Pepperdine University

Graduate School of Education and Psychology

TREATMENT OF SCHIZOID PERSONALITY:

AN ANALYTIC PSYCHOTHERAPY HANDBOOK

A clinical dissertation submitted in partial satisfaction

of the requirements for the degree of

Doctor or Psychology

by

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For Marne & Ol-Budd

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ABSTRACT

This volume presents a contemporary psychodynamic treatment for schizoid personality and related non-psychotic schizophrenia-spectrum personality disorders. Recent theoretical advances in psychodynamic nosology and important contributions from a century of psychoanalytic research on schizoid phenomenon are operationalized to provide clinicians with comprehensive suggestions with respect to assessment, technique, format, areas of thematic focus, countertransference, defense, and the process of change with schizoid patients. This handbook was developed as a Stage I treatment manual sufficient for an initial evaluation of feasibility and efficacy in clinical trials. Developing an understanding of the schizoid's personality organization and object relations is the ultimate goal of this handbook and the springboard from which treatment implications are suggested. New research on issues including attachment, neurobiology, etiological factors, relevant adjunct treatments, and medication are included to inform a broad and integrated approach to treatment. Short case vignettes are built in to help the practitioner understand how clinical theory becomes therapeutic process, while navigation tools, including outlines, indexes, summaries, and original flow sheets are included to summarize important concepts and reinforce learning. Self-adherence measures have been developed to aid the therapist in adhering to treatment guidelines.

Keywords: schizoid personality disorder, avoidant personality disorder, schizotypal personality disorder, transference-focused psychotherapy

Introduction

In recent decades, psychodynamic treatments have become susceptible to being labeled unscientific, financially unfeasible, confusing, and outdated, and are by now practically absent in managed medical care settings (Bleiberg, 2004). These trends are due to the paucity of operationally defined dynamic techniques and interventions, the relative scarcity of efficacy data from random control studies, the loose relationship between psychodynamic theory and clinical technique, and the limited emphasis placed on developing procedures for assessing progress in dynamic therapy (Bleiberg, 2004). As the demand for cost-effective treatment increases, dynamic practitioners are under pressure to define what it is they do.

There has been considerable growth in the development of manualized treatments for borderline personality disorder in recent years, most notably including Mentalization Based Treatment (Bateman & Fonagy, 2004), Dialectical Behavioral Therapy (Linehan, 1993), and Transference Focused Psychotherapy (Clarkin, Yeomans, & Kernberg, 2006). Yet, unlike Cluster B personality disorders, Cluster A personality disorders (paranoid, schizoid, schizotypal) have gotten significantly less attention in the literature and are often less understood. Despite the fact that some recent independent studies place the prevalence of schizoid personality between three to four percent within the United States (Grant, et al., 2004; Pulay, Dawson, & Hassin, 2009), there have been no prior efforts to create a manualized treatment protocol specifically for this disorder. Additionally, there is no generally accepted treatment for the schizoid personality at this time (Thylstrup & Hesse, 2009; Williams, 2010).

A recent milestone in psychodynamic treatment for schizoid personality is Transference-Focused Psychotherapy (TFP; Clarkin et al., 2006), an empirically validated treatment for a broad range of patients falling within borderline personality organization (BPO), including the schizoid personality. Given the decidedly heterogeneous nature of patients with borderline personality organization, one limitation of TFP seems to be the broad nature of its intended focus. While it's true that treatments designed for borderline personality disorder yield important insights for working with schizoid populations, these treatments were constructed for individuals who are far more outwardly emotive, dramatic, and aggressive than schizoid. As such, this handbook seeks to be the first to set forth a structured, object relations approach for the treatment of schizoid personality itself. Rather than summarizing the techniques of transference-based psychotherapy, this text seeks to highlight how standard transference-based psychotherapy should be *modified* to fit the particular needs and dynamics of schizoid patients in order to maximize therapeutic gains.

The broad treatment objectives of this research are: (a) to alleviate the lack of psychodynamic training resources and empirically-testable protocols for schizoid patients, (b) to illustrate necessary modifications to standard psychodynamic treatment to improve therapeutic outcome, (c) to explore the relevance of the schizophrenia-spectrum for conceptualizing and developing treatment recommendations, (d) to re-examine frequent negative assumptions about the treatability and pervasiveness of schizoid conditions, (e) to improve the assessment, identification, and diagnosis of schizoid patients, and (f) to provide didactic instruction on concepts relevant to the etiology, dynamics, and features of this personality type. Other specific objectives of this

handbook are to provide at least a basic understanding of the structure and format of schizoid treatment, the techniques and competencies required for treatment, and the basic processes of change.

Given the challenges of achieving personality change, the material discussed in this handbook is, of necessity, both nuanced and involved. Several changes have been made to the traditional formatting of psychodynamic research to provide a more streamlined, reproducible, and generalizable learning experience. As this handbook is meant in large measure for clinicians in training, key clinical points are reviewed at the end of each section to summarize and reinforce learning. A large number of *original* navigation tools, including flow sheets, textboxes, appendices, a glossary, and self-adherence measures, have also been included to this end.

Part One of this handbook offers a deep look at the structure of the schizoid personality. Following an introduction and brief literature overview (Chapter 1, "Background & History") and a section explaining the research methods used in the construction of this handbook (Chapter 2, "Plan of Action"), a comparison of common assessment techniques and issues related to diagnosis and symptom formation is presented (Chapter 3, "Diagnostic Assessment"). Etiological factors are then explored with respect to both environmental influences and temperamental factors (Chapter 4, "Etiology"). Finally, the major features and dynamics of the schizoid personality are explored, including attachment style, range of sexual adjustment, social functioning, and others (Chapter 5, "Selected Personality Features").

Part Two of this handbook focuses on treatment. First, specific challenges to working with schizoid patients, including resistance and defense and difficult

countertransference patterns are reviewed in preparation for beginning therapy (Chapter 6, “Preparing for treatment: Specific challenges with schizoid populations”). Next, a formatted treatment, covering issues related to the structure of sessions, attitude and frame considerations, the goals and techniques of treatment, and working with transference, is laid out in a systematic way (Chapter 7, “Treatment”). Specific strategies are offered for working with schizoid fantasy, somatic experience, omnipotence, and withdrawal, among other technical issues. The key focus of the treatment section is on outlining the schizoid’s inner object relations.

Finally, Part Three of this handbook provides supplemental materials. Issues related to medication and adjunct treatment are followed by a glossary, appendices, and self-adherence measures (Chapter 8, “Supplemental materials”).

Part I

The Schizoid Personality

Chapter 1 - Background & History

An Esoteric Topic?

Those students who have passed through American graduate training programs, having completed practica steeped in evidence-based treatments, are likely to enter the world as professionals having learned two basic ideas about the schizoid personality—that these individuals are not likely ever to seek treatment, and that there is subsequently little research on this population. It's telling to find that the DSM-IV-TR entry for Schizoid Personality Disorder, at just over three pages, is the only personality disorder within the manual without statistical information available about prevalence, listing the disorder only as "uncommon in clinical settings" (APA, 2000, p. 694). The schizoid's discomfort with interpersonal relationships, having been rashly translated into the DSM criteria 'neither desires nor enjoys close relationships,' both obfuscates the great longing these patients have for connection and creates confusion around the possibility for therapeutic relationship or positive therapeutic outcome. Clinical lore about the schizoid has by now become a generalization of extremes.

The great paradox of the schizoid personality is that things are rarely what they seem on the outside. Outwardly, they appear compliant, stoic, non-competitive, self-sufficient, feeling like an outsider, lacking assertiveness, while inwardly they are often cynical, inauthentic, depersonalized, and full of vengeful fantasies and hidden grandiosity (Akhtar, 1987). Yet, despite this fact, the cognitive and behavioral models, which have dominated the university setting for several decades, have pushed the emphasis of psychology ever more toward overt measurable symptomology and away from the rich

information about inner dynamics. In fact, the DSM criteria for schizoid personality emphasizes what is missing in the personality rather than what is present (Millon, 2004), taking negative symptoms at face value without recognizing the inner world behind the façade. Buffered by collective perception of schizoid populations that over time has become unduly laden with associations to grave primitivity and schizophrenia, the schizoid personality is infrequently taught, rarely understood, and has few established clinical treatment recommendations. It is not usual to find that often clinicians can do little more than throw their hands up in the air, and dismiss these patients as untreatable using established treatments.

Despite the fact that psychological investigation on the schizoid personality is nearly as old as the field itself, with a rich history dating back to the start of the twentieth century (Bleuler, 1908; Hoch, 1909; Kahlbaum, 1890; Kreapelin, 1913; Kretchmer, 1925; Ribot, 1890), the literature on schizoid personality can seem obscure or outdated, obfuscated or linked with research on schizophrenia, and unapproachable or not easily accessible to clinicians. Yet, this large body of research includes not only information about the descriptive, overt traits of these individuals, but also data on their dynamics, treatment, etiology, temperament, object relations, and common transference and countertransference themes. Though none have sought to outline a formal treatment manual, numerous excellent sources highlight multiple stages and aspects of schizoid treatment (Appel, 1974; Duryee, 1996; Guntrip, 1969; Khan, 1974; Klein, 1995; Laing, 1960; Manfield, 1992).

There is even a debate as to the legitimacy of schizoid personality as a diagnosis (Slavik, Sperry, & Carlson, 1992). Fairbairn was amongst the first to note that schizoid

states are present to some degree in all people, and span a continuum from normal to severe and debilitating (Fairbairn, 1940). Recent authors assert the normalcy of temperamental introversion (Cain, 2012), the biases of object relations theory toward the primacy of relationship (Modell, 1993; Storr, 1988), the creative and regenerative functions of reclusive behaviors (Storr, 1988), and the gains and pleasures of seclusion (Rufus, 2003) as counterarguments to pathologizing schizoid-like behavior.

Historical Assignments of the Word 'Schizoid'

The very term *schizoid* has been obscured by nearly a century of use to refer to very different phenomenon. In fact, one of the most blatant impediments to the dissemination of treatment recommendations for schizoid personality is and has been the wide-ranging semantic confusion about the very meaning of the word, 'schizoid.' The word schizoid comes from the Greek prefix *schizo-*, meaning cleaving or splitting, and the suffix *–oid*, meaning like or representing. First used by Bleuler (1924) to describe this personality type, it refers typically to the schisms observed in these patients between their inner emotional life and their outward behavior. Later, Laing (1960) used the word schizoid to refer to an individual who is split in two ways; he is disrupted in his relationship to himself and in his relationship to the world. More recently, McWilliams (2006) offered this articulate viewpoint:

> Schizoid people are overtly detached, yet they describe in therapy a deep longing for closeness and compelling fantasies of intimate involvement. They appear self-sufficient, and yet anyone who gets to know them well can attest to the depth of their emotional need. They can be absent-minded at the same time that they are acutely vigilant. They may seem completely nonreactive, yet suffer an exquisite level of sensitivity. They may look affectively blunted while internally coping with what one of my schizoid friends calls "protoaffect," the experience of being frighteningly overpowered by intense emotion. They may seem utterly indifferent to sex while nourishing a sexually preoccupied, polymorphously elaborated

> fantasy life. They may strike others as unusually gentle souls, but an intimate may learn that they nourish elaborate fantasies of world destruction. (p. 7)

In addition to its use to describe a personality disorder, the word 'schizoid' has historically been used in a number of different contexts, as summarized below in Figure 1.1. While each of these historical conceptualizations of what it means to be schizoid contributes something to current knowledge of this disorder, none of meanings tells the whole story. For example, while the historical focus on schizoid personality precursor or prodromal stage to schizophrenia is still being debated, there is no definitive evidence that schizoid personality is related to schizophrenia other than conceptually (Millon, 2012). Similarly, while introversion is considered an organizing component of all schizoid disorders, introversion itself is a normal human attribute around which pathological ways of defending are crystallized, and not the equivalent of schizoid pathology.

Other uses of the word schizoid are fundamentally broad. The Kleinian concept of the *paranoid-schizoid position*, referring to a state of mind in which the infant's paranoid concern about annihilation by the objects in his world leads to defensive splitting of these objects into their good and bad components (Klein, 1995), has relevance to a discussion of the developmental factors in schizoid personality disorder, but just as much relevance to the treatment of all the personality disorders at the borderline level of organization. The same could be said of the use of 'schizoid' to describe a defense mechanism; it is not only schizoid personalities that defend in this way. The use of the word 'schizoid' to describe a number of personality types falling between neurotic and psychotic (Fairbairn, 1940), has fallen out of use, having been replaced by the terminology, Borderline

Personality Organization (BPO; See Chapter 3, "Diagnostic Assessment"). At its broadest, the word schizoid can be used to describe an unavoidable state of differentiation from others.

To be clear, the focus of this handbook is on the treatment of schizoid personality, as a character type and, in more severe cases, as full-blown personality disorder. More broadly, this handbook conceptualized schizoid personality as one of three non-psychotic schizophrenia-spectrum personality types, bound by conceptual and symptomatic similarities covered in depth in the assessment section of this handbook. All treatment recommendations are made specifically for these disorders, and do not speak specifically to other historical designations of schizoid pathology.

(1) A prodromal stage of schizophrenia
(2) A personality type predisposing to psychosis or schizophrenia
(3) An introverted character style as described by Carl Jung
(4) A stage in infant development as described by Melanie Klein
(5) A defense mechanism drawing on isolation and emotional detachment
(6) A broad level of personality organization falling between neurotic and psychotic, precursor to borderline personality organization (Fairbairn)
(7) A specific personality disorder, or clinical phenomenon
(8) A non-psychotic schizophrenia-spectrum disorder
(9) A normal, unavoidable state of differentiation from others

Handbook Focus

Figure 1. Historical assignments of the word schizoid.

Brief Historical Literature Summary

Though it is not the purpose of this handbook to serve as a formal literature review, the contents of the handbook are, to a significant extent, a formatted distillation of historical research. As such, a brief overview of the historical literature is useful both

to alert clinicians to other resources, and to contextualize the suggestions and clinical concepts referenced herein. Following authors like Nanarello (1953) and R. Klein (1995), this literature review is bifurcated along two dimensions: (a) descriptive literature and (b) psychodynamic literature. Descriptive traditions focus on behavioral descriptions of observable traits and often explore issues related to genetic heritability and neurobiology, particularly regarding the relationship of schizoid personality to schizophrenia. In contrast, psychodynamic literature focuses on inner covert dynamics (i.e. object relations, unconscious motivations, character structure) and the subjective experiences of the patient. Together, the descriptive and psychodynamic literature give the fullest picture of the schizoid personality, particularly given the divergence between how these individuals present themselves and how they feel inwardly. For a more extensive historical review of the literature on schizoid personality, particularly as relates to assessment issues, see Millon (2004) or Millon (2012). For a more detailed review of the historical contributions to psychodynamic thought, see Akhtar (1992). Information covered in this section has been summarized in several figures for easy access.

- Descriptive Literature
  - Focus on behavioral descriptions of observable symptoms
  - Explores issues of heritability, biology and genetics
- Psychodynamic Literature
  - Focus on inner covert dynamics and subjectivity
  - Explores phenomenological relatedness to schizophrenia

Figure 1.2. Literature review sources.

Descriptive psychology. Schizoid personality has a long history of clinical investigation in the descriptive tradition. The early German and French psychologists

were the first to identify the existence of a schizoid character type that seemed fundamentally related symptomatically to psychosis. Kahlbaum (1890), described the 'heboid' character, a distilled versions of hebephrenia, a disorder modernly known as disorganized schizophrenia. At the same time, Ribot (1890) coined the term 'anhedonia' to describe the inability to experience pleasure he saw in patients with dementia praecox, a concept that would later have enormous relevance in the identification of schizoid symptomology. Not long after the turn of the century, Hoch (1909, 1910) wrote about what he identified as the 'shut-in personality,' noting the inclinations toward mysticism, reclusiveness and preoccupation with fantasy in these patients, while Kraepelin (1913) wrote about a prodromal phase of dementia praecox, a version of psychosis that was stable and ingrained in the personality, which he observed in extremely shy and retiring children. Kraepelin went on to later label this condition 'autistic personality' (Kreapelin, 1919).

In the 1920s, Eugene Bleuler was the first to actually use the word 'schizoid' to describe his patients. Bleuler, in his seminal work on dementia praecox, noted that psychotic individuals differed from normal people to the extent to which they were attentive and invested in their inner emotional world, and that these states were not necessarily untreatable (Bleuer, 1922, 1929). Bleuler essentially saw the schizoid personality as a lesser, non-psychotic version of schizophrenia. Kretchmer (1925) broadened the concept of the schizoid when he differentiated between the *hyperaethetic* type, which was shy and timid (resembling current conceptions of the avoidant personality), and the *anaesthetic* type, notable for it's indifference (like the classic

schizoid type). Kretchmer also recorded the striking sensitivity of these patients and their tendency to withdrawal.

As time progressed researchers explored different variants of the schizoid profile (Farrar, 1927), and began to flesh out the clinical and social variables related to these patients (Kasanin & Rosin, 1933). Some authors wrote about schizoid equivalents called the 'alythymic personality' (Kahn, 1931), and others about the 'parergasic personality' (Terry & Rennie, 1938), while Kallman (1938), established the term 'schizoid psychopath' to describe the secretive and delinquent acts he saw as being attributed to a shifting sense of morality. A similar theme was taken up by Asperger (1944) who wrote about the sensitivity, asexuality, and indifference of the 'autistic psychopath,' and by Heston (1966, 1970), who posited that schizoid psychopaths were prominent in the children of psychopathic mothers. Just as the DSM was going into it's first edition, Nanarello (1953) pulled together the existing schizoid literature to that point, and in exploring three essential schizoid traits, including feelings of inadequacy, social withdrawal, autistic thinking, helped to crystallize the concept of schizoid personality and focus future lines of research.

As psychological science continued to evolve, the descriptive research on schizoid personality increasingly moved toward establishing the genetic, neurobiological, and other childhood sources of the disorder. Sula Wolff's work on childhood schizoid states, presented in many ways as analogous to autistic spectrum disorders, explored the developmental trajectory schizoid disorders, as well as issues related to intellectual functioning, creative ability, and the relationship to schizophrenia (Wolff, 1991a; Wolff, 1991b; Wolff, 1995). Wolff & Chick (1980) had already established five criteria of

autistic states, including solitariness, impaired empathy and emotional detachment, increased sensitivity, rigidity of mental set, unusual communication, relevant to diagnosis. Modern authors, too numerous to mention, using brain imaging studies, have begun to show empirical proof of the relationship of schizoid personality to the schizophrenia spectrum (Siever, 1991, 1992). Others have produced research on neurological correlates for working memory deficits (Harvey, Reichenberg, Romero, Granholm, & Siever, 2006), context processing (McClure, Barch, Flory, Harvey, & Siever, 2008), negative symptoms (Hazlett, Zhang, et al., 2012b), and brain abnormalities (Hazlett, Collazo et al., 2012) in schizotypal presentations.

Kahlbaum	1890	"Heboid"
Robit	1890	"Anhedonia"
Bleuler	1908, 1922, 1924, 1929	"Schizoid"
Hoch	1909, 1910	"Shut-In Personality"
Kraepelin	1913, 1919	"Autistic Personality"
Kretchmer	1925	"Schizoid Characterology"
Farrar	1927	
Menninger	1930	
Kahn	1931	"Athymic temperament"
Kasanin & Rosen	1933	
Terry & Rennie	1938	"Parergasic personality"
Kallman	1938	"Schizoid Psychopath"
Fisher	1944	
Asperger	1944	"Autistic Psychopath"
Wing	1981	"Autistic Personality"
Wolff, S	1991a, 1991b	
Siever, L	1991, 1992	"Schizophrenia-Spectrum"
Hazlett et al.	2003, 2008, 2011, 2012	
Mitropoulou et al	2002, 2004, 2005	

Figure 1.3. Summary of descriptive psychology.

Dynamic psychology. The early dynamic authors made broad, though sometimes unfocused efforts to define what it is to be schizoid. While Freud did not make contributions to the literature on schizoid states, many of his early ideas are indeed applicable (Freud, 1908, 1914). It was Carl Jung's (1917/1971) work on introverted character types and Wilhelm Reich's (1933) writings on the conflict between desires for and against relationships in his patients that set the stage for later research developments. Other early contributors begin describing the 'as-if personality,' marked by tendencies for rapid identification with others, shallow affect, and weak moral structure (Deutsch, 1942), while some questioned the analyzability of these patients given an assumed disposition to psychosis (Fenichel, 1945). Fairbairn (1940) wrote extensively on the schizoid, though he alternated in this discussion between describing a personality organization and a distinct personality type. Fairbairn was the first to flesh out the developmental issues of the schizoid, though his focus was often wide-ranging, and applicable to other forms of pathology as well. Similarly, Melanie Klein (1946) wrote about pre-oedipal schizoid defense mechanisms involving splitting and characteristic of an early stage of infant development, without describing a specific personality type.

It was the late British Middle School writers who began to focus the discussion on a specific personality type. Donald Winnicott (1965), in his well-known paper on the false self, described the essential nature of the schizoid personality as one with a strong split between mind and body. Harry Guntrip (1969) delineated schizoid dynamics, object relations, ego functioning and treatment, and formulated a number of key traits of schizoid patients that made possible the assessment of schizoid pathology, particularly as related to the *schizoid dilemma*, the *schizoid compromise*, and the role of fantasy. Masud

Kahn, after deepening the work of Fairbairn on the clinical aspects of these patients (Kahn, 1960), later suggested the etiological role of cumulative trauma (Kahn, 1963) and added symbiotic omnipotence (Kahn, 1974) to the conceptualization of this disorder.

The writers of the modern era were notable for greatly expanding and differentiating the clinical phenomenology of schizoid disorders. For example, R.D. Laing (1960) wrote about the lack of embodied self, the false self system, and tendency toward psychotic anxieties. Otto Kernberg classified schizoid personality as a borderline disorder (Kernberg, 1967), then placed it on the lower end of this taxonomy (Kernberg, 1970), while Millon (1969) suggested that the actively detached avoidant personality was a separate diagnostic entity from passively detached schizoid personality, a change that was eventually taken up by the DSM. In the 1970s, Appel (1974) wrote on countertransference issues and relational themes, Johnson (1975) provided insight into the subjective experience of self-alienation, Rey (1979) explored the overlap between schizoid and borderline personality organization, and Giovacchini (1979) elaborated on primitive mental states, providing numerous suggestions for the process goals, and technique of schizoid treatment. Later, Akhtar (1987) summarized historical research findings and created a composite profile highlighting the differences between the outward and inward experience in schizoid patients, and Storr (1988), in an essential contribution, provided an extensive examination of the normal functions of schizoid-like mechanisms to individuation and self-actualization.

The last 20 years have seen movement toward ever more refined treatment techniques. Seinfeld (1991) described in detail the sadomasochistic master/slave object relations that characterize schizoid patients, and provided explicit suggestions for

	Foundational Era	
Jung, C.	1917	"Introverted Type"
Reich, W.	1930	
Kallman	1938	"Schizoid Psychopath"
Deutsch, H.	1942	"As-If Personality"
Fenichel, O.	1945	"Schizoid Character"
	British Middle Group	
Fairbarin, W.	1940	
Klein, M.	1946	
Winnicott, D.	1965	
Guntrip, H.	1969, 1977	
Kahn, M.	1963, 1974, 1983	
	Modern Era	
Laing, R.D.	1960	
Weiss, J.	1966	"As-If Personality"
Millon, T.	1969, 2006, 2012	
Klein, D.	1970	
Kernberg, O.	1967, 1970	"Borderline Organization"
Appel, G.	1974	
Johnson, F.	1975	
Rey, J.	1979	"Schizoid Organization"
Giovacchini, P.	1979	
Burland	1986	"Autistic Character Disorder"
Akhtar, S.	1987	
Storr, A.	1988	
Seinfeld, J.	1991	
Manfield	1992	
Modell, A.	1993	
Klein, R.	1995	
Duryee, J.	1996	
Koenigsberg et al.	2000	
Doidge, N.	2001	
Clarkin, et al.	2006	"Borderline Organization"
McWilliams, N.	1994, 2006, 2011	
Thylstrup & Hesse	2009	
Williams, P.	2010	

Figure 1.4. Major dynamic literature contributions.

working with inner emptiness, fantasy, and withdrawal. Manfield (1992) wrote on the clinical implications of schizoid ego splitting, while Modell (1993) contrasted normal strivings for a private self and the biases of the social mindset with pathological isolation. Ralph Klein (1995) laid out the first operationally defined treatment for schizoid patients, advocating similar treatment for avoidant and schizotypal pathology, and Duryee (1996) focused on the optimal frustration of schizoid resistance, addressing concerns related to frame issues, suggesting alterations to standard psychodynamic treatment for schizoid patients. More recent authors have focused on articulating techniques for establishing transference in the absence of affect (Koenigsberg, Kernberg, Stone, Appelbaum, & Yeomans, 2000), also describing the experience of hypersensitivity and hyperpermeability in schizoid patients (Doidge, 2001), and the role of anxiety as an impasse to dependency and trust in schizoid treatment (Williams, 2010). Clarkin et al., (2006) created the first manualized treatment applicable to schizoid personality, with strategies, tactics, techniques, and delineated process of change. Nancy McWilliams, whose work on schizoid types is nuanced, articulate, and insightful (McWilliams, 2006), has sought to expand current research to lesser known dynamics and aspects of these patients (McWilliams, 2011a).

Chapter 2 - Plan for Constructing Handbook

This handbook was designed for the purpose of providing a detailed description of the psychodynamic nosology and treatment of schizoid personality disorder with a focus on object relations. This was accomplished by: (a) conducting a systematic review of the literature available, both classic and modern, (b) isolating consistencies within the literature with regard to theory and treatment using a process of *distillation and matching* (Chorpita, Daleiden, & Weisz, 2005), and (c) using this data to organize and construct operationalized guidelines for a treatment handbook. Explicit decisions have been made with respect to: delineating the limits of the literature included in the study, defining the dimensions along which the core elements of treatment are to be identified, condensed and matched from the literature, and structuring the sections of the handbook. A documentation of the methodological assumptions made for examining the literature on schizoid personality and constructing a treatment manual are now presented.

Literature Selection

Studies contributing to this paper were identified through two strategies: (a) computerized searches of electronic databases for related published materials, and (b) personal exchange of ideas with scholars in the field. The complete criteria for inclusion and exclusion of literature are listed in Figure 2.3 below. All three personality disorders on the schizophrenia-spectrum (avoidant, schizoid, schizotypal) were considered entry points within the literature. All literature on the psychoanalytic treatment of schizophrenia was considered a secondary resource. Related topics, such as introverted types, autistic types, or phenomenology of personality factors such as withdrawal or fantasy were also utilized.

Sources determined SUITABLE to infer primary treatment recommendations if:

(1) The source material's approach to theory, assessment, or treatment was primarily based on a psychodynamic, psychoanalytic, or object relations model

(2) **AND** The source material referenced 'schizoid personality disorder,' 'schizoid personality', 'schizoid element/phenomenon,' 'schizoid type,' 'schizoid character,' or other historical designations of the same disorder, including 'Shut-In Personality,' 'As-If Personality,' and 'Schizoid Psychopath.' **Note**: Sources were not required to have established diagnoses using DSM, ICD or similar instruments given the study's focus on psychodynamic nosology.
OR The source met the above criteria, but was written primarily about any of the following disorders considered structurally or theoretically related to schizoid personality: Avoidant Personality Disorder, Schizotypal Personality Disorder, and Schizophrenia, or contained references to 'Schizophrenic-Spectrum Disorders.' **Note**: While these sources were included in a search of the literature, they are considered secondary sources and were referenced with respect to their original focus if used in the text.

(3) **AND** Source materials referenced specific theoretical considerations, interventions, recommendations, considerations, therapeutic stages, progress, or outcomes related to schizoid personality treatment.

(4) **AND** Sources primarily made references to the treatment of adults, even if references to developmental trajectory and etiological factors included information about childhood.

Sources determined UNSUITABLE to infer primary treatment recommendations if:

(1) The source was primarily written about the treatment of personality disorders in general, rather than being diagnosis-specific.

(2) The source was written primarily about any of the following disorders theoretically related to schizoid personality: Autism, Asperger's, or Paranoid Personality Disorder.

(3) The source concerned theoretical considerations, assessment, or treatment using methods or nosology from alternative perspectives (i.e. CBT, DBT, Support psychotherapy, Body Psychology).

(4) The source was written generally about *schizoid personality organization* as a broad level of personality organization between neurotic and psychotic, about the *paranoid-schizoid* position, in the context of Kleinian developmental theory, or about *introversion* or *introverted type* in the context of Jungian theory

(5) The source was derivative, or duplicative of another more original source material. **Note**: Given the limited numbers of original publications on schizoid personality, many sources only recapitulate or discuss previous research and were considered redundant for the purposes of this handbook.

(6) The source was primarily concerned with the assessment or treatment of children.

(7) The source had not been published, was not in English, or was a dissertation.

Figure 2.1. Inclusion / exclusion criteria for literature.

Data Sorting

Because of the difficulty analyzing the treatment approaches of many authors with differing perspectives, the current study seeks to eliminate redundancy in the literature by identifying *core therapeutic practice elements*. A therapeutic practice element can be defined as a discrete area of clinical focus (i.e. hierarchy of thematic material), a technique (i.e. transference interpretation), or an approach to treatment (i.e. technical neutrality) that is both *pervasive* and *elemental*, and therefore considered a requisite component of treatment. These coding dimensions are summarized in Figure 2.4 below. The *distillation and matching model* (Chorpita, et al., 2005) was utilized as a model for how to condense and organize therapeutic practice elements from within the literature, generating exploratory hypotheses about the theoretical links between these practices, and then generalizing treatment recommendations. Coding of therapeutic practice elements will be performed on the best obtainable description of the practice procedures as provided in the text of an original source. Due to the broad nature of the current study, the codings will not be analyzed using a strict empirical approach and will be assumed to be generally intuitive and apparent from the literature.

(1) **Active Treatment Techniques** – (e.g. 'interpreting up,' somatic experiencing, confrontation, interpretation)
(2) **Treatment Operations** – (e.g. therapeutic attitude, utilization of counter-transference, technical neutrality)

Figure 2.2. Dimensions for coding therapeutic elements.

Structure of the Handbook

Decisions have also been made about the structural components of this handbook. Following the general outline for the creation of a Stage I treatment handbook, as defined by Carroll and Nunro (2002), this handbook will be constructed to be minimally sufficient for an initial evaluation of feasibility and efficacy at a later time. Research findings will be divided intuitively into the following handbook sections: (a) An overview, description, and rationale for the handbook, (b) a theoretical conception of schizoid personality, (c) treatment goals, (d) specification of defining interventions, (e) session content, and (f) the general format for sessions (Carroll & Nuro, 2002). This handbook will not offer a comparison with other forms of treatment for schizoid personality given the scarcity of alternative resources, though brief outlines of alternative modalities are presented as possibilities for adjunct treatment. Sections outlining theoretical mechanisms of change, issues of frame and frequency, therapist stance, therapeutic relationship, view of countertransference, and other core dimensions considered necessary to standardize complex treatments in long-term psychodynamic therapy will also be included, as is consistent with current standards for the construction of manuals for long-term psychodynamic psychotherapy and psychoanalysis advocated by Caligor (2005).

Inherent Difficulties in the Current Approach

The construction of a ‘manual’ for psychodynamic practitioners presents several methodological and philosophical issues. Manualized treatment are rightly criticized for several important flaws, such as the limits they impose on clinical innovation and existing clinical expertise, an over-emphasis on strategy and technique at the cost of relationship

and universal elements of treatment, the vast range of clinical training experience in those utilizing the handbook, and difficulty in applying handbooks to diverse and complicated patients (Addis, Wade, & Hatgis, 1999). However, the dangers of creating a 'manualized' treatment do not prohibit the possibility that such an resource, when used correctly, may contributive to better outcomes, further research, and improve training for clinicians. The author does not advocated that this handbook be used rigidly or that it supercede the expertise or clinical judgment of the therapist. Instead, it is hoped that the strategies and techniques of this handbook will serve as a framework, leaving the therapist to determine the best means of adjusting for the myriad of differences in individual patients across time. Treatment progress and outcome is not linear, and what is useful for one patient may be less so for another. Moment-to-moment interactions between therapist and patient are the entry point to all successful treatments and no resource could possibly hope to address a fraction of these possibilities or presage how the course of a treatment of several years or more will progress.

Chapter 3 - Diagnostic Assessment

The assessment of personality pathology is innately complicated. Schizoid personality, in particular, has a well-deserved reputation for being difficult to diagnose given the great disparity between symptomatic presentation and deeper psychological features in these patients (Akhtar, 1987). Part of the difficulty in diagnosing this condition lies in the fact that descriptive diagnostic tools, like the DSM, draw on criteria that are too narrow, underemphasize aspects of internal functioning that characterize the patient, and are often attached to a single defining trait (Shedler & Westen, 2004). The perception in mental health institutions that schizoid personalities do not show up very often for treatment may in part reflect the biases of the tools in use to identify these patients at intake. This section seeks to present and critique many of the available means of assessing schizoid personality currently available to increase the chances for successful diagnosis. Tools are judged clinically functional to the degree that they are able to capture both outward behavioral observations while also accounting for the intricacy and richness of the inner personality dynamics that are hidden by defensive splitting.

This discussion addresses schizoid assessment broadly at first, and then narrows. After contextualizing schizoid personality as one disorder on the greater schizophrenia spectrum, descriptive approaches, emphasizing observable and behavioral traits, such as the DSM-IV-TR (APA, 2000) and the ICD-10 (World Health Organization, 2008) and newer psychological assessment tools like the SWAP-200 (Shedler & Westen, 2004) are presented to assess at the level of the personality itself. Assessment approaches

influenced by the psychodynamic tradition, such as the Rorschach Inkblot, the MMPI, and the Adult Attachment Inventory, are presented along with stereotypical profiles, as are other non-standardized assessments such as Akhtar's schizoid profile, and Gruntip's core traits (Klein, 1995). Afterward, issues related to differential diagnoses, both at the level of personality organization and between personality types are presented. Last, common symptom formations secondary to a schizoid disorder are reviewed to increase the chances of a sound multi-axial diagnosis.

The Schizophrenia Spectrum

At the broadest level, this handbook assesses schizoid personality as one personality type on a spectrum of disorders that are phenomenologically linked to schizophrenia. This spectrum is referred to as the *schizophrenia-spectrum.* While the schizophrenia-spectrum also encompasses psychotic disorders, including the five types of schizophrenia, shizophrenoform and schizoaffective disorders, and delusional disorders, the focus of this handbook is on the three personality disorders that together make up the healthiest, and non-psychotic, arm of this continuum, including the avoidant, schizoid, and schizotypal personality. (Paranoid personality, though also considered a Cluster C disorder by the DSM (APA, 2000), has been demonstrated to be functionally unrelated to the schizophrenia spectrum (Siever, 1992) and is not discussed in this text.) Once conceptualized as 'latent schizophrenia' (Federn, 1947), schizophrenia-spectrum disorders show many traits and symptoms that are functionally related to schizophrenia but differ significantly in that their presentations are rarely if ever florid, their underlying organization is not psychotic, and they do not share the negative prognostic implications of schizophrenia.

A spectrum approach to the classification of mental disorders requires that individual disorders not be considered discrete or detached from other functionally related disorders, but rather a part of range of presentations from mild to severe. Unlike categorical approaches to diagnosis, such as those advocated by the DSM and ICD, the concept of the schizophrenia spectrum is based on the precept that sees the same underlying mechanisms underlie a range of *schizophrenia-like* syndromes that differ in the characteristics of their symptomatic expression.

Diagnostic guides, such as the DSM and ICD, have historically emphasized that a certain type or number of symptoms or a specific constellation of symptoms must be present to give a diagnosis, and classify a disorder as being present or absent while disallowing diagnostic gradations (APA, 2000; World Health Organization, 2008). The considerable limitation of the DSM-IV-TR criteria to take into account the underlying dynamics of these individuals only exacerbates these issues. Fortunately, it now seems that the DSM-V may include a revised conceptualization of schizoid personality that allows for a spectrum-type approach, as advocated in this handbook. The DSM-V Work Group has recommended that schizoid personality be diagnosed on a dimensional continuum and represented by a combination of core impairment in personality functioning and specific pathological personality traits (i.e. social withdrawal, social detachment, intimacy avoidance, restricted affectivity, anhedonia). Avoidant personality and schizotypal personality would remain diagnostic entities, whereas schizoid personality would not (www.dsm5.org).

A spectrum approach to schizophrenia-spectrum disorders has deliberately been emphasized for the purpose of encouraging continuity between theoretical and clinical

aspects of treatment both between related personality disorders and, by extension, to the research on schizophrenia. The most basic reasons for contextualizing schizoid personality within the broader spectrum of the schizophrenia spectrum is that this conceptualization allows for (a) increased continuity of theoretical constructs, (b) increased applicability of relevant treatment recommendations across these personality disorders, (c) increased clinical and conceptual applicability of research findings from across the spectrum, (d) reduced pressure to focus on specific symptomatic clusters or any one individual criteria, opting instead for a gradation of symptomatology.

The downside of contextualizing the schizoid within the schizophrenia-spectrum is that is draws undue comparison to schizophrenia, both in functionality, prognosis, and severity. It is essential to understand that schizoid disorders of the self can be present in a large range of individuals, from healthy to pathological. The concept of a spectrum is important because it allows for a great range of presentations. Rather than limiting a discussion only to the most pathological, a spectrum recognizes that a clinician may wish to speak of a personality organization, personality traits, clinical phenomenon, or a full-fledged personality disorder. From this vantage point, a spectrum approach attempts to de-stigmatize schizoid disorders from only referring to primitive and severe patients to encompassing a broader organizing framework.

- Increased continuity of theoretical constructs
- Increased applicability of treatment recommendations
- Increased applications of research findings
- Less focus on specific symptomatic clusters or individual criteria; allows for gradations in symptoms
- Reduction of diagnostic stigma associated with schizoid diagnosis

Figure 3.1. Why a spectrum approach is useful.

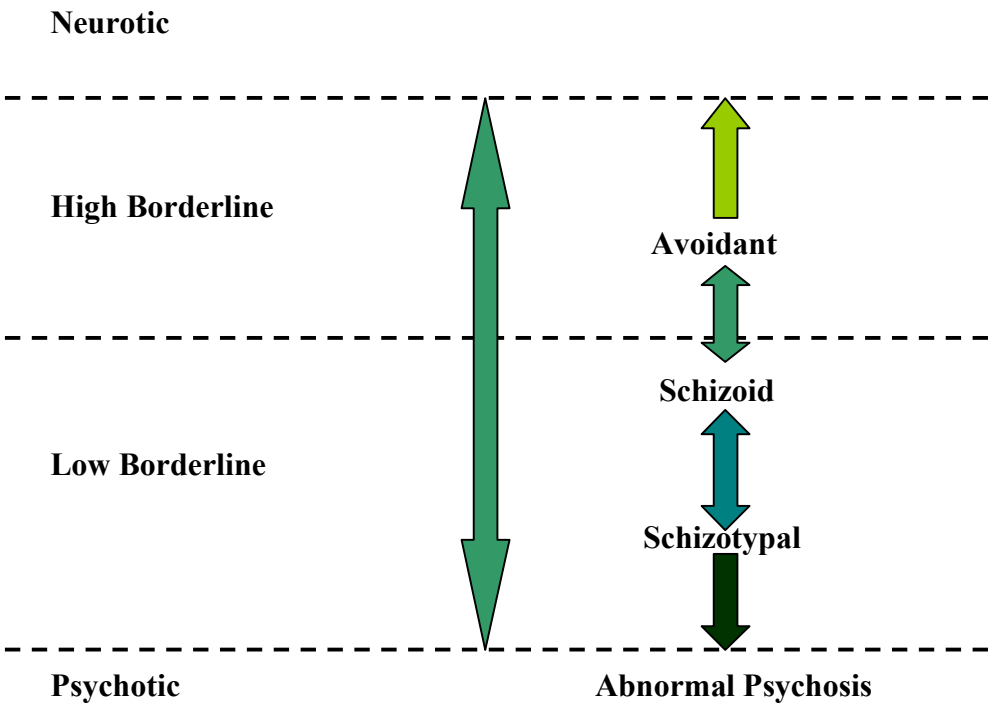
	Severity			
Diagnosis	**'Avoidant'**	**Schizoid**	**Schizotypal**	**Psychosis**
	←			→
Personality Organization:	High Borderline	Low Borderline	Low Borderline	Psychotic
Attachment Style:	Anxious-Avoidant	Dismissive-Avoidant	Dismissive-Avoidant	Disorganized-Avoidant
Affect:	Anxious, Depressed	Anhedonia, Serious	Distressed	Incongruent, Catatonic
Cognitive style:	Preoccupied, Vigilant	Intellectual, Constricted	Bizarre, Eccentric	Nonsensical
Symptomology – Negative:				
• Anhedonia	No	Yes	Yes	Yes
• Isolation	No	Yes	Yes	Yes
• Withdrawal	Yes	Yes	Yes	Yes
Symptomology – Positive:				
• Perceptual Disturbances	No	No	Yes	Yes
• Psychotic Episodes	No	Rare	Pockets	Yes
• Agitation	No	No	Yes	Yes
• Magical Thinking	No	No	Yes	Yes
• Paranoia	No	No	Yes	Yes
• Though Disturbance	No	No	Yes	Yes
Psychic Structure:				
• Reality testing	Intact	Largely intact	Largely intact	Impaired
• Interpersonal style	Timid	Withdrawn	Secretive	Ineffectual, Timid
• Attitude toward self	Excluded, Unwanted	Self-sufficient, Superior	Unique, Transcendent	Unreal, Dreamlike
• Core conflict	Dependency	Dependency	Dependency	Dependency
• Aggression	Self/Other directed	Inhibited/Self-directed	Anger storms	Self-Directed
• Oscillation in Relationships	Yes	Yes	Yes	Yes
• Identity	Mostly consolidated	Unconsolidated	Unconsolidated	Unconsolidated

Figure 3.2. Schizophrenia-spectrum personality disorders.

The schizophrenia spectrum stretches the length of the borderline organization with avoidant personalities placing in the high borderline range, to schizoid proper as a low borderline, and schizotypal approaching, though rarely entering psychotic organization, where it would otherwise qualify as an abnormal psychotic state (Clarkin et al., 2006). Schizoid personality has predominantly been considered a borderline level disorder for some time (Kernberg, 1967), and specifically as a low borderline disorder (Kernberg, 1970). While there is often a parallel of neurotic and psychotic anxieties in schizoid patients, schizoid patients generally do not have neurotic-level conflicts (McWilliams, 2006). Figure 3.3 below depicts schizophrenia spectrum personality disorders by severity using personality organization as a reference.

Avoidant personality is disputed as a diagnostic category by some authors who maintain that this diagnosis most frequently conceals a deeper personality constellation, rather than constituting a diagnostic entity in and of itself (Clarkin et al., 2006). The splitting of avoidant and schizotypal pathology from schizoid pathology that occurred first in the DSM-III, and was reinforced in the DSM-III-TR may have come with the unintended consequences of implicitly suggesting that different goals and treatment recommendations may be indicated for these conditions. While ongoing literature on the difference between avoidant, schizoid, and schizotypal presentations has yielded important research, this handbook operates under the broad assumption that the treatment for these presentations should be broadly congruent, adjusted for the severity of presenting issues.

Avoidant personality remains controversial as both a diagnosis and in its placement as a schizophrenia spectrum disorder. Millon (1969) was among the first to



modified from Clarkin, Yeomans, & Kernberg, 2007

Figure 3.3. Schizophrenia spectrum personality disorders.

suggest that avoidant pathology formed a separate symptomatic constellation, suggesting that avoidant pathology reflect active detachment from a desired closeness with others, while schizoid pathology usually reflected a passive detachment indicative of limited interest in relationships. This distinction was also noted years prior by Kretchmer (1925) who also observed both presentations in his schizoid patients. While some believe that avoidant personality is separable diagnostic entity within the schizophrenia-spectrum based on the focus on social anxiety symptoms and failure to meet the full clinical picture of a schizoid disorder (Fogelson et al., 2007), a deeper look at Avoidant pathology may reveal the presence of schizoid or schizotypal traits, usually to a lesser degree.

Interestingly, avoidant personality traits were shown to predict performance on neurocognitive measures in the first-degree relatives of schizophrenia (Fogelson, et al, 2010). However, avoidant behavior can occur with other personality disorders due to the fact that avoidance is at its most basic, *a defensive tactic*.

Commonalities in phenomenology & symptomatology. Schizoid spectrum disorders share many of the phenomenological issues of schizophrenia, though to a far lesser degree (Laing, 1960). Many key schizoid traits, such as social withdrawal, oscillation in and out of relationships, and denial of dependency needs are also observed in schizophrenic patients. More broadly, phenomenological commonalities with psychosis include the disruption of relationships to others in the world and to the identity of the self, identification with inner fantasy objects, trouble maintaining relationships, limited range of emotion, omnipotence, loss of inner self and heavy reliance on the false self, feelings of emptiness, difficulty sustaining autonomy and identity, psychotic fears of implosion and engulfment, and lack of embodied experience (Laing, 1960).

The severity of a schizoid spectrum disorder can sometimes be determined by the intensity of the symptomatology that is reported or observed in treatment. Figure 3.4 attempts to classify symptoms belonging to the schizoid spectrum by relative severity drawing on the work of Shedler and Westen (2004) in the SWAP-200. Patients that most frequently qualify for an avoidant diagnosis are often in touch with their neediness for others, but often run from opportunities for intimacy because they fear rejection, feelings of inadequacy, abandonment and failure in these situations. Accordingly these individuals often experience high levels of depression and anxiety in their lives, and a good deal of shame, embarrassment, and feelings of inferiority in relationship to other. These occurs

only to a limited degree in schizoid and schizotypal presentations where neediness for others is deeply denied or split off, and fears of rejection and embarrassment do not often materialize because relationships are avoided and the emotional implications of interpersonal associations are dismissed. Anxiety and depression do occur, but usually only arise when connection to others is in some way unavoidable.

Like schizoid personalities, avoidant personalities and schizotypal personalities also appear shy and reserved, have difficulty expressing anger, can be passive and unassertive, and fear humiliation. Most patients in the schizoid spectrum are likely to lack close relationships and feel like an outsider or a misfit, and all schizoid spectrum disorders oscillate between wanting relationship and fearing relationship, though this struggle is usually easier to see in the avoidant, rather than the schizoid or schizotypal personalities. The avoidant personality differs mainly in that these individuals are capable of warming up to others once an accepting relationship has been established, whereas the schizoid and schizotypal presentations tend to experience strong anxiety within relationships that does not easily abate.

As the severity of the schizoid pathology increases, the patient is likely to show deficits in his social skills and increasingly constricted or absent emotional experience. At the same time, the more acute cases show increasing or total denial of dependency needs and seem to have little need for human closeness. Those presenting with deficits in social skills show great difficulty making sense of other people's behavior and show less ability for empathy and insight. At the most severe end of the spectrum, the typically schizotypal presentations begin to show 'positive symptoms' such as superstitious or magical beliefs. Reasoning patterns become more and more idiosyncratic and speech is

often rambling, highly concrete or circumstantial. These low-functioning individuals are easily impaired under stress and show limited insight. As the range of experiences stretches at last toward the border of psychotic organization, communication becomes eccentric, paranoid, irrational, or incongruent and difficult to comprehend.

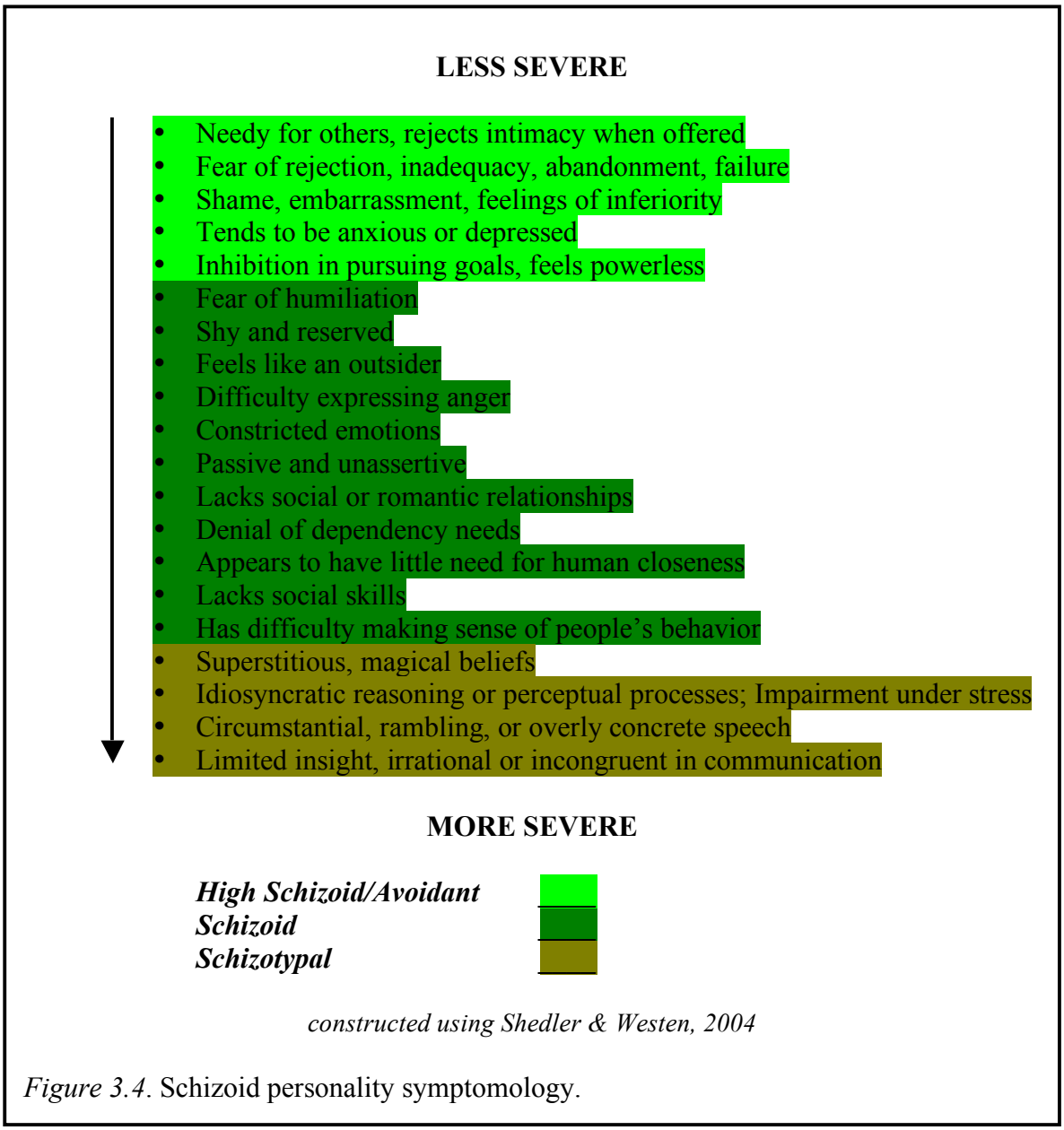
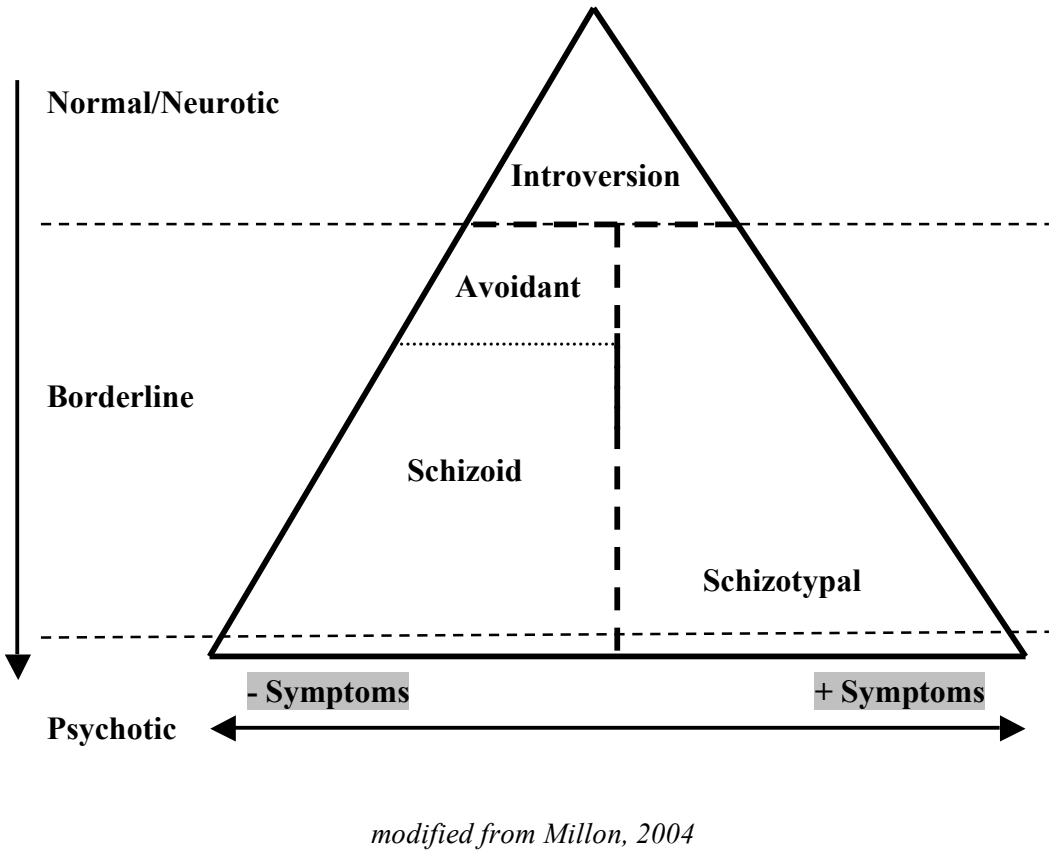


Figure 3.4. Schizoid personality symptomology.

Figure 3.5 below, modified from the work of Millon (2004), illustrates schizoid disorders by positive and negative symptoms. On the left, avoidant personality and schizoid personality manifest strong negative symptoms such as limited affect and social withdrawal. In contrast, schizotypal personalities, shown on the right side of the diagram, show more positive symptoms like bizarre thoughts and magical thinking and idiosyncratic reasoning. These three disorders are shown to be stemming from normal introversion.



modified from Millon, 2004

Figure 3.5. Schizoid spectrum disorders (by +/- symptoms).

A preponderance of neurotic features is likely to greatly reduce the chances that a personality disorder from the schizophrenia spectrum disorder is present (Clarkin et al., 2006). While neurotic level personality organization is marked by a coherent sense of identity and an ability to make strong investments in work and leisure, borderline level personalities are marked by an incoherent sense of self and others, and usually show marked difficulty investing in work and leisure (Clarkin et al., 2006). Borderline and neurotic patients also differ in their ability to manage reality testing, in how they handle and direct aggression, in their internal system of morals and values, and in the quality of their object relations. While high-functioning schizoid characters may not always show identity diffusion and marked difficulty with reality testing, they are not prone to guilt, or to rigid inflexibility around moral systems as neurotic characters would be (Clarkin et al., 2006). Schizoid pathology is also marked by the use of mostly primitive defenses such as splitting, denial, and withdrawal over the more advanced defenses of the neurotic patient, such as repression, regression, displacement, and rationalization.

Borderline level patients also struggle to empathize with others, have difficulty with social convention, and show self-directed aggression. Internally, borderline level patients often have contradictory or rapidly shifting value systems that they have a difficult time putting into practice, and in severe cases, may appear to lack moral systems at all. Interpersonal relationships at the borderline level are often chaotic or troubled, a factor that is also reflected in confused sexual relationships, or frequently in the case of schizoid populations, a paucity of sexual relationships (Clarkin et al., 2006). Neurotic level patients do not generally share these characteristics, and are able to accurately perceive reality, have strong, although rigid moral systems, and relatively stable

interpersonal and sexual relationships coupled with more specific issues of conflict Figure 3.6 outlines these described differences between neurotic and borderline level disorders, as cited in Clarkin, et al. (2006).

	Neurotic	**Borderline [Schizoid]**
Identity	Coherent sense of self and others; investments in work and leisure	Incoherent sense of self and others; poor investment in work and leisure
Defenses	Use of more advanced defenses; rigidity	Use of primitive defenses
Reality testing	Accurate perception of self vs. non-self, internal vs. external; empathy with social criteria of reality	Variable empathy with social criteria or reality; lack of subtle tactfulness
Aggression	Inhibited aggression; angry outbursts followed by guilt	Self-directed aggression; some with aggression toward others; hatred in severe cases
Internalized values	Excessive guilt feelings; some inflexibility in dealing with self	Contradictory value system; incapacity to live up to own values; significant absence of certain values
Object relations	Some degree of sexual inhibition, or difficulties integrating sex and love; deep relationships with others, with specific focused conflicts with others	Troubled interpersonal relationships; absence of or chaotic sexual relations; confused internal working model of relationships; severe interference with love relationships

cited from Clarkin, Yeomans, & Kernberg, 2006

Figure 3.6. Differentiating neurotic and borderline organization.

Comparative Assessment Summary

In the next section, individual means of assessing schizoid pathology are discussed. The figure on the following page lists the individual assessment measures mentioned in the next section, and identifies these tools by the dimensions of psychological functioning they address. Those measures that are primarily descriptive are listed in green, while those that are primarily psychodynamic are presented in red. Though a combination of assessment techniques may be used to assess for personality pathology, those measures highlighted in gray are those most recommended for use in conjunction with this handbook given the balanced and holistic approach they offer relative to other approaches.

Figure 3.7. **Comparison of schizoid assessment techniques by domain.**

	Primarily Descriptive	Primarily Dynamic	Social	Emotional	Behavioral Obs	Sexual	Self Concept	Object Relations	Defenses	Introvert Introspect
Negative Symptoms	X		X	X	X					
DSM-IV-TR	X		X	X		X				
IM-SZ	X		X	X	X					
ICD-10	X		X	X		X				X
SWAP-200	X		X	X	X	X	X	X		
Guntrip's Traits		X	X	X			X	X	X	X
Akhtar's Profile	X	X	X / X	X / X	X	X / X	X / X	X		
MCMI-III		X	X	X		X	X	X	X	
MMPI-2		X	X	X			X	X		X
PDM		X	X	X			X	X	X	
AAI		X	X				X	X		
Rorschach		X	X	X			X	X	X	
Meyers-Briggs		X					X			X
Five-Factor		X	X	X			X			X

X Primarily Descriptive
X Primarily Psychodynamic
Recommended

Descriptive Assessment Tools

Negative symptoms. One of the most broad and basic descriptive means for assessing schizoid personality is based on the presence of the so-called 'negative symptoms' of schizophrenia, first identified in the late 1880s by J. Hughlings Jackson (Berrios, 1985). Negative symptoms stand in contrast to hallucinations, delusions, bizarre behavior, or frank thought disorders, which are considered positive symptoms, often present in more floridly schizotypal presentations. The negative symptoms observable in the schizoid personality include *flat or blunted affect and emotion* (similar to the DSM criteria "Shows emotional coldness, detachment, or flattened affect")*, social withdrawal* (similar to the DSM criteria "Almost always chooses solitary activities"), *asociality* or the lack of desire to form relationships (similar to the DSM criteria "Takes pleasure in few, if any, activities with other people"), *anhedonia* or the inability to experience pleasure in activities, *avolition* or the lack of motivation, and *alogia* or poverty in speech (APA, 2000). These symptoms are summarized below in Figure 3.8.

