# INTRODUCTION

Lately there has been increasing focus on the concept of "emptiness" as a symptom of Borderline Personality Disorder, most recently recognizing it as an actual experience and not just a metaphor. My own studies over the past four decades have led me to a similar but much more encompassing conclusion.

I believe that emptiness is only one of a group of similar patient experiences, which are not limited to Borderline patients, but may be universal to severe psychopathology in general. Such experiences relate to an inner sense of numbness, emptiness, and deadness among many others and lie at the center of many patients' behavioral difficulties. Among such experiences are hollowness, aloneness, a black hole, an abyss, as well as certain expressions of pain: pain in my stomach, stomach ache, dead stomach. Depending on how intensely such experiences are felt, they can be horrific. This is a point missed or underestimated by many clinicians: these experiences can be excruciating and very literal for patients; and they cannot be felt by those who do not have severe psychopathology. These are not some form of existential state and they can lead directly to people's wanting to die; in fact, the presence of such states is, I believe, the *sine qua non* of suicidal behaviors. This first factor is known by the (for some) scary name, "the dead zone". Some prefer the less scary title, "the big empty".

A second factor in serious mental illness is not well studied directly, though there is a great deal of focus on it, misunderstood but surprisingly effective, in areas such as distress tolerance and emotional regulation. This second factor relates to the difficult concept of boundary intrusions. Basically, when someone with serious mental illness starts to experience an emotion, vulnerable ego boundaries leave that person feeling assaulted, literally. *The problem is not the emotion, but the sense of invasion the person perceives as the emotion arises within them.* It is this sense of assault which leaves the person in extreme distress. Again, many clinicians will underestimate the degree of pain associated with this experience, even though in many cases it is psychologically equal to an actual traumatic situation and can be accompanied by a total sense of being violated and out of control, and gives rise to the well known reactivity of such patients. This second factor is known as "the done to".

These two factors, the psychological equivalents of *dying* and *being assaulted,* are cyclically related: a person can end the sense of assault by shutting down the emotion which was originally perceived to be invasive; but then they move into the dead zone. If they are in the dead zone, they can move toward more stimulating environs, but then more affect will arise and they will perceive more instances of being assaulted. They are trapped.

This paper is intended to provide information on this cycle, how it causes problems, and what one might do about it. This is not a complete work, but truly a work in progress. And while there may be some grey or questionable areas, overall the information should be helpful, as it has been for hundreds of others who have treated with me.

# DISCLAIMER

This article is not based on strict research studies and methodologies. Moreover, many of the terms used, even those as simple-appearing as "feelings", have several definitions and often have poorly or only partially understood physiological bases.

What this article is, is a compendium of patient's phenomenological responses to, and their experiences of, major psychological issues. That is, in asking hundreds of patients the same questions over the years, I began to hear the same or similar answers from many of them. These answers were often largely ignored or unintentionally distorted by clinicians whose primary source of information was not patients' statements directly, but other clinicians' written impressions of those statements, a type of clinical version of the children's game, "telephone".

Because what you are about to read is taken from others who have had exactly the same experiences as you, when you read some of the ensuing material, you may actually feel jolted and deeply shaken. It is not that you will disagree with the explanations, necessarily, but it may seem much "too close" to home for any initial comfort.

I have to caution you that some people who hear these concepts and then struggle to work with them too soon have had to be hospitalized. The material is simply too powerfully revealing and stark for some people to handle. Others of you may feel confused or turned off, feeling the material does not apply to you. However you approach this, make sure you have a clinician (therapist) with whom you can discuss the material if you are upset. Again , this is not my caution per se, it comes from others like you have been helped, but initially overwhelmed to hear what you already know to be true but have never heard spoken directly.

**DO NOT TAKE THIS MATERIAL LIGHTLY, IT CAN BE VERY UPSETTING FOR SOME**. It is written to help and elucidate, as it has done for many people; but please be very aware of its potential impact, mostly helpful, I hope, but occasionally incredibly scary in its initial hearing.

Those of us who have worked closely with you over the years and who have gained some of this insight are moved by the heroic struggles in which you engage every day. I hope this material will help you understand why and to alleviate some of the struggle.

If you are reading this material on the internet, I suggest that you print out copies for you and your therapist so that you may read the material together in your therapy sessions. In that way, if you are upset or confused, you have an immediate opportunity to process the information.

## UNDER SEIGE ON THE EDGE OF THE BIG EMPTY

THE PHENOMENOLOGY OF SEVERE MENTAL ILLNESS

This work is dedicated to Jalna Perry, MD, without whose guidance I might never have known what I was hearing

This paper has a dual purpose: first, it is for you, the countless patients over the last 30 years who have asked, "Is there anything written about this so I can learn more?" For some of you, the concepts discussed here will leap off the page at you, so powerfully that they may scare you, as if someone has looked deep within you without your permission. The explanations presented here have been gathered from the words of others like you who have suffered with the same issues, so the words ring true and very close to home.

For others of you, the ways you have currently found to cope with the issues to be discussed here may prevent you from seeing exactly how they relate to your daily struggles; and for still others, you may see yourself as exactly opposite from what it seems is being discussed.

I urge all of you to take the time to sift through this material: it is at once crystal clear and totally opaque. Even a slight grasp of some of these concepts, however, can begin to help your recovery in ways you have never experienced.

For clinicians who are reading this book, I hope these concepts are equally helpful, but they will require that you be willing to understand old concepts in different ways, ways in which you were not trained in your graduate schools and training programs. Basically I will be suggesting that you hear what your patients are saying as *they mean* what they are saying. I have trained hundreds of the brightest psychology, social work, and psychiatry students over my forty years of supervising those in clinical training. What I am proposing to you will be difficult at first to see in its comprehensiveness, until you pick up the language; but once you do, you will grasp far more of what makes your patients tick, including their self-destructiveness and suicidality, than you do now.

The constructs we will explore are universal to severe mental illness; and in today's world where new psychological theories proliferate and demarcate innumerable

aspects of psychopathology as foci for treatment, this paper aims to simplify and to highlight *what may be common to all serious problems*.

The second purpose of this paper is to provide, for clinicians, an integrative basis for modifying empirically supported treatments (EST's). As is clear from the latest literature, since EST's are typically validated on specific research groupings of subjects or patients, they are not easily applied to more typical patient populations, and so must be modified. While knowledge of a particular diagnostic group, or of a particular patient with whom a therapist is working, or of special cultural considerations, can all suggest ways to modify an EST, such modifications are rarely related to some underlying theoretical principles of psychopathology. As such, there is often no set of principles suggesting a theoretical basis for modifying EST's in a systematic way.

Very often in my training of "new" therapists, those trained in Cognitive Behavioral (CBT) or Behavioral methodologies can recoil at the notion that one needs any extensive theory of pathology or personality to support the consistent implementation of CBT or Behavioral techniques. However, when it comes to severe psychopathology, in order to avoid a "well-let's-try-this-and-see", individually-tailored approach, a theoretical understanding that informs treatment modifications is not only necessary, but critical. The second part of this paper will therefore address using the theoretical explanations set forth in the first part of the paper as one basis for modifying EST's.

## **Part I** - F**eelings and the Sense-of-Self**

Deadness, numbness, emptiness, and aloneness, among other experiences, are prominent serious mental health issues. In fact, very often when one explores reasons for depression and anxiety, such issues are incredibly frequent in patients' explanations. As clinicians we are prone to hear such complaints as vague symptoms of a mood disorder which we can help patients learn to understand, or to work around. For example, a patient who finds loneliness intolerable might learn techniques for lessening the pain of the loneliness or for finding social relationships to end the loneliness at least situationally. While such techniques can provide help in these situations, I believe that we undermine our own best intentions by making an erroneous assumption about what patients actually mean by states such as deadness, emptiness, and numbness. So we might assume that someone "feeling" dead is struggling with some anhedonia. This formulation would lead

a clinician to a well-meaning but empathically faulty idea of the depth of this patient's agony. The deadness patients experience can be excruciating, as if a weight is crushing the life out of them. Literally! Far from being a "lack of pleasure" in their lives, it is more akin to their being murdered, however distorted such an experience is. If a clinician can begin to see some of their patient's emotional reactivity and intensity as deriving from the patient's sense of an impending near-death experience, suddenly a patient's screaming at you seems more empathically understandable.

