SEQ CHAPTER \h \r 1**Some Thoughts about Schizoid Dynamics**

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For many years I have been trying to develop a fuller understanding of the subjectivities of individuals with schizoid psychologies. I am not referring to the version of Schizoid Personality Disorder that appears in descriptive psychiatric taxonomies like the DSM, but to the more inferential, phenomenologically oriented psychoanalytic understanding of schizoid issues. I have always been more interested in exploring individual differences than in arguing about what is and is not pathology, and I have found that when individuals with schizoid dynamics--whether patients, colleagues, or personal friends--sense that their disclosures will not be disdained (or "criminalized," as one therapist recently put it), they are willing to share with me a lot about their inner world. As is true in many other realms, when one becomes open to seeing something, one sees it everywhere.

I have come to believe that people with significant schizoid tendencies are more common than is typically thought, and that there is a range of mental and emotional health in such people that runs from psychotically disturbed to enviably robust. Although I have become persuaded that the central issues for schizoid individuals are not "neurotic-level" conflicts (cf. Steiner, 1993), I note that the highest-functioning schizoid people, of whom there are many, seem much healthier in every meaningful respect (life satisfaction,

sense of agency, affect regulation, self and object constancy, personal relationships, creativity) than many people with certifiably neurotic psychologies. Although the Jungian concept of "introversion" is perhaps a less stigmatizing term, I prefer "schizoid" because it implicitly refers to the complex intrapsychic life of the introverted individual rather than to a preference for introspection and solitary pursuits, which are more or less surface phenomena.

One of the reasons that mental health professionals seem not to notice the existence of high-level schizoid psychology is that many people with schizoid dynamics hide, or "pass," among non-schizoid others. Not only does their psychology involve a kind of allergy to being the object of someone else's intrusive gaze, they have learned to fear that they will be exposed as weird or crazy. Given that non-schizoid observers do tend to attribute pathology to people who are more reclusive and eccentric than they are, the schizoid person's fears of being scrutinized and found abnormal or less than sane are realistic. In addition, some schizoid people worry about their own sanity, whether or not they have ever lost it, and their fears of being categorized as psychotic may constitute the projection of a conviction that their inner experience is so private, unrecognized, unmirrored, and intolerable to others that their isolation equates with madness.

Many nonprofessionals regard schizoid people as peculiar and incomprehensible. But to add insult to injury, mental health professionals have had a tendency to equate the schizoid with the mentally primitive, and the primitive with the insane. Melanie Klein's

(1946) brilliant construal of the "paranoid-schizoid position" as the precursor of the capacity to comprehend the separateness of others (the "depressive position") has contributed to this habit of mind, as has the general tendency in the field to see developmentally earlier phenomena as inherently "immature" or "archaic" (cf. Sass, 1992, p. 21, on the Great Chain of Being fallacy). In addition, we have tended to suspect schizoid personality manifestations as being possible precursors of a schizophrenic psychosis. Behaviors common in schizoid personality can certainly mimic the early stages of schizophrenic withdrawal. The adolescent who begins to spend more and more time in his room and in his fantasy life and eventually becomes frankly psychotic is a familiar clinical phenomenon. And schizoid personality and schizophrenia may, in fact, be cousins: Recent research into the schizophrenic disorders has identified genetic dispositions that can be manifested anywhere on a broad spectrum from severe schizophrenia to normal schizoid personality (Weinberger, 2004). (On the other hand, there are many people diagnosed with schizophrenia whose premorbid personality could be conceptualized as predominantly paranoid, obsessional, hysterical, depressive, or narcissistic.)

Another possible reason for associating the schizoid with the pathological is that many schizoid individuals feel an affinity for people with psychotic disorders. One colleague of mine, self-described as schizoid, prefers working with psychotically disturbed individuals to treating "healthy neurotics," because he experiences neurotically

troubled people as “dishonest” (i.e., defensive), whereas he perceives psychotic ones as engaged in a fully authentic struggle with their demons. Some seminal contributors to personality theory--Carl Jung and Harry Stack Sullivan, for example--not only seem by most accounts to have been characterologically rather schizoid, but may also have had one or more short-lived psychotic episodes that never turned into a long-term schizophrenic condition. It seems safe to infer that the capacity of these analysts to grasp the subjective experience of more seriously disturbed patients had a lot to do with their access to their own potential for madness.

