Psychotherapy of Schizoid Process

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Abstract

Schizoid process is one of the most ubiquitous personality patterns, but it is insufficiently discussed in the literature. This article offers a description of both the true schizoid and the more prevalent schizoid process that runs through various types and levels of functioning. Schizoid process and personality type are described, including the characterological organization, interpersonal processes, and developmental origins of schizoid process. Therapy of schizoid process is discussed in terms of presentation of the schizoid in psychotherapy, development of the therapeutic relationship, stages of therapy, and treatment suggestions and cautions.

The schizoid process is important enough to warrant more attention than it currently receives, partly because, to some degree, everyone experiences some facets of it. Discussions about the schizoid process can clarify issues related to contact, isolation, and intimacy in relation to people with a variety of character styles who operate at levels of personal functioning ranging from normal neurosis through serious character disorders.

True schizoids are also fairly common. These are individuals for whom the schizoid process is central to their dynamics and who fit the DSM-IV (American Psychiatric Association, 1994) diagnostic criteria. They tend to be quiet patients who do not cause much trouble or make many demands. If the therapist does not know about the schizoid process and how to work with it, such clients may well be in therapy for a long time without really dealing with their most basic issues.

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In this article I use the term "schizoid" to refer both to the true schizoid and to the patient who functions with significant schizoid processes or defenses but does not fit the full diagnostic picture.

Presenting Picture of the True Schizoid

The true schizoid usually presents as a loner, someone who is profoundly emotionally isolated, who has few close friends, who is not very close even in "intimate" relationships, who drifts through life, and for whom life seems boring or meaningless. Schizoid patients usually show extreme approach-avoidance difficulties. They often come to therapy because of loss or threat of loss of a relationship or because of relationship difficulties at work. They frequently describe themselves as depressed and tend to identify more with the spaces between people than with interhuman connections. In therapy, as in many of their relationships, they tend to be present but not with vitality—that is, not "in their body" or with their feelings.

Schizoid patients tend to come to therapy regularly but do not appear to be engaged emotionally. A common reaction of the therapist in response to a schizoid patient is to become sleepy, even if he or she does not have this reaction with other patients. There is so little human connection during sessions that it is like not having enough oxygen in the room. The first time this happened to me was with a patient I liked. I thought perhaps I was getting sleepy because 1 saw her right after lunch, so 1 changed her hour. But that was not the problem. In fact, 1 never get sleepy with patients —except occasionally with a schizoid patient.

The Existential Terror Underneath

To people with schizoid character organization, real human connections are terrifying. In their fantasy life and their behavior, these individuals try to live as if in a castle on an

island where they are totally safe. The main feature of this isolation is a denial of attachment and the need for other people. Of course, living that way brings on another terror—the terror of not being humanly connected. If their tendency to defend themselves by isolating were to be fully realized, they would not be connected enough to maintain a healthy ego.

Schizoid individuals have to struggle to maintain their human existence as individual persons. The human sense of self and good ego functioning cannot develop and be sustained without interpersonal engagement, but schizoid isolating defenses attenuate the interpersonal bond to the point of endangering ego development and maintenance. Often schizoid people will create in their fantasy life the satisfaction or safety they lack in their experienced interpersonal world. They also have human connections in safe contexts (e.g., at a geographical distance), and disguised longings are often found at a symbolic level (e.g., in dreams and daydreams). One frequent symbolic wish is to return to the womb, which is seen as a state of oneness and safety. But, if that were possible, it would make sustained human identity impossible since it would exclude interpersonal contact.

Contact and Contact Boundaries

To understand the importance of the schizoid process in all human functioning, we need to consider the concepts of contact and contact boundaries. Contact is the process of experiential and behavioral connecting and separating between a person and other aspects of his or her life field. The contact boundary has the dual functions of connecting and separating the person and his or her environment (including other people), just as a fence has the dual function of connecting and separating two properties. These dual functions involve movement along a continuum between the two poles or functions of connecting and separating.

The connecting process involves a closing of the distance between people, a receptiveness or openness to the outside—and especially to other people—with the boundary becoming porous so that one takes in from and puts out to others. The separating process involves increasing distance, closing off the boundary, being alone and not taking in, with the boundary becoming less porous and closed to exchange; at the extreme, the boundary becomes closed, like a wall. People need both connecting and separating.

All living creatures need to connect with their environment to grow. Just as we can only survive physically by taking in air and water from the environment, human psychological development and maintenance also requires connection with the environment, especially with other people. People can only grow and flourish by connecting to the interhuman environment.

At the extreme end of the connection pole is merger, enmeshment, and a loss of separate existence, will, need, and responsibility; such total connection means death by merger, a disappearance of autonomous existence. Physically it means merger with the environment; psychologically is means a loss of individuation and separate existence. Human existence requires some degree of experienced separation from the environment.

So we see that oneness can be healthy or unhealthy, just as separating can be. Intimacy is a healthy form of oneness, whereas a spiritual retreat is a healthy example of separation from ordinary contact. Ideally, the movement between contact and withdrawal is governed by emerging need. We become lonely, we need to connect; we move into intimacy, momentary confluence, or ongoing commitment. Then we move away from connecting with the other to be with self, to rest *s.nd* recover, to center, or to find serenity. Thus we connect to the point of satisfaction of need, then change focus according to a new emerging need. We separate from a particular contact when withdrawal or different contact is needed. However, in health, a person withdraws from contact while sustaining a background sense of self connected with other people and the universe.

This flexible movement between close connection and separation preserves the sense of being humanly connected. It is unhealthy when this flexibility is lost and either separation or

connection becomes static because movement in and out of contact according to need is diminished or restricted. At one unhealthy extreme the individual separates and isolates to the point of losing a sense of being humanly bonded. Isolating in this way and to this degree is crucial to understanding the schizoid process. For schizoids, the process of separating with underlying connectedness and connecting while maintaining autonomy is foreign. Their lives are marked by the profoundly frightening and disturbing fact of separating without maintaining a sense of emotional connectedness and without a developed ability to connect again. They do not connect to others with much hope of being met and lovingly received. Schizoids do not believe they can be loved, and they fear that even if a relationship is established, the intimate connection means losing autonomy of self and other. Even feeling the need to connect would, in either case, be painful and/or frightening.

It is dangerous to move into intimate connection if you cannot separate when needed. If you think you are going to be caught up, devoured, or captured in the connection, it is terrifying to move into intimate contact. On the other hand, if you do not feel connected with other people, especially if you do not believe you can intimately connect again, the separation or isolation is both painful and terrifying.