Using the negative symptoms as a checklist for schizoid pathology is not a standard assessment technique and the presence of these symptoms is not ever enough to give a schizoid diagnosis or to rule out other conditions without a deeper understanding of the patient's dynamics. For example, anhedonia, social withdrawal, and avolition can also be observed in depressed patients, often occurring secondary to guilt, negative self-worth, and depressed mood that are rarely observed in schizoid patients. Yet, this method can provide a good snapshot if not a simple starting place to assess for the gaps in affective and social engagement associated with schizoid pathology.

(1) **Flat or blunted affect**
(2) Social withdrawal
(3) **Alogia** - Poverty of speech
(4) **Anhedonia** - Inability to experience pleasure in activities
(5) **Asociality** - Lack of desire to form relationships
(6) **Avolition** - Lack of motivation/Passivity

Figure 3.8. Negative symptoms of schizophrenia.

DSM-IV-TR & ICD-10. The most commonly used criterion for the assessment of the schizoid personality are the DSM-IV-TR and the ICD-10, included in Figure 3.9 for quick reference. There are large similarities between DSM and ICD criterion sets, including their shared focus on restricted emotionality, the lack of desire to form relationships or to engage in sexual experiences, and indifference to praise and criticism. The ICD-10 includes two criteria beyond the DSM, one focusing on the schizoid's preoccupation with fantasy and introspection and the other on his typical indifference to social norms and conventions. Unlike other personality disorders, the DSM defines the schizoid personality by what it lacks outwardly (i.e. blunted affect; Millon, 2004), rather than by what it has. The difficulty of using the DSM to adequately assess the schizoid personality is covered extensively elsewhere (Akhtar 1992; Gabbard 1994), as is the large diagnostic overlap between avoidant and schizotypal disorders with schizoid personality (Livesley, West, & Tanney, 1986; Shedler & Westen, 2004).

The DSM eliminates the focus on aspects of subjective experience, particularly aspects like defense, as well as subjective sources of experience, attachment, affect, or development (McWilliams, 2011b). The largest problem with DSM and ICD criteria seems to be that they tend to take schizoid disconnection at face value (Kernberg, 1984)

and ignore the longing for friendship, love, and attachment (Klein, 1995), prompting therapists to believe positive therapeutic outcome is limited. Moreover these criteria underestimate the psychological pain these patients may experience, emphasizing lack of affect instead and ignoring their experience of depression and despondency, relationship avoidance as a result of fear of embarrassment or humiliation, and inhibitions about seeking gratification, and high levels of anxiety (Shedler & Westen, 2004). Other aspects of schizoid functioning missing from these criteria include the schizoid's introversion, loneliness, oscillation in and out of relationships, denial of need, inability to express anger, preoccupation with idiosyncratic activities, and omnipotent self-image.

International Classification of Diseases (ICD-10)

Schizoid PD is characterized by at least four of the following criteria:

- Emotional coldness, detachment or reduced affect
- Limited capacity to express either positive or negative emotions towards others
- Consistent preference for solitary activities
- Very few, if any, close friends or relationships, and a lack of desire for such
- Indifference to either praise or criticism
- Taking pleasure in few, if any, activities
- Indifference to social norms and conventions
- Preoccupation with fantasy and introspection
- Lack of desire for sexual experiences with another person

Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)

A pervasive pattern of detachment from social relationships and a restricted range of expression of emotions in interpersonal settings, beginning by early adulthood (age eighteen or older) and present in a variety of contexts, as indicated by four (or more) of the following:

- Neither desires nor enjoys relationships or human interaction, including being part of a family
- Almost always chooses solitary activities
- Has little, if any, interest in having sexual experiences with another person
- Takes pleasure in few, if any, activities with other people
- Lacks close friends or confidants other than first-degree relatives
- Appears indifferent to the praise or criticism of others
- Shows emotional coldness, detachment, or flattened affect

APA, 2000; World Health Organization, 2008

Figure 3.9. Contemporary diagnostic criteria.

The first DSM, published in 1952, defined schizoid personality for the first time as a personality disorder with three broad criteria. The third version of the DSM (APA, 1980) included a definition of schizoid personality that distinguished from Schizotypal Personality Disorders and Avoidant Personality Disorder, while the DSM-III-R (APA, 1987) transferred severe forms of schizoid pathology to schizotypal personality disorder and transferred milder forms of schizoid pathology to avoidant personality disorder. Recent proposals for the DSM-V recommends that schizoid personality be represented and diagnosed by a combination of core impairment in personality functioning and specific pathological personality traits (i.e. Social withdrawal, Social detachment, Intimacy avoidance, Restricted affectivity, Anhedonia), rather than as a specific personality type (www.dsm5.org). These historical changes have been noted in Figure 3.10 below.

Version	**Alterations**
DSM-I (1952)	Defined as a personality disorder with three broad criteria
DSM-III (1980)	Schizoid criteria distinguished from Schizotypal personality Disorders and Avoidant Personality Disorder
DSM-III-R (1987)	Transferred severe forms of schizoid pathology to schizotypal personality disorder; Transferred milder forms of schizoid pathology to avoidant personality disorder
DSM-V (*Proposed*)	The Work Group recommends that schizoid personality be represented and diagnosed by a combination of core impairment in personality functioning and specific pathological personality traits (i.e. Social withdrawal, Social detachment, Intimacy avoidance, Restricted affectivity, Anhedonia). Schizoid personality is no longer considered a specific personality type

Figure 3.10. The DSM revisions to schizoid personality.

IM-SZ. The Interpersonal Measure of Schizoidia is a relatively new assessment method based largely upon behavioral observations about the quality of interpersonal engagement during a clinical interview. The IM-SZ is intended to provide clinicians with an assessment tool not based entirely around the self-report of the schizoid patient, particularly given the poor insight that characterizes those with more serious pathology (Kosson, et al., 2008). The IM-SZ is scored along fourteen dimensions, included in Figure 3.11 below. Dimensions capturing observable aspects of schizoid emotional detachment include *constricted facial affect, lack of non-verbal or verbal expression, lack of variability in expression*, and *absence of spontaneous speech*. Issues related to poor interpersonal rapport include detach*ment, lack of responsiveness to interviewer, guardedness*, and *lack of interpersonal synchrony*, among other categories. Given the centrality of interpersonal dysfunction in schizoid pathology, the IM-SZ is of great help in rapidly quantifying these aspects of the patient's functioning in the clinical setting.

1. Constricted facial affect
2. Lack of nonverbal expression
3. Detachment (lack of engagement)
4. Lack of verbal expression
5. Indifference (lack of interest)
6. Guardedness
7. Lack of variability in affect/expression over time
8. Poor rapport
9. Absence of spontaneity in speech
10. Lack of verbal responsiveness to interviewer's remarks
11. Lack of interpersonal synchrony
12. Poor personal hygiene
13. Physical anergia
14. Social isolation

Kosson et al., 2008

Figure 3.11. Interpersonal Measure of Schizoidia (Subscales).

SWAP-200. Shedler and Westen (2004) sought to identify the central features of personality disorders as they are conceptualized by practicing clinicians and observed empirically in patients treated in the community. A national sample of experienced psychologist were asked to use the Shedler-Westen Assessment Protocol (SWAP-200) to describe prototypical cases of each personality disorder in its purest form. A prototype-based approached was developed from this data in an effort to capture the complexity of the correlates, antecedents, and sequelae of each personality disorder (Shedler & Westen, 2004). A major theme of the findings indicated that DSM-IV criterion sets for the personality disorders tend to be far narrower than clinicians' conceptualizations of these disorders and tend to underemphasize aspects of inner experience. Moreover, the authors found that composite descriptions of schizoid and schizotypal personalities were found to be statistically similar enough to one another (r=0.83) that separate diagnostic categories are not warranted (Shedler & Westen, 2004).

The great strengths of the SWAP-200 protocol is its ability to capture a large amount of rich detail in quantifiable form, the flexibility it allows the clinician to consider the overall gestalt in diagnosis without having to rely on polythetic diagnostic decision rules, and the emphasis it places on diagnosing pathology on a continuum rather than as present or absent (Shedler & Westen, 2004). The schizoid profile isolated in the SWAP study has been included on the following page in Figure 3.12, with criteria listed in order of the frequency that these traits were reported by clinicians involved in the study, and the rubric for diagnosis. Appendix I and Appendix II at the end of this handbook present the SWAP-200 criteria for both avoidant and schizotypal personalities.

In each case, the criteria sets are highlighted in gray where they share similar traits with schizoid profile.

1. Lacks close friendships and relationships.
2. Appears to have a limited or constricted range of emotions.
3. Tends to be inhibited or constricted; has difficulty allowing self to acknowledge or express wishes and impulses.
4. Appears to have little need for human company or contact; is genuinely indifferent to the presence of others.
5. Lacks social skills; tends to be socially awkward or inappropriate.
6. Tends to be shy or reserved in social situations.
7. Has little or no interest in having sexual experiences with another person.
8. Tends to feel like an outcast or outsider; feels as if s/he does not truly belong.
9. Has difficulty allowing self to experience strong pleasurable emotions (e.g., excitement, joy, pride).
10. Has difficulty acknowledging or expressing anger.
11. Has difficulty making sense of other people's behavior; often misunderstands, misinterprets, or is confused by others' actions and reactions.
12. Tends to deny or disavow own needs for caring, comfort, closeness, etc., or to consider such needs unacceptable.
13. Appears unable to describe important others in a way that conveys a sense of who they are as people; descriptions of others come across as two-dimensional and lacking in richness.
14. Appears to find little or no pleasure, satisfaction, or enjoyment in life's activities.
15. Appearance or manner seems odd or peculiar (e.g., grooming, hygiene, posture, eye contact, speech rhythms, etc. seem somehow strange or "off").
16. Appears afraid of commitment to a long-term love relationship.
17. Tends to be passive and unassertive.
18. Tends to avoid social situations because of fear of embarrassment or humiliation.

Please form an overall impression of the type of person described, then rate the extent to which your patient matches or resembles this prototype:

5	very good match (patient exemplifies this disorder; prototypical case)	**Diagnosis**
4	good match (patient has this disorder; diagnosis applies)	**Diagnosis**
3	moderate match (patient has significant features of this disorder)	**Features**
2	slight match (patient has minor features of this disorder)	
1	no match (description does not apply)	

from Shedler & Westen, 2004

Figure 3.12. Schizoid clinical profile using SWAP-200.

Psychodynamic Assessment Measures

MMPI-2. The most frequently cited paper on the assessment of schizoid personality using the MMPI is Golden and Meehl (1979), which reported the results of a psychiatric sample of hospitalized men who were administered the MMPI prior to initial diagnosis at intake. A 2-7-8 Three-Code Type (Depression, Psychasthenia, Schizophrenia) was most common among patients who were later diagnosed with schizoid personality, a profile similar to preschizophrenic populations, though the validity of the classification was relatively low (about r=.40; Golden and Meehl, 1979). A second study found that the two-code type 1-8/8-1 (hypocondriasis, schizophrenia) is often indicative of schizoid pathology wherein interpersonal connection is limited (Graham, 2000). These findings, along with other possible Two-Code Types are listed in Figure 3.13 below.

The MMPI subscales capture schizoid pathology in an indirect way. For example, an elevated 2-Depression, while not usually reflecting depressed mood per se, does capture the schizoid's hopelessness and pessimism about life. An elevated 8-Schizophrenia captures the schizoid's alienation and interpersonal difficulties, apathy, inertia, and feelings of unreality, without indicating frank psychosis. An elevated 7-Psychasthenia can reflect the schizoid's expression of his stress through diffuse tension states that take the place of feelings, as well as his occasional obsessions, apprehensiveness, and tendency to intellectualize. Amongst the most likely elevations in any schizoid profile is 0-Social Introversion, indicating a tendency toward shyness, social anxiety, social timidity and awkwardness, and social avoidance.

Additional elevations are also possible. The presence of an elevated 4-Psychopathic Deviate is not likely to be related to antisocial tendencies in the schizoid, but would more likely indicate his asocial nature, his shifting or absent set of consistent inner morals, and his maladjustment in social situations. Additionally, an elevated 5-Masculine/Feminine, could indicate the schizoid's lack of sexual interest or difficulty with sexual relations, and generally passive approach to life.

Likely Elevation:	0 – Social introversion 8 – Schizophrenia 7 – Psychasthenia 2 – Depression
Possible Elevation:	4 – Psychopathic Deviate 5 – Masculine/Feminine
3-Code Type:	2-7-8 – Depression, Psychasthenia, Schizophrenia**
2-Code Types:	2-0/0-2 – Depression, Social Introversion 8-0/0-8 – Schizophrenia, Social Introversion 4-8/8-4 – Psychopathic deviate, Schizophrenia 1-8/8-1 – Hypocondriasis, Schizophrenia*

** Graham, 2000*
*** Golden & Meehl, 1979*

Figure 3.13. Possible MMPI-2 profile for schizoid personality.

Five-Factor Model. Though much empirical research has been conducted on the Five Factors model, its use in the assessment of schizoid pathology is somewhat limited in the literature. In particular, the atheoretical nature of the factors, the indistinct gradations of measurement, the use of broad factors in place of deeper conceptualization, and the model's non-recognition of other known aspects central to character formation

restrict the applicability of this measure in the assessment of personality pathology (Block, 2010).

Robert McCrae's (1994) use of the model to evaluate schizoid personality, included here for reference in Figure 3.14 below, classifies the schizoid as high in neuroticism, which captures the schizoid's anxiety, fearfulness and tension, while also suggesting the presence of guilt, high dependence on others for emotional support, and chronic negative affects not usually found in these patients. Extraversion is understandably low, while openness is justifiably set high given the schizoid preoccupation with fantasy, eccentric thinking, non-conformity and tendency toward

Neuroticism: HIGH

- Chronic negative affects, including anxiety, fearfulness, tension, irritability, anger, dejection, hopelessness, guilt, shame; difficulty in inhibiting impulses: for example, to eat, drink, or spend money; irrational beliefs: for example, unrealistic expectations, perfectionistic demands on self, unwarranted pessimism; unfounded somatic concerns; helplessness and dependence on others for emotional support and decision making.

Extraversion: LOW

- Social isolation, interpersonal detachment, and lack of support networks; flattened affect; lack of joy and zest for life; reluctance to assert self or assume leadership roles, even when qualified; social inhibition and shyness.

Openness: HIGH

- Preoccupation with fantasy and daydreaming; lack of practicality; eccentric thinking (e.g., belief in ghosts, reincarnation, UFOs); diffuse identity and changing goals: for example, joining religious cult; susceptibility to nightmares and states of altered consciousness; social rebelliousness and nonconformity that can interfere with social or vocational advancement.

Agreeableness: LOW

- Cynicism and paranoid thinking; inability to trust even friends or family; quarrelsomeness; too ready to pick fights; exploitive and manipulative; lying; rude and inconsiderate manner alienates friends, limits social support; lack of respect for social conventions can lead to troubles with the law; inflated and grandiose sense of self; arrogance.

Conscientiousness: LOW

- Underachievement: not fulfilling intellectual or artistic potential; poor academic performance relative to ability; disregard of rules and responsibilities can lead to trouble with the law; unable to discipline self (e.g., stick to diet, exercise plan) even when required for medical reasons; personal and occupational aimlessness.

from McCrae, 1994

Figure 3.14. Five Factor Model for schizoid personality.

vague pursuits (McCrae, 1994). McCrae also lists the schizoid as low in agreeableness (reflecting the cynicism, hidden omnipotence, and their lack of respect for social conventions), and low on conscientiousness (given the tendency of these patients to resist rules and regulations because of fears about being coerced).

Psychodynamic Diagnostic Manual. The Psychodynamic Diagnostic Manual (PDM Task Force, 2006) was constructed in response to perceived limitations of the DSM's descriptive criteria sets, particularly because DSM taxonomies omit clinically relevant concepts such as defense, isolate artificial factors in the definition of psychopathology, favor behavioral descriptions over subjective experience, and offer a particularly narrow categorical approach to pathology (McWilliams, 2011b). To address these limitiatons, the diagnostic profiles of the PDM include information about contributing tempermental issues, defensive styles, beliefs about self and others, and core conflicts unique to each personality (PDM Task Force, 2006).

The PDM entry for schizoid persoanity disorder is listed below in Figure 3.15. It offers a concise summary on the overall schizoid picture while allowing for a continuum of presentations. The schizoid's tendency to be highly sensitive and easily overstimulated is cited as a prime constitutional pattern, while longing for and fearing connection with others is cited as the primary interpsychic conflict. The schizoid's tendency for withdrawal and preoccupation are noted as primary defensive functions. Finally, the schizoid's view of others as dangerously engulfing is also highlighted in this critera (PDM Task Force, 2006).

Schizoid PD is characterized by the following:

- Contributing constitutional-maturational patterns: Highly sensitive, shy, easily overstimulated
- Central tension/preoccupation: Fear of closeness/Longing for closeness
- Central affects: General emotional pain when overstimulated, affects so powerful they feel they must suppress them
- Characteristic pathogenic beliefs about self: Dependency and love are dangerous
- Characteristic beliefs about others: The social world is impinging, dangerously engulfing
- Central ways of defending: Withdrawal, both physically and into fantasy and idiosyncratic preoccupations

from PDM Task Force, 2006

Figure 3.15. Psychodynamic Diagnostic Manual (PDM).

Adult Attachment Interview. The Adult Attachment Interview was developed in the early 1980's by Carol George, Nancy Kaplan, and Mary Main, and consists of a semi-structured interview of twenty questions. Some authors have proposed that the dismissive avoidant attachment style is synonymous with schizoid personality, which may have implcations for how schizoid disorders are conceptualized in the future (West & Sheldon-Keller, 1994). Schizoid personalities are often seen as qualifying as dismissive-avoidant attachements given their tendency to see themselves in a positive light, and others in a negative light. Tending to agree with the statements (a) "I am comfortable without close emotional relationships," (b) "It is very important to me to feel independent and self-sufficient," and (c) "I prefer not to depend on others or have others depend on me," the schizoid tendency toward self-sufficiency is made clear. These aspects are summarized in Figure 3.16 below. Detailed information on schizoid attachment is discussed in Chapte 4 ("Selected Personality Features").

Attachment Type: Dismissive-Avoidant

Agrees with these statements:

- "I am comfortable without close emotional relationships."
- "It is very important to me to feel independent and self-sufficient."
- "I prefer not to depend on others or have others depend on me."

Figure 3.16. Adult Attachment Inventory (AAI).

Meyers-Briggs Inventory. Generally, schizoid patients score the code type INFJ on the Meyers-Briggs Inventory, a code type found to apply to about one percent of the overall population (McWilliams, 2011a). Though other scores are also possible (e.g. INTP or INFP), schizoid personalities are most likely to show high scores in introversion as well as a preference for intuition over thinking (e.g. focusing on abstract over concrete details), feeling over sensing (e.g. refer to their own subjective experience over objective criteria), and judgment over perception (e.g. derive a sense of control from a predictable environment). While this measure is not meant to be useful for diagnostic purposes, given some of the conceptual overlap between the schizoid personality and Carl Jung's 'introverted type,' it can be an interesting starting place for therapists who are interested in Jungian approaches to treatment. In many ways, the Meyer-Briggs may come closest of any assessment to capturing the overall feel of this quiet, numinous personality type. Appendix III, outlining Jung's introverted typology, is included at the end of the handbook for a more detailed look at the Jungian perspective on schizoid personality.

Code Type: **INFJ**

I – Introversion preferred to extraversion: Tend to be quiet and reserved. Generally prefer interacting with a few close friends rather than a wide circle of acquaintances, and expend energy in social situations (whereas extraverts gain energy).
N – Intuition preferred to sensing: Tend to be more abstract than concrete. Focus on the big picture rather than the details, and on future possibilities rather than immediate realities.
F – Feeling preferred to thinking: Value personal considerations above objective criteria. When making decisions, often give more weight to social implications than to logic.
J – Judgment preferred to perception: Tend to plan their activities and make decisions early. Derive a sense of control through predictability.

retrieved from url: http://en.wikipedia.org/wiki/INFJ

Figure 3.17. Meyers-Briggs Inventory.

MCMI-III. Though tied structurally to the categorical diagnoses of the DSM and ICD, the Millon Clinical Multiacial Inventory scales are based on psychodynamic theoretical constructs. The MCMI-III provides information on schizoid patterns in the areas of self- expression (*impassive*), interpersonal style (*unengaged*), cognitive style (*impoverished*), self-representation (*complacent*), object relations (*meager*), defensive style (*intellectualization*), organization of self (*undifferentiated*), and affect expression (*apathetic*; Millon, 2004, 2012). Millon's diagnostic schemas are uniquely descriptive in their languaging, and do a fine job of capturing many of the core issues of the schizoid patient. Millon has identified the two key traits defining this personality above all other aspects, including (a) the lack of interpersonal engagement, and (b) apathetic mood temperment (Millon, 2004, 2012). Millons schizoid subscales are included below in Figure 3.18.

The clinician reviewing results from the MCMI should be careful to look at evalations on the schizoid subscales mentioned above, but also subscales for avoidant personality and schizotypal personality. In general, schizoid performance on the Millon is also likely to have low overall scores on histrionic, narcissistic and bipolar-manic (Choca & Van Denburg, 1997). However, this should not rule out subscale elevations in narcissistic personality, (e.g. *cognitvely expansive*) given the schizoid's tendency toward omnipotent fantasy, or even under histrionic, (e.g. *expressively dramatic*) indicating the schizoid's forced pseudo-social false self. Additional possibilities include subscale elevations under compulsive (e.g. *reliable self-image*), or under masochistic (e.g. *discredited representations*) indicative of the sadomasochistic object relations that are a part of this personality type.

Millon has also created a schizoid prototype based on three polarities, including a pain-pleasure polarity (i.e. experiences limited experience of pain or pleasure), an accommodation-modification polarity (i.e. tends to be strongly passive), and an individuation-nurturance polarity (tends to be moderately self oriented; Millon, 4 2012). Millon has divided subtypes for schizoid personality based on the combination of schizoid traits with secondary personality traits. Millon has identified four main subtypes, including those with secondary depressive traits (Languid type), avoidant (Remote type), schizotypal (Depersonalized type) and compulsive (Affectless type; Millon, 2006; Millon, 2012). Millon's schizoid prototype profile and diagnostic subtypes have been included in Appendix IV and V for reference at the end of this handbook.

Expressively Impassive (e.g., appears to be in an inert emotional state, lifeless, undemonstrative, lacking in energy and vitality; is unmoved, boring, unanimated, robotic, phlegmatic, displaying deficits in activation, motoric expressiveness, and spontaneity).

Interpersonally Unengaged (e.g., seems indifferent and remote, rarely responsive to the actions or feelings of others, chooses solitary activities, possesses minimal "human" interests; fades into the background, is aloof or unobtrusive, neither desires nor enjoys close relationships, prefers a peripheral role in social, work and family settings).

Impoverished Cognitive Style (e.g., seems deficient across broad spheres of human knowledge and evidences vague and obscure thought processes, particularly about social matters; communication with others is often unfocused, loses its purpose or intention, or is conveyed via a loose or circuitous logic).

Complacent Self-Image (e.g., reveals minimal introspection and awareness of self; seems impervious to the emotional and personal implications of everyday social life, appearing indifferent to the praise or criticism of others).

Meager Object Relations (e.g., internalized representations are few in number and minimally articulated, largely devoid of the manifold percepts and memories of relationships with others, possessing little of the dynamic interplay among drives and conflicts that typify well-adjusted persons).

Intellectualization Regulatory Mechanism (e.g., describes interpersonal and affective experiences in a matter-of-fact, abstract, impersonal or mechanical manner; pays primary attention to formal and objective aspects of social and emotional events).

Undifferentiated Morphological Organization (e.g., given an inner barrenness, a feeble drive to fulfill needs, and minimal pressures either to defend against or resolve internal conflicts or cope with external demands, internal morphologic structures may best be characterized by their limited framework and sterile pattern).

Apathetic Mood-Temperament (e.g., is emotionally unexcitable, exhibiting an intrinsic unfeeling, cold and stark quality; reports weak affectionate or erotic needs, rarely displaying warm or intense feelings, and apparently unable to experience most affects - pleasure, sadness, or anger - in any depth.)

Core traits = 

from Millon, 2004; Millon, 2012

Figure 3.18. MCMI-III subscales for schizoid personality.

Rorschach Inkblot Test. While the Rorschach Inkblot Test often provides a wealth of interesting and clinicial useful information on personality characteristics, relatively little empirical research has been conducted on the validity these scales within the literature. In his book on Rorschach assessment of personality disorders, Huprich (2006) outlines how schizoids might be expected to perform on the inkblot test, condensed below in Figure 3.19. A schizoid profile is likely to include a high degree of emotional complexity (Blends:R), in addition to relatively pronounced difficulties with regulating emotional intensity (CF). The schizoid's difficulties binding and expressing anger is liable to be reflected in elevated aggression scores (AG), as well as in measures of negativism and anger regulation (S; Huprich, 2006). Overall, few emotional responses are likely (C) and the overall record is likely to be restricted. Look for the schizoid patient to reject blocks, limit the number or quality of responses, or have a slow reaction time to the cards (Exner, 1986).

The schizoid's passivity and difficult, putting emotional impulses into action and tendency toward fantasized action over action in the real world, are likely to be reflective in more passive movements scores than active (Mp>Ma; Huprich, 2006). This can also be indicated by a higher experience-potential than experience-actual score, and human movement (M) will be relatively high relative to the content of the responses (Exner, 1986). The schizoid's discomfort with interpersonal engagement and preference for fantasized interaction is likely to manifest in low human contents scores ((H) + Hd + (Hd)). In place of people, it is likey to see many references to inanimate objects (Hd, Ad) spoken of or related to as if they were human objects instead (Huprich, 2006). A large number of animal responses (A) reflects the same dynamic (Exner, 1986).

High Blends:R	Emotionally complex
High CF	Difficulties regulating emotional intensity
High S	High unmetabolized aggression and negativity
High AG	High unmetabolized aggression and negativity
Mp>Ma	Passivity: Ambitions don't translate to plans
	Fantasy: Escaping instead of interacting in the world
Low H: (H) + Hd + (Hd)	Reflects limited capacity to deal with real people
High Ad, Hd	More likely to reference inanimate objects than real people

from Huprich, 2006

Low C	Limited emotional acknowledgement
High M	Higher experience potential than experience actual
Rejected block	Reluctance to engage the task
Restricted responses	Reluctance to engage the task

from Exner, 1986

Figure 3.19. Possible Rorschach profile for schizoid personality.

Other Assessment Tools

Guntrip's schizoid traits. Few people have contributed to the literature on schizoid phenomena as much as Harry Guntrip. While the depth of his contributions is beyond the scope of this handbook, the great advantage of Guntrip's work is that he outlined nine core traits that he saw as defining personality type that allowed for the assessment of schizoid personality for the first time (Klein, 1995). As much of this handbook is given to explaining Gruntrip's traits, no elaboration is offered here. These traits speak to the object relations, defensive patterns, affective themes, relational themes, and other phenomenological aspects of the patient in a way that standard assessment does not allow for, increasing the chances for successful diagnosis during clinical interview and increasing the therapists capacity for subsequent empathic resonance. Clinicans

should consider reading *Schizoid phenomena; Object relations and the self* (Guntrip, 1969), or, for a briefer summary of Guntrip's early thoughts on the topic, the paper '*A study of Fairbairn's theory of schizoid reactions'* (Guntrip, 1952) for a full understanding of these concepts.

1. Introversion
2. Withdrawal
3. Narcissism
4. Self-sufficiency
5. Sense of superiority
6. Loss of affect
7. Loneliness
8. Depersonalization
9. Regression

From Klein, 1995

Figure 3.20. Guntrip's core schizoid traits.

Akhtar's dimensional profile. Akhtar's profiles represent an effort to link the descriptive and the psychodynamic psychology traditions by placing 'overt' and 'covert' traits side by side along several domains of psychological functioning, including self-concept, interpersonal relations, social adaptation, love and sexuality, ethics, standards and ideas, and cognitive style (Akhtar, 1987). This method is advantageous for its coherent method of illustrating the striking divergence between the schizoid's outer demeanor and inner subjective experience. The covert and overt aspects are not suggested to imply that certain aspects are conscious or unconscious, but rather seek to emphasize the splitting and identity diffusion of the schizoid character and to translate these issues to psychotherapy goals and processes (Akhtar, 1987). Akhtar's original profile for schizoid personality is included below in Figure 3.21.

Figure 3.21. **Schizoid phenomenological profile by Akhtar (1987).**

AREA	FEATURES	
	OVERT	COVERT
Self-Concept	Compliant Stoic Noncompetitive Self-sufficient Lacking assertiveness Feeling inferior and an outsider in life	Cynical Inauthentic Depersonalized Alternately feeling empty robot-like and full of omnipotent, vengeful fantasies Hidden grandiosity
Interpersonal Relations	Withdrawn Aloof Have few close friends Impervious to others' emotions Afraid of intimacy	Exquisitely sensitive Deeply curious about others Hungry for love Envious of others' spontaneity Intensely needy of involvement with others Capable of excitement with carefully selected intimates
Social Adaptation	Prefer solitary occupational and recreational activities Marginal or eclectically sociable in groups Vulnerable to esoteric movements owing to a strong need to belong Tend to be lazy and indolent	Lack clarity of goals Weak ethnic affiliation Usually capable of steady work Sometimes creative and may make unique and original contributions Capable of passionate endurance in certain spheres of interest
Love & Sexuality	Asexual, sometimes celibate Free of romantic interests Averse to sexual gossip and innuendo	Secret voyeuristic interests Vulnerable to erotomania Tendency towards compulsive perversions
Ethics, Standards, & Ideals	Idiosyncratic moral and political beliefs Tendency towards spiritual, mystical and para-psychological interests	Moral unevenness Occasionally strikingly amoral and vulnerable to odd crimes, at other times altruistically self sacrificing
Cognitive Style	Absent-minded Engrossed in fantasy Vague and stilted speech Alternations between eloquence and inarticulateness	Autistic thinking Fluctuations between sharp contact with external reality and hyperreflectiveness about the self Autocentric use of language

Differential Diagnosis

Like the schizoid, obsessive-compulsive personalities often show great caution around emotional expression, though unlike the schizoid they are otherwise able to express a full range of feelings. Both personalities also show strong intellectualizing defenses, and isolate or deny their feelings, though unlike the obsessive, the schizoid is apt to separate from relationships that would have his feelings expressed (McWilliams, 1994). Like the schizoid, obsessive personalities can also be interpersonally unengaged and show undue self-reliance, but are capable of interpersonal relationships when they are not busy investing his energy in work-related activities. Both the schizoid and the obsessive show hidden omnipotence and grandiosity, though the obsessive's grandiosity is based on his ability to meet his own perfectionistic standards for himself, whereas the schizoid's grandiosity derives from his self-sufficiency (Akhtar, 1992). The most telling difference may be that the obsessive rigidly adheres to a well-defined system, and is highly conforming to community norms, while the schizoid's values are shifting and unstable allowing himself to appear to adapt to a range of situations(Akhtar, 1992).

Anxious (phobic) personality, in some ways synonymous with generalized anxiety disorder (GAD), is similar to schizoid personality for having excessive anxiety in social situations, for using avoidance to handle feared situations, and for having a restrictive lifestyle (Akhtar, 1992). Unlike schizoid personality, however, the anxious personality fears many different types of situations rather than interpersonal relationships alone, and presents as overtly anxious where the schizoid keeps anxiety under control by seeking refuge in his internal world of fantasy (Akhtar, 1992).

Depressive personalities often present with apathy, anhedonia, and report difficulty experiencing joy or pleasure in their lives, much like the schizoid. However, the key difference between theses disorders is that the depressive personality is accompanied by depressed mood that limits positive affect, while the schizoid shows apathy and lack of joy because he is immune from all feeling—he is no more able to feel joy than he is to feel sadness. Moreover, the characteristic depressive's struggles with guilt and his self-worth are absent in the schizoid who rarely experiences guilt and does not often judge his self worth by social comparison.

Both the narcissist and the schizoid have a libidinal attachment to the self. Like the schizoid personality, the narcissist struggles with deep issues related to separation-individuation and often finds himself in symbiotic union with others, but unlike the schizoid, remains ambitious and competitive in his efforts to overcome the adversity he sees in the world, whereas the schizoid fatalistically withdraws into his private world (Akhtar, 1992). Where the narcissist is actively grandiose in the service of his self-esteem, the schizoid is secretly omnipotent and maintains a sense of superiority that protects him from being dependent on others. Moreover, unlike the narcissist, the schizoid: (a) is able to contain himself, (b) isn't burdened with envy or possessing the other, (c) does not feel a desire to annihilate or destruct the other, and (d) does not have a grandiose self (Klein, 1995). Unlike the self-sufficient schizoid, the narcissistic patient is generally parasitic in relationships, exploiting others for his needs. Like the schizoid, the narcissist will avoid social situations where he is not certain to fit in, though unlike the schizoid, the narcissist will otherwise seek external validation to the point of being compulsively social (Akhtar, 1992).

Autistic spectrum personalities are typically diagnosed in childhood, unlike the schizoid who is not usually diagnosed until adulthood, though the developmental trajectory of these disorders in children and adolescents is strikingly similar and difficult to differentiate (Wolff, 1995). Both disorders reflect a deep hypersensitivity to stimuli that leads to being easily overwhelmed, an idiosyncratic use of language, a focus on restrictive interests, and preoccupation with fantasy. Interpersonally, both disorders also show impaired social interaction, lack of empathy for others, rarely express spontaneous enjoyment of joint activities, and seek to spend most of their time in solitude (Wolff, 1995). Yet, autistic personalities usually include pervasive and global neurodevelopmental issues, such as learning and sensory processing problems, and ritualistic repetitive behaviors that the schizoid does not. At a deeper level, the autistic personality may be functionally unable to engage with others due to social deficits, whereas the schizoid more frequently elects to avoid social situations out of engulfment and impingement fears. The information covered in this section is summarized in Figure 3.22 on the next page.

A Note on Schizoid Symptom Formation and Diagnosis

Following the DSM-III (APA, 1980), mental disorders began to be clumped and conceptualized together by the type of presenting symptoms (i.e. mood disorders, anxiety disorders), rather than by the mechanisms conceptualized to be causing those symptoms. Given the use of categorical diagnostic approaches currently in use, and the increasing focus on treatment planning for symptomatic relief, understanding symptom formation in schizoid personality becomes essential to avoid misdiagnosis at intake. This section briefly

Figure 3.22. **Differential diagnosis of schizoid patients.**

SIMILARITIES	DIFFERENCES
NEUROTIC DISORDERS **Obsessive Compulsive Personality** • Rigidity • Use intellectualization • Caution in emotional expression, limited affect • Often interpersonally unengaged • Undue self-reliance • Hidden omnipotence **Anxious (Phobic) Personality** • Excess anxiety • Use avoidance as defense against feared situations • Restrictive lifestyle **Depressive Personality** • Apathy, anhedonia, flat affect • Difficulty experiencing joy, pleasure	**NEUROTIC DISORDERS** **Obsessive Compulsive Personality** • Usually lack traumatic histories • Strict morality rather than uneven • Inwardly possess the capability for emotional expression • Neurotic personality organization rather than borderline **Anxious (Phobic) Personality** • Avoid feared situations rather than avoiding relationships • Neurotic personality organization rather than borderline **Depressive Personality** • Experiences depressed mood, feelings of worthlessness • Self-accusatory, excessive guilt • Neurotic personality organization rather than borderline • Often see themselves as inferior rather than ignoring social comparison
BORDERLINE DISORDERS **Narcissistic Personality** • Avoids social situations that make them feel like outsiders • Lack of rooted bodily experience • Arrested separation-individuation • Uneven morality	**BORDERLINE DISORDERS** **Narcissistic Personality** • Has grandiose self and is active rather than passive • Exploits others for dependency needs rather than being self-sufficient • Ambitious and competitive rather than resigned and fatalistic • Compulsively social and has not given up external object relations rather than being solitary and focusing on internal object relations
DISORDERS DIAGNOSED IN CHILDHOOD **Asperger's / Autistic Personality** • Idiosyncratic use of language • Focus on restrictive interests • Preoccupation with fantasy • Impairment in social interaction, lack of empathy • Loss of spontaneous expression of enjoyment • Solitariness • Hypersensitive / Easily overwhelmed • Has ritualistic repetitive behaviors	**DISORDERS DIAGNOSED IN CHILDHOOD** **Asperger's / Autistic Personality** • Pervasive neurodevelopmental issues (i.e. learning, sensory processing) • Diagnosable in early childhood rather than adolescence or adulthood • Unable to engage with others rather than choosing not to engage because of fear of danger or abuse

examines some of the most common DSM Axis I disorders most likely to be confused with an underlying schizoid disorder.

Often, schizoid personalities will not qualify for Axis I diagnoses given that they have few relationships and can be minimally in touch with their feelings (Millon, 2004). Yet, if the patient is able to elaborate on his emotional experience, the patient may describe symptoms that would otherwise qualify for several co-morbid Axis I diagnoses. In particular, some schizoid patients can appear to qualify for dissociative disorders, psychotic disorders, OCD (Millon, 2004), GAD, somoatoform disorders, depression, dysthymia, and depersonalization disorders (Rasmussen, 2005), as well as hypochondriasis, schizophrenoform, and disorganized or catatonic schizophrenias (Sperry, 2003). The relatively obscure DSM diagnoses sexual aversion disorder may also appear to fit with the schizoid's limited comfort with sexual contact.

As elaborated by Millon (2012), schizoid patients show particular symptomatic patterns related to their personality type. For example, sometimes the schizoid demonstrate evidence of manic qualities or bizarre behavior, but these episodes tend to be quite brief and often reflect efforts to compensate for underlying experiences of depersonalization and deadness (Millon, 2012). It is not uncommon for schizoid patients to come to therapy reporting feeling detached from their body, as in a dream, as well to report déjà vu phenomenon, both indicative of the loss of self that often accompanies schizoid states. Similarly, somatoform syndromes or hypochondriacal concerns in schizoid patients can reflect the schizoid's preoccupation with something tangible as a means of escaping feeling unembodied or depersonalized (Millon, 2012). Psychotic pockets in schizoid patients are very rare and usually appear to be concentrated periods of

irrational thinking, combined with flat affect, mixed with bizarre or uncharacteristic bursts of emotion, followed by periods of withdrawal, they do not reflect underlying psychotic organization (Millon, 2012).

Giovacchini (1979) provides the following vignette illustrating the assessment of a schizoid adolescent with a symptomatic profile falsely suspected of being schizophrenic:

> The parents of an eighteen-year-old male sought the advice of a psychiatrist because they believed their son was "vegetating." Although they had always thought of him as a quiet, pensive, and moody child, his behavior since puberty had become so peculiar that its abnormality was inescapable. In essence, they painted a picture that suggested simple schizophrenia. He showed no interest in anything around him. He had no friends, never spoke to anyone unless spoken to first and then he would mumble an inaudible reply. He was not at all involved in social, academic or vocational activities. He seemed to be totally inept, gauche, and often appeared stupid, although he did well on psychometric examinations. His mood was neither depressed nor elated, just apathetic, and his parents were particularly disturbed about his lack of feeling.
>
> The referring psychiatrist was not quite convinced that he was dealing with a typical schizophrenic adolescent. There were no organized delusions or hallucinations. He was impressed by the flat affect and the degree of withdrawal, but he did not believe that he was fundamentally dealing with a thought disorder. Since the patient's behavior was not unruly or unmanageable and did not disturb others, the psychiatrist saw no need for hospitalization. He felt at a loss in prescribing drugs and in view of the patient's youth, he believed that an attempt at psychotherapy might be justified. He diagnosed him as a schizoid adolescent and encouraged the parents to send him to me for treatment.
>
> When I first saw him he seemed markedly withdrawn and was completely indifferent about treatment. He saw no purpose in anything and kept his appointments only because his parents insisted. Nothing mattered, nothing would ever change, there was absolutely no hope in him. It was useless to try to change him. He was beyond help. (p. 96-97)

While schizoid personalities do not often present with issues related to depression, it should be remembered that schizoid patients are not protected from loneliness, however adept they may be at defending against these feelings. Loneliness is one of the most

difficult emotions to talk about with others, and is often accompanied by hopelessness, futility, anxiety, manic states, and existential terror the longer it persists (Fromme-Reichmann, 1959). Inescapable seclusion for extended periods of time is likely to lead to restlessness, panic, suggestibility, mental distress, nightmares, and even hallucinations, regardless of the individual's comfort or preference with reclusive behavior or the quality of their mental health (Storr, 1988).

Though states of chronic anxiety are rarely found in schizoid personalities they often experience bouts of anxiety, particularly when they are required to spend extended time with others, or when they have been isolated for long periods of time and have become increasingly self-alienated and depersonalized (Millon, 2012). The schizoid's fear of re-entering the social world, particularly following a reclusive period, can stir up anxiety about interpersonal connections or prohibited desires that manifests as OCD symptoms (Millon, 2012). The following case material illustrates how OCD symptoms can conceal a schizoid disorder.

> A shy, soft-spoken, forty-five year old man presented to treatment complaining of OCD-related fears. He reported constant anxiety that he would throw-up or soil himself in front of his colleges during daily staff meetings. He stated that he would often wait to eat breakfast until after this meeting and sometimes made strenuous efforts to have a bowel movement before the meeting. The man mentioned he would often sit as close as he could to the door so that if he needed to leave at a moment's notice he could do so relatively unnoticed.
>
> The therapist interpreted the patient's fears as stemming from his conflict around interpersonal needs. The therapist suggested that the patient was afraid that his needs and feelings might explode out of him suddenly and leave him humiliated. Even basic human needs common to all, such using the restroom, were to be hidden and controlled at the risk of being embarrassed. The patient's compulsions reflected an attempt to eliminate and evacuate needs before engaging with others, a refection of his underlying schizoid traits.
>
> The patient initially rejected the therapist's view, preferring to continue discussion about his eating and bathroom rituals. It was nearly a

> year and a half into his therapy that the patient began to grasp the meaning of the original interpretation. It was at that time his efforts to control his bodily functions began to ease somewhat.

Avoidant and schizotypal presentations. In general, avoidant presentations are those schizoid patients that tend to be seen as outwardly suffering. In particular, these patients often report loneliness and longing for relationships that are not usually present in pure schizoid types. The therapist should keep in mind that social withdrawal can be overt, as is suggested by the DSM criteria for schizoid personality, as easily as it can be covert (i.e. covered by a compensating pseudo-social self) as in avoidant cases (Klein, 1995). At other times, avoidant traits may be found concealing other types of personality pathology and do not predispose to schizoid organization per se (Clarkin et al., 2006). Schizotypal presentations, on the other hand, usually tend to share more of the classic schizoid traits, only with the addition of mild positive symptoms, eccentricity, magical thinking, and odd speech. A DSM-type specifier for schizotypal presentations (i.e. Schizoid personality, with positive symptoms) may be one way to indicate schizotypal presentations in the future, given the large overlap between these diagnostic categories.

Ralph Klein (1995) provides case material illustrating both avoidant and schizotypal presentations:

Case 1 – The Avoidant Style

> Mr. R., A man in his 30s, presented with an affable, friendly, outgoing demeanor with just a hint of reserve and shyness. Well liked and in a job that required a fairly high degree of interpersonal interaction, he conducted his life in a generally engaging fashion.
>
> After work he would participate in social events with his colleagues. He felt that it was part of his job requirement that he maintain these social connections, His free time was often spent playing various sports, and he was on several sports teams He was very popular among his peers.

In his personal life, he had a long-standing relationship with a woman and they had lived together for several years before his beginning treatment. Although he reported some feelings of closeness with this woman, he said he always felt a barrier separating him from her and from all others. There was always, as he put it, "a limit to the closeness." He stated, I can get only so close and then it feels like I get on a parallel track with the other person, like the rails on a railroad track, and I can get no closer. I don't know how to get closer, and I don't know if I want to be closer." His subjective emotional experience was that of anxiety, experienced when he felt that the woman knew too much about him because he had shared too much with her. These anxieties were evidenced by his unwillingness to consider marriage, despite the long relationship. The woman saw it as a difficult with intimacy on his part and made the questionable distinction that the problem lay not in the capacity for closeness, but in making a commitment to marriage. This is how his friends saw it too, often teasing him about his reluctance to get married. What was essentially an extreme sense of anxiety and even danger around getting close was rationalized as a fear of responsibility and commitment.

Mr. R. had presented for treatment because subjectively he was experiencing increasing frustration, both at work and in his personal relationship. He was feeling a growing wish to have greater closeness. Yet he was equally aware of a growing dysphoria associated with his efforts to do so. By all outward appearances, no one would have identified Mr. R. as schizoid. Always with a smile on his face and a friendly word on his lips, Mr. R. would satisfy no one's objective criteria for schizoid disorder.

Mr. R., however, was profoundly schizoid. Examination of his subjective experience revealed the essential core of schizoidness. Withdrawnness, introversion, and lack of affect were no less a part of his life than they were of Mr. I's, but they were manifest pervasively in his internal world and little, if at all, in external reality. Mr. R. revealed over time his profound feelings of disconnectedness from others and the amount of his time spent in fantasy, often the preferred place to be. This sociable, friendly man spoke with great pain (and unconscious irony) about whether he could experience real feelings and whether he was fundamentally lacking in his affective life. He feared that he was a kind of android, going through life pretending to experience and feel, but not really doing so. He wondered whether his external persona was a mask worn over what was essentially a shell of a man, devoid of the capacity for genuine feeling. (p. 25-26)

Case 2 – The Schizotypal Style

Ms. Q. came to treatment with a mixed picture of anxiety and depression associated with hallucinatory experiences that seemed to be in the nature of ruminative or obsessional thoughts. Ms. Q experienced this as losing my mind" and "falling apart." The specific precipitant for these feelings

was that she had been informed by her family that her invalid father was planning to live with her. A loner most of her life, she was 40, single, a virgin, and successful employed in a job that required much travel. In response to the family's plan to have the father move in with her, she had experienced terror that was manifest by the symptoms noted. Ms. Q. still hoped ultimately to have a relationship, a companion in her life. Descriptively and structurally, Ms. Q. was a schizoid-disordered woman whose sustaining fantasy of attachment had been dramatically interrupted by the anticipated imposition of a dreaded master/slave relationship from which she felt powerless to escape. Her symptoms were increasingly paralyzing her, and she seemed on the verge of a psychotic decompensation with loss of reality testing. (p. 97-98)

Chapter 4 - Etiology

This section reviews both temperamental and environmental factors contributing to the etiology of the schizoid personality. By no means is this discussion meant to be authoritative or comprehensive, but rather, to present the most compelling arguments from within the literature to inform clinical conceptualization with these patients. The *diathesis-stress model* is assumed as a foundation for understanding these unique factors contributing to the formation of schizoid psychopathology. No one etiological factor is considered primary or independent of this viewpoint. Constitutional factors contributing to schizoid personality include (a) hypersensitivity, (b) 'slow-to-warm up' temperament and passive infantile reaction patterns, (c) possible genetic or neurological predisposition, and (d) the body morphology hypothesis. Environmental influences most strongly implicated in schizoid pathology, including interaction with caregivers marked by (a) impingement, (b) over-stimulation, (c) anti-libidinal attitudes, and (d) deficient or neglectful engagement, are reviewed second. Finally, the role of introversion as an organizing personality factor in the schizoid personality is explored in depth. An exploratory effort to differentiate normal introversion from schizoid pathology is made.

Temperamental Factors & Neurobiological Factors

Recently, the focus on constitutional factors contributing to the formation of personality disorders has grown within the psychoanalytic literature. Biological predispositions toward impulsivity, affect sensitivity, disposition to aggression, and other types of brain abnormalities, have been noted as important factors increasing a child's susceptibility to develop a personality disturbance when coupled with chronic

environmental stress (Clarkin et al., 2006). In its entry for schizoid personality, the Psychodynamic Diagnostic Manual (PDM) lists the disposition to be highly sensitive, shy, or easily overstimulated, as constitutional-maturational factors in these patients (PDM Task Force, 2006).

- Hypersensitivity & 'Hyperpermeability'
- 'Slow-to-warm up' Temperament; Passive Infantile Reactions
- Body Morphology Hypothesis
- Genetics of Introversion
- Genetic Links to Schizophrenia
- Neurological Issues

Figure 4.1. Temperamental factors of schizoid personality.

Hypersensitivity & hyperpermeability. Doidge (2001) elucidates the etiological hypothesis of schizoid hypersensitivity and 'hyperpermeability' through an exploration of what it means to be 'thin-skinned.' Like autistic and bipolar patients, Doidge notes the schizoid often shows "an acute nervous hypersensitivity to stimuli, including smells, sounds, light, temperature, and motion, as though they lacked a filter or stimulus barrier" (Doidge, 2001, p. 290). The author distinguishes between (a) *constitutional sensitivity* (i.e. genetically-based sensitivity of the nervous system to emotional or sensory information) to stimuli and (b) *post-traumatic sensitivity* (i.e. nervousness, jumpiness, and agitation that results from chronic stress in the environment). Doidge suggests that while the post-traumatic sensitivity can be worked through in treatment, the constitutional sensitivity is usually a core part of the personality and relatively stable and thus, unchangeable.

'Thin-skinned' personalities are often uniquely attuned to nuanced gradations of feeling emanating both from within themselves and from the outside world. They tend to feel easily wounded and to feel vulnerable to being overrun by the feelings of other people. In contrast to extraverted, thrill-seeking personality types that can't get enough of parties and loud music, and constant companionship, to the schizoid personality a little stimulation goes a long way. Because the experience of overstimulation is akin to acute emotional pain (PDM Task Force, 2006), the schizoid seeks to create barriers to the outside world limiting the influx of stimuli, usually in the form of physical or psychic withdrawal, seclusion or reclusive behaviors, autistic states, interpersonal disengagement, or emotional blocking. Effectively, a fortress is created to protect the sensitive interior world from the intolerable intensity of living. Effectively, "while the schizoid person's surface may be nondescript, decorous, and emotionless, underneath he or she is terrified of experiencing the self as permeable—of being "seen through" or revealed as human and full of hunger" (Doidge, 2001, p. 291).

'Slow-to-warm-up' temperament & passive infantile reactions. Thomas and Chess (1977), in their well-known study on childhood temperamental patterns, identified a group of children who hard time adapting to school, making new friends, or interacting socially. Estimated to comprise about fifteen percept of the population, these children responded negatively to new situations and took longer to adapt than other children (Thomas & Chess, 1977). These children also showed a marked tendency to hide, to withdrawal, and to cling to a parent in unfamiliar situations or when engaged with strangers. These tendencies together were posited to be a part of a '*slow-to-warm-up*' temperament.

While the slow-to-warm-up temperament alone does not foretell the development of schizoid disorder, the combination of this disposition with environmental failures in childhood can exacerbate a vicious cycle of rejection and withdrawal that eventually crystallizes as a chronic relational pattern by adolescence. Without understanding their child's disposition to struggle getting close to others, parents can unknowingly pressure the future schizoid into interpersonal situations he cannot handle, triggering fear and overwhelming the child such that he cannot overcome through mere exposure to these situations. As Thompson (1990) notes:

> The schizoid, knowing she cannot adapt quickly or well enough to please anyone in the environment, chooses to please no one and retreats to isolation to protect her fragile sense of self. In this isolative world there is no criticism or rebuff but also no opportunity for any positive emotional experiences with others that would compensate for this low self-concept. The pathology has become self-perpetuating. Narcissistic injury becomes increasingly damaging with the length of isolation. (p. 233)

In other words, if parents of the slow-to-warm-up child are unable to help the child make up for his difficulties engagement, are impatient with the child, do not provide optimal frustration in strange or novel situations, or allow the child to be overly isolative for long periods of time, a schizoid-like deterioration may begin.

Millon (2012) posits that *passive infantile reaction patterns*, a concept complementary to slow-to-warm-up temperament, also contributes to the formation of schizoid disorders. Sometimes labeled 'easy babies,' passive infants are lauded and rewarded for being 'low-maintenance' in the light of their generally placid or restrained mood, limited motor activity, and unassertive stance with their own needs (Millon, 2012). A passive infantile pattern is less likely to activate the attention of caregivers than an infant who becomes fussy without attention. Subsequently, passive infant receives less

interaction, less holding, and less physical stimulation than other babies, all of which compound his generally idle stance toward interaction with others. A well-matched caregiver will compensate for such a child's lack of interpersonal engagement by approaching the child if he is hiding or isolating, offering help, providing optimal opportunities for growth, rewarding the child's efforts to be assertive in navigating his environment, and encouraging the expression of disagreement. In the absence of this type of interaction, passivity may come to dominate the child's attitude toward his own needs.

Body morphology. It has been suggested that *ectomorphic body structure* may produce shy or retiring personality types that bear similarity to the schizoid personality (Millon, 2012). Ectomorphic bodies are fragile, delicate, clumsy, or thin, often possessing long arms and legs, little body fat, and light bone structure. To compensate for their lack of physical prowess relative to others, ectomorphic types sometimes become passive, avoid physically or emotionally demanding activities, and feel more comfortable instead with intellectual or cerebral pursuits (Millon, 2012). Body morphology is generally not given the same weight as other temperamental factors, but nonetheless, makes some sense from the standpoint of evolutionary psychology.

Genetics of introversion. Introversion and extraversion have been demonstrated in earlier research to have a heritable basis (Gottesman & Shields, 1972), though the true extent of this contribution is still in question. Twin studies suggest that the genetic component of introversion may fall broadly between 39% to 58% (Tellegen, et al., 1988). While a third to a half of the human population may be introverted to varying degrees (Cain, 2012), at this time there is relatively little research on the genetic contributions to

normal introversion. The organizing function introversion plays in schizoid pathology, as well as the subjective experience of introversion, are covered later in this section.

Genetic links to schizophrenia. While mining psychodynamic research on schizophrenic populations can yield insights useful in schizoid treatment, generalizing neurobiological research on schizophrenia to schizoid populations poses a number of risks. Millon (2012) makes this case adamantly, stating, "Given our current state of knowledge, it would be presumptuous to assert with any degree of confidence that we have conclusive evidence implicating any of the biogenic influences to be hypothesized. The available research data often are contradictory, nonapplicable, or based on poorly designed studies" (p. 700). Complicating this picture is the fact that the majority of research on the biological basis of schizoid disorders has been has been extracted from studies performed on schizotypal patients. Despite mixed evidence of biological interrelationships, the genetic link between schizoid personality and schizophrenia remains speculative, unresolved, and largely exploratory at this point (Silverstein, 2007a, b).

These caveats named, few broad statements can be made with regard to the genetic link with schizophrenia. Family studies indicate that schizotypal personalities do occur more frequently in families where there is a history of psychotic illness amongst first-degree relatives (Siever, 1992), a finding also duplicated in twin studies (Kendler et al., 2006). Research also suggests that schizoid and schizotypal personality are the most common premorbid personality types in those who are later diagnosed with psychotic disorders. However, schizoid and schizotypal patients have been shown to account for only about one quarter of all schizophrenic cases, with other personality types

collectively assuming the remaining seventy-five percent of the variance (Weinberger, 2004). Moreover, there is no empirical support whatsoever for the idea that schizoid people are prone *ipso facto* to developing a psychotic disorder at some point in their life (McWilliams, 2011b).

Neurological issues. Though neurological research on schizoid personality has traditionally been fairly limited, the empirical literature on the neurobiology of schizotypal personality has expanded greatly in the two decades. Earlier studies established the biological similarities between schizotypal personality and schizophrenia using tasks measuring eye-movement dysfunction, backward masking, continuous performance tasks, evoked potential studies, and imaging (Siever, 1992). More recently, research is expanding to identify the neurological underpinnings for the negative symptomology (see Hazlett, et al., 2003; Hazlett et al., 2007; Hazlet et al., 2011; Hazlett, Zhang et al., 2012b), brain abnormalities (Byne et al., 2001; Buchsbaum et al., 2002; Downhill et al., 2001; Downhill et al., 2000; Goldstein et al., 2011; Goldstein et al., 2009; Hazlett et al., 2008; Halett et al., 2012a), positive symptomology (Barch et al., 2004; McClure et al., 2008), sensory disturbances (Hazneder et al., 2004; Kent, Weinstein, Passarelli, Chen, & Siever, 2011; Mitropoulou et al., 2011), and memory and processing deficits (Goldstein et al., 2011; Harvey et al., 2006; Koenigsberg et al., 2005; McClure et al., 2007; Mitropoulou et al., 2005; Mitropoulou et al., 2002; Moriarty et al., 2003; Roitman et al., 2000) in schizotypal patients. These findings have been briefly outlined in Appendix VI at the back of this volume.

Millon (2012) has provided some initial hypotheses about neurological issues that may contribute to schizoid personality disorder, as summarized below in Figure 4.2.

These issues include (a) deficits in limbic or reticular system leading to problems with arousal and activation, (b) parasympathetic system dominance (i.e. adrenergic-cholinergic imbalance in which the autonomic nervous system is functionally dominant, leading to apathy, emotional flatness), and (c) neurohormonal synaptic dyscontrol (excesses or deficiencies in acetylcholine and norepinephrine may result in the proliferation and scattering of neural impulses, leading to affectivity deficits; Millon, 2012, p. 701). In introverted patients, increased blood flow to the frontal lobes and the thalamus has been noted (Johnson, et al., 1999), though it is not clear the extent to which and of these result may predispose an individual to schizoid pathology.

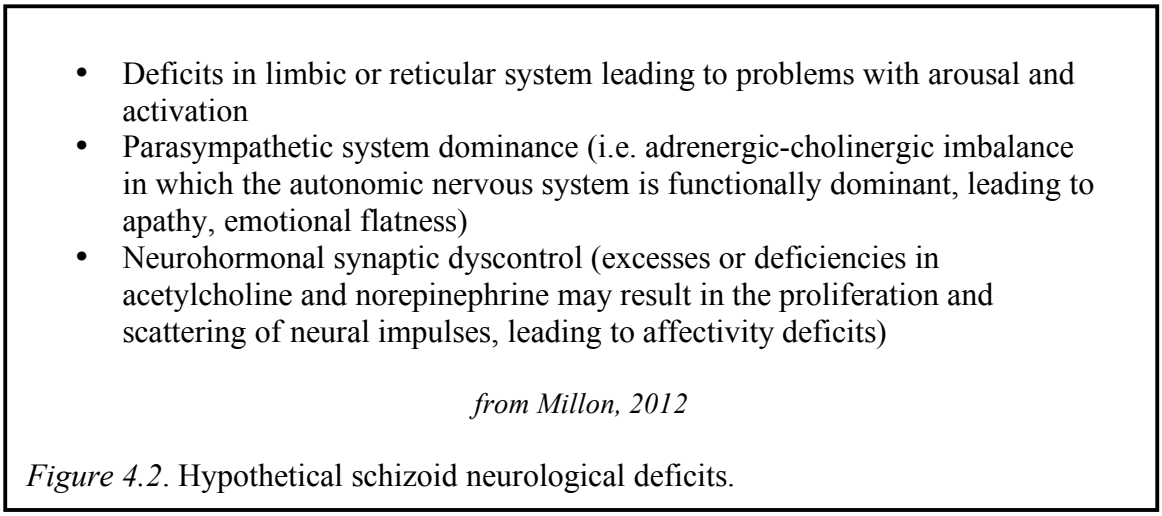


Figure 4.2. Hypothetical schizoid neurological deficits.