Even highly effective and emotionally secure schizoid people may worry about their sanity. A close friend of mine found himself distressed when watching the movie, *A Beautiful Mind*, which depicts the gradual descent into psychosis of the brilliant mathematician, John Nash. The film effectively draws the audience into Nash’s delusional world and then discloses that individuals whom the viewer had seen as real were hallucinatory figments of Nash’s imagination. It becomes suddenly clear that his thought processes have moved from creative brilliance to psychotic confabulation. My friend found himself painfully anxious as he reflected on the fact that, like Nash, he can not always discriminate between times when he makes a creative connection between two seemingly unconnected phenomena that are in fact related, and times when he makes connections that are completely idiosyncratic, that others would find ridiculous or crazy. He was talking about this anxiety with his relatively schizoid analyst, whose rueful

response to his description of this insecurity about how much he could rely on his mind was, "Yeah. *Tell* me about it!" (In the section on treatment implications, it will become clear why I think this was a responsive, disciplined, and therapeutic intervention, despite its seeming to be a casual departure from the analytic stance.)

Notwithstanding the existence of some connections between schizoid psychology and psychotic vulnerability, I have been impressed repeatedly with the phenomenon of the highly creative, personally satisfied, and socially valuable schizoid individual who seems, despite an intimate acquaintance with what Freud called the primary process, never to have been at serious risk for a psychotic break. The arts, the theoretical sciences, and the philosophical and spiritual disciplines seem to contain a high proportion of such people. So does the profession of psychoanalysis. Harold Davis (personal communication) reports that Harry Guntrip once joked to him that "psychoanalysis is a profession by schizoids for schizoids." Empirical investigations into the personalities of psychotherapists now ongoing at Macquarie University in Sydney, Australia (Judith Hyde, personal communication) are finding that although the modal personality type among female therapists is depressive, among male therapists, schizoid trends predominate.

My own guess about why this is so includes the observation that high-functioning schizoid people are not surprised or put off by evidence of the unconscious. That is, they have intimate--and at times uneasy--familiarity with processes that in most people are out

of awareness, an access that makes psychoanalytic ideas more accessible and commonsensical to them than they are to those of us who spend years on the couch hacking through repressive defenses to make the acquaintance of our more alien impulses, images, and feelings. Schizoid people are temperamentally introspective; they like to wander among the nooks and crannies of their mind, and they find in psychoanalysis many evocative metaphors for what they find there. In addition, the professional practice of analysis and the psychoanalytic therapies offers an attractive resolution of the central conflict about closeness and distance that pervades schizoid psychology (cf. Wheelis, 1956).

I have always found myself attracted to schizoid people. In recent years I have realized that most of my closest friends are describable this way. My own dynamics, which tilt more toward the hysterical and depressive, are implicated in this attraction, in ways I speculate about further on in this essay. In addition, I have been fascinated by an unexpected response to my book on diagnosis (McWilliams, 1994). Although it is not unusual for me to be approached by readers who tell me that they found a particular chapter useful in their understanding of some personality type, or that some section of the book was helpful in their work with a patient, or even that they found in the book a recognizable description of their own dynamics, something distinctive occurs with respect to the section on schizoid personalities. Several times, after a lecture or workshop, a person has come up to me (often someone who was sitting quietly in the

back, closest to the door), checked to be sure he or she was not impinging, and said something like, “I just want to thank you for your chapter on schizoid personality. You really *got* us.”

In addition to the fact that these readers are expressing personal gratitude rather than professional praise, I am struck by the use of the plural: “us.” I have been wondering lately whether schizoid people are in a similar psychological position to that of individuals in sexual minorities. That is, they are sensitive to the risk of being considered “deviant” or “sick” or “behavior-disordered” by those of us with more common psychologies simply because they *are* a minority. Mental health professionals sometimes discuss schizoid themes in a tone similar to the tone in which they once spoke about the gay, lesbian, bisexual, and transgendered population. We have tended both to equate dynamics with pathology and to generalize about a whole class of people on the basis of individuals who have sought treatment for something problematic about their idiosyncratic version of their psychology.

