

The Schizoid Personality

An ego that has not yet properly begun to be

Introduction

This paper will explore the schizoid personality in terms of *arrested* ego development. I will begin by presenting the work of Harry Guntrip, specifically, an understanding of the four-fold splitting of the ego which creates the core schizoid problem of ego weakness. The contributing developments of Freud, Melanie Klein, Fairbairn and Winnicott will be included. The schizoid's psychic structure will then be discussed in terms of dreams, the body, and energy dynamics.

Now, Please close your eyes and as Anodea Judith suggests... allow yourself to enter the experience of the newborn infant.

You have just left the warm and dark womb, where everything was provided for you and emerge now into dazzling light and cold.

You open your eyes and see blurred images. Hear sounds, louder than you have ever heard before.

You are scared and hungry, in a way you have never experienced.

Some basic instinct draws your mouth to a breast, and you suck your first juices of life, *warm milk flowing into your empty belly for the first time.*

You relax, temporarily feeling safe.

You have begun your lifelong journey with the most difficult task of all—

Getting born.

The first several months of your life, you are incapable of doing anything for yourself.

You understand nothing and have almost no control over your body or your surroundings.

You cannot speak the language, so you can neither communicate nor understand anything said around you.

Yet your life depends on getting your needs met.

Though you gradually master simple tasks, this is your basic state during the first year of life.

The meeting of your needs is beyond your control, yet you need everything.

There is a frightening feeling that was not present in the womb.

Things are not provided as automatically as they were.

There are periods of hunger, cold, discomfort, and pain. Whether these needs are miraculously met—creates your psychological foundation for relating to the world, ***trust or mistrust.***

Because you do not understand the mechanism for getting your needs met (crying is automatic, and unintentional at this stage), the issue of *trust* vs. *mistrust* becomes a basic experience of yourself.

This is your first vague sense of whether or not you are glad to be here.

Clinical Description of the Schizoid Personality

The child born into a situation in which he was unable to lay the foundation of a strong ego results in a schizoid character structure. He grows up feeling that he is unequal to the demands of living. Full of fear, he struggles to keep going and meet his responsibilities. This **basic ego weakness** is the *tap root* of the schizoid personality disturbance. Fairbairn states, 'the significance of human living lies in object-relationship, and only in such terms can our life be said to have meaning, for without object-relations the *ego* itself cannot develop! According to Guntrip, *this is where the schizoid's problems lay.* He is driven by anxiety to cut himself off from all object

relations. The more he cuts himself off from human relations in the outer world, the more he is driven back on emotionally charged fantasized object-relations in his inner mental world. But, it is still a world of object-relations ... the loss of which would be equivalent to psychic death.

Of concern for the therapist is the schizoid state of mind in which the client becomes emotionally inaccessible. He may describe feeling cut off, out of touch, feeling apart or strange, of things being out of focus, or unreal, or of life having lost its purpose. Because the schizoid has given up on objects, things seem meaningless and futile. As Guntrip points out, the client may call this 'depression' and in fact depression may alternate with schizoid states. However, depression differs in quality (*heavy, dark and brooding, with anger turned against the self*). The other difference is that depression is object relational. The schizoid state is not. In a schizoid state the conscious ego appears to be suspended between internal and external, but there is no relationship to either. The attitude of the schizoid is non-involvement. He observes the outer world from a distance without any feeling. Because of this massive withdrawal of the real *libidinal* self, external relationships feel empty.

I would like to take a moment to describe *Fairbairn's* use of the term *libidinal* since it will be used in this context throughout this paper. Libidinal need embraces all that is involved in the need for personal relationships on a simple and primitive level. The goal of libidinal need is not pleasure but the *object* that at first is the breast and the mother.

For the schizoid, effective mental activity has disappeared into a hidden inner world. His conscious ego is emptied of vital feeling and action; he seems to have become unreal. There may be an intense dream or fantasy world from which his conscious ego is detached. Guntrip explains that "*bad experiences cannot be digested and absorbed, they are retained as foreign objects which the psyche seeks to project*". The child is emotionally identified with these objects, and when he mentally incorporates them he remains identified with them. They become part of the psychic structure of his personality. In adult life, situations in outer reality are interpreted in light of the situations that persist in unconscious inner reality.

Fairbairn views the psychoneuroses (paranoia, obsession, hysteria and phobias) as basically defenses against internal bad-object situations, which would otherwise set up depressive or schizoid states. When you want love from someone who will not give it to you, they become a 'bad object'. The reaction to this bad object can be either or both the depressive or schizoid reaction. In the depressive reaction you become angry and want to attack the bad object. In order to force it to become good and stop frustrating you. This is love made angry and it arouses the fear that one's hate will destroy the loved and needed person. This fear changes into guilt. Earlier and more basic is the schizoid reaction which occurs when you cannot get what you want from the person you need it from and you just go on getting more and more hungry. This becomes a painful craving and longing to get complete possession of the love object so you won't be left to starve. In 1941 Fairbairn arrived at the view that love made hungry is the schizoid problem and it rouses the terrible fear that one's love has become so devouring and incorporating that love itself is destructive. *Depression* is the fear of loving lest one's hate should destroy. *Schizoid aloofness* is the fear of loving lest one's love or need to love should destroy, which is far worse.

The two fundamental forms of internal bad objects are in Fairbairn's terminology, the exciting object and the rejecting object. Over the years, many externally real figures of both sexes may be absorbed into the two internal bad objects, but basically they remain two aspects of the breast mother. These objects are always there, and split off parts of the ego are always having

disturbing relationships with them. In this disturbed situation the schizoid is always being tantalized, made hungry and driven into withdrawal. He seeks to withdraw from this intolerable situation and feel nothing. If the schizoid starts feeling for real people, he reacts to them as if they were identical to his internal bad-objects. He reacts with an exaggerated sense of need. Desire becomes hunger and hunger becomes greed. Greed is hunger grown frightened of losing what it wants. He is so uncertain about possessing his love object that he feels a desperate craving to get it inside himself by swallowing and incorporating it. He becomes so afraid of devouring and thus losing everyone, that he withdraws from external relationships.

Not only does the schizoid fear devouring and losing the love-object, he also fears that the other person will devour him. Owing to his intensely hungry and unsatisfied need for love, he cannot help seeing his objects in view of his own desires towards them. The result is that any relationship into which some genuine feeling goes, immediately comes to be felt deep down as a mutual devouring. Such intense anxiety results that there seems to be no alternative but to withdraw from relationships altogether, in order to prevent the loss of his independence and even his very self. Relationships are felt to be just too dangerous to enter into. This retreat into indifference is the true opposite of love, which is felt to be too dangerous to express. Thus, the dictum of the schizoid is...to want no one, make no demands, abolish all external relationships and be aloof, cold, without any feeling, *do not be moved by anything*. The withdrawn libido is turned inwards, introverted. The person goes into his self and is busy with internal objects. Outwardly and in consciousness everything seems futile and meaningless. Fairbairn considered this sense of 'futility' as the specific schizoid affect.

The worst object-relations problem arises when the ego is driven to seek security by doing without objects altogether, only to run into the most alarming and ultimate fear of disappearing in a vacuum. Guntrip states "*the chronic dilemma in which the schizoid individual can neither be in a relationship with another person nor out of it, is due to the fact that he has not yet outgrown the particular kind of dependence on love-objects that is characteristic of infancy*". This has two different but clearly related aspects; Identification, and the wish to incorporate. Identification is passive, incorporation is active. Identification can feel like being swallowed up in another person, incorporation is the wish to swallow the object into oneself. Identification suggests regression to a womb state, and incorporation urges belong to post-natal, oral infant at the breast. The whole problem antedates the *Oedipal development*. Thus, Fairbairn regarded infantile dependence, not the Oedipus complex, as the basic cause of psychopathological development. As a result, the schizoid is always rushing into a relationship for security, and at the same time breaking out again for freedom and independence. This is an alternation between regression to the womb and a struggle to be born; between the merging of his ego in, and the differentiation of his ego from the person he loves. The schizoid cannot stand alone, yet he is always fighting desperately to defend his independence. Another way the schizoid manifests this 'in and out' program is to be 'in' with one person and 'out' with another. This may lead to deep-seated fluctuations of mood with the same person. Or, there may be a split between the mental self and the bodily self so that if he is 'in' with one he must be 'out' with the other. According to Guntrip this 'in and out' program may be the most characteristic behavioral expression of the schizoid conflict. This 'in and out' behavior severely disrupts the continuity in living. This arouses so much anxiety that it cannot be sustained. It is at this point that the person completely retreats from object relations and becomes overtly schizoid, emotionally inaccessible, cut off. This state of emotional apathy can be masked. If the feelings are repressed it is possible to build up a mechanized, robot-like personality. The ego that operates consciously becomes a trained and disciplined instrument for 'doing the right and

necessary thing'. Real feeling does not enter in. Similarly, Stephen Johnson describes the schizoid's expression of feeling as having an 'as if' quality.

Once the schizoid succumbs to withdrawal identification is the only way for him to maintain his ego. But identification is a major problem for the schizoid in his relation to the external world, because it leads to the danger of over-dependence on objects. This creates the fear of absorption (into them), and enforces the defense of mental detachment. Thus the original schizoid withdrawal from an unsatisfying outer world is reinforced by the use of detachment as a defense against risking dangerous relationships. The only real solution is the dissolving of identification and the maturing of the personality, the differentiation of the ego and object, and the growth of a capacity for co-operative independence and mutuality, i.e. psychic rebirth and development of a real ego.

Fairbairn is explicit that from the start an infant is a whole dynamic ego, which strives towards the object relationships he needs in order to further his ego development. This primitive infantile ego is capable of experiencing intense 'personal anxiety' in a hostile environment. This is the sheer fear that Klein found could characterize the very first few months of life. The schizoid attempts to save his ego from persecution by withdrawal. This flight inside to safety creates an even more serious danger of losing the ego in another way....

We will now take a deeper look at regression.

