using and being used to equilibrate one's self-esteem and to repair damage to it. The narcissistic person's propensity for selfobject transferences was discussed, along with countertransference reactions in which a sense of unrelatedness prevails. Some implications for technique were derived from an appreciation of these special aspects of the narcissistic condition, although acknowledgment was made of current controversies in the psychoanalytic understanding of narcissism that make appropriate technique with this population a matter of some dispute. Finally, narcissistic character organization was distinguished from narcissistic reactions, from psychopathy, from depressive (melancholic) personality, from obsessive and compulsive character structure, and from hysteria.

SUGGESTIONS FOR FURTHER READING

There has been a voluminous psychoanalytic literature on narcissism since the 1970s, when Kohut (1971) published *The Analysis of the Self* and Kernberg (1975) offered an alternative conception in *Borderline Conditions and Pathological Narcissism*. Both these books contain so much jargon that they are almost impossible for someone new to psychoanalysis to read. More manageable alternatives include Alice Miller's (1975) *Prisoners of Childhood* (known in another edition as *The Drama of the Gifted Child*), Bach's (1985) *Narcissistic States and the Therapeutic Process*, and Morrison's (1989) *Shame: The Underside of Narcissism*. Morrison (1986) also edited a collection, available in paperback, titled *Essential Papers on Narcissism* that contains major psychoanalytic essays on the topic, most of which are excellent.

❖9❖

Schizoid Personalities

The person whose character is essentially schizoid is subject to widespread misunderstanding, based on the common misconception that schizoid dynamics are always suggestive of grave primitivity. Because the incontrovertibly psychotic diagnosis of schizophrenia fits people at the disturbed end of the schizoid continuum, and because the behavior of schizoid people is apt to be unconventional, eccentric, or even bizarre, nonschizoid others tend to pathologize those with schizoid dynamics—whether or not they are competent and autonomous, with significant areas of ego strength. In fact, schizoid people run the gamut from the hospitalized catatonic patient to the creative genius.

As with the other typological categories, a person may be schizoid at any level, from psychologically incapacitated to saner than average. Because the defense that defines the schizoid character is a primitive one (withdrawal into fantasy), it may be that healthy schizoid people are rarer than sicker ones, but I do not know of any research findings or disciplined clinical observations that support this assumption empirically.* Vocations like philosophical inquiry, spiritual discipline, theoretical science, and the creative arts attract people with this kind of character. At the high functioning end of the schizoid spectrum we might find people like Ludwig Wittgenstein, Martha Graham, and other admirably original and somewhat eccentric individuals.

*There is longstanding evidence that the most frequent premorbid personality type in those who become schizophrenic is schizoid (E. Bleuler, 1911; Nannarello, 1953; M. Bleuler, 1977; Peralta, Cuesta, & de Leon, 1991), but the converse idea, that all schizoid people are at risk of a psychotic break, has no empirical basis.

In 1980, with the publication of the DSM-III, conditions that most analysts would regard as different possibilities on the schizoid spectrum, or as minor variants on a general schizoid theme, appeared as discrete categories in the DSM. Complicated theoretical issues influenced this decision (see Lion, 1986), one reflecting differences of current opinion that echo old controversies about the nature of certain schizoid states (E. Bleuler, 1911; Kraepelin, 1919; Kretschmer, 1925; Schneider, 1959; Jaspers, 1963; Gottesman, 1991; Akhtar, 1992). Most analytic practitioners continue to regard the diagnoses of schizoid, schizotypal, and avoidant personality disorders as nonpsychotic versions of schizoid character, and the diagnoses of schizophrenia, schizophreniform disorder, and schizoaffective disorder as psychotic levels of schizoid functioning.

DRIVE, AFFECT, AND TEMPERAMENT IN SCHIZOID PERSONALITIES

Clinical experience suggests that temperamentally, the person who becomes schizoid is hyperreactive and easily overstimulated. Schizoid people often describe themselves as innately sensitive, and their relatives frequently mention their having been the kind of baby who shrinks from too much light or noise or motion. It is as if the nerve endings of schizoid individuals are closer to the surface than those of the rest of us. Controlled observation and research on temperament in children (Thomas, Chess, & Birch, 1970; Brazelton, 1982) have confirmed the reports of generations of parents that while most infants cuddle, cling, and mold themselves to the body of a warm caregiver, some newborns stiffen or pull back as if the adult has intruded on their comfort and safety. One suspects that such babies are constitutionally prone to schizoid personality structure, especially if there is a "poor fit" (Escalona, 1968) between themselves and their main caregivers.