Such experiences as deadness, aloneness, emptiness, hollowness, and being devoid of a heart, cannot be typically empathically recreated within a treater because they are not states that a healthy person can ever begin to experience. That is, patients use such words to describe a level of reality which is so much more painful than most clinicians can understand and which cannot be "normalized", the loss of one's sense of aliveness. *This process is not metaphorical; it is concretely descriptive of a horrific internal state: a patient experiences some symptom which tells them are dying.*

A "sense of self" is a concept developed to capture the ongoing sense of one's aliveness on an emotional level. It is a premise of this book, based on what hundred's of patients have reported, that the sense of feeling emotionally alive is crucial to human functioning. In order to have a sense of self, one must (1) feel one's feelings and (2) feel them as one's own. The word "feel" here is critical: it is not sufficient to "know" or "behave" one's feelings. One must <u>feel</u> them. And it is commonplace among patients to believe (cognition) that one *is* feeling or to appear (behavior) that one is feeling while actually *feeling* nothing.

Many years ago I led a group of inpatients at a time during which we were trying to cut lengths of stay on inpatient units. I asked these patients, some of whom had been in the hospital for 2 or 3 years, "what do you need to get better faster?" A patient answered, "you [therapists] tell us to talk about our feelings. We do! But it doesn't help!"

Ordinarily a therapist might hear this as a transference rebuke ("you don't do enough for us") or as a statement of learned helplessness, but I heard something different that day by listening concretely to what patients were saying. I asked what was it about talking about their feelings that did not work. The answer to this question was startling, but an answer I have now heard hundreds of times: "we talk about our feelings, but we

don't feel them." I was fortunate at the time to have a few supervisors who understood the meaning of what these patients were saying. With these patients' comments and with my supervisors' help, I began to explore the nature of "feeling".

In our culture we tend to use "feeling" for all sorts of experiences. Whether cognitive ("I feel confused"), behavioral ("I feel achy"), or emotional ("I feel sad"), we tend to speak of all of our experiences as types of feelings. However, experiencing an emotion* is not a cognitive or behavioral event per se, though to the detriment of our field we often muddy the waters by talking or writing about a "feeling" whether we really mean a thought, a behavior/physiological response, or truly an emotion. Cavalierly we note that emotional experiences are just a way of capturing a change in blood pressure or cortisol or some other physical change. I disagree. I think human emotion is far from understood in its complexity and it is arrogant of us to disdain the magic of the heart.

First a definition, or at least an attempt at definition is in order. A <u>feeling</u> is an internal sensation, located within the trunk, as if one were a large container within which such sensations *move* about. Such sensations have two characteristics. First, the sensations seem physical, as if something is actually, really, literally moving inside. Second, the sense of movement is nonsensical. That is, the sensation could never actually occur as it seems it is. For instance, if one has "butterflies in [my] stomach", we recognize this as nervousness or anxiety. It is as if butterflies are flitting about inside one's stomach. It is not merely metaphorical, but is descriptive: it is the *sensation* of butterflies flying around in one's stomach, as if there were real butterflies there. But of course this is absurd. The same is true for other emotions: "my heart sank", "my heart leaped up into my throat", "my stomach dropped", "I had a sinking sensation", and so on. While we list scores of different emotions in our books and self-help manuals, I believe there are only a few handfuls of emotions and some variations on the theme. Happiness, sadness, fear (anxiety), anger, love and what are sometimes referred to as the social or combinatory emotions: jealousy, shame, embarrassment, humiliation, guilt. Other emotions are often related to these as more or less intense variations: terror, hatred, grief, and so on.

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* In this book I will be using "feeling" and "emotion" interchangeably, but with a careful distinction between them and thoughts and behavior. More will be presented below.

Often times, however, other non-emotions are added: confused, frustrated, overwhelmed, and so forth. While these experiences often connote feelings, they are not feelings per se. Even more confusing for both patients and therapists are those physical states which often accompany feelings (psychophysiologic responses) but which are similarly not emotion per se: tension, tightness, and pressure, for example.

The nature of emotions themselves is also poorly understood. A few clarifications might help, though I suspect many of you could find fault with what follows. (The difficulty here is that I am trying to link visceral experiences with brain function in an integrated and common-sense way.) First, a feeling is after all a nervous (*i.e.*, nerve) impulse, which though it may seem to be more complicated, is only that. But it is also an expression of one's heart at a moment in time, a vote about your heart's opinion. A feeling cannot do anything or cause anything independently: while they may be associated with certain behaviors, they cannot directly cause behaviors: there is a complexity of intervening processes which *correlates* behavior and feeling with cognition.

Second, feelings can never be wrong. One may not like how they feel, or wish they felt something else, but the feeling itself can never *be wrong*. A cognition can be irrational, and so the feeling which goes with it may seem illogical, but the feeling itself is not wrong; the cognition is false, not the feeling. For example if one is terrified to walk past a graveyard at night, we might say that's an irrational feeling. But in fact, the belief that there are unnatural things in the graveyard which could harm one is an irrational thought. The feeling of terror is what anyone would feel if they believed such a thought. Emotion is not supposed to be logical; logic is the province of the brain, of cognition, not of the heart.

Third, one cannot change a feeling at a given moment, that is, you cannot *not* have the feeling that is within you. You might not be aware of the emotion, but if it is within you, it is your feeling. If you want to have a different feeling at some later point, fine; but that change begins with being able to experience and accept your original feeling.

Fourth, as implied above, feelings can never harm you or anyone else. Never ever, ever, ever. A feeling can be excruciatingly painful, but as human beings we are

made to withstand such experiences (I am setting aside real trauma situations here, but will address them in a later section.) Your emotional heart cannot destroy you, or attack you, or damage you. It is a complex and immensely rich source of information for your brain to consider and use in guiding your life. (If you *express* a feeling, you have moved into behavior; and *expressing* a feeling can indeed hurt someone.)

A major difficulty in understanding these issues is that feelings are typically subtler than cognitions and behaviors: they chug along in the background of our awareness. So long as they are flowing (i.e., getting back to the brain from the point at which they arise, perhaps along the vagus nerve), they can be largely consciously ignored for long periods. This subtlety is necessary since when a feeling does come into awareness, it is often demanding of our attention. If this type of experience happened constantly, our attention and concentration would be interrupted at that moment by our becoming directly aware of our emotions. The point here is that most of us are largely unaware of actual feeling experience. So long as the feelings (the "absurd sensations") are being fed back to our brains, however, awareness can be quite variable: if we need to, we can most likely bring it into our awareness.

In some patients, however, the sensations which are the feelings are blocked on their way back to the brain. When the brain "looks" for those sensations, it then "sees" *nothing* within the nerve pathways coming from our "heart" or "gut". This absence of feeling, this nothingness, is then given a descriptive label and may even seem like a "feeling" (*e.g.*, "I feel numb"). If the feeling is blocked in its pathway back to the brain, however, then it cannot be brought into experiential awareness; and one has a very significant problem.

This type of block likely occurs before the feeling-nerve impulses reach the brain. Other psychological defenses, I believe, occur after a feeling registers in the brain. Such defenses (*e.g.*, denial) in effect modify affect and cognition to keep one from registering distress. The block about which I am speaking happens before the emotion registers in any conscious or preconscious way in the brain.

### The "Dead Zone" and the "Done To"

There are numerous systems (theories) which therapists use to try to understand and explain severe psychological problems. In the system which I am proposing, two

concepts can be used to understand the way patients describe their experiences and behave in diagnostically characteristic ways. Many people with these types of problems share two categories of experiences: some people "feel" dead, numb, empty, robotic, utterly bored, heartless, or alone*. Others constantly "feel" overwhelmed, trapped, smothered, pressured, or under attack in their daily lives, often thinking that they feel "too much" or "too intensely". Still other people have both types of experiences, and in fact move back and forth between them. The interplay between these two experiences captures the essence of severe psychopathology and can explain most severe psychopathology from a patient's perspective.

The first of these experiences is the "Dead Zone", "the Big Empty", the inability to *feel* the feelings which are within you. Often the sense of emptiness or hunger which patients experience is attributed to problems in infancy. I believe such "hunger" descriptions actually reflect only the sense of the emptiness, and not its origin.
The second experience, the "Done To", reflects the inability to feel your feelings *as your own*, as arising within you based on who you are: not "to" you, but "of" you.