It is Fairbairn's theory of the endopsychic structure that enables us to understand regression as a withdrawal from a bad external world, in search of security in an inner world. This can be seen as the essence of the schizoid problem and as the deepest element in all psychopathological development. To quote Freud, "*regression to the womb* is the [most profound] expression of infantile dependence, [which occurs] when a weak infantile ego cannot cope with an inadequate or traumatic environment". As Guntrip points out, it is a grave question whether this schizoid withdrawal and regression will lead to rebirth or to actual death. The schizoid person can withdraw so thoroughly into himself that he fears losing touch completely with the external world. It is at this point that he faces the danger of depersonalization of his ego of everyday life, along with derealization of his environment. Loss of a definite self may lead to suicide, which may primarily be a longing for escape that ends in death. It is important to note that regression in search of safety is only safe when there is a real person to regress with and to, as in psychotherapy.

Although schizoid withdrawal and regression are basically the same phenomenon they have different meanings for different parts of the self. From the viewpoint of the conscious self of everyday living (central ego) withdrawal means total loss. But from the viewpoint of the withdrawn self, it is not 'loss' but 'regression'; a retreat backwards to a safe place. In the extreme schizoid case this can be a fantasy of a return to the womb. Womb fantasies cancel post-natal object relations but breast and incest fantasies do not. This fact makes an enormous difference to the ego, which is dependent on object relations for its own reality. A return to the womb is a flight from life and it implies a giving up of the breast and incest fantasies, which involve a struggle to go on living.

There are three basic developmental positions to consider here;

- The *schizoid* (or regressed).
- The *paranoid* (or persecuted).
- And the *depressed* (or guilt burdened).

The depressed and the paranoid positions can be used as a defense against the schizoid position. Just as the 'depressive position' is guilt-burdened, so the paranoid position is fear-ridden. The still deeper position of the schizoid is that of a withdrawn infantile ego seeking safety from persecution.

('Paranoid' represents danger and 'schizoid' represents flight.) Melanie Klein holds that failure to work through this situation renders the child unable to solve the problems of the later 'depressive position'. This would mean that the child might regress and reactivate earlier problems when the pain of unresolvable depression overwhelms them. Klein regarded the 'depressive position' as the one central for development. Winnicott called this the stage of '*ruth*' or *concern for others*. This is the developmental stage of moral feelings. The earlier paranoid (or persecuted) and the schizoid (or withdrawn) positions are pre-moral and allow for no concern for others.

Guntrip states that the process of withdrawal in successive stages through *fear* emerges as a major cause of the loss of the unity of the self and has come to be called '*ego splitting*'. This creates two problems. The part of the self that struggles to keep touch with life feels intensely afraid of the deeper more secret withdrawn self which has the capacity to draw down more and more of the of the personality into itself. Hence, extensive defenses are used against it. If those defenses fail, the ego of everyday consciousness experiences a progressively terrifying loss of interest, energy, and zest, which verges towards exhaustion, apathy, derealization and depersonalization. If this goes too far the outer world self becomes incapable of carrying on its normal life, and the whole personality succumbs to a '*regressive breakdown*'. If, however, the emotionally withdrawn person can ward off the impact of real life, and prevent its pressures from playing on the inner fear-ridden feeling life, then a relatively stabilized schizoid character may result. Three ways that the schizoid is able to function in the world is for the intellectual schizoid to live on the basis of thinking, the obsessional moralist on the basis of duty, and the organization person on the basis of carrying on automatically in a fixed routine. Behind all of these ways that the schizoid struggles to save himself from extreme withdrawal and ego loss there lies a hidden danger of that point of his personality, which is devoted to a fixed attitude of a retreat from life in the outer world. This is the part of the self that most needs help and healing! Its two most extreme expressions are *regressive breakdown* and *fantasies of a return to the womb* or a *passive wish to die*. Because of this constant internal threat, maintaining an ego is fraught with relentless anxiety. *In short*, THE SCHIZOID PROBLEM IS AN EGO PROBLEM. The too hard-pressed child retreats in order to save himself from annihilating defeat. In protected security he attempts to recover his strength. *The schizoid withdrawal is actually a healing response to the circumstances that initiated it*. Yet this retreat in order to save his 'hidden ego' undermines his manifest ego, which experiences it as a threat of breakdown or death.

The cause and stages of schizoid withdrawal will now be examined more closely.

1. Fear of, and flight from, external reality-

Schizoid withdrawal is a fear and flight reaction in response to danger. The most pathological form occurs in the first year of life and is deeply embedded in the personality structure. It can then be intensified and consolidated throughout childhood and be evoked by the pressures of real life at any time. (Schizoid withdrawal may occur at any other time of life as a generalized reaction.) Frustration of the libidinal need for a good object-relation arouses aggression, and also intensifies the need, until the infant fears that his love needs are destructive to the object. At this early stage fear leads to the schizoid withdrawal, because for the infant, losing the object means losing the ego. Here lies the difference between the moral and the pre-moral level of development. This pre-moral level of development explains the callousness that the schizoid can display. Since the need for an object arises from the fact that *without object-relations a strong ego-development is not possible*, Guntrip concludes that the satisfaction of libidinal needs is not an end in itself. It is an experience of good-object relationships in which the infant can discover himself as a person. His ego-development will then proceed firmly and self-confidently. Deprivation of need

is not the only cause of schizoid withdrawal. Winnicott emphasizes that besides meeting the needs of the infant when he feels them, the mother must not force herself on him in ways, and at times, that he does not want. This 'impingement' causes the infant to shrink away. Trouble may also arise because of parental pressures on the child and he may be exploited in the interest of the parent's needs. These impingement experiences create a basic impression that the world is hostile and unsupportive. This is the true source of '*persecutory anxiety*', *fear of annihilation*, and of *flight back inside*. *In severe schizoid states of total fear, deprivation and impingement combine.*

For the infant the world is a frightening *emptiness* when it does not respond and meet his needs, and a frightening *persecutor* when it actively and hurtfully impinges. The infant cannot develop a secure and strong ego-sense either in a vacuum or under intolerable pressure. Consequently, he seeks to return to a vaguely remembered safe place. Although in fact, he can only withdraw into isolation within himself. *Impingement, rejection, and deprivation of needs for object-relationships*, define the traumatic situation that drives the infant into a retreat inwards in search of a return to the womb.

Diagram

2. A two-stage withdrawal from external and internal objects-

The initial escape is from the outer material world into the inner mental world. Because contact with the object world cannot be given up without the threat of ego loss, the ego splits. Part of the self is left to keep touch with the world of external objects. This is Fairbairn's '*central ego*'. The withdrawn part of the self must also be in object relations in order to maintain its experience of itself as a definite ego; the infant internalizes his objects and builds up an *inner world of object relations*. *The internal unsatisfying object is split into three main aspects: libidinal exciting, libidinal rejective, and emotionally neutral or good and undisturbing.* The neutral or good aspects of the internalized object are then projected back onto the real object, which becomes an ideal object. What appears to be an external object relationship is then maintained between the central ego and the ideal object. Thus, once schizoid withdrawal has occurred, contact with the outer world is defective and is governed by the projection of partial and over-simplified images of the object. The unity of the *withdrawn ego* becomes split into *an ego attached to the rejecting object* and *an ego attached to the exciting object*. Just as the exciting object arouses libidinal needs, the rejecting object denies them. The attachment to the exciting object results in a **libidinal ego**. This libidinal ego is characterized by ever-active unsatisfied desires, which come to be felt in angry and *sadistic* ways. Attachment to the rejecting object results in an **anti-libidinal ego** based on identification, which reproduces the hostility of the rejecting object to libidinal needs. Inevitably the libidinal ego is hated and persecuted by the anti-libidinal ego as well as the rejecting object, so that *the infant has now become divided against himself*. So, as long as a fantasy life can be kept going by the libidinal and anti-libidinal egos, the ego is kept in being though cut off from outer reality. This kind of internal life results in states of acute '*persecutory anxiety*'. At this point the ego makes one further attempt to escape from the intolerable inner pressure. It is the *libidinal ego*, which feels the persecutory pressure. And it is this part of the ego that splits and leaves part of itself to carry on relations with the exciting and rejecting objects of the internal fantasy world while *the traumatized, sensitive, and exhausted heart of it withdraws deeper still*. This is the return to the womb state of the **passive regressed ego**. The passive regressed ego seeks to return to the antenatal state of absolute passive dependent security. Here in silence, rest, and immobility it may find the opportunity for recuperation and rebirth. It is the irresistible pull of this regressed ego under certain circumstances that precipitates the schizoid breakdown in the most extreme cases. Stubborn resistance and defense accounts for all of the tensions and illnesses that arise out of this desperate struggle to possess and retain an ego.

3. Regression to a symbolic womb-

Although pathological development stems from this regressed ego, it is important to realize that this regression is a necessary and healthy reaction to danger. In other words, the hostile environment is the problem not the infant. What the frightened and regressed infant seeks is not psychopathological in itself, but it has been judged as something he should not want.

The primitive wholeness of the ego is now lost in a four-fold split:

1. *a depleted central ego coping with the outer world...*
2. *a demanding libidinal ego persecuted by...*
3. *an angry anti-libidinal ego (2 and 3 are the Kleinian internal world)*

and finally,

4. *a regressed ego that knows and accepts the fact that it is overwhelmed by fear and in a state of exhaustion*

The regressed ego will not be in any fit state to live unless it can escape into a mental convalescence where it can be quiet, protected and be given a chance to recuperate. The traumatized regressed ego is the hidden cause of all regressive phenomena from conscious escapist fantasies to complete schizoid apathy. Understanding and meeting the needs of the regressed ego, as Guntrip points out, is the greatest difficulty and challenge to therapy. It is important to realize that once the regressed ego has retreated to the hidden womb-like state of the deepest unconscious, the central ego will not be able to retrieve it. Therefore, we can see that living in both an internal and a projected fantasy world is a schizoid defense. This protects against the loss of ego by complete regression and depersonalization while at the same time remaining withdrawn to varying degrees from external reality. Although this defense aims to prevent the ultimate danger of ego loss by depersonalization, three further dangers of ego-loss arise in this mid-region of defensive activities: The flight back to objects is at first a flight back to the original bad objects. The frightened person becomes quarrelsome and may get out of control. This creates a persecutory anxiety in his inner world and provokes the schizophrenic fear of being torn to pieces. One way to escape this terror is the flight to good objects. But the relationship to the good object is one of fear-enforced infantile dependence and can feel smothering. The claustrophobic fear of being stifled by being shut in is the cost for seeking safety back inside. The active ego is now in danger of being lost, by reduction to a state of passivity in which no self-expression is possible. The remaining possibility for escape from terror is a compromise between bad and good objects. In other words, if he hates the good object instead of the bad object, there will not be the same danger of retaliation and smothering is avoided. This results in fear for both the self and the object, which arouses guilt and 'depressive anxiety'.