Without movement one is fixed, stuck, stagnant, and unable to grow. Being stuck in any position on the continuum of connection and separation—which is the case when the schizoid process is operating—involves a degree of dysfunction, with some needs not being met. Being stuck in an isolated position, a connected position, or a middle position between intimacy and isolation are all problematic.

Being fixed in a middle position is common in the schizoid process: The person is neither truly alone nor truly with another. This immovable position between connecting and separating is a compromise to avoid the terror of being completely alone in the universe, on the one hand, or of being threatened by engulfment, enmeshment, attack, and rejection, on the other.

Twin Existential Fears

The typical childhood of the schizoid patient is marked by the experience of too much or too little human connection. Too little refers to a lack of warmth and connectedness and a sense of emotional abandonment; too much refers to intrusive parenting that emotionally overrides the capability of the infant or young child and causes him or her to isolate or dissociate to survive. Sometimes the abandonment and intrusion alternate.

Given what we know about the importance of flexible movement between connecting and separating for the growth and well-being of the individual, it is easy to understand how the typical childhood experiences of the schizoid leave him or her with deep-seated, often unconscious feelings of merger-hunger, on the one hand, and simultaneous fear of entrapment and suffocation on the other. These lead to universal twin fears that are fundamental to the schizoid process: the panic or terror of contact engulfment/entrapment and the panic or terror of isolation. These are particularly intense and compelling for the schizoid, who experiences them at the existential level of survival or death.

Because the schizoid splits connecting and disconnecting, thus losing easy movement between them, he or she is faced with the threat of becoming stuck at one pole or the other. Therefore, schizoids think of relationships mostly in terms of potential for entrapment, suffocation, and bondage. They do not trust that they will not devour the significant other or be devoured. They do not believe that separation will happen as needed, and thus they do not feel safe to be intimately connected. Of course, the danger of entrapment comes in large part from their own hunger for oneness and fear of abandonment, and the connection between their own merger-hunger and the fear of entrapment is mostly not in their conscious awareness.

Many schizoid patients start treatment with the expectation that they will be devoured or abandoned in therapy. Although they may be conscious of this fear early in the process, the extent of the dual fears and the connection to

their merger-hunger is usually not in awareness until much later. Until then the denial of both attachment and the need for intimacy predominates. Their own merger-hunger is projected onto others as a way of avoiding the awareness by attributing it to someone else. Sometimes these anticipations or perceptions are a projection, although they can also be accurate.

Total isolation or abandonment is like death, especially for the young child. Part of the schizoid process is terror—although not necessarily conscious—of a triple isolation: isolation from others, isolation of the core self from the attacking self, and isolation within the core self. A significant part of the schizoid process is a splitting between attacking selves and core selves. At a deeper level there is also a kind of isolation between aspects of the core self. In gestalt theory this is conceptualized as a boundary between parts of the self that interferes with the boundary between self and other.

Experiencing the self in a vacuum means loss of the sense of self as a living person. The resulting loneliness is profound. It is real progress in therapy when the true schizoid patient is able to experience loneliness and the desire for connection.

The Schizoid Compromise: The In-and-Out Program

One solution to the problem of avoiding complete deadness of self from lack of human connection while also avoiding the threat to existence and continuity of self from intimate contact is what Guntrip (1969) called "the schizoid compromise" (pp. 58-66). This refers to not being in but also not being out of engagement with other persons or situations. An image that I think I borrowed from Guntrip seems apt here: "How do porcupines make love? Very carefully." There are several common "very careful" patterns of the schizoid compromise.

For example, a writer is too lonely to write in his apartment, so he goes to a coffee shop with his laptop computer and manuscript. There he is not really connected with anybody, especially since he does not give out signals that he wants to talk to anyone, but he is not alone either.

Another example is a man from Los Angeles who has a relationship with a woman who lives in New York City. He can have a weekend connection without the risk of losing himself or being trapped in the relationship. When Monday morning comes, he will be thousands of miles away in Los Angeles again while she stays in New York.

Another type of schizoid compromise involves the person repeatedly pulling out of relationships before making a commitment. Such individuals go through a series of relationships, always finding a reason why they cannot continue. A similar pattern is having multiple lovers at the same time; the person engages one part of the self with one partner and another part of the self with someone else. One typical configuration is having a sexual relationship with a lover, but without companionship and building a life together, while maintaining a primary but nonsexual relationship with a spouse. Sometimes individuals who show this pattern will say something like, "Gee, why can't 1 get this together?" or ask "Why can't I get a woman who has both?"

Such patterns illustrate a core pattern: *the schizoid is impelled into relationship by need and driven out by fear.* When faced with someone with whom they might be intimate, they find it both exciting and frightening. They are afraid that they will devour their lovers with their need or that the lover will be devouring, deserting, or intrusive. They might lose their individuality by overdependence and merger-hunger or lose the relationship by being too much, too toxic, or too needy.

The solution to these dilemmas is Guntrip's schizoid compromise—to remain half in and half out of the relationship, whether in the form of marriage without intimacy, serial monogamy, or two lovers at the same time. Needs and fears will often be either denied or acknowledged in an intellectualized manner. Frequently such individuals will oscillate between longing for the intimate other and rejecting him or her, or they may stay in a stable halfway position not able to commit to being

fully in the relationship or discontinuing it. They are tempted repeatedly to leave the relationship and live in a detached manner, but often they return again and again.

When touched emotionally or feeling intimate, the schizoid may become annoyed, scared, fault finding, and disinterested. Meaningful contact with another leads to crisis, and crisis leads to abolishing the relationship. They cannot live fully with the other, but they cannot live without the other either. Being with threatens death-level confluence; being alone threatens death-level isolation. So the schizoid lives suspended between his or her internal world and the external world without full connection with either. Suspended in the death-level conflict between total isolation and being swallowed up, these individuals often feel tired of life and the urge for temporary death. This is not active suicide, just exhaustion from living a life with insufficient nourishment.

Themes in Therapy

The discussion so far points out the major themes that emerge in therapy with schizoid individuals: isolating tendencies, denial of attachment, themes of alienation, and feelings of futility.

Isolating tendencies. Since being close causes schizoids to feel claustrophobic, smothered, possessed, and stifled, they often turn inward and away from others. Thus commitment to relationship is very hard. They treat their internal world as real and the external world as not real. They often have a rich fantasy life and tepid affective contact with others. In isolation they often fantasize about merger or confluence as something to be longed for or to feel panicked about—or both. In actual or fantasy contact they fantasize about isolation either as a positive way of getting their own space or as something terrifying—or both. Schizoids manipulate themselves more than they interact with the environment.