While there are different theoretical ways of grasping these two concepts (the "Dead Zone" and the "Done To"), and while the literature suggests different theoretical explanations (such as the projection of anger for explaining one's feeling attacked), this book takes another position. In its simplest form that position is this: some people at some times perceive their emotions as alien and foist upon them by the outside world, as if they were being assaulted via the world with their feelings as the weapons of attack. While such people can then struggle with the outside world to stop this perceived attack, it may be easier for them to shut off their feelings and become unfeeling, emotionally dead. If there is no feeling, they cannot perceive themselves to be attacked by it. The sense of being assaulted via one's feelings is what is meant by an "ego boundary intrusion" *as a person experiences it*. The experiences of deadness, emptiness, and numbness then are actually caused by a person's turning off their emotions to some critical degree. Technically, people cannot actually turn off their emotions in this way; it happens as a protective mechanism outside their awareness, like a circuit breaker

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* "Alone" in this explanation is not a feeling or a physical description. "Loneliness" is an emotion. Alone, however, implies that you have shut down the feelings which otherwise would connect you to the world around you in some way. Patients often use "lonely" when they actually mean "alone".

"blowing" and shutting off the flow of electricity in your home.

Why would someone, even unconsciously, make themselves "feel" dead? The answer is straightforward. If someone perceived that they were being assaulted when they began to feel something, wouldn't it perhaps be preferable to "feel" nothing rather than to feel assaulted? Those of you who deal with trauma may see parallels between this discussion and aspects of traumatic responses. In fact, there is a major connection between the more general perception of being assaulted and the actual assault which triggers trauma. An example may prove instructive.

> A patient reported "feeling" increasingly suicidal over the previous evening. He explained that he had begun to think about a past love. Though what he had been thinking about was of very happy times, he had a "rush" of intensely painful "feeling", as if something destructive was happening to him, almost as if he were being attacked. Then, over the next several minutes he found himself getting "depressed" over his memories, and ended up wanting to kill himself.

I use the word "feeling" in a very specific way, as noted above, but in terms of this vignette, the patient's using "feeling" to describe different human experiences confuses the picture of what he was actually experiencing. Technically, a person really does not "feel" suicidal. In fact, it will be a major focus of this paper that <u>if a person is really feeling their emotions, they will never become seriously suicidal.*</u> What the patient above meant was that he had thoughts and urges (behavioral tensions) about killing himself. What had he actually told us about his feelings (emotions)? Nothing. Many people would assume he was sad thinking about his lost love. But more likely his feeling in the initial moments actually was happiness, as the memories were of very happy times.

So what went wrong? Again, most people would assume that he just became overwhelmed by his grief that such happiness had been lost; and so he wanted to "end it

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* For clinicians reading this, you may be able to test this statement. Picture yourself cutting your wrists. Try to "get into" the experience, to see it vividly, actually, in your mind. Note the reaction you are having which occurs as you imagine cutting into your own flesh. If you are like the scores of trainees I have asked to imagine the same scenario, you will experience such horror, fear, or revulsion, that you cannot even imagine such a reality.

all". But this would be jumping to conclusions and misunderstanding what was actually happening. It is incredibly important for clinicians not to assume that they know their patients' experiences without asking them. Consensual understanding may not be so obviously consensual in the context of a patient's pathology.

As the above patient's experiences were clarified with him, the following understanding emerged. Basically, he could not really identify his emotional experience in its simplest form. The "rush" of intensely painful "feeling" was not emotion per se, but rather was his sense of being assaulted by his emotion as it arose within him (the "done-to"). Before he could identify his actual feeling (which I suspect, as I noted, was real happiness) he responded to the perception of being attacked by shutting down the feeling which was just starting to come into focus. Once he had shut down the feeling, he stopped the perception of being attacked by the emotion. Far from being safe, however, he had moved into the "dead zone" (what he called "depression"), and feeling dead, he began to think about being dead (suicide).

A further word about the "dead zone" is in order. The dead zone (or "the big empty" as a patient once called it), is not a real situation (no one is ever really dead because they are affectively shut down), but rather it is a real experience. The direct experience of the dead zone is actually horrific, an intolerable sense of psychologically dying. It is an intense state of psychic dissolution which seems real to the person experiencing it. Much of the time people have the ability to defend against experiencing the dead zone, so often they are unaware that they are "in it". People who do not have a sense-of-self problem cannot understand this: the dead zone only occurs to people who shut off their feelings. It is utterly different from the sense of existential aloneness that humans can experience. If one has never dealt with the experience of the dead zone, one cannot even begin to imagine the horror of this non-feeling state. For those of us who daily practice psychotherapy, this inability to grasp the degree of pain generated by the dead zone makes true empathy nearly impossible.

But even people who are contending with the dead zone can be unaware of its presence or effect. For instance, a patient once presented with chronic, intense stomach pain. No physical cause had ever been found but the pain was debilitating to him. One session he noted that smoking a cigarette made the pain go away. Although there is some experimental medical data suggesting the role of nicotine in anesthetizing pain, I began to

ask him to describe the pain, what it was like. He answered by noting how painful it was ("It's awful!"). I pushed him to *describe the pain* itself, rather than its intensity. He immediately said that it was like a "terrible emptiness" inside him, "like a hole". Through further exploration, it became clear that what this patient was experiencing was not physical pain, nor the pain of some emotional state, but the pain of *not feeling*, i.e., the dead zone. Smoking was a way to "fill himself up" and no longer to feel empty.

Although the comparison is far from perfect, this description of patients' experience of the permeability of their ego boundaries is sometimes more easily understood as an "emotional auto-immune" response. That is, on the physical level, the "brain" may respond to a healthy cell as if it is a germ, an invader from the outside. Having perceived the cell as dangerous, it sends immune bodies to destroy it, thereby "saving the day". However, the cell was not invading, it was part of the self: the perception of the cell as a killer was wrong, not the cell itself. Substituting an emotion for the cell, in this example, the brain perceives the emotion as dangerous because it is "intruded" into the self, so it tries to destroy the feeling by shutting down its experience. No feeling, no sense of being assaulted by it.

## Aliveness

Feelings serve several crucial purposes in our lives. Obviously they tell us what we are feeling, and how much we are feeling. As feelings circulate within us throughout the day, however, they provide a background sense of our being alive, responsive, emotionally connected to the world. This continual ebb and flow of connectedness to our lives provides us with a sense of emotional aliveness and of being grounded in our real experiences. If something occurs to diminish that sense of aliveness, after a certain point, one begins to enter the "dead zone", to lose one's sense of aliveness and move into a particular version of hell.

Feelings also play a major role in numerous other psychological functions. For example, many patients with sense-of-self problems report poor memory. Typical emotional content can help people recall material either by bringing back the emotional surroundings in which the learning occurred, or by bringing back the emotional importance of the material.

Motivation also depends on feelings, as the ability to feel happiness or the lessening of fear provides an emotional push to a particular course of action. The idea of making something better is far more activating when it is accompanied by a feeling of happiness about a change.

Hope is also tied to feelings, as a shift from how one feels today to how one could feel tomorrow as things get better provides a gut level shift which makes "hanging in there" more real. You can anticipate the shift in feeling when you can experience today's emotion compared to tomorrow's emotion if things were to get better.

As anyone who struggles with psychological problems knows, or who treats those who suffer from them, problems with motivation and hope pose formidable obstacles to the desire to get well. Without feeling actual feelings, people are often left with wishes and will power, cognitive states/skills which can ring hollow without the energy behind them provided by emotion.

**Input** Types of Input: As just noted, the constant internal flow of emotional changes provides a sense of aliveness. It is a type of constant input confirming our existence, a type of eternal flame that burns steadily no matter how awful our daily lives appear. When emotions shut down, this crucial input disappears. There are few coping mechanisms one can find to deal with the resulting dead zone, but the most critical involves getting other sources of input. Initially, however, let's step back and begin with other, simpler, forms of coping. It is my belief that all people with self problems use the same categories of coping skills. **First**, if feelings are shut down, a person is forced to try to **use logic** to compensate, to try to figure out what the feeling "must" or "should" be. Basically such a person is left to make educated guesses or to collect opinions about what they are probably feeling. Unfortunately, they can never just "go with their gut" because there is no gut level experience except empty. Using one's brain to monitor all situations in life becomes taxing and eventually can contribute to depressive burn out, but it is more risky *not* to use your cognitions to guess at your feelings when you cannot actually feel them.

