the test as having been passed, then the mind-moments involved in weakening the pathogenic beliefs would also be wholesome, with the following mental factors playing a prominent role: 1) wisdom faculty—this leads to new insight, and 2) appreciative joy (Bodhi, 2000). This last mental factor may be correlated to what Weiss (1993) has put forth as one of the telltale signs of a passed test: the observable reaction of becoming relaxed, uplifted, and often revealing new insights into her situation.

The presence of the "path factor" is also an indication of a move toward *sunyata*. By definition, this indicates a movement away from pathogenic beliefs about the self, and leading to the disconfirmation of pathogenic emptiness. This seems to imply that within *any* moment in which there is a passed test, having moved away from unwholesome roots, there is the potential for moving toward a wholesome self-experience of *sunyata*. This is logical within the Buddhist framework since the singular definition of mental health is that experience of emptiness, therefore any movement away from "illness" is naturally a move toward *sunyata*.

Testing pathogenic emptiness. Having established the mind-moments that are involved in testing and disconfirmation of pathogenic beliefs, I will now inquire into what specific kind of testing would be done to disconfirm pathogenic emptiness. It is difficult generalize this because

of how closely tied testing is to the specific situations that caused the pathogenic belief to take hold. Thus even if we were to pinpoint a limited number of types of pathogenic emptiness, the specific tests that may be used to disconfirm them are as varied as the people on earth. It is helpful, then, to turn back to our specific example of Ellen to illustrate how testing, in her case, served to disconfirm pathogenic emptiness.

Clark (1996) was not using a CMT framework when working with Ellen, or in presenting her case material, but she does make use of basic ego psychology. In particular, she referred to Ellen's use of defenses, including projective identification. Just as Ellen's defensive use of emptiness is tied with pathogenic beliefs about her self, her use of the defense of projective identification is tied with her attempts to disconfirm these beliefs through testing. Projective identification is the process through which an unwanted or threatening aspect of the self is projected unto another, and that person is experienced as having those traits.

> Since that which is projected is a segment of the self, a connection to the expelled part is maintained, through an unconscious identification. The projected psychic content is not simply gone; the person struggles to keep some connection to and control over that content. (Mitchell & Black, 1995, p. 101)

Moreover, the person who is projected upon is often induced or influenced to feel or behave in ways that confirm this identification.

In Clark's (1996) assessment of Ellen there were two complimentary parts of herself tied with her fears about having and expressing a self. On one hand Ellen feared being controlled or destroyed by a sadistic object. To rid herself of this impotent and vulnerable part of herself, she projected it unto the therapist while Ellen herself assumed a cruel and contemptuous role. On the other hand, Clark (1996) felt that Ellen also projected her sadistic and controlling part onto the

therapist at the same time she became submissive and empty. The author also notes the provocative quality of Ellen's submissiveness.

Many qualities of Ellen's use of projective identification support the possibility that she tested her therapist using both passive-into-active and transference testing. In projective identification, the therapist often finds herself experiencing powerful negative feelings that don't seem to come from within. This experience is also one of the primary circumstances identified by Weiss (1993) that may signal to the therapist that a test is occurring—when a client "behaves in such a way as to arouse powerful feelings in the therapist—for example, by being provocatively boring, contemptuous, seductive, or impossible" (p. 95). Moreover,

> The patient who disturbs the therapist is almost always turning passive into active; that is, he is testing the therapist by behaving as a parent or older sibling behaved toward him. He hopes that the therapist will not be crushed by his behavior as he was crushed by a parent's or sibling's behavior. In most instances the patient is also transferring… [hoping] that despite his disturbing behavior, the therapist will not reject him by giving up on him. (Weiss, 1993, p. 113)