In the area of drive as classically understood, the schizoid person seems to struggle with oral-level issues. Specifically, he or she is preoccupied with avoiding the dangers of being engulfed, absorbed, distorted, taken over, eaten up. A talented schizoid therapist in a supervision group I belonged to once described to the group members his vivid fantasy that the physical circle of participants constituted a huge mouth or a giant letter "C." He imagined that if he exposed his vulnerability by talking candidly about his feelings toward one of his patients, the group would close around him, making the "C" into an "O," and that he would suffocate and expire inside it.

While fantasies like those of my colleague invite the interpretation that they constitute projections and transformations of the fantasizer's own hunger (Fairbairn, 1941; Guntrip, 1961), the schizoid person does not experience appetitive drives as coming from within the self. Rather, the outer world feels full of consuming, distorting threats against security and individuality. Fairbairn's understanding of schizoid states as "love made hungry" addresses not the day-to-day subjective experience of the schizoid person but the dynamics underlying the opposite and manifest tendencies: to withdraw, to seek satisfactions in fantasy, to reject the corporeal world. Schizoid people are even apt to be physically thin, so removed are they from emotional contact with their own greed (cf. Kretschmer, 1925).

Similarly, schizoid people do not impress one as being highly aggressive, despite the violent content of some of their fantasies. Their families and friends often regard them as unusually gentle, placid people. A friend of mine, whose general brilliance and schizoid indifference to convention I have long admired, was described lovingly at his wedding by an older sister as having always been a "soft person." This softness exists in fascinating contradiction to his affinity for horror movies, true-crime books, and visions of apocalyptic world destruction. The projection of drive can be easily assumed, but this man's conscious experience—and the impression he makes on others—is of a sweet, low-keyed, lovable eccentric. Most analytic thinkers who have worked with people like my friend have inferred that schizoid clients bury both their hunger and their aggression under a heavy blanket of defense.

Affectively, one of the most striking aspects of many high-functioning individuals with schizoid dynamics is their *lack* of common defenses. They tend to be in touch with many emotional reactions at a level of genuineness that awes and even intimidates their acquaintances. It is common for the schizoid person to wonder how everybody else can be lying to themselves so effortlessly when the harsh facts of life are so patent. Part of the alienation from which schizoid people suffer derives from their experiences of not having their own emotional, intuitive, and sensory capacities validated—because others simply do not see what they do.The ability of a schizoid person to perceive what others disown or ignore is so natural and effortless that he or she may lack empathy for the less lucid, less ambivalent, less emotionally harrowing world of nonschizoid peers.

Schizoid people do not seem to struggle unduly with issues of shame or guilt. They tend to take themselves and the world pretty much as is without the internal impetus to make things different or to shrink from judgment. Yet they may suffer considerable anxiety about basic safety. When they feel overwhelmed, they hide—either literally

with a hermit's reclusiveness or by retreat into their imagination (Kasanin & Rosen, 1933; Nannarello, 1953). The schizoid person is above all else an outsider, an onlooker, an observer of the human condition. The "split" that is implied in the etymology of the word schizoid exists in two areas: between the self and the outside world, and between the experienced self and desire (see Laing, 1965). When analytic commentators refer to split experience in schizoid people, they refer to a sense of estrangement from part of the self or from life; the defense mechanism of splitting, in which a person alternately expresses one ego state and then another opposite one, or divides the world defensively into all-good and all-bad aspects, is a different use of the word.

DEFENSIVE AND ADAPTIVE PROCESSES IN SCHIZOID PERSONALITIES

As noted previously, the pathognomonic defense in schizoid personality organization is withdrawal into an internal world of imagination. In addition, schizoid people may use projection and introjection, idealization, devaluation, and to a lesser extent, the other defenses that have their origins in a time before self and other were fully differentiated psychologically. Among the more "mature" defenses, intellectualization is the clear preference of most schizoid people. They rarely rely on mechanisms that blot out affective and sensory information, such as denial and repression; similarly, the defensive operations that organize experience along good-and-bad lines, such as compartmentalization, moralization, undoing, reaction formation, and turning against the self are not prominent in their repertoires. Under stress, schizoid individuals may withdraw from their own affect as well as from external stimulation, appearing blunted, flat, or inappropriate, often despite showing evidence of heightened attunement to affective messages coming from others.