**Second**, people with self problems all **use distraction** as a major means of staying away from the dead zone. That is, anytime the dead zone comes into a person's awareness/experience, their brain will direct that person to get involved in something else. Anything which takes a person's focus off the internal sense of numbness is an

effective distraction, and almost anything can be a distraction. From watching TV to playing video games, to going to school or to work, to sleeping, all can be effective distractions and move one away from an encroaching sense of inner deadness.

The **third** coping strategy people employ to deal with deadness takes us back to the above discussion of input. If a person is not getting input internally, from their feelings, they will be forced to **get input from other sources**. The basis of input is that it gives a person a sense of being alive or at least a belief that they are alive. Anything which can provide such a substitute sense of aliveness can be "external input". That is, anything which the brain can use to deduce aliveness can be substitute input. If someone looks at you, talks to you, gives you a raise, flunks you in a course, all these relational situations can reflect that you are alive (*e.g.*, professors do not give dead people grades, therefore you exist). Another type of external input which can be effective is to recognize that one is reacting affectively, even if one "feels" dead inside. For instance, I had a patient who, whenever she "felt" empty, would go out to window shop in Harvard Square. When asked how this helped, she noted that she could see her smile reflected in the windows and knew from that image that she was alive.

Problems with External Input: The best external input comes from other people, regardless of the situation. If someone cares about you and is "there for you" when you need them, their presence indicates that you exist and pushes the dead zone away. Unfortunately, this type of use of external input carries several problems with it. First, whenever the input source leaves, or stops, you will begin to drift back to the "dead zone", *i.e.*, you begin to die psychologically. People with sense-of-self problems are often seen to be attention seeking, demanding, manipulative, and unstable in their interpersonal relationships. I feel that these "clinical" views are pejorative and "put down" these patients. Let me ask, if you experienced yourself about to die if someone left you, would you not be desperate as well? When someone is battered, others often ask, "Why does she/he stay and endure such pain?" The answer on one level is that if they leave, they die (emotionally/ experientially). Being beaten is then better than losing the input and becoming (psychologically) dead.

Second, the quality of input defines your value. That is, if the input is positive, you are alive and good; if the input is negative, you are alive but bad. People in these situations prefer negative input to no input at all, yet it is painful to be defined by the

outside as unlikeable, so people will struggle with the outside to have the external world switch the input to good. This aspect of the input process often adds to the view of such patents as even more manipulative.

Third, if the loss of input happens suddenly, it can leave the person "feeling" murdered by the outside. While this may seem a strong way to phrase things, I believe it just barely captures the experience of the person needing the outside input. On the one hand, I believe that most impulsive suicides have this experience of being "murdered" as part of the impetus behind their attempt. I have interviewed dozens of people in this circumstance and all report some sense of being wiped out (made "dead") by the other person and then struggling to take some type of control over their own "death" by making themselves dead.

> Perhaps the most dramatic example of this for me occurred years after I began to see these dynamics play out. I was sitting at the dining room table in a halfway house, waiting to interview a patient. Another patient was talking to her mother in the phone booth next door to the dining room. Their conversation became heated so that I could hear the last several statements the patient made. Finally, she dropped the phone and stormed out of the booth, screaming, "You can't kill me! I'll kill myself!", and she pulled a bottle of pills from her pocket and attempted to swallow them (staff were next door in the kitchen and immediately intervened to keep the patient safe).

Another example of the loss of critical input occurs in stalking relationships. While much is written about stalking, my interviews with stalkers reveal the following: the stalker fixates on some external source of input, sometimes in these circumstances, say, a celebrity. When they think about the celebrity they have a belief in their own sense of aliveness, which they then try to foster. In this case, the belief that the celebrity cares about them is sufficient to provide a substitute sense of self. However, if the celebrity tries to have the person cut off from them (e.g., a restraining order to have the person not hang around their house), the person needing the external input is threatened with a potential "death". Such a person is then "forced" to defend their life, in the following paradigm: "You can't kill me! I'll have to kill you first!" And then we read about it in the newspapers. The point in all these situations is that people with sense of self problems are often dependent on the outside world for their experience of existence, and

the loss of external input is perceived as life threatening, as depicted in the movie "Fatal Attraction".

Sleep and Addictions: Sleep difficulties for patients with severe psychopathology are rampant. There are multiple possible reasons for sleep difficulties, but some of the problem may be connected to sense-of-self issues. In order to go to sleep at night, one must relax and let their mind wander. To the extent that this means one must stop distracting and give up any vigorous pursuit of outside input, as a person tries to relax, they might drift toward the dead zone. They become restless, nervous, and may get up to reestablish some distraction or outside input to offset the encroaching emptiness. And sleep fails.

Addictions also seem to bear some specific relationship to the loss of a sense-of-self. I run a CBT group currently within a partial hospital program. The group is called, "Anxiety and Substance Abuse", though all types of addictions are addressed. A primary method in the group is to have patients identify their automatic thoughts in situations in which they get anxious *and* have an urge to use. With surprising frequency, people identify thoughts of the following type: "If I decline to drink, to go along, if I'm different, I'll get rejected, extruded from the group. I will be alone." What is meant by "alone" here is some state of emotional disconnection from one's social group, one's "herd"; "alone" is a version of the "dead zone" in these circumstances.

As patients in this group discuss their issues, their views confirm certain aspects of the relationship between addictions and sense of self concerns. First, any addiction can be a distraction from the "dead zone". That is, if one focuses on using, it can take one's mind off the inner emptiness. Second, using substances is external input; for example, if one drinks and gets even a little "high", the experience of the high is proof (external input) of existence: dead people don't get high. The fact that one behavior can serve two means of distancing one from the dead zone makes that behavior, the addiction, a powerful reinforcer to continue using.

When an addict sits without using and reflects on their mood, they become immediately uncomfortable. They realize (cognition) that they are anxious. If they can sit long enough, often the first internal state they can identify is, tragically, some version of the dead zone...and they will get a powerful urge to jump up to use. AA or NA and the

like are less powerful distracters and sources of input, but much safer and often available in the evening when other sources of external input are less available.

## The Bad

Patients are often plagued by negative thoughts of their badness or defectiveness. Such thoughts can come in all types of shapes and sizes, but usually follow the form of "I'm [some negative judgment: lazy, stupid, sick, weak, unlovable, etc.]" Such statements are not evaluative; they are judgmental. They are all-or-nothing, black-and-white, distortions. CBT therapists have techniques to disprove to oneself such judgments, and dynamic therapists have ways to undercut the harsh, primitive superego effects displayed in such thoughts. In any case, such thinking can be extremely stubborn and resistant to attempts to change it. Do such thoughts serve some purpose that would indicate why one holds onto them?

> I was once called in to consult on a patient who was extremely suicidal, and was being "specialed", one-to-one nursing, due to safety concerns. Her thinking was filled with extreme self-loathing as she was facing a court appearance in which her ex-husband was trying to gain custody of her children. She hated herself and felt she should be dead. When I asked her how she had been feeling during the day, she noted that she actually could not feel anything except this inner deadness. Try as I might, she would not, could not, abandon or even lessen her extreme self-hatred. Finally, I decided to try to push through the sense of deadness she was having. I kept instructing her to imagine her situation and to look within to see if she could experience any feeling. She worked for several minutes, then was able to get in touch with some of her rage at her ex-husband's taking advantage of her when she was sick. I pressed her to make sure she was actually having a sensation and not simply reporting what she thought one should feel under such circumstances. She was quite clear she could feel her anger. In the course of our discussion after that, I eventually asked her what was going on with her negative self thoughts. She paused to think, then said, "Huh!" I asked what was happening; and she replied that the negative thoughts had gone completely, disappeared. In other words, when she was able to experience some of her rage (feel), the self-hatred stopped immediately and totally.

