Character Styles: Stephen M. Johnson

CHAPTER 5

The Hated Child: The Schizoid Experience

Jeanine: You don't want to talk about it?
Conrad: I don't know, I've never really talked about it. To doctors, but not to anyone else; you're the first person who's asked.
Jeanine: Why'd you do it?
Conrad: I don't know. It was like falling into a hole. It was like falling into a hole and it keeps getting bigger and bigger and you can't get out and then all of a sudden it's inside and you're the hole and you're trapped and it's all over—something like that. And it's not really scary except it is when you look back on it because you know what you were feeling, strange and new . . .

—*Ordinary People*

ETIOLOGY

AS THE HUMAN infant awakens to the social world, she may not be met by one welcoming, contactful, and responsive to such a totally dependent being. Indeed, the parents may be cold, harsh, rejecting, and full of hate, resenting the infant's very existence. The parental reaction may, of course, not be that extreme and it may not be consistent. But we know that many human infants have been unwanted, and those who have been wanted on a conscious level are not always wanted unambivalently. Furthermore, many parents who think they want children find out differently when the full impact of the totally dependent human being is thrust upon them, when circumstances change, or when their resources to deal with the reality of an infant are much less than expected.

Perhaps even more common is the situation in which parents think they want a child but what they really want is an ideal reflection of

their own idealized self. They want a "perfect baby" instead of an alive human being with elements of animal nature. Every infant will sooner or later and repeatedly disappoint this ideal, and the parental rejection and rage which that elicits can be shocking. In every case, it is the real, spontaneous *life* in the child that provokes the parental rejection and hatred.

When one couples the common reality of the hated child with the understanding that the newly "hatched" human being has no *conscious* discrimination of the difference between self and caretaker, one can begin to speculate on the nature of the unfortunate result.* One can imagine that when the caretaker is sufficiently harsh, the infant may simply choose to go back where he came from—to detachment which is his only avenue of escape. The cold or hateful treatment of the caretaker may be total or partial, continuous or periodic. The infant's defensive retreat will be more profound as a result of repeated child abuse, for example, than as a response to occasional outbursts or periodic coldness on the part of the caretaker. This continuum of environmental failure will then be reflected in the resulting structural continuum presented in Chapter 1—personality disorder, character neurosis, and character style.

Winnicott (1953) refers to the concept of "good enough mothering" to describe the requisite empathic caretaking ability that will usher a newborn into the state of symbiosis and keep her there until the process of differentiation leads to conscious individuation. Where mothering is not "good enough"—and indeed where it is abusive and punishing—distancing, detachment, and literal turning away from social contact result. Because of the very primitive nature of the neonate's cognitive processes at this point in development, it is difficult to understand exactly how this chain of events is interpreted at any mental level. Nevertheless, we may surmise that at a very primitive level of awareness, and then at increasingly complex levels of understanding, the infant experiences an intense fear, which some have labeled the fear of annihilation (Blanck & Blanck, 1974; Lowen, 1967).

The infant's natural initial response to a cold, hostile, and threatening environment is terror and rage. Yet, chronic terror is an

*I am not saying here that the infant is operating with a symbiotic fantasy, only that the infant is insufficiently conscious to conceptualize the I-thou distinction.

untenable position from which to lead a life, as is chronic rage. Furthermore, such rage invites retaliation, which is experienced as life-threatening and terrorizing. So, the infant turns against herself, suppresses the natural feeling responses, and uses the very primitive defenses available in this early period to deal with a hostile world. In addition to, or as part of, the retreat inward, the organism essentially stops living in order to preserve its life. The ability to do that is limited by the ego development of the infant in this period. However, through the months of symbiosis she can regress to the previous developmental period which Mahler called autism and later wished she'd called awakening. During this earliest period, the child is more withdrawn and less reactive than she will shortly be. The hatred of the caretaking parent will be introjected and will begin to suppress the life force of the organism, such that movement and breathing are inhibited and there develops an involuntary tightening of the musculature to restrain the life force.

Therapeutic experience with clients who share this type of history suggests that, sooner or later, they make two core feeling decisions: (1) "There is something wrong with me," and (2) "I have no right to exist." These cognitive representations may, of course, be conscious or denied, but at a core level of existence the individual has taken the environmental response personally and has incorporated it into her self-concept. Enhancing this effect is the fact that at this symbiotic point in development there is no conscious differentiation between oneself and one's caretaker. It is the preverbal assimilation of these damning "script decisions" that renders them so insidious and difficult to change.