The most adaptive and exciting capacity of the schizoid person is creativity. Most truly original artists have a strong schizoid streak—almost by definition, since one has to stand apart from convention to influence it in a new way. Healthier schizoid people turn their assets into works of art, scientific discoveries, theoretical innovations, or spiritual pathfinding, while more disturbed individuals in this category live in a private hell where their potential contributions are preempted by their terror and estrangement. The sublimation of autistic withdrawal into creative activity is a primary goal of therapy with schizoid patients.

OBJECT RELATIONS IN SCHIZOID CONDITIONS

The primary relational conflict of schizoid people concerns closeness and distance, love and fear. A deep ambivalence about attachment pervades their subjective life. They crave closeness yet feel the constant threat of engulfment by others; they seek distance to reassure themselves of their safety and separateness yet may complain of alienation and loneliness (Karon & VandenBos, 1981). Guntrip (1952), who depicted the "classic dilemma" of the schizoid individual as "that he can neither be in a relationship with another person nor out of it, without in various ways risking the loss of both his object and himself," refers to this dilemma as the "in and out programme" (p. 36). Robbins (1988) summarizes the dynamic as the message, "Come close for I am alone, but stay away for I fear intrusion" (p. 398).

Sexually, some schizoid people are remarkably apathetic, often despite being functional and orgasmic. The closer the other, the greater the worry that sex means enmeshment. Many a heterosexual women has fallen in love with a passionate musician, only to learn that her lover reserves his sensual intensity for his instrument. Similarly, some schizoid people crave unattainable sexual objects, while feeling vague indifference toward available ones. The partners of schizoid people sometimes complain of a mechanical or detached quality in their lovemaking.

Object relations theories of the genesis of schizoid dynamics have been, in my own view, burdened by efforts to locate the origins of schizoid states in a particular phase of development. The adequacy of the fixation–regression hypothesis in accounting for *type* of character structure is, as I have suggested previously, problematic, yet its appeal is understandable: It normalizes puzzling phenomena by considering them simple residues of ordinary infantile life. Klein (1946) thus traced schizoid mechanisms to a universal paranoid–schizoid position of early infancy. Other early object relations analysts followed suit in developing explanatory paradigms in which schizoid dynamics were equated with regression to neonatal experience (Fairbairn, 1941; Guntrip, 1971). Current theorists have tended to continue the developmental bias of the fixation–regression model, yet they differ about which early phase is the fixation point. For example, in the Kleinian tradition, Giovacchini (1979) regards schizoid disorders as essentially "prementational," while Horner (1979) assigns their origins to a later age when the child emerges from symbiosis.

Perhaps more productive speculations about the sources of schizoid personality lie in analytic observations about the kinds of rearing that influence youngsters in a schizoid direction. One type of

relatedness that may encourage a child's withdrawal is an impinging, overinvested, overinvolved kind of parenting (Winnicott, 1965). The schizoid man with the smothering mother is a staple of recent popular literature and can also be found in scholarly work. A type of family background commonly observed by clinicians who have treated male patients with schizoid features is a seductive or boundary-transgressing mother and an impatient, critical father.*

The *content*, not just the degree, of parental involvement may also be relevant to the development of a pattern of schizoid aloofness and withdrawal. Numerous observers of the families of people who developed a schizophrenic psychosis have stressed the role of contradictory and confusing communications (Searles, 1959; Laing, 1965; Lidz & Fleck, 1965; Singer & Wynne, 1965a, 1965b; Bateson et al., 1969). It is possible that such patterns foster schizoid dynamics in general. A child raised with double-binding, emotionally dishonest messages could easily come to depend on withdrawal to protect the self from intolerable levels of confusion and anger. He or she would also feel deeply hopeless, an attitude often noted in schizoid patients (e.g., Giovacchini, 1979).

In apparent contrast to the parental-impingement theory of the development of schizoid features, there are also some reports of people for whom loneliness and relative neglect characterized their childhoods to such a degree that their preference for withdrawal, no matter how profoundly isolating, can be understood as their having made a virtue out of necessity.† It is typical of the literature on schizoid phenomena—an extensive literature because of the huge social cost of schizophrenia—that contrasting and mutually exclusive formulations can be found everywhere one looks (Sass, 1992). It is not impossible that both impingement and deprivation codetermine the schizoid problem: If one is lonely and deprived, yet the only kind of parenting available is unempathic and intrusive, a yearning–avoidant, closeness–

*Although recent editions of the DSM give no information on sex ratio for schizoid, schizotypal, and avoidant diagnoses, most therapists see more males than females with schizoid personalities. This accords with the psychoanalytic observation that because in most families the primary caregiver is female, with whom girls must identify and from whom boys must separate psychologically, women are more prone to disorders characterized by too much attachment (e.g., depression, masochism) and men to those expressing excessive isolation from others (e.g., psychopathy, schizoid conditions). See Dinnerstein (1976) and Chodorow (1978, 1989).