This powerful example shows the relationship between harsh, critical thinking and not feeling. As I have carefully conducted scores of chain analyses on this process,

the following pattern emerges. As one begins to experience a feeling, its origin is misperceived, as if the feeling is being caused, sourced, from the outside (the "done to"). This is a perceptual distortion, and perceptual distortions cannot be directly experienced, only the result of the distortion. For instance, in color blindness, a person does not see colors shifting before his eyes: the colors simply look one way, and there is no initial awareness that the colors as seen are not as they really are. In the case of sense-of-self problems, the perception of ones' feelings as caused by others is totally outside awareness.

As noted above, another way to conceptualize the "done to" is as a type of emotional auto-immune response. That is, the brain erroneously sees a part of self-experience, feeling, as if the feeling is alien, a virus which has attacked from the outside and if not contained, could prove lethal. The brain then sets about to destroy the invader. Unfortunately, the invader is actually one's emotion, and destroying it (blocking it out) makes the individual sick as in an auto-immune disease.

Even though this process occurs outside awareness, there are clues to the existence of this perceptual distortion. The first clue is that as the distortion occurs there is some sense that something is wrong, bad. A person is then left to figure out what is really "bad". There are only two basic answers to this in terms of self: either the outside is bad, and one will become paranoid; or the inside is bad, and one will become negative toward oneself. While CBT provides methods for lessening such negative self-talk, if a therapist can help a patient get in touch with the emotion which gives rise to the "done to", the negative self-talk can totally drop out. It is quite impressive and humbling to see this process work. In other words, instead of helping a patient contend with the "bad' self thoughts, ask the patient to focus on their experience the moment before the negative thinking began.

A critical note needs to be repeated here: no one can *cause* a person to feel something. People can do things to one another, and while they may direct behavior at another, they do not cause a feeling within that other. Rather, what a person feels is a reflection of their own, independent feeling about what has just happened. This is the fundamental meaning of separation, of one's being psychologically independent: one's internal life is not causally related to what happens to them, it is independent of the source, though reactive to it. There are basically two "done to's" in any situation: the

behavior directed by the outside toward you, and the misperception that the feeling about what was just "done to" you is caused by the behavior itself. For people with a sense of self, a person is clear that while the behavior may be done to them, the feeling is totally their own.

Other manifestations that the "done to" or the 'bad" is operative come in other reactions people have to the situations in which it arises. Patients will report "feeling" trapped, smothered, backed into a corner, controlled, and some actually use the words: "Why are you doing this to me?" The extremeness of their responses, often in relatively minimally distressing situations, allows a therapist to get a sense of the inner "done to", which often seems like an assault to the person. One further note concerns the use of the word "overwhelmed". For people with sense-of-self problems, the use of "overwhelmed" not only means that they are having a tough day, it also means that they are experiencing their emotions as if they were invading them against their will.

Reacting with a feeling is more a matter of stimulus-response; but this is an extremely difficult notion for patients to accept since their view is based on the "done to" and the absolute belief that others can cause them to feel things. So frequently in our society we hear someone say, "You *make* me sad, angry, happy, etc." While most times we understand that we do not really believe that another person can truly "make" us feel anything, for those with sense-of-self issues, it is an entirely different experience; and the sense of being made to feel something by someone else is experienced quite literally.

## Trauma

Traumatic experiences and symptom formation share much in common with these sense-of-self problems. In sense-of-self problems, people can feel under attack when they attempt to experience emotion. This attack is seen as real much of the time and is terrifying, since it seems someone outside of oneself can intrude within and cause one to have an experience. But this view is based on a distortion. Nevertheless, one is reacting to an internal "mistake" in perception, which is both terrifying and painful, and attributed to something or someone outside themselves, who is seen as the source of the assault.

In trauma, I believe a person shuts off emotionally (and often cognitively, as well, in the case of dissociation) as the traumatic experience is too horrifying for a human being to bear. As with a sense-of-self problem, the trauma victim creates a "dead zone"

for protection. In one case, the attack is only perceived, a violation of one's boundaries (sense-of-self); in the other (trauma), the attack is actual.

However, when a trauma victim later has to deal with some of the emotions around the trauma, as the emotions arise, they will be misperceived as being caused within them against their will (the "done to"), a view which reactivates the sense of violation of the original trauma. It is at such times that patients report being "re-traumatized". The misperception of something being done to them in the present (via the "done to" of the re-experiencing the emotions about the original trauma) powerfully recapitulates the actuality of something being done behaviorally to them in the past.

In other words, perceiving one's feelings about the trauma as attacking one in the present is too powerfully tied to the real past experience of having been actually assaulted. The past reality of assault blends too easily with the current *perception* of assault via the "done to', and the patient becomes flooded. Dealing with this confabulation is the same for both non-trauma and trauma "sense-of-self" problems. That is, people have to learn to distinguish the "real done to" from the misperceived "feeling done to."

## Reclaiming the Sense-of-Self

Nearly every time I talk with a group of patients about these issues, I get two questions: one, is this problem curable; and two, how do you fix it? Whether this problem is curable is a question which must await research, but in my experience it is fixable, in the sense that people afflicted with sense-of-self concerns can feel significantly better; and you don't have to wait to be "all fixed". Each step in the process of recovery can lead to feeling better.

As a general lead-in, let me say that a lot of getting better from psychological problems depends on coping with anxiety. In my oversimplified view of one aspect of psychopathology, as someone encounters difficulties in their life, these trouble spots generate anxiety, as do any failed attempts to cope with the anxiety. Eventually, either the anxiety itself or, more often, increased depression from wrestling unsuccessfully with the anxiety, brings folks into treatment. As they become stabilized and the intensity of their moods is lessened, they still need to solve the issues which generated the initial anxieties in their life. This need again raises their anxiety level and creates a fight/flight

scenario with their treatment: it is counterintuitive to "want" to deal with anxiety. Often when focusing on current issues which reflect past problems, people think, because their anxiety is increasing again, that they are getting worse, or that their treatment is not working. And then they want to get new treaters, or drop out of therapy, or get more medicine to make the anxiety go away. The uncomfortable truth of the therapeutic session is that while anxiety in other situations leads to a fight/flight reaction, in therapy anxiety often means you are on to something important, and need to sit and reflect, instead of running away. (Easier said than done, it's true.)

In dealing with sense-of-self problems, coping with anxiety is critical. Anyone who even approaches the "dead zone" or the "done to" will begin to get anxious. Even if one does not feel the anxiety, they will have cognitions and behavior which quite clearly manifest the anxiety. Such anxiety is totally understandable: anyone faced with death or assault would most likely get anxious. So the <u>first step in recovery</u> from a sense-of-self problem is to recognize that <u>anxiety is useful and necessary...and unavoidable</u>. (See p. 26)

The next step is to learn to look inside, within the trunk, to note any feeling sensations moving within. It is critical to be careful about accepting a non-feeling for an actual feeling: if someone is in the dead zone, and you are trying to help them with distress tolerance, you may be really helping them bear a non-feeling (often, emptiness) as opposed to actually learning to bear a true emotional *experience*.

Once someone can begin to look within, if they try to see any emotion, it is likely to scare them, because their only two choices are the following: they might run into the "dead zone" directly, or they might begin to glimpse the feeling but then be threatened by the "done to". In either case, a patient will want to get away, to change medications, or perhaps to hope their therapist drops dead. Learning that such anxiety is a positive sign in one's getting better and that one needs to learn to sit with it is critical.

While this may seem clear, in actual practice, getting in touch with feelings is difficult. A careful therapist will often be uncertain if a person is actually experiencing an emotion, and a patient who is working hard will often feel incredibly frustrated and criticized by a therapist's relabeling their experiences as "not-feeling". For instance, a patient in a group today reported that she could feel her anger clearly, and when asked to focus in on the experience, she said it was "a rising sensation in [her] chest." Ordinarily that would suffice for most therapists, but I pressed the patient to describe the situation in

her body more thoroughly. She said that the feeling felt as if there were a tightening beginning in her upper chest and moving up toward her jaw. I suspect that what she was actually feeling was muscle tightness, and not the emotion behind it. I told her that I was unclear about her actual experience, but that she should pursue that kind of exploration with her therapist. It is better for a therapist to admit they do not know if a patient is feeling than to assume the patient is and thereby contribute to an underlying misconception which actually fosters pathology.