Environmental Factors

A distillation of the psychodynamic literature on schizoid personality yields references to a number of specific environmental influences believed to negatively impact the development of the schizoid patient as a child. In particular, interaction with caregivers marked by impingement, over-stimulation, anti-libidinal attitudes, and deficient or neglectful engagement, are the most frequently mentioned negative patterns

contributing to schizoid pathology. To understand how these types of interactions impact the maturation process over time, the concept of cumulative trauma, as well as its causes and effects, are reviewed to provide a context for understanding the ontological development of the patient's borderline level personality. Generalizations about the qualities of the schizoid's mother, implied from the collective literature, are also briefly delineated.

Cumulative trauma. Masud Kahn (1963), in observing that character disorders of a schizoid type "present a clinical picture whose etiology needs constructs that include disturbances of infant-mother relationship that were at the time neither gross nor acute" (p. 300-301), was suggesting that the concept of cumulative trauma holds particular relevance for these patients. *Cumulative trauma* results from breaches in the mother's role as a protective shield for the child, from his infancy to his adolescence. These breaches are chronic rather than discrete, and moderate rather than severe. This type of trauma, reflecting the failure of the mother to meet the anaclitic dependency needs of the child over time, retroactively appears as trauma once it has become ingrained in the personality (Kahn, 1963). The effects of cumulative trauma on the child can include slowed development of ego functions and autonomy, hyper-responsiveness to the caregiver's needs, as well as difficulty with separation and individuation (Kahn, 1963). At a broader level, if the infant is not able to cope with the anxieties of the depressive position, the transition to depressive or neurotic functioning will not be successful (Klein, 1946).

The concept of cumulative trauma is not meant to stand for simple analytic constructs, like the 'bad breast,' but rather takes on a more global meaning encompassing

the total picture of how the individual's needs were met by the objects in his environment. There are many ways in which this trauma can occur. For example, the mother may fail to help the child address his own developmental conflicts or expose the child to life experiences he is not developmentally equipped to deal with (Kahn, 1963). In other cases, the intrusion of the mother's unconscious pathology, particularly narcissistic needs for love or approval, prevent the caregiver from adequately empathizing with the child, and place the needs of the parent above those of the child. In unfortunate cases, constitutional sensitivity of the child, illness or physical handicap can create a special demand on the caregiver that is beyond the reasonable abilities of the caregiver to meet the child's needs, subsequently creating strain.

The signs of cumulative trauma within the schizoid personality are distinct. Foremost amongst these is the schizoid's characteristic identification with the needs of his mother, and subsequent failure to individuate (Giovacchini, 1979; Kahn, 1974; Seinfeld, 1991; Weiss, 1966). Under ideal circumstance, a mother should respond to the needs and dependency strivings of the infant and provide mirroring functions that help the child establish its own identity. In the case of schizoid children, however, the mother's needs intrude upon the child, forming an identification so strong that the child's deeper sense of self is not able to develop. Perhaps owing to the hypersensitive and adaptable nature of these children, a '*special relationship*' is formed in which the child comes to feel important and powerful in his ability to regulate the needs of his other (Kahn, 1974), reinforcing and perpetuating this cycle. Over time, the child becomes aware that he no longer is allowed to exist for himself or to have his own subjective

experience in the presence of others, and thus begins the process of fleeing from others to regain his autonomy (Seinfeld, 1991).

This dynamic also leads to other unintended consequences for the schizoid child. Often the child develops precocious intellectual abilities in place of emotional awareness, heightened responsiveness to the needs of others, an exaggerated or obsessive sense of self-awareness, a failure to integrate aggression, and an intensification of pseudo-maturational processes (i.e. adultification; Kahn, 1974). Because the child assumes a false maturity, his actual emotional maturity remains stunted and he is limited in his ability to form meaningful relationships later in life. As such, the schizoid also shows a characteristic difficulty finding an object for emotional investment (Deutsch, 1942). As Weiss (1966) describes this situation: “The "as if" personalities have undergone a loss of object cathexis, and their behavior is simply mimicry, based on very early identification. Their facile capacity for identification is such that they characteristically undergo kaleidoscopic shifts in behavior, reflecting the personalities of the individuals with whom they come in contact” (p. 574). Thus, it is from the effects of cumulative trauma that the schizoid, devoid of a permanent sense of self, is forced to abandon all relationships.

Mother of the schizoid. Several generalizations can be made about the qualities of personality often attributed to the mother of schizoid children. In general, the schizoid’s mother seems *cold* and unable to show spontaneous love. She may lack deeper warmth even if at the surface she appears to be warm, outgoing, or engaging in perfunctory shows of affection. She may also seem unwelcoming or distant, speak in harsh tones, or throw cold, hard looks at her children. The schizoid’s mother is also *emotionally immature* and caught up in her own unresolved issues. She is a person who is

Characteristics:
- Not usually acute or severe
- Cumulative; reinforced over many years
- Condensed; creating a strain that is absorbed into the personality structure

Main Causes:
- Failure of the caregiver to shield the child from instinctual conflict within himself; failure to provide the optimal exposure to life experiences
- Excessive intrusion of the caregiver's unconscious pathology spoils her empathic connection to the child
- Constitutional sensitivity, illness, or physical handicap of the child creates a special demand and an impossible task for the caregiver to meet

Effects:
- Slowed development of ego functions and autonomy
- Hyper-responsiveness to the caregiver's needs, identification with caregiver
- Difficulty differentiating from the caregiver and achieving independence
- Obsessive sense of self-awareness
- Failure to harness aggression

from Kahn, 1963

Figure 4.3. Cumulative trauma.

easily overwhelmed by the needs of her child and feels helpless to meet the responsibilities of child rearing. The schizoid's mother is not a woman who is comfortable with conflict within relationships, and often avoids intimacy when she can. She often finds sexual relations unpleasant, is lacking in desire, or immature when it comes to sexual matters.

The schizoid's mother is also *unempathic*. She likely had little awareness of the child's emotional reality, was indifferent to this experience, made no attempt to consider the child's needs and wants, or placed the child's needs second to her own. In severe cases, the schizoid's mother was completely indifferent to the child, made little or no

contact, or was absent much of the time, intentionally or not. The schizoid's mother also tends to be *rejecting* of her children, and perhaps did not feel the child had the right to speak his mind, to be discontented, or to assert his preferences. Feeling burdened by the child, the mother was hateful, antagonistic, or hostile in some way, communicating to the child in some way or another that he was not truly wanted. Finally, the schizoid's mother is often *obsessive*. She is perfectionistic, anxious, over-controlling, and restrictive with the child. As a result, the child easily becomes anxious when his emotions arise, and learns to control his behavior severely and inflexibly.

- Cold
- Immature
- Obsessive
- Unempathic
- Rejecting

Figure 4.4. Typical characteristics of the schizoid's mother.

The following cases illustrate common dynamics between the schizoid patient and his caregivers, as discussed in this section:

Case 1

> Mrs. D., a woman of forty, presented the initial complaint of vague but intense fear. She said she was frightened of everything, 'even of the sky'. She complained of an abiding sense of dissatisfaction, of unaccountable accesses of anger towards her husband, in particular of a 'lack of a sense of responsibility'. Her fear was 'as though somebody was trying to rise up inside and was trying to get out of me'. She was very afraid that she was like her mother, whom she hated. What she called 'unreliability' was a feeling of bafflement and bewilderment which she related to the fact that nothing she did had ever seemed to please her parents. If she did one thing and was told it was wrong, she would do another thing and would find that they still said that that was wrong. She was unable to discover, as she put it, 'what they wanted me to be'. She reproached her parents for this above all, that they hadn't given her any way of knowing who or what she really was or had to become. She could be neither bad nor good with any

> 'reliability' because her parents were, or she felt they were, completely unpredictable and unreliable in their expression of love or hatred, approval or disapproval. In retrospect, she concluded that they hated her; but at the time, she said, she was too baffled by them and too anxious to discover what she was expected to be to have been able to hate them, let alone love them. (Laing, 1960, p. 59)

Case 2

> One patient began to create distance from an intrusive mother by lying to her about his plans and avoiding her whenever possible. The therapist did nor pressure him to deal with the mother more directly. Lying was the only way he could, at this point, evade her prying. In his childhood, the patient had never lied because he believed that his mother could read his mind. He had been warned that he better not lie because mother would certainly know. When he did not give in to his mother's demands to visit at her beck and call, but instead lied and said he had important plans, the therapist remarked on his efforts at autonomy and the growing sense that his mother could nor read his mind. (Seinfeld, 1991, p. 168)

Case 3

> [His] whole family life had been one of anxiety, a nagging mother, a drinking father, quarrelling parents, pressure on the child to be 'no trouble' from babyhood, and then as he grew older a mother and aunt who made actual and literal castration threats, sometimes as a joke, sometimes semi-seriously: 'if you're not a good boy I'll cut it off', accompanied by half gestures towards the little boy with knife or scissors which terrified him. But that well-founded castration complex, which brought back a wealth of detailed memories, was but the end-product of all the child's memories of a mother whose basic hostility to him he had always sensed. His serious schizoid-regressive illness was the result of a withdrawal into himself which must have taken place first at an extremely early age to escape intolerable impingement by his family life. (Guntrip, 1969, p. 69)

Major Themes in the Histories of Schizoid Patients

Impingement. In the histories of schizoid patients, some of the most commonly heard narratives involve caregivers that were intrusive and impinged upon the child in a way that he did not want to be treated (McWilliams, 1994). Psychological impingement involves the undue influence, pressure, or intrusion by one person unto another. In

particular, impingement can result from a parent exploiting the child, burdening the child with his need for love and attention, being possessive or controlling of the child, or frightening the child (Guntrip, 1969). As a result of the impingement, the child's immature ego functions are overwhelmed, his capacity to be alone fails to develop, and he is chronically overstimulated.

Chronically suffering an invasive breach of his personal boundaries, the child begins to develop a pattern of withdrawal to moderate this experience (Guntrip, 1969). When withdrawal is not possible, the child forms a deep identification with his parents in place of differentiation as a means of reducing conflict and interpersonal dissidence. Unable to set boundaries, the schizoid child chronically yields to maternal gestures in an effort to please. Unfortunately, the schizoid's tendency to by symbiotically responsive can be seductive to his parents, inadvertently reinforcing the tendency of caregivers to impinge over time. Given this fact, it is not uncommon to find that the schizoid's mother persists in her duties as mother over a much longer period of time than is developmentally requisite, inadvertently impinging on the maturing child with support that is no longer needed or wanted (Khan, 1974).

Over-stimulation. A second common theme in the histories of schizoid individuals is traumatic overstimulation, particularly in the early years of life. The caregiver, who does not notice or respect the sensitive constitution of the child, allows for an atmosphere overly-saturated with sounds, smells, movement, or stimuli that create a painful activation of the child's nervous system. Over-stimulation can also be derived from contact with the child that is too intense to handle. For example, a parent who plays with the child when the child is tired or restless may overload the child with this contact.

Similarly, a mother who makes strong emotional displays in front of the child can overtax the limitations of the child's ability to cope with the intensity of contact. Overstimulation can also result form overexposure to internally derived sensations, such as the child's own needs and bodily processes. A mother who consistently delays feeding the infant when he becomes hungry may overwhelm the infant's ability to deal with it's own instinctually driven internal processes. If the child's parents let hunger pangs go on for too long, the child's frustration tolerance may be unduly taxed.

As a result of over-stimulation, the child may construct an autistic stimulus barrier to the outside world to limit his painful exposure to external stimuli. The schizoid tendency to look to inanimate objects, animals or internal objects for attachment bespeaks the need to regulate the amount of emotional stimulation he receives. The dissociation and estrangement from his own need may also help regulate stimuli originating from within himself.

Anti-libidinal family life. Schizoid personalities often come from families that were undemonstrative, formal, mechanical, lacked expressed affect, or discouraged the expression of spontaneous feelings (Millon, 2012). Perfunctory filial relationships in which physical and educational needs were met but there was little warmth, play or social and emotional interactions tend to predominate (Benjamin, 1996). Unable to tolerate aggression from the child, the parents of schizoid children often do not provide the child with the right amount of exposure to anger, and do not recognize the aggressive needs of their children (Kahn, 1974). Alternatively, the parents may have actively punished the child for having needs or rewarded the child for being easy and compliant. In either case, the schizoid's caregivers are rarely warm, caring, or adept with feelings themselves.

The schizoid's caregivers may also discourage, explicitly or implicitly, the expression of feelings, aggression, dependency, or attachment. Often parents who fail children in this way are themselves incapable of loving in the mature sense, or are preoccupied with their own unconscious needs and conflicts while neglecting the child's. The infant subjectively experiences the cumulative empathic failure of his caregivers as rejection and soon believes that his love for his caregiver is not valued or accepted (Seinfeld, 1991). These children both come see their parents as bad for not loving them, but also, more pathologically, come to believe that it is their love, rather than their anger, that is destructive, dangerous, and best kept out of sight (Fairbairn, 1940).

Gradually, the child internalizes a parent who is rejecting of his feelings (the '*anti-libidinal internal object*'; Guntrip, 1977), learning not to be too needy and risk overwhelming his parent. Splitting off or suppressing affects so that they never reach the surface, the schizoid journey to self-alienation, emptiness, and inertia begins. As Doidge (2001) summarizes:

> Fairbairn observed that children with a rejecting or disappointing parent develop an internalized image of a tantalizing but rejecting parent—the antilibidinal object—to which they are desperately attached. Such parents are often incapable of loving, or are preoccupied with their own needs. The child is rewarded when not demanding, and is devalued or ridiculed as needy when expressing dependent longings. Thus, the child's picture of "good" behavior is distorted. The child learns never to nag or even yearn for love, because it makes the parent more distant and censorious. The child may then cover over the resulting loneliness, emptiness, and sense of ineptness with a fantasy (often unconscious) of self-sufficiency. Love and anger get hopelessly intertwined. Fairbairn argued that the tragedy of schizoid children is that their conscience has been warped: they believe it is their love, rather than their hatred, that is the destructive force within. Love consumes. Hence the schizoid child's chief mental operation is to repress the normal wish to be loved. (p. 286)

Neglect. Neglect can take many forms within the schizoid narrative. Schizoid children are often subject to misattunement or misinterpretation, lack of empathy, deprivation, indifference, and limited affection (Fairbairn, 1940; McWilliams, 2004). Stimulus impoverishment during the sensory attachment stage, unstructured or fragmented family communication patterns, and even desertion are also common (Millon, 2012). In other cases, a mother who is emotionally immature, physically ill, handicapped, or just overwhelmed with her maternal duties can lead the schizoid to repress his own need (Seinfeld, 1991). It is also possible that constitutional sensitivity of the child creates a special demand and an impossible task for the caregiver to meet, and subsequently the child feels mistreated or neglected (Kahn, 1963).

Unfortunately, the wrong type of response from a caregiver is more than enough to invalidate a child's feelings. Parents who are not psychologically minded may be unintentionally invalidating the child through misinterpretation, lack of clarity, or lack of interest in the inner world of the child. To the exquisitely sensitive child, these small misses add up, leaving the child feeling alone in the world, without a fully developed sense of self, and with only himself to look to for guidance. Often the schizoid child is left with a nagging sensation that his feelings are not being handled correctly, acknowledged fully, or given meaningful feedback, coupled with an awareness of the need and possibilities for self-sufficiency (Klein, 1995). As Johnson (1975) notes:

> The schizoid is split in his growing emotional life by the inconsistency of his primary parental objects and becomes a prey to loss of internal unity, radical weakness, and helplessness. While still partly struggling to deal with the outer world, he also partly withdraws from it and becomes detached or out of touch, finding refuge in his internal fantasy world. (p. 394)

Eventually, finding that the misattunement to his needs has become too severe and intolerable, the schizoid child simply gives up on getting what he needs from his parents, and enters a state of non-attachment and self-sufficiency (Klein, 1995).

Klein (1995) provides the following case material reflecting common themes in the family histories of schizoid patients:

Case 1

> Ms. J was born into a family characterized by chronic unpredictability and instability. Her father was a minister who was repeatedly hired and fired by various congregations, necessitating multiple family moves. Her mother was a very disorganized woman who had "multiple nervous breakdowns." Ms. J. felt that neither of her parents had ever really heard her or understood her. At around three years of age, she had surgery for a bowel obstruction, and she recalled being told by her parents in the hospital that if she cried, she could not come home. Ms. J. also reported that the mother had the last of her severe breakdowns when the patient was eight and that her father deserted the family shortly thereafter. She stated that at that point she finally gave up hope that she would ever receive any sort of consistent stability or, more important, love from her family. (p. 49)

Case 2

> Mr. J. reported that he had been born strangling—the umbilical cord had been wound around his neck. This served as a metaphor for his entire childhood, and perhaps for his entire life. His father was described as a passive man who suffered silently and was "afraid to act like a man around my mother." His mother was erratic and angry most of the time. Mr. J. remembered how hard he had tried to figure out what set her off in order to prevent her outbursts of rage. He never was able to, and so could never avoid her verbal, and occasionally physical, abuse. Mr. J. said that at around the age of seven he decided "not to love my parents anymore," and subsequently he remained true to that decision. (p. 49-50)

Case 3

> Ms. M. had a memory from early childhood of her mother turning her back and walking out of the room as Ms. M. was standing in her crib crying. This memory pervaded the patient's entire history. There was

> evidence that her parents would leave her unattended for long periods during the day when the patient was between two and five years of age. Both parent were very religious, and Ms. M. was not permitted to associate with anyone outside of the family's own religious group, She felt alienated from he family, frightened by her father and uncomforted by her mother. She described herself as afraid, shy, and unable to make friends throughout childhood. (p. 50)

Introversion

Schizoid personality is often confused with introversion as if these terms were equivalent. Though schizoid personality is fundamentally organized around introversion, introversion itself is not pathological. Fairbairn (1940) noted: "Schizoid individuals who have not regressed too far are capable of greater psychological insight than any other class of person, normal or abnormal—a fact due, in part at least, to their being so introverted (i.e. preoccupied with inner reality) and so familiar with their own deep psychological processes" (p. 3). This section seeks not only to define introversion, but also to differentiate introversion from schizoid pathology, to explore the organizing principles of introversion, and to touch upon currently unresolved controversies around introversion as a diagnostic entity.

This handbook maintains that while epistemologically related, introversion and schizoid pathology are not analogous concepts. According to Fairbairn (1940), introversion refers to *temperament* and schizoid refers to *psychopathology*. In other words, introversion is used as a descriptive term, while schizoid is expounding in a psychogenetic sense (Fairbairn, 1940). As stated previously, the term 'schizoid' refers to a disorder or illness partly organized around introverted temperament, but not endemic to this temperament. While all schizoid and schizotypal patients are likely to be temperamentally introverted (regardless of the presence of an outgoing false self), the

Figure 4.5. **Summary of environmental influences in schizoid personality.**	
Major Environmental Themes	**Possible Child Reaction**
Impingement by caregivers • The caregiver impinges on the child in a way he doesn't want to be treated • The caregiver's emotional issues intrude into the relationship with the child (i.e. burdening the child, exploiting the child, possessive of the child)	• The child's immature ego can't stand the impingement and withdraws • The child does not develop the capacity to be alone • The child begins to identify with others or imitate others (i.e. self and object representations are partially fused and confused)
Over-stimulation by caregivers • The parent does not notice or does not respect the sensitive constitution of the child and creates an atmosphere saturated with motion, sounds and other stimuli • Parent is not in tune to child's frustration tolerance, parent allows child's needs go unmet too long	• The child creates a stimulus barrier or autistic barrier to the caregiver • Child turns attention to inanimate objects, animals, or internal objects to avoid excess stimulation
Anti-libidinal/Unemotional attitude of caregivers • The parent was cold or devalued the expression of feelings • The child is rewarded when not demanding and punished when expressing dependency longing. • The caregiver can't tolerate aggression or spontaneous displays of feelings • The parent is tantalizing but rejecting • Formal or emotionless family atmospheres	• Interpersonal needs are repressed and eventually split off • The child fails to find an object for cathexes; the child gives up hope of getting what they need from parents and becomes self-sufficient • The child loses ability to express feelings spontaneously • Aggression is split off and is not bound in the personality • Child turned inward to internal emotional cues, self-soothing
Deficient/Neglectful engagement by caregivers • Stimulus impoverishment • Failure to respond by caregivers (i.e. neglect, rejection) • The caregiver is inadequate (i.e. emotionally immature, physically ill, overwhelmed by caregiver duties) • Parent fails to shield the child from demands the child cannot meet • Impaired or limited family communication • The parent is preoccupied with or frightened of the child's needs	• The child does not develop object constancy, splitting of internal representations of self and other occurs • Child develops ambivalent attachment style • Child does not develop embodied sense of self

reverse proposition, that all introverts qualify for schizoid or schizotypal diagnoses is fundamentally untrue. Some estimates suggest that from a third to a half of the human population may have introverted orientation (Cain, 2012), however, only a small percentage of introverted people, usually those suffering from cumulative childhood trauma, will qualify for these diagnoses.

Terminology. Introversion is among the most misused and misunderstood concepts in psychology. Introversion is the quality of being concerned primarily with one's own thoughts and feelings (in contrast to thoughts and feelings of the other). It is the proclivity to direct one's mind, attention, or focus to aspects of experience inside the self. Because of their focus inward, introverted individuals often have an easier time identifying and acknowledging their own psychological feelings, needs, and conflicts. The term introversion is descriptive of an *ongoing* process of self-directed attention. Introversion is not the same as daydreaming, fantasy, or reverie, but does create an intense focus on these aspects of mental life. Introversion is also not the same as thinking, problem solving, analyzing, or scientific reasoning about aspects of the inner world. Finally, introversion is not the same as withdrawal or avoidance. While introversion may be what allows the schizoid to create inner distance from his feelings, introversion cannot be considered a form of defense, resistance, or a protective strategy in and of itself.

Introversion is often confused with introspection and intuition. Introspection the active and discrete process of examining one's conscious feelings, thoughts, and bodily sensations in which the person acts as both subject and object (Johnson, 1975). The difference between introversion and introspection is that introversion is an engrained passive tendency to favor inner thoughts and feelings, while introspection is an active

process of evaluation over a finite period of time. Introversion is a major organizing aspect of the schizoid personality (Guntrip, 1969), whereas introspection is not.

Introversion is also different from intuition and self-consciousness. Intuition is the ability to infer knowledge without the use of reason but rather based on the perception and application of experiences in the inner world. Self-consciousness is an awareness of the self and the simultaneous awareness of the self as the object of another person's observation. Both intuition and self-consciousness alike can be maintained or accentuated by an introverted disposition, but do not constitute a function or essential feature thereof.

- **Introversion** A temperamental preference for one's inner thoughts, feelings, or sensation over information from the external world
- **Introspection** An active process of examining one's conscious feelings, thoughts, and sensations; the person acts as both subject and object
- **Intuition** - The ability to infer knowledge without the use of reason but rather based on the perception and application of experiences in the inner world
- **Self-Consciousness** – Awareness of the self and the simultaneous awareness of the self as the object of another person's observation

Figure 4.6. Key terminology.

Unresolved diagnostic controversies. Unlike extraversion, introversion has been debated historically as a psychological domain indicative of psychopathology. The inclusion of 'Introverted Personality' and 'Introverted Disorder of Childhood' as diagnostic categories in the International Classification of Diseases (ICD) reflects the uncertainty in the clinical community about psychological wellbeing of the introverted character. In its originals proposals for the DSM-V, the work group originally proposed including introversion as a factor contributing to the formation of personality disorders

(www.dsm5.org). Though it appears that this language has been removed from consideration, these abandoned guidelines have been included below to illustrate the ways in which introversion is conceptualized as a contribution to personality pathology.

1. Introversion: Intimacy avoidance - Disinterest in and avoidance of close relationships, interpersonal attachments, and intimate sexual relationships
2. Introversion: Social withdrawal - Preference for being alone to being with others; reticence in social situations; avoidance of social contacts and activity; lack of initiation of social contact
3. Introversion: Restricted affectivity - Lack of emotional experience and display; emotional reactions, when evident, are shallow and transitory; unemotional, even in normally emotionally arousing situations
4. Introversion: Anhedonia - Lack of enjoyment from, engagement in, or energy for life's experiences; deficit in the capacity to feel pleasure or take interest in things
5. Introversion: Social detachment - Indifference to or disinterest in local and worldly affairs; disinterest in social contacts and activity; interpersonal distance; having only impersonal relations and being taciturn with others (e.g., solely goal- or task-oriented interactions)

www.dsm5.org

Figure 4.7. Discarded APA guidelines (DSM-V).

While it does seem that introverted individuals are more likely to exhibit internalizing disorders (and extraverted individuals are more likely to exhibit externalizing disorders), issues like social withdrawal, social detachment, anhedonia, or otherwise, can be indicative of different underlying issues. One recent study seeking to extract broad internalizing and externalizing factors from DSM disorders found that anxiety disorders, depressive disorders as well as schizoid, avoidant, schizotypal and other personality disorders usually have strong internalizing components. In contract, externalizing factors were found to be predominant in drug and alcohol abuse and

dependence, as well as histrionic, narcissistic, and antisocial disorders (Røysamb et al., 2011). Nevertheless, descriptive behavioral criteria like social withdrawal and anhedonia cannot stand for introversion individually, and are negatively biased in their language and appraisal of introverted phenomenon.

Organizing principles. This section briefly reviews the main organizing principles of introversion as a means of increasing empathic attunement with schizoid patients and to decrease the chance that introversion will be unfairly pathologized. Introverted temperament primarily implies that (a) attentional processes are primarily directed at thoughts and feelings originating from within the self rather than within the object (as illustrated below in Figure 4.8), in turn creating (b) increased access to primary process, (c) a tendency to be outwardly inhibited, and (d) a predisposition to be self-stimulating and self-soothing rather than seeking stimulation and soothing from the object (Jung, 1917/1971; Morris, 1979).

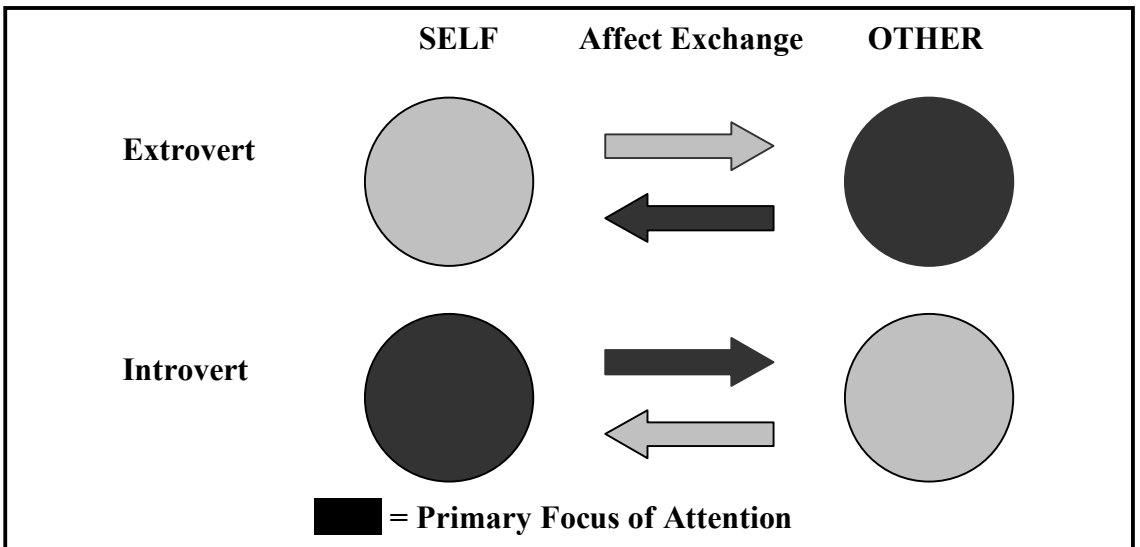


Figure 4.8. Extroversion vs. introversion: Focus of attention.

At the most basic level, introversion implies only a tendency to trust and be informed by subjective data over information from the object (Jung, 1917/1971). In other words, introverts are perceptually and cognitively oriented to their own thoughts, feelings, and experiences, over stimuli from the external world. Facts about the world are therefore determined to be true based on how much they match up with the subjective experience of the individual, rather than by 'objective' standards (Jung, 1917/1971). As such, introverts tend to be less amenable to outside influence, are less conforming, and prefer independence. In a sense, introversion reflects a fundamental need to establish independency by moving away from objects, in contrast to extraversion, which reflects a search for and move toward objects (Storr, 1988).

Given his tendency to orient to subjective information, the introvert also shows increased access to primary process. The schizoids amplified access to his inner fantasy life bespeaks this fact. Introverts are often more in touch with the depth and variety of their emotion and tend to appreciate introspective and self-reflective processes (Morris, 1979), but are less interested in the external world and thus appear inhibited, quiet, unexpressive, and controlled.

Finally, the introvert is also self-stimulating and self-soothing. Guntrip (1969) refers to introversion as the inclination to seek inner relief rather than external relief from the frustrations of the world. It is for this reason that the introvert feels more rejuvenated when he has had the chance to separate from others and spend time alone. Because introverts experience higher cortical arousal from environmental cues, they are more likely to want to reduce these cues to avoid over-stimulation (Morris, 1979). In contrast, extroverts have lower levels of arousal and seek to increase arousal from the environment

to avoid boredom. The hypersensitivity observed in schizoid patients may in part reflect these higher levels of cortical arousal that comes with introverted temperament, forcing the schizoid to modulate the intensity of his experience through withdrawal and other measures.

(1) **Favors information from the self over the object**
   a. Perceptually and cognitively oriented to subjective information over information that comes from the object
   b. Prefers independence, less amenable to outside influence, less conforming
   c. Facts are judged on how they match the subjective
(2) **Self-stimulating & Self-soothing**
   a. Limits stimulation from environment, easily overstimulated
   b. Feels restored by aloneness, seeks relief inwardly
(3) Increased access to primary process
   a. Self-reflective and introspective
   b. More in touch with the depth and variety of their emotion
(4) Outwardly inhibited
   a. Quiet, inhibited, unexpressive, controlled
   b. Intellectual, cerebral

condensed from Jung, 1917

Figure 4.9. Organizing principles of introversion.

The shadow of introversion. Normal introverted attitudes and preferences, when allowed to dominate the personality in a rigid or inflexible way, can complicate psychological functioning. While introversion does not *ipso facto* create issues with intimacy and attachment, excessive anxiety in the wake of cumulative trauma increases the chances that chronic withdrawal inward and subsequent depersonalization will result. This section offers some hypotheses about how this process occurs.

To begin, the introvert's intense focus on inner world can eventually give rise to anxiety, negative self-assessment, and circular thinking if he is not able to break this

cycle and take a broader perspective on himself. Unmitigated, compulsive preoccupation with inner reality can create intense self-consciousness that makes the introvert feel exposed as if others were constantly observing him (Johnson, 1975). The experience of visibility also heightens vulnerability and the perception of risk, in turn creating persecutory fantasies that are projected onto the other. In this state, spontaneity becomes difficult because all the actions of the self are being observed and evaluated by the individual. Johnson (1975) notes some of the downsides of compulsive self-awareness:

> Awareness of the self lessens the potential danger of becoming nothing or being engulfed. Intense self-awareness is often used to ramify the self. The schizoid scrutinizes himself. It is a scanning mechanism that forestalls danger. He is then persecuted by his own insights. The observing self kills anything under its scrutiny…..
>
> Relationship to others is accompanied by such intense self-consciousness that any kind of action seems overwhelmingly synthetic, hence phony or "plastic." Like sincerity, spontaneity appears to be a meaningless word, since the schizoid person is so wretchedly aware of the mechanisms underlying his specific actions. It is therefore inconceivable to him that interaction could ever be construed as spontaneous, always acting instead as an automaton. (p. 388)

Feelings of uniqueness, individuality, independency, and eccentricity are often the result of the process of unmitigated self-reflection in deeply introverted individuals (Johnson, 1975). Without being able to contextualize the self as a part of greater human reality, there can be an increased tendency to see parts of self as idiosyncratic, strange, peculiar, deviant, inconsistent, and even dangerous to others. Johnson (1975) explains the schizoid's tendency to see himself as deviant from others in this way:

> Especially at times of crisis, introspection can lead to the experiencing of threatening or dangerous thoughts and see these thoughts to be a confirmation of their own sense of peculiarity. This can simplistically be based on the assumption that the mere existence of such diffuse thoughts, feelings, and fantasies pronounces them deviant, strange, or even mad, insofar as it differs from what other people are thinking…. (p. 375)

> He is distracted by the sound of his own internal machinery, which diminishes his capacity to know or feel others. He is so concerned with his own interior filtering, processing, and reacting 'equipment' that he finds little time to examine the actions of others. (p. 388)

In introversion, the object is not given it due importance and is devalued and dismissed (Jung, 1917/1971). The introvert's intense focus on his own experience may also lead him to devalue information coming from other sources. Because their orientation is always on the subjective, introverted individuals are often wrongly accused of being arrogant or narcissistic, and are often seen as cold and ruthless because they relate more to the subject they are talking about than to the person they are talking to (Jung, 1917/1971). Of course, this one sided approach can make others feel that their opinions are being neglected and ignored. Many introverted or eccentric people celebrate their differences from others, and are happily opinionated, outspoken, are eager to convert others to their way of thinking, and enjoy being free of social convention (Weeks, 1995; See Appendix VII).

The more another person tries to control the introvert or impinge upon him, the more the introvert tries to break free of the object and maintain independence (Jung, 1917/1971). As the struggle to detach from the object intensifies, the ego increasingly relies on defensive withdrawal and retreat to fantasy as a means of safeguarding the autonomy and superiority of the individual. Over time, particularly when this struggle becomes chronic, and unwarranted, excessive fear of the object begins to develop, and the object is attributed destructive power (Jung, 1917/1971). As the introvert moves further and futher away from the relationships, his connection to the outside world becomes imperiled and depersonalization results. The deeply defended introvert then

faces a loss of contact with reality in the same way that the deeply defended extravert suffers a loss of personal identity (Storr, 1988).

(1) An increased focus on inner world gives rise to anxiety, negative self-assessment, and circular thinking
- Compulsive self-consciousness makes the individual feel exposed or persecuted
- Spontaneity becomes difficult because the mechanisms behind action are visible

(2) The importance of one's own thoughts, feelings, and sensations becomes exaggerated
- Feelings of uniqueness, individuality, independency, and eccentricity increase
- There is an increased tendency to see the self as idiosyncratic, strange, peculiar, deviant, inconsistent, and dangerous

(3) Objects in the world are devalued and not given their due
- The individual neglects to observe what others are doing because he is preoccupied with his own inner world
- There is an unreasonable fear of the object
- The other is endowed with frightening magical powers

Condensed from Johnson, 1975; Jung, 1917

Figure 4.10. The shadow of introversion.

Towards a framework of clinical differentiation. Currently, there is no available system differentiating schizoid pathology from normal introversion. Figure 4.11 on the following page, seeks in a preliminary way to tease these concepts apart. Introversion and schizoid pathology are compared on a continuum along multiple axes of psychological functioning, including relationships, sexual functioning, affective experience, and social functioning. More research is needed in the future to further distinguish between these associated clinical entities in a manner that is scientific and generalizable.

	Normal Introverted Temperament	Schizoid Pathology
Relationships:		
• Desire for relationships	Yes, but recharges alone	Limited /Boundless desire
• Has close friends	A smaller number of deep relationships	No, except first degree relatives
• Solitary lifestyle	Reflecting personal choice	Reflecting avoidance of intimacy
• Acknowledgement of need	Acknowledged, partially acknowledged	Unacknowledged, dissociated
• Chronically lonely	No	Often
• Has 'Capacity to be Alone'	Yes	No, symbiotic strivings present
• Can enjoy alone time	Yes	Variable
• Interpersonally unengaged	Spontaneous	Involuntary, chronic
• Self sufficiency	Spontaneous	Involuntary, chronic
• Oscillates in and out of relationship	Spontaneous	Involuntary, chronic
Sexuality:		
• Sexually active	Yes, yet does not suffer with abstinence	No, asexual, sexual aversion
• Sexuality	Genital, often integrating perverse strivings	Perverse trends present
Affect:		
• Introspection	Observant, intuitive	Preoccupied, obsessive, vigilant
• Emptiness	No	Yes, closed internal system
• Can utilize anger	Variable	No
• Emotionality	Intense, contained, even-tempered, calm	Detached, Inaccessible
• Experiences pleasure	Variable	Limited range of positive feeling
• Easily overstimulated	Yes	Yes
Social:		
• Poise	Self-possessed; self-willed	Aloof, omnipotent
• Withdrawal	Unprompted, but does not enjoy attention	Triggered, pathological and chronic
• Communication	Thinks before speaking	Shut down, cryptic, inscrutable
• Response to praise/criticism	Acknowledging, but often unswayed	Indifferent
• Social anxiety, Shyness	Yes	Yes
• Morals	Moral	Premoral, ascriptively morality

Figure 4.11. Toward a differentiation of introverted temperament & schizoid pathology.

Chapter 5 - Selected Personality Features

In this section, the major aspects of the schizoid personality are reviewed. The purpose of this section is to provide a deeper look at the schizoid personality structures beyond those aspects covered in the Chapter 3 ("Diagnostic Assessment") and to help guide the explorative process in treatment.

(1) Love and Relationships

The danger of loving. Fairbairn (1940) famously noted the schizoid's fundamental belief that it is his love, rather than his hate, that destroys relationships. Fearing that his needs will weaken and exhaust the other, the schizoid disowns these needs and moves to satisfy the needs of the other instead. The net result is a loss of ego within any relationship he enters, eventually kicking off an existential panic. Since love becomes equated with unsolicited obligation, persecution, and engulfment, the schizoid defaults to self objects instead, consuming himself with love to avoid being consumed by the love of the other (Laing, 1960). As Appel (1974) notes, "From these fears derive the negativism, stubbornness, and reluctance of the schizoid to love. Since he equates love with fusion, control, and persecution, the schizoid must hate what he loves—the classic ambivalent position" (p. 102).

The central conflict of the schizoid is between his immense longing for relationship and his deep fear and avoidance of relationships (PDM Task Force, 2006). As Akhtar (1987) notes, while the schizoid is outwardly withdrawn, aloof, having few close friends, impervious to others' emotions, and afraid of intimacy, secretly he is exquisitely sensitive, deeply curious about others, hungry for love, envious of others' spontaneity, and intensely needy of involvement with others. When in relationships, the

schizoid maintains a pattern of oscillating towards and away from intimacy, alternatively desiring, and being excited at the chance for contact, and becoming claustrophobic, smothered, choked, imprisoned and terrified of being devoured or smothered by the other. The schizoid then must break free and recover independence (Guntrip, 1969). The oscillation in and out of relationships is the real world enactment of these conflicts around involvement. The schizoid's legendary avoidance of relationships reflects his assessment that abandonment of others is a lesser evil than facing engulfment and loss of self, despite his longing for relationships (McWilliams, 2004; Seinfeld, 1991).

Guntrip (1969) provides the following case material illustrating the schizoid patient's longing for and fear of relationships:

> Thus the patient who had become more conscious of her love-hunger with the result that on the one hand her appetite for food had increased enormously, and on the other her anxious attitude to her husband had become more acute, said: 'When he comes in I feel ravenously hungry, and eat, but towards him I'm afraid I'm a nuisance. If I make advances to him I keep saying "I'm not a nuisance am I, you don't' 'not want me' do you?" I'm terribly anxious about it all, it's an appalling situation, I'm scared stiff, it's all so violent. I've an urge to get hold of him and hold him so tight that he can't breathe, shut him off from everything but me.' She has the same transference reaction to the analyst. She dreamed that
>
> I came for treatment and you were going off to America with a lot of people. Someone dropped out so I went and you weren't pleased.
>
> Her comment was: 'You didn't want me but I wasn't going to be thrown off. I was thinking today of your getting ill, suppose you died. Then I got in a furious temper. I'd like to strangle you, kill you.' That is, get a strangle-hold on the analyst so that he could not leave her, but then he might be killed. The schizoid person is afraid of wearing out, of draining, or exhausting and ultimately losing love-objects. (p. 29-30)

Figure 5.1 below illustrates the dynamics. On the one hand, the schizoid chooses to be alone, reveling in self-sufficiency and omnipotence, but remaining deeply lonely and empty. On the other hand, the schizoid may choose to enter relationships but then feels pulled toward symbiosis, engulfment, and servitude to the other. This basic dilemma

has been called different things by different authors. For example, Wilhelm Reich discussed the *wish for and against involvement* (Reich, 1933), H.R. Guntrip referred to the '*In-And-Out Programme*' (Guntrip, 1977), Ralph Klein discussed the '*Schizoid Compromise*' (Klein, 1995), Henri Rey referred to the '*Suffocation-isolation preoccupation*' (Rey, 1979), and others describe '*approach-avoidance*' conflicts.

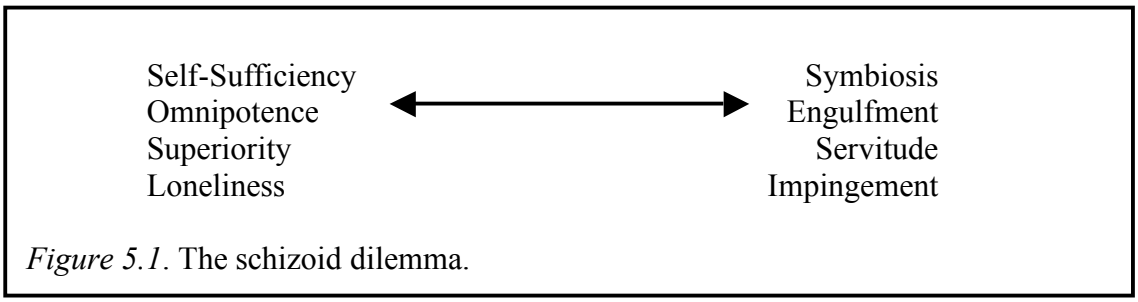


Figure 5.1. The schizoid dilemma.

The schizoid dilemma is demonstrated in the following three separate cases:

Case 1

> The patient, Lisa, oscillated between periods of intense object need and intervals of complete isolation and disinterest in objects. Lisa stated that when a boy treated her well or acquiesced to her demands, she was not easily satisfied but became needier. She would feel insatiable and make more demands. She was aware of a vague sense that if she allowed herself to care she would lose all interest and forget about him. This anxiety became apparent in an intense and stormy relationship in which she and a boyfriend spent every day together fighting and making up. When she finally became interested in pursuing some minimal activities for herself that would not include the boyfriend she was seized with a panic attack. She explored this problem and became aware that she was not afraid that the boyfriend would desert her for her individuation but rather that if she ceased to think of him and involved herself in a new interest, she might forget about him altogether. (Seinfeld, 1991, p. 21-23)

Case 2

> A nurse residing in a hostel, says: 'The other night I decided I wanted to stay in the hostel and not go home, then I felt the hostel was a prison and I went home. As soon as I got there I wanted to go out again. Yesterday I rang mother to say I was coming home, and then immediately I felt exhausted and rang her again to say I was too tired to come. I'm always switching about; as soon as I'm with the person I want, I feel they restrict me. I have wondered if I did get one of my two men friends would I then want to be free again.' (Guntrip, 1969, p. 37)

Case 3

> One spinster patient had longed for years to marry and at the age of forty was able to develop her first serious friendship with a male. He was an excellent man in general but a rather reserved bachelor and not very forthcoming as a lover. As long as she was not sure how much he cared for her, she impatiently and often angrily desired him to be more demonstrative. In fact she did draw him out and then it suddenly dawned on her that he really did want her, and she at once took fright, lost interest, and became critical and off-putting. A crisis developed in her which exploded in one session the moment she entered the consulting room. She stood in the middle of the floor and said in a tense voice: 'I can't come near you. Don't come near me. I'll have to go away, miles away, and live all alone.' I asked her what she was afraid of and she replied: ‘If you get close to people you get swallowed up, you go inside.’ (Guntrip, 1969, p. 59-60)

On entering relationships. The schizoid does not avoid relationships *per se*, as is often stated, but does avoid intimacy, self-disclosure, conflict, and the expression of positive and negative emotions within relationships he does enter (Mansfield, 1992). His tendencies toward symbiotic omnipotence lead the schizoid to think that he will be acceptable to any potential partner, while his passivity toward his own needs and preferences often lead him to become involved with those who simply express interest in him rather than those he himself is interested in. Unable to fully make a distinction between himself and those in the outside world, he may think he is moving toward a separate person when in fact he has found a piece of himself to intensify his focus on in

the outer world. In a sense, the schizoid is learning to experience himself by using another person as a patron or promoter of that effort (Kahn, 1974).

Complicating the process of finding a potential partner is the fact that the schizoid also has problems holding other people in his mind for very long if he is not making a direct effort to do so. In other words, "A blind man does not see an external object because he cannot see (Giovacchini, 1979, p. 93)." It is often not until conflict within the relationship has been activated and brought to the schizoid's attention that he comes to realize who it is that he is involved with. The schizoid needs so much help acknowledging the presence of the other that he is often in no position to pick a potential partner.

Relationships are often most actively entered into when the stress level of the schizoid is at its lowest because the schizoid is not as needy for his own internal objects and can focus more of his energy on the external world. However, during times of stress, the schizoid may hunker down and need extra time alone to get through whatever is going on, and relationship becomes a last priority. At these times the schizoid is occupied enough with meeting his own mental health needs without also having to attend to others. If the schizoid is not able to return to his internal objects when the pressure and strain of his daily living increases, he becomes frantic and resentful of any relationship he is in.

Partner choice. When the schizoid does fall in love with another, it is often one who is the image of his rejecting or intrusive parent. The schizoid is apt to find relationships with those that are either very needy or not at all interested in intimacy (Slavik, Sperry, & Carlson, 1992). In contrast, when a nurturing person comes along, the schizoid may find that he feels guilty or disloyal to the parental imago, leading to an

internal backlash that has been formulated around the principle that acknowledging and nurturing one's needs is unacceptable (Doidge, 2001).

Laing (1960) provides the following case material about a schizoid patient struggling to find a partner with whom he could be himself:

> He felt that he was not really alive and that anyway he was of no value and had hardly the right to the pretension of having life. He imagined himself to be outside it all, yet he cherished for a while one shred of hope. Women might still have the secret. If he could somehow be loved by a woman, then he felt he might be able to overcome his sense of worthlessness. But this possible avenue was blocked for him by his conviction that any woman who had anything to do with him could only be as empty as he was, and that anything that he might be able to get from women, whether he took it or whether they gave it to him, could only be as worthless as the stuff of which he himself was made. Any woman who was not as futile as he was could, therefore, never have anything to do with him, least of all in a sexual sense. All his actual sexual relationships with women were entirely promiscuous and through them he was never able to break through his 'shut-upness'. With the one girl whom he regarded as 'pure', he maintained a tenuous and platonic relationship for some years. But he was unable to translate his relationship with this girl into anything more than this. (p. 135)

There has been much written about the schizoid's attraction for hysterical or histrionic types. This compatibility is typically explained as a mutual enactment of unconscious issues playing on both the schizoid's fear of engulfment and loss of self and the hysterical patient's separation anxiety and fear of abandonment. McWilliams (2006) offers an excellent summary of these dynamics, but comes to a different conclusion about the ultimate nature of the attraction:

> Clinical lore abounds with observations about hysterical–schizoid couples, about their misunderstandings and pursuer–distancer problems, about each party's inability to imagine that the other sees one as powerful and demanding rather than as one sees oneself—that is, fearful and needy. Just as the hysterically organized woman idealizes the capacity of the schizoid man to stand alone, to 'speak truth to power,' to contain affect, to tap into levels of creative imagination that she can only dream of, the schizoid man admires her warmth, her comfort with others, her empathy, her grace in expressing emotion without awkwardness or shame, her capacity to

> experience her own creativity in relationship. To whatever extent opposites do attract, hysterical and schizoid individuals tend to idealize each other—and then drive each other crazy when their respective needs for closeness and space come into conflict. Whereas the schizoid person fears being overwhelmed by external sources of stimulation, the hysterical individual feels endangered by drives, impulses, affects, and other internal states. Both types of personality have also been associated with trauma of the cumulative or strain variety. Both are almost certainly more right- than left-brained. Both suffer a consuming sense of hunger, which the schizoid person may try to tame and the hysterical person may sexualize. If I am right about these similarities, then some of the magic between schizoid and hysterical individuals is based on convergence rather than opposition. (p. 15)

The hypomanic personality may also be viewed as seductive by the schizoid because he believes that he stands to soak up the energetic, driven and spirited approach of the hypomanic, compensating for the lack of these qualities in himself. Secretly he envies what he believes is the hypomanic ability to be assertive and social, not seeing that the hypomanic can be overbearing, unrestrained, and socially intrusive. Desiring to infuse his life with excitement, the schizoid is oblivious to the fact that this excitement is forced and unremitting in the hypomanic, and will require him to have super human strength in order to keep up.

Special relationships, identification, & symbiotic omnipotence. The schizoid is bound by many primitive issues—powerful symbiotic strivings, passive identification with the other—that together make relationships hard to bear for long (Kahn, 1974). Guntrip (1969) notes that the schizoid's dependency on love objects will give way inevitably to *passive identification*. This process of identification still feels good to the schizoid because it allows them to prop up their own weakened ego by taking in a stronger person, and because the process of identification eliminates conflict and the discomfort in establishing individuality (Guntrip, 1969). "Like someone who is still in a

symbiotic state of development and does not dare develop opinions or wishes of his own or see himself as a separate person, for any such step would flood him with difficult feelings of impotence, anxiety and depression" (Mitmodedet, 2002, p. 189). Fearing the process of differentiation that would allow him to harness anger and set boundaries with another, the schizoid simply identifies with the other instead. Unable to say no, unable to make his own needs and directions known, he becomes suffocated trying to please and accommodate others.

The schizoid is also known for cultivating *special relationships* with others. By making the object feel special through their attunement and responsiveness, the schizoid makes himself indispensable and beyond reproach (Kahn, 1974). The schizoid's ease in adaptation to the environment and to picking up signals from the outside world are tools that allow the process of identification to take place. Much like the children Alice Miller described in *Drama of the Gifted Child* (Miller, 1981), schizoid children are hypersensitive and hyper-responsive to their mothers, learning to anticipate and meet mother's needs while hiding away their own. The schizoid seeks to create a relationship that is free of hostility and in which both partners always get along. The schizoid doesn't see why life should ever be unpleasant or conflictual and hopes that it will be possible to have a relationship without ever exerting himself or having to put effort or work in.

Defensive identification with others implies that the *capacity to be alone is somehow missing* and that differentiation from others has not occurred (Winnicott, 1958). The schizoid's tendency toward symbiotic relationships belies his difficulty experiencing his own needs and feelings while someone else is present. As a result he tends to feel suffocated and impinged upon by external demands and loses the freedom of speech, of

behavior and of feeling. The therapeutic setting provides an ideal opportunity for the schizoid to be in the presence of the therapist without feeling impinged upon or needing to respond to the therapist. The patient needs to learn to sense the presence and availability of the therapist without having to check in on how the therapist is doing.

The experience of being alone while someone else is present.

Optimally manifested when:

- The availability and presence of another person is sensed, but frequent reference to that person is not needed
- The person does not feel external impingement, or external demands
- The person is free to discover and identify needs, feelings and impulses
- There is no semblance of a false life built on reactions to external stimuli

from Winnicott, 1958

Figure 5.2. The capacity to be alone.

Schizoid personalities tend to feel powerful in their ability to respond to the needs of the other (Kahn, 1974). The concept of *symbiotic omnipotence* refers to a prolonged association between the schizoid and another person characterized by enmeshment and lack of differentiation, from which the schizoid comes to feel effective and in control. Symbiotic omnipotence precludes actual connectedness and harkens back to earliest childhood when mother and child are, of necessity, moving in unison. Kahn (1974) identified several factors that characterize the phenomenon of symbiotic omnipotence, including weak ego development, the failure to harness and use aggressive energy (anger), exaggerated awareness of the feelings of others, severe difficulty distinguishing the self from the other, and the feeling that responsiveness to others is a powerful talent.

While gratifying for the moment, symbiotic omnipotence denies the schizoid a chance for an authentic experience, and requires huge amounts of psychic energy.

Prolonged association between the schizoid and another person characterized by enmeshment and lack of differentiation, from which the schizoid comes to feel powerful and in control. Fearing the process of differentiation, the schizoid identifies instead.

Characterized by:

- Weak ego development
- Failure to harness and use aggressive energy (anger)
- Fear of the differentiation process
- Exaggerated awareness of the feelings of others
- Severe difficulty distinguishing the self from the other
- Responsiveness to others is felt to be a special, powerful talent

summarized from Kahn, 1974

Figure 5.3. Symbiotic omnipotence.

Eventual rejection. Once in a relationship, the schizoid begins to project his disowned needs into the other, as if he wants to make use of the other person's body and life. The affection that forms in the schizoid during this process is not usually one of genuine warmth and bonding, but rather the imitation of these things created to meet an assumed need by the other (Deutsch, 1942). As Doidge (2001) notes, "…the schizoid's conscience demands that he or she focus on the new love interest in an active, picky, prosecutorial, and faultfinding way. Love becomes about as pleasant as litigation, for both parties. To avoid feeling picky, schizoid individuals may try to withdraw or simply enter a defensive, turned-off state, finding the potential lover 'boring' or 'a turn-off' (p. 286). They go into total affect shutdown. Alternatively, they may become prickly and chronically irritable, so that others know not to approach (Doidge, 2001).

As the early excitement of the relationship wears off, emptiness, dullness, and coldness begin to creep in. Though initially finding the schizoid too 'special' and highly responsive, his partner often begins to wonder why the relationship feels so stagnant and flat. The schizoid, unable to surrender emotionally, steps around commitment as long as possible (Kahn, 1974). The relationship becomes boring, emotionally deadened, and uncreative due to the lack of emotional investment. As the expectations for emotional investment grow and the schizoid feels pressured to commit to a long-term union, he experiences heightened danger, increasingly becoming withdrawn or distant, eventually seeking to re-establish the primary relationship to himself alone (Kahn, 1974). This shift in turn triggers his partner to provoke, reject and eventually abandon the schizoid. The schizoid, rarely envious or possessive of partners (Klein, 1995), doesn't put up a big fight when this happens. Privately he may experience relief that the ordeal is over, and retreat to solitude to restore his depleted energy stores. Becoming inward and engrossed in his own self-experience, he comes to reflect on his inadequacies and feels bad for failing again to succeed in relationships when he tried so hard to do just that.

(2) The Alternatives to Dependency

The schizoid has many way of compensating and coping with his inability to love and his loss of object relations, including (a) the splitting or eradication of his needs, (b) the cultivation of self-sufficiency, (c) the reliance on force of will and perfectionism, (d) cultivating a sense of superiority, and (e) investing in omnipotent self-representations. This section briefly outlines some of these techniques.

Splitting and eradication of need. Jeffrey Seinfeld's book *The Empty Core*, describes the dead, silent nucleus at the center of the schizoid personality, reflecting the

deprivation of love in early childhood (Seinfeld, 1991). The core is insatiable. Within, sealed-off and impenetrable by the outside world, the schizoid's needs for love, attachment, and connection are encapsulated. Because the patient has no ability to have his needs gratified in the outside world, and does not believe others will be helpful to him, his needs become dangerous and he has no other means of relieving this tension other than through the process of withdrawal (Giovacchini, 1979). The split and weakened ego, frightened of the relationship it needs to become healthy again breaks with reality to recover its function.

While an idealized relationship goes on with the outside world, a battle with inner persecutory objects rages on (Mansfield, 1992). The schizoid splits off what does not fit with the picture of their own pristine wholeness, while secretly the desire for true synthesis and integration still goes on (Seinfeld, 1991). The ability of the anti-libidinal ego to achieve this end comes with a sense of power and being in control over the ego itself, creating a sense of security, quiet, and calm in the schizoid when he would otherwise be overwhelmed with fear (Guntrip, 1969). However, unable to feel gratified by interactions with others, he becomes exhausted by interaction. Expressing needs and feelings are often experienced as giving the contents of the self away needlessly, after which a period of time alone is needed to replenish these reserves (Fairbairn, 1940).

According to Fairbairn (1940), the schizoid has three subsidiary egos, each identified with different internal objects. The *anti-libidinal ego* reflects the hatred, rage, and frustration for the rejecting object, having identified with the withholding and depriving aspects of the caregiver. In contrast, the *libidinal ego* is identified with the promising and enticing aspects of the caregiver and holds the hope for future gratifying

relationships with others (Greenberg & Mitchell, 1983). Finally, the *central ego*, or schizoid false self, is bound by an idealized relationship with the mother, given that the frustrating parts of the caregiver have been split off and internalized.

In the following two cases, Guntrip (1969) illustrate the painful manifestations of the anti-libidinal ego:

Case 1

> This is strikingly illustrated in the case of a female patient who seemed, on the face of it, to be a gentle-natured person who made no secret of her nervousness, timidity and fear of being alone and need for constant support. Nevertheless, in a quiet and rather secret inward way, she revealed a most unyielding need to keep herself going without help, and found it exceptionally hard to put any real trust in and reliance on me. She wanted to but 'it did not happen'. She complained repeatedly that she felt I was a support during session time but she had to live her life when I was not there, so that I was not really of much use to her. She knew that she was free to ring me up when she was in a panic, but for the most part she would rush to a drug instead. It took her a very long time to admit that the trouble was not really that I was not physically present with her at work and in her home life, but that the moment she got out of the consulting room she mentally dismissed me: 'Now I'll have to get on without help and do it myself.' Then she fell into panics of isolation, would be driven in desperation to carry on long conversations with me in her head, and yet when she arrived for the next session would have nothing to say. Often the session began with her not even being able to sit down. She would stand immobile and speechless, aloof and uncommunicative. As usually happens with such patients, as the end of the session began to draw near she would have so much to say that she found it hard to get it all in. But even then it was a monologue that kept me at a distance. (Guntrip, 1969, p. 291-292)

Case 2

> One patient, a single woman in her early forties, in whom the illness so seriously sabotaged her capacity to carry on normal relationships that it was with great difficulty that she could keep a job, revealed this internal self-persecutory situation naively and without disguise. She would rave against girl children and in fantasy would describe how she would crush a girl child if she had one, and would then fall to punishing herself (which perpetuated the beatings her mother gave her). One day I said to her, 'You must feel terrified being hit like that' She stopped and stared and said, 'I'm

> not being hit. I'm the one that's doing the hitting.' Another patient, much older, exhibited the same self-persecutory set-up verbally. Whenever she made any slight mistake, she would begin shouting at herself at the top of her voice: 'You stupid thing! Why don't you think! You ought to have known better!' and so on, which in fact the very words her mother used against her in daily nagging. We see in an unmistakable way anti-libidinal ego as an identification with the angry parent in a vicious attack on the libidinal ego which is denied comfort, understanding, and support, treated as a bad selfish child, and even more deeply feared and hated as a weak child. The first of these patients said she was always crying as a child and despised herself for it. Ultimately she managed to suppress this symptom of childhood misery and depression and its place was taken by these furious outbursts of self-hate. (Guntrip, 1969, p. 191)

When the schizoid's needs do arise when in the presence of others, he is often gripped with existential panic and fears something terrible may happen. Needs often feel pressured and grow in intensity until the patient feels he has an emergency on his hands (Guntrip 1977). Without being able to gratify his needs at all, withdrawal from social life for the purposes of recuperation is needed. Because so much energy goes into keeping needs at bay, the schizoid's needs seem weaker and inaccessible much of the time. This is not a reflection of limited need for others, but of the ferocity of antilibidinal efforts.