†Harry Stack Sullivan and Arthur Robbins, two analysts whose own schizoid trends prompted their efforts to interpret the schizoid experience to the larger mental health community, both report considerable early deprivation of companionship, and a consequent sense of loneliness and isolation (Mullahy, 1970; Robbins, 1988).

distance conflict would be inevitable. Masud Khan's (1963, 1974) studies of schizoid conditions emphasize the combination of "cumulative trauma" from failures of realistic maternal protection and "symbiotic omnipotence" inherent in the mother's intense overidentification.

THE SCHIZOID SELF

One of the most striking aspects of people with schizoid personalities is their disregard for conventional social expectations. In dramatic contrast to the narcissistic personality style covered in the previous chapter, the schizoid person may be markedly indifferent to the effect he or she has on others and to evaluative responses coming from those in the outside world. Compliance and conformity go against the grain for schizoid people, whether or not they are in touch with a painful subjective loneliness. Even when they see some expediency in fitting in, they tend to feel awkward and even fraudulent making social chitchat or participating in communal forms, regarding them as essentially contrived and artificial. The schizoid self always stands at a safe distance from the rest of humanity.

Many observers have commented on the detached, ironic, and faintly contemptuous attitude of many schizoid people (E. Bleuler, 1911; Sullivan, 1973; M. Bleuler, 1977). This tendency toward an isolated superiority may have its origins in fending off the incursions of an overcontrolling or overintrusive Other noted in the preceding etiological hypotheses. Even in the most seemingly disorganized schizophrenic patients, a kind of deliberate oppositionality has long been noted, as if the patient's only way of preserving a sense of self-integrity is in making a farce of every conventional expectation. Under the topic of "counter-etiquette," Sass (1992) comments on this phenomenon as follows:

> Cross-cultural research has shown . . . that schizophrenics generally seem to gravitate toward "the path of most resistance," tending to transgress whatever customs and rules happen to be held most sacred in a given society. Thus, in deeply religious Nigeria, they are especially likely to violate religious sanctions; in Japan, to assault family members. (p. 110)

One way of understanding these apparently deliberate preferences for eccentricity and defiance of custom is to assume that the schizoid person is assiduously warding off the condition of being defined—psychologically taken over and obliterated—by others.

Abandonment is thus a lesser evil than engulfment to people with schizoid character structure. Michael Balint (1945), in a famous essay with the evocative title "Friendly Expanses—Horrid Empty Spaces," contrasted two antithetical characterological orientations: The philobat (lover of distance), who seeks the comforts of solitude, and the "ocnophil" (lover of closeness), who when under stress gravitates *toward* others, seeking a shoulder to cry on.* Schizoid people are the ultimate philobats. Perhaps predictably, since human beings are often drawn to those with opposite and envied strengths, schizoid people tend to attract (and to be attracted to) warm, expressive, sociable people such as those with hysterical personalities. These proclivities set the stage for certain familiar and even comic problems in which the nonschizoid partner tries to resolve interpersonal tension by continually moving closer, while the schizoid person, fearing engulfment, keeps moving farther away (cf. Wheelis [1966] on the "illusionless" man and the visionary woman).

I do not wish to give the reader the impression that schizoid individuals are cold or uncaring. They may care very much about other people, yet still need to maintain a protective personal space. Some, in fact, gravitate to careers in psychotherapy, where they put their exquisite sensitivity to use safely in the service of others. Allen Wheelis (1956), who may be assumed to be in close touch with his own schizoid characteristics, wrote an eloquent essay on the attractions and hazards of a psychoanalytic career, stressing how people with a core conflict over closeness and distance may be drawn to the profession of analysis, a vocation that offers the opportunity to know others more intimately than anyone else ever will, while concealing the self behind the couch and the neutrality of one's interpretations.