One way to gain an appreciation for the initial dilemma of the schizoid person is to remember those times when in a supermarket, laundromat, or other public place you have witnessed the explosion of a mother or father at a young child. This often alarming public example of child abuse demonstrates the not uncommon loss of parental control, and one cannot help but wonder about the limits of this kind of outburst. Presumably, the child herself is not sure of those limits either, and on occasion the parent may have gone well beyond mere yelling or minor corporal punishment. In these public circumstances, you may have witnessed the child herself taking on the maternal role and doing whatever was necessary to get the parent to pull himself together and leave the situation. In parents with mar-

ginal emotional stability, these abusive outbursts often have very little to do with what the child has or has not done. As a result, the child will often develop rather profound vigilance, as well as the ability to parent her parents when loss of control is imminent or realized. Schizoid character neurosis or style can also be created by environments that are simply chronically cold though not neglectful of physical needs nor ever openly hostile. The "hated child" label then seems a bit of an overstatement. To appreciate the metaphoric truth of that label, one must put oneself in the place of that child who has an inborn need for a great deal of attuned holding. The absence of such required human warmth and caretaking results in a kind of disembodied existence and the same kinds of phenomenological steps that I am outlining here for the more openly abused child, though often to a lesser degree.

As will be outlined in greater detail with the exploration of the behavior, attitudes, and feelings of this character structure, the hated child begins to find a safe haven in withdrawal into cognitive and spiritual endeavors. "If mother doesn't love me, then God will," and if the world on face appears to be hostile, it is really a beneficent unity in which one's current life is a mere flash in the eternal pan and "life on this physical plane is really irrelevant." In these ways, life is spiritualized rather than lived. The hated child may be one who loves mankind but twists away almost automatically from the closeness required in an ongoing love relationship.

As the person matures, the sophistication and complexity of the defenses increase, yet at a core emotional level the defensive structure is very primitive and essentially reflects *denial* of what really happened in relation to the mothering person. That denial freezes the situation present in symbiosis—an unfulfilled wish for intimate union on the one hand and an automatic refusal to merge on the other. The frozen symbiotic condition yields a continuing propensity to *introject* whole the ideas, characteristics, and feelings of others, as well as a tendency to *project* both good and bad feelings and motivations onto others. In this character structure there essentially was never a completed symbiotic attachment leading to a later individuation with autonomous functioning. The hated child's experience is: "My life threatens my life." The seeming independence and detachment of this basically frightened and angry person are purely

defensive, and there is developmental arrest in the humanizing process and an arrest of life before it really began.

The classic research of Ainsworth (1979) and all the work it has spawned is very relevant to our understanding of the patterns of character and adaptation formed in this first year of life. Like the work of Bowlby and Mahler, Ainsworth's research is relatively pure observation in minimally contrived situations and employs global and qualitative categories of observation. In her procedure, a mother and her child of one year are brought into a novel playroom. After a relatively brief period for adaptation, the mother is asked to leave and then return at a predetermined time.

Ainsworth and her colleagues found that they were able to reliably characterize the child's pattern or syndrome of behavior in this situation. Furthermore, the three patterns or syndromes they delineated showed remarkable predictability to future adjustments up to five years of age.

In the first pattern, called "anxious/avoidant attachment," babies showed little affective resonance with their mothers and had little preference for interaction with her over interaction with a strange examiner. They were able to explore the room independently and showed little or no disturbance when their mothers left. As in all cases, the most noteworthy behavior occurred on the mother's return. At this point, these babies actively ignored their mothers, and a good portion of these children turned away from their returning mothers.

In "secure attachment," the child appeared to use the mother as a secure base for exploration. The child easily separated from the mother to explore the environment but also freely shared her experience with the mother, and the pair was more affectively attuned. The child was readily comforted by the mother when distressed and could then quickly return to playing after such comforting. When distressed by the mother's departure, these children would go to their mothers for comforting and reconnection when she returned. If not distressed by the mother's departure, which also occurred in these securely attached babies, they acknowledged, welcomed back, and happily approached their mothers on her return. All of these behaviors suggest that a child is positively and unambivalently attached to the mother.