It is conceivable, then, that Ellen's use of projective identification was in fact a way for her to test her pathogenic beliefs. She did so by introducing into the therapeutic relationship the traumatic relational dynamic that originally caused her to form pathogenic beliefs about her empty self. She alternated projecting different roles onto the therapist and assumed the opposite role. When Ellen projected the impotent and vulnerable parts of herself onto her therapist, she herself became "cold, supercilious… with a hint of cruelty and contempt" (Clark, 1996, p. 158). This made her therapist feel "controlled by her and, in response, helpless and impotently enraged" (Clark, 1996, p. 161). Conversely, when she projected the sadistic and controlling

parts (internalized from her parents) on the other, she became "fluttery, dithering, [and] provocatively air-headed" (Clark, 1996, p.161). This, in turn, elicited in her therapist "a powerful urge to sadistically attack her" (Clark, 1996, p. 161). These alternating roles between Ellen and her therapist through projective identification were manifestations of the two modes of tests; in the former case, Ellen was using passive-into-active testing while in the latter, she was using transference testing.

Ellen's immediate responses to Clark's (1996) interventions in these moments of testing indicate that these interventions passed Ellen's tests. When Clark (1996) experienced feelings of either sadism or impotence, instead of acting on these feelings she responded by asking Ellen how she was feeling, and at times by interpreting Ellen's behavior as her way of "revealing and not revealing herself simultaneously," (p. 161). Ellen's response shows clear signs of a passed test:

> First she tried to control the behaviors and then she was able to express her hatred and hostility toward me directly. Most of this hatred was generated by her fantasy that, if I knew her, I controlled her. *When she noticed that her expressions of anger failed to provoke retaliation, she became more able to identify and express all her feelings* [emphasis added]. (Clark, 1996, p. 161)

As stated earlier, one of the signs of a passed test is when the client response by becoming more relaxed and insightful (Weiss, 1993). Ellen's expression of her feelings was both evidence of insight and a clear sign that her pathogenic beliefs about the dangers of doing so were weakened. She used both transference and passive-into-active testing to disconfirm her belief that expressing her feelings, or even having feelings of her own, is dangerous. Clark (1996) passed these tests with her attitude just as much as, if not more than, her interpretations. According to

CMT, interpretations "are only useful to the extent that they disconfirm the patient's specific pathogenic beliefs" (Silberschatz, 2005, p. 11). The author's interpretation that Ellen was finding ways to hide her feelings may have implied to Ellen the therapist's acceptance of her feelings and the expression of them. It seemed equally effective for the author simply to inquire about how Ellen was feeling in those moments. In other words, by simply showing benign interest in Ellen's feelings, Clark (1996) was responding to her in a way that directly disconfirmed her beliefs that she would be harmed, controlled, or rejected for having and expressing them.

After these passed tests, Ellen continued using projective identification, something for which her therapist expressed concern. The nature of this projection changed, however, and that seems to imply that Ellen was engaged in testing a different aspect of her pathogenic beliefs around emptiness. Instead of feeling "sadistically engaged," her therapist felt bored and sleepy, at times struggling to stay awake. Clark's (1996) own words precisely describe the nature of this transference test and the pathogenic beliefs beneath it:

> Hard as it was to bear, I thought that my sleepiness was, in fact, a good sign. Ellen was on the move, trying more boldly to express her feelings and needs. In other words, she was becoming more separate and autonomous. Correspondingly, feelings of abandonment by a bored, indifferent, and unresponsive image of her mother were emerging… I was being induced to reenact the mother who slept through Ellen's psychological awakening and who, by failing to notice and support that awakening, made it too terrifying and shaming for Ellen to continue to express herself. (Clark, 1996, p. 162)

The therapist's intervention in these moments was the same as before: she would simply ask

Ellen how she was feeling. In this case, Ellen responded by revealing her feeling of aloneness and terrifying emptiness, the emptiness of "shouting into space" with no response (Clark, 1996, p. 162). Once again we see that the response of the therapist to the projective identification evokes a positive response in the client, allowing her to access and discuss her experience with some insight.