The schizoid sensitivity to being stigmatized makes sense to me in light of the fact that the rest of us may unthinkingly reinforce in one another the assumption that our more mainstream psychology is normative and that exceptions to it must therefore constitute psychopathology. Obviously, another possibility is that there are significant internal differences among people, expressing psychodynamic factors as well as others (e.g., constitutional, experiential, and contextual), that are neither better nor worse in terms of

mental health. The human propensity to rank differences along some hierarchy of value runs deep, and minority groups are typically relegated to the lower rungs of such hierarchies.

Consider further the significance of the term "us." Schizoid people recognize each other. They feel like members of what one reclusive friend of mine called "a community of the solitary." Like homosexually oriented people with "gaydar," many schizoid individuals can spot each other in a crowd. I have heard them describe a sense of deep and compassionate kinship with one another, despite the fact that these relatively isolative people rarely verbalize such kinship or approach each other for explicit recognition. I have noted, however, that there is starting to be a genre of popular books that normalize and even valorize such schizoid themes as extreme sensitivity (e.g., *The Highly Sensitive Person* [Aron, 1996]), introversion (e.g., *The Introvert Advantage* [Laney, 2002]), and preference for solitude (e.g., *Party of One: The Loner's Manifesto* [Rufus, 2003]). A schizoid man I know described walking through a hall with several classmates on the way to a seminar with a teacher he suspected of having a similar psychology. On the way to the instructor's office, they passed a photo of Coney Island on a hot day, a beach scene with people crowded together so tightly that the sand was hardly visible. The teacher made eye contact with my friend, nodded toward the picture, and made a wincing gesture indicating dread and avoidance. My friend opened his eyes wider and nodded. They understood each other.

How am I defining the schizoid personality?

I am using the term "schizoid" as it was used by the British object relations theorists rather than as it appears in the DSM (see Akhtar, 1992, p. 139; Doidge, 2001, p. 284; Gabbard, 1994, p. 431; Guntrip, 1969). The DSM, arbitrarily and without empirical basis, differentiates between schizoid and avoidant psychology, postulating that Avoidant Personality Disorder includes a wish to be close despite the taking of distance while Schizoid Personality Disorder represents an indifference to closeness. Yet I have never seen a person, among mental health patients or otherwise, whose reclusiveness was not originally conflictual (cf. Kernberg, 1984). Recent empirical literature supports this clinical observation (Shedler & Westen, 2004). We are animals who seek attachment. The detachment of the schizoid person represents, among other things, the defensive strategy of withdrawal from overstimulation, traumatic impingement, and invalidation, and most experienced psychoanalytic clinicians know not to take it at face value, however severe and off-putting it may appear.

Before the discovery of the neuroleptics, when pioneering analysts used to work with unmedicated psychotic patients in facilities such as Chestnut Lodge, there were many reports of even catatonically withdrawn men and women who emerged from their isolation when they felt safe enough to reach out for human contact. (One famous case, for which I can find no written account, involves Frieda Fromm-Reichmann, who is said

to have sat quietly next to a catatonic schizophrenic patient for an hour a day, making occasional observations about what was happening on the ward and what the patient's feelings about it might be. After almost a year of these daily meetings, the patient abruptly turned to her and stated that he disagreed with something she had said several months previously.)

The psychoanalytic use of the term schizoid derives from the observations of "schisms" between the internal life and the externally observable life of the schizoid individual (cf. Laing, 1965). For example, 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.

The term may also have been influenced by the fact that the characteristic anxieties of schizoid people concern fragmentation, diffusion, going to pieces. They feel

all too vulnerable to uncontrollable schisms in the self. I have heard numerous schizoid individuals describe their personal solutions to the problem of a self experienced as dangerously fissiparous. They include wrapping oneself in a shawl, rocking, meditating, wearing a coat inside and out, retreating to a closet, and other means of self-comfort that betray the conviction that other people are more upsetting than soothing. Annihilation anxiety is more common than separation anxiety in schizoid people, and even the healthiest schizoid person may occasionally suffer psychotic terrors such as the sense that the world could implode or flood or fall apart at any minute, leaving no ground beneath one's feet. The urgency to protect the sense of a core, inviolable self can be profound (Elkin, 1972; Eigen, 1973).