A few more clarifying thoughts: feelings are never experienced in the head. Tightness, pressure, pain, all are physical manifestations of affect, not actual emotions. "Pain" can be used to describe a feeling experience, but can also be the result of a feeling's being blocked, as if one is going through a doorway and the door slams on you and you cannot get in or out, so tightly are you being crushed: you can't go "in" and get back to the empty, but neither can you get "out" and have the feeling. Another manifestation of this blocking experience is that patients often experience a horrible "cutting" experience (usually through their head), or a "stabbing" experience, usually in their chest. While such reactions could be a manifestation of the "done to" assault misperception, they might also be a sense of "being killed" as the dead zone comes in precipitously, or perhaps a combination of both.

A further word about other techniques used to help patients improve. Treatments such as DBT or Mentalization provide patients with significant relief at times. However, the explanation given by their proponents may miss the mark, I believe. For instance, helping a patient learn "distress tolerance' is useful in many settings. But asking someone to learn to sit with an "emotion" which is actually a horrible sense of dying (non-emotion) or attack is far different than explaining to them that they must learn to temporarily tolerate these not-emotion experiences as a way of ending the deadness or assault eventually. However, learning to sit with the distortion that they are dying is necessary to getting beyond the dead zone, so the technique may help, though for the wrong reasons.

## Suicide and Self-destructiveness

The reasons for someone's harming or trying to kill themselves are as numerous as the people who do so. Life stressors, family dynamics, demographics (age, marital

status, *etc.*), and a number of historical factors (past suicide of a relative) all contribute to the ways one can understand someone's hurting themselves. Within the sense-of-self perspective, however, the vast majority of such behaviors fall into three categories.

First, with respect to self injury (sometimes called "parasuicidal" behaviors), it is a premise of this theoretical orientation that people do not actuality *want* to hurt themselves as an end in itself. Whatever self-hatred or self-loathing someone is experiencing, the concept of taking one's anger out on oneself, I think, is a misleading read of the situation. While I will talk about the role of anger in self-harm in a few moments, anger itself is not the basis of the act of self harm. Rather, the act of cutting, burning, and so on is related to trying to relieve the underlying sense of deadness, that is, to create some sensation, in this case, physical, where otherwise no sensation exists: "I exist because I can experience pain, or see blood," and so on.

The *sine qua non* of any suicidal or self-destructive behavior is the presence of a significant inner emptiness, numbness, deadness. On the other hand, as long as you are in touch with your feelings (as noted earlier in this paper), your feelings will keep you from harming yourself.

The second scenario in self-harm is the mechanism which underlies impulsive suicide attempts, as well as many self injurious behavioral patterns. In impulsive suicidal behaviors, a person has a rush of powerful emotion and, feeling under extreme attack from the perceptual distortion of where that feeling is coming from (the "done to"), they shut down hard and fast. This shut down creates an immediate sense of deadness. Without a sense-of-self, a person will "leave themselves out of the equation of their own life", that is, never assume any real agency. So when a person shuts down and enters the dead zone, the resulting sense of deadness is not recognized as coming from one's own actions. Rather, the scenario becomes, "I don't exist as an active force in my life, so where did this deadness come from?"

Whatever the person had just been dealing with is then seen as the source of becoming dead, whether it is talking with another, seeing something on TV, reading what someone else has written about you. If the feelings about the stimulus situation are powerful enough, and the shutdown is fast enough, a person with a sense-of-self disorder will believe unconsciously that the outside stimulus "killed" them, wiped them out. (See the example on page 14.) The whole pattern evolves in a split second: "You (this) can

make me dead. I can't stop you (this) from wiping me out, but I will take control of this process and kill myself." The issue of control here is related to feelings of shame and humiliation which are tied into the role of anger, which I will discuss below.

As mentioned earlier, this same pattern can be seen in self-defeating behaviors which, while not suicidal, are self-injurious.

> A patient regularly ate breakfast in the sunny front window of a local restaurant, where she could see others going to work; and in the process she would gain distraction and input. She typically sat in the middle of three tables in the window. One day a waiter came over to her and asked if she could move over one way or the other so he could push the other two tables together for a larger party. In that moment she was devastated and saw him as having destroyed her peaceful breakfast. Overtly, however, she acknowledged his request, but did so by moving to the farthest back corner of the restaurant beside a wait station piled with dirty dishes and across from the bathrooms.

I am familiar with this restaurant, and the space she chose in back is absolutely depressing as a place to eat one's breakfast. When queried in therapy about what had happened, the patient was aware that she felt wiped out by his request, but actually experienced no emotion. She believed that he was somehow controlling her situation; and to take back that control, she both moved herself and was in charge of also making herself miserable. This taking control of what one perceives is being done to them by the outside is the second scenario of self-destructiveness.

The third and most dangerous scenario is one in which the sense of deadness is so profound that it sets up a dissonance between the experiences of *cognitively knowing one is alive, yet walking around feeling dead*. This dissonance creates a terrible internal state which is excruciatingly painful. Typically a person has lived in this state for weeks or months and has not really told anyone how awful it is for them. They also typically have tried numerous ways to get away from the dead zone, all to no avail. After a period of utter pain and perhaps going through the motions of living life, they give up trying to make the inside come alive. They begin to think, "I can't make the inside come alive, but I can make the outside dead, and then the inside and the outside will both be the same (dead) and I won't have to live with this terrible twisted experience any longer." This is

the most serious type of suicidal state for a human to enter. They develop a logic which seems clearly bound to relieve their pain.

In my years working with hospital populations, I have had the opportunity to interview many patients who have tried to kill themselves. What becomes clear is that the second a feeling breaks into actual experience, *the suicidal urge goes away*. I have interviewed patients who have jumped from heights which should have, by all rights, killed them; but they survived by some miracle. When asked about their experience, they noted that the minute they went over the edge and looked down, they became terrified and realized that they had made a terrible mistake. These people had walked around in the dead zone for weeks and felt they could not bring themselves back to life. When they went over the edge, the view and its consequences were so horrifying that they generated enough of a feeling to break through the block and end the "dead zone", where other, less dangerous behaviors had not. The minute the "dead zone" lifts, the urge to live comes flooding back.

Perhaps another example will help. I was treating a patient who came into the hospital after a very serious attempt on her life. She was a beautiful young woman who valued her looks highly and hoped to do some modeling. But she had walked around in the dead zone for weeks and could not stand being alive yet feeling dead. She described the following scenario.

> She closed herself in her pantry at home, and taped the swinging doors at either end of the narrow room so no air could get in. She then turned on the gas, took all her psych meds (a sizeable amount), cut her wrists severely, and sat down to wait to die. As she sat waiting, she began to muse on what was happening. As time went by, she began to wonder if she might not succeed, but rather might end up "crippled" or "brain damaged". As she imagined these possible outcomes, she gradually became increasingly frightened. At some point the fear of disfigurement got so intense that it broke through the block. She then felt alive again, and therefore no longer needed to die. She jumped up and called "911".

Some patients and clinicians feel that by reducing all self-destructive situations to three types, I am oversimplifying a terribly complex situation and am demeaning the struggle of many patients. As I said earlier, there are numerous factors and ways of assessing suicidality. But I find that categorizing self-destructiveness into these three

types of suicidal actions gives a clinician a better chance of truly connecting with a patients' phenomenology and in tailoring a crisis plan accordingly.

One of the most difficult situations for a clinician is to know when patients are in an emergency and need to call their therapist. I work with patients to be able to identify when they are beginning to shut down and moving toward some empty state. At this point I have them use an input list (ways of getting outside input) so as to forestall the emptiness. If they have genuinely tried to get input to ward off the dead zone, but cannot, or if they have plunged without warning into the dead zone abyss, it is then an emergency and they may call: no dead zone, no emergency, but patients may need practice to be able to identify when they are entering the "big empty". Until such time, it is necessary for a clinician to err on the side of over-inclusiveness, that is, assuming when the patient is unclear that they may be heading for the dead zone and therefore treating the situation as an emergency.