Giovacchini (1979) notes that while the schizoid has some ability to recognize his needs as they arise, he tends to gratify his needs in a hierarchical fashion, usually saving his energy for basic biological needs while letting aesthetic needs go with regularity. While the schizoid may not be able to put words to his needs or to understand where these needs derive from, he is nonetheless aware that something exists within him. The patient communicates his needs in an unclear, confusing, indirect way to the therapist. Often, libidinal drives are channeled into intellectual or artistic systems instead, and the thought process becomes a substitute for the discussion of feelings (Fairbairn, 1940). Alternatively, the patient often expresses his preoccupation with need through oral

associations, particularly in fears of eating and being eaten by other (Thompson, 1990). The fundamental question seems to be, how does one eat without provoking an attack or being consumed by their needs. The schizoid's hunger, at a deeper level, may well be the acknowledgment of their subjective experience of the world (Benjamin, 2000).

Self-sufficiency. The schizoid becomes *self-sufficient* by creating and nurturing his own absolute fullness and fulfillment (Seinfeld, 1991). Having been neglected by others as a child, the schizoid attempts to take care of all his own needs so that he does not burden or intrude upon others and face rejection or abandonment, or get too close to others and risk impingement or engulfment by their needs (Gruntrip, 1969). The more he knows about himself the more he is able to perform the duties of raising himself. Much of the time it is not necessary to enter relationship, because the schizoid has learned how to fulfill the functions for himself, and imagines that he is better capable of helping himself than others ever will be.

> The following case material describes the self-sufficient efforts of a young wife: She had been talking of wanting a baby, and then dreamed that she had a baby by her mother. But since she had often shown that she identified herself very much with babies, it represented being the baby inside the mother. She was wanting to set up a self-sufficiency situation in which she was both the mother and the baby. She replied: 'Yes, I always think of it as a girl. It gives me a feeling of security. I've got it all here under control, there's no uncertainty.' In such a position she could do without her husband and be all-sufficient within herself. (Guntrip, 1969, p. 43)

The schizoid will work as hard as he can to maintain this gratifying relationship to himself as much as an attached person would protect their relationship to another, and tends to feel anxious and futile when he is not involved in this undertaking (Kahn, 1974). Anything that reactivates the schizoid's hunger (ideas, food, relationships, a helping hand, empathy) must be denied and rejected so that his ego is not overwhelmed by the

reactivation of his need to attach (Appel, 1974). If someone comes along who shows the schizoid something he has not been able to see for himself, he often responds with surprise and disbelief. It is a shattering of the false sense that there are no good objects in the world other than those inside himself.

Force of will. The schizoid, as a self-sufficient and contained individual, seeks through his *force of will* to ensure his continued existence in the world without the help of others. He learns to endure any difficulty without leaning on anyone as a means of maintaining unity in his personality and avoiding fragmentation. In order to ensure his survival, the schizoid is willing to put off gratification and give up the needs of the mind and body in order to achieve what he needs to achieve. His self-sacrifice and willingness to go without happiness, comfort, soothing, or respite make this process possible. He is, above all, a *survivalist*. When the schizoid does take action it is often in a preset, motivated, goal-directed way that is forced and determined in its application. Dismissing social convention and the input of others, the schizoid's willfulness can seem obstinate, defiant or arrogant to others. Yet, at a deeper level, the schizoid force of will is so strong because he cannot risk being wrong, inconsistent, conflicted, contradictory, or changeable without opening up the forbidden need to ask for help.

Sense of superiority & perfectionism. Schizoid self-sufficiency is usually buffered by a strong *sense of superiority* over others. The sense of superiority functions as a rationale for maintaining a safe distance from others who might activate dependency conflicts (Guntrip, 1969). Seeing himself as being above others eliminates the possibility that others might be able to provide nurturance or support. Because it terrifies the schizoid to be dependent, he strives to place himself above being understood or benefited

by acquaintance to others. Schizoid personalities assume pseudo-adult roles and responsibilities with ease, and are often aware of these abilities from a young age (Klein, 1995). By becoming an adult, the schizoid does not have to endure the pain of psychological growth and renders his teachers and parents irrelevant. For the same reasons that he is constantly caught up in *perfectionism*, endeavoring in this way to be beyond critique and without need for feedback or assistance.

Omnipotence. The psychoanalytic concept of omnipotence is used to reference (a) a primitive fantasy, (b) a normal oceanic feeling representing primary narcissistic need in infants, (c) an early primitive mechanism of defense, (d) a regressive idealized fusional state that emerges as a defense against the threat of frustration, trauma, pain and aggression, (e) a pathological psychic structure in borderline personality organization and other disorders, (f) the counterpart of devaluation of significant others in schizoid states, and (g) a natural state of the dreaming world and of daydreams reflecting an abandonment of real objects and a substitution of fantasy for real life (Kernberg, 1995; Pumpian-Mindlin, 1969).

In contrast to narcissistic and borderline personalities, in which unconscious omnipotence is often entrenched alongside other defensive operations, schizoid omnipotence is mostly a byproduct of self-sufficiency and presents much less of a technical problem (Kernberg, 1995). Omnipotent fantasies are mainly used by the schizoid in defense of libidinal issues rather than aggressive issues. Omnipotent fantasy directly counterbalances the denial of dependency on other objects and creates the possibility for undisturbed self-gratification, and splits off needy parts of the self (Kernberg, 1995). Omnipotent defenses are what allow the schizoid to live free of object

relationships and without having to come to terms with the reality of his painful upbringing. As such, omnipotence almost always reflects both a devaluation of significant others and an equal effort to elevate the self to compensate for the loss of significant others as a source of support (Kernberg, 1995).

Omnipotence in the schizoid, above all, serves as the counterpart to the devaluation of dependency needs. These omnipotent operations constitute a denial of reality that at times appears to be delusion-like and rigid, so important are these defenses in maintaining the unity of the personality. Omnipotent fantasy compels the schizoid to make attempts to comprehend all things rather than feeing exasperated by soothing his neediness on his own. Omnipotence reflects the schizoid desire to escape the impotence and frustration he feels as a free agent. At the most basic level, omnipotent fantasies are a desire to be free from normal human emotion, though schizoid omnipotence may also be a derivative of the fused, undifferentiated self-object representations of early infancy (Kernberg, 1995). As Kernberg (1995) notes, "Baby's sense of omnipotence when all his needs are met, in contrast to the sense of impingement when frustration of his desires faces him with the limits of his control of reality, and leads to the establishment of a transitional object in the road from primitive omnipotence to the acknowledgement of frustration and dependency" (p. 3).

Omnipotence is experienced as a pacific calm or as an oceanic feeling of connectedness to all things in the world. As McWilliams (2006) notes, schizoid patients often feel they are 'special,' and sometimes report strong experience of 'mystical' fusion with the universe, perhaps reflecting early symbiotic or fusional wishes for caregivers:

> Rather than being invested in preserving a grandiose self-image or maintaining a defensive need for control, schizoid people tend to feel

> connected with their surroundings in profound and interpenetrating ways. They may assume, for example, that their thoughts affect their environment, just as their environment affects their thoughts. This is more of an organic, syntonic assumption than a wish-fulfilling defense…
>
> This sense of relatedness to all aspects of the environment may involve animating the inanimate. Einstein seems to have approached his understanding of the physical universe by identifying with particles and thinking about the world from their perspective. Such a tendency to feel a kinship with things is usually understood as a consequence of turning away from people, but it may also represent unrepressed access to the animistic attitude that most of us encounter only in dreams or vague memories of how we thought as a child. (p. 14-15)

Schizoid omnipotence is not the same as the grandiosity observed in narcissistic personalities, and has several distinguishing features. Levin (1986) notes some of the main differences, as summarized below. The function of omnipotence is to create freedom and self-sufficiency and reflects the assuming of responsibility for the self. As such, omnipotent people are primarily concerned with increasing their own abilities rather than being in competition with others (Levin, 1986). If others cannot do what they can it may arouse sympathy or happiness, but usually is not an occupying concern. In contrast, grandiosity is a response to feeling a lack of power and often reflects an effort to cover up emotional unavailability and low self-esteem. Grandiose patients feel superior to others, feel others can't compete with them, and are aggressive and contemptuous of those who cant do what they can (Levin, 1986).

The formation of omnipotence in the schizoid is secondary to the identification with idealized parent figures created in lieu of their actual parents. The fantasized fusion between the good self and the idealized inner parent creates the illusion of a secure attachment and blissful dependency on inner objects. The ecstatic states that result serve a critical defensive process against possible fragmentation and the acknowledgement of negative feelings toward the parents. The role reversal between their infantile true self

and the internalized pseudo-adult self allows the schizoid to stave off feelings of weakness and helplessness (Seinfeld, 1991). In other words, omnipotence is used to overcome the limitations of the caregivers by falsely portraying the self as a perfect nurturing parent while denying the neglect and misattunement of his actual caregivers (Klein, 1946). The schizoid's fear of committing to a new relationship in the real world reflects the need to keep this fantasy in place. Because no man or woman can equal up to the idealized figures of his fantasy life, the schizoid has a rationale for staying single and unattached.

Omnipotence

- Ontology - Usually sounds unrealistic but is not pathological per se
- Function - To create freedom and self-sufficiency; not about a power struggle with others but rather of great responsibility to the self and the world
- Self-Concept - Think of their strengths as abilities they take for granted
- Attitude toward others - Primarily concerned with increasing their own abilities; if others cannot do what they can it arouses sympathy or happiness, but usually is not of much concern
- Countertransference – Omnipotence is often pleasant and relaxing to the other

Grandiosity

- Ontology - Usually pathological
- Function - A response to feeling a lack of power; seeks to cover up emotional unavailability and low self-esteem
- Self-Concept - Feel superior to others, feel others can't compete with them
- Attitude toward others - Hostile, sneering and competitive, as if to suggest, "I am very dangerous to you. I am stronger than you." Contemptuous of those who can't do what they can
- Countertransference – Grandiosity makes the other feel devalued or aggressed

summarized from Levin, 1986

Figure 5.4. Omnipotence vs. grandiosity.

The following case material illustrates schizoid omnipotence:

> Thus a very obsessional patient reveals the schizoid background of her symptoms when she says: 'I'm always dissatisfied. As a child I would cry with boredom at the silly games children played. It got worse in my teens, terrible boredom, futility, lack of interest. I would look at people and see them interested in things I thought were silly. I felt I was different and had more brains. I was thinking deeply on the purpose of life.' (Guntrip, 1969, p. 99)

- To overcome the limitations of the self as a provider
- To avoid feeling exasperated by neediness
- A desire to be above human emotion, godlike
- A need to see the self as 'special,' original or creative
- To escape impotence and frustration
- A regressive wish to hold onto infancy and live in a womb-like state
- A desire for 'mystical' fusion with the universe
- A refusal to accept as fact the emotional reality of early neglect
- To remain above the conflict of relationships

Figure 5.5. Some functions of schizoid omnipotence.

(3) Attachment Style

Avoidant attachment patterns in childhood tend to follow neglect, chronic misattunement, or intrusiveness on the part of caregivers. Children with avoidant attachments show a high degree of self-sufficiency, are independent, and experience stress internally even as they hide this experience from the world. Two adult subcategories were developed as extensions of avoidant patterns, including fearful-avoidant adults, who experience high levels of anxiety in relationships combined with low self esteem, and dismissive-avoidant adults who experience low levels of anxiety in attachment and report higher self esteem (Brandell & Ringel, 2007). While there can be no direct correlation between attachment diagnosis and attachment status, this handbook classifies schizoid and schizotypal presentations as dismissive-avoidant, while avoidant

personalities tend to fit more closely with fearful-avoidant given their fear of rejection and higher levels of anxiety.

Schizoid personality and *dismissive-avoidant attachment* are conceptually equivalent in many important ways (West & Sheldon- Keller, 1994). Dismissive-avoidant children are indifferent or trivializing of their own emotional needs rather than owning or developing these needs. Often, dismissive avoidant children internalize the attitude of caregivers who are themselves rejecting, intrusive or indifferent with the child. Because the parents of dismissive children often fail to mirror back the child's affective states, the child is often unable later in life to negotiate more advanced interpersonal tasks such as setting boundaries with others, or communicating information about the self to themselves or to others (Fonagy & Target, 1998). Dan Siegel (2012) summarizes the dynamics of dismissive-avoidant patients:

> In those adults whose early life probably included a predominance of emotional neglect and rejection, a dismissing stance toward attachment may be found. These adults often have relationships with their children marked by avoidant attachments. Communication appears to have little sensitivity to signals or emotional attunement. The inner world of such adults seems to function with independence as its banner – living free from the entanglements of interpersonal intimacy, and perhaps from the emotional signals from their own bodies. Their narratives reflect this isolation, characterized by the specific finding of insisting that they do not recall their childhood experiences. Life is lived without a sense that the past or others contribute to the evolving nature of the self. (p. 143)

As summarized below in Figure 5.6, people with dismissive-avoidant attachments aspire to high levels of independence and self-sufficiency, and usually avoid attachment. Typically these patients deny the need or importance of close relationships, have difficulty being vulnerable in relationships, and often view partners less positively than they view themselves. They also tend to suppress and hide their feelings and will often

deal with rejection by distancing themselves from the sources of rejection (Bartholomew & Horowitz, 1991; Pietromonaco & Barrett, 1997). In treatment, patients with dismissive-avoidant attachment are likely to devalue, criticize or ignore the therapist, and are often reluctant to engage emotionally in the process of therapy. These patients also tend to minimize the meaning of early relationships and use general, stereotypical language when talking about their parents (Brandell & Ringel, 2007). They will often be unwilling to acknowledge the transference in the room, and are unlikely to see the therapist as someone with whom they can develop an attachment.

Attachment Type: **Dismissive-Avoidant**

- Aspire to high levels of independence, seek to avoid attachments
- See themselves as self-sufficient and don't experience vulnerability in relationships
- Often deny the need or importance for close relationships
- Often view potential partners less positively than they view themselves
- Tend to suppress and hide their feelings
- Tend to deal with rejection by distancing themselves from the sources of rejection

from Pietromonaco & Barrett, 1997; Bartholomew & Horowitz, 1991

Figure 5.6. Adult attachment.

Guntrip (1969) pointed out that schizoid's primary attachment and libidinal investment seems to be to himself, given that object relationships have outwardly been abandoned. Klein (1995) refers to this fundamental state of non-attachment and the associated object relationship as the '*non-attachment unit*,' but simultaneously acknowledges that these patients have as much drive to attach as everyone else. Given his dismissive stance and relative comfort with being alone, the schizoid is not usually

burdened by abandonment anxiety in ordinary situations. Nonetheless, given that the number of other people they feel safe to connect with are precious and few, the loss of an important attachment can be secretly devastating (McWilliams, 2006). Klein (1995) notes that the schizoid's nonattachment leads to dysphoric affects that he calls '*abandonment depression*,' including emptiness and rage that fill the void of their isolation. Deep longing for friendship and love are also present and occasionally override the dismissive stance.

Indeed, dismissive-avoidant patients still have a fundamental need to attach and to belong to a social group, no matter how much they may deny this fact. One recent study indicated that despite claims of being comfortable without close relationships, dismissively attached individuals experience higher than average levels of self-esteem when learning other study participants accepted them, and higher levels of positive feelings when anticipating that they would be successful in future relationships relative to controls (Carvallo & Gabriel, 2006). The authors conclude that despite hypotheses that dismissive individuals have less need for attachment than others, it seems more likely that this desire is simply repressed or goes unacknowledged. In truth, the schizoid may simply feel more comfortable with abandoning attachments than being engulfed by them (McWilliams, 1994). It is not that the schizoid lacks interest in attachments, but rather that he assumes his own emotional fragility precludes the possibility of feeling safe in relationships. Because the schizoid feels that any form of attachment threatens him with loss of self, he transfers his need to attach to nonhuman things instead.

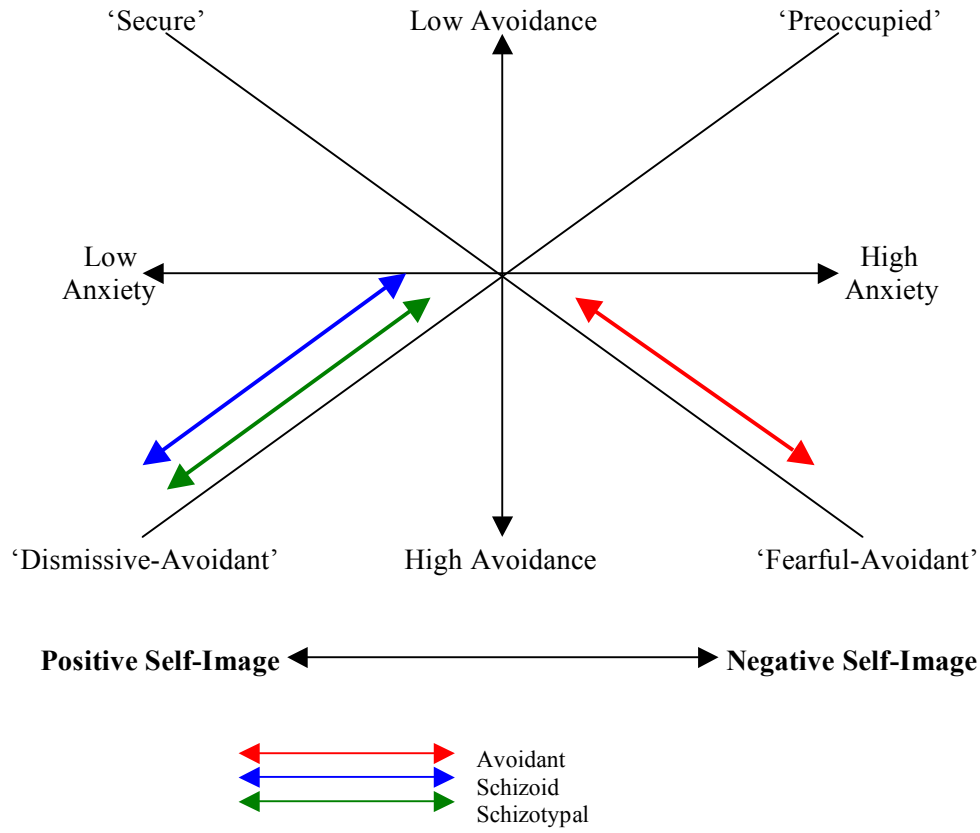


Figure 5.7. Schizophrenia spectrum attachment patterns.

(4) Range of Sexual Functioning

While patients at the higher end of borderline organization can function sexually and be orgasmic, at the lower end of the spectrum the capacity for sexual excitement is limited (Clarkin et al., 2006). Schizoid individuals often have a poorly balanced sexual instinct, appear uninterested in sex, and rarely take sexual partners (Hoch 1909; Hock, 1910). Yet, at a deeper level, schizoid patients often entertain a sexually preoccupied fantasy life, elaborated by polymorphous and sadomasochistic themes (McWilliams, 2006). Akhtar (1987) notes that while these patients appear outwardly asexual,

sometimes celibate, free of romantic interests, and averse to sexual gossip and innuendo, they often maintain secret voyeuristic interests, are vulnerable to erotomania, and have tendencies towards compulsive perversions. In short, the schizoid's sexual life is "inactive or polymorphous and chaotic, but hardly ever smooth-flowing" (Nanrello, 1953, p. 247).

These patients have been long noted for their perverse sexuality (Terry & Rennie, 1938). Polymorphous features of sexual relationships, especially sadomasochistic features reflecting the underlying ambivalence in the relationships, are an important part of erotic interactions found in the spectrum from normality to severe pathology (Kernberg, 1971). In the schizoid, perverse fantasy, including themes involving fetishism, voyeurism, bestiality, homosexuality, transvestism, and exhibitionism tend to increase as the severity of pathology increases, though these themes are rarely enacted within relationships. In general, the degree to which the perverse tendencies are transformed into action in the patient's life may follow the degree to which his aggressive instincts predominate, the regressive nature of his personality, the quality of his superego functioning, the predominance of ego splitting, and the weakening of ego boundaries (Kernberg, 1991).

The schizoid is often unfairly labeled asexual, or pansexual, when in fact his sexuality is simply undifferentiated. As Kernberg (1967) notes:

> The formulation often derived from psychological testing, that these patients present 'a lack of sexual identity,' is probably a misnomer. It is true that these patients present identity diffusion, but this identity diffusion has earlier and more complex sources than a simple lack of differentiation of any particular sexual orientation. Their 'lack of sexual identity' does not reflect a lack of sexual definition, but a combination of several strong fixations to cope with the same conflicts. (p. 682)

Yet, at the same time, this lack of differentiation is accompanied by perverse trends indicative of borderline level pathology:

> There are patients whose manifest sexual behavior is completely inhibited but whose conscious fantasies, and especially masturbatory fantasies, involve multiple perverse trends as necessary conditions for achieving sexual gratification. Such symptoms are presumptive evidence of borderline personality organization. The more chaotic and multiple the perverse fantasies and actions and the more unstable the object relationships connected with these interactions, the more strongly is the presence of borderline personality organization to be considered. (p. 649)

As Kernberg (1967) notes, polymorphous trends in borderline personality organization, often appearing as a combination of pre-oedipal and oedipal strivings, often reflects the failure to deal with the aggressiveness of genital trends, the persistence of primitive drives and fears in place of genital strivings. In schizoid pathology, perverse features tend to reflect a defense against genital sexuality, with its Oedipal implications and anxieties and particularly against the fear of enacting aggression within the relationship. In fact, a significant factor limiting the enjoyment of sexuality, and contributing to low sexual drive of schizoid patients is their striking inability to channel aggression within relationships (Klein, 1995).

Gabbard (2000) offers the following case material from a schizoid patient with perverse sexuality:

> Mr. FF was a 23-year-old single man with schizoid personality disorder. He worked as a nurse's aide on the night shift in a nursing home and took daytime classes at a local university. He liked working at night because very few interpersonal demands were made on him. His supervisor frequently slept, so he was free to read novels. When he was not sleeping, Mr. FF would spend many hours in vigorous bodybuilding exercises. He would then pose nude in front of the mirror and flex his muscles and admire himself. Much of the posing and flexing was accompanied by omnipotent fantasies of becoming an Olympic decathlon winner. He also imagined that if he achieved certain level of bodily perfection, he would

> then be attractive to a college girl in one of his classes that he could never bring himself to speak to.
>
> Mr. FF was deeply concerned about the fact that he had been adopted. He spoke about it with great shame, as though convinced that it reflected some inherent flaw. In his view, the early rejection by his biological mother was a sign that he was so inherently undesirable that others would also certainly reject him if given the chance.
>
> Like many schizoid patients, Mr. FF had a perverse streak that took the form of exhibitionism. He would place himself in situations where women would come upon him in the nude. He would then act surprised and immediately leave the scene so as to avoid prosecution. However, the sexual pleasure he derived from this activity led him into more and more risky adventures. He once switched the men's and women's labels on the locker room doors in a gymnasium so that women would enter the men's locker room and found him standing there nude, drying himself after showering.
>
> Mr. FF eventually came to an outpatient clinic where he sought group psychotherapy. He was concerned that his exhibitionism was getting out of hand and might lead to legal consequences, and he was genuinely disturbed by the loneliness of his existence. (p. 443-444)

Most frequently, the schizoid uses avoidance to deal with concerns about sexual intimacy and shows aloofness to the opposite sex that creates a barrier to engagement. Alternatively, the schizoid often substitutes autoerotic activities, or compulsive masturbation in the place of contact with potential partners (Klein, 1995). In the digital age, with fetish pornography readily available on the internet, the schizoid patient is able to live out his erotic fantasies while remaining anonymous and unengaged with the outside world. When theses patients do enter sexual relationships, they often gravitate toward sexually unavailable or sexually immature partners so that their fears about sexual contact are eased. Others chose celibacy and asceticism to eliminate sexual needs. Yet, as Doidge (2001) notes, none of these techniques are able to eliminate sexual desire completely:

> To squelch this hunger for love the schizoid may idealize asceticism. But like the ascetic who retreats to the desert to avoid human contact and temptation, the schizoid soon begins to see the temptress—in wet dreams,

> sanctuary drawings, and religious stories—in a tantalizing return of the repressed. Mistakenly, the schizoid concludes that desire is a bottomless pit; promiscuity and celibacy may alternate, both as attempts to deal with this perceived insatiability. Related to this is a wish to be inanimate. Such patients may describe a wish to be passionless, to become bone, or rock, an ice queen, sphinx-like. (p. 288)

A final factor complicating the schizoid's sexual functioning is pathological withdrawal (Laing, 1960). Although the body is in compliance with the physical demands of sexual intercourse, this physical action is not related to the wishes and desires of the schizoid individual. The resulting sexual experiences are often without excitement, perfunctory, mechanical, intellectual, and emotionless. Because of the tendency to become dissociated from the body during sex, the schizoid may feel like he is watching his body from a distance, or like he is watching a stranger having sex while simultaneously imagining himself having sex with another (Laing, 1960). Other issues include preoccupation with body parts, fetishes, and hypochondriacal concerns about the sensations of the body during sex (Klein, 1995). These preoccupations often reflect fears that their sexuality will erupt beyond their control. Laing (1960) describes complications in schizoid sexual functioning in the following two cases:

Case 1

> A patient, for instance, who conducted his life along relatively 'normal' lines outwardly but operated this inner split, presented as his original complaint the fact that he could never have intercourse with his wife but only with his own image of her. That is, his body had physical relations with her body, but his mental self, while this was going on, could only look on at what his body was doing and/or imagine himself having intercourse with his wife as an object of his imagination. He gave the guilt he was subject to for doing this as his reason for seeking psychiatric advice. (p. 86)

Case 2

It would be a profound mistake to call this woman narcissistic in any proper application of the term. She was unable to fall in love with her own reflection. It would be a mistake to translate her problem into phases of psychosexual development, oral, anal, genital. She grasped at sexuality as at a straw as soon as she was 'of age'. She was not frigid. Orgasm could be physically gratifying if she was temporarily secure in the prior ontological sense. In intercourse with someone who loved her (and she was capable of believing in being loved by another), she achieved perhaps her best moments. But they were short-lived. She could not be alone or let her lover be alone with her.

Her need to be taken notice of might facilitate the application of a further cliché to her, that she was an exhibitionist. Once more, such a term is only valid if it is understood existentially. Thus, and this will be discussed in greater detail subsequently, she 'showed herself off' while never 'giving herself away'. That is, she ex-hibited herself while always holding herself in (in-hibited). She was, therefore, always alone and lonely although superficially her difficulty was not in being together with other people; her difficulty was least in evidence when she was most together with another person. But it is clear that her realization of the autonomous existence of other people was really quite as tenuous as her belief in her own autonomy. If they were not there, they ceased to exist for her. Orgasm was a means of possessing herself, by holding in her arms the man who possessed her. But she could not be herself, by herself, and so could not really be herself at all. (57-58)

- Intense desires to escape the body and avoid physical activity
- Failure to harness aggressive energy resulting in low sex drive
- Polymorphous perverse sexuality defending against Oedipal anxiety and the activation of aggression within the relationship
- Fantasy with inner objects during sexual intercourse or as a substitute for real sex
- Hypochondriacal concerns, or distracting preoccupation with body parts
- Autoerotic activities in place of human contact, pornography addiction
- Sado-masochistic sexual enactments
- Attraction to sexually unavailable or sexually immature partners
- Aloofness or asociality that limits opportunities to meet sexual partners

Figure 5.8. Factors complicating schizoid sexual functioning.

(5) Superego Functioning & Morality

The moral structure of the schizoid has been subject to debate over the years. In ongoing treatment, some authors note that narcissistic or antisocial traits may emerge in the schizoid personality, along with fantasies of omnipotent control (Koenigsberg et al., 2000). Kallman (1938), in describing these personalities as 'schizoid psychopaths,' was among the first to associate this personality type with antisocial behavior. These findings were replicated in later psychodynamic research (Heston, 1970; Lewis & Shanok, 1978), though a number of recent studies have not been able to find any overt link between schizoid states and psychopathy (Hart & Hare, 1989; Raine, 1986; Rice & Harris, 1995), or alcohol and substance abuse (Blackburn & Coid, 1999; Drake, Adler, & Valliant, 1988; Kosson et al., 2008;). Akhtar (1987) gives a fuller picture in characterizing the schizoid as outwardly exhibiting idiosyncratic moral and political beliefs while at the same time being inwardly given to moral unevenness, occasionally strikingly amoral and vulnerable to odd crimes, and at other times being altruistically self sacrificing.

It is perhaps the fact that schizoid types are not usually burdened with guilt and shame that gives rise to the idea that they are prone to pathological superego functioning. In a sense, the failure of these individuals to achieve the depressive position means that they are pre-moral (Klein, 1946), though this does not mean that they do not have moral capability when interacting in the outside world. Shame and guilt, being socially and interpersonally derived emotions, are less likely to be found in those who invest little in social relationships. In a sense, without having invested in attachments or sought to be a part of the community or of society at large, the moral development of the schizoid is not able to reach its full potential.

In the place of a fully developed morality, the schizoid substitutes an idealized morality based on intellectual ideas or ascriptively engineered through observation of others. As Johnson (1975) notes, “Problems of ethics and integrity are always contextually and operationally determined in an attempt to be objective. Measurement of the integrity and accomplishment of themselves and others is similarly ascriptive, externalized, and objective” (p. 400). The actual experience of guilt is often not conscious, though it can be inferred through behavior. It is not a morality based on feelings, but ideas. Things do not always *feel* right or wrong to the schizoid. Right and wrong are determined objectively, separated from feeling, and then acted upon (Johnson, 1975). Helen Deutsch (1942), in her discussion of the ‘as-if personality,’ presents a similar picture:

> Completely without character, wholly unprincipled, in the *literal* meaning of the term, the morals of the 'as if' individuals, their ideals, their convictions are simply reflections of another person, good or bad. Attaching themselves with great ease to social, ethical, and religious groups, they seek, by adhering to a group, to give content and reality to their inner emptiness and establish the validity of their existence by identification. Overenthusiastic adherence to one philosophy can be quickly and completely replaced by another contradictory one without the slightest trace of inward transformation. (p. 329)

Though outwardly these patients appear without morals, at a deeper level they are not prone to true psychopathy. The Hare checklist looks for two factors in the psychopath: (a) Aggressive narcissism, and (b) socially deviant lifestyle (Hare, 2003). The schizoid is not aggressively narcissistic, but given his poverty of feeling he can appear to lack remorse or guilt, show shallow affect, callousness and lack of empathy, and shows superficial positive regard for others in the form of idealized relationships Socially deviant lifestyles are seen in these patients, but this is because they tend to stand

apart from society and follow their own idiosyncratic and eccentric pursuits, but not because they are prone to acting out or aggressive antisocial behavior.

Schizoid patients do not lack superego functioning or have psychopathic superego functioning. Quite to the contrary, these patients have a highly organized superego and ego-ideal (Kahn, 1974). There seems to be considerable overlap between the concept of the anti-libidinal ego and the superego structures in these patients that muddies the picture. The schizoid superego is organized to be anti-libidinal, having been constructed and based on the parental imago. The anti-libidinal ego is responsible for the elimination of all needs and feelings, not simply those that are socially or morally unacceptable and the superego may be thought of as colluding in these functions. According to Kahn (1974), the schizoid ego-ideal is not constructed from the introjection of primary parental objects, but rather *in lieu of* satisfactory parents. The schizoid idealizes his depriving parents, partly because he has never known any different, magically turning the bad object into good to fend off the hopelessness and barrenness they feel (Kahn, 1974). In this way, he is able to shape and evaluate his behavior on his own, in spite of input from the outside world.

In response to accusations of moral wrongdoing, the schizoid may be more likely to experience fear or anger than guilt. The schizoid is used to living in a fantasy space in which the rules of the real world do no apply and where one can rage without consequence (Laing, 1960). Without seeing consequences to behavior, morality cannot be realized. The schizoid's tendency to feel imposed upon by laws, rules, guidelines, feeling these to be appropriating and engulfing, reflects this internal conflict (Seinfeld, 1991). Though their passion for freedom can appear similar to antisocial traits, the schizoid is

not really invested in manipulating others to see what he can get away with. He mostly seeks freedom from restriction and suffocation (Laing, 1960).

(6) Relationship to the Body

The schizoid's relationship to his body is not usually a comfortable one. During periods of emotional withdrawal, the schizoid becomes estranged from his bodily experience, including its sensations, functions, gratifications, and basic needs. The patient's fundamental split from his feelings creates a fault that runs between the mind and the body, leaving the patient only to identify with the mind and view the body from a distance (Laing, 1960). This unembodied state makes the schizoid feel safe from the dangers of the physical world. This drive to escape is manifested in effort to avoid all physical activity, including sexual activity, as well as intense needs for sleep, and difficulty getting out of bed in the morning (Guntrip, 1969). Exercising is given a very low priority. In some cases, the schizoid can be so divorced from his need for sustenance that he becomes physically thin (Kretschmer, 1925), and his lack of attention to his presentation can cause issues with basic hygiene. The patient seeks to become anonymous by leaving his body behind, going incognito and blending into the background scenery. Essentially, in his attempt to *be* nobody, the schizoid makes efforts to *have* no body (Laing, 1960).

As R.D. Laing (1960) notes, in schizoid patients, the relationship to the body has been significantly disrupted (Laing's observations about the schizoids unembodied self are summarized in the table which follows this discussion). The body is viewed objectively from a distance as if it were a thing or an object unrelated to the self. In short, the body is felt to be unreal, like an empty shell. The schizoid distances himself from his

bodily functions and disowns his reactions. As such, the body becomes integrated as a part of the false self system, and is not capable of truly participating in relationships to other. The body does not function as a channel for gratification or as vehicle for the expression of true need. The actions of the body are merely an attempt to go through the motions, to imitate or impersonate others. Without housing his feelings, the schizoid's body is not capable of participating in emotional interactions or to penetrate and be penetrated emotionally. The body does not reveal the self in any kind of genuine way. Instead, the patient looks on from afar, omnipotent and removed from the chances of feeling pain.

In contrast, normal patients show a strong embodied sense of self. The body is felt to be alive and real, and subjective experience of the world is integrated and expressed through bodily processes. Because the desires, needs, and gratifications of the body are recognized, the spontaneous actions taken by the individual reveal who he truly is as a person. The body can be included as a participant in interactions with real things and real people, and as such, is capable of being penetrated emotionally and of penetrating others emotionally (Laing, 1960). The body can allow for autonomous strivings and is capable of receiving subjective feedback and to being enriched by the environment. Accordingly, the body is also capable of feeling pain, conflict, and frustration resulting from whatever activities or actions the person takes.

Because of his pseudo-relationship to parts of the self and efforts to render his body unreal, the schizoid often faces uncomfortable side effects. For example, rapid reversals between total identification with split-off bodily impulses or feeling persecuted by them are possible (Eigen, 1973). The depersonalization and loss of self that often

results from the dissociation of bodily impulse can be terrifying and disorienting. Moreover, the split from the body can feed preoccupations with body parts, fetishes and perversions, concerns about the body, and hypochondriasis (Klein, 1995), as well as difficulties with sexual relationships. Schizoid patients tend to concretize their negative feelings about themselves as somatic delusions and bodily concerns. For example, their fears about being lovable often manifest symbolically as concerns about the look, shape, and smell of their body, or the awkwardness of their movement. These beliefs about the body then become reasons to avoid getting closer to others.

The body during withdrawal. The schizoid's body serves not only as a part of the false self, but also as a barrier to contact with the world (Laing, 1960). When the schizoid is threatened by annihilation, or by his feelings of rage and longing, his body mobilizes defensively, becoming a rigid container that is built to withstand affronts from others. He fears that if he were to relax his body, he would collapse into emptiness, fragmentation, or catastrophe. When feelings or sensations arise in the body that he is not able to handle, the schizoid places his body under the control of his ego functions (Guntrip, 1977), almost using the head as a stronghold for all further operations. As the process of withdrawal occurs, all feeling and energy are removed from the body. The patient's musculature contracts to form a barricade to rejection and disappointment so he is no longer able to feel afraid or shocked. The rigidity in his body creates a protective barricade against pain and rejection that may come from the outside world (Bilotta, 1991). The schizoid's denial of being alive and his dissociation of bodily sensations lead to loss of self, making the body alien and cold.

Normal Embodied Experience	Unembodied Experience of the Schizoid
○ The body is felt to be alive and real	○ The body is felt to be unreal, there is a struggle to feel alive
○ Subjective responses occur	○ The person remains objective about his bodily responses
○ Actions are felt to be an expression of the real self	○ The self is rarely revealed through the actions of the body
○ Desires, needs, acts, and gratifications of the body are recognized	○ Desires, needs, acts, and gratifications are split off
○ The person may feel guilt and anxiety about his bodily needs	○ The body becomes a part of the false self, simply an empty object
○ The body is included as participant with real things and real people	○ The body is not a participant in genuine interactions with real things and real people
○ The body is capable of penetrating and being penetrated emotionally and enriched by others	○ The body is not capable of penetration or being penetrated emotionally or enriched by others
○ The body is a unique expression of self	○ The body is felt to be an object in the world among many, it has nothing to do with the person
○ The body is vulnerable to pain and being harmed	○ The body is omnipotent and cannot be harmed
○ The body allows for autonomy	○ The body is just an onlooker
○ The body acts spontaneously and reveals the personality	○ The body is a role player, an impersonator, a manifestation of the false self
from Laing, 1960	*from Laing, 1960*

Figure 5.9. The unembodied experience of the schizoid.

During withdrawal, the schizoid is afraid of making eye contact because he is afraid of taking in the experience of the other and becoming overstimulated, or feelings engulfed, or attacked. Communication through the eyes is threatening and therefore blocked and limited. The result is eyes that appear remote, glassy, faraway, vacant, and unexpressive (Bilotta, 1991). At the same time, the schizoid's facial features are mask-like, featureless, and frozen, often with only smile concealing his panic. As energy is withdrawn from the body, the limbs start to feel unconnected, flaccid, weak, and uncoordinated with the self. The head begins to feel inflated, overcharged, and almost floating disconnected from the body. Respiration becomes shallow and constricted from the patient's fear of letting the world in, or of breathing his fear and aggression out, and movement is shut down, making the patient feel inflexible and immobile (Bilotta, 1991).

As his energy becomes frozen in the head and face, the schizoid can no longer mobilize himself in the service of his needs. As if going into energy conservation mode, the discharge of energy is blocked and bound up, or withheld in the core of the personality (Bilotta, 1991). The patient becomes an iceberg, hibernating in an inert state. Accordingly, he feels fatigued and longs for sleep. As feelings and energy are withdrawn from the periphery of the body to head, the schizoid experiences his body as being numb, amorphous, and foreign, and his self-perception becomes limited (Bilotta, 1991). At the same time, there is a steep increase in the fantasy life to compensate for this deadness (Guntrip, 1969). These dynamics, and others are summarized on the following page.

Eyes	Clouded, remote, blank, cold, glassy, fish-like, unexpressive, blocked, blurry, frozen, dead, no one home, strained, dull, faraway, trance-like, distant, hard, vacant, unexpressive
Face	Mask-like, featureless, frozen, false smile, rigid jaw
Limbs	Disjointed, unconnected, uncoordinated, unproportional, flaccid, thin, no tone, narrow, weak, tense, tight
Head	Potent, overcharged, inflated, floating, spacey, bottlenecked with energy, fortified
Body	Damaged, weak, debilitated, shell-like, rigid, tight, immobile, thin, undeveloped, mechanical, lifeless, cold, inflexible
Respiration	Reduced, shallow, contracted, deflated, afraid to take in the world, wanting oxygen without exertion, holding breath
Movement	Immobile, without spontaneity, inexpressive, wooden, tense
Energy	Running on empty, on a slow burn, conserving energy, blocked, unable to discharge, cold, depleted energy frozen in the core, energy trapped in the head, energy bound in muscular tension
Fight/Flight	Becomes stiff, moves away, retreats, hides, hibernates, freezes, stops movement, stops breathing, goes numb, curls up, deadens, withdraws to head, becomes paralyzed, plays dead, plays opossum

inspired by Bilotta, 1991

Figure 5.10. The somatic experience of schizoid withdrawal.

The following case material includes a schizoid patient's description of her body during withdrawal:

> [One patient] said, 'I feel there's a gap in the middle of my body. There seems to be nothing between my legs and my arms and head.' She felt that the vital heart of her was missing and she was unreal, and she commented, 'It's not like that dream of the women ignoring the baby. If feels as if there isn't even anyone there at all to ignore me.' The earlier dream expressed loneliness, the later sensation of an empty gap in her personality expressed *isolation and unreality*, the loss of her ego, of her sense of selfhood, in experiencing object-loss through feeling out of touch with me. (Guntrip, 1969, p. 225)

(7) Social Functioning & The False Self

The social life of schizoid patients is usually highly constricted. Schizoid personalities tend to lack close friendships, appear outwardly to have little need for human company, or in some cases can be totally indifferent to the presence of others. Many schizoids are chronic homebodies, and feel more comfortable with only their closest friends or family because theses situations feel routine, familiar, and secure (Slavik, et al., 1992). At a deeper level, however, the tendency to avoid social situations can reflect a lack of social skills, a tendency to be socially awkward or inappropriate, to feel shy or reserved in social situations, or to feel like an outcast or outsider who does not truly belong to the group (Shedler & Westen, 2004). In groups, the schizoid often sits quietly and does not engage, hoping that if he is silent he stands less of a chance at being rejected, criticized or exposed. Sitting quietly on the sidelines he feels foolish, and believes it is pointless to even try engaging with others.

The following case material about a schizoid woman paralyzed by agoraphobia in social situations:

> Thus a young woman of nineteen who was chronically agoraphobic and experienced serious attacks of depersonalization if she went out even with

> her own family, said, ‘I get frighteningly claustrophobic in a big store and want to rush out.' It appeared that what actually happened was that she would feel overwhelmed and helpless in the midst of the big crowd of shoppers and before the fear could develop she would undergo an immediate and involuntary schizoid withdrawal. She said, 'I suddenly feel a lack of contact with everybody and everything around and I feel I'm disappearing in the midst of everything.’ Hence her agoraphobia. She felt overwhelmed by the world outside home and would 'lose herself'. (Guntrip, p. 20)

While outwardly the schizoid seems to prefer solitary occupational and recreational activities, he is often still marginally or eclectically sociable in groups and vulnerable to esoteric movements owing to a strong need to belong (Akhtar, 1987). Many are seemingly oblivious to pop culture. Ultimately the schizoid’s social performances and his inner world are vastly different and segregated. “They live, as it were, in two worlds and learn not to expect congruity between the internal self and the social reality” (Johnson, 1975, p. 400). Quietly behind the scenes of his social performances, the schizoid is often aware of how he is seamlessly orchestrating his attempt to become a social object like any other. When others buy into his performances he experiences relief and his omnipotent defenses are reinforced.

In general, schizoid people tend to find that large social gatherings create a stimulus overload and find these events can seem more like a chore than a source of enjoyment. They can easily panic in a room full of people. A significant part of the difficulty the schizoid has in socializing follows his struggles with spontaneous communication. Without a way to genuinely engage others, social events can place huge amounts of stress on the schizoid. In general, the schizoid feels fraudulent making small talk or participating in group conversations, more or less believing that these mediums are artificial, manufactured, and contrived (McWilliams, 2006). The schizoid is far more

comfortable with one-on-one conversations. Partly, these conversations are less likely to over-stimulate the schizoid, though on another level, the schizoid also feels much more in control when he can carefully tailor his reactions to a single person at a time, relishing in his omnipotent self presentation. Feeling more exposed, more vulnerable, and more isolated that other people, the schizoid opts to withdraw into a tiny space. Rather than showing their disinterest in socializing with aggression, they do so with distance-taking instead (Slavik et al., 1992).

Schizoid people often enjoy and feel comfortable with deep conversations with people who appreciate honest communication and are generally non-judgmental (McWilliams, 2006). This is in part because the schizoid is often aware of nuanced interpersonal dynamics that others are not, but fears that acknowledging these dynamics with non-schizoid others may create unwanted conflict or rejection. McWilliams (2006) explains the schizoid's approach to socializing:

> One seldom-appreciated quandary in which interpersonally sensitive schizoid individuals find themselves repeatedly involves the social situation in which they perceive, more than others do, what is going on nonverbally. The schizoid person is likely to have learned from a painful history of parental disapproval and social gaffes that some of what he or she sees is conspicuous to everyone, and some is emphatically not. And since all the undercurrents may be equally visible to the schizoid person, it is impossible for him or her to know what is socially acceptable to talk about and what is either unseen or unseemly to acknowledge. Thus, some of the withdrawal of the schizoid individual may represent not so much an automatic defense mechanism as a conscious decision that avoidance is the better part of valor.
>
> This is inevitably a painful situation for the schizoid person. If there is a proverbial elephant in the room, he or she starts to question the point of having a conversation in the face of such silent disavowal. Because schizoid individuals lack ordinary repressive defenses and therefore find repression hard to understand in others, they are left to wonder "How do I go forward in this conversation not acknowledging what I know to be true?" (p. 13)

The schizoid does not trust the mob and sees social conventions as trite and lacking in meaning. In general, schizoids do not find themselves drawn strongly to identification with ethnic or religious identities or to participate in these aspects of community life, unless it is in the service of the false self. Schizoid characters may privately devalue or mock what they see as repetitive conversations, empty gestures and meaningless ritual. Ironically, however, as much as the schizoid dislikes making small talk, in most of his interactions with others, he is apt to do just that to avoid saying anything that reveals his true feelings. Though he may view himself as capable of consequential exchanges, he is fearfully compelled to keep things banal. He fears that something will come out of him that he is not expecting. Unconsciously involved in this inner compensatory struggle, the schizoid usually reports feeling exhausted after social occasions without knowing why.

The following case material illustrates one schizoid's difficult maintaining a social life:

> It was at the second office that he first experienced attacks of anxiety. By then, the central issue for him had crystallized in terms of being sincere or being a hypocrite; being genuine or playing a part. For himself, he knew he was a hypocrite, a liar, a sham, a pretence, and it was largely a matter of how long he could kid people before he would be found out. At school, he had believed that he had been able, to a large extent, to get away with it. But the more he dissembled what he regarded as his real feelings and did things and had thoughts that had to be kept hidden and secret from every other, the more he began to scan people's faces in order to try to make out, from what he could read in them, what he imagined they either thought about him or knew about him. At the office what he regarded as his 'real feelings' were largely sadistic sexual phantasies about his female colleagues, particularly one woman there who, he thought, looked respectable enough but who, he imagined, was probably a hypocrite like himself. (Laing, 1960, p. 124)

The false self. Laing (1960) outlines the dynamics of the schizoid's false self. Unlike a normal false self, made up of simple mechanistic behaviors that can be rejected rather easily for more spontaneous behavior, the schizoid false self is compulsively compliant to others, and only partly autonomous. Unlike the false self of the hysterical or narcissistic character, the schizoid's false self does not gratify or nourish the needs of the individual (Laing, 1960). The schizoid's false self is based on what those around them define as good and normal behavior, as a form of compliance. Accordingly, the false self of the schizoid will change along with the company he keeps and is not uniform like it may be with other personality types. As Laing (1960) puts it, the schizoid can just as easily conjure a phoney sinner as a phoney saint, the point of the false self will always be to avoid danger of conflict. It is an attempt to go undercover, to blend in and become anonymous. This imitation of others is reinforced by the split the schizoid has between his body and his true feelings. Because the schizoid can become depersonalized, the expressions, gestures, words, and actions of the body are not actually connected to the true personality, allowing the body to become an active extension of the false self in the most literal sense of the term.

The schizoid has several facets of his false self that help to moderate anxiety in social situations. First the schizoid will often engage in *role-playing* to defend against a real intimate connection with others, making himself appear social and affable without really engaging his own personality (Laing, 1960). It should be noted that the schizoid is usually aware that his true personality is not involved in these interactions; he actively disowns the social role he is playing (Fairbairn, 1940). At other times, the schizoid may

create *omnipotent fantasy* for himself in which he is able to control the actions of the other (Doidge, 2001).

Exhibitionistic techniques, in which the schizoid demonstrates emotion for others to see without actually experiencing them, can be likened to a form of acting, creating the impression of spontaneous interaction (Fairbairn, 1940). In this way, the schizoid aims to show others that he is vivacious, affable, charming and engaged, even though at a deeper level he knows this is not the case. The patient may be used to substituting pseudo-connections for real friends. Social contacts that are mere acquaintances, or are evasive and unsupportive are usually preferred, while genuine contact is avoided. These connections are meant to create a façade that conceals the schizoid's aloneness and difficulty relating. At a deeper level, it is the empty core at the center of the schizoid's experience that allows him an effectual blank slate onto which he can create any persona he would like (Seinfeld, 1991). One final way that the false self operates is through *imitation of others*, the purpose of which is to assume a new identity. The schizoid has a strong ability to pick up emotional signals from the environment given his symbiotic tendencies, using any object as a possible bridge for identification (Deutsch, 1942). This identification can take many forms, including echo-praxia (imitating movements), echo-lalia (repetition of vocalizations), voice inflections, gestures (Laing, 1960), posture, or the adoption of the scientific or avocational interests of the other (Weiss, 1966).

The easy ability of the schizoid to mimic others, earning him the nick name 'as-if' character (Deutsch, 1942), is the result of deficiencies in the early environment that did not allow these patients to move beyond stages of imitation (the precursor of identification), to object cathexes and true identification (Weiss, 1966). As Laing (1960)

notes, imitations of others become more and more stereotyped over time, forming the basis of the odd and eccentric behavior of the schizoid. Eventually the imitation of the other becomes a caricature, and gradually forms a parody or what seems like aggressive mocking. The schizoid may also develop pseudo-relationships to various manifestations of the false self that have formed through partial identification with others, and begin to refer to these parts in depersonalized ways, as if they were separate dialects or language that he can speak (Laing, 1960). Far away the true personality lies dormant and uninvolved.

The following case material illustrate the schizoid's pathological use of the false self, as discussed in this section:

Case 1

> A third patient, of extensive philosophical interests, says: 'I'm adept at the art of brinkmanship. In group discussion I don't put forward a view of my own. I wait to hear what someone else will say and then I remark "Yes, I rather think something like that" but I'm thinking "I don't really agree with him." I won't belong to an organized school of thought yet I have a dread of going out into the wilderness and standing alone on some definite views of my own. I hover half way. It has stopped me doing any creative work.' (Guntrip, 1977, p. 167)

Case 2

> His view of human nature in general, based on his own experience of himself, was that everyone was an actor. It is important to realize that this was a settled conviction or assumption about human beings which governed his life. This made it very easy for him to be anything his mother wanted, because all his actions simply belonged to some part or other he was playing. If they could be said to belong to his self at all, they belonged only to a 'false self', a self that acted according to her will, not his.
>
> His self was never directly revealed in and through his actions. It seemed to be the case that he had emerged from his infancy with his 'own self' on the one hand, and 'what his mother wanted him to be', his

'personality', on the other; he had started from there and made it his aim and ideal to make the split between his own self (which only he knew) and what other people could see of him, as complete as possible. He was further impelled to this course by the fact that despite himself he had always felt shy, self-conscious, and vulnerable. By always playing a part he found he could in some measure overcome his shyness, self-consciousness, and vulnerability. He found reassurance in the consideration that whatever he was doing he was not being himself. Thus, he used that same form of defense which has been already mentioned: in an effort to mitigate anxiety he aggravated the conditions that were occasioning it.

The important point he always kept in mind was that he was playing a part. Usually, in his mind, he was playing the part of someone else, but sometimes he played the part of himself (his own self): that is, he was not simply and spontaneously himself, but he played at being himself. His ideal was, never to give himself away to others. Consequently he practiced the most tortuous equivocation towards others in the parts he played. Towards himself, however, his ideal was to be as utterly frank and honest as possible. The whole organization of his being rested on the disjunction of his inner 'self and his outer 'personality'. It is remarkable that this state of affairs had existed for years without his 'personality', i.e. his way of behaving with others, appearing unusual.

The outward appearance could not reveal the fact that his 'personality' was no true self-expression but was largely a series of impersonations. The part he regarded himself as having been playing most of his schooldays was that of a rather precocious schoolboy with a sharp wit, but somewhat cold. He said, however, that when he was fifteen he had realized that this part was becoming unpopular because 'It had a nasty tongue'. Accordingly he decided to modify this part into a more likeable character,' with good results'.

However, his efforts to sustain this organization of his being were threatened in two ways. The first did not trouble him too seriously. It was the risk of being spontaneous. As an actor, he wished always to be detached from the part he was playing. Thereby he felt himself to be master of the situation, in entire conscious control of his expressions and actions, calculating with precision their effects on others. To be spontaneous was merely stupid. It was simply putting oneself at other people's mercy.

The second threat was the more actual, and one upon which he had not calculated. If he had a personal source of complaint to bring to me, it was based on this threat, which indeed was beginning to disrupt his whole technique of living.

All through his childhood he had been very fond of playing parts in front of the mirror. Now in front of the mirror he continued to play parts but in this one special instance he allowed himself to become absorbed into the part he played (to be spontaneous). This he felt was his undoing.

> The parts he played in front of the mirror were always women's parts. He dressed himself up in his mother's clothes, which had been kept. He rehearsed female parts from the great tragedies. But then he found he could not stop playing the part of a woman. He caught himself compulsively walking like a woman, talking like a woman, even seeing and thinking as a woman might see and think. This was his present position, and this was his explanation for his fantastic get-up. For, he said, he found that he was driven to dress up and act in his present manner as the only way to arrest the womanish part that threatened to engulf not only his actions but even his 'own' self as well, and to rob him of his much cherished control and mastery of his being. Why he was driven into playing this role, which he hated and which he knew everyone laughed at, he could not understand. (Laing, 1960, p. 71-73)

- **Role playing** – Playing the part of one who is socially outgoing defends against exposing fear of embarrassment
- **Exhibitionism** – Showing others faux-emotions without experiencing these emotions at a deeper level
- **Imitation & Impersonation** – Making the self fit the characteristics of others to avoid conflict
- **Omnipotent fantasy** – Feeling that one can control the actions of others by calculating social responses of the self
- **Depersonalization** – The body, emptied of feeling and desire, becomes a representative for the false self, an imitator, a mimicry

Figure 5.11. Factors complicating schizoid social functioning.

(8) Withdrawal & Retreat to Fantasy

The markers of withdrawal. Withdrawal is a process that has both physical and emotional components. Identifying the signs of withdrawal requires attention to body language, the quality and quantity of communication, and the emotional experience of the patient. Physical withdrawal is associated with closed body language, limited eye contact, slumped or shrinking posture, and the orienting of the body away from others. The withdrawn individual seeks to create distance between the self from others, be it moving back a few steps, moving to the perimeter of the room, or becoming reclusive and cloistered within the home. Physical activity reduces often to the point of inactivity, and

the person may report feeling weak, tired, sleepy, or exhausted. The emotional experience of withdrawal often includes an increase in fantasy life, feeling boredom or apathy, or even disgust, revulsion and aversion. The emotional state of the withdrawn self is passive, disconnected and lacking the energy to make emotional contact, which over time leads to depersonalization and emptiness.

Schizoid withdrawal is illustrated in the following case material:

Case 1

> The dream of a University lecturer which shows how little his academic life had touched his deeper mentality, illustrates this two-stage retreat:
>
> I was on a tropical South Sea Island and thought I was all alone. Then I found it was full of white people who were very hostile to me and surged at me. I found a little hut on the shore and rushed into it and barred the door and windows and got into bed.
>
> He has retreated from civilization to his lonely island (his internal world) only to find that his bad objects, white people, are still with him. So he makes a second retreat which is a complete regression. (Guntrip, 1977, p. 74)

Case 2

> The schizoid person can withdraw so thoroughly into himself that he fears losing touch altogether with his external object world. A young wife, who had become deeply schizoid in early childhood through sheer maternal neglect, was faced with the coming into the home of a loud voiced and domineering mother-in-law. She said simply: 'She scares me. I feel I am just going miles away. Its frightening. I fear I'll get so far away I can't get back. I fear I'll go insane.' She had to ring me several nights in succession to keep touch and allay fear. (Guntrip, 1969, p. 162)

Recognizing withdrawal is important in treatment. A sudden drop off in communication or interaction that becomes stilted and forced can reflect withdrawal in session. The patient may also appear to experience a loss of affect, energy, and interest in discussion. Unlike obsessive or histrionic patients who are 'actively remote' by creating excess verbalization, perseverate on trivial themes, and ignore the therapist, schizoid

patients are ‘passively remote’ by remaining quiet and inactive, producing limited material in session (Heyman, 1990).

Withdrawal is a primitive and non-verbal defense (McWilliams, 1994). Small babies often turn their heads away, zone out, stop paying attention, or nap when they are feeling overstimulated. Withdrawal is not the absence of interest, disinterest, or dispassion, but rather it is an attempt to pull back from contact and modulate the intensity of emotional experience. McWilliams (2012) notes that withdrawal is a defense typically adopted by those who are temperamentally disposed to being sensitive or impressionable to external input. He states, “Experiences of emotional intrusion or impingement by caregivers and other early objects can reinforce withdrawal; conversely, neglect and isolation can also foster that reaction by leaving a child dependent on what he or she can generate internally for stimulation” (Millon 2012, p. 104). McWilliams (2012) further notes that the advantage of withdrawal as a defensive strategy is that while it is an escape from reality, it does not distort reality and allows for a degree of insight into the behavior of the self and others.

Withdrawal has a huge effect on a person’s life because of its tendency to create alienation and loneliness, and paralyze interpersonal relations. Withdrawal can be passive aggressive and conceal secret omnipotent efforts at self-control, but more frequently, is an attempt to protect the self or the other from the intensity of feelings. Usually the patient experiences withdrawal passively. It is like the feelings have been suddenly drained from the body, leaving only an empty shell to interact with others. At other times, the patient feels he has the ability to create inner distance from feelings on command. Withdrawal can be used both to express and to avoid the expression of anger, to avoid

exposing fragility, to move inward to a place of safety and escape the dangers of the world. Often withdrawal precedes an attempt to deal with conflict with inner objects and escape the dangers of being overwhelmed or suffocated by others (Laing, 1960). Whatever the reason for its use, withdrawal shuts down the ability to communicate, to feel and to engage with others.

Active (Less Severe) - The patient distances himself from emotional contact with the therapist through excess verbalization, trivialization, not listening, or resisting insight (e.g. avoidant, obsessive, or histrionic personalities)

Passive (More Severe) – The patient remains quiet and inactive, producing limited material (i.e. schizoid personality)

from Heyman, 1990

Figure 5.12. Distinguishing withdrawal behavior.