Such individuals usually appear detached, solitary, distant, undemonstrative, and cold ("cold fish"). They do not seem to enjoy much and have few if any friends. They appear to live inside a shell, and in most relationships (including in therapy), those with whom they are relating have the sense of being shut out while the schizoid is shut in, cut off, and out of touch.

What is not always obvious with these individuals is that they still have a capacity for warmth, in spite of the schizoid process. This may come out in various ways, for example, with pets but not with people. 1 remember one schizoid woman who said that "the only people 1 trust are dogs," which she did not mean as a joke. With such patients the therapist needs to be sensitive to subtle shifts in order to pick up and gauge emotional reactions. This is especially true since schizoids often show a low level of manifest interest and affective energy, appearing to be absent minded and mentally half listening.

Most often schizoids will express a desire to be free of any impingement or requirement to do anything. In a relationship they will often talk about how they want to be able to go out and not have to face any limitations. At these times the desire to connect is usually out of awareness.

However, the schizoid process involves more than the simple isolating behavior of a shy or anxious person, more than social anxiety, obsessive compulsive behavior, or intellectualizing, although a schizoid character pattern may underlie any of these other isolating patterns. The issues of the schizoid involve life-threatening levels of existential vulnerability. Because this profound vulnerability makes the relationship with the therapist deeply terrifying, it takes a long time for the therapeutic relationship, including trust, to develop.

It should be noted that the cognitive descriptions in this article provide a kind of a map for the therapist, but one that only points the way to work at a feeling level. Awareness and working through with these individuals requires developing a trusting relationship; no fundamental change can happen with the schizoid on a purely cognitive basis.

Denial of attachment. For children who later become schizoid adults, one way of coping with a world that is too big, menacing, intrusive, unresponsive, and/or abandoning is to

deny any need, weakness, and dependency and to promote the illusion of self-sufficiency. They learn to survive by living without feeling dependence, desire, need, or fear. The schizoid is especially trying to avoid burdening and killing parents with his or her needs.

Schizoids avoid awareness of attachment in various ways. The most common is splitting off or disassociating from needs and feelings that are overwhelming. Conformity can also be a means of avoiding awareness of need and fear as can obsessive-compulsive self-mastery, addiction to duty, or service to others. One can avoid attachment needs by being regulated by rules and regulations rather than by vitality affect, or by conforming and serving, thus forming a false self that consists of a conventional, practical pseudo-adult who masks a frightened inner child.

Denial of attachment results in shallow relations with the world. Compulsive activity, compulsive talking, and compulsive service to causes can all mask a shallowness of affective connection. Some people who appear to be extroverted are actually schizoid in their underlying character structure.

In the extreme, the schizoid's denial of attachment results in his or her being mechanical, cold, and flat to the point of depersonalization; the individual loses a sense of his or her own reality and experiences life as unreal and dream like. Of course, not all schizoids depersonalize to this extent.

Schizoids often may deflect the importance or impact of praise and criticism as protection against attack, disapproval, disappointment, and so on. Although they strive to feel and appear unaffected by praise and criticism, they are actually sensitive, quick to feel unwanted, and suffer from a deep underlying shame (Lee & Wheeler, 1996; Yontef, 1993). Their self-representation is always a shameful sense of self as being defective, toxic, and undesirable. They live internally as if they were always deserted because of their own defect. They are especially contemptuous of their own "weak (needy) self."

When the need they have been denying starts to emerge into awareness, schizoids experience intense shame. In fact, shame is a fundamental process for schizoids. They are easily shamed, although that is not always obvious because they deny that they are attached or that they need anything. When they feel safe enough to start exploring their shame, they manifest a great deal of loathing for their needy self. However, if the therapy is confrontive (e.g., in the way encounter groups and some confrontive gestalt therapists used to be), demands quick change, or is insensitive to issues of shame, these feelings will not emerge because the patient will not experience the necessary fundamental trust in the therapeutic relationship.

Themes of alienation. Schizoids feel so alienated and different from others that they can experience themselves literally as alien—as not belonging in the human world. I have a patient from Argentina who quoted a saying in Spanish that describes her experience: She feels like a "frog who's from another pond."

In their alienation, these individuals cannot imagine themselves in an intimate relationship. The people world seems strange and frightening, even if also desirable. When they see couples being intimate, they are often mystified: "How do they do that?" No matter how they force themselves to date or to meet new people, they cannot imagine themselves in a sustained intimate relationship. This leads to the fourth theme.

Feelings of futility. The schizoid experiences loneliness, futility, despair, and depression, although the latter is somewhat different from neurotic, guilt-based depression. Both are comprised of dysphoric affects and an avoidance of primary emotions and full awareness. However, neurotic depression has been described as "love made angry." That is, the depressed person feels angry at a loss followed by sadness and broods darkly against the "hateful denier." This aggressive emotional energy then gets turned against the self.

In contrast, schizoid despair has been described as "love made hungry." The person experiences a painful craving along with fear that his or her own love is so destructive that his or her need will devour the other. The

schizoid feels tantalized by the desire, made hungry, and driven to withdraw from the "desirable deserter." The deep, intense craving is no less painful because it is consciously renounced or denied.

In ordinary depression the person has a sense of the self as being bad; usually he or she feels guilty, horrible, and paralyzed. The schizoid, on the other hand, feels weak, depersonalized, like a nonentity or a nobody without a clear sense of self. Guntrip said that people much prefer to see themselves as bad rather than weak. They will typically refer to themselves as depressed more readily than weak, bad rather than devitalized, futile, and weak.

Guntrip (1969) called the depressive diagnosis "man's greatest and most consistent self-deception" (p. 134). He went on to say that psychiatry has been slow to recognize "ego weakness," schizoid process, and shame. "It may be that we ourselves would rather not be forced to see it too clearly lest we should find a textbook in our own hearts" (p. 178). Fortunately, I think in the last few years there has been a real opening in therapeutic circles to recognizing relationship and shame issues present in the therapist as well as in the patient (Hycner & Jacobs, 1995; Yontef, 1993).

Healthy Development

The self can only experience itself in the act of experiencing something else—and being experienced. Cohesive, healthy self-formation depends on contact with the mothering person that is neither too little nor too much.