Distinguishing a true emergency from wanting to use the therapist to experience less distress (but not outright deadness), is an important assessment to be made in outside-appointment calls to the therapist. Outside the office, patients need to distract and get outside input, but not from the therapist, unless the patient is slipping into the "dead zone." Often patients see a therapist's refusal to be available as cruel and unintelligible: "when I talk to you I don't feel so overwhelmed; anyone with a heart would take a few minutes to help me not die". This view on the part of patients is the basis of many empathic failures in the treatment process. Helping a patient see that in order to get better they need to create moments when they do not distract or get input but rather need to look inward for the actual emotion: this is tricky, and when to bear the "dead zone" to seek the feelings "underneath" the "dead zone" and when to avoid the dead zone (distract/get input, seek emergency treatment) is a complex process.

**Anger XXXXXXXXX5/13/12**

The power which anger provides to situations of self loathing is quite impressive; and it often appears that the self-hatred which is manifest is driving the attack against the self. I believe that such self-anger is actually coming from two sources, or a single source with two slightly different manifestations of the hatred. One aspect of self-hatred appears to be related to the perception of being "done to"; that is, as a feeling arises and

its origin is misperceived as outside the self, a person's awareness registers a sense that something is "wrong" or "bad". If the "badness" is attributed to self ("I am bad"), negative self-talk or automatic thoughts begin. Such thinking has the clear sense of attacking the self. What could be the purpose of such attacks on the self?

A patient once described the experience as if he were a mole in the arcade game "Whack-a-Mole", in which a plastic mole pops its head above the game board surface and the player has to bludgeon it with a rubber mallet before it disappears into its hole again. The patient's experience was that every time he had a sense of things beginning to lighten emotionally, he began again to "beat-up on" himself. After some time, he entered a numb state in which the original feeling which gave rise to the "bad" was destroyed. In this model, the beating up on one's self was designed to stop the misperception that the outside, via one's own feeling, was attacking one's self. In other words, an attack engineered by the patient was needed to stop an attack (perceived as) engineered by the outside: one anger to fight off another anger. In this scenario, by beating down the self through negative automatic thoughts, one drives the original feeling out of experience: no feeling, no sense of being attacked, and no sense of being bad, just numb.

A second aspect of the self-hatred we see so often may come from a sense of shame, embarrassment, or humiliation. The misperception that something outside the self can get into the self and cause pain, and that there is nothing one can do about it is scary and humiliating. An analogy would be a situation in which someone were living is a dangerous part of a city and had no front door on their house: any thug could walk in and wreak havoc, and most likely could not be stopped. Sam Peckinpah's ulta-violent and misogynistic 1971 movie, *Straw Dogs*, which depicts a life and death struggle to maintain one's boundaries, in this case physical, is a chilling example of this type of lack of ability to protect one's self. The sense of vulnerability and initial humiliation when others simply ignore a person's boundaries is powerfully captured in the movie.

As a person (mis)perceives such a sense of invasion, a normal feeling would be shame for many people and it could generate self-hatred. Such shame and anger, however, will also be further misperceived as caused (done to you) by the outside, and will feed the shame cycle of feeling unable to defend one's self. As with the first source of anger ("the bad"), this anger born of being "done to" by shame will eventually cause a person to shut down more, eventually entering the dead zone. At this moment, a person is

dead inside and one of the self destructive models noted above will take over. The anger and self-loathing may persist cognitively and behaviorally for a while, and appear to be causing suicidal behavior when in fact it is the underlying appearance of deadness which in fueling the actual self-destructive behaviors.

The point of this discussion is that anger, while a source of power in self-hatred and self-destructive processes, is not the real problem. The main issue in this "anger turned against the self" view is that such anger is related to a profound sense that, try as you might, you cannot protect yourself from an invasion of your boundaries. In trying to cope with this sense of being overwhelmed, one shuts down and becomes emotionally dead; and this state precipitates the suicidal behaviors.

## Separation Anxiety

Years ago, clinicians were taught to identify many types of anxiety based on developmental models. In terms of the dead zone, two types of anxiety from this previous nomenclature can prove quite useful: *annihilation* anxiety and *separation* anxiety. Annihilation anxiety is the fear that occurs when the sense of ones' impending death arises psychologically: *e.g.*, "I am being wiped out", or "I am disappearing". The anxiety can be extreme, but it may be present in cognition and behavior, without being felt: if it were genuinely being experienced, one would feel alive without fear of death.

Separation anxiety is a more confusing concept as its original conceptualization has been often blurred. Technically, separation anxiety is the anxiety which accompanies self-individuation in a child. "If I am separate from you, something bad will happen to me", or in a different version, "If I am bad in your eyes, you may leave me alone." In either case, being an individual is threatening.

A word about this process: if one pushes a human being as to the consequences of "their being bad, wrong, lazy, stupid, etc.", an interesting issue arises. So for example, if you press someone about "what's the big deal with being bad or stupid?", and you keep pressing, eventually nearly all human beings will come to some version of "I will be alone," or "then I'll have to die, or "no one will want to be with me". The point here seems to be that fear of being too individuated or individuated in a bad way is a terror for us all at some level. For one to experience their emotional death as a result of growing

puts them in a terrible bind: "you need to be individuated, but in your experience, you will then die."

How does this process come about? Most of us are familiar with a patient's making good progress and then "falling apart" and regressing. There are numerous theoretical and dynamic reason for this, but I think the culprit is once again the "dead zone". Individuation comes in tiny leaps: every time a person feels a feeling with some sense of that experience's being their own, there is a moment of individuation. However, for patients in the beginning stages of such growth, the risk that such a feeling will still be perceived as too "done to" leads to the further risk of the person's still shutting down and going into the "dead zone". The phenomenological scenario is as follows: "I felt whole and my own person for a slight moment, but then I felt attacked and ended up wiped out! Getting better is too dangerous!" If you ask someone at that moment about their anxiety over growing and getting better, invariable they come up with the cognition, "if I am better or different, no one will like me (and I'll be alone/dead").

This scenario and how a therapist handles it is crucial to someone's being able to grow. From a therapist's perspective, at such points a patient will become angry or terrified with treatment: "this isn't helping me!" Alternatively, they may simply leave treatment, or seek medication changes from their psychopharmacologist, as noted above. It is important for treaters not to accede to such demands, since tremendous anxiety may mean major progress but progress accompanied by tremendous separation anxiety. If a treater helps a patient avoid such anxiety prematurely, growth may not occur.

It is not sufficient to say to a patient, "well, you seem to be progressing fine; you appear stable behaviorally". A therapist must ascertain if the patient's distress is really about growing and being scared, or if the patient is experiencing some form of being pushed into the "dead zone". In fact, if the separation becomes unmanageable, and the patient seems too "done to", they could shut down and end up in the "dead zone" anyway. It is critical to try to sort out which of these options obtains in a given case.

### The Process of Getting Better – The "How To"

Earlier (See "Reclaiming the Sense of Self, p. 18), I noted a few critical observations on the process of "getting better". First, it is crucial to help patients grasp the incremental nature of this process: each small step in the process can lead to feeling a

little bit better. One does not have to be "all" done with treatment to feel significant relief.

Second, when one develops a self problem, they are forced to use three mechanisms to cope with the "deadness". These three coping skills were reported on earlier in this paper, but it is worth repeating them again, because so much of a patient's behavior can actually be understood in terms of these three skills. All people with these self issues use the same three coping mechanisms. The brain does not recognize what is happening to cause the dead zone, but it does know how to help a person lessen encroaching deadness. The first coping skill is to use cognition to substitute for emotion. That is, the brain typically knows what a particular emotion "should" feel like, and when it sees no feeling in the emotional nerve pathways coming back from the "gut" or "heart", it makes an educated guess and assumes what the feeling must be. This cognitive substitution occurs instantaneously and the person is kept from experiencing the deadness directly for a moment. Knowledge replaces emotional experience. While this is protective, in the long run, it is exhausting, too: one must always be on guard. Moreover, using this technique may render certain skills training endeavors ineffective. For example, in doing a "Mood Monitor" with these patients, often instead of noting a "thought, a feeling, and a behavior," many patients actually list "a thought, a behavior, and the thought of a feeling". Even though such an effort can help, I suspect it will not be as powerful as the technique is intended to be when someone is in touch with their feelings. People trying to use such techniques can become discouraged or see themselves as failing and must be supported in understanding that the skill is important but may only be partially effective because of the self problem.