Markers	Functions
Physical Signs • Limited eye contact • Avoidance, detachment • Moving to the perimeter of the room • Closed body language • Avoidance of physical activity • Sleepiness • Weakness and exhaustion • Loss of energy **Psychic Signs** • Loss of interest, boredom, apathy • Autoeroticism • Isolation of affect • Disgust, revulsion, aversion • Passivity or inertia • Abandonment of object relationships • Fantasies of a return to the womb or sleep	• To avoid expression of anger, or negative feelings • To avoid exposing fragility • To move inward to a place of safety • To safeguard sovereignty • To work out conflict with internal objects • To escape the dangers of the world • To avoid being overwhelmed, suffocated • To escape impingement or hostility

Figure 5.13. Schizoid withdrawal.

in the world with others, and increases his proximity and emotional availability with this purpose in mind. (b) As he moves toward relationships that would have his feelings expressed, the schizoid's fears activate and he begins to fear criticism, rejection, and his own weakness and fragility (McWilliams, 1994). (c) As the defensive process of withdrawal activates, the schizoid feels disgust and aversion and begins the process of evacuating his needs and feelings and sinking deeper and deeper into himself. (d) Next a loss of self occurs; engulfment and implosion fears accelerate creating confusion and inertia, paralyzing the individual (Laing, 1960). At the same time, a dramatic increase in awareness of fantasy life grabs the patient's attention (Gruntrip, 1969). Compulsive self-assessment and introspection then occur, impaling the patient on his own gaze and dramatically limiting the possibilities for spontaneous action (Johnson, 1975). (e) Withdrawal complete, the schizoid struggles to regain contact with others. Obsessive or histrionic behavior, intellectualism, and eccentricity often take the place of real interactions and real feelings (Laing, 1960). Usually schizoid withdrawal is accompanied by a simultaneous increase in fantasy activity, the abandonment of object relations with others, and the identification with internal objects instead. Fantasies about returning to the womb, of attaining a symbiotic state, of longing for sleep, or longing for death are often prominent themes in this material (Guntrip, 1969). Meanwhile, all the patient's efforts go into making it appear that nothing has happened outwardly. The whole process consumes large amounts of energy and often retreat is necessary to regain enough energy to interact again. These stages are illustrated on the following page in Figure 5.14 for review.

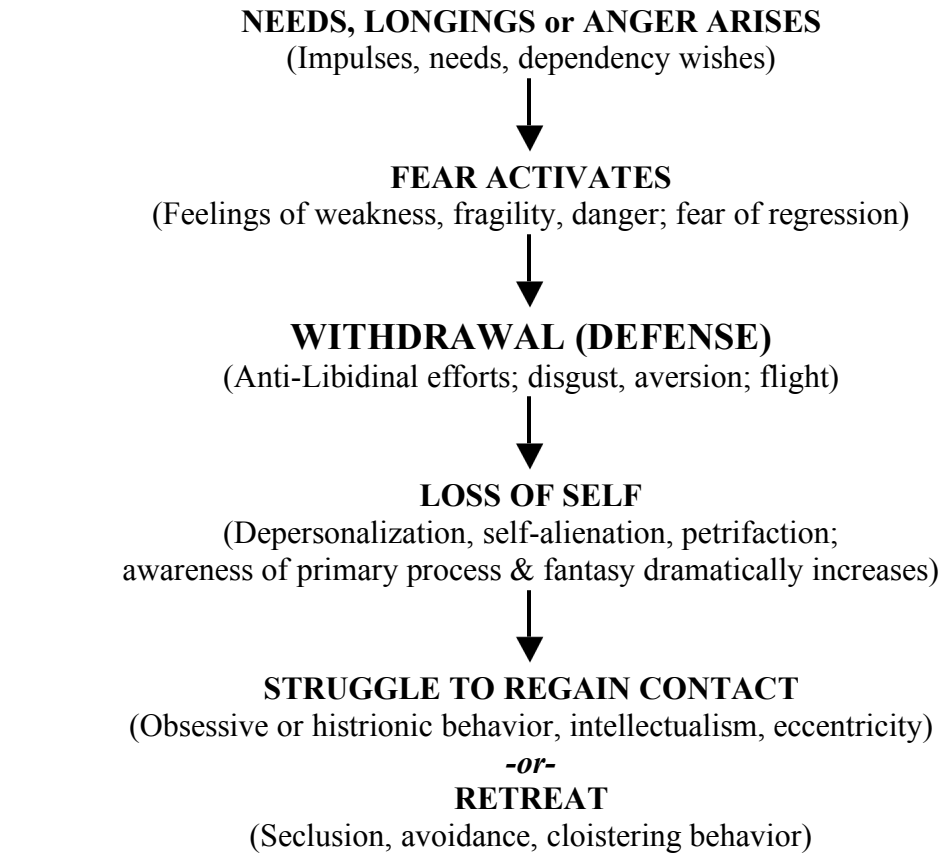


Figure 5.14. The process of schizoid withdrawal.

The following case material relates one schizoid patient's longing for regressive withdrawal to the oblivion of sleep:

> At one point she said: 'I feel so exhausted that I just want to lie down flat and not move at all, go into a deep sleep and never wake up.' She was in fact alternating between periods of exhausted apathy and feverish excited activity. She dreamed that one of her children, certainly representing herself, 'didn't like people and had gone right away alone', and commented, 'I'm interested in food, not in people, I don't want anyone near, not even you. I feel I'm in a plastic bag.' She visibly started when I said that her loving self was shut in, and she sobbed and said, 'There's nothing to live for, life's empty.' She then brought this dream:
>
> I had been turned inside. I don't know how, but I was just 'like that'. I could hear what was inside but I couldn't hear anything outside. I

> could vaguely see my husband and some other people but they didn't mean anything to me, they didn't seem real. But I felt safe.
>
> Here is the clearest possible expression of a motivated withdrawal into herself, breaking off relations with real people in the outer world to find security in an enclosed retreat, a shut-in introverted state. No one reacts in this drastic way for the first time in adult life. The normal reaction even to severe difficulty is to be stimulated to greater effort. She withdrew into unreality as an adult because she had already been driven into a schizoid state as a child. The result was derealization of her outer world and depersonalization of herself. She found that in the evening, when the children were in bed, if her husband went out of the room she suddenly felt unreal. She needed the family present to give her pressing reasons to 'keep in touch' or she lost her own ego. Yet all the time she felt a powerful secret wish for this complete withdrawal because it enabled her to feel safe. She did not want to die but simply to escape into absolute inactivity and the oblivion of deep sleep, and never wake up. (Guntrip, 1969, p. 92-93)

Non-pathological withdrawal. Schizoid states and spontaneous withdrawal play an important part in defining the human experience. While the experience of separateness from others, of solitude, loneliness, isolation, privacy, alienation, and disengagement are not always selected for, nonetheless, they seem to be inescapable parts of life (cf. Koch, 1994). What's more, schizoid states can serve adaptive functions. Human creativity and imagination are to some extent a reflection of this aspect of human development. Since the dawn of self-awareness, some form of relational asceticism has been used, virtually universally, as a consciousness-raising technique. Freud's own theory of personal development features an ego capable of strengthening itself through its resistance to the collective culture, offsetting the toxic side-effects of civilization (Eigen, 1973).

Koch (1994) notes some of the many universal functions drawing on schizoid-like behavior. For example, solitude offers retreat and respite from social life and obligations, restorative or medicinal healing, and the freedom and liberty to go where one pleases. Solitude also allows for self-actualizing behaviors, such as attunement to the needs,

wishes, and wants of the self, connection with nature and the universe, reflection on events of life or on psychic contents, as well as creativity. The process of mentalization, in its reliance and encouragement of the recognition, and appraisal of inner emotional experiences relies on schizoid processes to a large extent. These functions are summarized below for reference.

Functions

- Retreat, respite from social life and obligations
- Restorative or medicinal healing
- Freedom, the liberty to go where one pleases
- Attunement to self, needs wishes, and wants
- Attunement to nature, connection to the universe
- Reflection on life, or psychic contents
- Creativity, creative functions

Structures of Solitary Experience

- **Solitude** – A state of disengagement with others, whether alone or in the presence of others
- **Loneliness** – A feeling of longing for other people
- **Isolation** – Experiential sense of being separate from other people in a way that can not easily be overcome
- **Privacy** – Separating from others so they don't engage in our private thoughts or feelings
- **Alienation** – A painful condition imposed upon a victim from within a society
- **Disengagement** – Impervious to the presence of other people

from Koch, 1994

Figure 5.15. The phenomenology of solitary experience.

Retreat to fantasy / autistic fantasy. Freud, in his paper *Creative Writers and Day Dreaming* (1908), posited that fantasy was a relic of childhood, a form of escapism, and a means of denying reality. Yet, Freud's assessment of fantasy missed the positive functions of fantasy, such as its function in human creativity, initiative, progress,

intuition, and self-growth (Storr, 1988). It can also be tempting to romanticize fantasy for its creative functions, for its magical qualities, for its omnipotent freedom, and for its novelty. Young children often engage in fantasy as an exciting part of playtime, inventors are in the business of making fantasies into truth, artists use fantasy to connect to their imaginative drive and channel it into original production. Modern writers differentiate healthy fantasy in adults from schizoid fantasy in one pivotal way: a healthy fantasy is preparation for action in the outside world, whereas with schizoid fantasy, fantasy is action for its own sake (Johnson, 1975).

While every person fantasizes, in the schizoid patient, this tendency is usually running on overdrive. Through fantasy, he seeks to internally address conflict with his internal objects, to safeguard his sovereignty, to avoid impingement, hostility, engulfment, and other perceived dangers (Gruntrip, 1969). In other words, schizoid fantasies usually are a means of keeping in touch with internal objects while keeping withdrawn from real ones (Johnson, 1975). This tendency of the schizoid to spend inordinate amounts of time in fantasy is often a forced choice—the result of defensive functions preventing him from inserting his feelings into real relationships and the channeling of unacceptable desires into the inner world. Laing (1960) noted the many functions fulfilled by schizoid fantasy, including the desire to enjoy a sense of freedom, to be out of danger or frustration in the real world, to escape mediocrity, to engage in omnipotent fantasy, to rage in unchecked aggression, and to achieve independence. Fortunately, if the schizoid can learn to understand his fantasy, and thusly his internal working models of relationships, he can begin to make steps toward releasing the

defensive use of the fantasies, infusing his real life with affects and understandings driven inward. Information from this section is summarized in tables on the following page.

The following four case vignettes show how the schizoid patient uses fantasy as a refuge from the anxieties of the outside world:

Case 1

> One patient said: 'I begin to see what you meant when you said that dreaming is an alternative policy to psychotherapy. I'm not interested in anything real, because if you're interested in anything you come slap up against people. I can only live my dream and fantasy life. lf I were interested in people I could be interested in lots of things. But I'm afraid of people. In my dream world I'm really all by myself and that's what I want to be, to get back to my dream world, a protected world. If I get too deep into it I may not be able to get back from it, but what will I do if I stop dreaming. My real interests are so few. I've nothing to think or talk about.' I reminded him that he was too afraid of people to have any interests. He replied, 'I'm cross with you now.' I said I thought that was because I am a real, not an imaginary person, and called him out of his dream world into the real one. He said: 'I'm angry because I feel anything you say is interference in my private world. Dreaming is against psychotherapy and it's against life.' (Gruntrip, 1969, p. 301-302)

Case 2

> When I questioned him about this behavior, his response was succinct and to the point: 'Talking to myself is better than talking to no one. Any communication is better than no communication at all.' However, such longings were felt only episodically. Much more often he felt that he lived in the middle of an 'emotional minefield,' partly of his own creation and partly the creation of others. This minefield, contrary to what one might think, was really a safety zone, in the middle of which he lived. Around him was a 100-yard space that separated him from everyone else. Within this 100-yard radius were innumerable bombs that kept him safe from intrusion, because anyone who ventured into the area would be blown apart. However, this minefield also kept him from venturing out and contributed to his feeling of being alone and isolated. He described it as his safe place, which was half jail and half paradise. Although Mr. C. used the minefield as a metaphor, his depiction of his fantasy was so intense as to make it feel real. (Klein, 1995, p. 117)

Case 3

A female adult patient was isolated. In her fantasy life she had a series of intense love affairs with persons whom she barely knew. She experienced these love affairs daily, similar to a soap opera. In her most recent fantasied love affairs, she was infatuated with her English teacher. One day several weeks after the course had been completed, she unexpectedly met him. He astounded her by saying he had thought and dreamed of her. She was in a panic. What became apparent in the course of the analysis was that her terror was not due to the temptation of a forbidden, symbolically incestuous affair, but rather more basically, that she was the object of another person's thoughts or dreams. The idea that he thought negatively or positively about her threatened her with becoming whatever he thought of her. She felt that if she became involved with him she would be consumed with endless worries about how he perceived her. She had avoided all relationships because she feared becoming petrified into the object of the other. She restricted her relationships to the world of fantasy to assure that she could remain the subject in control of the other as object. (Seinfeld, 1991, p. 36)

Case 4

Following are some typical fantasies reported by schizoid patients. One patient recalled that as a young girl four or five years of age, she most enjoyed playing alone with her many dolls, with which she would construct elaborate and extensive fantasies of family life. These fantasies could go on for the entire day if she were uninterrupted, which was frequently the case. By that age, she also could read very well, and she began a lifetime habit of creating very small and safe places for herself, such as in a closet or under a desk, where she would curl up and read for hours. She would supplement her reading with fantasy. One fantasy was that of being Superwoman, a powerful woman whom no one could harm. Rather than focusing on themes of power or perfection, her focus was on the endless romances she would have with superman. Together they would fight the world of cruel injustices, their true identities known only to each other. (Klein, 1995, p. 66)

Healthy fantasy is a preparation for action in the outer world.
Schizoid fantasy means keeping in touch with internal objects while remaining largely withdrawn from real ones.

from Johnson, 1975

Figure 5.16. Distinguishing defensive fantasy.

- To make the self unreal
- To remain uncommitted and free
- To escape failure, mediocrity, frustration
- To rage, to engage in unchecked aggression or omnipotence
- To achieve independence

Laing, 1960

Figure 5.17. Some functions of schizoid fantasy.

(9) Schizoid Loss of Self & Its Distinctions

The schizoid experience cannot be understood without appreciating the experience of loss of self that occurs secondary to withdrawal. Often schizoid patients arrive at therapy suffering acutely from phenomenon related to loss of self, without being able to pinpoint or describe these experiences fully. Derealization, déjà vu experiences, and self-alienation are not symptom formations that have a home in descriptive diagnostic guidelines like the DSM. To the clinician in training, the markers of loss of self, or ego weakness, can be confused readily with phobic reactions or simple neurotic anxiety. While the loss of self accompanying schizoid states is not to be confused with the profoundly severe version of this experience endemic to psychotic states, it is a regular marker of the interpersonal relationships of these patients. Indeed, schizoid

patients may be so overtaken by anxiety in social and relational situations that depersonalization and derealization occurs.

To address these issues, this section briefly reviews these symptoms, including engulfment, implosion, depersonalization, derealization and déjà vu, petrification, and self-alienation. Many authors describe the experience of the schizoid loss of self, but none so well as R.D. Laing in *The Divided Self*, which the majority of this section is based upon. Psychotic anxieties, including concerns about bodily or psychic fragmentation or terror about the complete loss of subjective experience, are often reported by schizoid patients. This section examines the quality of loss of self, in particular, examining the experience of engulfment, implosion, depersonalization, derealization, self-alienation, petrification and diffuse tension states, and the all important concept of self-alienation.

- Depersonalization, Derealization & Déjà vu
- Petrification & Diffuse tension
- Engulfment
- Implosion
- Self-Alienation

Figure 5.18. The schizoid experience of loss of self.

Depersonalization, derealization, & déjà vu. The terms for depersonalization and derealization refer to much the same phenomenon, with one crucial difference; depersonalization is what the individual experiences in relationship to himself, while derealization is what he experiences in relationship to his environment. When derealization occurs as a result of regression, the world feels dreamlike, unreal, airy-fairy, and out of the ordinary. The senses do not seem to function as they would normally.

Mundane objects seem unfamiliar, lifeless, and surreal. Déjà vu experiences may occur in this state. In contrast, depersonalization is an extreme form of self-alienation, reflecting the subjective experience of being disembodied, directionless, aimless, neutral, quiet, and disoriented. It is a gross form of indifference to the self and to the other.

The following three cases illustrate the experience of depersonalization in schizoid patients:

Case 1

> I was about twelve, and had to walk to my father's shop through a large park, which was a long, dreary walk. I suppose, too, that I was rather scared. I didn't like it, especially when it was getting dark. I started to play a game to help to pass the time. You know how as a child you count the stones or stand on the crosses on the pavement - well, I hit on this way of passing the time. It struck me that if 1 stared long enough at the environment that I would blend with it and disappear just as if the place was empty and 1 had disappeared. It is as if you get yourself to feel you don't know who you are or where you are. To blend into the scenery so to speak. Then, you are scared of it because it begins to come on without encouragement. I would just be walking along and felt that I had blended with the landscape. Then I would get frightened and repeat my name over and over again to bring me back to life, so to speak. (Laing, 1960, p. 110)

Case 2

> At the twenty-eighth session she suddenly came out with the following: ‘When I’m upset I feel I’m not on the ground. I’m floating in space, not in touch with realities, my mind’s floating off miles away, not really there. I go off like that and have to have someone to reassure me and bring me back to reality. I have to keep very calm to cope with real life. As soon as there’s any pressure I panic, and float off and become quite unreal. I’m not in possession of my own person. I’m not there at all. If my husband’s in a hurry or a lot of people are talking, I panic and find I’m going off. (Guntrip, 1969, p. 228)

Case 3

> His attempt to save his ego from persecution by a flight inside to safety creates an even more serious danger of losing it in another way. This is the indispensable starting-point for the study of regression. It is illustrated with startling clarity in the dream of a University lecturer of a marked schizoid intellectual type. He reported 'I dreamed that I took off from the earth in a space ship. Floating around in empty space I at first thought it was marvelous. I thought 'There's not a single person here to interfere with me.' Then suddenly I panicked at the thought 'Suppose I can't get back.' (Guntrip, 1977, p. 162)

The depersonalized person is without subjectivity and without the experience of his body (Laing, 1960). He has becomes an android machine, so that no harm will come to himself or anyone else. Normal communication and interaction is greatly impaired by this process and give-and-take interactions can no longer take place. In many ways, depersonalization can feel pleasant and soothing for its absence of incoming stimuli from the rest of the body, though eventually, split-off material re-emerges, often in unrecognizable and frightening forms. Depersonalization is primarily a means of dealing with other people when they have become frightening, overstimulating or irritating (Klein, 1995). According to Laing (1960), depersonalization also functions to turn the other into a neutral it-like being, denying his existence and nullifying his significance and power to harm. A person without feelings cannot be reciprocal in interactions and can thusly still be acted upon.

Petrification & diffuse tension. Petrification in the schizoid reflects the experience of immense terror during interpersonal contact. It is to become so frightened that one is turned to stone, or becomes frozen, immobile, stationary, and locked in. Laing (1960) described this process as the equivalent of feigning death or becoming a possum as a means of staying alive. Because the schizoid patient struggles to tolerate anxiety in

the body, it is sometimes transformed into diffuse tension states instead (Kahn, 1974). Diffuse tension accompanying these anxieties is experienced often times as numbness in the body, of flatness, as if the body has been packed and pressed into a tiny space. Tension reflects a process of holding or gripping the body tightly to avoid flying to pieces.

> The following case illustrates the schizoid's deep states of fear and anxiety: By the next session (session 15), Mr. C. reported 'being afraid, being much more afraid, having deeper fears than I have ever experienced. It is like an endless reservoir of fears.' Briefly he wondered why he was so afraid, but he responded to his own question by stating that his reservoir of fear had filled over all the years of his life. It had been, he said, not one specific event that did it; it had filled day after day after day. I commented at this point that it had been my observation in life that often other people can play a role in helping to bail out a sinking ship or to drain an overflowing reservoir. I wondered aloud if there were not perhaps a better place between the prison of enslavement by capricious authority and the loneliness of the minefield. His response came from deep within the self-in exile: 'I'm afraid of myself. I'm afraid of living, afraid of growing. My fears are primal. It is like I have a reptilian brain and other people are malignant to me, malicious, capricious.' (Klein, 1995, p. 120)

Engulfment. When a loss of self occurs, the schizoid becomes estranged from his needs and feelings and is unable to be assertive, even in relatively harmless situations he fears that he is vulnerable to being controlled, appropriated, or taken over by another person. Laing (1960) describes the subjective experience of engulfment to being buried alive, being drowned, being caught in quicksand, losing one's self, being absorbed by another person, being placed under unsolicited obligation, enclosed, swallowed up, eaten up, suffocated, smothered, and stifled. No longer feeling real or autonomous, he is then faced with either withdrawing to re-establish his sovereignty.

Implosion. When loss of self occurs, the core of the schizoid's psychic structure is felt as emptiness, outwardly maintained and perpetuated by strong encapsulating

defenses. Unoccupied by the feelings of the individuals, the inner emptiness is experienced as a vacuum capable of sucking up the feelings of others as if it were a black hole (Laing, 1960). If implosion occurs, the experience of the other is pulled inside, impinging and invading his space like an alien presence. The schizoid then becomes frantic, trying to purge these feelings and regain a sense of himself.

Self-alienation. Self-alienation is the state of being a stranger to the self or to parts of the self as a result of disowning or distancing one's self from one's own feelings, needs, and behaviors. The schizoid often uses self-falsification to fit in with others in social situations (Eigen, 1973). It is isolation and dissociation of affect that leads to a deep loss of identity and individuality. "At an extreme, the capacity to visualize his own extinction and death as an objective, insignificant, and cosmic event gives a schizoid person the sense of security" (Johnson, 1975, p. 396). Self-alienation reflects the process of denying that events in the world, particularly in relationship to other people, have any meaning.

The following case material describes a severely self-alienated patient in her struggle to regain contact with her own psychic reality:

> One patient maintains that the worst fright she ever had was an experience which she thought occurred at the age of two years: 'I couldn't get hold of the idea that I was me. I lost the sense for a little while of being a separate entity. I was afraid to look at anything; and afraid to touch anything as if I didn't register touch. I couldn't believe I was doing things except mechanically. I saw everything in an unrealistic way. Everything seemed highly dangerous. I was terrified while it lasted. All my life since I've been saying to myself at intervals "I am me." (Guntrip, 1969, p. 44)

(10) Loss of Affect

With its one-sided focus on the schizoid's anhedonia and blunted affect, the descriptive psychology tradition paints the portrait of a person completely unfamiliar with anger, affection, joy, or sadness. Yet, it is not that schizoid personalities are without feelings, but rather that feelings are usually channeled inward and played out within an emotionally charged fantasy life rather than being expressed outwardly. The schizoid is all too familiar with the feeling of overwhelming terror that he will fall apart, become unglued, exposed, or annihilated if his feelings were to surface. He knows what it is to experience intense hopelessness, powerless, and vulnerability interacting with others in the world. Living a life without companions, he often feels needy, deprived, unloved, and lonely. In social situations, unable to make meaningful contact, he feels rejected, unwanted, and even hated.

While it's true that the schizoid can become grossly out of touch with his feelings during periods of depersonalization, these episodes are often discrete and activated specifically when there are underlying feelings that are too painful to acknowledge. Only in the more severe schizoid patients does the experience of being without feelings become persistent and chronic, and in these cases, the outer limits of treatability are often tested. Still, for most schizoid people, the smallest surge of emotion feels like a bomb going off (Doidge, 2001). Fearful that any feeling can quickly become overwhelming, the schizoid denies and isolates all his feelings so that this does not occur. The coldness he experiences is directly related to the fear of his own personality. Without being able to

get support when he needs it, the schizoid must minimize his feelings as much as he can so he does not feel overwhelmed. It is a matter of practicality.

The following case materials illustrate the schizoid's loss off affect:

Case 1

> He went on to describe how, over the ensuing years, he had increasingly experienced periods of having no feelings. He stated that he had countless 'exits out of getting in touch with my feelings.' And, he added, he thought that he would rather be a person who had feelings than one who had none. He then paused, and remarked that at the moment, he was feeling totally overwhelmed with anxiety about his fiancée and the marriage. He stated, 'I'll be trapped by the permanence of it, and it terrifies me again.' I intervened, 'I suspect that getting in touch with your feelings pushes you out of the hiding place in your head, and potentially into thoughts about your fiancée and being with her. But being with somebody while feeling such itense need has never been a safe place to be.' (Klein, 1995, p. 110-111)

Case 2

> An example of a patient describing herself as depressed when she was really schizoid may be useful at this point. She opened the session by saying: 'I am very depressed. I've been just sitting and couldn't get out of the chair. There seemed no purpose anywhere, the future blank. I'm very bored and want a big change. I feel hopeless, resigned, no way out, stuck. I'm wondering how I can manage somehow just to get around and put up with it.' (Analyst: 'Your solution is to damp everything down, don't feel anything, give up all real relationship to people on an emotional level, and just "do things" in a mechanical way, be a robot.') Her reaction brought out clearly the schizoid trait: 'Yes, I felt I didn't care, didn't register anything. Then I felt alarmed, felt this was dangerous. If I hadn't made myself do something I'd have just sat, not bothered, not interested.' (Analyst: 'That's your reaction in analysis to me: don't be influenced, don't be moved, don't be lured into reacting to me.') Her reply was: 'If I were moved at all, I'd feel very annoyed with you. I hate and detest you for making me feel like this. The more I'm inclined to be drawn towards you, the more I feel a fool, undermined.'
>
> The mere fact of the analyst's presence as another human being with whom she needed to be emotionally real, i.e. express what she was actually feeling, created an emotional crisis in her with which she could only deal by *abolishing the relationship*. So her major defense against her anxieties was to keep herself emotionally out of reach, inaccessible, and

> keep everyone at arm's length. She once said: 'I'd rather hate you than love you', but this goes even further. She will neither love nor hate, she won't feel anything at all, and outwardly in sessions often appeared lazy, bored at coming, and with a *laissez faire* attitude. (Guntrip, 1969, p. 18-19)

The schizoid personality inhibits the discharge of feelings with relative ease, though the person is only partially aware of this process. Unfortunately, while the schizoid is able to create inner distance between his feelings and his ego functions when need be, he is relatively limited in his ability to otherwise bind feeling states to ego functions in a way that would allow for their cathexes interpersonally or internally (Kahn, 1974). Rather than experiencing sadness at the effectual loss of ability to relate with others, the schizoid feels indifferent. He similarly finds little or no pleasure, satisfaction, or enjoyment in life's activities and has difficulty allowing himself to experience strong pleasurable emotions such as excitement, joy, and pride (Shedler & Westen, 2004). In sum, both positive and negative feelings are restricted in this process.

The primary reason for loss of affect observed in schizoid patients is their inability to invest emotion in others (Guntrip, 1969). Because the schizoid is fearful that his love and need will destroy any relationship he enters, he has no choice other than to love and take care of himself, and must therefore save every bit of his energy to remain self-sufficient, self-contained, and self-reliant (Guntrip, 1969; Klein, 1995). Subsequently, he will not allow himself to waste his energy empathizing or connecting with others when this process offers him nothing in return. Feelings are something to precious to be lost. If he does express feelings to others, he defends against the loss of his feelings by pretending that the loss was worthless and meaningless, then loses interest (Fairbairn, 1940). Without being able to be dependent on others, the schizoid seemingly becomes uncaring, unconcerned for the events and people in his world. Yet, at a deeper

level, the schizoid deeply desires emotional connection with others, but fears that establishing any emotional bond with others elevates the chances that engulfment and subsequent activation of master/slave relationships will occur (Klein, 1995). In the grand scheme of things, the schizoid is actually not cold and uncaring, but rather limits emotional involvement so as to preserve personal space and avoid symbiosis (McWilliams, 2004). Relationships are simply a luxury he cannot afford.

Another reason for the schizoid's difficulty in making himself emotionally accessible is that he is has become fearful and jaded in the wake of cumulative trauma, rejection and neglect by caregivers (Kahn, 1963). Rather than reflecting a frank numbness, the schizoid's lack of feeling reflects a striking uncertainty and confusion about how to respond to others without endangering himself (Klein, 1995). Withdrawal, his main defense against a world that is uncaring and impinging, removes libido from all external objects to avoid impingement or engulfment by others. Often there is a fear of being exposed to criticism or rejection that leads directly to the isolation of affect. Lingering conflicts around separation-individuation make the expression of anger intolerable, while conflicts around dependency make the expression of happiness, enthusiasm, and love into a repulsive experience.

Often, those who interact with the schizoid come away with the impression that the schizoid is callous, cynical, unempathic, and cruel. In fact, they are really witnessing the misanthropic relationship he has with himself, for the schizoid's objectification of his needs and feelings leads him to objectify others in the same way (Klein, 1995). Part of the 'strangeness' attributed to less healthy schizoid patients is also due to the fact that they are so estranged from feeling as to no longer be in a position to understand or

empathize with the experience of others. At the same time, the schizoid unconsciously hates and envies those who have potency, warmth, and abundance in their lives (Laing, 1960), unaware that their disdain, indifference, and disgust for others is a symptom of their own loneliness and lack of meaning.

In seeking to eliminate his feelings, the schizoid is actively cultivating death within life. Uninvolved with their emotions, robot-like, and objective, the schizoid loses many of his human attributes and begins to feel cold, dry, dead, impotent, empty, worthless, and desolated (Laing, 1960). Yet ironically, it is the experience of feeling dead that reveals the schizoid's underlying humanity. As Giovacchini (1979) notes:

> The poverty of affect causes these patients to resemble living vegetables, which, unfortunately, do exist. They are alive and go through the motions of living. They may seem devoid of feelings, but they are unmistakable alive. They are not patients who feel and act as if they were dead. On the contrary, to feel dead means that some part of the self, no matter how poorly conceived, must know something about being alive. Inasmuch as there is some feeling of aliveness, no matter how deeply it may be submerged, there is some hope. The patients I am discussing are alive but know nothing about either aliveness or deadness. They find it difficult to sustain hope. (p. 86)

It is important to remember that however restricted they may outwardly appear, most schizoids are highly sensitive and show a heightened awareness to their own feelings. "Possibly because they are undefended against the nuances of their own more primal thoughts, feelings, and impulses, schizoid individuals can be remarkably attuned to unconscious processes in others. What is obvious to them is often invisible to less schizoid people" (McWilliams, 2006, p. 13). Many schizoid individuals seek careers in psychology and other helping professions for this very reason. Their powers of emotional observation are of great utility in these settings and do simultaneously require the schizoid to reveal their own feelings and needs to others. Most schizoids have a deep

longing to have their feelings and observations known and understood as well, but often feel that this process is just too painful to bear.

- Defensive withdrawal removes affect from objects in the outside world
- Emotion is invested only in the self rather than in the process of empathizing or connecting with others
- Trauma and neglect have created uncertainty and confusion about how to respond to others

Figure 5.19. Main causes for visible loss of affect.

(11) Language, Communication, & Creativity

Verbal communication. Guntrip (1969) noted the autistic qualities of the schizoid's thinking and communication. Given their difficulty with expressing feelings, schizoid communication is often highly concrete, stilted, and lacking in affect. Schizoids tend to become focused on abstract situations rather than specific feelings and desires. These communication difficulties tend to worsen during periods of stress or withdrawal resulting in circumstantial speech and rambling (Shedler & Westen, 2004). In treatment, these patients often demonstrate a lack of basic verbal responsiveness to the therapist's remarks, show poor rapport, indifference or lack of interest in the therapist's communication, the absence of spontaneous speech, or outright detachment (Kosson et al., 2008). For whatever similarities schizoid communication may have to autism, any comparison to these states is not diagnostic. In fact, autistic pockets can be found even in healthier neurotic patients (Tustin, 1986).

Akhtar (1987) notes that the schizoid's cognitive style outwardly appears to be absent-minded, engrossed in fantasy, using vague and stilted speech and alternating

between eloquence and inarticulateness. At a deeper level, he is inwardly given to autistic thinking, fluctuations between sharp contact with external reality and hyperreflectiveness about the self, and autocentric use of language (Akhtar, 1987). Tendency to use concrete thinking is a defense against various repressed emotions (i.e. tendency to project feelings into the nonhuman world and talk about them in that way; talking about a collapsing building to refer to a self state; Seinfeld, 1991). As Laing (1960) described, a good deal of schizoid communication can be nonsense, a red-herring, or filibustering to throw people off the scent of their empty inner core and to make the therapist feel futile or disengaged.

Though interpersonally they may seem that they have nothing to say much of the time, often what is really happening is that the schizoid does not want to talk about topics that have the potential to be uncomfortable or cause conflict. If the schizoid communicates feelings, he makes himself real, uncomfortably exposed, and vulnerable to attack. To be comprehended in the emotional sense by another person is analogous to the concept of being physically grasped and squeezed (Laing, 1960). To offer up his feelings seems like stepping uncomfortably close to another person. The schizoid wonders what will be safe to talk about without leaving his own boundaries open to invasion, and without provoking a negative response from the other person. Duryee (1996) beautifully describes the thought process of the schizoid when he is attempting to communicate with another:

> For schizoid patients, to speak at all is an anxiety-ridden enterprise if only because to speak establishes contact. Silence therefore reflects verbally what their behavioral withdrawal reflects interpersonally. However, not speaking, while thus protective in a sense, is also anxiety provoking because it does not meet the analyst's explicit instructions and implicit wish to hear. Thus schizoid patients, when silent, are anxious lest they

> disappoint the analyst/parent, or appear dysfunctional or defective. When they talk on the other hand, their anxiety around contact safety is activated: What is safe to express? What might harm my listener? What might prompt him or her to want to harm me? Or to bond him or herself to me suffocatingly? Or to invade my self-boundaries and annihilate me with retaliation for the hostility I have projected into him or her? (p. 107)

Schizoid patients often relate more to the subject they are talking about than to the object they are sharing their thoughts, making them seem egocentric and eccentric to the listener. Schizoid communication often reflects a fixation on their own private logic or unusual spheres of intellectual or metaphysical interests (Guntrip, 1969). McWilliams (2006) notes, "In contrast to obsessional patients, who avoid emotion by intellectualizing, schizoid patients may find it possible to express affect once they have the intellectual vehicle in which to do so. Because of this transitional function, the art therapies have long been seen as particularly suited to this population" (p. 19).

Fairbairn (1940) notes that the schizoid sometimes shows narcissistic over-valuation of the contents of his mind and fantasy life. To share internal objects feels to the schizoid like the internal objects are being lost or given away. Possession of the mind's contents makes the schizoid feel special and unique, revealing how important and dependent the schizoid is on these internal objects. As an extension of these dynamics many high-functioning schizoids tend to possess knowledge of the unique, the rarefied, the undiscovered (Rufus, 2003), while in schizotypal patients, superstitious or magical beliefs as well as idiosyncratic reasoning or perceptual processes predominate.

The following case materials illustrates the schizoid's fear of communication:

Case 1

> Thus, after weeks or even months of refusing to speak of her intimate feelings a patient said: 'You don't understand. If I speak to you I hit you, I poison you with the rotting and mouldy things which I am full of.' She

> had previously simulated a suicide attempt in order to get stomach washed out, to clean out some of these contents. Another patient said: 'When you speak to me and ask me questions you bite me and tear out a piece of my flesh. I won't speak any more, I won't listen.' (Rey, 1979, p. 452)

Case 2

> He acknowledged this interpretation and elaborated, 'It's times like this that I feel I have to get away. So I go inside myself.' He paused at that point, and wondered aloud what he should do. 'should I feel? Should I commit myself.? And if so, how? I'm trying to stay in touch a little longer with these feelings.' He paused, and suddenly remembered an incident that had happened when he was 12 years old, He had been trying to convince his parents to get him a telephone for his room. Although he did not have many friends or plan to use the phone extensively, he remembered wishing very much to have one as a connection between himself and the world beyond his home. With sadness he reported that when his birthday arrived, his parents had actually bought him a phone, but the cruel irony was that it was an antique decorative telephone that was one for display and did not work. It was, in other words, a phone that connected to no one and over which communication was impossible. The session was over. (Klein, 1995, p. 111)

Nonverbal communication. Noting the schizoid's non-verbal communications is essential given that he does not often express his feelings verbally. Non-verbally, the schizoid is known for constricted facial affect, lack of variability in emotional display, lack of interpersonal synchrony, and physical anergia (Kosson et al., 2008). Poor personal hygiene may also be present, an indicator of the schizoid's lack of concern about his needs, and also a reflection of his lack of engagement with the outer world. Often, doing therapy with these patients there is an air of unreality, as if the individual is split off and out of touch with his feelings. Lack of facial expression, closed body language, guardedness, or complete lack of nonverbal expression is often seen (Kosson et al., 2008). Given these deficits, it is not reasonable, particularly with primitive schizoid states to expect the schizoid to use language to describe his feelings. As Giovacchini (1979)

explains, "To force our language, in this case our adult modes of comprehension and communication, onto the patient, will lead to irritating confusion and often enough feelings of helpless impotence and despair if we insist that our style must prevail" (p. 120).

Imagination & creative output. The most captivating ability of the schizoid is his creativity and imagination, though these traits are usually present only in healthier individuals. A huge number of artists, writers, philosophers, musicians, and scientists have strong schizoid traits. Schizoid individuals often seem by nature to be deeply curious about the world and committed to being innovative, original, and unique. The non-conforming attitude of these individuals frees them from convention to move in directions other personalities would not dare to venture. Standing apart from others gives the schizoid a unique vantage point in the world that sometimes finds a voice through creative mediums. While it does not seem to be true that greater inner conflict produces greater creative ability in schizoid patients, creativity output and imagination are the most commonly cited argument against the pathologizing of schizoid states.

The schizoid's highly charged fantasy life is fertile ground for artistic inspiration. While Freud believed that fantasy was escapist, reflecting a denial of reality common to childhood play, fantasy can be used to find new ways of solving problems and of bridging the gap between the inner world and the outer world (Freud, 1908). The schizoid's identification with inner objects is also a source of creative adaptation. Because the schizoid did not have consistent parental figures, he identifies with inner idealized parental objects instead (Kahn, 1974). Raised by his own inner parents, the schizoid is able to shape himself into whatever he would like to be. Though this

adaptation gives rise to omnipotent self representations, it is also a source of great creativity, given that the schizoid only feels partly bound to external reality. As Storr (1988) notes, "The capacity to create provides an irreplaceable opportunity for personal development in isolation" (p. 154).

Creative capacities can thereby be used to compensate for the loss of relationships, or to express, channel, or exercise control over emotion (Storr, 1988). The libidinal investment in music, medicine, metaphysical interests, or even more eccentric hobbies speaks to the enormous energy and passion that would otherwise be invested into relationship. Creative activities, which also become a primary means of communicating private feelings, provide soothing self-object functions and can be an important source of self-esteem to schizoid patients (Weeks, 1995). Unlike narcissistic types, the schizoid often keeps his creative products private to avoid unwelcome attention or the feeling that one's private thoughts and feelings are being appropriated by the public (Rufus, 2003).

To the creative schizoid, his art will often come before his relationships. The schizoid with creative talents often fears that a relationship will destroy his imaginative drive and creative output. There is often a deep fear that accompanies this prospect, as it evokes the loss of the idealized internal parents. In these individuals, the secondary gain of creative output creates a pseudo-barrier to improvement in other areas. Creativity is largely a solitary pursuit, but it does not prohibit having relationships in the schizoid's life. Learning to negotiate personal space in relationships for creative schizoids goes a long way to allay fear that creative capacities will somehow disappear.

The following case materials illustrates how the creative abilities of the schizoid stem from his rich fantasy life:

Case 1

The content of his creative writing revealed the schizoid quality of his inner life. He described the family history as if they were living through the adventures of a Marx Brothers comedy and always coming out on top despite the formidable problems they encountered. The stories suggested that the family was comprised of ineffectual and silly, but well-meaning persons and he was the all-conquering hero who kept everyone afloat. There was certainly much truth to this description but it was also an idealization in that he greatly exaggerated his capacity to keep himself and the family afloat and also neglected to describe many instances in which the behavior of the adults may have been described as less than well-meaning. The adventures were written in a hysterically funny way, but also neglected to describe many of the painful incidents in his life in which he was deprived of food, lived in circumstances in which he was realistically endangered, and experienced severe neglect and abuse. The stories of his family closely resembled his long-ago play with cockroaches in which he would imprison them or set them free 'for their own good.' The fact that he pretended that the cockroaches were criminals reflected his rage at the parental objects for their not taking adequate care of him and his unconscious view of them as bad objects. His creative writing therefore reflected a manic defense in which he fantasized having omnipotent control over an ideal internal family. In this way, he defended against the pain and rage over the severe deprivation and chaos of his actual family life and personal history. (Seinfeld, 1991, p. 44-45)

Case 2

In his own writings, Roger concentrated upon the complexities of relationships. The characters lived in his mind more fully and vitally than any of his relationships in reality. It was as if they lived out the story and he was more of a witness and transcriber than the author of events. He felt that he lived vicariously through the adventures of the characters of his books. When they came together in love, their union warmed his being. When one misunderstood the other, he felt the frustration and the wish for clarification. When one was abandoned, he himself experienced the sense of rejection. He might be engaged in an activity and not thinking of his writing when a character would intrude on his thoughts and continue the story. Roger had always lived in his mind, absorbed in a rich fantasy life. In his relations to outer reality, he was an astute observer but not an active participant. He was especially interested in observing the subtleties and complexities of relationships, which then served to further stimulate his fantasy life. (Seinfeld, 1991, p. 47-48)

(12) Passivity

In schizoid patients, chronic passivity often creates therapeutic stagnation, limiting the process of working-through substantially. As Guntrip (1969) noted, passivity is the defining factor of the schizoid's regressed ego, which is constantly in flight from the objects of the world, withdrawing all libidinal investment in the outside world and leaving the schizoid libidinally uninvolved with his outer life. The active portion of the patient's life occurs inwardly in fantasy, reverie, and dreams, while in his real life no action occurs. The schizoid maintains such a passive relationship to his feelings as a means of both defusing his destructive urges and hiding the conflicted and contradictory nature of being human (Kahn, 1974).

It is essential for the clinician working with the schizoid personality to understand the intrapsychic pressures creating passivity and inertia so that this tendency does not impact the patient's progress in the work. The concept of passivity in psychodynamic theory broadly refers to the process of having something done to the self rather than being the agent of doing (Davis, 1993). The passive self is characterized by contemplation, pause, and gestation in preparation for meaningful action. Passivity is most often used to describe the natural characteristics of the feminine principle, but is more usefully understood clinically in the context of describing the experience of (a) being acted upon, victimized or traumatized by others, or (b) as roughly equivalent or descriptive of masochism and exhibitionism (Davis, 1993).

The schizoid's passivity is the well-engrained marker of his defensive inhibition against spontaneous reactions and impulses, and the foundation onto which the calculated constructions of his false self are laid (Weiss, 1966). The schizoid inhibits the discharge

of his feelings by creating inner distance from his feelings using his ego functions and uses this passivity to neutralize libidinal and aggressive urges alike. Self-alienated and uninvolved with feelings, psychic inertia results. The schizoid's difficulty harnessing his aggressive urges is one of the main factors in maintaining his meek, pleasant, and compliant self (Kahn, 1974). Because the schizoid cannot and will not harness his need and feelings outwardly in the world, he becomes helpless to have an effect on his environment, and can only be assertive in fantasy.

Johnson (1975) spoke to many of the dynamics underlying the schizoid's inertia, lack of spontaneity, and uncertainty in acting and thinking. Johnson notes that ambivalence and hesitation in performance destroys the normal impulse-tension that would otherwise allow for the discharge of affect. Because the schizoid fears how others will react to his needs, he is unable to use his needs to create directionality in the world. Johnson also explains that compulsive introspection creates unreasonable efforts at self-control. The omnipotent fantasies the patient enjoys in his fantasy life can undermine his own normal realistic self-presentations, which may feel embarrassingly boring or insubstantial by comparison. The schizoid notes the contradictory, irrational and inconsistent nature of his inner world and seeks to take charge of the situation to create continuity. Johnson (1975) explores these dynamics in depth:

> Authentic, spontaneous communion is antithetical and threatening to the security operations of the alienated person. Security resides in the schizoid person's capacity to conceptualize himself as just another social object—a mechanism, a thing. (p. 395)
>
> Like sincerity, spontaneity appears to be a meaningless word, since the schizoid person is so wretchedly aware of the mechanisms underlying his specific actions. It is therefore inconceivable to him that interaction could ever be construed as spontaneous, always acting instead as an automaton. (p. 388)

> The spontaneous expression of impulses is threatening insofar as the meaning connected with this behavior cannot be modulated and may therefore expose the person to feelings which he cannot manage. (p. 398)
>
> The severely schizoid person operates as the technician busy twirling dials and pulling levers behind the public screen of his social performances. He supposes that the insubstantiality of his own performance might be glimpsed by others if he were to act more casually. Spontaneity, therefore, would allow the outsider to look in on his disheveled apparatus and see the frenzy, the disguise, and, worst of all, the "badness" and the loneliness which are his hallmarks. (p. 398)

The schizoid's masochistic tendencies are also related to his passivity. In relationships, the schizoid's symbiotic strivings and marked reactivity to needs and feelings of others, coupled with his own non-involvement and alienation from his own desires, feelings and needs create sado-mashochistic relationships (Klein, 1995). Frightened by how others will respond to his needs, the schizoid eliminates his own needs to solve the problem, moving to satisfy the needs of others instead (Johnson, 1975).

Seinfeld (1991) describes how one schizoid patient learned to become quiet, compliant, and passive in relationship to her mother:

> Her mother was forced to work full-time and felt it was too much, given her emotional fragility. The mother was also overburdened in trying to meet the excessive neediness of her infantile husband. Annette's mother would come home exhausted and collapse upon the bed. Annette felt that she could not ask for anything emotional from her. The mother's message was to 'be quiet and be perfect because I am dead tired.' Annette tried to cooperate. In turn, the mother could love her for leaving her alone. The mother would always say, 'She is a wonderful child, she leaves me alone.' Thus, Annette learned that she would not be abandoned if she was inert. The mother mirrored her for being compliant. If she needed anything, the mother gave her food. The giving of things was nor out of love, but just to placate her. At other times, when the mother felt depressed, Annette would lift the mother's spirits by becoming lively and gay. Annette's liveliness was never for herself, only for the object. The problem became that to be a quiet person was equivalent to being dead. As an infant, she felt her mother was 'dead tired.' Thus, she identified with her mother in her deadness. (p. 157-158)

- Failure to harness aggression
- Non-involvement and alienation from feelings and need
- Masochistic object relationships
- Overwhelming fears about the consequence of action (i.e. rejection)
- The anti-libidinal ego or superego blocks discharge of impulses
- Withdraw of libido from the outer world
- Overwhelming fears about transparency and exposure during authentic activity
- Compulsive introspection, unreasonable efforts at self-control

Figure 5.20. Forces creating schizoid passivity.

Part II

Treatment

Chapter 6 - Specific Challenges With Schizoid Populations

Resistance

The schizoid's resistance to participate meaningfully in his own therapy is amongst the greatest challenges facing the clinician. In particular, the patient has a well-earned reputation both for resisting sustained involvement in treatment over time, as well as for resisting increased emotional contact within the session (Duryee, 1996). Handling schizoid resistance requires a measured approach that protects the patient's sense of autonomy even as it encourages greater intimacy with the therapist. This section explores the most common manifestations of resistance in schizoid patients. In particular, (a) the resistance to sustained contact with the therapist over time, (b) the resistance to enhanced emotional contact in sessions, (c) the refusal to fully accept or reject the therapist, and (d) the idealization or defensive use of secondary gains of the schizoid condition are explored. Suggestions for how to work with schizoid resistance without unduly exceeding what the patient can handle are presented in the hopes of helping the clinician reduce the chances that the patient will to drop out prematurely.

Common forms of schizoid resistance. What the schizoid patients fears most, driving his intense resistance to remain in treatment, is the possibility of a regression to primitive states of dependency on the therapist (Khan, 1974). Allowing closeness to another person, including the therapist, creates internal conflict within the patient that is difficult to manage. For the schizoid to become dependent on another person means to undo the inversion he has made between his infantile, needy, dependent self and the pseudo-adult image he has adopted instead (Seinfeld, 1991). The very idea of this dependency is enough to instill a feeling of unimaginable dread, disgust, revulsion, and

danger so powerful that it drives the schizoid to resist any relationship in which this scenario may occur. These dynamics so grossly impede the schizoid's ability to express needs in treatment that the therapeutic process is often shut down before it has a chance to begin.

The following case material illustrating a schizoid patient's strong resistance to becoming dependent on her therapist, reflecting underlying anti-libidinal splitting:

> One patient expressed a serious degree of ego weakness followed by equally virulent self-rejection, thus: 'I feel inferior, I'm not sure of my identity, I've made a mess of life, I'm feeble, poor, and don't feel worth anything. Away from mother it all feels messy inside me, not solid, like a jellyfish. I'm nothing definite and substantial, only frightened, waffling, and clinging to anything for safety, it's an indescribable feeling.' 'Then she went on: 'I hate myself I wish I wasn't me, I'd like to get rid of myself.' Here is her self-rejection, her antilibidinal concentration on running herself down, but on another occasion her antilibidinal reaction turns to rob her of my help. She said: 'I felt very small all this week and dependent on you. Then I felt I ought to be more independent of you and stop coming to you. Mother thinks I ought to be able to do without treatment now. I feel guilty about it, but I'm not strong enough yet not to have your support.' Often the antilibidinal reaction against the analyst is more serious. One patient, at a time of great strain over an event which greatly disturbed her, oscillated between an intensified need for my help and, on one occasion, an outburst, motivated by very serious fear of her panicky feelings of weakness, in which she said with great tension: 'You want me to come creeping and crawling to you, but I'll show you.' (Guntrip, 1969, p. 197)

The most hindering form of resistance is the schizoid's reluctance to participate in therapy for a period of time long enough to form a stable relationship (Guntrip, 1969). Given his lack of comfort with interpersonal connection, and desiring to remain ever free and independent, the schizoid may skip treatment or fail to show up regularly, show up late, or terminate treatment without warning. The patient is quick to rebel against efforts by the therapist to point out the importance of regular attendance. As such, while the

therapist does not alter the frame for the patient (i.e. allowing extra time, not charging for missed sessions), unfavorable outcomes can result from trying to push through this form of resistance by contracting or otherwise pressuring consistent attendance.

A second form of resistance in the treatment of schizoid personality is the reluctance to engage with the therapist on an emotional level. The patient is unlikely to acknowledge or express anger, longing, or loneliness, despite overwhelming evidence for these things in his dreams, behavior, and fantasy life (Guntrip, 1969). He will struggle to admit his need for help, and is likely to reject or repudiate all references to a transferential relationship to the therapist. Rather than using the session to discuss emotional material, the schizoid fills the space with communications that are often intended to throw the therapist off the hunt for emotional themes, filling the space by talking about things he already understands, or discussing trivial topics in stead (Laing, 1960). The patient seeks to create an emotionally neutral relationship with the therapist to stave off his fears of engulfment and will try to get the therapist to agree to work within a controlled and limited emotional experience (Kahn, 1970). Often the patient will come in without material to discuss and will not know how to make good use of the time (Guntrip, 1969).

The schizoid patient, unable to express his own needs in the session, often moves to take care of the therapist's needs instead. Because this experience can feel like being forced into a symbiotic relationship with the therapist, the schizoid wishes for an emotionally dead relationship so that this scenario can be avoided (Seinfeld, 1991). The following case material describes how a schizoid patient perceives the threat of a

symbiotic, sadomasochistic relationship with his therapist, increasing his resistance to enhance contact:

> One patient says: 'I felt I must get possession of something of yours. I thought I'd come early and enjoy your arm chair and read your books in the waiting room.' But then she switches over to: 'You can't possibly want to let me take up your time week after week.' Fear and anxiety then dictate a reversal of the original relationship. The patient must now be passive and begins to see the analyst as the active devourer. He drains the patient of resources by charging fees, he wants to dominate and subjugate the patient, he will rob him of his personality. A patient, after a long silence, says: 'I'm thinking I must be careful, you're going to get something out of me.' The analyst will absorb or rob the patient. (Guntrip, 1969, p. 33)

Another common form of schizoid resistance is their tendency to try to systematically and methodically apply insight to their lives (Seinfeld, 1991). The patient effectively becomes a part-time psychologist, or a laboratory scientist rather than leaning on his therapist. This phenomenon, based on strong intellectualized defenses, reflects their ongoing desire to remain separate from their emotional experience while feigning involvement. As Johnson (1975) notes, "The exquisitely schizoid person becomes, as it were, an amateur sociologist studying his own operations. He looks on himself as a collection of roles rather than a self. He is able to expound on the nature of his perceptions, integrations, and reactions" (Johnson, 1975, p. 388).

Resistance to the resolution of the transference (Gill, 1979) is another important theme with schizoid patients. Fearing his own weakness and seeking to avoid the possibility of being impinged upon or engulfed by the therapist, the schizoid oscillates in and out of the therapeutic relationship (Guntrip, 1969). This oscillation precludes the possibility that his negative transference can be resolved in treatment and a new emotional experience with the therapist can occur. The patient fears the relationship he needs to heal. Caught between a longing for closeness and a need to avoid closeness, the

patient creates a therapeutic standoff with the therapist, or in the worst case, a deadlock or an end to the therapy (Guntrip, 1969).

As Appel (1974) notes, this predicament can lead to an ambivalent relationship to the therapist in which the patient is reluctant to utilize the relationship:

> Detachment, intellectualization, withdrawal, emotional splitting, and schizoid compromise—all defend against the ego disintegration the schizoid fears as a result of persecution, abandonment, or impingement. He must take nothing in lest hunger be reactivated or his ego overwhelmed —ideas, food, relationships—all carry the threat and must be expelled. From these fears derive the negativism, stubbornness, and reluctance of the schizoid to love. Since he equates love with fusion, control, and persecution, the schizoid must hate what he loves—the classic ambivalent position. (p. 102)

Refusal to give up secondary gains. Gains from psychiatric illness are conceptually divided into 'primary gains' (e.g. the resolution of intrapsychic conflict), and 'secondary gains' (e.g. the rewards that follow from a primary gain that fortify the primary gain), both of which can create serious resistance to treatment (Thompson & Cotlove, 2005). While reclusive and avoidant behaviors help the schizoid resolve his interpersonal fears and conflicts (primary gains), secondary gains from the disorder include the experience of freedom from societal restrictions, pleasurable feelings of being above critique, praise or social comparison, and unrestricted time for productivity and creativity. Often the schizoid holds on to his freedom passionately, as if he was a revolutionary striking back against some repressive government (Guntrip, 1969).

For high-functioning schizoid individuals who gravitate toward careers in research, unlimited time spent alone pursuing intellectual interests and nurturing a variety of private hobbies can feel like a privilege that is too good to be given up. Instead of adopting social conventions and rules, the schizoid often prefers to celebrate his

difference from others instead, doing things according to personal preference (Weeks, 1995). Often overlooking his apathy, loneliness, and anxiety, the schizoid is often left wondering if relationships are really worth giving up what he sees as the richness of a life lived in solitude. It is important that the therapist not downplay the importance of solitude, but rather to illustrate how the schizoid rigidly idealizes these behaviors while dismissing the possibility that he may also find enjoyment in relationships as well. The patient needs to know that his private life does not disappear simply because he enters a relationships. Learning to inject the rich experience of his fantasy life into relationships goes a long way to allay these fears.

- Resistance to sustained treatment involvement over time (i.e. not maintaining regular sessions; excessive lateness; early dropout)
- Resistance to enhanced emotional contact within treatment (i.e. refusing to ask for help or admit to needs; refusing to discuss fantasies or feelings; unwillingness to acknowledge anger; filibustering in session to avoid discussing underlying emptiness or fear)
- Refusal to fully accept or reject the therapist (i.e. maintaining the schizoid compromise (resisting the resolution of the transference); maintaining a negative or rejecting attitude toward therapist)
- Refusal to give up secondary gains (i.e. idealization of the freedom of fantasy over the limitations of the 'real world;' unrealistic concerns about the loss of productivity or creativity)

Figure 6.1. Typical forms of schizoid resistance.

Approaching schizoid resistance. The biggest risk in trying to overcome resistance is overtaxing the schizoid's most basic defense, that of withdrawal—a defense that the schizoid individual has in part relinquished in agreeing to come to therapy in the first place (Druyee, 1996). Pushing the schizoid patient too quickly, abruptly, or intensely toengage with the therapist can lead to negative therapeutic outcomes and, in some cases,

to termination. The therapist should express the expectation for engagement in therapy, while allowing the patient to determine the intensity to which he will participate (Druyee, 1996). For example, the therapist will schedule weekly sessions with the patient with the understanding that the patient will be there and will be financially responsible for paying for his sessions, while at the same time allowing the patient to miss sessions if he feels the sessions have become too intense (Duryee, 1996). If the schizoid uses withdrawal or silence in the session as a means of moderating intensity, this too should be allowed by the therapist, and interpreted as an effort to preserve autonomy. Efforts to moderate treatment intensity should be discussed in the context of the schizoid's need for distance and his fear of being suffocated, intruded upon, or enslaved by the therapist (Duryee, 1996). As with all interpretations with these patients, the therapist should be mindful that observations and interpretations may lead to feelings of being over-exposed, or shamed, so the therapist should take care to be direct, but supportive in these instances.

The therapist should expect a negativistic, rejecting, or ambivalent attitude from the patient as resistance intensifies, a projection of his feelings for early caregivers (Seinfeld, 1991). Rather than suggesting the patient reject or accept the therapist, it may be best to simply point out the patient's ambivalence and note this as a key obstacle to his improvement in therapy. It is important that the therapist *gently* confront this stalemate in the patient so that a successful working-through may eventually occur (Guntrip, 1969). Self-monitoring by the therapist is crucial at these times to avoid passive aggressive acting out in response to this resistance.

- Don’t overtax the patient's most basic resistance to a sustained relationship to others
- The idea is to communicate the expectation of serious involvement while affording the patient the major voice in determining its intensity
- Flexibility is the key ingredient for helping the schizoid preserve his autonomy in therapy, particularly around attendance and use of silence
- Be mindful that frank observations or interpretations around resistance may be felt as highlighting the presence of excruciatingly exposed, or shameful aspects of the self

cited from Druyee, 1996

Figure 6.2. Optimal frustration of schizoid resistance.

Defense Mechanisms & Defensive Themes

This section reviews the most common defense mechanisms and defensive themes in schizoid patients. First, borderline-level defenses are reviewed and their primary uses in schizoid patients are explored. Next, the signature defenses of this population are discussed, as are common defensive themes and patterns, defensive uses of solitude, the use of thoughts as defense, and infrequently observed defenses.

Borderline level defenses. For the most part, schizoid patients rely on primitive borderline defenses over neurotic or mature defenses (Giovacchini, 1979). Patients who rely on primitive defenses often have difficulty with reality testing and show impaired ability to interact in the world. These defenses, as listed in Figure 6.3 below, include splitting, extreme projection, primitive denial, devaluation and idealization, projective identification, and omnipotent control (Clarkin et al., 2006). In general, however, the most common of these observed in schizoid patients are splitting, denial of feelings, devaluation of objects, and idealization (Kahn, 1974).

- Splitting
- Idealization & Devaluation
- Extreme Projection
- Primitive Denial
- Projective Identification
- Omnipotent Control

Figure 6.3. Borderline level defenses in schizoid personality.