For someone with schizoid dynamics, self-esteem is often maintained by individual creative activity. Issues of personal integrity and self-expression tend to dominate their self-evaluative concerns. Where the psychopath pursues evidence of personal power, or the narcissist seeks admiring feedback to nourish self-regard, the schizoid person wants confirmation of his or her genuine originality, sensitivity, and uniqueness. This confirmation must be internally rather than externally bestowed, and because of their high standards for creative endeavors, schizoid people are often rigorously self-critical. They may

*Scholars outside the psychoanalytic tradition have made comparable observations of differential preference for closeness or distance, as in the pursuer–distancer paradigm or the concept of approach–avoidance conflicts. It seems to be a universal tension and a central dimension of personality from almost anyone's perspective. See also Lachmann and Beebe (1989) and Livingston (1991).

take the pursuit of authenticity to such extreme lengths that their isolation and demoralization are virtually guaranteed.

Sass (1992) has compellingly described how schizoid conditions are emblematic of modernity. The alienation of contemporary people from a communal sensibility, reflected in the deconstructive perspectives of 20th-century art, literature, anthropology, philosophy, and criticism, has eerie similarities to schizoid and schizophrenic experience. Sass notes in particular the attitudes of alienation, hyperreflexivity (elaborate self-consciousness), detachment, and rationality gone virtually mad that characterize modern and postmodern modes of thought and art, contrasting them with "the world of the natural attitude, the world of practical activity, shared communal meanings, and real physical presences" (p. 354). His exposition also calls effectively into question numerous facile and oversimplified accounts of schizophrenia and the schizoid experience.

TRANSFERENCE AND COUNTERTRANSFERENCE WITH SCHIZOID PATIENTS

Although one would assume intuitively from their predilection for withdrawal that schizoid people would shun encounters as intimate as psychotherapy and psychoanalysis, they are in fact typically appreciative of and cooperative in the therapy process when treated with consideration and respect. The clinician's discipline in addressing the client's own agenda, and the safe distance created by the customary boundaries of treatment (time limitations, fee arrangements, ethical prohibitions against social or sexual relationships with clients, etc.), seem to decrease the schizoid person's fears about enmeshing involvements.

Schizoid clients approach therapy with the same combination of sensitivity, honesty, and fear of engulfment that typifies their other relationships. They may be seeking help because their isolation from the rest of the human community has become too painful, or because they have circumscribed goals related to that isolation, such as a wish to get over an inhibition against dating or pursuing other specific social behaviors. Sometimes the psychological disadvantages of their personality type are not evident to them; they may want relief from a depression or an anxiety state or another kind of symptom neurosis. At other times, they may arrive for treatment afraid—often rightly—that they are on the brink of going crazy.

It is not uncommon for a schizoid person to be tongue-tied and to feel empty and lost in the early phases of therapy. Long silences may

have to be endured while the patient internalizes the safety of the setting. Eventually, however, unless a client is excruciatingly nonverbal or confusingly psychotic, most analytically oriented therapists enjoy treating people with schizoid character structures. As one would expect, they are often highly perceptive of their internal reactions, and they are grateful to have a place where the expression of them will not arouse alarm, disdain, or derision.

The initial transference–countertransference challenge for the therapist working with a schizoid patient is to find a way into the patient's subjective world without arousing too much anxiety about intrusion. Because schizoid people withdraw into detached and obscure styles of communication, it is easy to fall into a counterdetachment, in which one regards them as interesting specimens rather than as fellow creatures. Their original transference "tests," in the terms of control–mastery theory, involve efforts to see whether the therapist is concerned enough for them to tolerate their confusing, off-putting messages while maintaining the determination to understand and help. Naturally, they fear that the therapist will, like other people in their lives, withdraw from them emotionally and consign them to the category of hopeless recluse or amusing crackpot.

The history of efforts to understand schizoid conditions is replete with examples of "experts" objectifying the lonely patient, being fascinated at schizoid phenomena but keeping a safe distance from the emotional pain they represent and regarding the schizoid person's verbalizations as meaningless, trivial, or too enigmatic to bother to decode. The current psychiatric enthusiasm for physiological explanations of schizoid states is a familiar version of this disposition not to take the schizoid person's subjectivity seriously. As Sass (1992) has argued, efforts to understand biochemical and neurological contributions to schizoid and schizophrenic states do not obviate the continuing need to address the *meaning* of the schizoid experience to the patient. In *The Divided Self*, R. D. Laing (1965) reassesses a schizophrenic woman interviewed by Emil Kraepelin. The patient's words, which had been incomprehensible to Kraepelin, gain meaning when regarded from Laing's empathic perspective. Karon and VandenBos (1981) present case after case of helpable patients who might easily be dismissed as "management" projects by clinicians who are untrained or unwilling to understand them.