In this case, Ellen was testing a deeper, more vulnerable aspect of her pathogenic emptiness. This makes the test itself more dangerous should it fail. Whereas before she tested with her therapist the defensive aspect of her emptiness—of whether or not she must repress or empty herself of a self—now she was testing the profound emptiness she felt from not having her emerging self nurtured or supported as a child. This is the pathogenic emptiness associated with the deficiency in the development of her sense of self (Singer, 1977a). Due to just how deep and vulnerable this particular emptiness was, it could only be tested after safety was established through the therapist's passing of her earlier tests.

Sunyata and Healing

Disconfirmation of pathogenic emptiness, in the end, appears to result in a more nuanced self-experience that, though it may not be the experience of *sunyata*, is at least a movement in that direction. The mental factor of *wisdom* is present in the mind-moments that weaken the pathogenic beliefs. It has a particular meaning in *Abhidhamma* as insight into the three marks of existence: impermanence, suffering, and non-self. In Chapter III *sunyata* is described as a middle way that neither reifies nor denies the self. Instead, *sunyata* involves a nuanced understanding of the self as having "a momentary reality of its own in the ongoing flux of change and transformation" (Engler, 2003, p. 76). The techniques of CMT do not put forth specific recommendations about working with pathogenic beliefs about the self. A therapist

working in this modality starts from the presumption of a drive for mastery, and expects that the client has both the problem and the solution, and the therapist is there mostly to create a safe environment and to pass tests. However, the therapist's own assumptions about what it means to have a healthy sense of self would influence her understanding about the nature tests that are occurring, the pathogenic beliefs being tested, and most importantly the correct response that passes the test. It is easy to see how this could influence which pathogenic beliefs about the self are disconfirmed or reinforced. Take, for example, a client who has pathogenic beliefs about the self at the opposite end of the spectrum, experiencing rigid boundaries of self, a sense of permanence, separation. Rather than providing comfort, for this client it results in feelings of "otherness" and aloneness. While the therapist will easily recognize the symptoms, she may not recognize the nature of the test if this reflects her unconscious beliefs about the self. She may "fail" these tests by responding in ways that reaffirm the pathogenic self-experience of her client.

Yet despite this, working within a theoretical framework that incorporates Buddhism and CMT, and focusing just on the phenomenon at hand—*empty* self-experience—the observation that disconfirmation appears to naturally lead toward *sunyata* is striking; and we find evidence for this even in the case of Ellen.

Ellen's example. As passed tests serve to weaken Ellen's pathogenic beliefs about emptiness, and she gradually begins to abandon them. What emerges is a self that is full of confusing ambivalence and contradictions, which at first she finds difficult to tolerate. But she is able to tolerate them more in more having been provided a safe environment to do so. Having moved from emptiness as "not having any self" she is now ready to have a self but is struggling to pin down what that is. The ambivalence seems to her to be an obstacle to that at first. As time goes on she learns to allow the ambivalence to exist and to accept multiple, fluid, and

contradictory parts of herself as that self. According to Clark (1996), Ellen came to recognize the importance of experiencing her shifting, contrary wants and needs as a pathway to separation/individuation, and her "correct experience of that perception as the doorway to her dawning recognition of the nature of her real self" (p. 164). Ellen expresses this in her own words:

> There are a lot of different feelings in me, and I am beginning to accept it. I am beginning to enjoy the day, maybe not even a day, maybe a moment when I feel joy, knowing that there may be utter turmoil in the next moment, because I can accept the turmoil. Because of this, I feel a bit more spontaneous, more social, more relaxed. (Clark, 1996, p. 165)

This sounds remarkably close to a Buddhist understanding of mental health. The spontaneity and effortlessness of action was also reported by Tarrant (2007) in discussing his experiences with sunyata, characterizing his actions as "blowing out from the depths." Wisdom, which as we noted is present in the mind-moments that weaken the pathogenic beliefs, is defined specifically in reference to insight into the three marks of existence: impermanence, suffering, and non-self. We also see Ellen's insight into the "three marks of existence"—she experiences a real, existent self that is not fixed, rather it is in flux. Insight into non-self means both not reifying the self as well as not reifying emptiness.