From birth, infants are equipped to be both separate from and connected with others. Stem's (1985) research confirmed that from the beginning infants know themselves and connect with the human environment. For their maturational potential to develop, infants must be welcomed into the world and supported in being themselves and being connected. This support starts with the mother restoring the connection severed by birth. The infant needs to be made to feel that he or she belongs in the world of people. Through a dependable mother and infant relationship, the infant leams that he or she is not emotionally alone in the world even when physically separated. This support for connection and separation is needed throughout infancy and toddlerhood.

Ideally, the infant/child leams that he or she can be alone in the presence of the mother and thus in intimate relations with others. In this way children learn that they can have privacy and self-possession without loss of the other, that they can be physically separate or have their own feelings and thoughts in the presence of the parent and still feel connected and feel connected-with when they have needs and feelings. The child can be alone in outer reality because he or she is not alone in inner reality. The development of these capacities depends on early parental experience, the development of object constancy, and so forth.

Schizoid Development

Unfortunately, the course just described is quite unlike the early experience of the schizoid, whose childhood tends to be marked alternately by experiences of intrusion and being overwhelmed, on the one hand, and feeling empty and alone in the universe, on the other. The schizoid then uses worry, fantasy, and isolation to protect against these experiences. Although nature and mother arouse powerful emotional needs in the child, if there are either insufficient warm, loving responses or an excess of intrusive, overwhelming responses, the need only increases, and the child experiences painful deprivation or unsafe feelings as well as anxiety at separation and/or connection. A deep intimacy-hunger grows in the child.

The schizoid's early experience is that mother is not reliable, usually because she is alternatively intrusive and abandoning. Mother not only cannot tolerate, contain, and guide the child's affects (e.g., need, anger, exuberance, even love), she finds them threatening and overwhelming and treats them as toxic. These mothers usually become overwhelmed because of their own depression, life situation, or characterological issues; often they do not have the support they need to meet the child in intensive affective states and to stay with him or her until the affect has run its course. Clearly, the problem is with the mother, not with the child.

However, the infant or child's experience is that his or her life forces and vitality appear to kill mother—or at least the connection to and relationship with mother. If a young child has a tantrum and mother withdraws to her room for three days, the child's reality is that he or she has emotionally killed mother. And, of course, killing mother would make the infant's life impossible as he or she cannot live without a parent.

The legacy for the child is that his or her life force threatens mother, which is equivalent to the child experiencing that "my life threatens my life." Anything from within, even something good, turns bad and destructive with exposure. The only hope is to keep everything inside and thus invisible. The child must, at all costs, avoid causing total emotional abandonment by or intrusion and annihilating counterattack from mother. Therefore, the child suffers isolating himself or herself to avoid an even more devastating deprivation—the loss of the mother and the child's relationship with her. Unfortunately, this leaves the child with a huge hunger that cannot be satisfied, a hunger that is projected onto the mother, who is then seen as devouring. And a mother who actually does devour makes this even more real and frightening.

Splitting the Self

An important part of how the child copes with this situation is by splitting the self. Survival is achieved by relating to the world with a partial self or "false self," one that is devoid of most significant affect and relates on the basis of conforming to others' requirements rather than on the basis of organismic experience. Guntrip (1969) used the phrase "the living heart fled" (p. 90) to describe the situation in which the vital energies, emotions, and vitality affects are held inside, leaving an empty shell to interact with others and to direct human relations.

This schizoid pattern creates external relations that are not marked by warm, live, pulsing feelings. Instead, when interpersonal nurturance is available, schizoid individuals fear a loss of self from being smothered, trapped, or devoured. When strong desire or need is aroused, they tend to break off the relationship. Hatred is often used to defend against love with its dangers and disappointments, a pattern that starts in early childhood.

However, what happens to the lively emotional energy that is held in? And how does the schizoid stay sufficiently related to people to support the survival of the self? One key process is the development of internal rather than interpersonal dialogues. Instead of someone with a relatively cohesive sense of self interacting with others, there is a sense of self in which aspects of personality functioning are split off from each other. The most commonly encountered manifestation of this in psychotherapy is the split between an attacking self and the "core" or "organismic" self. When the organismic self shows characteristics of being in need or emotional, the attacking self makes self-loathing, judgmental statements about being "weak" or "needy." One might characterize this as attacking and shaming the organismic self, which it calls the "weak self." The person often identifies with the attacking self and thinks of his or her own love as so needy that it is devouring and humiliating.

To the degree that the person's contact is between parts of the self rather than a relatively unified self in contact with the rest of the person/environment field, the person is left with a deep and painful intimacy-hunger (often denied), dread, and isolation. The internal attack is usually not only on the self that is needy, hungry, and weak, but also on the self of passion and bonding—even happy passions.

Within the core self there is another split, which I will only consider briefly. This split is between the self (or the self-energy) that connects and fights with the attacking self and the core energy that has an urge to isolate even more, to go back to the womb. The retreat from the internal self-attack is designed to protect the core life energy, which is kept isolated in the background to protect it. It is a fight for life.

There are a couple of other things that occur because of this process that I have not yet mentioned. One is that, as part of schizoid

dynamics, cognitive processes are often used in the service of feeling humanly connected while remaining isolated rather than in preparation for interpersonal contact.

Self-attack is an internal dualism that divides the person into at least two subselves. When the self-attack is on the feeling self, it results in shame, humiliation, and psychological starvation. It creates the defect of a divided rather than unified self and makes the life energy (i.e., feelings) a sign of being defective. It creates a sense that since I feel, want, and need, therefore I am unworthy of love and respect. So it is not surprising that schizoids often attempt to annihilate or master their feelings of need, sometimes in a sadomasochistic way. For them, self-attack is not directed toward their "doing"; it is an attack or attempted annihilation of the "being."

However, being and being-in-relation are inseparable. The sense of self only develops in relationship, not in a vacuum. Feeling with and feeling for other persons—and being felt for by them—is vital for a healthy sense of self. Shared emotional experience is a part of learning to identify and identify with the self and to identify with bonding with others. Because of their isolating and denial of attachment, schizoids often operate without a sense of being —the empty shell experience. This "doing" without a sense of "being" leads to a sense that being or life is meaningless. Schizoids usually feel this way, although they often attribute it to a particular activity being meaningless rather than to their own process.