In the schizoid, the use of *splitting* manifests in unique ways. Though the structural model for schizoid pathology is somewhat complicated and unwieldy, some discussion is warranted in order to grasp how this occurs. Most of the work on the psychic structure of the schizoid was developed by Fairbairn in the 1940s, and further developed by Guntrip in his work on schizoid phenomenon in the 1960s. Fairbairn believed that the normal integrated ego split as a consequence of failure to form healthy relationships to external objects. *Ego splitting* in the schizoid results in the formation of three subsidiary egos: (a) the *libidinal ego*, which remains identified with promising and enticing aspects of the mother, (b) the *anti-libidinal ego*, which remains identified with the rejecting aspects of the mother, and (c) *the central ego*, which is bound and identified with the an idealized relationship with the mother (Greenberg & Mitchell, 1983). There is frequent conflict amongst the three subsidiary egos, evident, for example, in the oscillation of the schizoid in and out of relationships. As a result of the splitting, the ego has difficulty coping with outer reality. Inner fantasies develop to guard against the loss of self that would otherwise occur in the real world. These fantasies are in turn filled with object relations that are not dictated by reality, but rather frequently overestimate and underestimate the good and bad qualities in others.

Guntrip (1969) revised Fairbairn's model by suggesting the concept of the *regressed ego*. While the normal ego is active, powerful, and alive, the regressed ego is passive and seeks to flee contact with the world into silence and inactivity. The principle aim of the regressed ego is to return to the security of the womb, and even longs for death as an escape from painful and conflicted relationships in the real world (Guntrip, 1969). The regressed ego seeks to pull the schizoid out of relationship to others, depleting the personality, like a black hole swallowing all things up as defense against dependency longings. Guntrip posits that *ego weakness* is what causes the libido to withdraw from external objects, and that this ego weakness was the outcome of ego splitting rather than the original cause of the ego splitting (Guntrip, 1969).

- **Anti-libidinal ego** – The part of the ego that is identified with the rejecting aspects of the mother
- **Libidinal ego** – The part of the ego that is identified with promising and enticing aspects of the mother
- **Central ego** – The part of the ego that is identified with idealized aspects of the mother
- **Regressed ego** – The part of the ego that seeks to avoid conflict
- **Schizoid withdrawal** – The process of removing the libido from external objects
- **Ego weakness** – The result of ego splitting, rather than the cause of splitting

from Fairbairn, 1941 & Gruntrip, 1969

Figure 6.4. Splitting and the schizoid ego.

Idealization, like devaluation, is the result of defensive splitting. Unable to express anger or be assertive, schizoid patients tend instead to internalize frustrating components of the object, as well as the corresponding self-states, while maintaining an

idealized relationship with external reality (Seinfeld, 1991). In other words, the schizoid splits off parts of others that are disappointing and reacts only to those positive attributes that are left, while an internal world of persecutory object relationships haunts him in private. By creating idealized relationships with others, the schizoid can fend off his sense of hopelessness, emptiness, and futility in relationships. This tendency of schizoid children to develop 'special' relationships with caregivers reflects this pattern. Adult schizoids, who are particularly prone to infatuation with love interests, often find that the relationship becomes unbearable and difficult after the idealization stage has passed and ambivalence sets in (Doidge, 2001).

Devaluation, the counterpart of idealization, is equally present in the schizoid but is latent and rarely obvious or premeditated. Schizoid devaluation of feelings and objects most frequently occurs as a means of fortifying their omnipotent self-representations (Kahn, 1974). If the patient feels that the therapist has something to offer him beyond what the patient can offer himself, considerable anxiety is generated. The patient needs to devalue the therapist in order to maintain his self-sufficiency and to avoid opening his secret longings to depend a powerfully responsive parent figure. Substituting hate for love protects the schizoid from the vigor of his needs for connection (Akhtar, 1992). The patient feels it is better to destroy the therapist with his hate rather than allow himself to love and risk disappointment. Accordingly, the schizoid devalues the therapist by making him an it-like thing, disavowing the ability of the therapist to show him anything he does not know, then questions the validity or rejects the therapist's interpretations in favor of his own. One of the most difficult challenges in working with schizoid patients is tolerating the patient's efforts to neutralize the therapist (Kahn, 1974).

The schizoid uses *denial* in a variety of ways. Denial of affect is the primary force underlying the patient's pattern of depersonalization and loss of self. The patient's enacts an aggressive denial of all his affects and needs as a means of defending against the pain of being alive, in turn rendering himself nothing more than a robot, or a thing (Laing, 1960). The patient literally disavows that he is alive and susceptible to normal human limitations. During periods of gross denial, the patient is often unable find meaning in what the therapist is saying. The schizoid is particularly apt at denying the primitive rage he feels about the neglect and impingement he suffered as a child, though his most fervent use of denial is to eliminate his longings for and need to attach. The near magical use of omnipotent denial is also utilized by the schizoid to remove the power of others who seek to coerce him (Laing, 1960), thus destroying the emotional reality of persecution by a bad object.

Schizoid populations are not prone to extreme use of *projective identification* given the interpersonal nature of this mechanism. Similar observations have been noted both in regressed schizophrenics (Grotstein, 1981; Ogden, 1982) and autistic children (Metzler, 1975). However, when used, the use of projective identification by the schizoid frequently functions to neutralize others. In this case, the projection of the schizoid's neglectful parent into the therapist induces a state of disconnection and apathy (Seinfeld, 1991), limiting the treatment. The patient typically tries to make others into non-engaging, distant, and neglectful objects because in this way the other will remain unengaged and far less frightening. In other words, projective identification reduces the chances that the other will smother or impinge on the schizoid with too much

engagement. The tendency for the therapist to feel bored, indifferent, and lethargic, and tired of treatment can be a strong sign this defense is at work.

Schizoids are also not overly burdened by *projection* or paranoid tendencies. The schizoid usually does not tend to see others as dangerous and persecuting, but rather views the world as unsafe because of their own relative weakness and subsequent fear of conflict (Giovachini, 1979). Their most prominent use of projection is actually that of projecting their own needs into other people. For example, the schizoid patient is apt to spend large amounts of time in discussion about the problems and issues of other people as a means of not talking about themselves (Seinfeld, 1991). Schizoid patients tend to be avid people watchers, and intensely curious about the interaction of others. It is because the schizoid's primitive oral needs are most frightening to him that he places these in other people. Of course, when the schizoid projects his own hunger for closeness, he perceives others as trying to eat him alive, not realizing that it is his own voracious cravings he is seeing in others (Thompson, 1990). It is then that he starts to plot his escape.

Omnipotent control is the derivative defensive operation of omnipotence, in which the fantasy of omnipotence operates in conjunction with the mechanism projective identification (Kernberg, 1995). Omnipotent control ultimately forms as an effort to protect the patient from the bad object against an underlying paranoid transference. Though prominent in borderline organization, omnipotent control, in the traditional sense, is relatively limited in schizoid patients given that these patients are not overly burdened with hatred and envy. However, the schizoid's fantasy life is often filled with examples of omnipotent control over inner objects, even though this rarely manifests

outwardly. As a result, while the therapist may not experience the patient trying to manipulatively force his agenda in session, he should be attuned to these themes in fantasy, particularly when the patient has become angry.

Signature schizoid defenses. In addition to the borderline level defense mechanisms discussed above, the schizoid personality is distinguished by a signature defensive profile. These defenses include withdrawal, fantasy, identification, intellectualization, and dispersal of affect, as listed below in Figure 6.5. A core reliance on withdrawal and fantasy, in particular, are considered diagnostic features of this personality type (PDM Task Force, 2006).

- Withdrawal
- Fantasy (i.e. retreat to fantasy, omnipotent fantasy)
- Identification
- Intellectualization
- Dispersal of affect & sublimination

Figure 6.5. Signature schizoid defense mechanisms.

Schizoid patients are known for their strong reliance on the mechanism of *withdrawal* as well as *retreat to fantasy*. These defenses were covered in greater depth earlier in this handbook. In a way, schizoid defenses carry with them an interesting picture of childhood and infancy given their predominantly primitive nature (Kahn, 1970). When an infant is overstimulated or distressed it will often turn itself away or fall asleep to get away. Just as in the adult schizoid, the main function of withdrawal is to disavow, or literally, make the outer world disappear in order to seek relief. Withdrawal is not always related to the world of external events, but may function just as well in eliminating the schizoid's inner need (Giovacchini, 1979).

Fantasy allows the schizoid to leave the constraints of reality for the pleasure of omnipotent control and total freedom. While all people daydream and fantasize about scenarios they wish for, the schizoid's use of fantasy is more pervasive and is used instead of addressing interpersonal needs and feelings in the real world. To live in fantasy is effectually an effort to make the true self disappear, and to allow the person to be whom ever he wishes, to go anywhere, and to be totally unshackled from the emotional constraints he would otherwise feel (Laing, 1960). At other times, the schizoid will use fantasy to escape being alone so that he can feel alive and active, even when he is not.

Identification, the process of taking into the self an aspect of another person to the extent that it is experienced as if it were a part of the self, is another signature schizoid defense. Identification is a passive experience, as opposed to the active experience of introjection. As Guntrip (1969) explains, the defensive nature of identification is that it eliminates the distress of establishing one's individuality from the other. In the case of the schizoid, identification usually feels like one is being swallowed by the other and losing independence of thought and action (Guntrip, 1969). Fear of the destructive power of his own anger forces the schizoid into a symbiotic relationship with those he comes across. Quite simply, the schizoid identifies instead of asserting himself and risking that he will harm the other. The schizoid's passive attitude and readiness to pick up signals from others are then used to mold his behavior into what is required by the environment on a moment-to-moment basis (Deutsch, 1942).

The following case material illustrating how one schizoid man experienced deep defensive identification with others:

> A man with strongly, in fact exclusively, religious interests, showed markedly this characteristic of helping people without really feeling for

> them. He said: I've no real emotional relationships with people. I can't reciprocate tenderness. I can cry and suffer with people. I can help people, but when they stop suffering I'm finished. I can't enter into folks' joys and laughter. I can do things for people but shrink from them if they start thanking me.' His suffering with people was in fact his identifying himself as a suffering person with anyone else who suffered. Apart from that he allowed no emotional relationship to arise. (Guntrip, 1969, p. 38)

Another signature defense of the schizoid personality is the *dispersal of affect* (Kohut, 1971; Kernberg, 1967). Libidinal affects that would otherwise be put into object relationships are withdrawn from the object. These affects are most frequently channeled into non-human things, such as animals, inanimate possessions, or creative interests. At other times, affects may be drained from the body with auto-erotic activities (Kahn, 1974), or alternatively sublimated in conjunction with obsessive defenses into work-related activities. The ability to create distance between himself and his feelings allows the schizoid to *sublimate* affects very easily into work and productivity (Kahn, 1974), as well as to fuel fantasy.

The following case example is of a schizoid patient who dispersed his feelings onto the non-human aspects of his therapy:

> The patient may also manifest concrete thinking by displaying an attachment to the nonhuman aspects of the therapeutic environment. Thus, one patient never expressed any interest in the therapist as a person but was quite interested in the paintings on the wall, the view from the window, the furniture, and the rug. He eventually noticed the plants and said he experienced comfort in the sessions by looking at the plants. Eventually, he expressed separation anxiety at the end of the session at having to leave the comforting room. At intervals between sessions, he soothed himself by thinking of the building, the elevator, the waiting room, the magazines stacked on the table, and finally the therapeutic office. It was only after a prolonged period of treatment that he told the therapist that he could help him by sitting as still as the plants. It was necessary that the therapist tolerate being related to as a nonhuman object so that the patient could gradually allow him to become alive and human. This recognition by the patient also coincided with him becoming more alive and human. He expressed a beginning recognition of the significance

> of the inanimate object world, saying, 'I have always been a collector of furniture, especially antiques. One could love furniture and beautiful things for their own sake and I guess I do. But I suspect there is another motive operating. Take a chair. When I get up from it and walk away I know it isn't going anywhere. At least nor by itself. It will be there when I return. With people, you never know.' (Seinfeld, 1991, p. 200)

Intellectualization in schizoid personalities differs from that more traditionally seen in obsessive-compulsive patients. As McWilliams (2006) mentions, "In contrast to obsessional patients, who avoid emotion by intellectualizing, schizoid patients may find it possible to express affect once they have the intellectual vehicle in which to do so. Because of this transitional function, the art therapies have long been seen as particularly suited to this population" (p. 18). The schizoid's use of intellectualization is often integrated as a part of his pseudo-adult self, particularly given that he regards his emotional life as childish and his intellectual life as adult (Johnson, 1975).

Other defensive themes and patterns. This section briefly reviews the contributions of R.D. Laing (1960) and Jeffrey Seinfeld (1991) on common defensive themes and patterns unique to schizoid personalities. These themes are summarized in Figure 6.6 following the discussion. In the right hand column, the defensive theme is presented, and in the left hand column, the defensive function is summarized. Other major defensive patterns including *depersonalization*, *self-sufficiency*, and *sense of superiority* are not included here because they are given serious treatment elsewhere (See Chapter 4).

The schizoid's *apathy* and *cultivation of death* defend against the sheer ruthlessness of his needs. This occurs primarily as the results of the patient denying he has feelings, needs, and proclivities, or an identity. The use of c*oncrete thinking* draws on the process of projection by placing the schizoid's feelings into the inanimate world.

Because non-human world is not bound by human emotion, the subtraction of emotional content occurs easily in the displacement. *Pseudo-objectivity*, also seen in obsessive characters, reflects an underlying isolation of affect combined with intellectualized defenses. Rather than acknowledging or owning his subjective experience, the schizoid looks at the events of his life from afar and evaluates himself based upon impartial standards. C*ompulsive, frantic talking or behavior* helps the schizoid to compensate for his apathy and inner emptiness by giving others the impression that he is alive and engaged. This may include pressured talking, imitation of others, exhibition of pseudo-emotions, or efforts to become funny or entertaining. His *constant desire to discuss other people* instead of himself reflects not only his tendency toward identification, but also his preference for vicarious living over the pain of living his own experience. The patient is happy to spend copious amounts of time talking about the tribulations, struggles and conflict he observes in others without having to bear the discomfort of acknowledging his own distress and neediness. Instead of facing feedback about his behavior from others, the schizoid instead employs *compulsive self-analysis*. By arming himself with self-knowledge, his self-sufficiency is reinforced and he eliminates the need for help from others. Finally, the tendency to *invert his infantile self with a parental imago*, the schizoid's 'biggest secret' (Seinfeld, 1991), occurs as the patient compensates for his needy infantile self with the construction of a pseudo-adult persona.

ASPECT	DEFENSIVE FUNCTION
Apathy	• Rather than acknowledging needs, needs are devalued and denied until inconsequential
Pseudo-objectivity	• By staying objective the subjective feelings of the self or the other are disavowed
Inverting the infantile self and parental imago	• Defends against splits in the ego by allowing the person to place neediness into the other
Compulsive or frantic talking and behavior	• To compensate for emptiness and lack of vitality and spontaneity in language and behavior, hysterical or compulsive behaviors are used to imitate human behavior
Concrete thinking	• Having been projected into the nonhuman or inanimate world, the self is discussed with emotional content subtracted
Constantly in discussion about other people	• Allows the person to escape talking about themselves as feelings about the self get displaced into other relationships
Cultivation of death	• A defense against the pain of life, all emotional activity is denied
Depersonalization	• Leaving the body to escape the implications of being around others • To nullify the danger of the self or the other having feelings • To disarm another by stealing his emotional potency
Compulsive self-analysis	• To avoid being gripped by the comprehension of another *from Seinfeld, 1991; Laing, 1960*

Figure 6.6. Defensive themes & patterns.

Defensive use of self-actualization. Self-actualization processes can also be used by the schizoid in defensive ways. For example, imagination can be used to escape reality, rather than for problem solving or preparation for action in the real world, and re-inventing one's self in fantasy can easily subsume mature working through processes. A 'love of freedom' can form in reaction to feeling coerced and restricted in relationships to others. Auto-didacticism, can actually reflect underlying fears of allowing the self to be taught by others, and limits exposure to a diversity of viewpoints. While the schizoid celebrates his 'iconoclastic' views, this may reflect a tendency to devalue and dismiss the viewpoints of others rather. 'Auto-didacticism' can be used to avoid the pain of learning from others, denying the individual the ability to refine his ideas with others, while productivity at work may be used as a rationale to sublimate or drain off feelings into neutral activities. Even the creative process, when used as a sole form of emotional expression, and creative output as the sole object for cathexes, can be utilized primarily as a substitute for real relationships.

- **Imagination & Fantasy –** Fantasy is used to escape reality, rather than for problem solving or preparation for action in the real world.
- **Freedom & Self-Individuation** – The freedom of doing things according to preference forms in reaction to regularly feeling sadistically restricted by others
- **Spiritual awakening / Psychological growth** – The ability to reinvent the self in fantasy forms as a substitute for actual working-through processes
- **Limiting peer pressure** – The opinions of peers are devaluated, dismissed and avoided rather than disagreed with on their own merits
- **Auto-Didacticism** – Learning alone to avoid the pain of learning from others
- **Productivity** – Affect is drained through sublimation into work-related activities, feelings drained and channeled into neutral activities
- **Creativity** - Creative process is used as sole form of emotion expression and attachment to creative output used as a substitute for relationships

Figure 6.7. Defensive rationales for solitary functioning.

Thoughts operating as defense. Though dynamic psychotherapy is not primarily concerned with the modification of thoughts, it is helpful in the case of the schizoid personality to understand how thought patterns collude and fortify defensive operations. Schizoid thought processes are often structured to protect the individual from the discomfort of strong negative affects and human conflicts. Aaron Beck, in his book on cognitive therapy for personality disorders, identified many of the automatic thoughts most frequent to schizoid personalities (Beck, Freeman, & Davis, 1990). In Figure 6.8 below, Beck's thoughts have been re-organized around several defensive processes discussed in this handbook, including (a) thoughts that reflect denial or devaluation of needs and feelings, (b) thoughts fortifying the schizoid dilemma, (c) thoughts reflecting devaluation of objects and relationships, and (d) thoughts fortifying omnipotence and self-sufficiency.

If an event is likely to produce a strong emotional reaction, thereby disturbing the non-being of the schizoid, thoughts mobilize to devalue and neutralize the event (Johnson, 1975). Thoughts reflecting the denial or devaluation of needs and feelings include simple statements, such as 'Why bother?,' 'Who cares?, and 'It is what it is.' Other thoughts more aggressively seek to deny reality, such as 'It doesn't matter,' 'I'm not real,' and 'This isn't actually happening.' Drawing the schizoid's attention to these thought processes is an important part of treatment. While a full exposition of Beck's original attitudes, beliefs, and automatic thoughts in schizoid personality is beyond the scope of this section, this information has been included in Appendix VIII for reference at the end of this volume.

Thoughts reflecting the denial or devaluation of needs and feelings

- 'Why bother?'
- 'Who cares?'
- 'It doesn't matter'
- 'It is what it is'
- 'This isn't actually happening'

Thoughts fortifying the schizoid dilemma

- 'I can use other people for my own purposes as long as I don't get involved.'
- 'It's better to be alone than to feel "stuck" with other people.'
- 'It is better for me to keep my distance and maintain a low profile.'
- 'It is important for me to be free and independent of others.'

Thoughts reflecting devaluation of objects and relationships

- 'Intimate relations with other people are not important to me.'
- 'Relationships are messy and interfere with freedom.'
- 'I enjoy doing things more by myself than with other people.'
- 'Life is less complicated without other people.'

Thoughts fortifying omnipotence and self-sufficiency

- 'I am not influenced by others in what I decide to do.'
- 'I set my own standards and goals for myself.'
- 'What other people think doesn't matter to me.'
- 'I can manage things on my own without anybody's help.'

modified from Beck, Freeman, & Davis, 1990

Figure 6.8. Schizoid thoughts reflecting dismissive processes.

Infrequent defenses. Some defenses are less frequently seen in schizoid personality. According to McWilliams (1994), schizoid populations infrequently use repression, compartmentalization, moralization, undoing, reaction formation, or turning against the self, as summarized in Figure 6.9 below. Most significantly, repressive functions, as commonly found in hysterical and obsessive characters, are not seen with schizoid patients. To the contrary, the schizoid is often able to make keen observations

about the emotional state of himself and others, but avoids talking about these things because he is frightened of the consequences (McWilliams, 2006).

- Repression
- Compartmentalization
- Moralization
- Undoing
- Reaction formation
- Turning against the self

from McWilliams, 1994

Figure 6.9. Infrequently observed schizoid defenses.

Countertransference

One of the most difficult aspects of schizoid treatment is the management of countertransference. On the one hand, any therapist who has not had the opportunity to experience the depth of his own personality through individual therapy is likely to have a difficult time fully grasping the schizoid patient (McWilliams, 1994). The schizoid's natural capacity for introspection, particularly at the healthier end of the spectrum, and his ability to notice subtle shifts within himself and others, can at times be uncanny. On the other hand, schizoid treatment requires maximal awareness of countertransference because of the strong feelings the patient can stir in the therapist that can tax the therapy significantly over time, instigating damaging enactments, and creating a therapeutic stalemate that can be hard to tolerate. This section first examines difficult countertransference themes, and then outlines common countertransference enactments, and cultural biases and attitudes of the therapist that can interfere with successful treatment.

Difficult countertransference themes. The 'negative symptoms' (e.g. anhedonia, withdrawal) carry the potential to stimulate challenging countertransference reactions. The primary countertransference reactions to schizoid personalities tend to be apathy and hatred (Seinfeld, 1991), as well as confusion, sleepiness, boredom, and sensory deprivation. The therapist may find that he has a hard time remembering or concentrating on the patient's material and that the process of listening is extraordinarily draining. Eventually, the therapist can feel exhausted by the amount of efforts it takes to keep focus or maintain interest on the patient and become indifferent about the treatment. If the therapist loses interest in the patient completely, this lack of emotional regard may come to replicate what the schizoid has known for most of his life: that others do not often notice them or react to them, unless somehow are forced to do so (Thystrup & Hesse, 1999).

` The patient's passivity also creates countertransference issues. Passivity can stir frustration in the therapist leading him to feel he is not able to be of use or that the responsibility for conducting therapy is entirely upon him. Alternating between feeling he is not doing enough, and exhausting himself trying to come up with ways to activate the patient, the therapist eventually wears himself out and ceases to believe that progress is possible. As Thylstrup and Hesse (2009) note, "As time goes by in the treatment process, clinicians tend to tire because of lack of visible changes in schizoid patients; the clinicians lose interest in the treatment, which they find is not progressing (p. 150)."

The experience of working with a self-sufficient patient is another testing aspect of treatment. The therapist, who is used to functioning within a therapeutic alliance, has to learn how effectively to carry on with treatment in the absence this bond (Duryee,

1996). The schizoid's attempts to analyze himself, his narcissistic tendency of rejecting feedback in favor of his own ideas, and his negativistic attitude can undermine the therapist's confidence in his abilities (Seinfeld, 1991) and lead to resentment, anger, and frustration about being devalued or excluded. The tendency of some more healthy schizoid patients to show a high degree of insight about their own issues only reinforces the therapist's feelings of ineffectiveness. Often the patient speaks about himself in the third person, as if he is deciding to examine himself in the presence of the therapist. Having been cut out of the process of therapy, the therapist may experience guilt or discomfort at the thought that he is not doing anything to earn his fee, or that he is unable to help the patient (Duryee, 1996). Feeling underutilized, left out, and unconnected, the therapist eventually comes to question his relevance and the usefulness of the patient continuing to come in. Alternatively, the therapist may come to feel that the patient is not suffering acutely, when in fact he is (Seinfeld, 1991).

Silence is another aspect of the schizoid patient that often stirs strong reactions in the therapist. The patient's silence is often a communication of the overwhelming fear or anger the patient is experiencing, and is a sign the withdrawal has activated. The therapist may find that he, too, experiences mild dissociation and depersonalization at the same time, or finds that he has suddenly become tired and has difficulty concentrating. These experiences are a good indication for the therapist of what it may be like to be the patient, empty of all feelings and need. Similarly, the schizoid's own desire to regress to a womblike sleep may make the therapist feel sleepy, sluggish, or listless.

Schizoid withdrawal may lead the therapist to feel anxious or concerned that the patient is too fragile to handle direct contact, over time becoming overly protective of the

patient and fearful of intruding upon him. A pullback on the part of the therapist, though not always unwarranted, may be detrimental to treatment, however. While the schizoid often withdraws from others when he feels unable to handle the emotional intensity, he is angered and hurt when others withdraw from him (Guntrip, 1969). On the other hand, in response to silence the therapist may come to feel bored and let his mind wander to aspects of his own life, or wrongly feel that the patient is not suffering acutely because he has nothing to talk about.

Klein (1995) notes the difficult countertransference that can emerge while working with a schizoid patient who is interpersonally unengaged:

> Mr. J, was briefly described earlier as the patient who felt like a puppet sitting on his mother's knee. Initially, Mr. J. also struggled for many months in treatment to reveal his true feelings, thoughts, and needs. His style was quite different from that of Ms. J. All his comments seemed lifeless; his manner lacked animation. Facts were communicated fairly easily but without aliveness of affect and often with a strong suggestion of compliance. Unlike the initial situation with Ms. J., it seemed that there was no question I could ask that was beyond Mr. J.'s ability to answer extensively. He was able to activate himself, for the most part, and to take charge of the session, supplying me with interesting details about what was going on in his life. Still, throughout the initial year of treatment, there was a remarkably shallow, disengaged quality to his communications. My own feeling, in response to being equally disengaged, had grown increasingly uncomfortable. Subtle at first, this feeling had become pervasive, and I had begun to experience enormous boredom and disinterest. (p. 82)

The schizoid's tendency to invoke rejection by projecting the image of his cold, unengaged caregivers onto others often has the effect of rendering the therapist indifferent to the patient. The therapist may also come to feel inept and doubt his confidence about being able to meet the patient's needs. Consequently, the therapist may forget about the patient's session, hope that the patient does not show up, or approach

treatment carelessly without attention to detail. In the worst case scenario, the therapist unavailable or disinterested in the patient's material.

The following case material illustrates the complex countertransference reactions of one therapist working with a schizoid patient:

> A male adult patient spoke in his sessions as if he were talking to himself or to the furniture in the room, never pausing so that the therapist could respond, and not seeming to care if the therapist understood what he was saying. On the few occasions when the therapist commented, the patient ignored the therapist's remarks and continued his monologue as if the therapist had never spoken. The therapist felt left out of the patient's relationship with himself; the therapist felt he was of no use or value to the patient. Increasingly, the therapist interrupted the patient's monologues with questions or comments that the patient found annoying. The therapist became jealous at being left out of the patient's exclusive relationship with himself and felt the need to be noticed by the patient. During these sessions, the therapist felt disturbingly as if he was invisible or did not exist for the patient in the same way that the patient had felt invisible in the presence of his extremely narcissistic primary caregiver. (Seinfeld, 1991, p. 202)

If treatment is allowed to progress in spite of these obstacles, love may eventually emerge in the transference. This is dependent on many factors, not least of which is if the therapist has penetrated the patient's encapsulated inner self and allowed the patient to express his expectations for gratification. As the schizoid begins to identify and assert previously split-off needs in therapy, the therapist may suddenly begin to feel drained by overwhelming neediness of the patient. This will be an indication that the therapy has progressed far indeed.

Countertransference enactments. The acting-out of negative countertransference to schizoid patients is among the greatest impediments to ongoing successful treatment with this group. Identifying when negative countertransference has

Schizoid Relational Theme	Possible Countertransference
• Self-sufficiency • Narcissism	• Underutilized, unconnected, left out • Feeling one is not earning therapeutic fee • Irritation / Rage / Sadistic impulse • Uninvolved or excluded • Feeling devalued or unimportant • Feeling patient doesn't need treatment
• Silence • Passivity • Disengagement	• Apathy / Lack of concern about patient • Boredom / Loss of interest in patient • Sleepiness / Exhaustion • Depersonalization / Dissociation • Sensory deprivation • Confusion • Feeling the patient is not suffering acutely • Irritation / Rage / Sadistic impulse • Lack of initiative to work actively
• Loss of affect • Alienation form needs	• Loss of memory of the content • The patient is not benefiting from treatment • Hypnotic state • Blocked emotion • Sleepiness • Sensory deprivation • Distracted • Feeling the patient is not suffering acutely • Apathy / Lack of concern about patient
• Withdrawal • Loss of self	• Anxiety / Fear • Feeling patient is fragile • Sleepiness / Exhaustion • Depersonalization / Dissociation • Anger / Disgust
• Projection of neglectful parent	• Empathic withholding • Apathy / Lack of concern about patient • Inept / Doubts about confidence • Desire for patient to miss sessions
• Symbiotic strivings • Omnipotence	• Feeling the patient is similar to one's self • Feeling the patient knows much • Feeling unusually successful as a therapist • Feeling the patient is special or uniquae

Figure 6.10. Common countertransference reactions to schizoid patients.

been activated and seeking a professional forum to discuss these issues, be it individual supervision, seminars, group supervision, individual psychotherapy, or a combination, is the best way to avoid therapeutic error (Tompson & Cotlove, 2005). Figure 6.11 lists some of the possible ways that a negative countertransference may be enacted within the treatment of schizoid patients, some of which are discussed in this section.

Among the most difficult experiences to tolerate by the therapist is the perception that patient is not presenting a workable transference. While this perception is incomplete and simplistic, it is often used as a rationale for terminating treatment or shifting prematurely to supportive therapy. With schizoid patients there is often much brewing right below the surface. The feeling that one is not being effective, or the identification with the patient's own feelings of futility, is very difficult to tolerate and may lead to unnecessary termination early on, forestalling opportunities to make inroads into the buried object relatedness of the patient. The patient's efforts to deaden the interpersonal relationships are strong, and usually speak to defunct relationships with early caregivers. If the therapist takes personally the patient's rejection or a negativistic response he may feel devalued, angry, or hurt. These dynamics can lead the therapist to develop a lack of concern for the patient, to become passive-aggressively withholding or silent, or to react angrily in session. Similarly, the patient's dismissive-avoidant attachment can lead the therapist to feel devalued and insecure.

Tolerating silence in session, particularly when sitting face-to-face, can also be uncomfortable for the therapist. As the patient is prone to limit communication for long periods of time, managing countertransference to silence is an important skill. Often, less experienced therapists will react by trying to end the silence by offering a topic for

conversation, or by offering theoretical guesses at what the patient might be experiencing without checking in with the patient. In the worst case scenario, the therapist may infer that the patient is electing not to participate in therapy or is not making a good use of the time, when in fact the patient is not knowing what to communicate or how to communicate without offending the therapist or getting too close.

The patient's passivity can also lead the therapist to feel he needs to work harder to keep the momentum of therapy going. Feeling that there is no directionality and there is no way to reach the patient, the therapist may move robotically through sessions without trying to find new ways of interpreting or understanding the patient's experience. On the other hand, the therapist may lose interest in the therapy, and hope that the patient will decide to skip sessions.

- Therapist believes that in the absence of a stable transference the patient will not benefit from dynamic therapy and decides to terminate the treatment
- Given the scarcity of emotional material from the patient, the therapist becomes frustrated and accuses the patient of not participating in therapy
- Due to the lack of interpersonal connection with the patient, the therapist becomes unempathic, or passive-aggressively withholding
- The client's silence/passivity leads the therapist to try to keep the conversation going by asking questions, or selecting topics for discussion
- The therapist loses interest in the treatment and begins robotically going through the motions of therapy without finding ways to reach the client
- The therapist becomes uncomfortable with silences following schizoid withdrawal and begins to disregard the patient's need for space
- The therapist, in confusion about what's going on with the patient during a long silence, makes theoretical guesses about his mental state
- The therapist falls asleep in the absence of communication from the patient

Figure 6.11. Enactment of countertransference to schizoid patients.

Therapist cultural biases

Cultural acceptance of reclusive or unsocial behaviors vary widely. In general, Eastern cultures tend to place greater value of introversion than is seen in Western countries and accept the quiet social conservative as a cultural ideal. At a deeper level, collective cultures often view quietness or shyness as a positive trait reflecting the ability of the individual to show self-control and respect for group norms, while unsocial behavior is seen as a threat to the unity of the group (Johnson et al., 1999). In contrast, individualistic cultures see shyness as weakness of character, but accept unsocial behaviors when they can be interpreted as being in the service of establishing autonomy, independence, or self-sufficiency (Goldberg, 1992).

In the Western world, quiet, introverted, loners are often unfairly characterized and labeled. Extraverted cultural values are likely to feel invalidating to those who place high value on their private lives. As Rufus (2003) laments:

> The mob thinks we are maladjusted. Of course we are adjusted just fine, not to their frequency. They take it personally. They take offense. Feel hurt. Get angry. They do not blame owls for coming out at night, yet they blame us for being as we are. Because it involves them, or at least they believe it does, they assemble the troops and call us names. Crazy. Cold. Stuck-up. Standoffish. Aloof. Afraid. Lacking in social skills. Bizarre. Unable to connect. Incapable of love. Freaks. Geeks. Sad. Lonely. Selfish. Secretive. Ungrateful. Unfriendly. Serial killers. (p. xvi)

As Jung (1917/1971) noted, there is a tendency in extraverted societies to devalue introversion because it is different and threatening to the extraverted self-concept. In the clinical psychology, it is common to hear introverted individuals being referred to with pejorative adjectives such ‘narcissistic,’ and ‘egocentric.’ There is no doubt that human beings are born to interact with other human beings. In the collective therapeutic traditions, a focus on attachment is nearly ubiquitous. But this focus should not allow the

importance of attachment to overshadow the meaning and importance of solitary functions.

The therapist should consciously assess his attitudes and beliefs about solitary behavior for evidence of negative biases that may influence treatment. Figure 6.12, below, lists some of the most frequently held extraverted cultural biases about solitary behavior. For example, the idea that solitary preferences are indicative of pathological or dangerous behaviors is common in Western society, perhaps given the tendency of the media to characterize criminal or antisocial individuals as 'loners.' While sociopathic individuals may choose solitary lifestyles, this is hardly the trait that defines personality disorders of this type (see section "Super-ego function"). Similarly, the idea that solitary behavior is avoidant of social duties, self-indulgent, or reflects misanthropic tendencies follows this same thinking; if someone is alone, they are angry or self-centered.

Determining the nature of the schizoid's preferences for solitude takes time and clarification. The empathic therapist needs to be able to distinguish the difference between obsessive preoccupation with inner experience, shame-bound self-critique, and the pleasurable cultivation of a private self. Assuming that being alone *always* fulfills the schizoid's need to escape is a mistake. For the therapist to know his own cultural biases regarding solitary behavior goes a long way to create an environment of safety in which the schizoid client can explore the meaning he gives his need to be alone. Above all, it prevents the activation of defensiveness or pseudo-social compensation in these patients when they sense the preconceived judgments of the extraverted viewpoint.

- Being solitary is usually unnatural, pathological, or dangerous
- Being solitary is usually escapist
- Being solitary is usually self-indulgent, narcissistic, or selfish
- Being solitary is usually antisocial/psychopathic
- Being solitary is usually avoidant of social duties
- Being solitary usually reflects misanthropic tendencies
- Being solitary usually reflects a lack of social skills

Figure 6.12. Common attitudes about solitary behavior.

Chapter 7 - Operationalized Treatment

The purpose of this section is to present formal aspects of schizoid treatment, including (a) the format and structure of sessions, (b) common presenting issues, (c) the goals of treatment, (d) factors leading to early drop out, as well as (e) issues related to therapeutic attitude and frame. The core of this section examines the process of (f) working with transference, (g) common barriers to schizoid transference analysis, as well as (h) typical object relations dyads and (i) common role reversals.

This section does not review the basics of transference-focused psychotherapy (TFP) and assumes a basic familiarity with this material. For those interested in a refresher on object relations theory, the structural features of borderline organization, or a review of the techniques, tactics, and interventions of TFP, consulting the previous TFP handbooks, *Psychotherapy for Borderline Personality* (Clarkin et al., 2006) and *Dynamic Therapy for Higher Order Personality Disorders* (Caligor, Kernberg, & Clarkin, 2007), will be essential.

Overview of Treatment

Carroll and Nunro (2005) made a formal comparison of three manualized, long-term, psychodynamic psychotherapy modalities. Using the format developed in this research, the distinguishing elements of the current treatment are presented on the following page to provide a basic overview for the therapist.

Aspect of Treatment	Format
Format	Individual psychotherapy
Frequency of sessions	Start at once per week; move to 2X-3X/week when possible without overtaxing
Duration of treatment	3-10 years
Theoretical frame of reference	Object relations, attachment theory
Patients	Avoidant personality, schizoid personality, schizotypal personality
Therapists	Psychodynamic clinicians
Focus of treatment	Identity diffusion and attachment
Explicit treatment goals	Agreed upon before beginning
Explicit treatment frame	Clearly explain format, roles, and policies beforehand
Contract setting	Proscribed
Supportive interventions	Used as a prelude to interpretation
Advice	Proscribed
Clarification	Yes
Confrontation	Proscribed early in treatment
Interpretation	Yes
Central area of inquiry	Fantasy life and current relationships
Making links to past relationships	Yes
Therapist stance	Active; talk should be economical and kept to a mindful minimum
Therapist neutrality	Yes
Use of therapeutic relationship	Transference analysis
Transference management	Clarification, interpretation
View of countertransference	Source of information for treatment
Medication	Rare cases require anxiolitics or anti-psychotics
Rating adherence/competence	Specific competencies and skills required; therapists self-rating scales provided

Figure 7.1. Formatted treatment characteristics.

Format & Structure

The treatment outlined in this handbook is for patients who have been diagnosed with schizoid or schizotypal personality. High-functioning schizoid patients who fit the criteria for avoidant personality are also suitable for treatment. In general, schizoid patients that are high functioning and exhibit some capacity for warmth are a better match for psychodynamic work than those who do not (Stone, 1983). With these patients, beginning at two or more sessions per week may be possible, and, if so, is desirable. More severe schizoid cases are unlikely to be able to make this commitment early in treatment and should be started at one session per week. When it becomes possible for the severely schizoid patients to tolerate treatment more frequently without feeling overtaxed, moving up to twice a week can be discussed. While motivated, high-functioning patients can make dramatic gains with two to three sessions a week over several years (Sperry, 2003), patients with more overt schizoid traits will likely require up to five years treatment.

Treatment is to be conducted by psychodynamic clinicians trained in transference-focused therapy. Object relations and attachment theory are used as the theoretical frame of reference with the focus of treatment being on consolidating identity diffusion and increasing the possibility for secure attachment. Issues related to the format of sessions, the roles for therapist and patient, and office policies, are discussed beforehand so that the patient does not feel unduly engulfed or overwhelmed as treatment progresses. However, contract setting, particularly around requirements for attendance, is strictly proscribed because of its tendency to produce negative therapeutic outcomes with these patients.

In treatment, the extensive use of supportive interventions and advice giving is generally proscribed. Confrontation is also proscribed early in treatment, as discussed later in this section. While some higher-functioning patients may be able to tolerate confrontation later in treatment once a solid relationships has been established, confrontation should always be used with extreme care. Primarily, the therapist will be using clarification and interpretation as primary interventions, with the central area of inquiry being the patient's current relationships and fantasy life. The therapist maintains an active stance in working with patient transference, utilizing his countertransference as an important source of information. In rare cases, anxiolitics or anti-psychotics may be used to target specific symptoms in the service of advancing treatment.

Presenting Issues

Schizoids whose need for interpersonal connection is completely gone are unlikely to ever seek therapy (Klein, 1995). The remaining schizoid patients who present to therapy often have no idea what their needs, wishes, or goals are for the treatment (Giovacchini, 1979; Thylstrup & Hesse, 2009). The patient may not mention social or interpersonal concerns at all and is often unaware that he has a conflict in this area. Vague complaints, such as a chronic sense of emptiness, deadness, or meaninglessness, are common and often mistakenly diagnosed as depression, dysthymia, or generalized anxiety (Doidge, 2001). The patient may also struggle with phobias or obsessive-compulsive symptoms that unknowingly displace interpersonal concerns.

In some schizoid patients, loneliness and longing for friendship or love are conscious motivators for seeking therapy. These patients may be seeking relief from an isolated existence and want specifically to work on their inhibitions to social contact or

dating (McWilliams, 1994). Such presenting issues tend to be good prognostic indicators for treatment, particularly when combined with self-sufficient capabilities, as these patients may be better equipped to risk attachment again (Klein, 1995). Longings for attachment often bring these patients to treatment in their late 30s and 40s believing that treatment may be their last chance for love and family (Klein, 1995).

Treatment Goals

In general, schizoid patients do not do well with structured, goal-oriented treatments because goal setting and stepwise evaluation of progress feel coercive and superficial. These patient prefer treatments that focus on creating safety and present an atmosphere in which long-term, deep, open-ended self-exploration can occur (Thylstrup & Hesse, 2009). This caveat named, the therapist should keep in mind several important overarching objectives in the treatment of schizoid personalities at the outset of therapy.

Decreasing self-alienation through the process of identifying needs and feelings and learning to assert needs interpersonally is a major goal of any schizoid treatment (Giovachinni, 1979). Slavik, et al. (1992) recommend the need to open primal feelings of rage and terror around interpersonal relationships, to resolve symbiotic tendencies, to model social skills and assertiveness, to strengthen attachment, to increase community involvement, and to foster social interest. These authors further suggest that goals of treatment include decreasing perfectionism and 'specialness,' and developing the self-determination to face the ambivalence and conflict of human relationships (Slavik, et al., 1992). Klein (1995) focuses on the goals of decreasing interpersonal anxiety, increasing relational contact, as well as on the interruption of withdrawal and approach-avoidance cycles. Millon (2012), in his Personality-Guided Therapy, suggests that the schizoid's

goals should include decreasing his passive stance to life, increasing his exposure to pleasurable activities, and learning to tolerate ambivalent feelings.

(1) Open primal feelings of rage and terror ξ
(2) Resolve symbiosis ξ
(3) Teach social skills and assertiveness ξ
(4) Strengthen attachment ξ
(5) Increase community involvement ξ
(6) Decrease perfectionism and 'specialness' ξ
(7) Foster social interest and self-determination to face life's ambivalence ξ
(8) Get patient in touch with underlying needs and feelings
(9) Make patient aware of emptiness and meaninglessness
(10) Lessen interpersonal fear and anxiety ω
(11) Interrupt pattern of physical and psychic withdrawal ω
(12) Decrease defensive isolation and promote interpersonal connection ω
(13) Reduce energy spent on approach avoidance ω
(14) Decrease passivity and promote and active, assertive stance to life ψ
(15) Enhancement of pleasurable activities ψ
(16) Counter isolation from real world contacts ψ
(17) Draw attention to lack of social and emotional awareness ψ

ξ *from Slavik, Sperry, & Carlson, 1992*
ψ *from Millon, 2012*
ω *from Klein, 1995*

Figure 7.2. Broad schizoid treatment goals.

Attitude

As schizoid patients are uniquely sensitive to the subtlest nuances in the therapist's approach, creating the right therapeutic atmosphere can be a delicate undertaking. This section examines the most important ways that the therapist can modify his attitude and stance to increase therapeutic engagement and outcome.

The most important quality in the therapist is that he uses his real personality with the patient. Schizoid patients are highly capable of sensing evasiveness, elusiveness, or

false fronts. They tend to be most comfortable around those who are calm, unceremonious, and willing to admit to having needs and to making mistakes (McWilliams, 2006). As one author notes, these patients enjoy "people who are in touch with themselves, who do not fear to reveal their weaknesses and appear mortal. I refer to an atmosphere that is relaxed and informal, where it is accepted that people err, may even lose control, behave childishly or even act unacceptably" (Mitmodedet, 2002, p. 190). This type of engagement frees the patient from having to hide his needs and feelings. If the therapist makes a mistake, he should be quick to admit as much. As McWilliams (2006) notes, "the willingness of the analyst to be 'real'—to be flawed, wrong, mad, insecure, struggling, alive, excited, authentic—may be the most believable route to fostering the schizoid person's self-acceptance" (p. 20). Schizoid patients can be grateful for small self-disclosures on the part of the therapist and, out of a fear of intruding on the therapist, are not likely to become more intrusive should the therapist elect to share something of himself. In modeling authenticity, the therapist may even consider being playful or humorous within the session, if appropriate (McWilliams, 1994). As a caution, the use of such techniques varies largely based on where the patient is in the treatment and the severity of pathology.

The analytic atmosphere, emphasizing listening and free-association, is ideally suited for this populations because of the limited possibility that the therapist will intrude upon or suffocate the patient (Duryee, 1996). The therapist must not be critical, judgmental, or dogmatic during the treatment, offering the patient total acceptance so that the patient's need to withdrawal is not activated (Guntrip, 1969). In general, schizoid populations also enjoy the therapist's efforts to maintain technical neutrality (Klein,

1995). The danger of using technical neutrality is that it may mirror the early family life of the schizoid; because the schizoid's caregivers did not notice him, interact with him, or encourage his emotional expression, the patient may come to confuse neutrality with disinterest on the part of the therapist (Thylstrup & Hesse, 2009). At worst, technical neutrality, or a reserved and ceremonial style on the part of the therapist, can make the patient feel rejected or threatened. As such, the therapist should be sure not be distant, unengaged, cold, or unresponsive to the patient.

Given the patient's passive stance, the therapist may have to assume the responsibility to create connection with the patient when the patient is unable to do so. Even as the therapist tolerates the patient's need to withdrawal, the therapist remains active in his desire to engage with the patient, asking questions, seeking associations, or checking in with the patient if he has drifted too long into fantasy or a disengaged state. Maintaining engagement without becoming impinging or intrusive is key to these interactions. Ultimately, the therapist communicates to the patient the expectation for serious interpersonal involvement during treatment, but also allows the patient to determine its intensity at any given moment (Duryee, 1996). The patient should understand that while the therapist is aware of his pattern of interpersonal disengagement, the therapist is not going to coerce him to participate, nor going to criticize his lack of participation.

Frame Considerations

Unlike other borderline level disorders, schizoid patients are rarely intrusive, are not prone to acting out, and can be surprisingly protective of the therapist's space. As such, while it is essential that patient and therapist roles should be defined definitively

- Maintains technical neutrality without being cold, distant, or unengaged
- Uses real personality at all times; is open, genuine, human, and authentic
- Actively engages in maintaining connection to patient
- Communicates expectations for serious interpersonal involvement but allows patient to determine its intensity
- Is non-impinging, non-controlling, and allowing autonomy
- Change-oriented rather than goal-oriented
- Accepting and non-rejecting

Figure 7.3. Therapist stance with schizoid patients.

early in therapy (Klein, 1995), in general, the patients should be given more flexibility within the therapeutic frame than other patients to encourage interpersonal engagement. A strict, inflexible application of therapeutic frame is not appropriate with this population, outside charging for skipped session. As Giovacchini (1979) notes, "the analyst will have to make some adaptations of his own, beyond those he might make with patients suffering from considerably less psychopathology. The form of the relationship may have to modify the more usually traditional interaction, but analytic setting will be preserved" (pg. 92).

The schizoid is likely to be ambivalent about the therapist setting boundaries. On the one hand, the schizoid is deeply relieved by these boundaries because they preclude the possibility of being overwhelmed or fused with the therapist (Thylstrup & Hesse, 2009). Moreover, the discussion of therapeutic boundaries helps to strengthen the schizoid ego, teaching him how to set boundaries on his own outside the therapy room (Duryee, 1996). On the other hand, the schizoid may feel angered or threatened by boundaries that seem too restrictive, reacting to these boundaries with intense resistance and efforts to re-establish autonomy. Thus, the optimal use of frame with schizoid

patients may be one where boundaries are explicitly defined and relatively set, but within which the patient is acknowledged to have autonomy to shut the therapist out or remove himself from sessions if he feels it is necessary (Duryee, 1996; Giovacchini, 1979). Naturally, there will be times during treatment in which the therapist has to set boundaries with the schizoid patient. In these circumstances, it is best to be calm and gentle. Schizoid patients can become quickly shutdown and unconsciously angered by a therapist who is strict, rash, angry, or abrupt while setting boundaries. It can awaken a sense of dread within the patient that he has somehow trespassed on the therapist, or become too needy. An authoritarian approach to boundary setting may ally with the anti-libidinal part of the patient in a way not intended.

Important frame issues often arise around attendance. Early in therapy, fewer sessions per week help to keep the patient from feeling overburdened by the requirements for engagement (Klein, 1995). Duryee (1996) suggests that is often helpful to ask schizoid patients what they feel the optimal amount of times to meet per week would be, while also advising the patient that sustained regular meetings is probably what will be required. While the therapist should schedule a set weekly time with the patient, the patient should be allowed to determine if he is going to attend that session or not (Duryee, 1996; Giovaccini, 1979; Seinfeld, 1991). Skipped sessions should be gently explored in the context of the patient's resistance to closeness with the therapist and need for distance. The patient should be made aware that the therapist holds a weekly time for him and that he will be financially responsible for all missed sessions (Duryee, 1996).

Allowing the schizoid to give small gifts may be beneficial to the treatment (Manfield, 1992). All attempts by the schizoid to make contact with the therapist, to show

interest in the therapist, or move toward the therapist, should be recognized as both an acknowledgement of the relationship and an attempt to create closeness. Rejecting the spontaneous giving of gifts may undermine such attempts. The patient should also be allowed to decide on whether he prefers to sit in the chair or use the couch. Duryee (1996) makes several observations on the schizoid's negotiation of proximity in the therapy room:

> The fact that schizoid patients often prefer not to use the couch reflects their underlying (if under acknowledged) contact hunger. That is, they get more of the therapist if they can see him or her. They typically also have not just a hunger for contact per se, but also an anxiety about their safety or security under circumstances of less contact while on the couch—will the therapist go to sleep, will his or her attention wander from them, and similar concerns. (p. 105)

Small self-disclosures, those that may fall outside normal frame boundaries for other borderline-level patients, may be useful in making the schizoid feel more comfortable engaging with the therapist. Schizoid patients are often grateful for small disclosures on the part of the therapist and are not likely to become disrespectful or invasive in response (McWilliams, 2006). A word of caution, however, is that too much self-disclosure can set off frightening symbiotic sensitivities and lead to aloofness and detachment. Intersubjective approaches that emphasize the sharing of the therapist's feelings within session should be used economically. It is the infrequent, spontaneous self-disclosure that helps the schizoid feel more courageous to take his turn admitting who he is.

When the therapist makes changes to his schedule, it is important to be aware of the schizoid's tendency to minimize the meaning of these changes. These patients often deny reactions to the therapist going on vacations, rationalizing these absences as

opportunities to save money or to be alone (Seinfeld, 1991). Their fantasy life, however, often reveals great anger, fear or disappointment at the loss of the therapist. The following cases illustrate how the schizoid patient can experience separations from the therapist during vacations:

Case 1

> When I returned [from vacation] he faced the task of continuing to develop the capacity for object relationships with a person who had bitterly disappointed him. This made it all the more difficult. I recall another patient who had a similar, thought not so intense, reaction to separation because he resented the analyst's mobility. How dare the analyst come and go as he pleases, because once the patient was able to stabilize a relationship, he felt inextricably tied to it. He could not do without it, even for a moment, otherwise the tenuously formed mental representation of the analyst would lose its cathexis without the reinforcement of his actual presence. The patient then felt even greater anger at the therapist when he returned. He should have stayed away for two reasons. First, his reappearance was an intrusion, and the patient could no longer integrate it since he had let the analyst "die"; he had lost, relatively speaking, the introject of the therapist. Second, returning meant leaving. To have someone there also included the possibility that the person could again forsake him. This attitude was a reflection of periodic maternal absences during infancy. (Giovacchini, 1979, p. 121)

Case 2

> About a year and a half into the treatment, another incident occurred that was critical to my understanding of the intrapsychic world of the schizoid patient. Ms. J. went on a vacation. There had seemed little reaction on her part to the fact that the therapy would be interrupted for approximately three weeks. The exact date of the patient's return was not clear, and it had been agreed that she would call when she returned. About three weeks after she left, I received a message on my answering machine that said, "My name is Ms. J., I don't know if you will remember me, but I am a patient of yours and would like to make another appointment with you."
>
> This message had a profound impact on me. I could have assumed that this was a striking example of a failure in object constancy or even object permanency. (Klein, 1995, p. 80)

Factors Leading to Early Dropout

The therapist should be sure to acknowledge the difficulty of the therapeutic process on the schizoid from the outset. Many personality types experience a rush of relief early in the process of therapy because of the new source of support they have found in their lives. To the schizoid patient,

- Roles and frame are explicitly defined to help the patient feel safe from impingement
- While the meeting time is set, the patient determines if he will attend or not
- Boundary setting is done in a sensitive and gentle way
- Minor self-disclosure can increase patient willingness to be authentic; major self-disclosure can lead to symbiotic strivings and should be avoided
- Be aware of the patient's tendency to deny reactions changes to therapist's schedule
- Consider allowing the patient to give small gifts
- Allow the patient to determine if he would be more comfortable lying on the couch or sitting face-to-face

Figure 7.4. Schizoid frame considerations.

however, leaning on the therapist runs contrary to the self-sufficiency that has been his greatest coping mechanism. The schizoid patient is often deeply identified with his role as an empathic helper and comes to feel upon entering treatment the area of his greatest self-esteem, his ability to be useful to others, is being undermined (Seinfeld, 1991). While it is important that the therapist acknowledges the client's abilities as a regulating other, joining with the self-sufficient aspects of the schizoid can undermine the therapy, reinforcing the patient's omnipotent defenses by attributing to him the maturity, wisdom, or understanding he may not truly have (Kahn, 1974).

The contract setting stage of therapy can also be very threatening to the patient. As the therapist reviews numerous policies and expectations, and makes treatment recommendations, the schizoid can quickly become overwhelmed and question whether seeking contact with a therapist was a good idea. The weekly attendance requirements and financial obligations of therapy create large concerns in the patient about his liberty early on (Duryee, 1996). Requests for personal information by the therapist may initially feel like intrusiveness, while the therapist's desire to meet more than once a week may be interpreted by the patient as neediness on the part of the therapist. Office policies may be taken by the patient as efforts to control or coerce him to conform to the therapist's ways of doing things (Duryee, 1996).

In order for the schizoid to persist in treatment, he must feel safe with the therapist. If the unconscious issues of the therapist intrude upon the schizoid, the patient may begin silently taking care of the therapist without being able to advocate for himself, a situation that will be difficult for the patient to bear for long. Yet, while overly burdened or preoccupied therapist can easily spook the schizoid patient away, an overly sympathetic or encouraging interventions can make the schizoid feel patronized and question the usefulness of the therapy (McWilliams, 2006). Another primary threat to continued treatment is moving too deeply into emotional processing before safety has been established. Though the therapist may identify places to intervene with the patient, to engage with the patient in a way that he is not ready for will repeat the failure of his intrusive, overstimulating, and frightening caregivers. The therapist can also frighten the patient away early in treatment by being intrusive, being overly confrontational, by

offering too many 'brilliant' interpretations, or by calling the patient too frequently outside session to check-in or reschedule appointments.

Negative transferences and hopelessness can develop rapidly early in treatment. The schizoid patient, fearing the destructiveness of his own negative feelings, is not likely to raise his concerns with the therapist. It is, therefore, essential that the therapist help the patient give voice to his negative feelings about the therapist, else he become frustrated or angry in the treatment without having an outlet for these emotions (Seinfeld, 1991). The therapist must be willing to take up the functions of the schizoid ego that it cannot fulfill for itself so that negative emotionality does not force early termination.

- The therapist fails to acknowledge the difficulty of the therapeutic process for the patient
- The patient feels the therapist is coercive or impinging
- The therapist does not help the patient give voice to his negative transference
- The patient feels his role as a helper of others is being undermined by the therapy, devaluing the area of his greatest self-esteem
- The therapist tries to get the patient to engage in ways he is not ready for
- The therapist intrudes on the schizoid in session

Figure 7.5. Factors that lead to early dropout.

Klein (1995) describes the difficulty in forming an early therapeutic alliance in the following case material:

> When Ms. J. first presented for treatment, she described her conflict over feeling as if 'everyone wants to control me, like my parents tried to do.' During the initial weeks of treatment, I went from feeling like an interested observer to someone trying-to 'pull teeth' with my questions. I began to feel more and more like a sadistic object. The patient had extreme difficulty responding to any of my questions or intervention with anything other than long silences. It soon became clear that what I

> regarded as innocuous questions or helpful interventions represented to the patient my efforts to intrude on her and to control her.
>
> The tools that one uses with most patients to convey one's curiosity, interest, and concern (that is, thoughtful questions and interpretations) seemed useless and counterproductive. Her responses, when she did speak were usually one-word sentences. I could see no particular rhyme or reason as to why she answered some questions and not others. When she spoke spontaneously, her speech had a staccato quality. She would start, stop, start again, and then conclude, often in the middle of a phrase. It was confusing and infuriating. (p. 75-76)

Working with Transference

Freud (1914) suggested that schizoid patients were not treatable with psychoanalysis owing to the fact that a sustained transference was not possible. As Appel (1974) notes:

> Freud recognized the primitive, oral, and narcissistic qualities of the schizoid personality and attempted to reconcile primitive wishes to fuse with the maternal breast and womb with the centrality of the Oedipal conflict in psychic disorder. He conceptualized narcissism and withdrawal from object relations in terms of libido withdrawn from object cathexis and saw delusions as restitutive attempts to regain contact with the objects so lost. (p. 100-101)

We now know that, rather than being without transference, schizoid patients actually show intense, primitive, infantile, and highly regressive transferences. Schizoid transference is a fundamentally different line of transference than Freud observed in his neurotic patients. Schizoid transferences are rarely about Oedipal conflicts, but rather, deal with early, archaic issues around dependency and trust. In fact, it is usually not possible to address Oedipal issues in the schizoid until theses infantile conflicts around dependency are resolved first (Guntrip, 1977).

Schizoid transferences are nuanced and rarely appear with potency early in treatment. The patient’s efforts to neutralize the relationship to the therapist using

withdrawal, denial of needs and emotions, and other defensive operations, are a reflection of the grave difficulties he has with trust and connection. This relationship he achieves "by assuming a part self-representation of a trapped, helpless, completely compliant person relating to another person whom he perceives of as rigid, easily offended, and extremely controlling. The linking affect is fear, anxiety, obsessive caution, and control (Manfield, 1992, p. 222)." At this stage, the best relationship the patient imagines he can have is one in which he is not being attacked by the therapist. Much of the time, defensive splitting removes all affect from the schizoid transference, making transference analysis difficult. When this occurs, the patient is often compelled to dismiss the therapist's interpretations as speculative, incorrect, or spurious because he cannot access his emotional experience.