"Anxious/resistant attachment" is characterized by far more clingingly dependent behavior. Initially, these babies have trouble separating from their mothers to explore the novel environment and tend to be more apprehensive of the examiner as well as showing a definite preference for their mothers. They're more likely than the other two groups to be distressed by the mother's departure, yet, when she returns, they often are even more upset, oscillating from anxious contact to obvious "resistance." They may, for example, reject the mother's attempts to initiate play, kick, squirm, or otherwise display negativity or ambivalence. Occasionally, these children show an alarming degree of pacivity in showing no attempts to interact either with the environment or with the returning mother.

For our purposes, this research is important for any number of reasons. These attachment patterns seem reliably established by one year of age and predict well to the same types of attachment observed six months later (Main & Weston, 1981; Waters, 1978). These types of attachments also have proven to be excellent predictors of relating to teachers and peers up through five years of age, always with the advantage going to those securely attached at one year (e.g., see Easterbrook & Lamb, 1979; Lieberman, 1977; Matas, Arend, & Sroufe, 1978; Waters, Wippman, & Sroufe, 1979).

Consistent with our developmental model, then, crucial patterns of relating to others are established quite early. While some of this may be related to genetic factors, I believe a good deal of it is related to the parent-child relationship. If it is not already obvious, the anxious/avoidant attachment is virtually identical to what I am describing as schizoid, while the anxious/resistant attachment is virtually identical to what I am describing as oral. By the time one has reached adulthood, these patterns may be intermingled with other characterological patterns. Furthermore, they may be more effectively covered by defensive styles or social skills. Yet, the underlying phenomenology of the anxious/avoidant or anxious/resistant attachment remains and characterizes the individual's process.

EXTERNAL CIRCUMSTANCES AND GENETIC ENDOWMENT

Some element of the schizoid structure seems apparent in many patients who present themselves for treatment. In understanding the

prevalence of these failures in attachment and the associated results, it may be well to consider the effects of particular external circumstances during the symbiotic period that may have put considerable strain on the mothering figure and thereby further diminished her ability to be contactful and accepting. For example, a mother who may have been "good enough" under ordinary circumstances may not be if she loses her husband to divorce, death, or military service. The experience of early serious childhood illness and particularly early hospitalization can also severely disrupt the attachment. The child may experience the disruption of object impermanence during this sensitive period, together with agonizing and severe pain associated with the treatment administered by the caretaker or others. Similarly, war, economic depression, or environmental catastrophe may be involved in diminishing the parents' ability to be contactful and loving in this crucial period. Obviously, there are levels of hateful or contactless environments, and environmental events can either enhance or detract from the quality of life in symbiosis.

There is also considerable individual variation in the ability of infants to sustain a human relationship. The innate ability of the child to provide the mothering person with the nonverbal signals on which she bases her responses will differ. Some infants will seek to maintain proximity to a greater extent than others or be more motorically responsive to contact. Individual differences that affect the attachment process have been noted by those who have systematically observed these child-caretaker interactions (e.g., Bowlby, 1969; Murphy & Moriarty, 1976). It seems clear now that a good deal of serious infantile autism is the result of some processes internal to the child and not primarily the function of environmental influence (Judd & Mandell, 1968). While the focus of the present work will be on environmental influences, the effects of early external circumstances and genetic endowment should be taken into consideration in each individual case.

AFFECT, BEHAVIOR, COGNITION

Affect

The psychoanalytic concept of developmental arrest assumes that cognitive and behavioral resources, as well as the form of affective

expressions, are in some very meaningful way *frozen* at the point of serious environmental frustration. Thus, in the classic case of the hated infant, there is an arrest in the attachment–bonding period, and in some cases even in the prior period, to which the infant may regress in defense. In the area of affect or feeling, the classic schizoid character can be characterized most meaningfully by underlying, often unconscious, feelings of terror and rage in response to a life-threatening environment. The terror may be expressed in a variety of symptoms, including anxiety or panic attacks in response to situations that are perceived as threatening. Such stimuli may not necessarily be consciously experienced as threatening and the individual may be totally unaware of the nature of the triggering stimuli. But, at an unconscious level at least, the stimuli release the terror response. The terror may be circumscribed in phobias; in more conscious individuals it may be perceived as generalized anxiety or tension specific to social situations or intimacy. There may be a general expression of discomfort or lack of belonging in the world and even a sense of unreality about one's connection with it all.