Even the core self—in reaction to the top-dog, critical self—is split. There is an engaged, contact-hungry core self that does battle with the top-dog self, which can manifest in sadomasochistic and bondage and discipline fantasies. In contrast, the passive, isolating core self is regressive and imagines going back to the womb. It is this self that is in danger of losing human connectedness; it fears existential starvation, loss of ego or sense of self, depersonalization, being alone in a vast, empty universe, even death. These fears can become known during quiet times, which may make calm, peace, quiet, sleep, or meditation frightening.

The unfinished business of schizoids, their most central life script issue, centers on the struggle to make "bad introjects" into "good introjects." However, this usually does not succeed easily. The bad introject usually stays rejecting, indifferent, and hostile until very late in therapy. While the therapist may think that progress is being made as some of these issues are uncovered, the schizoid patient often experiences only intensified self-loathing. Frustration and failure trigger the unfinished business and the rest of this negative script, including isolating defenses, retroflected anger and rage, strong defense of the negative sense of self, harsh self-attacks, and shame. It takes a great deal of patience and a long time to work through these issues.

Working with Schizoids and the Schizoid Processes in Psychotherapy

The Paradoxical Theory of Change. The gestalt concept of the paradoxical theory of change (Beisser, 1970) says that the more you try to be who you are not, the more you stay the same. That is, true change involves knowing, identifying with, and accepting yourself as you are. Then one can experiment and try something new with an attitude of self-acceptance. This contrasts with attempts to change that are based on self-rejection or trying to make yourself into someone you are not.

Working in the mode of the paradoxical theory of changes promotes self-support, self-recognition, and self-acceptance as well as growth from the present state by experimenting with new behavior. This experimentation can be either the spontaneous result of self-recognition and self-acceptance or on the basis of systematic experimentation. The therapist's task is to engage with the patient in a way that is consistent with this paradoxical theory of change. With schizoids, this means engaging with the patient at each moment and over time without being intrusive or abandoning, without sending the message that the patient must be different based on demands or needs of the therapist or the therapist's system. While many therapists might endorse this in the abstract, often their nonverbal communication creates

pressure for the patient to change based on will power, conformity, or as a direct result of the therapist's interventions.

The Dialogic Therapeutic Relationship. Some of the principles guiding work from this perspective are the characteristics of dialogue according to Buber's (I965a, 1965b, 1967; Hycner & Jacobs, 1995) existential theory. They include: inclusion, confirmation, presence, and surrendering to what emerges in the interaction.

Buber's (1965b, p. 81; 1967, p. 173) term *"inclusion"* is similar to the more common term "empathic engagement." Inclusion involves experiencing as fully as possible the world as experienced by another—almost as if you could feel it within yourself, within your own body. Buber (1965b) called this "imagining the real" (p. 81), that is, confirming the other's reality as valid. Both inclusion and empathy involve approximation; however, inclusion calls for the therapist's more complete imagining of the other's experience than does empathy. Inclusion is more than a cognitive, intellectual, or analytic exercise; it is an emotional, cognitive, and spiritual experience. It involves coming to a boundary with the patient and joining with the patient's experience, but it also requires the therapist to remain aware of his or her separate identity and experience. This allows for deep empathy without confluence or fusion.

Inclusion, or imagining the patient's reality, provides *confirmation* of the patient and his or her experienced existence. It involves accepting the patient and confirming his or her potential for growth. Such confirmation does not occur in the same way when the therapist needs the patient to change and thus aims at a conclusion rather than meeting the patient with inclusion.

A dialogic approach requires genuine, unreserved communication in which the therapist is *present* as a person—that is, authentic, congruent, and transparent—rather than as an icon of seamless good functioning. The therapist cannot practice this kind of therapy and also be cloaked in a psychological white coat. He or she must be present by connecting with the patient's feelings as well as by acknowledging his or her own flaws, foibles, and mistakes.

The dialogic therapist must trust in and *surrender to what emerges from the interaction* with the patient rather than aiming at a preset goal. This approach recognizes, centers on, tolerates, and stays with what is happening as the therapist practices inclusion and thus focuses on present experience and moment-to-moment, person-to-person contact. In a sense, progress is a by-product of a certain kind of relating and mindfulness rather than something that is sought directly. The therapist relinquishes control and allows himself or herself to be changed by the dialogue just as the patient does. As a result, truth and growth emerge for both.

Subtext. Attitudes are often communicated not by the text of what the therapist says, but by the subtext or how things are said. Nonverbal cues have an especially powerful influence on schizoid patients, even if neither they nor the therapist are consciously aware of them. For example, a gesture, tone, or glance will often trigger a shame reaction in a patient without the therapist intending to do so and without either the therapist or the patient being aware of the process (Yontef, 1993). And even when this operation (i.e., the effect of the subtext) is in awareness, it may not be expressed or commented on.

Although they may appear to be distant and only vaguely present, schizoid patients (and many other patients as well) are exquisitely sensitive to nuances of abandonment, intrusion, pressure, judgment, rejection, or pushing —in fact, to any message or subtext that says they are not OK as they are. Such messages are not only contrary to the paradoxical theory of change, but they also trigger unfinished business from painful childhood experiences of rejection and/or intrusion.

Sometimes I have tried to encourage a patient to feel better, to convince the self-loathing patient that he or she is not loathsome. By doing so, I inadvertently sent the message that the patient's feelings and sense of self were so painful that 1 as a therapist could not tolerate them. This was a repeat of the message the

patient received from infancy: You are too needy, too much of a bother. When you as the therapist have a view of the patient that is more positive than he or she has, the thing that you hear the most from the patient is, "You don't understand." 1 still hear that occasionally, and I have been working with these dynamics for a long time. In such cases, good intentions create disruptions in the contact between therapist and patient and an impediment to working through. (For a poignant example of this process, see Hycner & Jacobs, 1995, p. 70.)

I find it agonizing when patients I like hate themselves and describe themselves as loathsome, something totally contrary to how I and others (e.g., group members) experience them. For example, I have a bright schizoid patient who makes excellent comments in the group, comments that other patients appreciate and from which they benefit. But his self-description is, "I'm stupid," which for him is an untouchable reality. Attempts to induce him to take in the views of others and thus modify his view of himself have proved predictably futile. When people say they like him, think he is smart, or appreciate his remarks, his response is usually, "You don't understand." I eventually said, in effect, "You're right, I don't understand, your reality is that you are stupid." As 1 stopped fighting with him about his negative sense of self, deeper work started. Instead of pretense, I began to see more continuity of thematic work.