Having been originally trained in an ego psychology model, I have found it useful to think of the schizoid personality as defined by a fundamental and habitual reliance on the defense mechanism of withdrawal. This withdrawal can be more or less geographical, as in the case of a man who retreats to his den or to some remote location whenever the world is too much for him, or internal, as illustrated by a woman who goes through the motions of being present while attending mostly to internal fantasies and preoccupations. Theorists in the object relations movement emphasized the presence in schizoid people of a core conflict with interpersonal closeness versus distance, a conflict in which physical (not internal) distance usually wins out (Fairbairn, 1940; Guntrip, 1969).

In more severely disturbed schizoid people, withdrawal can look like an unremitting state of psychological inaccessibility, whereas in those who are healthier, there is a noticeable oscillation between connection and disconnection. Guntrip (1969, p. 36) coined the phrase "in and out programme" to describe the schizoid pattern of seeking intense affective connection followed by having to distance and re-collect the sense of self that is threatened by such intensity. Although this can be particularly visible in the sexual realm, it seems to be equally true of other instances of intimate emotional contact.

` I suspect that one of the reasons I find people with central schizoid dynamics appealing is that withdrawal is a relatively "primitive," global, encompassing defense (Laughlin, 1979; Vailliant, Bond & Vailliant, 1986) that can make it unnecessary to use the more distorting, repressing, and putatively more "mature" defensive processes. A woman who simply *goes away*, either physically or psychically, when she is under stress, does not need to use denial or displacement or reaction formation or rationalization. Consequently, affects, images, ideas, and impulses that non-schizoid people tend to screen out of their consciousness are freely available to her, making her emotionally honest in a way that strikes me and perhaps other not-particularly-schizoid people as unexpectedly and even breathtakingly candid.

A related characteristic of schizoid individuals (one that may be misunderstood either negatively as perversity, or positively as strength of character) is an indifference to, or outright avoidance of, personal attention and admiration. Although they may want

their creative work to have an impact, most schizoid people I know would rather be ignored than celebrated. Their need for space far outweighs their interest in narcissistic supplies of the usual sort. Colleagues of my late husband, esteemed among his students for his originality and brilliance, have frequently lamented his tendency to publish his writings in oddly marginal journals, with no apparent concern to build a broad reputation in the mainstream of his field. Fame *per se* did not motivate him; being understood by those who mattered to him personally was far more important. When I told a schizoid friend that I had heard him described as "brilliant, but frustratingly reclusive," he looked worried and asked "Where did they get 'brilliant'?" "Reclusive" was fine, but "brilliant" might have sent somebody in his direction.

How do people get that way?

I have written previously about the possible etiology of schizoid dynamics (McWilliams, 1994), and in this paper I prefer to stay at the level of phenomenology, but let me make a few summary statements about the complex etiologies of schizoid versions of personality structure. I have become increasingly impressed with the centrality of a constitutionally sensitive temperament, noticeable from birth, probably influenced by the genetic disposition I mentioned earlier. I suspect that one of the expressions of this genetic heritage is a level of sensitivity, in all its negative and positive meanings (see Eigen, 2004), far more extreme and painful than that of most non-schizoid people. This

acute sensitivity manifests itself from birth onward in behaviors that reject experiences that are felt as too overwhelming, too impinging, too penetrating.

I have heard a number of schizoid individuals describe their mothers as both cold and intrusive. For the mother, the coldness may be experienced as coming from the baby. Several self-diagnosed schizoid people have told me their mothers said that they rejected the breast as newborns or complained that when they were held and cuddled, they pulled away as if overstimulated. A friend confided to me that his internal metaphor for nursing is "colonization," a term that conjures up the exploitation of the innocent by the intrusive imperial power. Related to this image is the pervasive concern with poisoning, bad milk, and toxic nourishment that commonly characterizes schizoid individuals. One of my more schizoid friends once asked me as we were having lunch in a diner, "What is it about straws? Why do people like to drink through straws?" "You get to suck," I suggested. "Yucch!" she shuddered.

Schizoid individuals are frequently described by family members as hypersensitive or thin-skinned. Doidge (2001) emphasizes their "hyperpermeability," the sense of being skinless, of lacking an adequately protective stimulus barrier, and notes the prevalence of images of injured skin in their fantasy life. After reading an early draft of this paper, one schizoid colleague commented, "The sense of touch is very important: We're both frightened of it and want it." As early as 1949, Bergmann and Escalona observed that some children show, from infancy on, an acute sensitivity to light, sound,

touch, smell, taste, motion, and emotional tone. More than one schizoid person has told me that his or her favorite childhood fairy tale was "The Princess and the Pea." Their sense of being easily overwhelmed by invasive others is frequently expressed in a dread of engulfment, a fears of spiders, snakes and other devourers, and an Edgar Allen Poe-like preoccupation with being buried alive.