To Summarize, in order of decreasing severity-

- ➔ No objects involve the fear of Ego loss by depersonalization.
- ➔ Bad objects involve the fear of Ego loss by disintegration under destructive persecution.
- ➔ Good objects involve fear of the loss of an active Ego by imprisonment in smothering passivity.
- ➔ Ambivalent object-relations involve fear of Ego loss through the paralysis of depression; in which the Ego dare not do anything at all, for fear of doing wrong.

The last and deepest element to be reached and uncovered is the client's infantile experience of the failure, rejection by, or absolute loss of an adequate mother. This is the fear of Ego breakdown through the re-experience of the original 'maternal deprivation'. The range of 'maternal

deprivation' encompasses the death or illness of the mother during the first year of life; the failure of breast feeding without compensatory nursing; the frankly rejective mother who does not want her baby; the tantalizing mother who frustrates as much as satisfies; the mother whose primary maternalism fades out too soon and weans the baby too traumatically; and the depriving mother who fails to give the emotional rapport necessary to support the beginning of firm ego development. This deprivation trauma, the loss of the good mother in the first year of life, sets up an unbearable need for mother substitutes in the form of people and drugs, as well as a susceptibility to separation anxiety and depressive despondency.

Basic Ego Weakness –The Core Issue of Psychotherapy for the Schizoid

Guntrip states that the schizoid predicament is one of ego-weakness rooted in fear. The feeling of weakness that the schizoid experiences is not related to actual ability but to the lack of a reliable feeling of one's own reality and identity as an ego. Clients who say 'I don't know who I am or what I am', 'I don't seem to have a mind of my own', 'I don't feel to be a real person at all' reveal that their early object-relationships were such that they were unable to 'find themselves' in any definite way. Guntrip points out that essentially, the work of the psychotherapist is to help the frightened infant inside to grow up. The developmentally arrested psyche needs to experience support and understanding in a relationship with the therapist, and like a parent the therapist must wait while the child grows. He goes on to say that the qualities in the therapist that best foster the therapeutic alliance correspond in many ways to those intuitive responses in the mother, which lead to successful early ego development in the baby.

The frustrated, fear-ridden infantile libidinal ego is the seat of basic ego weakness and this is a deeper problem than the feelings of weakness that sometimes infiltrate the ego of everyday consciousness. What is experienced as resistance in therapy, is the schizoid's tremendous determination to keep this weak and panicky infantile ego under repression. According to Guntrip, the main practical problem for psychotherapy is ... '*can this client tolerate the return to consciousness of his basic ego-weakness?*' (When it does return, he is likely to feel, 'I can't stand it, I only want to die')

The endopsychic structure that developed in response to early trauma keeps the schizoid client in an intensified version of the original state of basic fear and weakness. Unable to face the requirements of living, he fears and hates his weakness. These attitudes become permanently embodied in the organizational structure of the psyche. Eventually he becomes ill because of these secret sadistic attacks on himself. His despising of his immaturity, his hating of his weakness, and his attempts to squash out his unsatisfied libidinal needs for spontaneous and creative living become more dangerous than the outer world. This condition of the psyche makes all the normal processes of maturing impossible and is the source of resistance to psychotherapy. Real life situations that could be coped with are felt to be overwhelming because of self-persecution. The degree of self-hate and self-persecution determines the severity of illness. And when taken to extreme may end in suicide as a way out. An assessment of the intensity of this inner situation may be derived from the client's reactions to difficult children and immature adults, also from their sado-masochistic dreams, and the painfulness of their physical psychogenic symptoms.

As I mentioned earlier, the central ego is partly a struggle to cope with the outer world and partly a defensive system against the dangers of the inner world. It is also important to realize that this enormous struggle makes use of actual abilities and has often achieved important results. Therefore, the knowledge and skill developed must remain a part of the whole matured self. But, Guntrip points out that the central ego is a 'false self' in so far as it is a conformist self in which creativity and originality have had to be sacrificed for safety and external support. The sado-

masochistic deadlock between the cruel anti-libidinal ego attacking the weak and suffering libidinal ego is the *hard core* of the illness against which the central ego is a defense. The libidinal ego feels weak because the focus of energy has shifted to the anti-libidinal self-persecuting function. Guntrip states that *"it's as if once the child is badly disturbed, and developed enough to realize that he is too weak to alter his environment, he feels driven to attempt the only other thing possible, namely to alter himself in such a way that he no longer feels so frightened and weak (or at least he seeks to prevent himself from being conscious of it)"*. This shows that it is possible for ego weakness to exist along with psychic strength.

The ego that needs strengthening in the schizoid client is his basic nature which is repressed, undeveloped and in a state of frustration, fear, and weakness. Psychotherapy needs to help him to accept his weakness so that the energies used by the anti-libidinal ego may be re-invested in the libidinal ego. According to Guntrip, *"if the primary natural self, containing the individual's true potentialities, can be reached, protected, supported, and freed from the internal persecutor, it is capable of rapid development and integration with all that is valuable and realistic in the central ego. The total psyche, having regained its proper wholeness, will be restored to full emotional capacity, spontaneity, and creativeness"*.

Resistance to this therapeutic process comes from the anti-libidinal ego. To quote Fairbairn (1952), *"The client in his anti-libidinal functioning uses a maximum of his aggression to subdue a maximum of his libidinal need!"* The libidinal needs of the dependant infant are hated as weakness by the anti-libidinal ego, which tries to maintain a personality without the need for other people. It does not recognize that its hard and rejective ways are patterns learned through identification with the rejective parent. And although it may feel powerful, relationships of domination over others only camouflage dependence. For healing to occur, this aggression needs to be matured and used in service of the libidinal ego. The anti-libidinal ego's hate of dependence will also be directed towards the therapist, from whom he *needs* help. He may not recognize that, his rejection and hate of the therapist and his own infantile libidinal self, go together. In other words, the anti-libidinal ego works to prevent any relationships that would strengthen the libidinal ego.

Often the anti-libidinal reactions to therapy are subtle and develop slowly in the unconscious. Guntrip points out *"that whenever a [client] begins to turn to the therapist with [a] deeper and more genuine measure of trust, dependence, and acceptance of help, at once a hidden process of opposition starts up. [This] will sooner or later gather strength and lead to a subtle change of mood that makes the [client] no longer able to co-operate as fully as he consciously wishes to. The client's mood can turn against anything that is helpful."* The therapist needs to determine the anti-libidinal ego's source of power but it is important to remember that it is an aspect of the total (but divided) self. It is to be respected as the client's genuine struggle to keep his ego in being when help was lacking.

Regardless of the desires of the central ego, the closed self-persecutory system of the schizoid's inner world will not admit the therapist unless he can fit into his own pattern. The therapist will not be welcome if his intent is to change the state of affairs and rescue the suffering libidinal ego.

Two challenges to the therapist are:

- ➔ How to avoid being fit into the client's pattern as either a persecutor hated by the libidinal ego or the libidinal object hated by the anti-libidinal ego. (These are two types of negative transference.)
- ➔ And how to break into the closed system in order to initiate change.

Since each opening (positive transference) evokes a powerful anti-libidinal reaction, (negative transference) aimed at closing it again.

Referring to the 'negative therapeutic reaction' Freud wrote that, "*There is something in these people that sets itself against their recovery and dreads its approach as though it were a danger... In the end we come to see that we are dealing with what may be called a 'moral' factor, a sense of guilt, which is finding atonement in the illness and is refusing to give up the penalty of suffering.*" However, the patient feels ill not guilty. And his resistance to recovery is the only indication of this guilt. Pathological guilt is the maintenance of a guilt-relation to an internalized bad parent, whom the client feels quite unable to give up. (*A bad object is better than the terror of no object.*)

As discussed, the identification with bad objects serves as a substitute for proper ego-growth. Consequently, the dissolving of this identification is likely to be felt by the client as the loss of his own personality, as well as the loss of his parents. The client is loyal to his parent's rules, or as Guntrip sums up, "*The anti-libidinal ego goes on bringing the [client] up in the same way as the parents did.*" Also, the schizoid feels a need to be controlled ... even if that is, in the same way that the upsetting parents controlled him.

Because the anti-libidinal ego represents both an object-relationship and an ego for the schizoid client, who does not have either in an adequate form, he will have difficulty outgrowing his distorted personality structure. The schizoid client gains some sense of power and satisfaction by exhibiting cruel and destructive repression over his own anxious child. This is a dangerous anti-libidinal condition that puts an end to all normal development, particularly the power to love. Relishing in the power of self-hate alternates with a sense of power over others by hating them. Guntrip concludes that, "*In and through his anti-libidinal ego, the client has a feeling of object-relationship and the security of being under control, the sense of the possession of an ego, and the feeling of power, even though it is all in a fundamentally self-destructive way!*" In order to heal, "*the client must drop all pretences with himself that he is more adult than he really [is], in order that he may come back to the anxious child that he once was and still feels to be inside. [He must begin] again from there, [but] this time in the security of a constructive parental personal relationship with the therapist.*"

Guntrip explains that, we do not find active sexual and aggressive impulses in the deepest regressed (libidinal) ego. What we find is fear and the desperate need to be quiet, still, safe, warm, and protected while recovery takes place. Thus, if we speak of instincts, then the deepest cause of psychopathological phenomena is fear and the instinctive reaction of flight from the outer world of real bad objects in infancy. Everything else in psychopathology is a defense; the struggle to counteract and over-compensate for the retreat of the withdrawn regressed ego.

We have seen how the child struggles to cope with a demanding outer world, while seeking to overcome his weakness by turning his aggression against his own libidinal needs. This leads to a 'closed system' of self persecution - the internal world of bad object-relations (the sado-masochistic inner world). The active (oral masochistic) libidinal ego is the ego of psychoneurosis and psychosis. The passive regressed libidinal ego is the deeply schizoid ego, driven by fear to retreat from life and threatened by depersonalization. The 'static closed system' represents the desperate attempt to ward off regression and depersonalization. It does this by using fantasized or 'acted out' bad relationships in order to keep the distinct and separate identity of ego in being. Psychotherapy 'competes' with the internal bad objects to save the ego. This internal 'closed system' is an attempt to force an adult ego into consciousness.