Kahn (1974) offered the following case material illustrating the schizoid's tendency to prefer a neutral transference to the therapist:

> [The patients] were profoundly attached to me and the analytic situation, clung to both and yet were imperviously dissociated. In their world of private experience I was a mixture of nagging nanny and a comforting transitional thing-person-object of whom they had little perception or affective awareness as a person. They needed my *presence* in the analytic situation so they could disregard and negate me, and in their life so they could be related to themselves.
>
> When I attempted to change this position of relatedness, the true nature of their early object-relations and ego-pathology began to articulate itself. My hitherto co-operative patients now reacted with panic, terror, depression, helplessness and vehement self-pity. They felt every intervention as an attack or cruel injunction compelling them to do and be what they felt utterly unable to do and be. They resented that they should be expected to do mental or emotional work. (p. 84)

Drawing the patient's attention to his feelings and encouraging mentalization is essential to undo his self-alienation. The more the schizoid is helped to put words to the frightening experience of discussing transference-related manifestations with the

therapist, the more he may feel relaxed and willing to elaborate. The acclimation to this process leads the patient to feel safer allowing his needs into the transference without having to rely so heavily on withdrawal. Williams (2010) offers case material illustrating how one therapist helped a schizoid patient begin to think about transference feelings related to a previous session:

> The patient, a middle-aged man in psychoanalytic psychotherapy three times weekly, began his session by complaining that he had felt bad after the session the previous day. He said he had had to drive to an appointment at lunchtime to see an acquaintance but got to a certain point on the journey and realized he could either branch off and go home or continue on the road to his meeting. He went to the meeting. He then said he had thought in his mind about his psychotherapy session and had wanted to stop and write them down but that he was on a busy road and so couldn't do that. He had now forgotten what the thoughts were. He got to his destination but felt too tired to go up to the house and ring the bell. He had no energy left and thought of turning back. He turned the car around, pulled off the road, and went to sleep for about an hour. Then he went home. It was early, he realized, but he was still tired, and when he got in he went to sleep for several hours—for 3 hours, he thought.
>
> Therapist: You said you felt bad after our session yesterday.
>
> Patient: Bad?...bad…[silence]…I thought I hadn't been eating properly. Physically I am not entirely well yet…[silence]… Tiredness …heaviness. I can feel it in my body…[silence] [pause]
>
> Therapist: You seemed a little surprised when I reminded you of what you said about feeling bad after the session yesterday.
>
> Patient: I don't recall saying that. I am not saying I did not, but if I did I am surprised that I did…[silence]…I don't remember what happened in the session. It feels a very long time ago…as if it were a long time ago. (p. 173-174)

Koenigsberg, et al (2000) provides a technique for establishing a schizoid transference when the splitting of affect limits the ability to work effectively. Affects that seem inaccessible in the consulting room are nonetheless analyzable from the patient's behaviors, fantasies, and dreams. The therapist remains actively attuned to this material, using it to reverse-engineer feelings present in the transference. This is a slow process, and must be performed over and over—identifying affect, linking it to object relations in

the room, and gently addressing resistance and defensive processes (Koenigsberg et al., 2000). Gradually linking up affects with object relations is one of the primary functions helping the patient consolidate his identity. The therapist should not focus on the loss of feeling per se, but rather on the reason it has been split off. This procedure is described

(1) Watch for split off affects in session in the patient's behaviors and, especially, in his fantasies. Once an affect is spotted, it should be used as a guide to help identify the active transference state.
(2) Call the patients attention to split off affect and encourage him to wonder about the connection in the session.
(3) Explain the meaning of the affect as it serves to link the part-self and part-object-representations he has identified in the transference and the defensive purpose of splitting it off. This reconnection is the central therapeutic tactic.
(4) Repeatedly do this so that the patient can see it will not lead to his destruction.
(5) Gradually transference will take on a more real quality and the patient will grow in his ability to use the transference interpretations.

cited from Koenigsberg, et al., 2000

Figure 7.6. Technique for establishing schizoid transference.

Schizoid transference is suffused with deep conflicts. As discussed, the desire to attach to the therapist and be nurtured is usually accompanied by fears about being smothered, attacked or rebuffed. Often the schizoid finds himself feeling repulsed by the therapist, imprisoned, claustrophobic, and often has to withdrawal again (Guntrip, 1969). Most importantly, the therapist should be sure to help the patient articulate the fears infused within the transference, particularly fears about implosion, engulfment, and loss of self. If the therapist is to be successful, the therapist must also be adept at recognizing within the transference the subtle shifts in relative distance between himself and the

patient, speaking to the various anxieties that suffuse the very experience of sharing and talking to another person (Mansfield, 1992).

Overview of Interventions and Techniques

This handbook describes a treatment in which interpretation plays an essential part but confrontation is generally proscribed for all but the highest functioning patients. This section reviews specific issues related to the use of supportive interventions, advice, mirroring, confrontation, and interpretation. Two specific techniques for softening interventions are also suggested.

Supportive interventions & advice. As overly supportive or reassuring interventions can make the schizoid feel objectified and foolish (McWilliams, 2006), the therapist should be sure, when he chooses to use such interventions, that they come from a genuine place. In general, such interventions should be used economically and as a prelude to interpretation. On the other hand, advice can make the schizoid feel coerced (Klein, 1995). The use of advice should be limited only to lower-functioning patients, particularly schizotypal cases, who require help with problems related to hygiene, issues of daily living, and social skills.

Mirroring. Mirroring interventions, particularly mirroring of withdrawal behaviors during periods of regression, are usually more than the schizoid patient can tolerate (Klein, 1995). Mirroring interventions are highly threatening to the severely schizoid patient because they increase his feelings of exposure and vulnerability to the point of discomfort. During withdrawal, such interventions can contribute to ontological insecurity during moments of already overwhelming anxiety (Klein, 1995).

Confrontation. In contrast to interpretation, the use of confrontation with schizoid patients is counterindicated (Williams, 2010). The therapist is advised to use confrontation judiciously and with respect to the patient's ego strength and overall level of functioning. Confrontation, along with advice giving, can easily feel manipulative to the patient, as if he is being told to obey what the therapist is saying (Seinfeld, 1991). Confrontation may also lead the patient to feel the therapist is being aggressive, handing out disciplinary action, or devaluing him.

If confrontation of defenses is made too hastily or bluntly, the patient may become frightened, depersonalize, and enter a state of non-being. Particularly early in treatment, the use of direct confrontation can easily overburden the patient's coping mechanisms, leading to premature termination (Duryee, 1996). Instead, the therapist should join with the schizoid in wondering aloud about how resistance and defensive functions defend against the possibility of the emergence of dependency in the therapeutic relationship. The therapist should not give any indication that the patient's defenses or resistance are being judged in a negative light (Kahn, 1974).

Interpretation. Schizoid patients often respond positively and feel safer when they sense the therapist is not afraid to make interpretations about their feeling states. As Appel (1974) notes, "In my experience some schizoid patients require, and respond very well to, early discussion of their competitive, ambivalent, and murderous impulses regarding me—indeed were quite reassured that I recognized, did not fear, and could deal with the material" (p. 105). Interpretation adds coherence to the patient's experience of treatment and frees up his embryonic ego to develop more fully (Eigen, 1973). With the therapist helping the patient compensate for his missing ego functioning, the patient is no

longer pressured to analyze himself in the therapist's presence as he would otherwise be prone to do.

Most authors emphasize the use of interpretation with schizoid patients, though also urging the therapist to take into account the exquisite sensitivity of these patients when making interventions (Appel, 1974; Heyman, 1990; Klein, 1995; Mansfield, 1992; Seinfeld, 1991). Other authors are more conservative in their estimation of what the schizoid can handle, suggesting that given the patient's existential fears, it is best to avoid too much focus on the patient's affect within any transference interpretation to avoid setting off a regression (Klein, 1995). These authors feel that interpretation with an already fragile personality can risk further disintegration and worsen the prognosis for a successful therapeutic outcome (Heyman, 1990).

Williams (2010) suggests that before making any transference interpretation, the therapist can make a supportive intervention to soften the interpretation for the patient. In this manner, the therapist avoids shocking the patient and gently eases the patient into a discussion of the transference material. This model includes two steps. First, the therapist makes a supportive intervention that demonstrates an understanding of the schizoid's fear of relationships, attempting to reassure the patient that the therapist is not intending to be critical or forceful. Second, the therapist makes the actual transference interpretation referencing the patient's dynamics.

Williams (2010) offers the following example of this two-step model:

> "I understand your wish to stop your therapy and, of course, I have no power to stop you: to do what we are doing would be a difficult undertaking for anyone and I think that recently you have been finding this especially painful" [*supportive intervention*].
>
> "I think you feel frustrated and hurt by the comings and goings to and from our session and are often left having to cope with a great deal on

> your own. I think this makes you feel resentful and you feel like quitting to stop the upset and pain. It must be very hard to talk about these feelings. I suspect that you are worried that I might not be able to stand it if you talk about them" [*interpretation of underlying anxieties*]. (p. 174-175)

A second process for softening intervention is known as *interpreting up*. Given that the schizoid has greater access to his unconscious material than many patients, traditional surface-to-depth interpretations are often not needed. Rather, schizoid patients benefit more from interpretations that move in the reverse direction, that is, from depth to surface (McWilliams, 1994). The therapist explores and interprets the material the patient presents, then focuses on establishing what in the schizoid's life may have triggered this emotional experience. In other words, to make meaning of the material, the therapist works backward to deconstruct why the patient might be feeling what he is feeling. Through this process, the schizoid come to understand that his inner experience is not crazy, but rich and vibrant, even if others are sometimes limited in their ability to understand it (McWilliams, 1994).

Two-step model

(1) Make a supportive intervention
(2) Make the transference interpretation

from Williams, 2010

Interpreting up

The therapist explores the material, names it, and then explains why that material may have been set off by the patient's life experiences.

from McWilliams, 1994

Figure 7.7. Softening schizoid interpretations.

Strategies, techniques, & tactics of TFP. The major strategies, techniques and tactics of Transference-Focused Psychotherapy (TFP), summarized from the work of

Clarkin et al. (2006), are summarized below for review and reference. These strategies and techniques are not elaborated individually in this handbook, but can be referenced in the TFP texts.

The Strategies of TFP

Strategy 1	Define the dominant object relations Step 1: Experiencing and tolerating the confusion of the patient's inner world as it unfolds in the transference Step 2: Identifying the dominant object relations Step 3: Naming the actors Step 4: Attending to the patient's reaction
Strategy 2	Observe and interpret patient role reversals
Strategy 3	Observe and interpret linkages between object relations dyads that defend against each other, thereby maintaining internal conflict and fragmentation
Strategy 4	Work through the patient's capacity to experience a relationship differently in the transference and review the patient's other significant relationships in light of this change

Techniques of transference-focused psychotherapy

- Management of technical neutrality
- Integration of countertransference data into the interpretive process
- Maintaining the frame of treatment
- Transference analysis
- Interpretive process: clarifying, confronting**, interpreting

The tactics of treatment

1. Setting the contract**
2. Choosing and pursuing the priority theme to address in the material that the patient is presenting (this includes monitoring the three channels of communication, following the three principles of intervention, and adhering to the hierarchy of priorities regarding the types of material that come up in a session)
3. Maintaining an appropriate balance between expanding the incompatible views of reality between the patient and therapist in preparation for the interpretation and establishing common elements of shared reality
4. Regulating the intensity of affective involvement

all materials from Clarkin, Yeomans, & Kernberg, 2006
**counterindicated for schizoid populations [*not from original source*]

Figure 7.8. Transference-focused psychotherapy.

Hierarchy of transferential material. The therapist actively approaches all obstacles to transference exploration as a first priority. Obviously, emergency issues, such as *suicidal or homicidal ideation*, are given precedence over any discussion of the transference material. Schizoid patients do not tend to exhibit acting out behaviors between sessions like other personalities at the borderline level of organization. In schizophrenic populations, patients with strong negative symptomology, including lack of motivation and flat affect, tend to have much lower risk for completed suicide (nearly eight times less) than those who have strong positive symptomology, such as suspiciousness and delusions (Fenton, 2000). Nonetheless, suicidal ideation and gestures should always be taken seriously as a primary barrier to treatment.

Other obstacles to transference exploration include *active withholding* by the patient, or efforts to keep secrets from the therapist. Threats to the continuity of treatment, such as missing sessions and chronic lateness, are also considered obstacles. However, the therapist is encouraged to tread lightly when addressing attendance related barriers, communicating the importance of attending regular sessions but never mandating or contracting for attendance. Finally, *non-affective and trivial themes*, particularly those supported by the schizoid's intellectualized defenses, should be addressed in the service of clearing the way for a deeper analysis of the transference. This is not to preclude the use of intellectual metaphor as a form emotional communication. In many cases, the therapist should be open to discussing art, literature, and philosophy, if it is in service of understanding the schizoid patient better (McWilliams, 1994).

The next priority for the therapist to address is the presence of *anti-libidinal manifestations*. Anti-libidinal phenomena are not the equivalent of withholding or lying,

though they do serve a defensive purpose. The *denial of feelings and needs* by these patients is often the greatest barrier to transference analysis because of the loss of affect that accompanies this denial. *Non-withholding silences* should also be investigated with respect to how they have been triggered by the presence of the therapist. Often, silences follow the activation of anger or fear, though this affective experience may be non-conscious to the patient. Finally, the patient's *oscillation in and out the relationships to the therapist* must also be addressed as a barrier to treatment. The reluctance to engage in an emotional relationship with the therapist must be discussed so that stagnation and impasse do not occur.

The next priority for discussion is *references to the transference*. References to the transference with schizoid patients are usually indirect and must be inferred through the patient's behavior or extracted from his fantasy life and dreams. Much of the transference analysis will take place at this level until the time that the schizoid is willing and able to tolerate his feelings for the therapist. Unfortunately, interpretations of split-object transferences sometimes lack potency with schizoid patients because the experience of the dependent, needy self is missing and cannot be integrated with other self-representations (Seinfeld, 1991). Nonetheless, to the extent that the patient is able to acknowledge the presence of the therapist, his communications about this relationship should be readily incorporated.

Other dynamics that are essential to interpret include subtle shifts in distance between the therapist and the patient (Mansfield, 1992), all instances of splitting (Koenigsberg et al., 2000), as well as the patient's phobias, obsessions, and delusions (Laing, 1960). The last priority in treatment is the discussion of *non-transferential, affect-*

laden material. This material should only be addressed in the absence of higher priority material.

The thematic priorities discussed above are summarized in Figure 7.9.

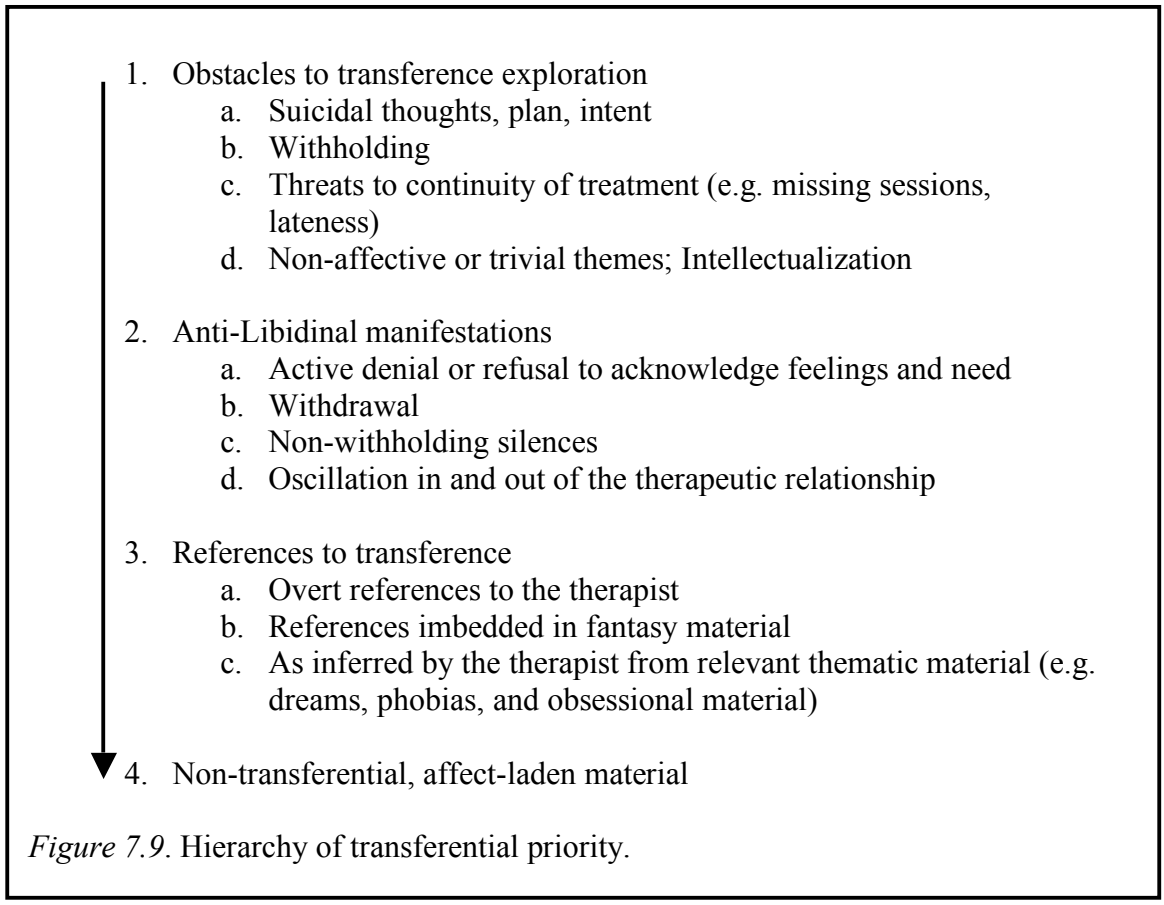


Figure 7.9. Hierarchy of transferential priority.

Primary Object Relations

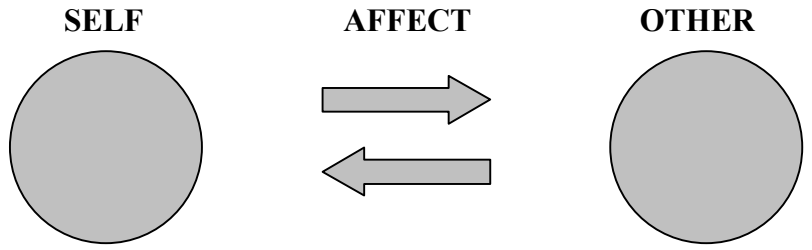
Defining the patient's dominant object relations is the cornerstone of transference-focused psychotherapy. The purpose of this section is to familiarize the therapist with the schizoid's world of internal representations. The therapist encourages the patient to describe his experience of interacting with the therapist, and presents the therapist's view of the patient for the patient to correct and refine (Clarkin, Kernberg, & Yeomans, 2006). The selection of adjectives the therapist uses to characterize the interaction should be

continuously developed until an agreement can be made, or until the patient and therapist agree not to agree, or the patient appears to be unable or unwilling to reflect further upon the interaction (Clarkin, Kernberg, & Yeomans, 2006).

Appel (1974) provides an excellent introductory summary to some of the main relational themes with schizoid patients:

> The schizoid's views of himself are revealed in his self-descriptions—'apathetic,' 'uninvolved,' 'small,' 'an observer of life,' 'empty,' and 'crazy.' He perceives close, sustained relationships as threatening and one who would be close to him as 'intrusive,' 'demanding,' 'controlling and 'smothering.' The schizoid's sense of separateness and integrity is fragile. In relationships he seems to fear loss of himself, of his boundaries, of his whole being. He repeatedly reveals the primitive nature of these fears in his language in sessions, through the fears he so often expresses of being 'devoured,' 'suffocated,' 'absorbed,' 'swallowed,' and 'merged.' Nor is the schizoid fearful only of external invasion. He senses too his own impulse to fuse and speaks of anxiety lest he become too 'dangerous,' 'devouring,' 'needy,' 'clinging,' and 'dependent.' He fears that his therapist will give in to him, that he will himself 'eat up' the therapist. Aloneness, however, carries its own terrors. Here, the experiences of 'emptiness,' 'hunger,' 'panic,' and 'confusion' prevail. Alone, the schizoid experiences the confusing and terrifying extent of his own impulses, which appear to him irrational, insatiable, and overwhelming, often 'crazy' thoughts and images, and finally and most frightening, the sense of utter emptiness and helplessness. (p. 99-100)

This section briefly discusses the schizoid's dominant self-object relational dyads by overarching themes. These themes include: (1a) libidinal dyads, (b) withdrawn dyads, (c) omnipotent dyads, and (d) sadomasochistic dyads. These dyads have been distilled and organized in Figure 7.10 for the therapist to refer back to. Of course, many other object pairings are possible beyond those explored in this section. The therapist should engage the patient in ongoing clarification and revision of these role pairs in the here-and-now of the therapeutic interaction.



The Withdrawn Self

Thing-Person	{Apathy	Cold, distant other
Empty self	Fear	Bored other
Cold, distant self	Anxiety}	Replaceable other
Petrified self		Ineffectual other
Eccentric, awkward, crazy self		Frightened other
Undecipherable self		Confused other
Quiet self		Disappointed other

The Dependent Self

Needy self	{Rage	Drained, depleted other
Longing self	Fear	Rejecting other
Intrusive self	Anger	Angry other
Clingy self	Disgust}	Revolted, repulsed other
Angry, destructive self		Endangered other
Sexually-excited self		Unsatisfied other

Sadomasochistic Themes

Slave self	{Anger	Manipulative, coercive other
Dominated self	Resentment	Sadistic other
Devoured self	Fear}	Devouring other
Drained, depleted self		Engulfing, appropriating other
Obliging, compliant self		Needy, controlling other

Omnipotent Themes

Idealized self	{Excitement,	Devalued other
Pseudo-adult self	Oceanic calm,	Infantile other
Exhibitionistic self	Pleasure}	Doting other
Special (symbiotic) self		Appreciative other
Knowing self		Unknowing other
Omnipotent, powerful self		Admiring other

Figure 7.10. Illustrated schizoid role pairs.

Libidinal dyads. When the schizoid is libidinally active, a variety of self-other dyads are activated. The schizoid's longing for others is usually kept at bay by the thought that the other will be rejecting and angry if he expresses need. Accordingly, as his longing for the other arises, the schizoid begins to fear the other will be worn out, drained, and exhausted by his presence. The schizoid, seeing himself as intrusive or clingy, begins to fear for the safety of the other. In this state, he guesses that others will be repulsed or revolted by his need. His greatest fear is that that he shows his need to the other and gets the wrong response or no response, if not a swift rejection. While he may understand on some level that the other is loving and concerned about him, but because it is not in a libidinal sense, he ends up believing that the other is cold, indifferent, bored, or uninterested in him (Guntrip, 1969).

Withdrawn dyads. Not able to get what he needs from the other, the schizoid withdraws once more to his internal world. As the process of withdrawal unfolds, the schizoid begins to feel numb and robot-like. As withdrawal persists, the schizoid starts to perceive himself as eccentric and awkward and projects that others are frightened, confused, or put off by his actions. Considering himself undecipherable, he shuts down even further; he sees himself as an 'It' or a thing. In this state, the schizoid's ability to empathize with other people is limited. Believing that no one can reach him or pull him back into the real world, other people become unimportant and replaceable. The schizoid loses his voice and goes silent; others in his world seem cold and distant. Alternatively, fearing and loathing his insubstantiability, the schizoid believes that others are disappointed, bored, and repelled by his wordless petrification.

Omnipotent dyads. The narcissistic elements of the schizoid manifest in specific ways. The schizoid tends to see himself as being special, invincible, and authoritative, and believes that others are admiring of these abilities. Cultivating special relationships with those he perceives as doting and appreciative generates pleasure and excitement. By exhibiting what he knows about the world and hiding what he does not, the schizoid feels he is an adult, knowledgeable, and capable of handling his affairs without any need for assistance or support. By devaluing others, who he sees as being needy, dependent, unknowing, and infantile, the schizoid can continue to maintain his own idealized self image.

Sadomasochistic dyads. The presence of sadomasochistic themes and master-slave dyads are often at the core of the schizoid transference (Klein, 1995). Having grown up with distant, punishing, or neglectful parents, the schizoid ultimately believes that love and attachment cannot be a part of his identity. Unable to be himself, the schizoid decides it is best to become what the other person needs him to be. Developing self-sacrificing defenses, the schizoid begins a masochistic pattern of relating to imposing and controlling others. In other words, the schizoid allows himself to be dominated because he has never learned to differentiate himself from his parents, to say no, or to assert his deeper needs and feelings (Klein, 1995).

Outwardly, the schizoid sees himself as reliable and compliant with the wishes of others. A deeper level, however, he feels helpless, depleted, and unable to stop himself from being consumed by an appropriating other. The schizoid feels that relationships strip him of his abilities, his possessions, his resources, and his hopes for the future (Klein, 1995). No matter how hard the schizoid works to please and satisfy the needs of

the other, the other seems insatiably hungry. Since he does not know how to defend himself, the only chance the schizoid has is to distance himself from relationships. The more needy or sadistic the parents were, the more distant and inaccessible the schizoid becomes later in life. In severe cases, coercion, manipulation, bullying, intimidation, and cruelty by caregivers all but destroy the possibility for mutuality in relationships (Klein, 1995). Sadomasochistic preferences may also manifest in sexual fantasy, but are more often evident in the tendency to choose partners that are distant and unengaged rather than nurturing and emotionally available.

The schizoid can alternate between rage, resentment, and fear as sadomasochistic dyads become activated. While the higher-functioning schizoid perceives the master/slave relationship with ambivalence, the lower-functioning schizoid responds with automatic withdrawal and return to involvement with fantasized relationships (Manfield, 1992). Yet the schizoid does not usually acknowledge his servitude to the other. Instead of hazardous, the external object, when capable of being somewhat acknowledged, is usually perceived as *hovering* (Giovacchini, 1979). The hovering object feels intrusive, unsettling, or disturbing, and, after prolonged exposure, leads to panic and withdrawal.

The following case material describes several schizoid patients with histories that include sadomasochistic relationships with coercive, controlling parent figures:

Case 1

> Ms. R. expressed her view of the fundamental experience of attachment as being a loss of control. Her description of her family relationships was that of an endless battle of wills. And in the end, she felt, she would surely lose. She felt that if she ever tried to be close to her parents in any way, she would have had to give up her self totally and become their live-in slave. Ironically Mr. R. had presented for treatment at a point when her elder sick father was threatening to move in, so that the patient could be his full time nurse. The expectation was that the patient would give up her

job and devote her life to assisting him. No one in the family had asked the patient how she felt about this assigned role. The inability to acknowledge the patient's own feelings and wishes was as strong now, when the patient was 39 years old, as when she was a young child. Although Ms. R. had lived her entire adult life away from her family, there was no acknowledgment of her having any life apart from that to which she was assigned by the family. (Klein, 1995)

Case 2

Mr. H. expressed similar fears when he described how his mother's words or actions, or even facial expressions, would ‘drain all the energy from me.’ Although he was now 24 years old, he reported that the only picture of him in the family home, where he was still living, showed him at the age of five or six sitting on his mother's knee, like ‘a puppet on a ventriloquist's knee . . . I was trapped . . . unable to move or act except as she commanded me to do. I had a mind of my own, but it made no difference. No one cared and no one asked. I simply mouthed the words that she wanted and expected to hear. And if I didn't submit, I felt I would be discarded. Put aside. I would be away from her control, but I would be alone, exiled. To stay connected, I had to be her slave.’ (Klein, 1995, p. 62)

Case 3

Mr. W. described his experience of appropriation, which seemed to start with his parents' refusal ever to have doors locked, or even shut, in his home. This almost psychotic intrusiveness and hypervigilance on the part of his parents left Mr. W. with the feeling that nothing he had could be kept private. For him, the open door became a symbol of the feeling that everything he was and had was there to be used by his parents, and that he was nothing and had nothing to which he could lay claim or of which he could feel ownership. Privacy was impossible, including the right to his own body. For example, his parents would always check on him at night to make sure that his hands were outside the covers, and he could never lock the door when he used the bathroom. He was discouraged from identifying himself as a sexual being. Mr. W., an extremely schizoid man, grew up with very explicit feelings of being asexual.

Mr. W. described his experience of appropriation in the following way. Whenever he would have an idea about what he wanted to do with his future and mentioned it to his mother, he felt that the idea would be lost to him forever because his mother would take it and use it to fuel her own fantasies and needs. She would alter or shape it to her specifications so that it no longer belonged to him. The idea or goal had been

> appropriated to provide emotional gratification for his mother, as opposed to any acknowledgment from his mother that the goal involved the patient's wishes, needs, or feelings. For example, the patient could never introduce a girlfriend to his mother without the prospect of a long lecture on how that girl met (or, more likely, failed to meet) the mother's specifications for a girlfriend. No sport played, interest pursued, or career considered was evaluated or even thought of in terms of the patient's feelings; rather, all were considered in terms of how they made the mother feel about herself, what she could tell her friends, and how they furthered the mother's success in shaping her son to gratify her needs. The patient described how he could never fight his mother on these issues, since he felt that all power eventually flowed from her to him. Her control was absolute. If she laid claim to something, it was hers. There was no sense in fighting. Surrender was inevitable. (Klein, 1995, p. 60-61)

Common role reversals. When role reversals occur, the attributes of the patient are unconsciously projected upon the therapist and enacted in treatment. In schizoid patient, these role reversals are most commonly between: (a) infantile self and adult-like other, (b) drained self and devouring other, (c) slave-like self and needy other, (d) idealized self and devalued other. These role reversals are illustrated in Figure 7.11 below for the therapist to visualize and refer back to.

Essential Therapeutic Competencies

This section reviews major therapeutic competencies important to the treatment of schizoid states, including tactics and strategies for handling: (a) withdrawal, (b) fantasy, (c) anti-libidinal forces, (d) somatic experience, (e) symbiotic strivings, (f) omnipotence, (g) approach-avoidance, and (h) schizoid communication and silence. These competencies aid the therapist in moving beyond those techniques discussed previously for working with transference. After a brief review of each topic, a box summarizing important information is provided for review.

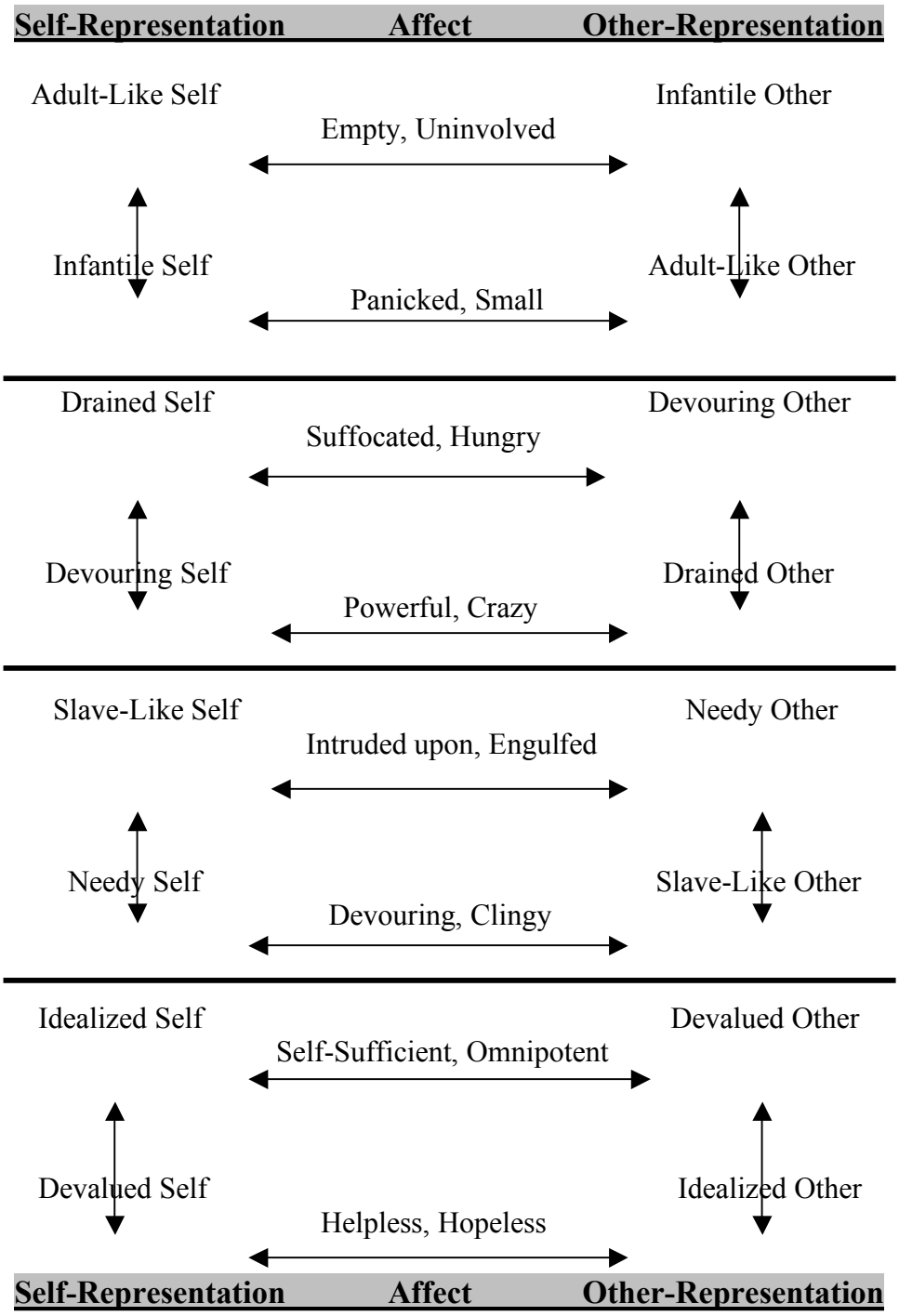


Figure 7.11. Common schizoid role reversal.

(a) Managing withdrawal. When schizoid withdrawal occurs, the therapist observes the withdrawal aloud, but should not make any attempt to force the patient to connect beyond that. Often, verbal communication is not necessary during withdrawal and should be kept to a mindful minimum as too much contact during this time can over-stimulate the patient further. While it is ok to allow for a certain amount of silence during the regression, the patient may eventually need help verbalizing his fear of the therapist, his desire to be left alone, and the loss of self that he has experienced. Even as the therapist maintains a benign and neutral poise at this time, he does not allow the patient to totally break off contact. Rather, the therapist should make his presence known to the patient even as he allows the patient to create distance. Ultimately, the therapist is responsible for re-establishing the interpersonal bridge with the patient in the event that the patient cannot himself. Later in treatment, the patient will begin to assume this role himself.

During the withdrawal period, the therapist should also limit mirroring interpretations, particularly those that accentuate the schizoid's difficulty to stay connected (Klein, 1995). The therapist may wish to focus instead on the patient's desire to create safety for himself, or his need for distance and space. As ever, the therapist should continue to interpret shifts in how close the patient is allowing himself to get (Klein, 1995). The therapist also identifies the feelings or impulses that may have caused the regression to occur. Any fantasy material that emerges during this period may be interpreted and used to reconstruct the causes for the patient's withdrawal.

High-functioning schizoid patients are capable of concealing withdrawal in a nearly seamless way and the therapist should be aware of the activation of the patient's false self in an attempt to conceal his inner distance. The therapist may also wish to note any intellectualized or eccentric communication that the patient uses as an attempt to re-establish contact. Ultimately, the patient needs to be able to see that he can regress in the presence of the therapist without flying to pieces, being destroyed by the therapist, or being embarrassed and ridiculed, so that he no longer needs to conceal or avoid this process in treatment.

- Allow the patient to withdrawal, but remind him of the presence of the therapist
- Help the client verbalize the process of withdrawal as it occurs, including the patient's impending fear, his desire to be left alone, and later, his desire to regain contact with the outside world
- Be mindful of the patient's extreme sensitivity to stimulation or engagement during withdrawal
- Limit mirroring interventions if the patient has become too activated
- Interpret the regression with respect to the patient's need to limit emotional connection in the therapeutic relationship
- Observe all efforts to activate a false self to cover regression (i.e. obsessive behavior, intellectualism, pseudo-adult self)
- Interpret any fantasy material that emerges during the regression and link this material to object relationships dyads

Figure 7.12. Managing withdrawal.

(b) Managing fantasy. Working with schizoid fantasy is an essential competency because it provides a primary means for accessing the schizoid transference. The therapist may choose to communicate to the patient the relevance of sharing fantasy material in session, but does not push the patient to share this material if he is not yet comfortable. Taking time to provide psychoeducation about this process may be useful. Any resistance to sharing the fantasy life should be explored so that the patient does not

withhold this material from the therapist. Ideally, the patient learns to recognize and present fantasy material spontaneously without needing to be prompted. The overall goal of working with fantasy is to help the patient understand this material, and to release this material into actual relationships in real life, particularly into the therapeutic relationship. Helping the patient reality test between the content in his fantasy life and the events of his real life is an important part of this process.

As always, a moment-to-moment assessment of the meaning and use of fantasy is required. Fantasy materials should be explored carefully for information about self-states, much as a dream would be. Even though the patient may describe his fantasy life without apparent feeling, the fantasy material is often saturated with intense feeling and information about object relationships. The therapist should watch for split off affects and interpersonal themes, calls the patients attention to these themes, and encourages the patient to wonder about the connection, explaining to him the meaning of the affect as it serves to link the part-self and part-object-representations (Koenigsberg et al., 2000).

It is never more important to be open and understanding of the schizoid patient that in a discussion of his fantasy life. Many schizoid patients are often surprised by the raw violent and sexual impulses contained within this material. Themes of enslavement or suffocation by therapist, fears of contact with the therapist, and rage about perceived coercion may emerge. Omnipotent themes are also prominent.

The following case material briefly demonstrates one patient’s replacement of fantasy with real relationships over the course of his treatment:

> After obtaining consultation about the case, Mr. M.'s therapist began to interpret his massive fear of attack and his use of pornography and fantasy as his only semblance of a relationship with another person. Mr. M. resumed regular attendance in treatment, and over time gradually reduced

> his dependence on pornography as he was able to develop a stable and safe relationship with the therapist. He gradually began to take risks both within and outside of treatment, tentatively forming minimal relationships on the outside. After six years of treatment once a week, Mr. M. is still slowly emerging from his fantasy cocoon. (Manfield, 1992, p. 225-226)

Manfield (1992) provides a separate example focusing on how the therapist can help the patient to see his own defensive use of fantasy:

> Patient: I can be in the middle of something and then boom, the whole combination of emotions. . . . I don't think I should be treated this way. I feel I'm being harmed, taken advantage of, misunderstood. She interprets me to myself without listening to me. 'You feel this way or that way.' She doesn't have the foggiest notion of how I feel. I feel she picks a fight, accuses me of being a failure. A fight develops and I feel like an innocent bystander. But that misunderstanding is really frustrating. Every day an action or state of mind is the basis for picking a fight and what she faults me for is usually not even what I meant. I'm getting a shorter and shorter fuse. I'm less willing to avoid the fight, more willing to slug it out……(etc.) (talks more about the incident)…and she misunderstood me deliberately.
>
> Therapist: Did you try to clarify the misunderstanding with her?
>
> Patient: No, I thought of a lot of things I might say but I didn't think I'd get anywhere with any of them.
>
> Therapist: You feel so embattled and threatened that you feel you dare not say anything to her directly, so all your negotiations concerning the relationship take place internally. (Manfield, 1992, p. 230-231)

- The therapist communicates the relevance of fantasy material to treatment
- The therapist uses clarification to solicit fantasy material
- As affect-laden fantasy materials are presented, interpretations of the patient's object relations can be made
- The overall goal of working with fantasy is to help the patient understand this material, and to release his fantasies into actual relationships

Figure 7.13. Managing fantasy.

(c) Working with the anti-libidinal ego. Fearful of his own neediness, the schizoid rejects the help of anyone who might be nurturing, pleasing, or encouraging of him (Guntrip, 1969). The patient is unlikely to be able to admit he needs help from the

therapist, and will resist becoming dependent on the therapeutic relationship. Making the patient conscious of his tendency to dismiss his need for others is a principle aim of treatment, and an essential step in the consolidation of the patient's identity diffusion. The therapist explores how the patient makes himself easy and non-demanding so he will be accepted by the therapist. The patient needs to become aware of self-destructive tendencies that hinder, impede, and prevent him from getting close to others.

Though the patient may report a desire to be helped by the therapy, the patient's anti-libidinal efforts are not usually conscious to him (Guntrip, 1969). Seinfeld (1991) notes that while the therapist should be actively involved in exploring the patient's conflicts around dependency, it's important that the patient be allowed to continue dissociating his needs so that he can remain in relationship to the therapist early on. If the patient's needs are allowed into treatment before the patient's ego has been developed, a malignant regression may occur. Teaching assertiveness is often beneficial only *after* significant work has been done to resolve this underlying conflict.

As the patient's need becomes conscious, a negative transference may develop. The therapist should be careful never to ally with the libidinal parts of the patient alone. Though the schizoid will try to keep the therapist as a good object as much as he can, his associations, dreams, and fantasies usually reveal rage and existential fear about the dangers of dependency (Guntrip, 1969). As Gruntrip (1977) notes, "A naïve enthusiasm on the part of the analyst in taking sides with the Libidinal Ego, and an over-anxious pressing desire to 'save' the patient, can only provoke sooner or later a fierce antilibidinal reaction and is self-defeating" (p. 145). Frequent regressions occur at this point, and the

patient will alternate between leaning on the therapist and moving back into self-sufficiency (Kahn, 1974).

Over time, the patient must learn to feel comfortable being dramatic, demanding, bothersome, critical, and dissatisfied with the therapist. He must dissolve his identification with others and learn to balance his ability to give love with his ability to take love. He must, above all, come to understand his right to exist in the world.

The following case material illustrates how one patient's attitude toward the neediness of his son, and ultimately toward his own needs, shifted over the course of a successful treatment:

> Another patient described how his attitude to his small son changed during the course of his analysis. At first when the boy cried, the father would feel an absolute fury of intolerance and shout at the boy to stop it at once, which only made him worse. Then later on he managed to moderate this and would say: 'Come on now, stop this crying. You're a big boy now.' The patient explained that as a boy he was himself often very frightened of his father but never dared to cry, though he often felt like it. But his son was not 'a big boy now' and the father was trying to force him to a premature assumption of an attitude older than his years, because this was what had happened in his own case. Finally, however, he worked through to a third position, and said: 'Now, when the lad cries I don't feel that old fury. I can accept his childishness better and I say 'I'm sorry old chap you're so upset. I know how you feel, but never mind. You have your cry and you'll feel a lot better soon.' That, he says, works far better, and in a short time the tears are dried and the boy has forgotten it all. (Guntrip, 1969, p. 187)

- Identify, explore, and interpret all anti-libidinal manifestations
- Dissolve the patient's identification with the needs of others
- Teach patient to balance ability to give love with ability to take love
- Explore patient anxieties about the dangers of having needs gratified
- The patient must learn to feel comfortable being demanding, bothersome, critical, and dissatisfied

Figure 7.14. Working with the anti-libidinal ego.

(d) Managing somatic experience. Given the schizoid's tendency to utilize his body as a primary part of the false self (Laing, 1960), a strong focus on somatic experiencing is warranted in treatment. Before authentic, spontaneous bodily action can occur, the schizoid must regain a felt sense of himself. As Eigen (1973) notes:

> A 'dialectic' between the activation of the detached ego sense and an activation of repressed body-life eventually must go hand in hand in order to prevent a one-sided development. Again, however, it is the therapy relationship itself which will permit the integration of split-off body-impulses into central ego structures. (p. 497)

The overarching goal of somatic experiencing in schizoid treatment is the identification and integration of split off bodily needs (i.e. hunger, lethargy, elimination, sexual impulses, etc.) and sensations so that these repressed experiences can be allowed into consciousness. The patient needs to learn to identify with his bodily experience rather than only with his intellect. As many schizoid patients lack the vocabulary to describe their bodily impulses, sensory information must first be transformed from impulses, symbols, and images, into words with the help of the therapist.

The therapist can be creative with somatic exercises. Bilotta (1991) offers several suggestions. For example, the patient may benefit from practicing using his eyes as a means of making contact with the therapist, and exploring the experience of fear that arises in this process. Focusing the patient's attention to his hands, feet, or genitals, helps to draw energy downward from its stronghold in the head. Drawing the schizoid's attention to his exaggerated rigidity, lack of expressive body movements, and restrained mobility, in conjunction with progressive muscle relaxation exercises, may begin to release the patient's embodied defense against contact. Similarly, having the patient

notice the mask-like, frozen features of the face and describe this experience can add awareness to the split these patients have between their mind and body (Bilotta, 1991).

- Experiences of bodily need (i.e. hunger, lethargy, elimination, sexual impulses) must be identified, normalized, re-claimed, and integrated
- The patient must learn to accept and identify with his body
- The patient must acknowledge and accept desires for physical intimacy

Figure 7.15. Managing somatic experience.

(e) Managing symbiotic strivings. The schizoid's unresolved symbiotic strivings often create a technical problem in treatment. The patient unconsciously seeks to fuse his identity with the therapist by assuming the role of caretaker or rescuer while making the therapist into a needy and dependent other. Often, he seeks to minimize any chance at conflict by adhering as seamlessly as possible to the frame. The patient is adept at minimizing the philosophical differences between himself and the therapist, taking up the therapist's goals for treatment, and making the therapist feel successful. The therapist should note when he feels he is being taken care of by the patient and integrate this countertransference information into treatment. If the therapist comes to feel the patient is always easy and enjoyable to work with, this may be viewed as a sign of disconnect in the treatment and should be addressed.

The overarching goal when working with symbiosis is to help the patient acknowledge that he is a separate person from the therapist and capable of having his own subjective experience of the world, even if it differs from the therapist. The therapist must maintain engagement at the same as he aggressively asserts his separateness from the patient, essentially letting the patient know, '*you are you, and I am me* (Kahn, 1974).' Therapy becomes an opportunity to confirm both parties' experience of the world, and,

subsequently, their ability to communicate together as independent beings (Duryee, 1996).

The schizoid often seeks to maintain an idealized relationship with the therapist while splitting his negative transference inward. The patient must learn to modify his pattern of making himself into what the environment needs. The clinician should be careful to observe and interpret the patient's defensive identification, and interpret every time the patient projects his disowned needs and feelings into the therapist or uses other people to talk about himself. It is particularly important, given the patients symbiotic strivings, that the therapist be aware of the risk of *transference cures* at all points during treatment (Laing, 1960).

- Help the patient see that he is a separate person from the therapist
- Observe and interpret identification with the therapist and projection of needs into the therapist

Figure 7.16. Managing symbiotic strivings.

(f) Managing omnipotence. Schizoid omnipotence does not create a technical problem in treatment the way the omnipotent control does in other borderline level conditions. However, because schizoid omnipotence is ego syntonic, the patient is not likely to be conscious of the ways in which omnipotence distorts his view of himself. Ultimately, the therapist seeks to make it possible for the patient's observing ego to question his feelings of invulnerability. In treatment, the schizoid must learn to admit that he can't do anything and everything well for himself on his own. Reality testing with the therapist is often enough to give perspective and encourage working-through. At other times, the acting out of omnipotent fantasies can help highlight the patient's realistic

limitations. When the gratification of omnipotent fantasy no longer brings pleasure, the schizoid's sense of superiority and need for self-sufficiency is weakened. Over time, confronting and interpreting omnipotence in the transference will resolve omnipotent fantasy and will be accompanied by a rise in anxiety about the emergence of libidinal needs. However, if the underlying conflict with dependency and loneliness is too great, the schizoid may retreat back to omnipotent fantasy once more.

- The schizoid must learn to admit that he can't do anything and everything well for himself
- Reality testing, acting out, or putting omnipotent fantasies to work =gives perspective and leads to working-through
- The patient learns to question the feelings of invulnerability using his observing ego

Figure 7.17. Managing omnipotence.

(g) Managing schizoid compromise. The patient's oscillation in and out of relationships should be one of the major focuses in the course of treatment. The therapist should not simply allow the patient to struggle in therapy, hoping that he will work through his fear of connection with the therapist (Klein, 1995). Ralph Klein (1995) offers specific suggestions for how to work with the patient's pattern of approach-avoidance, as summarized in Figure 7.18, below. Klein suggests the following generic interpretation of the schizoid's oscillation when it manifests in the patient's life:

> 'It seems to me that as you try to connect (share, get close, communicate, take a risk), you feel unsafe (anxious, in danger, imposed on, intruded on), and then you withdraw (retreat, shut down, turn off, go into exile) in order to feel safe (free, in control, self-possessed, self-contained). However this place of safety brings with it its own anxieties (dangers, alienation, isolation, disconnection, despair).' (p. 100)

This interpretation should be used liberally so that the schizoid's perception of his enslavement to the therapist is interrupted and his anxiety is reduced. The therapist also works with the patient to explore possibilities for getting closer in treatment (i.e. sharing thoughts and feelings, easing of boundaries, increased communication) without allowing his fear to become unbearable (Klein, 1995). The therapist should make sure to emphasize that the anxiety the schizoid experiences is a necessary risk to overcome his fears about connection.

The following case material illustrates how one therapist addressed the activation of the schizoid compromise in treatment:

> One male patient proceeded with his defense against analysis by flooding every session with long recitals of endless dreams, simply recounting one after another without a stop. That this was a quite serious compulsion was evident from the fact that for a long time my assertion that these dreams were a waste of time since he had never made any use of them, and they made no impression on him. By cramming sessions with dreams he was seeking to prevent my saying anything that might stir up anxiety. When at last he did consent to have a look at a dream before hurrying on to the next, he would set about the intellectual analysis of its meaning (which he was able to do since he was well versed, professionally, in symbolism), or else keep on asking me questions as to what I thought this or that meant. I judged it inadvisable to let him come up against too blank a wall of non-response on my part, and carefully selected the points on which I did comment, to help him to become aware of his deeper anxieties. Gradually he became able to drop this compromise method of coming for analysis without having it, and then he began to 'feel' how much his very schizoid personality was out of real touch with his environment. The theme of loneliness took the place of somewhat excited dreaming. (Guntrip, 1969, p. 298)

Another essential part of the patient's growth will be realized through his efforts to branch out into new relationships and friendships (Klein, 1995). Though the patient may learn to tolerate closeness to the therapist, he can easily use the therapy as a protective shelter from the world instead of applying what he has learned in treatment to

their other relationships (Klein, 1995; McWilliams, 2006). Encouraging the patient to branch out socially is a delicate task. As McWilliams (2006) notes, "Because the line between being an encouraging presence and being an insensitive nag can be thin, it is a delicate art to embolden the patient without being experienced as impatient and critical in ways reminiscent of the early love objects" (p. 21).

- The therapist demonstrates awareness of the patient's oscillation in the therapeutic relationship
- The therapist focuses on the patient's conflict around wanting but fearing closeness
- The therapist and patient explore possibilities for getting closer to therapist (i.e. communication, sharing of feelings)
- The therapist conveys to the patient that his anxiety is manageable during closeness
- The therapist emphasizes that the client tolerate the risks of closeness for the sake of learning, but does not let the patient become overwhelmed
- The therapist explores how the patient applies efforts to get close in his life outside the session

from Klein, 1995

Figure 7.18. Managing the schizoid compromise.

(h) Managing schizoid communication. Active listening and attention to non-verbal communication go a long way toward establishing trust with the schizoid patient, while simultaneously gratifying his deep longing to have his subjective experience acknowledged by the outside world (Benjamin, 2000). The therapist should be sure to acknowledge the danger the schizoid feels about making contact with others though communication. Allowing the patient to communicate in whatever way he can, without interfering or trying to change that process, is important early in treatment. To this end, the therapist might consider being open to discussing music or visual and dramatic arts,

as these topics may provide conduits for the schizoid to begin to find a means of expressing his feelings (Robbins, 1988).

Periods of silence are likely to be frequent in long-term treatment. Schizoid silence tends to reflect either: (a) the defensive process of withdrawal indicative of a deeper emotional experience, or (b) the deadness, coldness, and emptiness of the schizoid's closed-off inner world (Seinfeld, 1991). The therapist should be careful not compensate for the lack of verbal communication by the patient when silence occurs. Allowing the patient to stay with his emptiness allows space for new spontaneous feelings to eventually emerge. As the schizoid's empty core manifests fully in treatment, a transformative therapeutic regression can eventually occur in which the patient begins to reclaim a more authentic sense of self (Eigen, 1973). The therapist needs to be aware that the patient is likely to feel defective during long silences, believing that he is disappointing the therapist because he does not have anything to say.

Given their symbiotic tendencies, schizoid patients may feel pressured to produce associations so that the therapist can feel useful. This is a form of *pseudo free association* that interferes with genuine communication, creating a serious therapeutic obstacle (Seinfeld, 1991). Free associations that plod along, lack richness, or display psychic components as if being talked about in the third person, are often used to cover up the schizoid's underlying emptiness (Seinfeld, 1991). This form of relating is exhibitionistic—it is meant to entice, lure, charm, and fascinate the therapist, thus distracting him from a discussion the patient's true feelings (Laing, 1960). This dynamic creates the possibility of *over-interpreting* the patient's materials, or assigning feeling and meaning to this material that are not really present (Laing, 1960).

The following case materials illustrate how the difficulty of the schizoid patient to communicate with the therapist can be addressed in treatment:

Case 1

> Patient: If I talk to you, I can't hide. I don't think there is any way of continuing in this process without going beyond that point I don't want to go beyond. It just seems to be built into the process, just by being here and the way you conduct the sessions, it's going to happen. I don't know what that point is or why I don't want to go beyond it. I feel at risk. There is some part of me I don't want to know about, hear about. In the last two days I've examined my skull. What is my anxiety about? What is all this feeling about? I've come up with nothing. I know I'm very unhappy with myself in certain areas, especially the way I'm handling health issues, but I just don't know.
>
> Therapist: You come here and find that you are exposing yourself, and it is not what you expected……..(*etc.*)
>
> Patient: Uh huh. It's not just that I don't want anyone else to hear it, it's that I don't even want to hear it myself, because once I hear myself say it out loud, I can't deny it; then, I feel like I have to do something about it. Ideally, I should be able to stuff it—to never know it was there. If I was really good I'd be eagerly addressing rough edges to patch them up so I wouldn't see it, like a drunk who doesn't want to know she is. But you are right. I feel safer with you than I would with anybody, because of your technique. You don't judge. But I wouldn't care if you were some kind of saint, I still don't want to get into this stuff—I don't want to change. But if I come here, it seems like I can't not get into it. I say to myself, 'I'm paying for it, let's not waste my time.' (Manfield, 1992, p. 209-211)

Case 2

> Sometimes, she preferred not to talk in sessions, remarking 'There is no use to talking, things are miserable, I am wretched and nothing can help.' At other times she would ceaselessly go over all of her failures or her despicable life, denigrating herself, her circumstances, and me. Then, I could not get through with interpretations. I felt hate in the counter-transference based upon my helplessness and her communication that she felt wretched and might kill herself, but there was nothing she would do to help herself or allow me to do.
>
> I said, 'Unfortunately you are absolutely correct. If you refuse to look at what is making you feel this way, if you will not even talk, or reflect on what is going on with yourself, if you remain totally at one with hating yourself and defeating yourself, then this cannot help. It is not helping because you are not cooperating. You are completely closing off

from me and the vulnerable part of yourself that needs help. You are telling it and me that nothing can help, so we should give up. In prophesizing that nothing can change, you maintain everything as unchanged. You shut out all communication but then feel deprived and as if nothing is helping.'

Annette: But it has not helped. I've been coming here a month.

Therapist: A month is not enough time, and it will not help unless you try to make it help by looking at what is happening and why you're withdrawing this way. The purpose of this is to look at yourself, to understand what is going on. So when you feel completely destructive or hopeless, the thing is not to go entirely with that feeling, but to look at what makes you feel that way, thereby beginning to separate yourself from it.

Annette: I don't know if I can.

Therapist: Of course you don't. You have no experience doing it. It is brand-new. You are just going with the destructive feeling, speaking to yourself in the voice of negatives and hopelessness. You are withdrawing and saying that you do not want to take in what goes on here just as you do not take in food. (Seinfeld, 1991, p. 153-154)

- Therapist remains actively attuned to non-verbal communications
- The therapist allows for silence in the room, but does not allow the patient to remain disconnected indefinitely
- The therapist acknowledges the patient's empty, quiet core
- The therapist acknowledges the danger the schizoid feels about making contact though communication
- The therapist is open to discuss music, visual arts, dramatic arts, literary metaphors, spiritual and religious ideas, particularly early in therapy
- Therapist is mindful of pseudo-association, free associations that plod along and lack richness, or exhibition of psychic components

Figure 7.19. Working with schizoid communication.

Factors of Change

This section reviews important factors of change in the treatment of schizoid personality using psychodynamic psychotherapy. While many of these aspects of treatment would apply to other forms of pathology, this discussion addresses these aspects as they apply to schizoid patients in particular. This information has been distilled

and matched from the collective literature, as outlined in Figure 7.20 on the next page. The factors of change include: (a) overcoming resistance to engagement and improving the quality of the defenses, (b) decreasing the splitting of needs and feelings, (c) differentiating the ego from the object, (d) modifying self/other representations, (e) allowing dependency on the therapist, and (f) movement toward the depressive position. Not every domain, or the mechanisms and sequences contained therein, will be applicable to each and every patient.

Overcome resistance & improve the quality of the defenses. Improving the quality of the schizoid's defenses is critical to prevent early dropout from treatment. A focus on the patient's use of withdrawal and fantasy comprises the largest part of working with defense and resistance. The process of withdrawal needs to become conscious, and the patient must learn to communicate his needs and feelings without having to distance himself from others. The patient also needs to become comfortable speaking about his fantasies in treatment so that, ultimately, through this process he can begin to releases his fantasy life into his real relationships. Abandoning aspects of the false self, including his pseudo-adult representation, his self-sufficiency and omnipotence, as well as relinquishing the schizoid compromise as the primary intermediary in his relationships, are essential for the schizoid to improve his ability to relate with others.

Decrease splitting of needs and feelings. As the patient's dissociation of his needs and feelings is explored, the therapist actively confronts all anti-libidinal manifestations as they occur. The therapist also works to expose the empty inner core at the center of the patient's experience. The patient must be able to tolerate his own inner silence long enough for spontaneous feelings or associations to emerge. As needs begin

[Distillation & Matching]

- **Overcome resistance to closeness & Improve the quality of the defenses**
  (1) Overcome resistance to sustained contact with others
  (2) Remove the schizoid compromise as the primary organizer of experience
  (3) Decrease omnipotence and sense of superiority
  (4) Abandon pseudo-adult façade and social false self (i.e. exhibitionism, imitation)
  (5) Interrupt the process of withdrawal
  (6) Release fantasy life into relationships

- **Decrease splitting of needs and feelings**
  (1) Expose infantile empty core; make patient aware of inner emptiness
  (2) Tolerate silences until spontaneous feelings can emerge
  (3) Reconstruct feeling states in the transference using fantasy material and behavioral observations
  (4) Work-through primal rage and terror
  (5) Learn to recognize and become a willing carrier of feelings
  (6) Learn to become a willing and assertive carrier of personal needs

- **Differentiation of the ego from the object (i.e. decrease symbiosis)**
  (1) Dissolve identification with the object
  (2) Learn to harness and express anger
  (3) Reduce symbiotic omnipotence and role as regulating other
  (4) Learn to hold external object in mind
  (5) Develop capacity to be alone
  (6) Improve assertiveness and ability to maintain autonomy**,** Reduce passivity

- **Modify self/other representations**
  (1) Wean patient off internalized objects
  (2) Modify the master/slave (sadomasochistic) dyads
  (3) Modify narcissistic/omnipotent dyads
  (4) Reduce splitting and identity diffusion

- **Allow for dependency on therapist**
  (1) Identify and decrease defensive self-sufficiency
  (2) Decrease splitting off of needy self
  (3) Undergo a period of dependency on therapist
  (4) Permit attachment
  (5) Take risks to explore other new social connections

- **Movement toward depressive position/Other**
  (1) Learn to handle ambivalence and conflict in relationships
  (2) Mourn lost relationships and childhood trauma
  (3) Mature underlying personality
  (4) Improve social awareness and communication

Figure 7.20. Theoretical factors of schizoid therapeutic change.

to emerge, the patients primal fear and rage about connection with others can be worked through. Ultimately, the patient needs to learn how to become a willing carrier of his own needs and feelings, and learn to assert these in the world.