In general, when the patient tells me that I do not understand, he or she is right. As the therapist you do not have to agree with the patient's viewpoint, but it is important to realize the patient's reality is as valid as the therapist's. Moreover, you cannot talk the patient out of his or her reality even if you believe it is acceptable to do so. Rather, the task is to connect with and tolerate the patient's experience so that he or she can leam to tolerate it—and then to grow beyond it according to the paradoxical theory of change.

The "friendly" message of persuasion is actually an attempt to get the patient to change his or her perception, belief, experience—that is, to be different. If the patient is in despair, and the therapist works to get the patient not to feel despair, whose need is being served—the patient's or the therapist's? Can the therapist stand to stay in emotional contact as the patient experiences despair, depression, hopelessness, shame, and self-loathing? If the therapist cannot or will not stay with the patient's experience, he or she gives the patient the message once more that the patient's experience is too much to bear. This is like demanding a false self, and it triggers shame and reinforces the childhood script.

The most important thing the therapist can do with schizoid patients is to work patiently and consistently to inquire about and focus on the patient's experience, on what it is like to live life with the subjective reality of being stupid and loathsome. This approach is most useful when combined with careful attention to subtle signs of disruptions in the contact between therapist and patient. Although schizoid patients will not tell you about them, you can see subtle signs of connection and disconnection if you are observant. Often the latter indicate that subtext (nonverbal signs from the therapist) have triggered a shame reaction. This is rich material if the therapist is willing to take the initiative to explore it.

The same holds true when the patient has a different view of you, the therapist, than you have of yourself. If you honor the patient's experience as one valid reality, not *the* reality, you can explore the discrepancy between your "reality" and the patient's "reality" and thus be consistent with the principles of dialogue, phenomenology, and the paradoxical theory of change. Working with this attitude offers growth for both patient and therapist.

Techniques: Schizoid patients are amenable to *creative approaches that center on their experience, on contact, and on what emerges in the therapeutic relationship rather than on programs that try to get the patient somewhere.* This can be maximized by identifying schizoid themes as they emerge rather than trying to formulate them according to a preset plan. If you show interest and inquire about the themes as they emerge, you do not need elaborate formulations to explain to the patient

about his or her process or life script. Insight will emerge from the interaction when the therapist follows these basic principles. Although this may seem to take a long time, in the end it is more effective, safer, and no lengthier than approaches that appear to obtain a quicker cognitive understanding.

Working through—that is, destructuring and integrating core processes—requires identifying and staying with feelings as the patient explores his or her experience. It involves feeling the affect and is, of necessity, more than cognitive and/or verbal. The therapist must be able to experience with the patient the feeling of the empty shell, the core self, and the critic and to work with these feelings as they emerge and naturally evolve. It means feeling the inner child's painful hunger, terror, and need for the defense and how, when, and why it worked. It means feeling the experience of being an alien. Such working through requires more intensive work over time than therapy that is only palliative. Any cognitive identification of a theme before the patient can feel it is, at best, preparatory for deeper work, work based on the patients felt sense of self and others. An interpretation is only valid when it is confirmed by the patient's felt sense of it. A cognitive identification before the patient can feel it lacks the patient's felt sense as a means of confirming or disconfirming the therapist's interpretations. The cognitive focus is often a barrier to deeper work based on a felt sense.

The schizoid needs the therapist to be able to contact the hidden core self without being intrusive. This requires much sensitivity and awareness of the process so that openings can be found where the therapist and patient can discover a way to symbolize the very young, primitive, preverbal sentiment of the inner core self. It also requires that the therapist be willing and able to admit errors and counter-transference so that breaches in the therapist-patient relationship can be healed.

A woman who wants to marry and raise a family but who relates to men using the schizoid compromise is not likely to benefit from either an emphasis on contact skills and relationship discussions that prematurely consider themes before they emerge in the therapy or a therapy in which the therapist does not understand the schizoid process. A man who says he wants intimacy but is always unavailable, critical, busy, or too impatient is in the same predicament. Treatment must proceed step by step by exploring issues as they emerge with a therapist who is informed by an understanding of the schizoid process.

For example, a man in a relationship keeps asserting that he wants his freedom. Inquiry and mental experiments start to clarify the situation. He is asked to describe in detail what happens when he is at home and to imagine what he would do if he were free. What emerges is a relationship pattern in which there is no movement into intimate contact and no movement to separate while maintaining the sense of emotional bonding. This eventually links to early childhood experiences of being emotionally isolated within a troubled family, with freedom only coming by being away from the warring family situation. These isolating defenses were necessary in childhood, but subsequent exploration led the patient to discover other solutions for himself as an adult.

For most schizoids, *resistance* to awareness and contact were necessary for survival in childhood, and they often still play a healthy function in adulthood. My advice is to treat resistance as just another legitimate feeling state of the patient, something for you and the patient to experience, understand, identify with, and make clear. It should not be treated as something to be gotten rid of.

It is necessary to bring together the parts of the self that the patient has kept isolated from each other. This can be done by bringing the split off parts into the room at the same time —the desire and the dread, the active and the passive core selves, the attacker and the core self. By bringing into awareness both parts of a split self, the parts are clarified and a dialectical synthesis or assimilation can begin. Certain techniques, such as the gestalt therapy empty chair and two-chair techniques, may be helpful, but the techniques are less important than the attitude of bringing the separated parts into some kind of internal dialogue.

With regard to *groups,* schizoid patients often attend regularly and are important to the group process, although they may not be very active. They often come to group for a long time and may feel ashamed about this. When schizoid patients do work in group and even manifest some change, they can become discouraged by their own shame over how long it is taking or over how the group process is not encouraging them. At such times they need support for understanding that it is legitimate for the therapy to take that long. This is particularly the case when other group members come and go more quickly. If growth is occurring, they need help to see themselves as other than defective for still being in group and encouragement to stay and continue their work.

The Course of Therapy

The schizoid compromise in therapy. The schizoid patient is often emotionally neither in nor out of therapy, just as he or she is neither in nor out of other relationships. In therapy this is accomplished by an infrequent but stable schedule, by being present without being intimately connected or allowing strong affects, and/or by being in a group but not working.

Schizoid patients will often be "untouchable" in the sense of putting up a mask or wall or showing other signs of lack of intimacy, defense, resistance, or retreat from contact. However, they are usually not otherwise controlling or manipulative.

These individuals usually focus on wanting something fixed or external regulation, on "How do I change this?" rules, fix-it approaches, and shoulds (especially for other people) rather than on affects, needs, or deeper understanding. Expressing emotion is difficult, delayed, or restrained, and they often react to narcissistic injury with painful, prideful, withdrawal. Isolating is easier for schizoids than feeling despair or injury.