Guntrip states that psychotherapy for the schizoid client ... "*is really an invitation into an open system in touch with outer reality, an opportunity to grow out of deeper down fears in a good*

object-relationship with the therapist. But this will only succeed in a radical way if the therapist can reach the profoundly withdrawn regressed ego, relieve its fears, and start it on the road to rebirth and growth, and the discovery and development of all its potentialities. The deeply regressed ego feels unable to get in touch with anyone. The masochistic libidinal ego cannot give up bad objects without succumbing to depersonalization. [So], unless the therapist can intuitively sense the manifestations of the client's predicament in this respect – and by the needed interpretation at the right moment get through to that part of the person which is cut off from all communication, the client cannot undergo any change!" If this contact is established, then what Winnicott (1955) calls '*therapeutic regression*' can take place.

Guntrip explains that the therapist will meet the *regressed ego* most undisguised in tendencies to schizoid suicide, and less extremely in states of exhaustion, fatigue and loss of energy. The schizoid client may experience a 'life tiredness' – a needing to stop living for a time but not wishing to die. A fear of dying emerges clearly in some clients who experience definite schizoid suicidal tendencies. These phenomena will emerge when the fanatical self-driving of the anti-libidinal ego has diminished. An apathetic state may also repeatedly break through the tension of constant over-activity. What drives the schizoid to want to stop living is the feeling of being absolutely isolated. In extreme form it is accompanied by a sense of horror. There is a deep feeling in the schizoid client that no one has ever understood him and no one ever will. This makes it difficult to contact the hidden isolated core – but it is essential that the therapist do just that, because the client cannot contact anyone from that place. The schizoid is too stripped of life experience to be able to feel like a real person. He is unable to communicate with others or be reached by others. What the client feels is, 'I can't get in touch with you. If you can't get in touch with me – I'm lost.' He feels hopeless because he has never been reached. Consequently, his message to the therapist is, 'I'm hopeless, I've tried everything, I'll never get better, this will never change ...and you can't help me!'

The most valuable concept for understanding the inner core of the schizoid condition is the quality of ego-relatedness developed in early infancy.

To reiterate:

The importance of object relations lies in the fact that without them human beings cannot develop an ego.

Winnicott sees object-relatedness as, "*a positive and persisting quality or experience of a well-mothered infant ... [The child] develops a growing sense of his own ego-wholeness and ego-identity as a part of his overall experience of being in a reliable, secure, supportive relation to his mother. As this experience becomes a permanent characteristic of his 'self feeling' he is able to be alone, without anxiety or panic, for longer periods*". Having grown to be an intrinsically ego-related child he feels positive and trusts his environment. Because of ego-relatedness, he will not feel isolated or out of touch when he is alone.

Separation at birth will result in isolation unless good mothering immediately restores connection. Winnicott writes in his paper '*The Capacity To Be Alone*' (1958) that ... "*the capacity to be alone ... is one of the most important signs of maturity in emotional development!*" Fairbairn (1963) states explicitly that, "*the earliest and original form of anxiety, as experienced by a child is separation anxiety*". Guntrip expands this by saying, "*vulnerability to separation-anxiety exists when the human being is not basically ego-related, is in fact in a state of 'ego-unrelatedness*". *The individual who has been securely ego-related from earliest infancy can bear the loss of his external supports, either personal or impersonal. The individual who, from earliest infancy has remained ego-unrelated is wide open to the worst and most terrifying fears when his outer supports*

fail him. Primary ego-unrelatedness is the substance of ego-weakness, and any degree of ego-development maintained over the top of it is only precariously held by means of anti-libidinal repression of the weak ego, and compulsive forced activity." We may say that, one can only stand being alone in outer reality if one is never alone in inner reality. Winnicott writes, "*The ability to be truly alone has its basis in the early experience of being alone in the presence of someone ... [this] can take place at a very early age, when the ego-immaturity is naturally balanced by ego-support from the mother.*" In the course of time the individual introjects the ego-supportive mother, and in this way becomes able to be alone without frequent reference to mother or a mother symbol. This is the essence of what needs to happen with the therapist in order for the schizoid client to heal.

He urgently needs the therapeutic relationship to fill the gap left by inadequate mothering. But he is deeply afraid of being found and will pull away when the therapist gets close. Johnson states that, "*what the schizoid individual needs to learn in a purely experiential way is that human bonding is safe, that it feels good, and that it produces good results ... the schizoid [client] has a residual hope for that but a persistent doubt that it can be true for him. As a consequence, he may repeatedly test the therapist, and in one way or another withdraw just at the point where hope is at its highest. In doing this, the client will often attempt to stimulate the therapist's rage, and rejection. If he succeeds in this, the therapy not only will have failed but also will have established one more supporting situation for the primary script decision. It will be in the handling of this very issue that the treatment will succeed or fail.*" Johnson shares that, "the best single piece of advice [he had] ever received regarding how to treat the schizoid [client] ... is, **BE THERE – BE AVAILABLE, PRESENT, AND CONGRUENT**". ... "*To be present, available, and congruent in this situation is to be frustrated, disappointed, and even angry at the withdrawal or provocation of the patient. The job of the therapist is ideally to work through on his own time that part of this reaction which is counter-transferential and to work through with the client that part which is currently involved in their ongoing relationship. As a part of learning all that human bonding can be, the schizoid client needs to have the experience of real relationship, including the elements in which his behavior is disappointing, frustrating, and anger-provoking, without its eliciting destructive rage from others. He needs to learn that the expression and working-through of such frustration and anger are among the most intimate and caring things that people do with one another. Because of the schizoid's history, however, he will usually need a period of positivity and nurturance to stay present through the resolution of such conflict.*" Guntrip points out that, "*psychotherapy for the deeply schizoid client usually involves a prolonged process of drawing near and taking flight from the therapist, over and over again, while slowly and secretly the capacity to trust grows.*"

The schizoid client also fears losing his 'specialness' by becoming something different than he is, if communication were to seep through his defenses. This can cause him to shy away from therapy and hold onto his illness. In order to comprehend this, we must realize that he is unable to appreciate what his true self could be. Guntrip concludes that, "*for all practical purposes, mental health must consist of having basic ego-relatedness and therefore the ego-strength to be capable of controlling one's 'communication situation'. One must be able to either withdraw into privacy that is not empty, or venture forth into relationship without fear!*"

As discussed thus far – psychotherapy must provide a good object relationship in order for the schizoid client to develop an ego. But, what are the intrinsic qualities that make this relationship therapeutic? According to Winnicott, "the 'female element breast' above all makes it possible for the infant to develop a sense of 'being' prior to 'doing'. This represents the most

complete experience of security possible in human life, and lays the foundation of the basic inner strength needed for ego development. THIS IS THE ABSOLUTE START OF THE EGO. Guntrip states that, "if 'being' exists, 'doing' will follow naturally from it ... *The experience of 'being is the beginning and basis for the realization of the potentialities in our raw human nature – for developing as a 'person' in personal relationships*". A state of 'being' is the female way of knowing. *In the fullest sense it is the mother's intuitive knowledge of her baby – of knowing by identification. This is how the central core of the self communicates – non-verbally and absolutely personally. In therapy it is the female way of relating (by identifying and sharing in a sense of being, knowing by feeling, and communicating by emotional empathy) which enables the deeply schizoid client to establish ego-identity. The deep feeling of at-oneness is the soil out of which a sense of separateness can grow. Accordingly, Winnicott takes the mother–infant relationship as the model for, and basis of, psychotherapy. He considers intellectual knowledge to be used as an adjunct to, not a substitute for, personal knowing. Johnson states it simply ... "presence must be the basic orientation to the treatment of the schizoid client...as therapist, I model not having to do anything 'special' to justify my existence. I am enough as I am and can be healing in the wholeness of my presence. I provide contactfulness and acceptance – that which the schizoid did not originally receive. In this, the therapist will need to be willing to assume a nurturing, even parental, role with clients, a stance which may lead to a symbiotic – like attachment. The attachment must be established before it can be resolved."* Guntrip poses the question, "how can the need of the exhausted regressed ego for recuperation in, and rebirth from a reproduction of the womb-state be met at all? And, how can it be met without the risk of undermining the central ego of everyday living." This, states Guntrip, "seems to be the ultimate problem for psychotherapy". If left to himself, the schizoid can only do what he was driven to do as a child... By developing the hostile attitude of the anti-libidinal ego he repressed any weakness in himself. If the pull of the regressive ego became irresistible he could only provide for it by regressive illness. Without the chance for care from the environment he could die of psychic self-exhaustion. The psychotherapist must help the client find a way of substituting a controlled and constructive regression for an uncontrolled and involuntary one. The main obstacle to the clients acceptance of a constructive regression is his own anti-libidinal ego which needs careful uncovering.

The final aim of therapy is to convert regression into rebirth and regrowth.

In order for this to occur, the regressed ego must find for the first time an object relationship with the therapist that is understanding and accepting. The therapist must also safeguard the rights of the client. Even if the schizoid client's regressed ego finds safety in the therapeutic relationship there are two situations that need to occur if 'rebirth' is to take place;

- ➔ First, the schizoid client will need to relinquish the anti-libidinal driving of himself. This will develop slowly as he takes on the therapist's understanding attitude towards his frightened child within.
- ➔ Second, is the growth of faith, that if the needs of the regressed ego are met, recuperation will occur.

Guntrip states that, "*nature heals in a state of rest, and that is the goal.*"

It is important to understand the difference between regression and illness. Regression is a flight backwards in search of security and a chance of a new start. But regression becomes illness in the absence of any therapeutic person to regress with and to! The regression and regrowth level of psychotherapy is when contact is made with the terrified infant and thus involves specifically schizoid problems. Guntrip makes note that when a client begins psychotherapy by presenting schizoid and regressed reactions, he is more ill than average. However for most schizoid clients,

going to the tap-root of all problems would be a premature attempt to reduce all problems to one problem. We must deal with what the client presents and let the next phase grow from there. The two other levels of therapy are the oedipal conflict (which involves the problems of the child struggling to adapt and maintain himself in an unsupportive family which are then transferred into other areas of living) and the schizoid compromise (where the client marks time in therapy by bringing about more modified obsessional or schizoid behaviors). All the oedipal and compromise positions involved in his defensive system must be patiently worked through, and in that process the person comes to feel strong enough, and well enough understood and supported, to face the ultimate test of bringing the fear-ridden infant into the therapy relationship. Guntrip states that, *"the Pathological Oedipus complex always masks poor relationships with parents in reality. [It] should be worked with in such a way as to lead to the discovery of the hopeless, shut in, detached infantile ego which has given up real object-relations as unobtainable and sought safety in regression into deep unconscious"*. (For the schizoid, sexual relations both in reality and in fantasy are a common substitute for real personal relationships.)

