Schizoid Psychologies

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Not the DSM Version of Schizoid

• The term “schizoid,” as it has been used in psychoanalytic clinical writing, does not imply schizophrenia, nor does it imply indifference to closeness. It refers to a central conflict around closeness versus distance.

• Schizoid individuals are introverted and sensitive and often have rich inner lives. In the extroverted cultures of contemporary Western societies, schizoid people are often misunderstood and seen as pathological.
In fact . . .

- A schizoid temperament is the second most common personality type in therapists, and is especially common, it would seem, in psychoanalysts: “Psychoanalysis is a profession by schizoids for schizoids” (attributed to Harry Guntrip by Harold Davis)

- The role of therapist allows one to get very close to another person, but without being too exposed for one’s own comfort.

- Schizoid people are attuned to dynamics that are unconscious in other people.
Why not just call them introverts?

• Because this term lacks the connotation of a rich inner life and the dynamisms and internal splits that were captured originally by the term “schizoid.”

• On the Myers-Briggs inventory, they tend to score as INFJ (introverted, intuitive, feeling, judging), a group that is very small and sometimes called “the seers” or “the mystics” or “the confidants.”
The Schisms in Schizoid People

- **Overt presentation**
  - Detachment
  - Self-sufficiency
  - Absent-mindedness
  - Non-reactive
  - Blunted affect
  - Non-sexual and ascetic
  - Gentle, tentative

- **Covert phenomenon**
  - Longing to be close
  - Emotional neediness
  - Acute vigilence
  - Highly reactive
  - Intense affect
  - Sexually preoccupied
  - Fantasies of world destruction
Distinctive Characteristics

- Creativity/originality
- Unconventionality/indifference to how others may see them
- Deliberate eccentricity
Relational Patterns

- “Come close, for I am alone, but stay away, for I fear intrusion” (Robbins, 1988)

- The schizoid person “can neither be in a relationship with another person nor out of it, without risking the loss of both his object and himself” (Guntrip, 1969)

- Schopenhauer’s Porcupines
Affects

• Schizoid people may appear to be indifferent to emotion, but privately, they are frequently trying to manage intense feelings that threaten to overwhelm them.

• Most common feelings in this struggle are fear, anger and hatred, shame, sadness, and longing.
Defenses

• Withdrawal – either physically or into the mind

• Dissociation

• They notably lack distorting defenses such as repression and reaction formation
Problematic cognitions

• Love is more dangerous than hatred.

• Attachment hurts the other person and the self.
Temperamental contributions

• Some babies pull away rather than cuddle when held.
• People who become schizoid tend to have been highly sensitive infants, who are reactive to changes in light, sound, touch, and the emotional atmosphere.
• They have been described as having a porous stimulus boundary that makes them feel “hyperpermeable” (Doidge, 2001).
• In attachment research with young children, they tend to be rated as having “avoidant” or “dismissive” attachment styles.
Experiential contributions

• “Cumulative trauma” (Khan, 1963)
• “Toxic nourishment” (Eigen, 1973)
• “Impingement” (Winnicott)
• Parental difficulty accepting normal dependency, whether because of depression, intrusiveness, or lack of “fit” between caregivers and child (Escalona, 1968)
• Microtrauma and dissociation (Howell, 2005)
• Lack of validating messages because of the relative rarity of this temperament
Transferences in schizoid patients

- Resistance to attachment
- Pain because of exposure ("It hurts too much to talk")
- Expectation of lack of understanding and intrusiveness from the therapist
- Great sensitivity to any therapeutic mistake
- Pleasure in, and gratitude for, authenticity
Countertransference with schizoid patients

- Pleasure in the patient’s imagination, psychological talent, and honesty
- Feelings of painful disconnection and some difficulties with silent periods
- Fear of hurting the patient
- Guilt over hurting the patient
- Moments of symbiotic bliss
Treatment Implications

• Be aware of how schizoid people appreciate the clear boundaries of psychotherapy and react well to standard therapies.
• Be open to the patient’s sense of reality, even if it feels strange.
• Do not probe or quiz or make the patient feel like a “case.”
• Be willing to be seen as more “real” than may be wise with other patients.
• Be willing to talk about transitional objects and topics.
• Encourage the patient to take the growing capacity for pleasure in relationship beyond the therapeutic relationship.
And perhaps most important . . .

- Psychotherapy with individuals with schizoid psychologies is not really about “making the unconscious conscious” (psychoanalytic) or “changing the patient's irrational thoughts” (cognitive).

- It is instead about allowing the patient to elaborate his or her personality fully in an atmosphere of emotional safety.
Empirical support for these implications

• “Clients with internalizing coping styles may benefit more from psychotherapy that is focused on fostering insight and self-awareness rather than behavioral change and symptom reduction.”

Thank you!

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Paranoid Psychologies

• Also not the DSM version:

• The paranoid range includes many high-functioning individuals with significant paranoid streaks

• The central theme of trust versus distrust is more important in diagnosis for clinical purposes than specific traits such as suspiciousness and distrust
The Paranoid Process

- The experience of pain as inner badness that cannot be borne and is turned into an attack on something external.
Paranoid Syndromes

- People suffering from paranoid reactions are not just fearful or unreasonably suspicious
- Kraepelinian depictions of paranoid syndromes are all characterized by disavowal and projection. They differ depending on what is disavowed and projected.
Persecutory Paranoia

• “I love him; no, I hate him; no, he hates me”
  (Freud, 1911)

  What is projected and denied:
  • Angry affect
  • Hostile attitudes
  • Aggressive impulses

  Activation of Panksepp’s FEAR system
Paranoid Hatred

• What is disavowed and projected:

• Negative qualities in the self that are suffused with intense feelings of contempt

• Operates at the social as well as the individual level, and often a problem for therapists.

• “YOU are the aggressive, sex-crazed, greedy, needy, stupid, ugly, lazy . . . .”
Erotomania

- What is disavowed and projected:
  - Idealization
  - Desire
  - Aggression

- The psychology behind stalking
- "YOU are in really love with me and keep encouraging my attentions."
Paranoid Jealousy

• What is disavowed and projected:

• Desire (sometimes same-sex desire)

• Then this desire is displaced: “I’m not the one who desires a forbidden love object; YOU are. So I must monitor all your relationships.”

• Chronic expectations of betrayal
Megalomania

• What is disavowed and projected:
  • Self-contempt
  • Grief over limitation

• “YOU are the pathetic, defective ones, whereas I am flawless and superior.”
Etiologies of Paranoia

1. Humiliation (parental projection of negative qualities, bullying by peers, sadistic dominance by authorities)

2. Fusion and thwarting of efforts at psychological separation

3. Teasing, taunting, ridiculing

4. Distrust and contempt
Therapeutic Implications: Negative

- What to avoid doing:
  - Don’t invite regression or premature exploration of tender feelings
  - Don’t be too sympathetic
  - Don’t try to demonstrate one’s “goodness” in contrast to others in the client’s life
  - Don’t be conventionally “neutral”
Therapeutic Implications: Positive

- Convey unremitting respect
- Be unfailingly honest, including admitting to feelings that the patient picks up
- Facilitate a process of grieving