The second coping technique is distraction. Almost any activity which takes ones' mind off the inner numbness can be an effective distraction. Often such distractions are external: e.*g.*, listening to or playing music, reading writing, playing video games, texting, surfing the net, watching movies. Anything which shifts focus away from the inner emptiness can be effective. Certain internal mechanisms can also help to distance one from the deadness, fantasizing for example. In certain obsessive-compulsive patients I have treated, the obsessing seems at times to be a way of distracting from an underlying emptiness. Most distractions are not harmful except to the extent they cause one not to complete other tasks. However, some distractions are very

destructive, and these are typically the addictions. All addictions tend to distract one from underlying emptiness, but then, of course, a person has a sense of self problem and an addiction as well.

The third coping skill discussed earlier is getting "*outside input*". Feelings, as noted earlier, provide one with *inside input*, a sense of aliveness, an aliveness which is continuous and not variable, regardless of how stressful your day is. Often someone with a sense of self, encountering a situational disaster, will exclaim, "I'm dead!" But for a person with a sense a self, such a statement remains metaphorical. Not so for someone with a self problem. Their sense of aliveness can turn off and on over the course of single day. Sometimes, I am given to wonder if such alternations give rise to missed diagnoses with rapid cycling and mixed state bipolar presentations. Regardless, the repetitive loss of the sense of one's existence leaves one's sense of continuity variable. All clinicians who work with this patient population are familiar with patients saying, "I couldn't remember what you looked like when you went on vacation!" It's hard, if not impossible, to remember someone, or to remember a better time a few weeks ago, if your existence comes and goes unpredictably.

To fill the gaps in input from the absence of emotional experience, a person is forced to other sources of input, usually external input. Anything which the brain can use to intellectually "prove" existence can be an alternative to inner, emotional, input. Someone interacting with a patient is outside input, as the patient knows they exist because someone's talking to them proves it. If someone calls you, gives you a grade, gives you a job, fires you, sends you an email, "likes" you on Facebook, you exist. Managing such input is crucial to staying "alive". Unfortunately, friends and clinicians of such folk experience the desperation behind such "management" and often feel the "dependence" or "manipulativeness" of such patients. It seems to me that if your experience told you that you were about to perish, no one would like being called "dependent" or manipulative. I find such terms incredibly pejorative, and am often moved by patients attempts to stay "alive".

In the polio epidemics of the early 1950's, before vaccinations, patients stricken with the illness could not breathe on their own due to paralysis. The only treatment initially was an "iron lung": a long cylindrical tube in which patients were placed with only their head sticking out. By changing the air pressure inside the "lung", a person's

chest wall would rise and fall, thereby "causing" the polio victim to "breathe". This external device kept people alive. On a psychological level, outside input is the iron lung keeping people from dying. This mechanism of getting some proof of aliveness can be seen in many psychological issues. Although I have not discussed psychosis specifically in this paper, I will say that I believe delusions and hallucinations, in part, serve this same function. That is, if the CIA is out to get you, or if the TV is speaking to you, you exist within those frameworks; and you would be loathe to give up such input, lest you die (paraphrasing Freud).

People with self problems spend a great deal of time "reading" the outside as a way to gain and to keep input. They try to read the outside, to give the outside what it needs so as to be taken care of in turn: often in adolescence, unbeknownst to any of the parties, an agreement is reached, at least in the patient's view: "O.K. I will give up who I am, and do what you want, but you have to take care of me." When the day comes for a patient to go off to work or school, the rules are suddenly changed as they sense it and they are told: "O.K. Now you're on your own. Go out there and give 'em hell!" And the answer from most patients would be, "Who? Me? I don't know who I am!"

Getting better means taking back the focus from the outside. But before a person can do this, they have to insure they have ways to keep from slipping into the dead zone. I suggest that everyone make an "Input List" with three columns. Each column contains between five and ten items which you know will get you outside input. In the first column are items over which you have total control: listening to your IPod, watching TV or a video movie, writing, knitting, and so on. These are activities you can do when you need them. Work can be a powerful input, but often the risk of feeling "done to" at work makes it hard to use work at times as input.

In the second column are things you can do to get input which may be more powerful, but are less under your control: going to a movie, riding public transportation, going to lectures, taking classes, *etc*. These are activities over which you do not have total control: you can use them if they are open or otherwise available.

The third group contains the most powerful sources of input, but you have no real ability to control them. These typically involve relating to other people, but typically someone can refuse to meet you, or be unavailable to talk. A therapist can be input, but often only in specified ways or times.

It is critical that you write down such situations which can provide you input and that you keep trying them until you get out of the dead zone. If you cannot, and have tried several items on your lists, this may be an emergency and an appropriate time to call your treaters. Emergency rooms are often hostile to people with self problems because ER personnel frequently do not understand the pain you may be in, but even so, an ER is a powerful place for input; and if you are in the dead zone, whether they understand your situation or not, I believe you have a right to services. And even if you are disregarded, or ignored, as has happened to patients of mine, you will still have a powerful input potential (remember: negative input can be very existence affirming).

**Mindfulness:** I am leary about using the term "mindfulness" as it is becoming over-used in pop psychology culture. For much of its existence, however, practitioners have had a way of emphasizing the importance of types of self-monitoring and awareness: many years ago, the concept of an "observing ego" captured some of the elements of this monitoring, and Maxmen, at Dartmouth in the 1970's, taught patients to think "clinically" about their patterns. In any case, dealing with the sense of self dilemma means delaying action or outward expressing of response so as to be able to search within for what is happening. Reacting leaves one not focused on internal processes. When you notices an increase in distress, if possible, you must stop and try to become aware of what the process is which is happening within you.

In other words, stop and ask yourself, "What am I experiencing right now?" and try to look within your trunk for any sense of emotion (internal absurd motion). *Remembering* to stop to try to look within is incredibly difficult as you have spent a lifetime watching the outside and ignoring your own emotional experiences. It is often crucial to develop skills to stop to notice your internal processes. So for instance, often patients begin to get confused when they are shutting down. Such confusion can become a signal to stop and look within. Obviously a person cannot always stop at a given moment to explore their emotional life, but as soon as possible, try to sit down and look within. I had a patient who had particular trouble with her anger, but she learned to recognize her jaw's clenching as an indication of anger. She would then take a "bathroom break" as soon as possible during which she would try to relax and look inside to see if she could experience any anger (often experienced as a rising pressure within the trunk, but not simply rising blood pressure or muscle tension). Whatever means one can

use to notice distress associated with the dead zone as arising within, that awareness can be used to begin the observation process.

Observing, being mindful, is a passive activity, a "zen process" of watching flowers grow. One must be able to sit and turn their mind's eye on the space in their trunk, as if one is a big steel drum within which emotions move. Then one simply watches for a number of seconds. Trying to see feelings to hard can block of the process, just as trying too long. Simply look, and if you see nothing, move on; come back later and try again. **XXXXXXXXXXX 5/19/12**

This process does not have anything to do with expressing emotion: expression is behavior and people can express emotion without feeling (being in touch with) the actual experience. Similarly, many therapists who become aware of this process, believe, incorrectly so, that this is alexithymia. I suspect that when Peter Sifneos coined the term, he may have actually been trying to define some version of the dead zone, but may have missed the emphasis: alexithymia, as I understand it, is about the difficulty one has in describing their emotional life, understanding it, being aware of it, being clear about it. But the dead zone, while it can lead to such problems, is about not being able to "experience" emotions. It is not so much a cognitive or behavioral problem as it is a purely emotional-experience issue.

Let us return to pointers about handling the dead zone and the done to. Typically one becomes aware of the dead zone or the done to as a type of interruption in their daily life. It is as if something real has just happened to them to bump them off their track. And just as typically, they will look to the outside for what just happened to them so they can "fix it". This external focus is to be expected: if one does not have a sense of self, how can one be the source of anything? It is imperative, however, that they learn to look within for what is going on, using a sense of being wiped out, rejected, abandoned, assaulted, overwhelmed or "bad" as the indicator that something has just happened to their sense of self-homeostasis. Obviously learning to deal with the outside world at that moment is critical to being able to explore within; but to become caught up with what the outside is doing is ultimately, going forward, a waste of time: you can't get a sense of self from the outside; it can only come from within by feeling your emotions.