How do we work with the regressed schizoid client who wants to be treated as a baby, but believes that he should not be indulged in this? Guntrip states that, *"even when gross hysterical dramatization of illness is obvious, there is an infant in the client, an undermined basic ego, who needs to be accepted for who he is. [He will need to be] helped through whatever degree of 'therapeutic regression' proves necessary. But there is an anti-libidinal ego in the client who hates this."* If the therapist is on the defensive against the client's deepest needs, he may then become demanding and manipulative towards the therapist. If he realizes that the therapist accepts the baby in him it will bring out his resistance to the therapy. (The anti-libidinal defense not to depend on the therapist for help.) Like the demanding child, the demanding client cries out for love that he feels he is being refused. The resistant client does not want to accept a love that he fears will be smothering. Guntrip points out that, *"in either case the client is likely to be sensing accurately the [therapists] basic attitude behind his overt behavior."*

The schizoid's conflict between the need for, and the fear of, human relationships is apparent in his seeking therapy that he cannot fully accept. He will continue to suffer in his neurosis because he cannot admit his weakness and accept the therapist's help. This need for a compromise relationship will create difficulty for therapy. The essence of the schizoid compromise is to find a way to retain a relationship without full emotional involvement. He may derive some quite valuable support from the sessions but he does not experience any real development of personality". Guntrip regards a prolonged therapeutic stalemate of this type to be an important indication of the severity of the deepest level anxieties that the client will have to confront if he goes further. He is stuck; he cannot give up therapy because serious anxiety will erupt, and he cannot 'let go' and drop into genuine therapy because just as serious anxiety will be released. However, if therapy does not breakdown there is an opportunity to work with the forms of compromise and possibly make some progress.

Guntrip explains that, *"steady and determined persistence in blocked therapy can be a schizoid compromise that the person has no option but to maintain; and to support them in it may be the only way of giving the person [the] help that they can accept ... Resistance is ... a defense of the client's very existence as a person within the limits of what is possible for him"*. Guntrip's impression is, *"that if the client can face [his deepest problems] he will, and if he cannot, no amount of [therapy] will make him do so"*.

A compromise technique that the client may use is to turn therapy into an intellectual discussion. But, it is important to recognize that this may not be a defensive maneuver. It may be

an effort of the grown-up self to get the support and understanding it needs for the strain it has undergone by carrying the child within. Also, the client may genuinely need help in dealing with others. It will be important to work with this and help the client to see where his difficulties with others are tied to his own issues. If these kinds of discussions are overused then they must be challenged as a schizoid compromise (- an effort to keep going in relationship with the therapist while keeping the inner self withdrawn). A psychotherapeutic stalemate is often a necessary stage that the client must go through on his way to confronting his terrifying sense of isolation.

The emergence of the ultimate withdrawn infantile self is the hardest ordeal for the schizoid client to face. A feeling of utter hopelessness and aloneness will be evoked as the regressed ego comes into consciousness. There will also be a fear of the good object relationship as smothering. The schizoid's need for regressed dependence on the therapist will elicit his fear of losing his self-determination, independence, and individuality. He will not be able to feel the regression as the starting point of new growth and security. Guntrip emphasizes that, "*the need to regress cannot be taken lightly; in the most ill it involves hospitalization*". In less severe cases, regression can be experienced in the therapy session and the active self is kept going. Regression can be understood and contained, and normal 'resting' at home can be a form of intentional regression. Gradually, the need to regress will fade. There are some cases where regression is not needed. The tendency to withdraw can be reversed in the normal process of transference analysis.

Guntrip describes in three stages what the schizoid client needs as a foundation for recovery:

- ❖ In stage one he needs a parent figure that will protect him against overwhelming anxiety. Initially, the psychotherapist 'rescues' the schizoid client from the hopeless losing battle with problems that he does not understand. The schizoid's dependence on the therapist at this stage is equivalent to the aspect of the parent-child relationship where he needs a purely supportive, protective, reassuring love as a basis for existence.
- ❖ Stage two is the transference. It involves detecting all the ways in which the early inadequate relationships interfere with the forming of the new supportive relationship. (Maturation depends on getting beyond the second stage.)
- ❖ In stage three the schizoid client will begin to feel what he really needs – the non-erotic love of a stable parent in which he can grow up to possess an individuality of his own. In this relationship he will develop a strength of selfhood, which allows him to separate without feeling 'cut off'. His original relationship to his parents can now develop into an adult friendship.

Guntrip points out that these three stages of rapport, transference, and regrowing or maturing, are not clear-cut and they are intermixed. Guntrip reminds the therapist that, the more concerned we are about the 'person', and less about the 'symptoms', the more the personal relationship will prevail.

Generally, the schizoid client will surrender his internal bad object when the therapist becomes a sufficiently good object to him. However, the schizoid client who is so fear-ridden that he keeps outside of all real personal relationships may be unable to form a sufficiently real relationship with the psychotherapist. This is a real dilemma, because, until psychotherapy has helped him to become less afraid of relationship, he cannot make much use of therapy. All that the therapist can do is to keep sympathetically directing his attention to the fears of relationship. By keeping these fears conscious the client can repeatedly test them against the reality of his experience of the therapist. What often occurs is that just as some rapport is developed the client will suddenly detach. This has to be made conscious over and over again, since it is the relationship

with the therapist that creates the situation in which problems can be solved. Guntrip states that, *"the therapist can do no more than make the possibility of a therapeutic relationship available, and perhaps by being real himself give the client some reason for feeling that this is a worthwhile goal"*.

Throughout therapy the schizoid client will discover that he has more important goals than getting over his illness. In this case he will use the therapy to get worse. He will accuse the therapist of destroying everything he had to cling to. He may not be prepared to accept the transference element in this because he wants someone to 'hit back at'. This negative therapeutic reaction enables him to expose the bad parents or even the whole bad family and the bad therapist all at once. Hate has satisfaction in its destructiveness even at the price of self-destruction. Guntrip describes the path from the schizoid state, to reality and maturity of selfhood, *"Like an area sown with land mines. The final result a client achieves may well be the result he [unconsciously] sets out to achieve... And it may be exceedingly difficult to save him from himself by successfully analyzing this... In fact, the difficulties the client encounters within himself are so formidable that he is not likely to be able to overcome them, unless through all the ups and downs of treatment he comes to realize that the therapist is so to be trusted and relied on that it becomes possible and safe to be quite open with him."*

Besides the severe difficulty that the schizoid client has in entering into a personal relationship, there are two other internal obstacles to therapy. The hysterical defense of substituting a body problem for a personality problem creates a resistance to therapy. In conversion symptoms, physical pain can cover and defend against the more severe mental pain, which would emerge if the physical pain disappeared. The client cannot give up the more socially acceptable physical pain unless he knows that the therapist can help with the mental pain. Since the essential issue is always the schizoid's need for a personal relationship, which will enable him to grow a real self, the deepest problem to face will be one of these fears. The fear of having no relationship at all, and losing his ego in a vacuum, or the fear of entering into a relationship, and a feeling that his weak ego will be overwhelmed. In this dilemma, the hysteric conversion symptom diverts the attention from the human relationship problem to the physical symptom.

Another stubborn obstacle to psychotherapy is the schizoid's investment of libidinal energy in the bad object. The impulses and emotions that the therapist will deal with in the schizoid client are actually reactions of a weakened ego to people and situations. These reactions are appropriate to the way that the ego perceives the object and expresses his relation to that object. The therapist must look at the client's ties to his internal bad objects. As Guntrip makes clear, "it is the client's internal bad object world, NOT his instincts, that are the cause of trouble". Giving up the internalized bad parent figures will evoke two fear reactions – the repressed death wishes against the parents and the feeling of being 'utterly alone' for the first time. This will bring the fear of ego loss, depersonalization, and dying, unless the internalized parents are replaced by something better.

Guntrip sites the major source of resistance to psychotherapy for the schizoid client as the extreme tenacity of his libidinal attachment to his parents. This is perpetuated by repression in his unconscious by these bad figures, which generate the restrictive, oppressive, persecutory environment in which the child cannot find his real self or escape from. All he can do is fight desperately, suffer passively, or fly (i.e. withdraw into himself, break off object relations, and experience the anxiety of utter isolation in which he will lose his ego). Then when he gets over the fear of meeting his bad parents in his therapist (the negative transference) his fear of losing them is so great that he will regard the therapist as someone who will rob him of his parents. At the same time he is also looking to the therapist to rescue him from them. He will then face a terrifying

period where he has lost his internal bad objects but he feels unsure that the therapist can adequately replace them. This will feel to him like plunging into a mental abyss or black emptiness. It is important to realize that it will take a 'very long time' before the schizoid client can really feel that the therapist can be a better parent in terms of providing a relationship in which he can become his own true self. Long after he knows that this is so, the child inside may not feel it. The uncertainty of accepting the therapists help may still feel like disloyalty to the parents and arouse guilt. The fear of having no roots can evoke a defense, of parents against all outsiders. Or, he may go back to the negative transference and feel as if he encounters his smothering internal bad objects all over again in the therapist.

For the schizoid client who needs a relationship with the therapist in terms of infantile dependence, we must recap Winnicott's view of psychotherapy at this depth. Keeping in mind the nature of the infant-mother relationship will help us to understand how to start off the growth of an ego which not yet properly begun to be. In summary of Winnicott's view ... The mother is 'being there' for the infant in a way that he can share in her psychic state of secure being. This is a state of oneness prior to his being able to distinguish between himself and his mother. It is here, at the very beginning of life, that the foundation for ego security is laid by the mother in her state of 'primary maternal preoccupation' with the infant, and by his 'primary identification' with her. The baby must be able to feed actively at the 'male' breast that is doing something for him or he must protest at deprivation. He must also be able to sleep without anxiety at the 'female' breast that is just 'being there' for him. This is the beginning of the secure sense of 'in beingness', of ego-identity, that he does not have to worry about or work hard to maintain as he grows. Only the mother can provide this initial experience. The task of the father is in 'doing' all that is necessary to protect and support the mother-infant pair in their formative relationship. In psychotherapy at the deepest level, this situation has to be recovered. The therapist must meet the client's need for both mother and father. Home defines, "*analyzing' [as] a male function, an intellectual activity of interpretation, but based on [the] female function of intuitive knowing through identification.*" Guntrip states that "*'being there for the client' in a stable and not a neurotic state, is the female, maternal, and properly therapeutic function, which enables the client to feel real and find his own self*". To use Winnicott's distinction between 'being' and 'doing', technique is a matter of what the therapist is 'doing', but the therapeutic factor lies in what the therapist 'is', what he is 'being' unselfconsciously in relation to the client.