Underlying pattern. In the active core self mode the patient longs for love, and *the therapist becomes the avenue of hope.* Since it is difficult for schizoid patients to feel desire or need fully, they often show pride in renouncing need and shame or fear at becoming aware of need. This can take the form of total denial, acknowledging but trivializing, or intellectualizing the need without feeling it. These patients project hope onto the therapist but then fight it. They are usually unaware of this process and continue presenting problems to work on while stubbornly fighting. Although the fighting is ostensibly about what is being discussed, actually it is about core shame and terror.

So, how does the therapist know how meaningful the therapy and the therapist are to the patient? It usually shows subtly in behavior: For example, the patient keeps coming, and if the therapist does something that injures the therapeutic relationship, the patient reacts, often strongly. However, when the patient does become aware of his or her attachment to and need for the therapist, the immediate reaction is often anger: "1 don't want to need you, to depend on you. It makes me so angry!"

The schizoid patient *fears loss through abandonment.* "If you really knew what I am like . . ." is a frequent comment of schizoid patients, even late in therapy. The inner schizoid world is characterized by a constant fear of desertion and feelings of being unwanted and unlovable, all of which may remain out of awareness until they emerge well into the therapy. The fear of abandonment relates to the patient's attitude toward his or her own intense hunger, and even if the hunger itself is not in awareness, it colors the schizoid patient's adult functioning.

The schizoid patient wants to *ensure the therapist's or lover's presence,* to "possess" the other. This is most often represented in fantasy (e.g., using sadomasochistic symbolism). One aspect of this is an antilibidinal attack on the needy self. There is also a disguised dependence and or oneness (e.g., bondage can symbolically ensure connection or oneness with the significant other). Generally, schizoid patients are not demanding or controlling of the therapist, except for the isolating defenses. However, it is usually a long time before the patient is aware of these underlying processes.

No therapist can completely satisfy the schizoid patient's intense cravings. When the

therapist inevitably fails in his or her response, this supports the patient's projections that the therapist is intrusive and/or abandoning—or as useless as the patient's parents were in meeting needs. This is reinforced even more if the therapist actually is controlling, intrusive, or abandoning, which makes the patient's perception not entirely inaccurate. This is true regardless of the therapist's rationale or good intentions. Even ordinary reflection or simple focusing experiments can be controlling or intrusive depending on how they are done and how the therapist relates to the patient.

Schizoid patients often oscillate between hungry eating and refusal to eat. This is true both literally and figuratively, although more the latter. Mostly they isolate, occasionally approaching out of need and then isolating again. This is not surprising in light of the basic pattern of approaching in need and withdrawing in fear and dread.

In the *regressed, hidden, passive mode,* schizoid patients regard others as too dangerous, intrusive, devouring, subjugating, and smothering. They want to escape from this danger as well as to find security, which leads them to long for the womb or temporary death as a relief from an empty outer world and an attacking inner world. Relationships are too dangerous, so part of the self is kept untouchable even when the patient recognizes cognitively what is happening.

Stages of Therapy

Ordinary, utilitarian therapy. The beginning schizoid patient is often in search of relief of symptoms and ways to deal with practical situations. With therapeutic support and practical management of life situations comes relief and the possibility of either stopping therapy having gained some respite or going deeper and working with underlying issues.

The plateau created by the schizoid compromise. At this stage the schizoid patient usually has a vague sense that something is missing, that something more in life is possible. Sometimes this follows work at the previous stage; sometimes patients begin therapy at this stage. There is often resistance to or fear of going deeper as well as fear of being more dependent on the therapist. The patient usually feels shame at his or her weakness and need and fears collapse if the self becomes too weak.

Patients may stabilize at this stage and feel somewhat better. It is a stage characterized by the schizoid compromise, albeit with some beginning exploration into the twin fears of being more connected or more separate. However, at some point the patient must decide whether to stay in therapy and go deeper or leave. This depends in large part on how resistance fears are dealt with, how the relationship develops, and the supports available to the patient.

Deeper work begins with the development of the therapeutic relationship and as the patient becomes aware of and deals with feelings about the therapy itself. If the patient stays with feelings and beliefs that arise, the fear and shame are usually too strong to support more intimate work immediately. But from the half safety of the compromise position, the patient and therapist can develop the relationship as well as greater awareness and centering skills. Gradually, the fear and shame will decrease enough to go step-by-step beneath the plateau.

Going below the plateau. Some patients obtain enough relief by this point and decide to leave therapy rather than completing the deeper work. They are left living a half-in and half-out life, but perhaps with more comfort, connection, and connection while separating. Patients can survive here and perhaps even be thought of as leading lives of ordinary human unhappiness. Other patients at this stage will "take a break" from therapy and plan to return.

Going deeper is difficult and time consuming. It means reaching the level at which the inner, regressed, core material is dealt with and real character reorganization can occur. However, even after the fear is relatively worked through, the remaining shame requires a tremendous amount of work while trust develops and the preverbal, infantile levels of the self are worked through.

Interpersonal contact and intrapsychic work. At each stage there is a correspondence between the interpersonal contact or relationship development between therapist and patient

and awareness work on the powerful inner needs and terrors this contact arouses. The patient usually fears that these needs and feelings might be so intense that they will destroy the self and the therapist. The patient is also often terrified that his or her ego will break down as the self is experienced more fully. The experience of no intimate human relatedness and the accompanying experience of being utterly alone is understandably terrifying. It is often experienced as "black abyss." No one in the schizoid patient's past has understood the true, core self.

Thus it is not surprising to find tenacious resistance at this stage. After all, maintaining bad internal objects may well seem preferable to have no internal objects at all. This is one reason that deep trust and foundation work must be done before deeper working through can be both safe and effective.

Two related questions arise for the patient at this point: Can the therapist be of more use than the patient's parents were, and can the patient stand being aware of his or her early, core material?

Additional Guidelines

Relationship. Build support for good boundaries and good contact. Provide a safe environment. Watch for the twin dangers of intrusion and abandonment. Do not do what the patient experiences as intrusive—not even in a good cause. Needless to say, abandonment is not a good thing. Be contactful, emotionally direct and open, and easygoing. Let the relationship build with time, caring, and acceptance. Be inviting but not intrusive. The goal is contact, not moving the patient somewhere. Identify and validate the patient's experience using empathic reflections. Let it be OK that trust builds gradually and that movement is slow.