Her ability to tolerate this fluctuating experience of the self can be further represented in the presence of some of the other universal, so-called "beautiful," factors of wholesome mind-moments: tranquility, malleability, wieldiness, neutrality, non-greed (desire, for example, in wishing things to be some way that they are not). Just as with the reinforcement of pathogenic beliefs, this non-pathogenic self-experience of *sunyata* is subject to the same process, becoming

a part of a reinforcing cycle of wholesome kammic influence on perception. This is what eventually leads to type of consciousness seen in Buddhism as irreversibly leading to liberation from suffering, consisting of the supramundane mind-moments referred someone esoterically as *stream entry*, *once-returning*, *non-returning*, and *arahantship*[3]. However, this ultimate liberation from suffering is only possible through meditative practice. Although the essential role meditation plays in Buddhism may not find an equally venerated position in clinical practice, examining its elemental presence in mind-moments involved in disconfirming pathogenic emptiness, it could perform a beneficial adjunct role to therapy performed in a CMT framework.

Meditation. In all of the wholesome mind-moments involved in the disconfirmation of pathogenic emptiness, mindfulness and the other elements of meditation are present: wisdom, non-aversion, initial application, and sustained application. Since testing depends on the individual's ability to observe, even at an unconscious level, their own pathogenic beliefs in order to test and disconfirm them, these factors would play a key role in these mind-moments. Recall that the *adverting* phase is a functional mind-moment, devoid of *kammic* influence. This implies that in the cognitive process when one is examining a pathogenic belief, one cannot at the same time be distorted by that belief within that same cognitive process. In other words, at the precise moment where pathogenic emptiness is being examined, one is essentially free of its grasp. Furthermore, the meditative practices of *samatha* and *vipassana* are said to increase the intensity of these mental factors (Bodhi, 2000; Olendzki, 2008). It may therefore be surmised that meditation could make the process of disconfirming pathogenic beliefs more efficient by increasing the efficacy of the mind-moments responsible for testing and disconfirming these

[3] *Arahant* literally means "worthy one" and is traditionally used to refer to very advanced Buddhist practitioners who have eliminated all trace of *kamma*, wholesome or unwholesome, and therefore have become free from the forces of causation and will not be reborn upon death.

beliefs. Concerted effort to engage in a meditative practice could therefore be an effective way of increasing the potency of a CMT-based intervention.

This applies even more so in the specific case of pathogenic emptiness. This is due to Buddhist practice's predominant focus on understanding the nature of the self. Employing meditation from this tradition, including the practice of taking the three marks of existence as a meditation subject in *vipassana*, suggests that the primary pathogenic beliefs that will be examined will be those about the nature of the self.

Implications for Practice and Research

In this study, I set out to examine empty self-experience in both its pathogenic form and in its beneficial form known as *sunyata*. The goal was to determine what relationship might exist between them and the implications for clinical social work practice.

My investigation into the phenomena of pathogenic emptiness and *sunyata* began with an observation that pathogenic emptiness involves a cognitive framework that has the traits of a pathogenic belief. In observing this, pathogenic emptiness could then be divided into four basic stages that apply to pathogenic beliefs: formation, reinforcement, and disconfirmation. Using *Abhidhamma*, each of these four stages were then broken down even further into "atomic" parts of consciousness: cognitive processes, mind-moments, and mental factors. Through this process I was able to relate the lifecycle of pathogenic emptiness to the process of achieving *sunyata*.