Guntrip believes that, the only way we can know a 'living subject' is by identification. This gives us an understanding of the person, and particularly, how he is feeling. "*Provided that perception is accurate, and refined by the withdrawal of projections, cognition through identification gives us accurate information... [which cannot be obtained any other way].*" What is important to the client is that the therapist be a real human being who has a genuine capacity to value, care about, understand, see, and treat the client as a person in his own right. The therapist does not 'cast out' internal bad objects, but provides for the schizoid client a sound personal relationship in which the ego can grow secure enough not to need them any longer! The therapist must support the client as well as leave him enough freedom to develop his own nature. When the therapist finds the person behind the defenses, true therapy can happen. Fairbairn pointed out that, "*deep insight only develops inside a good therapeutic relationship. [This] is because the client cannot stand it if he feels alone. What is therapeutic when it is achieved, is the 'moment of real meeting' of two persons as a new transforming experience for one of them*". Which is, as Laing said (1965) "not what happened before [i.e. the transference] but what has never happened before [i.e. a new experience of relationship]. Guntrip concludes that, "*psychotherapy is a [progression]*

out of fantasy into reality, a process of transcending the transference. [And] The surest guide is simply to keep asking oneself: What is the [client's] genuine need at this moment, whether he knows it or not? ... [It is the] genuine meeting of two human beings as 'persons' ... that is ... really therapeutic [and enables] the client to feel real in himself".

Schizoid Dreaming

[Note: all dreaming is not schizoid and pathological.]

If the schizoid client fills his session with dreams it could be a compromise technique. Dreams could be used as a way of preventing anything that may stir up anxiety. Fairbairn pointed out that, "dreaming is a schizoid manifestation ...". Guntrip states that, "dreaming is the maintenance of an internal world, withdrawn from the outer world, in which the outer world – including the therapist – may not be allowed to share. It is a schizoid phenomenon based on the fact that the over-anxious or insufficiently formed ego cannot maintain itself in existence without object relations." To the degree that basic ego-relatedness is weak and there is a strong tendency to depersonalization, sleep presents a risk of ego loss. Then, dreaming can be a tool to keep the ego in being. In therapy, if too much interest gets 'fixated' on dreams it can help the schizoid client to maintain his defences. From the schizoid client's perspective dream analysis can be more intellectual than emotional. Guntrip points out that, "when [a client] begins to live out in a conscious emotional way, states of mind that they expressed quite clearly in one or two notable dreams in [previous years] they are giving up dreaming, as a defensive inner world and a struggle to solve problems by themselves, and they are bringing their real self into therapy."

There are several characteristics of the schizoid that show up in his dreams –

1. He may present dreams in which he is only an observer of the activities of others.
2. The clash in client's mind between parents and the therapist may show up in dreams. It will be important for the client to become aware that the parents in his dreams are processes going on in his own mind, and represent his own parent-influenced self (the anti-libidinal ego in which he possesses the parent(s) by identifying with them).
3. The fear of falling into the emptiness of his ego-unrelated state may have the schizoid client staying awake thinking, waking up frequently to make sure that he is still there, or creating complicated dream stories. This type of dreaming is the nighttime equivalent of daytime obsessional thinking that he uses to keep his 'self' in being.
4. The regressed ego shows up as deep dreamless sleep and seems to be equated with re-entry into the safety of the womb. But from the perspective of the central ego this is a threat of ego loss. So, dreaming is a defence. The dream world is then halfway between the womb and the outer world.

Dreams can allow withdrawal from reality and the maintenance of an active ego simultaneously. Daydreams depict a withdrawal from reality. Night dreams can show a resistance to passive dependence in sleep. Insomnia can be a refusal to give up the central ego control, which is a drastic attempt to defend against regression. Guntrip concludes that –“*good fantasies are a defence against bad fantasies, which are themselves a defence against unreality, depersonalization, emptiness, [and] and the loss of ego.*”

The Ego and the Body



Lowen states that, “*No words are so clear as the language of body expression ... [and] this is particularly true in the schizoid where the original trauma is pre-verbal.*” As we have discussed, the infant’s reaction to this trauma is to withdraw inwards. In the body, we see that the energy is withheld from the organs, which make contact with the external world (i.e. face, hands, genitals, feet). Johnson states that, “*Increasing the sense of grounding, and developing the client’s sense of his body and the environment are the very beginnings of realizing the real self... [This development is] the most essential ego-building task of psychotherapy, for the schizoid client. This sense of self is so fundamental, so nonverbal, that it is difficult to describe it, or its absence, in words. When this sense of self and the boundaries which help define it [are] incompletely developed, the [client] often does not experience incompleteness until the work enhances a more solid sense of self.*”

There are several exercises that Johnson uses to enhance this sense of self. I used these exercises in my bioenergetics class, so I won’t describe them in detail here. These intrapersonal processes are the ‘I am’ meditation, the visual and auditory clearing exercises, and simple awareness and relaxation exercises (stretching with a focus in breathing).

Through the ‘I am’ exercise the schizoid client can experience a state of ‘being with’ himself. The sensory awareness and clearing exercises help the schizoid client know all the dimensions of his awareness. When the schizoid client is able to develop a greater kinesthetic sense of his body he will have more sensory awareness of his feelings and sensory contact with his environment. An increased capacity to experience and tolerate feelings will develop through grounding. And will give the schizoid a more solid sense of himself from the ground up. According to Johnson, it is important for the schizoid client to initially have a positive experience with bodywork ... the schizoid client was scared out of his body and he can’t be scared back in. Johnson also suggests joining with the client in the awareness and relaxation exercises in order to enhance safety. Johnson reminds us that a sense of self is necessary before doing the more active and expressive work ... which may easily overwhelm the schizoid client.

In his book ‘Bioenergetics’, Lowen describes the body counterparts to the schizoid’s psychological characteristics. Lowen states that, “*there is an inadequate sense of self because the schizoid lacks identification with his body... The tendency to dissociation is represented on the body level by a lack of energetic connection between the head and the body... The schizoid shows hypersensitivity owing to a weak ego boundary, which is the psychological counterpart to the lack of peripheral charge. This weakness reduces his resistance to outside pressures and forces him to withdraw in self defense... [in regards to the schizoid’s...] tendency to avoid intimate, feeling relationships...*” Lowen explains that, “*such relationships are difficult to establish because of the lack of charge in the peripheral structures.*”

In ‘Language of the Body’, Lowen states that, “*the schizoid character maintains a body – mind unity by a tenuous thread. The body ... is the most immediate reality [and] it is also the bridge which connects his inner reality with the material reality of the outer world*”.

Lowen describes the key to therapeutic treatment of the schizoid personality as follows:

- ❖ To bring about identification with kinesthetic body sensation
- ❖ To develop a body relationship to objects such as food, love objects, work objects, clothes etc.
- ❖ To increase the depth and range of expressive movement

The effect of this approach is to strengthen and develop the ego, which, as Freud reminds us, "*is first and foremost a body ego*".

According to Otto Fenichel (1945), there are two muscular attitudes of the schizoid. "*Usually an extreme internal tenseness makes itself felt by hypermotility (or hypertonic rigidity) behind an external mask of quietness; at other times the opposite takes place – an extreme hypotonic apathy.*" Lowen explains that the former is a state of hypermotility dissociated from any emotional content. The body is tense and charged but movement is mechanical. In the second situation, motility is reduced, but there is less affective dissociation.

The hypotonicity is limited to the superficial muscles. Palpation always confirms that the deep muscles are spastic. I believe that these layers reflect the endopsychic structure we have discussed. The superficial is malleable to what is expected from outside. However, the deep tensions and restrictions correspond to the antilibidinal ego which restrains the expression of the deep feelings of the regressed ego and the libidinal needs which have been distorted by repression. And, as we well know, release of these deep muscular tensions would release schizoid terror and rage.

In 'Betrayal of the Body' Lowen points out "*that the mobilization of the schizoid client's body is a slow procedure. Since he abandoned his body because of pain, this pain will return as he establishes contact with it... Pain in the schizoid client's body can assume frightening proportions if it is associated with inner feelings of despair and terror ... [however], when a [client] realizes that the pain stems from the struggle of the body to come alive, and it is not an expression of a destructive process, he can accept the pain as a positive sign.*" In the simple awareness and relaxation exercises that Johnson suggests for the schizoid client, there is particular focus on breathing. As Lowen points out, "*One observes that the belly is sucked in during inspiration and pushed out during expiration*" when the schizoid client breathes. This way of breathing is an expression of fright. The immediate result of the immobility of the diaphragm is the division of the body into two halves, upper and lower. Lowen suggests forward bending to help release this diaphragmatic tension. I also see that this split could reflect the division between the central ego (Fairbairn) and the libidinal and regressed egos held back by the anti-libidinal ego (i.e. External and internal reality/ higher and lower selves).

Lowen also points out that the body structure of the schizoid lacks unity. The various segments of the body are functionally split off from each other, as are the split parts of the ego. The separation of the head from the body is the bioenergetic basis of the split between perception and excitation according to Lowen. The separation between the pelvis and the trunk implies a dissociation of genital sensation from total body feeling. The use of sex as a means of establishing contact with another person characterizes the sexual behavior of the schizoid. In addition, Lowen interprets the contracted and undercharged head, pelvis, and extremities, as a failure in development rather than a withdrawal from reality. I see both as true ... the initial withdrawal from reality means that development is stunted. And because of the resulting lack of development the state of withdrawal is perpetuated.