Differentiate the ego from the object. Separation-individuation is essential to the process of deep change. The therapist works first to dissolve the patient's reliance on defensive identification and symbiotic omnipotence within the transference. The patient needs to understand that a certain amount of conflict and ambivalence within relationships is normal and unavoidable. The patient also needs to gradually improve his ability to hold and keep the therapist in his mind as a separate object with whom collaborative mutuality is possible. Learning how to harness and express anger and to say no when he needs to allows the patient to eventually become more assertive and less passive in the world. As the patient begins to feel comfortable enough to criticize or show anger to the therapist, the treatment will be marked by the increase of neurotic anxieties.

The following case materials illustrate schizoid patients taking steps to dissolve their identification with others and to move toward greater autonomy:

Case 1

> Estelle said she was reviewing her gains in therapy. On paper it looked miraculous. A new job with a raise, new friendships, the first relationship with a man whom she shared her intellectual and cultural interests and sexual pleasure. She felt that the progress may not have been for herself but for the therapist. She said that it was true he never directed her in what to do. Nevertheless she could see that he was pleased with her progress. The problem now was that she did not know if her accomplishments were for herself or to please him. She said, 'I do not want to do anything for you any longer.' (Seinfeld, 1991, p. 231)

Case 2

> In the last session, the patient concluded with the following: 'I have been excited by this process. All the fears around change and decision are still there. But now it is easier to deal with it all, the whole emotional part. Will I ever be emotionally attached to anything, to anyone, and not experience this anxiety?' (He is aware of his continuing vulnerability to schizoid anxieties, and wonders whether he will ever be free of that vulnerability.) He went on, "I find myself at times trying to go too fast, to do too much, too soon. It feels like I am going full tilt at times. Now I'm able to stop, to pull back, not all the way back, just to take time, to take a deep breath and become more relaxed and then I can go back to it more slowly this time, steady. I am really trying to figure out relationships. When I am too close, there is still not a whole lot of 'I.' You know what I mean? Not a capital 'I,' it's more like just a small 'i' Like I have become smaller, expose less surface to danger. When I am outside, when I am still having those conversations at times in my head, then I can still be all of me. But I don't want to live on a desert or in a refrigerator box. That's my decision. So that I must make room for others in my world. The way I want my world to be- it cannot be either you or me. It has to be you and me." (Klein, 1995, p. 116)

Case 3

> The first sign of Estelle's autonomy emerged when she and her friends planned a party. Betty, the informal leader of the group, decided on the guest list, the food, the music, and the decor. Estelle discovered that she had her own preferences and did not went to depend only upon Betty's decisions and taste. She showed less dependence and the beginnings of oedipal rivalry (who had better taste?) with the mothering object. In the ensuing months, the autonomous self emerged in Estelle's pleasure in shopping, selection of clothes, and recreational activities. She expressed a preference for certain films she saw. Her descriptions of friends reflected opinions as to whom she liked and disliked. These changes were reflective of an awakening of her healthy narcissism. The therapeutic task in this period was primarily that of mirroring and providing Estelle with a reflection for the emergence of her true self. (Seinfeld, 1991, p. 229)

Modifying self/other representations. The modification of self/other representations is at the very heart of the therapeutic endeavor. The therapist draws heavily on the strategies, tactics, and techniques of transference-focused psychotherapy in these efforts. Clarification and interpretations are used to link split-off mental states. The

patient's internal object relations are reconstructed using behavioral observation and drawing on the patient's fantasy life. The analysis of withdrawn, omnipotent, and sadomasochistic dyads then occupies the majority of this process. Chronic masochism is balanced with self-assertive behavior and mutual consideration of the needs of the self. The patient learns that while it is important to nurture others, doing so in a mature way means that he is also allowed to take love at the same time (Seinfeld, 1991). Gradually, the therapist helps the patient both to: (a) wean himself slowly off internal objects and replace these with objects in the real world, and (b) to modify the quality of his object relations.

The following case material illustrates how one therapist helped a schizoid patient distinguish his inner objects from objects in the real world so that these representations could then be analyzed:

> I replied how there are two relationships with Liz. There is the subjective relationship with Liz in your mind. You were with the subjective Liz all weekend. She knew every thought and feeling in your mind just by virtue of being thought of by you. You return to work on Monday and there is Liz acting as if she hardly knows you. She sits at her desk working on her report—she has not heard one thought you have had all weekend. She acts as if her only concern is the report in front of her that she must finish. She looks when you say 'hi' as if it distracts her from this job she must finish. Thus you have two relationships with Liz. One is subjective, the Liz that you created, a witness to whom you bare every thought and feeling in your soul and who exists only for you. This is the subjective Liz whom you expected to find waiting around at work. Then there is Liz as she is who is not a part of your fantasy but living her own life, typing her report, not knowing your thoughts this weekend. (Seinfeld, 1991, p. 64)

Allowing for dependency on therapist . The undergoing of a period of dependency on the therapist is usually arrived at only in the more advanced stages of treatment when the patient is comfortable enough to attempt this transition. This is the most painful ordeal of the treatment, and is often accompanied by intense fear and

anxiety. Often the patient and therapist will have to spend considerable time working to decrease anti-libidinal resistance before such a move is possible. The following case demonstrates the difficulty of the schizoid to allow for dependency on the therapist:

> I was a little girl, standing at the door of a large room, trembling with fear. I saw you inside and thought, 'If only I could get to him I'd be safe.' I ran across the room but another girl strode up and pushed me back to the door.
>
> Some two years later, when the patient was trusting me much more fully, she dreamed this same dream again. This time she got to within an inch of being able to touch me when the other girl emerged, as it were, from nowhere at the last moment, smacked her viciously across the face and drove her away again. (Guntrip, 1969, p. 197)

The patient must be willing to give up his efforts to control the therapy. A considerable reduction in the splitting of the needy parts of the self usually leads to greater awareness of suppressed loneliness and longing for the company of others. Regressions during this period will be frequent. A primary attachment to the therapist is the ultimate hope for this period. If the patient is able to feel secure in this attachment, he may then be able to branch out and explore social and romantic connections outside the therapy room with some encouragement.

Movement toward the depressive position / other. As the patient relinquishes inner objects, experiences movement toward separation and individuation, and allows himself to feel more, depressive anxieties may enter the therapeutic work. The patient's difficulty handling ambivalence in relationships and his concerns about his own aggression will need to be addressed at this time. The following case materials explore the upsurge of depression and guilt in a patient seeking to reestablish friendships and relationships after many years in a schizoid state:

> She now began to experience acute anxiety about me and about her husband, and the point of her remark that 'I get anxious about loving. It isn't safe' became clear. I put it to her that she was unconsciously

convinced that if she loved anyone that person would die and she was bound to lose him; moreover she also felt that she dare not enjoy anything at all and could hardly let herself be alive. It was as if her mother was always saying 'Stop laughing or you'll be crying in a minute.' She replied, 'That is exactly what they were always saying to me', and in fact she rarely laughed, and felt it was wrong to enjoy oneself. Her mother began to come into this in a big way. The mother had become a widow only a couple of years after the patient's birth, had had a hard life, and was an awkward, hardworking, undemonstrative woman who endured life joylessly, provided for the family's material needs, and was unaware of their emotional needs. Earlier in analysis the patient had dreamed that

> she entered a room where a group of women (her mother and sisters) were talking together and entirely ignoring a baby lying on the table. She got on the table and lay down on the baby and became one with it.

She grew up in the position that, in order to escape depersonalization through a sheer lack of any genuine relationships she had to cling to mother with some sort of a relationship which would be, as it were, manufactured from her side because it was not given by the mother. She could not get a loving relationship so she tied herself to mother by ‘duty.’ She felt she must not ever leave her mother, must stay at home and look after her, and in the process because a passive, shy, silent, self-effacing girl. The one and only major revolt was when at sixteen she responded to the call of love. [The death of her lover at an early age] aroused intense guilt. She should never have let herself be drawn away from mother into the prospect of marriage, and his death was her punishment. She felt guilt towards both mother and the man, and was overwhelmed by depression, of a severity that would make life impossible but for the fact that gradually a friendship grew up with another young man whom she later married. This enabled her to bury the trauma and depression of her first tragic love. The man’s letters were put away and never look at, i.e. repressed, but the safety of her marriage was ensured by the fact that she was quite unable to enjoy it or anything else. To have enjoyed life would have been to release a flood of guilt and depression. Now, after lengthily analysis, she was beginning to ‘feel’ once more and escape from her schizoid, affectless condition only to find that she was compelled to revive her repressed depression and guilt. Every time her husband was out she was prey to anxiety about his safety until he returned. The unconscious conviction was active in her that her marriage was disloyalty to mother; she ought not to have made it and she would be punished for it. Thus her analysis recapitulated the development from the schizoid to depressive position, and opened the way for growth beyond that to normal relationships, though not till her depression was analyzed, was she able to go deeper into the analysis of her schizoid troubles. (Guntrip, 1969, p. 169-170)

Course of Treatment

Areas of focus in early, middle, and late treatment. Markers of the process of change in the early, middle, and late phases of treatment are outlined on the following pages. These charts outline the process of change across a range of domains, including resistance and defense, transference, relationship to feelings and need, overall focus of the therapy, and working-through processes. It is not expected that therapeutic progress through these stages will be linear or that all areas need to be achieved in a successful therapy. Patients may regress to earlier levels of functioning under periods of acute stress or following steps forward in treatment, particularly as dependency and attachment on the therapist begins to be allowed.

Measuring Progress

While schizoid patients are capable of doing well in therapy, their prognosis comes with a number of large caveats, the largest of which is the patient's willingness to attempt sustained closeness with the therapist. The stronger the need of the patient to safeguard his freedom, to maintain resistance in the form of self-sufficiency and omnipotence, or to assume control of the treatment, the more difficult it becomes to help the patient and the longer a successful treatment will take to achieve (Guntrip, 1977). If the patient is too frightened to re-open the primitive rage and fear of his early life, therapeutic outcome will be limited. In these cases, no amount of pushing or pursuing by the therapist can make up for the lack of impetus in the patient. If the patient is not willing or able to face therapeutic regression and undergo a period of dependency on the therapist, no amount of analysis will make him do so (Guntrip, 1977).

Figure 7.21. **Early phase of treatment.**	
Defenses	• Frequent automatic withdrawal and retreat to fantasy • Large resistance to sustained treatment and to involvement within session
Transference	• Transference tends to feel weak or absent • Large focus on fantasy or dream material to construct transference • Long periods of silence may occur within session • The therapist actively re-establishes contact with the patient when it has been broken • Interpretations and confrontations are used judiciously so as not to overtax or engulf the patient • Psychotic anxieties may permeate the transference • Patient remains largely passive in his approach to engagement with therapist • Patients inner emptiness is identified and allowed into the room
Dependency Needs / Feelings	• The patient's ability to acknowledge oral needs, feelings, sensation, and wishes is limited • Identification of needs is accompanied by swift regression • Patient highly ambivalent about therapist and denies attachment
Therapeutic Focus	• Therapeutic alliance is stressed • Roles and policies are jointly discussed • Therapist recognizes and validates the patient's subjective experience • Therapist contains patient's anxiety about contact • Resistance to free and spontaneous communication is explored • The relative distance that the patient places between himself and the therapist is explored • The patient's need to present pseudo-adult self or entertain the therapist is explored
Working-Through	• Patient does not improve, yet the therapeutic relationship has a stabilizing effect • Trust slowly develops

Figure 7.22. **Midphase of treatment.**	
Defenses	• Tendency to withdrawal and use fantasy become conscious, alternatives are explored • Resistance to treatment begins to ease as patient becomes comfortable with therapist
Transference	• Transference relationship strengthens interspersed with periods of regression or silence • The patient may begin to re-establish contact after it has been broken • Growing awareness of self/other states begins to occur • There may be shifting between active and passive roles; from object-relatedness to self-sufficiency; therapist is careful to note these shifts • Emptiness starts to be understood in terms of object relations dyads • New ways of conceptualizing the self begin to emerge
Dependency Needs / Feelings	• The patient experiments with allowing anger into the room with the help of the therapist • Dependency on analyst partially allowed for, but frequently disavowed • The patient's ability to acknowledge oral needs, feelings, sensation, and wishes is tentative but reflects growing awareness • Longing for relationship may emerge more strongly, setting off regression
Therapeutic Focus	• Dominant transference themes are identified and repeatedly defined • Increased use of interpretation of patient conflict
Working-Through	• Patient may be seen to get worse as feelings begin to emerge • Attachment may partially develop, albeit with serious anxiety and denial • Increasing shifts between inertia and self-involvement and object-relatedness occur • Partial working through of psychotic anxieties may occur • Increased ability to hold the therapist in mind is observed

Figure 7.23. **Late phase of treatment.**	
Defenses	• Markedly less use of withdrawal as defense • Fantasies are utilized in the service of relationships, or are diminished and altered in quality • The schizoid compromise is no longer utilized as a central regulator of relationship
Transference	• Transference readily manifests and is stable for increased periods of time • Fear of engulfment begins to recede • The patient takes responsibility for making contact when it has been broken • Patient begins to assume active role in treatment • Clearer self-concept in relationship to the therapist begins to emerge • Love feelings may occur in the transference
Dependency Needs / Feelings	• Anger is readily used in communication • Ability to communicate thoughts and feelings to therapist has strengthened • The period of dependency on the therapist is at its strongest • Greater self-assertion is possible
Therapeutic Focus	• Changing internal model of self in relationship to others • Ability to metabolize interpretations and use them in the service of self growth
Working-Through	• Strengthened ability to talk about the therapeutic relationship • The therapist can be questioned and criticized by the patient • The patient begins to establish relationships in the outside world • Already existing relationships are consolidated and show improved self-assertion • Clear evidence of reduced psychotic anxieties, neurotic conflicts may emerge

To measure progress in schizoid patients by symptomatic change is likely to be discouraging, both for the patient and for the therapist. The therapist must understand that rapid changes in the schizoid patient are rare, given that such basic human issues are at stake (Thylstrup & Hesse, 2009). For his part, the schizoid patient is not often interested in reducing symptomatic issues per se, but rather, tends to be more focused about how to reestablish basic human connection. It is truly a momentous task to establish the basic trust necessary for the schizoid to once again attempt dependency on another. Early in treatment, the largest issues are whether or not the patient will be able to tolerate the presence of the therapist long enough to form a therapeutic alliance at all (Lingiardi, Filipucci, & Baiocco, 2005). Visible changes are often limited until well after this obstacle has been overcome.

Clinicians working with schizoid populations tend to tire and become frustrated with these patient given their slow progress and dismissive attitude. It is common for the therapist to become bored with the treatment after a period of time and put less effort into the treatment (Thylstrup & Hesse, 2009). It is helpful at these times for the therapist to remember not to discount his own efforts. As Thylstrup and Hesse (2009) note, "The patients on the other hand, may value the therapeutic relationship far more than the clinicians realize, and may even benefit from the treatment in ways that the clinicians may miss altogether, or disregard as insignificant" (p. 150). One of the most important prognostic factors in treatment may therefore be the match between patient and therapist, and particularly, the capacity of the therapist to tolerate the patient distancing himself time and again. Kernberg (1971) notes the importance of the therapist's persistence and warmth to successful treatment:

> Patients with strong, overt schizoid features may present such a pervasive distance and withdrawal from the therapeutic interaction that the therapist's ability and even his willingness to engage the patient in a meaningful relationship may become seriously taxed. Schizoid patients utilize splitting mechanisms to such an extent that all emotional, one might even say, human elements of the patient-therapist relationship may appear to be completely destroyed or dispersed, thus producing an atmosphere of emotional shallowness and emptiness which is very hard for the therapist to tolerate over a long period of time…
>
> It may well be that the prognosis for schizoid patients depends especially on the personal qualities of the therapist as reflected in his technique. That is, the therapist cannot help the patient by "offering" him his own personality; only using his natural warmth, emotional wealth, and his capacity for empathy to systematically and persistently analyze the patient's defensive withdrawal can he help the patient. (pp. 602-603)

Ralph Klein (1995) provides a general means of measuring schizoid progress in psychotherapy, as summarized in Figure 7.24 below. Klein's rubric covers a number of important dimensions. Progress is primarily gauged by the decreased reliance of the patient on the schizoid compromise, and the increased readiness of the patient to tolerate anxiety while learning to engage interpersonally with others (Klein, 1995). Klein's other markers include the presence new friendships or romantic relationships outside the therapy office, and an increased willingness to attempt attachment to the therapist. Of course, while the growth of a deeper relationship to the therapist is a positive development, the therapist is not meant to become a stand-in for all meaningful relationships in the rest of the patient's life (McWilliams, 2006) and the therapist may need to encourage the patient from time to time in his efforts to get closer to others outside the therapy room.

A decrease in the use of withdrawal, as well as changes in the quantity and quality fantasy, will also be important markers of therapeutic success. Specifically, the schizoid will start to show more active efforts to interrupt his flights into fantasy, and begin to

attempt to replace these fantasies with real interactions (Klein, 1995). The patient should gradually learn to identify feelings or situations that trigger withdrawal, and begin

- The removal of the schizoid compromise as the fundamental organizer of experience and subsequent moves into neurotic experience
  - Seeking relationships outside the therapy office
  - Less isolation and more participations in groups
  - Greater possibility for attachment
- Less use of withdrawal and increased affect sharing
- Changes to the quantity and quality of fantasy
  - Active efforts on the part of the schizoid to interrupt flights into fantasy
  - Increased efforts to replace fantasy with real interactions
- Greater willingness to communicate thoughts, feelings

cited from Klein, 1995

Figure 7.24. Measuring progress with schizoid patients.

experimenting with alternative means of anticipating and addressing these conflicts beyond just distancing himself. Finally, the schizoid should show greater ability to identify his needs and feelings and communicate these with others (Klein, 1995).

Over the course of treatment, the patient will alternate between periods of attempted attachment and growth followed by a return to self-sufficiency and detachment. New emotional experiences will accompany periods of closeness and dependency on the therapist while regressive periods will leave the patient feeling cold, quiet, and unengaged. Masud Kahn (1974) describes this process in the following way:

> There is sometimes a noticeable shift between enthusiasm to inertia. They will become passive, unproductive, and self-absorbed. They will pull for the therapist to nurse them in this state. They don't desire to be acted upon at all, and any attempt will be perceived as an insult or criticism. This is part of a regression to a personal object-relatedness. The real affective self is not expressed at all in the transference during this time. This is the evidence of how the individual learned to deal with separation anxiety. (p. 309-310)

Over time, the schizoid spends increased periods of time attempting dependency on the therapist. While in the most severe cases, such a sustained therapeutic regression could require hospitalization, in most higher functioning individuals, regression may take place within the transference analysis without affecting the individuals everyday routine (Guntrip, 1977). Gradually, the patient learns that dependence will not destroy him and "will mean not collapse and loss of active powers for good and all, but a steady recuperation from deep strain, diminishing of deep fears, revitalization of the personality, and rebirth of an active ego that is spontaneous and does not have to be forced and driven" (Guntrip, 1977, p. 186). This is the most important part of the treatment.

The following case material describes one patient's progress toward greater dependency on his therapist, and the subsequent reduction in his interpersonal difficulties:

> At last his long repressed infantile depression had returned to consciousness, disclosing itself as the characteristic state of his isolated 'ego of infancy', which was the life-long cause of his marked dependence, feelings of weakness, inability to face life alone, panic at any threat of the loss of a supportive figure, and his ready addictions to food, sweets, and drugs. He had unearthed this trauma in its full emotional reality just in time, for his wife went to hospital a week later and he was able to cope well with the situation. The fear of ego-breakdown and of-re-experiencing infantile maternal deprivation, were here associated not only with manic-depressive tendencies, but in the first place with a severe regressive illness involving a drastic withdrawal from real life and human contacts, and showed that an actual schizoid 'thinness' of object-relationships had been superficially overlaid by his intense needs for someone to depend on. We must later consider further clinical evidence for this basic problem of extreme ego-weakness bound up with severe and early failure of the object-relationships necessary to nourish the growth of the infantile ego.
>
> But this patient's analysis proceeded from this point to develop into a quiet, uneventful, steady analytical uncovering and reintegration of his regressed infantile ego. The pattern was that some minor disturbance would occur and arouse enough anxiety for him to be aware of it, and to discover that he was having unconscious dream reactions to it, all of

which he could then talk out with me. He came to see that the regressed secret heart of his personality could be manifested in two ways. First (i) it broke through as an uncontrollable eruption which undermined his adult personality, and drove him into the illness which brought him to me, and landed him in hospital in the first place. That stage had long since been got over, and his adult self was being more and more strongly established. Now (ii) it was re-emerging in a gradual process of internal self-discovery, carried on relatively quietly over a long period of analytical psychotherapy, without any serious threat to his adult life. In this process he was getting this lost heart of himself more and more into relationship with me and reunited with his conscious self. This would be the final phase of his treatment, which could and should go on quietly and reliably until he found that he no longer reacted with unrealistic anxiety to very minor threats to his security in life, and he ceased to be vulnerable to the point of over-dependence on mother substitutes. Typical of the last phase of analysis were three dreams:

I went on board the Queen Mary. It was rocking violently. Mother was there with some tiny children and both they and she were spilling things.

Here was a simple statement of the instability of life in the care of the unreliable mother.

I stood on the deck of a small motor-boat which was rocking violently, so I went down into the cabin. There it was warn and snug and safe. I did not feel any rocking at all.

Here is a simple statement of flight from the frightening instability of the unreliable mother, and regression back into the womb, a withdrawal in fact deep into his own unconscious, where the heart of him remained out of touch with life.

I was in a hotel and felt very secure there in bed. No one knew where I was, and no one could get at me to trouble me. Then there was a knock at the door. I opened it and there were some clients of a professional college of mine, seeking my help. I helped them and they went away.

Here was his discovery. Deep within himself that he now felt strong enough to stand the impact of his adult life of the external world and not be undermined by anxiety about it. In fact, he had been contemplating asking this professional college to do a job for him, but hesitated because the college never made such a request of him, and wished he would. In the dream he had brought this about, and found that he could sustain the equal relationships involved**.** (Guntrip, 1969, p. 113-114)

Chapter 8 - Supplemental Materials

This section offers of an overview of the adjunctive treatments available for schizoid personality. Issues related to the use of psychotropic medications, as well as a review of available alternative treatments, including CBT, group therapy, supportive therapy, behavioral therapy, hypnosis, and psychodrama, are provided. Conceptualizations of schizoid pathology steeped in self-psychology and evolutionary psychology perspectives are also included for consideration. Self-adherence measures have been constructed for therapists to reinforce learning and to provide a quick reference to the therapeutic competencies outlined in this volume. Finally, a glossary of terms covered in this handbook, and other appendix materials referred in the text are presented.

Medications

Personality disorders are not treatable with medications as a whole, though targeting specific symptomatic clusters is possible. With schizoid personalities, it is often essential to stabilize the therapeutic relationship before considering psycho-pharmacological interventions because of the difficulties in creating a workable alliance with these patients early in treatment (Millon, 2012). It is important to consider that medications may activate frightening feelings that the patient is not emotionally equipped to handle, or alternatively, may undermine treatment if the schizoid's presenting symptoms suddenly disappear and the patient no longer feels he has need for support (Millon, 2007, 2012). Medications should not be used in place of a therapeutic relationship, and do not take the place of transference analysis with schizoid patients. Negative symptomology, and in schizotypal cases, positive symptomology, have

important interpersonal meanings and should be addressed within clinical setting. Higher-functioning schizoid individuals who are not prone to debilitating negative symptomology are very likely to do well in the absence of medications.

In contrast to schizotypal cases, there have been few specific studies on the effectiveness of medications for schizoid types (Sperry, 2003). The general use of antipsychotics and anxiolitics can be used to target significant anxiety, depression, or psychotic pockets should these issues present (Stone, 1989). Monoamine oxidase inhibitors and seratonin reuptake blockers have also shown efficacy in earlier studies for treating hypersensitivity in avoidant personality and schizoid patients (Liebowitz, Stone, & Turkat, 1986), as has the SSRI fluoxetine (Coccaro, 1993). Low-dose neuroleptics (haloperidol, thiothixene) have shown some efficacy in older studies to treat psychotic-like symptoms seen in schizoid patients (Barnes, 1977; Reyntjens, 1972). The antidepressant buproprion (Wellbutrin) has also shown some benefit for reducing apathy and anhedonia in these populations (Millon, 2012). Sperry (2003) recommends that schizoids presenting with psychotic-like symptoms be tested on atypical antipsychotics (i.e. risperdone) at a reduced trial dosage, such as a quarter to a half of normal dose. Dosage may then be increased if there is no response, or if there is only a partial response. Exploring several medications at lower doses improves the possibility of a favorable outcome and continued benefit for ongoing treatment.

Schizotypal personality can often be treated with smaller doses of medications primarily designed to treat schizophrenia. In particular, this disorder may respond to the use of dopamine agonists for cognitive abnormalities, antipsychotics for the reduction of clinical symptoms, sympatholytics for reducing context processing abnormalities

(McClure et al., 2007a), and anticholinesterase inhibitors for difficulties with visuospatial learning (Kirrane et al., 2000). These findings are relatively new and trials have not been conducted with schizoid patients. The medications discussed in this section are summarized on the following page in Figure 8.1 for convenience.

Medication	**Symptomatic Target**
Antipsychotics	Negative symptoms
MAOIs	Hypersensitivity, Social Anxiety, Inhibition
SSRIs	Social anxiety, Inhibition
***In more Schizotypal presentations*:**	
Antipsychotics	Positive symptoms, Thought disturbance Cognitive processing abnormalities
Anticholinesterase inhibitor	Visuospatial learning
Sympatholytic (i.e. Guanfacine)	Context processing

Figure 8.1. Medication for schizoid personality.

Adjunct Treatment Modalities

CBT / schema therapy. CBT for schizoid personality utilizes psychoeducation, feedback, social skills training, role-play, often with the use of video feedback to improve self-observation (Frist & Talsman, 2004). The goals of treatment are established collaboratively (in so doing, modeling mutuality within relationships for the schizoid), and the patient and therapist explore the pros and cons of trying new ways of handling relational problems (Sperry, 2003). Common schizoid assumptions, automatic thoughts, beliefs and attitudes (included in Appendix IX for reference) are explored and replaced with more adaptive thoughts (Beck et al., 1990). In addition, maladaptive schizoid schemas, including (a) *social isolation* (i.e. the idea that one is different from others), (b) *defectiveness* (i.e. the belief that one is bad or inferior), (c) *subjugation* (i.e. the belief that

one's needs and feelings should be suppressed to meet the needs of others), and (d) *undeveloped self* (i.e. the idea that closeness with others comes at the expense of self-individuation) are restructured (Bernstein, 2002). Currently, no psychoeducation protocols have been developed specifically for this population (Hoffman & Fruzzetti, 2005), though this technique is utilized frequently for social skills training.

For more severe schizotypal cases, a focus on practical advice, concrete feedback, and social skills training is considered central to CBT treatment (Piper & Joyce, 2001). Role-playing using scripts may also be useful (Frist & Talsman, 2004), as well as supportive interventions focused on improving reality testing and problem solving (Applebaum, 2005). Behavioral interventions and homework assignments have also been suggested for schizoid patients (Beck et al., 1990), though the therapist should be careful to ask the patient's permission when assigning exercises, homework or requesting information, as this technique may overwhelm the patient or make the patient feel he is being coerced into participation.

Group therapy. In many cases, group psychotherapy is a good adjunct treatment for schizoid personality (Azima, 1983; Bogdanoff & Elbaum, 1978; Gabbard 1994; Leszcz, 1989; Piper & Joyce, 2001; Yalom, 1995). A group setting provides opportunities for socialization, exposure to feedback, and may help the schizoid restructure his negative ideas about social interaction (Azima, 1983). Given the fears the patient has about socializing, working through frightening fantasies about potential group experiences in individual psychotherapy first is a necessity to avoid overstimulation when the group begins (Gabbard, 1994).

A majority of authors have suggested that the optimal group composition for a schizoid patient is one that is heterogeneous in composition (i.e. members have the same level of global functioning) but heterogeneous in terms of the personality types included in the group (Bogdanoff & Elbaum, 1978; Leszsz, 1989; Slavik, et al., 1992). It may also be beneficial for the group leader to bring the group's attention their role in allowing the schizoid to avoid participation (i.e. ignoring the schizoid). This technique can help in alleviating the pressure the schizoid feels to overcome his barriers to communication on his own (Bogdanoff & Elbaum, 1978). Over the course of treatment, the schizoid learns to negotiate his position within social settings, gradually abandoning his self-sufficiency (Leszsz, 1989), and learning to differentiate himself from others without the use of defensive avoidance (Yalom, 1995).

Behavioral treatment. There is currently no established behavioral conceptualization for schizoid personality, though some behavioral techniques such as assertiveness training, social skills training, and exposure, have been suggested. Behavioral modification may be of particularly little value to schizoid patients due to defensive splitting between mind and body seen in these patients. The lack of significant external sources of reinforcement, and the limited ability of the schizoid to experience activities as punishing or rewarding also highly complicate behavioral modification (Millon, 2012). The overuse of exposure techniques to acclimate schizoid patient to increased levels of socialization often leads him to put forth a façade of social comfortability even as his underlying concerns about connection persist unabated (Midmodetet, 2002).

Psychodrama / hypnosis. Other alternative forms of therapeutic intervention have been explored for schizoid personality, including psychodrama (Klassman, 1973; Leepson, 1980) and hypnosis (Lewis, 1979; Scott, 1989), though no recent literature has evaluated these modalities in a systematic way. Hypnosis is suggested to help the schizoid access feelings that are otherwise inaccessible or shut off (Lewis, 1979), while as psychodrama is used with the intention of making the schizoid an active participant in his own life, counteracting inertia and withdrawal, and getting him in touch with his body (Klassman, 1973; Leepson, 1980).

Supportive therapy. Supportive therapy approaches may be indicated for lower-functioning schizoid patients. Schizotypal patients with marked ego deficits and eccentricities are a good match for once or twice-weekly supportive psychotherapy with an emphasis on activities of daily living (Stone, 1989). Supportive approaches require clinicians to be more permissive, accepting, and tolerant with schizoid patients. Schizoid silences are not to be interpreted as resistance, but rather as a form of relating to the therapist, while interpretation and confrontation should be generally be avoided (Sperry, 2003). Suggestions for how the schizoid may gradually integrate intimacy and socialization should be suggested tentatively, slowly testing the patient's limits before moving forward.

Self-psychology. Kohut did not take up the subject of treating schizoid states, except briefly. Kohut considered the schizoid personality to be a preconscious defense guarding against a psychotic regression (Kohut, 1971). Pointing to the schizoid's extreme vulnerability to narcissistic injury, Kohut (1971) suggested that therapists proceed with

treatment cautiously to avoid causing severe regression, fragmentation or psychosis. Silverstein (2007a, b) posits that the fragility of the schizoid, due largely to the limited empathic responsiveness and accurate mirroring he received in childhood, necessitates the development of withdrawal behaviors and defensive self-sufficiency. Because self-cohesion never occurred, the schizoid patient does not experience a sense of invigorated self. As a result, the schizoid begins to detach, isolate, and constrict his emotions as protective measures, consolidating undeveloped self structures and warding off narcissistic injury.

Evolutionary psychology. The evolutionary perspective conceives that schizoid personalities believe family members are dangerous and aggressive, do not offer adequate shelter from the dangers of the world, and will not provide for basic survival needs. Thompson (1990) posits that early ancestors of the schizoid prototype failed to form secure attachments to other members of their clan or troop. Finding that other group members seemed aggressive or predatory, early schizoids may have perceived that others were unwilling to help him with hunting or gathering food or with protecting himself from being eaten by predators (Thompson, 1990) Confusing caregiving objects as potential predators lay the early foundation for the primitive oral fears that have come to saturate the schizoid's fantasy life throughout his later evolution, those of being consumed by the other.

CBT/Schema Therapy	Beck et al., 1990; Freeman et al., 1990; Bernstein, 2002; Rasmussen, 2005
Group Therapy	Azima, 1990; Bogdanoff & Elbaum, 1978; Leszcz, 1989; Piper & Orgrodniczuk, 2000; Yalom, 1995
Psychodrama	Klassman, M., 1973; Leepson, R., 1980
Hypnosis	Lewis, B., 1979; Scott, 1989
Self Psychology	Kohut, 1971; Silverstein, 2007
Evolutionary Psychology	Thompson, 1990

Figure 8.2. Adjunct modalities for schizoid treatment.

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Appendix I – Schizotypal personality profile using SWAP-200
(Traits listed by frequency in presentation)

1. Appearance or manner seems odd or peculiar (e.g., grooming, hygiene, posture, eye contact, speech rhythms, etc. seem somehow strange or "off").
2. Reasoning processes or perceptual experiences seem odd and idiosyncratic (e.g., may make seemingly arbitrary inferences; may see hidden messages or special meanings in ordinary events).
3. Lacks close friendships and relationships.
4. Lacks social skills; tends to be socially awkward or inappropriate.
5. Speech tends to be circumstantial, vague, rambling, digressive, etc.
6. Perception of reality can become grossly impaired under stress (e.g., may become delusional).
7. Appears to have a limited or constricted range of emotions.
8. Tends to be superstitious or believe in magical or supernatural phenomena (e.g., astrology, tarot, crystals, ESP, "auras," etc.).
9. Has difficulty making sense of other people's behavior; often misunderstands, misinterprets, or is confused by others' actions and reactions.
10. Feels some important other has a special, almost magical ability to understand his/her innermost thoughts and feelings (e.g., may imagine rapport is so perfect that ordinary efforts at communication are superfluous).
11. Tends to think in concrete terms and interpret things in overly literal ways; has limited ability to appreciate metaphor, analogy, or nuance.
12. Has little psychological insight into own motives, behavior, etc.; is unable to consider alternate interpretations of his/her experiences.
13. Verbal statements seem incongruous with accompanying affect, or incongruous with accompanying nonverbal messages.
14. Tends to become irrational when strong emotions are stirred up; may show a noticeable decline from customary level of functioning.
15. Appears to have little need for human company or contact; is genuinely indifferent to the presence of others.
16. Tends to be shy or reserved in social situations.
17. Appears unable to describe important others in a way that conveys a sense of who they are as people; descriptions of others come across as two-dimensional and lacking in richness.
18. Tends to feel like an outcast or outsider; feels as if s/he does not truly belong.

Trait shared with Schizoid Personality using SWAP-200

from Shedler & Westen, 2004

Appendix II – Avoidant personality profile using SWAP-200
(Traits listed by frequency in presentation)

1. Tends to avoid social situations because of fear of embarrassment or humiliation.
2. Lacks close friendships and relationships.
3. Tends to be shy or reserved in social situations.
4. Tends to feel ashamed or embarrassed.
5. Tends to be anxious.
6. Tends to feel like an outcast or outsider; feels as if s/he does not truly belong.
7. Tends to feel s/he is inadequate, inferior, or a failure.
8. Lacks social skills; tends to be socially awkward or inappropriate.
9. Tends to fear s/he will be rejected or abandoned by those who are emotionally significant.
10. Tends to be inhibited or constricted; has difficulty allowing self to acknowledge or express wishes and impulses.
11. Tends to be passive and unassertive.
12. Appears afraid of commitment to a long-term love relationship.
13. Appears inhibited about pursuing goals or successes; aspirations or achievements tend to be below his/her potential.
14. Has difficulty acknowledging or expressing anger.
15. Tends to feel helpless, powerless, or at the mercy of forces outside his/her control.
16. Tends to feel misunderstood, mistreated, or victimized.
17. Is simultaneously needy of, and rejecting toward, others (e.g., craves intimacy and caring, but tends to reject it when offered).
18. Tends to feel unhappy, depressed, or despondent.
19. Tends to deny or disavow own needs for caring, comfort, closeness, etc., or to consider such needs unacceptable.
20. Tends to feel s/he is not his/her true self with others; tends to feel false or fraudulent.

Trait shared with Schizoid Personality using SWAP-200

from Shedler & Westen, 2004

Type	Traits
Introverted Thinking	Interested in abstract thought Relationship to the outside world is given little consideration Interpretations of the environment are highly creative and subjective Often find work as mathematicians or philosophers
Introverted Feeling	Genuine, constant, and reliable; 'still waters run deep;' deeply empathic and understanding Make judgments based on internally established beliefs, often ignore social norms Feelings are intensive rather than extensive Often find work as a writer, physician, nurse, psychologist, or dramatist
Introverted Sensing	Sensitive and imaginative, overwhelmed by impressions, hard to understand Interpret the world subjectively, often see things others do not Make sense of the environment by giving it meaning based on internal reflections Often find work as an engineer, artist, or musician
Introverted Intuitive	Mystical and spiritual Outwardly reserved, secretive, lacking sympathy, or embarrassed Find meaning through unconscious, subjective symbols, and insights Often inclined to be mystics, poets, and religious enthusiasts

from Jung, 1917

Subtypes of Schizoid Personality (Based on Fairbairn's nine schizoid core traits)

Type	Core Traits	Diagnostic Issue
'Manifest Pure'	Withdrawal, Introversion, Lack of interest	Core traits manifested externally; Easy to diagnose "Leans away from others"
'Secret Pure'	Withdrawal, Introversion, Lack of interest	Core traits manifested internally; Hard to diagnose "Leans toward others"
'Pseudo-Narcissistic'	Narcissism, Self-reliance, Sense of superiority	Focus is on the need to remain autonomous, not to enhance the grandiose self
'Pseudo-Borderline'	Loneliness, Regression, Depersonalization	Focus is on frantic need to make contact with others to escape loneliness and regression; Badness about feeling different

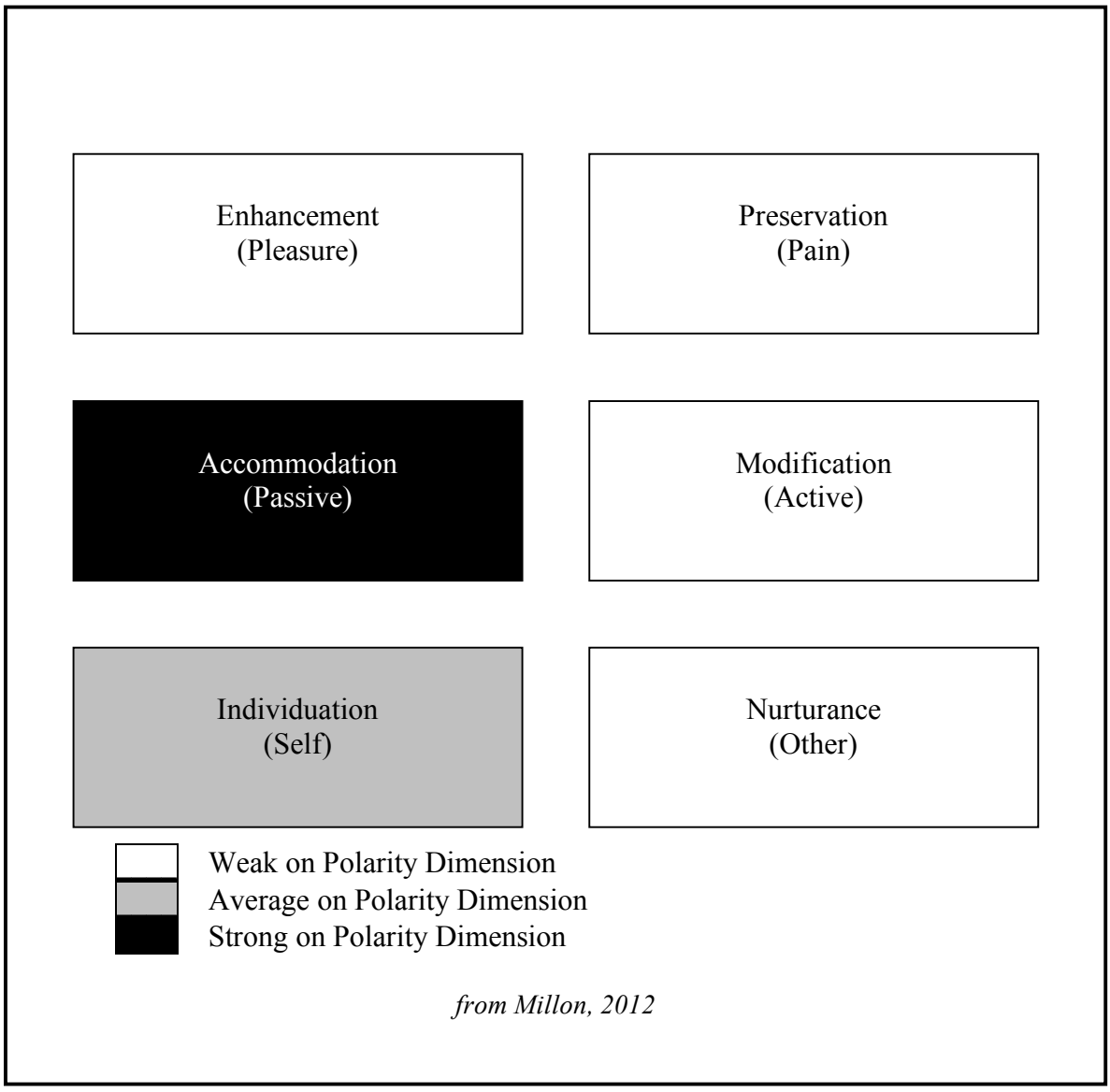
from Klein, 1995

Subtypes of Schizoid Personality

Secondary Traits	Type	Descriptors
Depressive	'Languid'	Marked inertia, deficient activation level, intrinsically phlegmatic, lethargic, weary, leaden, lackadaisical, exhausted, enfeebled.
Avoidant	'Remote'	Distant and removed; inaccessible, solitary, isolated, homeless, disconnected, secluded, aimlessly drifting; peripherally occupied.
Schizotypal	'Depersonalized'	Disengaged from others and self; self is disembodied or distant object; body and mind, sundered, cleaved, dissociated, disjoined, eliminated.
Compulsive	'Affectless'	Passionless, unresponsive, unaffectionate, chilly, uncaring, unstirred, spiritless, lackluster, unexcitable, unperturbed, cold; all emotions diminished.

from Millon, 2006

Appendix V – Millon's schizoid prototype



from Millon, 2012

Memory deficits:	
Working memory impairments	Roitman et al, 2000
Moderate cognitive impairment in working memory, episodic memory, delayed recall	Mitropoulou et al, 2005; Mitropoulou et al, 2002
Impaired information processing capacity	Harvey et al, 2006; Moriarty et al, 2003
Verbal and visual-spatial memory impairments	McClure et al, 2007b
Spatial working memory impairments, low ventrolateral prefrontal cortex volume	Goldstein et al, 2011; Koenigsberg et al, 2005
Sensory disturbances:	
Rely more on sensory association areas in cognitive tasks	Hazneder et al, 2004
Deficient visual sensitivity to contrast	Kent et al, 2011
Impairment on eye tracking tasks	Mitropoulou et al, 2011
Positive symptoms:	
Context processing deficits related to disorganization symptoms	McClure et al, 2008; Barch et al, 2004
Negative symptoms:	
Deficient attentional modulation of the startle responses	Hazlett et al, 2003; Hazlett et al, 2007
Blunted cortisol and normal dopaminergic responses to stress	Mitropoulou et al, 2004
Low fractional anisotrophy in left temporal lobe and right cingulum	Hazlett et al, 2011
Limited amygdala responses to emotional pictures	Hazlett et al, 2012b
Brain Abnormalities:	
Downward bowing of the corpus callosum, decreased hemispheric connectivity	Downhill et al, 2000
Reduced volume in pulvinar thalamus	Byne et al, 2001
Elevated metabolic rates in medial frontal and medial temporal areas, and Brodmann's area	Buchsbaum et al, 2002
Fronto-temporal cortical gray matter reduction (half that of schizophrenia); Increased prefrontal Brodmann's Area volume may protect from psychosis	Hazlett et al, 2008; Downhill et al, 2001
Less volume in the anterior limb of internal capsule	Halett et al, 2012a
Mild thalamo-frontal dysconnectivity	Halett et al, 2012a
Spatial working memory impairments, low ventrolateral prefrontal cortex volume	Goldstein et al, 2011
Smaller superior temporal gyrus volume; Dysfunctional auditory association area	Goldstein et al, 2009

Appendix VII – Study: 'Eccentrics: A study of sanity and strangeness'

Weeks, D. (1995). Eccentrics: A study of sanity and strangeness.
New York, NY: Villard.

Observed Traits

- Nonconforming (i.e. needs to feel free from convention)
- Not interested in the opinions or company of others
- Mischievous sense of humor or healthy, harmless irreverence
- Opinionated and outspoken (i.e. wants to convert others to their way of thinking)
- Idealistic (i.e. rarely motivated by greed, wants to make the world a better place)
- Non-competitive (i.e. not needing reassurance from society)
- Eccentricity is pleasurable to the individual (i.e. the individual knows they're different and takes pleasure in it)
- Avoids situations where they may not perform well; does not acknowledge failure when it occurs
- Creative (i.e. often experiments with new ways of doing things; strongly motivated by individual curiosity; creativity leads to higher self-esteem)
- Has obsession with a hobby or hobbies (i.e. tendency to use their free time constructively)
- Unusual living or eating habits (i.e. prefer their own way of doing things)

Correlated Attributes

- Highly intelligent
- Usually the eldest, or an only child
- Spent lots of time alone as children (i.e. knew very early in his or her childhood they were different from others)
- Single (i.e. difficult to live with others; when the initial enthusiasm wanes, have a hard time sustaining the relationship)
- A bad speller

from Weeks, 1995

Appendix VIII – Schizoid automatic thoughts, attitudes & schemas

Automatic Thoughts

- 'It is important for me to be free and independent of others.'
- 'I enjoy doing things more by myself than with other people.'
- 'In many situations, I am better off to be left alone.'
- 'It's better to be alone than to feel "stuck" with other people.'
- 'I can use other people for my own purposes as long as I don't get involved.'
- 'I am a social misfit.'
- 'Intimate relations with other people are not important to me.'
- 'My privacy is much more important to me than closeness to people.'
- 'Relationships are messy and interfere with freedom.'
- 'Life is less complicated without other people.'
- 'It is better for me to keep my distance and maintain a low profile.'
- 'I shouldn't confide in others.'
- 'It doesn't matter what other people think of me.'
- 'I am not influenced by others in what I decide to do.'
- 'I set my own standards and goals for myself.'
- 'What other people think doesn't matter to me.'
- 'I can manage things on my own without anybody's help.'
- 'Id rather do it myself'
- 'I prefer to be alone'
- 'I have no motivation'
- 'I'm just going through the motions'
- 'Why bother?'
- 'Who cares?'

from Beck & Freeman et al., 1990

Attitudes & Assumptions

- 'People are replaceable objects'
- 'Relationships are problematic'
- 'Life is less complicated without other people'
- 'Human relationships are just not worth the bother'
- 'Nothing is ever exciting'

from Beck & Freeman et al., 1990

Schemas

(1) Social isolation (i.e. the idea that one is different from others)
(2) Defectiveness (i.e. the belief that one is bad or inferior)
(3) Subjugation (i.e. the belief that one's needs and feelings need to be suppressed to meet the needs of others)
(4) Undeveloped self (i.e. the idea that closeness with others comes at the expense of self-individuation)

from Bernstein, 2002

Appendix IX – DSM-Based interviewing for schizoid patients

Interview Questions:

1. Do you have close relationships with friends or family? If yes, with whom? If no, does this bother you?
2. Do you wish you had close relationships with others?
3. Some people prefer to spend time alone, others prefer to be with people. How would you describe yourself?
4. Do you frequently choose to do things by yourself?
5. Would it bother you to go a long time without a sexual relationship? Does your sex life seem important or could you get along as well without it?
6. What kind of activities do you enjoy?
7. Do you confide in anyone who is not in your immediate family?
8. How do you react when someone criticizes you?
9. How do you react when someone compliments you?

Behavioral Observations: Note all pragmatic language, particularly eye contact, smiling or non-verbal affect.

from Zimmerman, 1994

Appendix X – Therapist Self-Rating Scales

Therapist Self-Rating

Attitude

Yes	No	Therapist maintains technical neutrality without being cold, distant, or unengaged
Yes	No	Therapist uses real personality at all times; is open, genuine, human, and authentic
Yes	No	Therapist actively engages in maintaining connection to patient; not passive
Yes	No	Therapist communicates expectations for serious interpersonal involvement, but allows patient to determine its intensity
Yes	No	Therapist is careful to be non-impinging
Yes	No	Therapist asserts the separateness of the therapist from the patient; disallows symbiosis
Yes	No	Therapist is change-oriented rather than goal-oriented
Yes	No	Therapist is non-controlling, allowing autonomy
Yes	No	Therapist minimizes reassurance and overly-supportive interventions

Frame

Yes	No	Frame is kept firm to help the patient feel safe from impingement; patient's autonomy within the frame is encouraged
Yes	No	Roles and frame are definitively defined to increase patient security
Yes	No	While the meeting time is set, the patient determines if he will attend or not though the patient remains financially responsible for the session
Yes	No	Therapist is gentle when setting boundaries, never authoritarian or abrupt
Yes	No	Therapist minimizes major self-disclosure
Yes	No	Therapist is aware of patient's tendency to deny reactions to changes in therapist's schedule
Yes	No	Therapist allows for fewer session during initial period, if indicated
Yes	No	Therapist considers allowing the patient to give gifts; encourages initiative to make contact
Yes	No	Therapist allows the patient to determine if he would be more comfortable lying on the couch, or sitting face-to-face

Somatic experiencing

Yes	No	Therapist helps patient transform impulses, symbols into words
Yes	No	Therapist explores patient's sense of his body during session
Yes	No	Therapist helps patient identify repressed experiences of bodily need (i.e. hunger, lethargy, elimination, sexual impulses)

Therapist Self-Rating

(Continued)

Handling of withdrawal

Yes No Therapist allows the patient to withdrawal, but reminds him of the presence of the therapist

Yes No Therapist notices subtle shifts in the patient's emotional proximity to the therapist; Therapist helps the patient put words to this process

Yes No Therapist is aware of the patient's extreme sensitivity to stimulation or engagement during withdrawal

Yes No Therapist helps the client verbalize his impending fear, his desire to be left alone, and later, his desire to regain contact with the outside world

Yes No Therapist interprets the regression in the context of closeness in the therapeutic relationship

Yes No Therapist observes all efforts to activate a false self to cover regression (i.e. obsessive or histrionic behavior, intellectualism, pseudo-adult self)

Yes No Therapist interprets any fantasy material or primary process that emerges during the regression and links this material to object relationships dyads

Yes No Therapist considers limiting mirroring interventions when patient becomes too activated

Interpreting schizoid transference

Yes No Therapist watches for split off affects in session in the patient's behaviors fantasies

Yes No Split off affects are used as a guide to help identify the active transference state

Yes No Therapist calls the patient's attention to split off affect; wonders about the connection to the therapeutic relationship with patient

Yes No Therapist explains the meaning of the affect as it serves to link the part-self and part-object-representations and the defensive purpose of splitting it off

Yes No If alienation from feelings co-occurs with the splitting, the interpretation links part-object transferences to fantasy material or behavior in session to increase the effectiveness of the interpretation

Working with oscillation in relationships

Yes No Therapist demonstrates awareness of the patient's oscillation in and out of the therapeutic relationship

Yes No Therapist focuses on the schizoid dilemma of wanting closeness, but fearing it; Therapist discusses the various forms and behaviors of this dilemma

Yes No Therapist and patient explore possibilities for getting closer to therapist (i.e. communication, sharing of feelings)

Yes No Therapist conveys to the patient that his anxiety is manageable during closeness

Yes No Therapist does not allow the patient to remain overwhelmed during connection

Yes No Therapist explores how the patient applies efforts to get close to others outside the session

Therapist Self-Rating

(Continued)

Working with fantasy

Yes No Therapist communicates the importance of sharing fantasy material and the relevance to treatment
Yes No Therapist uses confrontation and clarification to solicit fantasy material
Yes No Therapist explores resistance to sharing fantasies or efforts to hide this material
Yes No Therapist does not assume that all fantasy has a defensive function
Yes No Explores patient fantasies for themes of enslavement by therapist, fears of contact with the therapist
Yes No Links split off affects from elsewhere in the session to the fantasy material

Working with symbiosis

Yes No Therapist observes and confronts defensive identification with the therapist, and projection of disowned needs and feelings into the therapist
Yes No Therapist observes that the patient talks about other people to talk about himself
Yes No Therapist confronts the patient's need to fill the time with compulsive talking, to exhibit material for the therapist to work with, to entertain the therapist
Yes No Therapist allows for silences in treatment while maintaining his presence by being curious about the patient's internal process

Communication

Yes No Therapist acknowledges the danger the patient feels about making contact though communication
Yes No Therapist remains involved with the patient's mental processes without interfering or trying to change things
Yes No Therapist is mindful of pseudo-association as a sign of underlying disconnect

Silence

Yes No Therapist remains actively attuned to non-verbal communications
Yes No Therapist works to differentiate between defensive silence and silence as communication
Yes No Therapist acknowledges the patient's empty, quiet core
Yes No Therapist remains aware that the patient may acutely feel he is disappointing and defective if he does not have enough to say

Therapist Self-Rating

(Continued)

Confrontation & Interpretation

Yes	No	Therapist uses confrontation carefully and cautiously at all times
Yes	No	Interventions are softened so as not to be forceful or assertive
Yes	No	Therapists is familiar with '*Two-Step*' interpretations
Yes	No	Therapist is familiar with technique of '*Interpreting-Up*'

Working with the Anti-Libidinal ego

Yes	No	Therapist helps identify, explain, and interpret all anti-libidinal manifestations
Yes	No	Therapist explores patient resistance to admit need or to ask for help
Yes	No	Therapists works to dissolve patients defensive identification with the needs of others
Yes	No	Manifest empty core in transference so that it may be resolved
Yes	No	Therapist teaches patient to balance ability to give love with ability to take love

Appendix XI – Glossary

Glossary

Alienation	Isolation imposed upon a person by members of a society
Alogia	Poverty of speech or inability to produce spontaneous communication; A negative symptom of schizophrenia
Anhedonia	Inability to experience pleasure in activities; A negative symptom of schizophrenia
Anti-libidinal ego	The forces acting against the spontaneous expression of the schizoid's needs and feelings, actively rejecting dependency and attachment to others (Fairbairn)
Apathy	Lack or suppression of emotion or interest
As-If Personality	An historical diagnostic category, proposed by Helen Deutsch (1942), associated with schizoid-like behavior, and centered around a strong false self
Asociality	Lack of desire to form relationships, social withdrawal or indifference; a negative symptom of schizophrenia
Avolition	Lack of motivation reflecting an inability to choose, resolve or exercise the will; a negative symptom of schizophrenia
Autistic barrier	A split off part of the personality that has encapsulating archaic psychotic anxieties within a system of autistic-like defenses
Autistic thinking	The schizoid's preoccupation with inner thoughts, daydreams, fantasies, private logic; egocentric, subjective thinking lacking objectivity and connection with external reality
Blunted affect	Lack or suppression of emotional display though verbal or non-verbal means; A negative symptom of schizophrenia
Borderline Organization	A broad level of personality organization, falling between neurotic and psychotic, marked by identity diffusion, primitive defenses, and disturbances in interpersonal relationships, sexual, and moral functioning

Glossary

Capacity to be alone	The experience of being alone while someone else is present (Winnicott)
Cumulative trauma	The effect of early environments in which trauma was not acute, but rather reinforced in small increments over time, eventually creating a strain on the personality (Kahn)
Depersonalization	The experience of observing the self in action while feeling no control over the situation; an experience marked by limited perception of one's thoughts, feelings, and sensations, in which the self is felt to be unreal
Déjà vu Phenomena	The experience of having seen or experienced something at some time in the past, frequently reported in schizoid disorders
Derealization	The experience of the outside world is felt to be unreal or distant, as if being viewed through a pane of glass; normal perceptual abilities are impaired; familiar places seem foreign, surreal, or different
Disengagement	Consciously impervious to the presence of other people
Empty core	Jeffrey Seinfeld (1991) used this term to describe how the deprivation of love the schizoid's early environment is experienced as emptiness in the personality
Engulfment	The feeling of being smothered, stifled, swallowed up, or suffocated; An experience of the loss of self
Impingement/Intrusion	The perception of another person forcefully intruding into his mental space without permission
Implosion	Experiencing the self as an empty vacuum into which the feelings of others may suddenly invade and overrun
'In-and-out' program	Guntrip (1969) used this term to describe the schizoid's oscillation in and out of relationships; an approach-avoidance conflict enacted in schizoid relationships

Glossary

Introversion	A preference for one's inner thoughts, feelings, or sensation over information from the external world
Introspection	An active process of examining one's conscious feelings, thoughts, and bodily sensations
Isolation	The experiential sense of being separate from other people in a way that can not easily be overcome
Loneliness	A feeling of longing for other people
Negative symptom	Decrease or loss of normal human functions often seen in schizophrenia and often observed in schizoid disorders of the self
Ouroboric state	Self-referring, self-reflexive, self-consuming experience, often associated with the creative process
Passivity	The unengaged and submissive aspects of the schizoid personality
Petrifaction	A fear so strong that one feels immobilized, frozen or turned to stone
Positive Symptoms	Excess distortion or normal human functions seen in schizophrenia including delusions, hallucinations, disorganized speech and behavior; eccentric behaviors often seen in schizotypal patients
Psychotic anxiety	Extreme anxiety that creates a break with reality, forcing identification with internal objects, or in extreme cases, delusions and hallucinations; implosion and engulfment fears
Privacy	Separating from others so they don't engage in our private thoughts or feelings
Regression	In schizoid personalities, a type of defense marked by reversion to an earlier stage of development rather than handling conflict in a more adult way; defensive withdrawal or fantasy

Glossary

Regressed ego	The portion of the schizoid ego that takes flight from the external world to interact with internal objects (Gruntip)
Schism	In schizoid patients, the divisions or splits between the person and his feelings and the person and the external world
Schizoid	From the greek prefix schizo-, meaning cleaving or splitting, and the suffix –oid, meaning like or representing; First used by Bleuler to describe a personality type
Schizoid fantasy	A retreat into autistic fantasy that defends against intimate communication; an escape from the outer world
Schizoid organization	An historical term that correlates to the modern concept of Borderline Personality Organization; See *borderline personality organization*
Schizoid Psychopath	An historical diagnostic specifier for individuals who manifested traits of schizoid personality alongside psychopathic traits
Schizophrenia spectrum	A cluster of non-psychotic personality types related symptomatically, and conceptually to schizophrenia including avoidant personality, schizoid personality, and schizotypal personality
Schizoid withdrawal	*See withdrawal*
Self-alienation	A state of non-being in which a person is no longer in touch with his feelings, needs, or sensations
Self-sufficiency	A state of autonomy marked by a person's lack of need for support or interaction for survival
Shut-In Personality	An historical diagnostic category used by Hoch (1910) to first describe schizoid personalities
Social withdrawal	Reluctance to participate in interpersonal relationships; a negative symptom of schizophrenia
Solitude	A state of disengagement or seclusion from others

Glossary

Symbiotic omnipotence	Prolonged association between the schizoid and another person characterized by enmeshment and lack of differentiation, from which the schizoid comes to feel powerful and in control (Kahn)
Symbolization	A defense mechanism common in schizoid personalities, in which one idea, image or object comes to represent another because of similarity or conceptual association
Withdrawal	A defense mechanism marked by physical or psychic flight in the face of unbearable emotion; a negative symptom in schizophrenia