Complicating their adaptation to a world that overstimulates and agonizes them is the experience of invalidation and toxification by significant others. Most of my schizoid patients recall being told by exasperated parents that they were "oversensitive" or "impossible" or "too picky" or that they "make mountains out of molehills." Thus, their painful experiences are repeatedly disconfirmed by caregivers who, because their temperament differs from that of their child, cannot identify with his or her acute sensitivities and consequently treat the child with impatience, exasperation, and even scorn. Khan's (1963) observation that schizoid children show the effects of "cumulative trauma" is one way of labeling this recurring disconfirmation. It becomes easy to see how withdrawal becomes their preferred adaptation: Not only is the outer world too much for them sensually, it invalidates their experience, demands behaviors that are excruciatingly difficult, and treats them as crazy for reacting in ways they cannot control.

Referring to Fairbairn's work, Doidge (2001), in a fascinating analysis of schizoid themes in the movie *The English Patient*, summarizes the childhood predicament of the schizoid person:

> Children . . . develop an internalized image of a tantalizing but rejecting parent . . . 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 for 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. Fairbairn argued that the tragedy of schizoid children is that . . .they believe it is love, rather than 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. (pp. 285-286)

Describing the central dilemma of such a child, Seinfeld (1993, p. 3) writes that the schizoid individual has "a consuming need for object dependence, but attachment threatens the schizoid with the loss of self." This internal conflict, elaborated in countless ways, is the heart of the psychoanalytic understanding of schizoid personality structure.

Some seldom-noted aspects of schizoid psychology

1. Reactions to loss and separation

Non-schizoid people, among whom are presumably the authors of the DSM and

many others in the descriptive psychiatric tradition, often conclude that because schizoid individuals resolve their closeness/distance conflicts in the direction of distance and seem to thrive on being alone, they are not particularly attached and therefore are not reactive to separation. Yet internally, schizoid people may have powerful attachments. In fact, those that they have may be more intensely invested with emotion than are the attachments of people with much more obviously "anaclitic" psychologies. Because schizoid individuals tend to feel safe with comparatively few others, any threat to or loss of their connection with the people with whom they *do* feel comfortable can be devastating. If there are only three individuals by whom one feels truly known, and one of these is lost, then one-third of one's support system has vanished.

Thus, a common precipitant of a schizoid person's seeking treatment is loss. Another, a related concern, is loneliness. As Fromm-Reichmann (1959/1990) noted, loneliness is a painful emotional experience that remains curiously unexplored in the professional literature. The fact that schizoid people repeatedly detach and seek solitude is not evidence of their being immune to loneliness, any more than an obsessional person's avoidance of affect means that he or she is indifferent to strong emotion, or a depressive person's clinging denotes the absence of wishes for autonomy. Schizoid individuals may seek treatment because, as Guntrip (1969) notes, they have retreated so far from meaningful relationships that they feel enervated, futile, and internally dead. Or they come to therapy with a specific goal: to go on a date, to become more social, to

initiate or improve a sexual relationship, to conquer what they have been told is "social phobia."

2. Sensitivity to the unconscious feelings of others

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. Many times I have had the experience of thinking I was behaving relatively inscrutably, or no differently from how I behaved on any other day, only to have a schizoid friend or patient confront me about my "obvious" state of mind. In my book on psychotherapy (McWilliams 2004), I told the story of a schizoid client, a woman whose most passionate attachments were to animals, who was the only one of my patients to pick up the fact that something was bothering me in the week after I was diagnosed with breast cancer, when I was trying to keep that fact private pending further medical intervention. Another schizoid patient once arrived for her session on an evening when I was looking forward to a weekend with an old friend, took one look at me acting in what I thought was a thoroughly ordinary, professional way as I sat down to listen to her, and teased, "Well! Aren't *we* happy tonight!"