Lowen defines emotional health "*... in terms of the ability of an individual to involve all of himself in his actions and behavior. This also implies the equal ability in appropriate situations to restrain actions. On the psychological level this may be interpreted as a statement of the integrity of the ego; one that is not split. On the physical level this implies the absence of chronic spasticity*

and tension in the muscular elements of the body". Lowen concludes that, "the schizoid's ego needs to be [developed so that it can] function fully and adequately in a world that he did not know. This other world is the world of the body ... All schizoid clients will go through a phase of deep exhaustion ... [as they get into] fuller contact with their body. If the [client is able to give] in to this feeling of exhaustion, it stops all his compulsive activity and thereby decreases his feeling of desperation" ...

"To reclaim the body," and establish the foundation of an ego, "its pain must be replaced by pleasure and its despair by positive feelings". 'However', Lowen points out, "the way to pleasure is through pain... Apart from the body, life is illusion. In the body, the [schizoid client] will encounter pain, sadness, anxiety and terror, but these are at least real feelings, which can be experienced an expressed ... To be without feeling is to exist in a vacuum, cold and lifeless. No one knows this more than the schizoid person, but he has lost his way back to his body. Once [he] finds the way back, he will reclaim his forsaken body with all the fervor of the lost child who finds its loving mother!"

In 'Betrayal of the Body' Lowen states that, "*the schizoid client, comes to therapy seeking the acceptance and warmth that he[missed] as a child*". He needs the positive support of the therapist in order to contact the denied infant within. "*The therapist must come into contact with the [client] in the same way a mother does with a child, that is, via the body. If the therapist touches the [client] with hands that are warm and tender, he establishes a deeper contact than words or looks could achieve.*" Lowen warns that, "*the therapist who pays little attention to the physical needs of the [client's] body (to breathe and to move) confirms the schizoid dissociation of body and mind*".

Lowen also equates the loss of self-possession with 'bewitchment'. He describes a person with a split between the ego and the body as 'bewitched'. For the schizoid, the terror evoked in the infant elicits a split in the unity of his personality and destroys his feeling of identity. "*Since the mother holds the power of life and death over her infant, he is helpless and terrified in the face of her rejection. His undeveloped ego is incapable of coping with an attitude that denies him the right to the pleasure of his body and dooms him to death in life... If the ego is uprooted from the body, [such as it is in the] schizoid individual, he will feel ashamed of his body and guilty about his feelings. He will lose his feeling of identity.*"

As we have discussed, "*under stress, schizoid individuals will often express negative feelings, but in a form that does not promote a sense of identity. They become hysterical ... Hysterical reactions should be distinguished from emotional expression. The hysterical reaction is like an explosion, which overwhelms the ego's restraint; whereas a true emotion is expressed with the approval and support of the ego. An emotion is a unified and total response of the person; the hysterical reaction is split, with the body acting out, while the ego is helpless to stem the flood. Hysterical reactions are common in the schizoid personality, [and] their effect is to further the dissociation of the ego from the body*".

Lowen concludes that the ego rests on two foundations:

- ❖ The identification with the body (feelings).
- ❖ The identification with the mind (knowledge)

"Without knowing, the ego has no way to test reality. It depends, then upon magic to influence natural processes. Lacking a firm grounding in the body, the ego has no feeling of reality. Its knowledge then degenerates into abstractions, which are [powerless] to influence attitudes or behavior. Contact with the body provides the ego with an understanding of internal reality;

knowledge gives it a grasp of external reality. When these two realities conflict and cannot be harmonized a schizoid condition results."

Lowen states that, *"reality demands that one cannot treat a grown person as a child. The therapist can respond to the child in an adult if he bears in mind that he is ... dealing with an adult. A therapist represents reality as opposed to the emotional illness that denies or distorts reality."* But, as Lowen points out, *"reality seems to have different meanings to different people. What a therapist offers, therefore, is the reality of his own being and his own existence, an existence broad enough to comprehend the confusion and anxiety of the client [without getting lost in it]. The schizoid's assurance of help lies in the therapist's dedication to truth. The truth of his own personal being, the truth of the [client's] struggle, the truth of the body."*

The Foundation of the Ego – an Energy Perspective

According to Anodea Judith, *"the state of both mother and environment become, literally, the first experience of self"*. And, it is from this state, which includes the state of the womb, that the first chakra is formed. If the mother is cold and cruel, and the environment is painful, such as in the case of the schizoid, then the first experience of life itself has a negative charge. Barbara Brennan states that, *"the natural energetic defense used against early trauma is simply to draw back into the spirit world from which the soul is coming.* (Use the notch in the sternum with red energy to bring the soul back in the body during an energy session.) Judith describes that, *"When a young infant faces danger or neglect, it forces him to fall back on himself – an independence which is developmentally impossible. Instead, the child falls into an intolerable pit of fear and helplessness [this is] the experience of having no ground. When this happens, the downward current of energy is blocked. Instead, the life force moves towards the upper chakras where it feels safer. The upward movement then becomes habitual, depleting the lower chakras and sending the whole system out of balance"*.

Judith explains the hypervigilance of the schizoid in terms of this accelerated upward current. The schizoid person is extremely sensitive to external messages and it is, *"as if [he is] constantly searching for ways to connect with his caretaker or constantly watching for danger ... This, states Judith, " is the hallmark of a deficient first chakra: The body is deadened and consciousness is elevated, creating the profound mind-body split [of the schizoid]."*

Judith declares that, *"the healthy establishment of one's ground is the essential work of the first chakra, and the foundation of any further growth. Here, [in a healthy ground] lies the validation of one's own existence and the establishment of the basic rights of the first chakra : The right to be here and the right to have what we need in order to survive"*. Judith points out that in first chakra work for the schizoid client it is important to keep the person in touch with the sensation in his body rather than on emotional feelings. This will provide the containment for traumatic material.

A focus on body sensation is done through constant reference to, and mirroring of, the physical processes that are experienced during the session.

(i.e. when you feel scared, what does your body do? What happens to your belly or your breathing? A simple grounding suggestion can bring greater strength and calm.

i.e. "what happens when you put your feet back down on the floor and press your weight into them? What happens when you stand up?")

Judith reminds us that when the trauma occurred in early infancy the first chakra work will have to be done in postures that simulate that early stage, such as laying on the back with knees bent, the fetal position, and being held while leaning back on the therapist. Grounding-work can be done by working on the feet of the schizoid client. Judith suggests a gentle foot massage. I've also found that just putting my

palms on the soles of the feet and 'allowing' brings energy into the feet. The client makes contact with me via movements such as gently reaching, (testing like an infant would), or an energetic connection.

When doing energy work with the schizoid client it is important to remember that the body is very constricted. This will make it difficult for the person to tolerate too much charge. I have found that working in an allowing mode, and using rose energy, is effective for creating safety, and avoiding excessive charge in the schizoid client. For the tightly compressed schizoid structure an increased charge may be felt as anxiety. If anxiety arises Judith states that it must be processed or curtailed. In order to curtail the anxiety she suggests slowing down or stopping the exercise, shaking out the legs, or sitting in a chair with the head lowered.

Judith describes the general energy pattern for the schizoid in this manner –

- ❖ The first chakra is highly deficient with the energy pulled up towards the head.
- ❖ The second chakra is also deficient. The feelings are intellectualized and may be distorted.
- ❖ The third chakra can be both excessive and deficient. Because the upward current is strong there is the impression of abundant energy but because the downward current is weak, there is little focus.
- ❖ The fourth chakra is deficient because it is armored against any dependency. (The schizoid is aloof and distant.)
- ❖ The fifth chakra is excessive because the schizoid discharges energy through the throat.
- ❖ The sixth chakra is highly developed and may be excessive. The schizoid tends to be psychic and intuitive.
- ❖ The seventh chakra is also highly developed and may be excessive because of the schizoid's defense of withdrawing into the spirit world.

Healing the first chakra is fundamental with this structure. It is the base from which the healthy ego can grow.

When the first chakra is damaged the upper chakras are more likely to be intensified. An elaborate and creative imagination with a dedication to the intellect is formed as a defense against feeling. In the extreme, such intensification can cause confusion, vagueness, or a feeling of going crazy. Judith states that, "*the answer lies not in curtailing consciousness, but in grounding and embodying that consciousness*".

Brennan points out that the person with a schizoid character defense is afraid of other people and has a hard time connecting to them. She says that the schizoid person's third and fourth chakra cords to their parents never formed in a healthy way. And, because of this, they have no model for connecting with others. According to Brennan, the schizoid person is "... *afraid to bring consciousness and energy firmly into their physical body... [They] spend as much time as possible in the higher spiritual realms in a diffuse state of unity in which their individuality is not experienced.*" Brennan describes life in the physical world as a mirror of self-reflection that enables a person to recognize their individuated divinity. But, the schizoid person "*avoids the individuation process of incarnation through which they could recognize their core*". Therefore, they know themselves to be all there is, but they do not know the individuated God within. Thus, the schizoid client will have damage to the first chakra cords.

Brennan states that the "*cords from the first chakra, which also grow deep into the earth, represent the stability of the will to live in the physical body in relationship to the earth and in relationship with another person ... The main result of the damage to the first chakra cords is ungroundedness, an inability to absorb dense earth energies. This, in turn makes for a weakness in the overall energy field which cannot [support a strong physical body].*"

Brennan explains that the lack of connectedness to the earth results in a great deal of fear about life in the physical world. The schizoid feels like a tortured prisoner in his physical body, which seems cut off from what appears to be a hostile world. The schizoid person in this state feels as if they are being

punished for something terrible that they have done. They spend time trying to figure out what it is, so that they can make it right, and be released from their suffering.

The schizoid never feels safe; they may find that meditating, and moving as much energy-consciousness as possible out of the top of their head makes for a safe haven. And, they would like to be able to do this all the time. But, Brennan emphasizes, "*this meditation is the worst thing that they could do for themselves because it only weakens the cords that connect to the earth. And, in the long run, meditation makes them less able to deal with the physical world*".

Brennan points out several ways to help the schizoid client feel safe and come back into contact.

- ❖ First, it is important not to go through the schizoid's vulnerable boundary with any 'bioplasmic streamers' or they will be gone instantly.
- ❖ Second, remember that the schizoid person runs energy – consciousness on the high frequencies of the higher levels of the field.