People who are characterologically schizoid and in no danger of a psychotic break—the majority of schizoid people—obviously provoke much less incomprehension and defensive detachment in their therapists than do hospitalized schizophrenics, the subject of most of the serious psychoanalytic writing on pathological withdrawal. But the

same therapeutic requirements apply, in less extreme degree. The patient needs to be treated as if his or her internal experience, even if outlandish to others, has potentially discernable meaning and can constitute the basis for a nonthreatening intimacy with another person. The therapist must keep in mind that the aloofness of the schizoid client is an addressable defense, not an insurmountable barrier to connection. If the clinician can avoid acting on countertransference temptations either to prod the patient into premature disclosure, or to objectify and distance him or her, a solid working alliance should evolve.

Once a therapeutic relationship is in place, certain other emotional complexities may ensue. In my experience, the subjective fragility of the schizoid person is mirrored in the therapist's frequent sense of weakness or helplessness. Images and fantasies of a destructive, devouring external world may absorb both parties to the therapy process. Counterimages of omnipotence and shared superiority may also be present ("We two form a universe"). Fond perceptions of the patient as a unique, exquisite, misunderstood genius or underappreciated sage may dominate the therapist's inner responses, perhaps in parallel to the attitude of an overinvolved parent who imagined greatness for this special child.

THERAPEUTIC IMPLICATIONS OF THE DIAGNOSIS OF SCHIZOID PERSONALITY

The therapist who works with a schizoid patient must be open to a degree of authenticity and a level of awareness of emotion and imagery that would be possible only after years of work with patients of other character types. While I have known many practitioners who do well with most kinds of clients without having undergone a thoroughgoing personal analysis, I doubt that unless they are schizoid themselves, they can respond effectively to schizoid patients without having had extensive therapeutic exposure to their own inner depths.

Since most therapists have somewhat depressive psychologies, such that their fears of abandonment are stronger than fears of engulfment, they naturally try to move close to people they wish to help. Empathy with the schizoid patient's need for emotional space may consequently be hard to come by. A supervisor of mine once commented about my earnest and overly impinging efforts to reach a schizoid patient, "This man needs bicarbonate of soda, and you keep trying to feed him pumpkin pie." Emmanuel Hammer (1968) has commented on the effectiveness of simply moving one's chair further

from the patient, thus giving nonverbal reassurance that the therapist will not intrude, hurry, take over, or smother.

In the early phases of therapy, interpretation should be avoided on the basis of the patient's fears of being treated intrusively. Comments and casual reactions may be gratefully accepted, but efforts to push the client beyond what he or she is expressing will disconcert or antagonize the schizoid person, increasing tendencies toward withdrawal. Susan Deri (1968) has emphasized the importance of phrasing one's remarks in the words or images just used by the patient in order to reinforce the person's sense of reality and internal solidity. Hammer (1990) further cautions against probing, quizzing, or treating the patient in a way that makes him or her feel like a "case."

Normalizing is an important part of effective therapy with schizoid people. The general technique of "interpreting up" was discussed in Chapter 4 with reference to people at the psychotic end of the psychotic–borderline–neurotic axis; it is also useful for schizoid patients at any level of psychological health because of their difficulty believing that their hyperacute reactions will be understood and appreciated. Even if they are demonstrably high functioning, most schizoid people worry that they are fundamentally aberrant, incomprehensible to others. They want to be fully known by the people they care about, but they fear that if they are completely open about their inner life, they will be exposed as freaks.

Even those schizoid people who are confident of the superiority of their perceptions are not indifferent to the effect they may have in alienating others. By behaving in a way that communicates that the schizoid person's inner world is comprehensible, the therapist helps him or her to internalize the experience of being accepted without being asked to submit to the agenda of another person. Eventually, enough self-esteem accrues so that even when other people fail to understand, the patient can appreciate that the difficulty may not lie in the grotesqueness of the client's sensibilities; it may instead reflect the limitations of others. The therapist's reframing of imaginal richness as talent rather than pathology is deeply relieving to schizoid people, who may have had their emotional reactions disconfirmed or minimized all their lives by less sensitive commentators.