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?" There may be a paranoid edge to this experience of the unspoken/unspeakable: Perhaps the others are aware of the elephant and have decided not to talk about it. What is the danger they perceive that I do not? Or perhaps they are genuinely unaware of the elephant, in which case their naiveté or ignorance may be equally dangerous. Kerry Gordon (unpublished manuscript) notes that the schizoid person lives in a world of *possibility*, not probability. As with most patterns that re-enact a theme repeatedly and come to have a self-fulfilling quality, schizoid withdrawal both increases a tendency to live in primary process and creates further withdrawal because of

the aversive consequences of living increasingly intimately in the realm of primary-process awareness.

3. Oneness with the universe

Schizoid individuals have often been characterized as having defensive fantasies of omnipotence. For example, Doidge (2001, p. 288) mentions a seemingly cooperative patient who "disclosed, only well into treatment, that he always had the omnipotent fantasy that he was controlling everything I said." Yet the schizoid person's sense of omnipotence differs in critical ways from that of the narcissistic or psychopathic or paranoid or obsessional person. 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 (cf. Khan's [1966] writing on "symbiotic omnipotence"). Gordon (unpublished manuscript) has characterized this experience more as "omnipresence" than omnipotence and relates it to Matte-Blanco's (1975) notion of symmetrical thinking.

There is something about feeling a lack of ontological differentiation or elaboration of self that strikes me about such phenomena. Rather than omnipotence, it feels to me as if schizoid individuals retain some sense of primary fusion, of Balint's

(1968) “harmonious, interpenetrating mix-up.” The recurring narrative in schizoid psychology concerns how this relatedness has become inharmonious and toxic. In this connection, Doidge (2001) mentions the frequent assertion of Samuel Beckett, whose work resounds with schizoid themes, that he had never been born. A therapist in an audience to whom I talked about schizoid psychology voiced the perception that schizoid people are “insufficiently incarnated,” existing in a world in which their bodies are no more real to them than their surround.

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. Once when we were eating muffins together, a friend of mine commented, “I must be doing well. These raisins aren’t bothering me.” I asked what it was about raisins that was problematic: “You don’t like the taste?” She smiled. “You don’t understand. They *could* be flies!” This anecdote sparked an association in a colleague to whom I told it. She volunteered that her husband, whom she considers schizoid, dislikes raisins for a different reason. “He says they *hide*.”

4. The schizoid-hysterical romance

I mentioned earlier my attraction to people with schizoid psychologies. As I think about this phenomenon and reflect on the frequency with which other heterosexual women with hysterical dynamics seem to be drawn to men with schizoid trends, I find that in addition to my experience of schizoid people as inspiringly honest, there are dynamic reasons for the resonance. 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. But despite our recent appreciation of two-person processes, there is surprisingly little professional writing about the intersubjective consequences of specific and contrasting individual psychologies. Wheelis's short story, (1966/2000) "The Illusionless Man and the Visionary Maid" and Balint's (1945) classic depiction of the ocnophil and the philobat seem to me more germane to the schizoid-hysterical chemistry than any more recent clinical writing.

The admiration between a more hysterical person and a more schizoid one is frequently mutual. 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. Doidge (2001, p. 286) memorably compared love relations with a schizoid person to litigation.

I think the affinity between these personality types goes further, however. Both schizoid and hysterical psychologies can be characterized as hypersensitive, as preoccupied with the danger of being overstimulated. 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 schizoid men and hysterical women (at least those who regard themselves as heterosexual—my clinical experience is not vast enough for me to generalize about others) tend to see the opposite-sex parent as the locus of power in the family, and both feel too easily invaded psychologically by that parent. 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. Arthur Robbins (personal communication) goes so far as to say that inside every schizoid individual is a hysterical one, and vice versa. An exploration of this idea would constitute another paper, one I hope some day to write.

Therapeutic implications

People with significant schizoid dynamics, at least the healthier, more vital and more interpersonally competent individuals in that group, tend to be attracted to psychoanalysis and the psychoanalytic therapies. Typically, they cannot imagine how anyone would want to comply with manualized interventions that relegate individuality and the exploration of the inner life to a minor role in the therapeutic project. If they have the resources to afford it, higher-functioning schizoid individuals are excellent candidates for psychoanalysis proper. They like the fact that the analyst intrudes relatively little on their associative process, they enjoy the inviolable space that the couch can provide, and they appreciate being freed from potential overstimulation by the therapist's corporeality and facial affect. Even in once-a-week and face-to-face arrangements, schizoid patients tend to be grateful for the therapist's careful avoidance of intrusion and premature closure. And because they "get" primary process and know that a training program has acquainted the therapist intimately with it, they can hope that their inner life will not evoke shock or criticism or disdain.