Therefore, to reach them the therapist must raise their vibrations to a high frequency and let the client feel them through harmonic induction. If this is done without any bioplasmic streamers then the person will begin to feel safe. (Note: Brennan says to focus spherically in all directions at once in order to prevent projecting bioplasmic streamers.) Brennan notes that direct eye-to-eye contact during this process will be too threatening for the schizoid client. Once the therapist is in sync and has contacted the person through harmonic induction, then gently decrease the frequency of vibration. Brennan says, once the therapist has accomplished a feeling of safety then they can ask permission to touch. If granted, the therapist has the client stand up and bend his knees. The therapist places their right hand on the back of the second chakra and holds a calm vibration (do not send any bioplasmic streamers). Then the therapist carefully allows a bioplasmic streamer to flow from their hand. And, with intention, directs it down the inside center of the person's body into the earth. Once that is accomplished, the therapist allows cords to connect from their heart and third chakra to the client's. The cords will have to come from the center of the therapist's chakras and sink all the way into the client's because the schizoid client does not know how to connect the third and fourth chakra cords.

Brennan describes an exercise designed to take yourself out of a schizoid defense. I think that this exercise would be helpful to teach to the schizoid client.

- ❖ First, the schizoid client must be able to recognize when they are out in the stratosphere.
- ❖ Next, they will need to realize that they are out there because they are afraid.

And, in order not to be afraid it is necessary that they change what they are doing... the instructions are – Bend your knees, breath deeply, and keep your eyes open.

In this position, bring your consciousness to the top of your head, then down into your face, neck, upper chest etc. until your consciousness has reached the bottom of your feet.

Feel the bottom of your feet, and then keep going down into the earth.

Repeat the mantra, "I am safe. I am here."

When you can feel the earth firmly beneath your feet, try to feel the other person, or environment.

Judith states that, "*in order to fully ground into a solid foundation ... the demon of fear must be overcome*". To live in fear, as the schizoid does, weakens the first chakra. And, in order to combat fear and strengthen the first chakra, fear must be worked through. This will allow the schizoid client to relax and feel the subtle energies of the body. Judith suggests that the fear must first be understood, then the instinctual response to fear must be released and integrated. Once the fear cycle is broken, a healthier pattern can be created. Finally, the schizoid client must develop the strength and resources to effectively meet similar threats in the future. Judith explains that, "*fear exists as an ally of self-preservation*". And, if the client can process the unconscionable fear and develop faith, then he will have a natural antidote to the first chakra demon.

In order to create a solid foundation, work with the schizoid client will also have to sort out the roots of childhood. 'Roots' can be seen as the way the individual system plugs into the larger system of the planet. And this, states Judith, *"is our source [of energy], the origin of the liberating current from which all things grow up."*

Reclaiming the right to be here, learning to ground, attending to our needs for nourishment are all first chakra necessities. A healthy first chakra allows a person to be energetically grounded – a concept which is critical to understanding basic aliveness and well-being [as well as the forming of healthy boundaries]".

Stanely Keleman states, *"if you are an alive body, no one can tell you what truth is because you experience it for yourself. The body doesn't lie."*

Bibliography

- Brennan, Barbara Ann, *Hands of Light – A Guide to Healing Through the Human Energy Field*, Bantam New Age Books, 1988
- Brennan, Barbara Ann, *Light Emerging – The Journey of Personal Healing*, Bantam Books, 1993
- Guntrip, Harry, *Schizoid Phenomena, Object Relations and the Self*, Karnac Books, London, 1992
- Johson, Stephen M., *Characterological Transformation – The Hardwork Miracle*, W.W. Norton and Company, New York, 1985
- Judith, Anodea, *Eastern Body Western Mind – Psychology and the Chakra System as a Path to the Self*, Celestial Arts, Berkeley, CA, 1996
- Lowen, Alexander, *Bioenergetics*, Coward, McCann and Geoghegan, Inc., 1975
- Lowen, Alexander, *The Betrayal of the Body*, Collier Macmillan, New York, 1967
- Lowen, Alexander, *The Language of the Body*, Collier Books, New York, 1958

APPENDIX 'A'

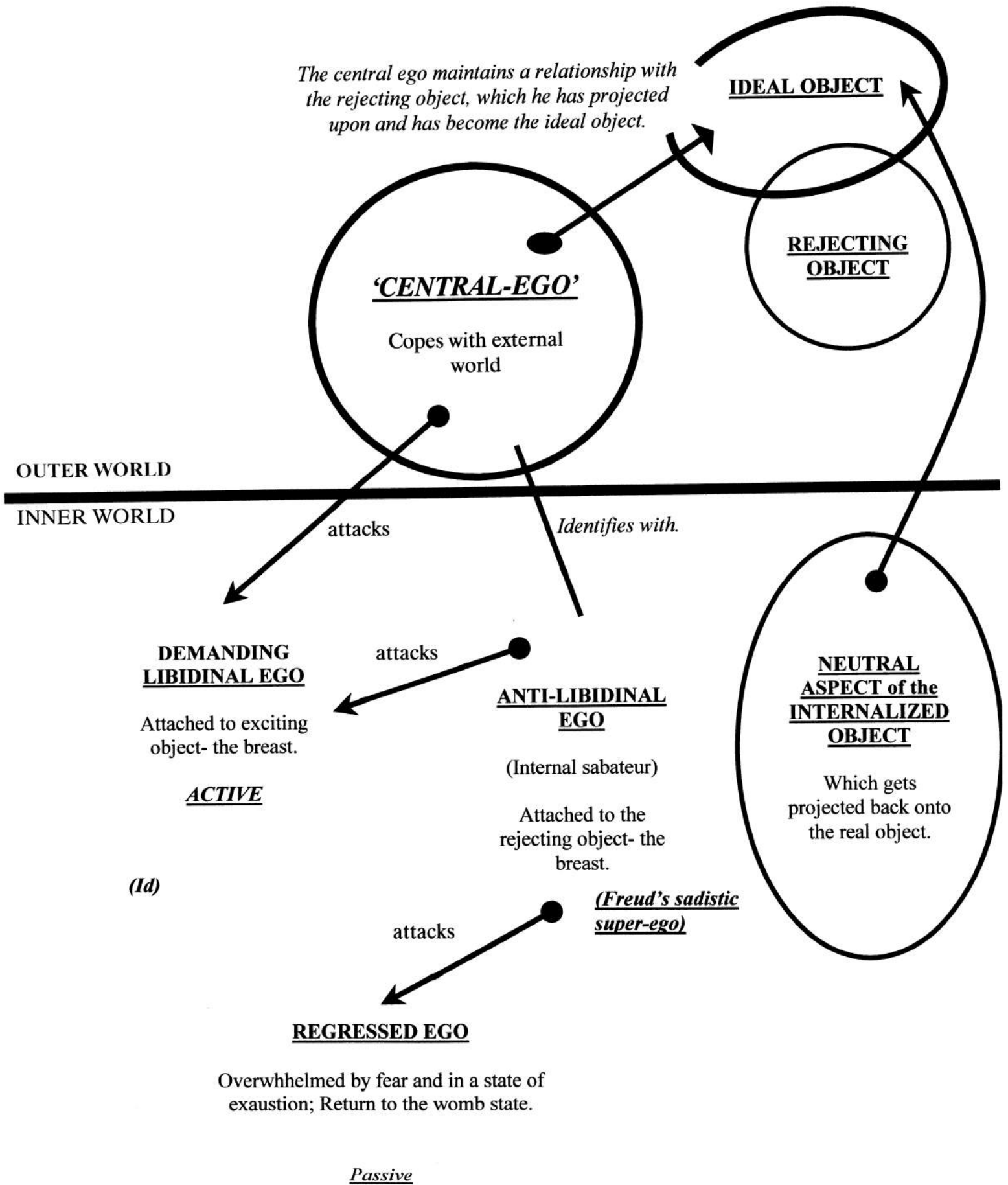
Schizoid Characteristics

These characteristics specifically mark the schizoid personality:

1. **Introversion** – meaning that the person is emotionally cut off from outer reality; all his libidinal desire and striving is directed inward towards internal objects and he lives an intense inner life. This fantasy life is usually carried on in secret. Often it is hidden away from the schizoid's own conscious self. His ego is split. But the barrier between the conscious and the unconscious self may be very thin in a deeply schizoid person. This allows the world of internal objects and relationships to flood into and dominate consciousness very easily. Deeper down than this level of 'internal objects' lays the ultimate introverted regressed schizoid.
2. **Withdrawnness** – detachment from the outer world.
3. **Narcissism** – is a characteristic that arises out of the predominantly interior life the schizoid lives. His love-objects are all inside him and he is greatly identified with them.
4. **Self-sufficiency** – is the attempt to get on without external relationships. Introverted, narcissistic, self-sufficiency that does without real external relationships while all emotional relations are carried on in the inner world is a safeguard against anxiety breaking out in dealing with actual people.
5. **A sense of superiority**- because of this self-sufficiency one has no need of other people. This over-compensates for the deep-seated dependence on people that leads to feelings of inferiority, smallness, and weakness. Along with this sense of superiority is a feeling of being different from other people.
6. **Loss of affect in external situations**- as a result of this lack of feeling, schizoid people can be cynical, callous, and cruel, having no sensitive appreciation of the way they hurt other people.
7. **Loneliness**- is an inescapable result of schizoid introversion and the doing away with external relationships.
8. **Depersonalization**- loss of the sense of identity and individuality, loss of oneself and derealization of the outer world. [**Derealization**- lack of comprehension of the outer world.]
9. **Regression**- represents the fact that the schizoid person basically feels overwhelmed by the external world and is in flight from it both 'inwards' and 'backwards', to the safety of the womb.

ENDOPSYCHIC STRUCTURE

The central ego maintains a relationship with the rejecting object, which he has projected upon and has become the ideal object.



**Fear dictates the retreat to inner world.*

APPENDIX 'C'

1. **Fear**- short, sharp, intense, and directly object related reaction.
2. **Anxiety**- persisting, pervasive fear state that arises out of a prolonged danger situation.
*In *pathological anxiety* the danger situation is an internal one, ultimately the fear of ego breakdown.
3. **Healthy fantasy**- is preparation for action in the outer world.
4. **Pathological fantasy**- is when the psychic self creates for itself a means of keeping in touch with fantasy objects while remaining withdrawn from real ones.
5. **Identification**- the process by which a person either
 - a) extends his identity into someone else
 - b) borrows his identity from someone else
 - c) fuses or confuses his identity with someone else

Primary identification – is the state ... presumed to exist in infancy when the individual has yet to distinguish his identity from that of his objects.