One way to give a schizoid patient confirmation without being experienced as either engulfing or minimizing is to use artistic and literary sources of imagery to communicate understanding of the patient's issues. Robbins (1988), in the honorable and now mostly ignored Freudian tradition of talking about oneself in the context of discussing some psychological dynamism, describes the early part of his own psychoanalysis as follows:

> When there were many lengthy silences in which I had little sense of what to say or how to communicate my feelings regarding my life history, fortunately my analyst did not desert me. Sometimes he would offer me "bedtime stories" [Robbins had never been read to as a child] in the form of citing plays, literature, and movies that had some relevance to the diffuse threads and images I presented to him in treatment. My curiosity was aroused by the references, and I made a point of reading the material. The likes of Ibsen, Dostoyevsky, and Kafka became important sources of rich symbolic material that seemed to mirror and clarify my inner experiences. Literature, and later art, seemed to give symbolic form to what I was trying to express. Most importantly, this material provided a significant means of sharing emotionally with my analyst. (p. 394)

Robbins and his colleagues (Robbins et al., 1980; Robbins, 1989) have made extensive contributions to the creative arts therapies and have elaborated on the aesthetic dimension of psychoanalytic work with clients, aspects of therapy that hold particular promise for those who are schizoid.

Perhaps the most common obstacle to therapeutic progress with schizoid patients—once the therapy relationship is soundly in place and the work of understanding is proceeding—is the tendency for both therapist and patient to form a kind of emotional cocoon, where they understand each other perfectly and look forward to therapy sessions as a respite from a demanding world. Schizoid people have a tendency, with which an empathic therapist may unwittingly collude, to try to make the therapy relationship a substitute for, rather than an enhancer of, their lives outside the treatment room. A considerable length of time may go by before the therapist notices that although the patient develops rich insights in nearly every session, he or she has not gone to a social function, asked anybody out, improved a sexual relationship, or embarked on a creative project.

The generalization to the outside world of the schizoid client's attainment of a safe intimacy with the therapist can be a considerable challenge. The therapist confronts the dilemma of having been hired to foster better social and intimate functioning yet realizing that any reminders to the patient that he or she is not pursuing that goal may be received as intrusive, controlling, and unempathic with the need for space. This tension is analyzable eventually, and it may deepen the schizoid person's appreciation of how powerful is the conflict between desire for closeness and fear of it. As with most aspects of therapy, timing is everything.

Robbins (1988) has emphasized the importance to the schizoid patient of the therapist's willingness to act like, and to be seen as, a "real

person," not just a transference object. In recent years, the "real" relationship that coexists with transference reactions has been rediscovered and stressed by many dynamically oriented practitioners (e.g., Paolino, 1981). This has particular relevance for the schizoid person, who has an abundance of "as if" relationships and needs the sense of the therapist's active participation as a human being: supporting risks in the direction of relationships, being playful or humorous in ways that were absent in the client's history, and responding to the patient with attitudes that counteract his or her tendencies to hide or to go through the motions of connecting emotionally with others. With schizoid people, one finds that the client's transference reactions are not only not obscured by a more responsive therapeutic style, they may even be more accessible to interpretation.

DIFFERENTIAL DIAGNOSIS

Schizoid psychology is easy to recognize, given the relative indifference of schizoid people to making a conventional impression on the interviewer. The central diagnostic challenge is assessing the strength of the client's ego. Less portentously, some obsessive and compulsive people, especially in the borderline-to-psychotic range, are easily misconstrued as more schizoid than they are.

Degree of Pathology

It is critical, first of all, to evaluate how disturbed a person in the schizoid range is. It is probably experience with the importance of this dimension that led the contributors to the recent editions of the DSM to give several alternative schizoid diagnoses, something they did not do for several other characterological conditions that also exist with a wide range of severity. Obviously, it is critical to consider possible psychotic processes in an intake interview; questions about hallucinations and delusions, attention to the presence or absence of disordered thinking, evaluation of the patient's capacity to distinguish ideas from actions, and, in puzzling instances, psychological testing are warranted with people who present with a schizoid style. Medication and/or hospitalization may be indicated when the results of such inquiries suggest psychosis.

Misunderstanding a schizophrenic person as a nonpsychotic schizoid personality can be a costly blunder. It is an equally unfortunate mistake, however, to assume that a patient is at risk of decompensation

simply because he or she has a schizoid character. Schizoid people are often seen as sicker than they are, and for a therapist to make this error compounds the insults these clients have absorbed throughout a life in which their individuality may have always been equated with lunacy. (Actually, even with a psychotic patient, the therapist's stance that the client is not "just" a schizophrenic but a person with significant strengths, who can reasonably expect to be helped, is the most effective reducer of psychotic-level anxiety.)