Despite the fact that most high-functioning schizoid patients accept and value traditional analytic practices, what goes on in the successful treatment of such patients is not well captured in Freud's formulation of making the unconscious conscious. Although some unconscious aspects of schizoid experience, most notably the dependent longings

that stimulate defensive withdrawal, do become more conscious in a successful therapy, most of what is therapeutically transformative to schizoid individuals involves the experience of *elaborating the self in the presence of an accepting, nonintrusive, but still powerfully responsive other* (Gordon, unpublished paper). The celebrated hunger of schizoid individuals is, in my experience, mostly a hunger for the kind of recognition about which Benjamin (e.g., 2000) has so evocatively written, a recognition of their subjectivity. It is their capacity to engage in the struggle to attain such recognition, and their capacity to reinitiate that process when it has broken down, that has been most deeply injured in those who come to us for help.

Winnicott, whose biographers (e.g. Kahr, 1996; Phillips, 1989; Rodman, 2003) depict him in ways that suggest a deeply schizoid man, has described development in language directly applicable to the treatment of the schizoid patient. His concept of the caregiver who allows the child to "go on being" and to "be alone in the presence of the mother" could not be more relevant. His appreciation of the importance of a facilitating environment characterized by nonimpinging others, who value the true and vital self over compliant efforts to accommodate to others' defenses, might be a recipe for psychoanalytic work with schizoid patients. Because the analytic frame supplies the essential ingredients of a nonimpinging atmosphere, relatively conventional technique is well suited to high-functioning schizoid patients. Unless the analyst's narcissism expresses itself in a need to bombard the analysand with interpretations, classical analytic

practice gives the schizoid person room to feel and talk at a tolerable pace.

Still, there has been some attention in the clinical literature to the special requirements of those schizoid patients who need something that goes beyond standard technique. First, because speaking from the heart can be unbearably painful for the schizoid person, and being spoken to with emotional immediacy may be comparably overwhelming, a therapeutic relationship may be furthered by transitional ways to convey feeling. One woman I worked with, who struggled every session to talk at all, finally called me on the telephone, weeping. "I want you to know that I do want to talk to you," she said, "but it hurts too much." We were eventually able to make therapeutic progress in a highly unconventional way, by my reading to her from the more accessible and less pejorative psychoanalytic literature on schizoid psychology and asking her if the descriptions fit her experience. My hope was to spare her the agony of formulating and giving voice to feelings she regarded as incomprehensible to others and symptomatic of a profound, lone madness. She reported that it was the first time she had known that there were other human beings like her.

A schizoid person who cannot directly describe the anguish of isolation can probably talk about such a state of mind as it appears in a film or poem or short story. Empathic therapists working with schizoid clients often find themselves either initiating or responding to conversations about music, the visual arts, the dramatic arts, literary metaphors, anthropological discoveries, historical events, or the ideas of religious and

spiritual thinkers. 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.

Second, sensitive clinical writers have also noted that schizoid individuals have radar for evasion, role-playing, and the false note. For this reason and others, one may need to be more "real" with them in therapy. Unlike analysands who eagerly exploit information about the therapist in the service of intrusive demands, or the fueling of idealization or devaluation, schizoid patients tend to accept the analyst's disclosures with gratitude and continue to respect his or her private, personal space. Writing under a pseudonym, an Israeli patient notes that

> "People with schizoid personality . . . tend to feel more comfortable with 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 unacceptably. In such surroundings a person who is very sensitive by nature may be more open and expend less energy on hiding his/her differences. ("Mitmodedet," 2002, p. 190)

Robbins (1991), in a case report exemplifying both a sensitivity to transitional topics and the awareness of the patient's need for him to be real, describes a schizoid

woman who came to him devastated by the sudden death of her analyst and yet unable to talk about her pain. The image she evoked in him of a stranger on a lonely island, simultaneously contented and crying out for rescue, seemed potentially too frightening to share with her. The therapy began to deepen, however, when the two participants talked about an ostensibly trivial topic:

> One day she came in and mentioned that she had just had a quick bite at a local pizza shop. . . . We started to talk about the wide variety of pizza places on the West Side, both agreeing that Sal's was by far the best. We continued to share our mutual interest, now extending throughout Manhattan, in pizza shops. We traded information and seemed to take mutual pleasure in the exchange. Certainly quite a deviation from standard analytic procedure. On a far subtler level, both of us started to learn something very important about the other though I suspect her knowledge was largely unconscious. Both of us knew what it meant to eat on the run, to hungrily grab something that filled an inexplicable dark hole but which at best was a temporary palliative to an insatiable appetite. This hunger, of course, was kept to oneself, for who could bear to reveal the intensity of such rapaciousness. . . .The pizza discussions became our bridge to a union, the re-experiencing of a shared relatedness that ultimately became the starting point for the patient to give form and shape to her past and present. Our pizza connection served as a haven, a place where she felt understood.

One reason that a therapist's willingness to reveal personal experiences catalyzes the therapy with schizoid clients is that even more than other individuals, these patients need to have their subjective experience acknowledged and accepted. Reassurance feels patronizing to them, and interpretation alone, however accurate, may fall short of conveying that what has been interpreted is unsurprising and even positive. I have known many people who spent years in analysis and emerged with a detailed understanding of their major psychodynamics, yet experienced what they uncovered as shameful admissions rather than as expressions of their essential humanity in all its ordinary depravity and virtue. 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. This is why I view the quip of my friend's analyst, the "Yeah, *tell* me about it!" response to his anxieties about losing his mind, as both quintessentially psychoanalytic and deeply attuned.

Finally, there is the danger with schizoid patients that as they become more comfortable and self-revealing in therapy, they will make the professional relationship a substitute for the satisfactions they could be pursuing outside the consulting room. Many a therapist has worked with a schizoid client for months or years, feeling increasingly gratified in their engagement, before remembering with a jolt that the person originally came for help because of wanting to develop an intimate relationship that has so far shown no signs of being initiated. 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. And when the therapist inevitably fails to be perceived differently, it takes discipline and patience to contain the patient's hurt and outrage about once more being pushed into toxic relatedness.

Concluding comments

In this paper I have found myself feeling a bit like an ambassador for a community that prefers not to involve itself in public relations. It is interesting what aspects of psychoanalytic thinking enter the public professional domain, as it were, and what aspects remain relatively arcane. On its own merits, the work of Guntrip should have done for schizoid psychology what Freud did for the oedipal complex or Kohut did for narcissism; that is, expose its presence in many domains and detoxify and destigmatize our relationship to it. And yet even some experienced psychoanalytic therapists are relatively unfamiliar with or indifferent to analytic thinking about schizoid subjectivities. I suppose that, for obvious reasons, no writer who understands schizoid psychology from the inside has the urge that a Freud or Kohut had to start a *movement* touting the universality of the themes that pervade one's own subjectivity.

I also find myself wondering if some large-scale parallel process is at work in the lack of general attention to psychoanalytic knowledge about schizoid issues. George

Atwood once commented to me that the controversy over whether or not multiple personality (dissociative identity disorder) "exists" is strikingly parallel to the ongoing, elemental internal struggle of the traumatized person who develops a dissociative psychology: "Do I remember this right or am I making it up? Did it happen or am I imagining it?" It is as if the mental health community at large, in its dichotomous positions about whether there really *are* dissociative personalities or not, is enacting a vast, unacknowledged countertransference that mirrors the struggle of the patients in question. Comparably, we might wonder whether our marginalizing of schizoid experience parallels the internal processes that keep schizoid individuals on the fringes of engagement with the rest of us.

I think that we in the psychoanalytic community have both understood and misunderstood the schizoid person. We have been privy to some brilliant writing about the nature of schizoid dynamics, but in parallel to what can happen in a psychotherapy that produces insight without self-acceptance, the discoveries of the most intrepid explorers in this area have too often been translated into the language of pathology. Many of the patients who come to us for help do have quite pathological versions of schizoid dynamics. Many others, including countless schizoid individuals who have never felt the need for treatment, exemplify highly adaptive versions of similar dynamics. I have tried in this paper to explore some ways in which schizoid psychology differs from other self-configurations, emphasizing that this differentness is neither inherently worse

nor inherently better, neither less nor more mature, neither a developmental arrest nor a developmental achievement. It just is what it is and needs to be appreciated for what it is.

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