Contact the hidden, isolated core self. The patient needs the therapist to contact the patient's core self so that he or she can feel like a person. The schizoid patient cannot do this for himself or herself. The trick is to do it without being intrusive or confrontive. This is done by good contact, experiments and reflections, and a steady, inviting presence. Cathartic release of emotions is not helpful with the schizoid patient unless expressed by the core self.

Remember that resistance to awareness and contact was necessary for survival and may still be. Respect it and bring it into awareness as something to be accepted. With this awareness comes a choice that the patient did not have previously.

Work on integrating parts of the self: desire and dread, active and passive core selves, internal attacker and core self.

In group invite participation but allow the schizoid patient to play a passive role without being pejorative. Follow the patient's lead about timing. If the patient wants to continue and feels ashamed of how long it is taking, offer support by acknowledging progress (truthfully only), clarifying what is in process and what is next, and normalizing the lengthiness (truthfully only).

Audience Questions and My Answers

Question: What kind of contract do you make for continuing therapy with schizoid patients?

Answer: I don't make explicit contracts. I work in a here-and-now mode so I'm not sure how to answer that question. I try to be as straightforward as I can about what can be done in therapy and how long it takes. It's the only way I know to work with what is emerging rather than with something preset.

Question: Transactional analysts use contracts, particularly in groups. Everyone has a contract, and group members all know what contracts the other members have. When someone new joins the group, that person struggles to decide what his or her contract is. I've experienced schizoid patients repeating the same contract for years, and I'm wondering if you've dealt with that.

Answer: I guess it would be appropriate to ask the person what he or she wants to focus on and to get out of the group—or out of individual therapy. That may be the rough equivalent of a contract. But if everybody else in group has a contract, I'm not sure how I would handle that. I would not want to single out a

schizoid patient as being too defective to have a contract.

Question: What are some of the less obvious cues for connection and disconnection?

Answer: Eye contact, change of facial color, muscle tightening. There's a subtle increase in the quality of connecting in the eyes with a connection. With disconnection, the energy moves away, the color in the face changes, and often the breath is held. There are also cues in the flow of speech, especially in fluency. The stream of talk becomes blocked or disrupted when the patient disconnects.

Question: Please say something about the gestalt techniques that you use with schizoid patients and how they differ from traditional psychoanalytic approaches.

Answer: First, I'd be careful about techniques, including gestalt techniques. I would lead with the paradoxical theory of change, although many gestalt therapists don't operate that way. They pull up the empty chair or the pillows to pound without regard to what's happening in the relationship. 1 do not advocate that at all.

Gestalt experiments that are more interpersonally contactful are more suitable for schizoid patients than the empty chair. This would include, for example, experiments that involved looking at you (or others in a group) and maintaining good breathing. Experiments that involve exploring distance can also be useful, for example, moving close and then away. One can either move around the room in doing this or change the position of chairs: "How do you feel if I move closer?" Then you observe to see what the patient does, for example, if he or she wants more distance: Does he or she push me away? Signal me away? Take no action? Supporting the feeling and movement with good breathing is crucial. When it becomes spontaneously obvious that there is an internal conflict one can experiment with an internal dialogue between the parts using two chairs or other forms of role playing. I have also done this kind of exploration using psychodrama techniques rather than the empty chair. I don't use a lot of techniques, but they can be useful in this way—as long as they are within an emphasis on the relationship, are not used to avoid patient-therapist contact, are arranged mutually by therapist and patient, and do not become an end in themselves.

Question: More on contact and distancing: As you observe the cues you mentioned, how do you avoid the paradox of pointing out contact and the patient feeling intruded on or pointing out distance and the patient feeling some kind of abandonment?

Answer: Or feeling criticized merely because of the observation. 1 don't think you can avoid that. I try to be careful with my own self-awareness and not deceive myself about what I am actually feeling and doing. Am I really trying to connect with what is emerging, for example, the distance issue, or am 1 feeling judgmental or aiming at changing the patient? I try to notice what happens when I make an observation. If the patient feels criticized and I can be open to that—and not have to defend my honor as a therapist, so to speak—then I can work with the patient feeling intruded on or feeling I'm watching them so closely that they're like a bug on a board. 1 pay particular attention to the context and to the subtext of how I made my observation. If I am tense, offhanded, sarcastic, flat, and so on it may be relevant to why the patient feels intruded on. You work with the patient's experience openly, without assuming you are not a part of the problem. If you are open, the patient will pick up your openness in exploring the interaction between him or her and you. If the therapist is not defensive and is open, the interaction can be useful, and a breach in the relationship or safety can often be repaired. And in the repair, there is often growth such that the relationship and the patient are stronger.

Often what emerges is that the exposure the patient feels on hearing the therapist's observation triggers shame in him or her. This must be explored and respected. The therapist must take responsibility for being part of that process. However, you can't be too careful about trying to avoid such risks and still be an effective therapist. We can only be sensitive, aware of the context, our patients, our mood, and how we are present, and be willing to repair.

Question; I believe you said schizoid patients often feel humanly connected while in isolation without being.. . .

Answer: Unfortunately they don't. They want and need to feel humanly connected while they are separated. They will often substitute being connected symbolically—for example, in dream imagery or fantasy.

Question: For 11 years I worked with a severely schizoid patient who was diagnosed as an extroverted schizoid. He had such a strong need to be in contact and community that it appeared as an "as if self. But internally there was this severe schizoid process going on, and I had to work hard to undo that extroverted quality—in the Jungian sense that he came into the world with that innate extroverted self. What do you think about such an individual?

Answer: I don't know about the innate self from the Jungian standpoint. One of the ways that people with schizoid issues often present to the world is with extroverted behavior, with schizoid processes underneath. Often I am surprised at how much shame and schizoid process can be found in people who appear to be very extroverted. They will experience this themselves, with surprise, when they get to a deeper level of awareness. 1 see a lot of the schizoid process underlying apparently extroverted, hysterical, dramatic behavior. That is part of why some people think that the schizoid process underlies everything. Even extroverts who make good social contact reveal schizoid issues when you get to an intimate level with them or get beneath the words.

Richard Erskine (moderator): I appreciate the broad theoretical overview you have offered us, Gary, and how much you have condensed into this short presentation. To summarize a bit, I think perhaps one of the most important things you have been saying—and something that needs to be emphasized—is that the schizoid process is often not observable. Frequently, schizoid patients present as highly functioning individuals, and it is only through phenomenological experience that they and we come to understand and appreciate the schizoid processes that underlie so much of their lives.

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