Admiration for the high-functioning schizoid person's originality and integrity is a therapeutic attitude that is easy to adopt once one has accepted the fact that schizoid processes are not necessarily ominous. Some healthy schizoid individuals who have come about a problem not inextricably tied up with their personality will not want their eccentricities to be addressed. This is their right. Therapeutic knowledge of how to make a schizoid person comfortable and disclosive can still facilitate work on the issues that the patient does wish to confront.

Schizoid versus Obsessive and Compulsive Personalities

Schizoid people often isolate themselves and spend a great deal of time thinking, even ruminating, about the major issues in their fantasy life. They can also, because of their conflict about closeness, appear wooden and affectless, and respond to questions with intellectualization. Some have quirks of behavior that are or appear to be compulsive, or they have arranged their lives according to an idiosyncratic set of rituals. Consequently, they can be readily misunderstood as having an obsessive or obsessive compulsive personality structure. Many people combine schizoid and obsessive or compulsive qualities, but insofar as the two kinds of personality organization can be discussed as "pure" types, there are some important differences.

Obsessive individuals, in marked contrast to schizoid people, are usually quite social and, in similar contrast to the schizoid person's march to a unique drummer, may be highly concerned with respectability, appropriateness, the approval of their peers, and their reputation in the community. Obsessive people are also apt to be moralistic, observing carefully the mores of their reference group, whereas schizoid people are not particularly invested in conventional questions of right and wrong. People with obsessive compulsive personalities deny or isolate feelings unlike schizoid individuals, who identify them internally and pull back from relationships that invite their expression.

SUMMARY

I have emphasized how people with schizoid personalities preserve a sense of safety by avoiding intimacy with others from whom they fear engulfment and by escaping to internal fantasy preoccupations. When conflicted about closeness versus distance, schizoid people will opt for the latter, despite its loneliness, because closeness is associated with having the self taken over in noxious ways. Possible constitutional components include hypersensitivity and a consequent avoidance of stimulation. In addition to the use of autistic-like withdrawal into fantasy, the schizoid person employs other "primitive" defenses but also shows enviable capacities for authenticity and creativity. The impact of these tendencies on relations with other people was discussed, with attention to the patterns of family interaction that may have fostered the schizoid person's approach–avoidance conflict, namely the coexistence of deprivation and intrusion.

Relevant transference and countertransference issues include difficulties in the therapist's initial admission into the client's world, a tendency for the therapist to share the client's feelings of either helpless vulnerability or grandiose superiority, and temptations to be complicit with the patient's reluctance to move toward others. Treatment recommendations include maximal self-awareness in the therapist, as well as patience, authenticity, normalization, and a willingness to use one's "real" personality. Finally, the importance of assessing accurately a person's location on the schizoid continuum was stressed, and the schizoid character was differentiated from obsessive and compulsive personalities.

SUGGESTION FOR FURTHER READING

Most commentary on the schizoid condition is buried in writing on schizophrenia. An eloquent and absorbing exception is Guntrip's (1969) *Schizoid Phenomena, Object-Relations and the Self.*

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Paranoid Personalities

Most of us have a clear mental image of a paranoid person and recognize the type when it is portrayed fictionally. Peter Sellers's brilliant performance in *Doctor Strangelove*, for example, captures the suspiciousness, humorlessness, and grandiosity that strike familiar chords in any of us who have paranoid acquaintances, or who recognize the comic elaboration of the paranoid streak we can all find in ourselves. Identifying less flagrant paranoid presentations requires a more disciplined sensibility. The essence of paranoid personality organization is the habit of dealing with one's felt negative qualities by projecting them; the disowned attributes then feel like external threats. The projective process may or may not be accompanied by a consciously megalomanic sense of self.

The diagnosis of paranoid personality structure implies to many people a serious disturbance in mental health, yet as I argued in Chapter 4 with special reference to paranoia, this type of organization exists on a continuum of severity from psychotic to normal (Freud, 1911; Shapiro, 1965; Meissner, 1978).* It may be that "healthier" paranoid people are rarer than "sicker" ones, but as was true for the subjects of the preceding three chapters, someone can have a paranoid character at any level of ego strength, identity integration, reality testing, and object relations. Recent DSM accounts of Paranoid

*As with the personality types discussed in Chapters 7 through 9, the defense that defines paranoia derives from a time before the child had clarity about internal versus external events, where self and object were thus confused. Paranoia by definition involves experiencing what is inside as if it were outside the self.