The case of Ellen illuminated the integral role that testing, a core CMT idea, had in her own healing. This is already presupposed in the classical CMT understanding of testing and the drive to mastery. We can see, however, in the case example the psychological risk involved in testing pathogenic beliefs about the self, especially pathogenic emptiness. Therefore the tests involved are very strong and trigger very strong emotional responses in the therapist. Since

emptiness is so often associated with more severe pathology, it is easy to ascribe these experiences in therapy to the client's pathology. It is tempting, for example, to view Ellen's continued use of projective identification as counterproductive or evidence of a stalled therapeutic process, as Clark (1996) had done. Instead, accepting it as the method through which pathogenic emptiness is being tested, one understands the adaptive motivation behind it (Silberschatz, 2005); it is a part of Ellen's unconscious plan to heal herself of her pathogenic beliefs and an essential part of her work in therapy. Instead of being "stuck," by testing Ellen is continuing to work to disconfirm other pathogenic beliefs, or other aspects of a single pathogenic belief. This underscores an inherent clarity or wisdom implied by the very notion of mastery as a fundamental drive.

This is also supported by the observation above of the involvement of the mind-door process in testing. Recall that the adverting phase is a functional mind-moment, devoid of *kammic* influence. This implies that in the cognitive process when one is examining a pathogenic belief, one cannot at the same time be distorted by that belief within that same cognitive process. In other words, at the precise moment where pathogenic emptiness is being examined, one is essentially free of its grasp. Combined with the mental factor of right action, not only does this accord with the view held by CMT of mastery as an innate drive, but it also has potent implications for the use of meditation as an adjunct modality in CMT-based therapy.

In light of these findings, there are several implications for clinical social work practice. A relationship was revealed between testing and meditation that suggests meditation may be a beneficial adjunct to the process of disconfirming pathogenic beliefs about the self. Specifically, the involvement of the mind-door process in testing and disconfirming pathogenic beliefs suggests a role for meditation in expediting the disconfirmation process by strengthening the

mindfulness mental factor within the mind-door processes responsible for testing and disconfirming these beliefs. This appears to be a strong *theoretical* justification for the systematic inclusion of meditation in CMT-based clinical social work.

More significantly is the application of this to the phenomenon at hand, the empty self-experience. In clinical social work practice with clients suffering from pathogenic self-experience, the CMT approach allows one to treat this as a pathogenic belief, and to design one's interventions so as to disconfirm these beliefs. Furthermore, in taking the three marks of existence as meditation subjects in *vipassana*, Buddhist meditation is specifically targeted to transforming one's self-experience from pathogenic emptiness to *sunyata*. This suggests that such an approach that employs the interventions of CMT and Buddhist meditation would especially serve those experiencing this type of pathology. What remains unclear is whether the explicit and ultimate goal of *sunyata* is a necessary part of this framework, or whether it suffices to work solely with disconfirming pathogenic beliefs about emptiness.

It is helpful to imagine the outcome if Ellen engaged in Buddhist meditation in the course of therapy focused on disconfirming her pathogenic emptiness. One might suppose a number of things, one of which might be that her testing, having gained in efficiency through meditation, might disconfirm her pathogenic beliefs about her self sooner. The insight into the conditioned nature of her self that Clark (1996) mentions as an outcome of her therapy would then be a springboard from which to continue her healing process, as the focus of *vipassana* meditation into the three marks of existence. Presumably over time, through the similar reinforcing actions of the cognitive process according to Abhidhamma, her new understanding would eventually become an unconscious belief that becomes part of her perceptual frame and self-experience and lead to the lived day-to-day experience of *sunyata*.

This hypothesis could be tested in the future via an empirical study that compares outcome variables of patients engaged in CMT-based therapy and *vipassana* meditation. Participants would be those suffering from pathogenic emptiness (for example, those diagnosed with schizoid personality disorder), and they would be divided into an experimental group that also practices *vipassana* meditation, and a control group that does not. Aside from affirming the usefulness of meditation in CMT's particular therapeutic approach, such research might also be another validation of some of the basic tenets of CMT such as the drive to mastery and the individual's level of control over their unconscious processes. It could also demonstrate the viability of meditation to combat our "everyday neuroses" and suffering that result from more subtle, and perhaps more socially accepted, forms of pathogenic emptiness or, in our society, the opposite pole of narcissistic craving.

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