In those who share this schizoid condition, yet defend against it more completely, absence of any real spontaneous affect and a machine-like manner of self-expression will be characteristic. There may be a hyperrationality and a tendency to see those who are emotional as irrational, out-of-control, or crazy. There may be a concomitant "as if" quality in the expression of feelings, almost as if the person were badly acting an expected role. In some cases the person may express concern about what he or she "should feel" under certain circumstances.

In the widely acclaimed film, *Ordinary People*, Conrad enters psychotherapy under the strain of no longer being able to control powerful negative affective states in his adolescent years. In the initiation of that treatment he asks for more emotional control and in the course of it relates an incident after the funeral of his brother in which he does not know what to say or how to feel and wonders how the TV character John-Boy would feel and what he would say in that situation. Timothy Hutton's portrayal of Conrad in this film is one of the best current exemplifications of a person with this character structure. And, Mary Tyler Moore renders a good portrayal of one type of "schizoid-genic" mothering.

In sum, the hated child's most basic underlying feeling is that of

terror associated with annihilation or, on an adult level, with failure to make it in the world. All defenses are marshaled to stave off rejection and failure. The more complete the defense against this fear, the more extreme the withdrawal into machine-like behavior and total absence of any apparent feeling.

To an even greater extent than with the terror, there is usually a denial and avoidance of the emotion of anger or rage. In infancy, the destructive rage would risk the destruction of the caretaker and therefore the infant himself and could provoke the caretaker's destructive retaliation. Thus, the repression of this emotion is life-preserving. What is encountered, then, in the adult patient, is typically an avoidance or withdrawal from conflict, an inability to get angry or to face anger in others, and the propensity to express it, if at all, in passive-aggressive withdrawal. The hated child has learned to leave rather than fight back and feels that anger is useless and accomplishes nothing. Very often the hated child denies completely his own anger and idealizes and spiritualizes his own loving nature.

As these individuals become more aware of the deep levels of rage in them, they often express considerable fear of their own destructive power. The fantasy is that they may let go suddenly and destroy everyone and everything in their path. The sudden explosions that result, for example, in that quiet, withdrawn, unassuming boy shooting down innocent people at random from the top of a building suggest that this fantasy is occasionally realized. In the course of a well-engineered therapy, however, where the capacity to tolerate feeling is systematically developed, the existing defenses are made conscious, fortified, and then gradually melted, there is little danger of anything so dramatic. It is not uncommon, however, for some socially inappropriate anger to spill over in the course of treatment; in fact, it is often useful for schizoid individuals to experience loss of control, which, while regrettable, is usually nowhere near the feared fantasy. Similarly, it is useful for these people to achieve a rapprochement with those to whom they have expressed the anger and experience that loss of control of this emotion does not result in anybody's annihilation and usually not even in prolonged disaffection.

The therapeutic context is particularly valuable, I think, in providing an atmosphere in which a good deal of this rageful affect can be literally dumped with no negative environmental consequences. It is important to caution, however, that this should not be done prema-

turely, before the capacity to tolerate this affective experience and self-observe its release is developed.

Whenever there is a death in the family there is sorrow and grief. When there is a death of the self, as in the schizoid experience, there is similarly a mourning for the self that could have been and for the loving relationship that was instinctively expected but not forthcoming. As a consequence, the affect of sorrow, grief, or depression is common in individuals with this characterological makeup. It is usually the least suppressed affect, though its active expression in deep crying or sobbing may be partially or totally absent. As with the other affects, it is not fully and deeply experienced by the organism; rather, it may be experienced as a long-standing or periodic chronic depressive state, characterized more by withdrawal and whining discomfort than by deeply felt grief. In order to get on with life, the hated child also had to deny this feeling and persevere in spite of a chronic underlying depressive condition. Such depression, particularly accompanied by suicidal ideation, the termination of self-caring functions, and the self-recognized inability to feel anything else, may well be the referral complaints of those with this general history and character structure.

Just as there is very little negative affect in this structure, there is a concomitant absence of positive affect. Possible exceptions to this include a not-uncommon ungrounded euphoria triggered by some philosophical or religious idea or artificially induced by drugs. In these situations, there may be a euphoria, which is fleeting and artificial in connection with the briefly experienced realization of some of the symbiotic illusion—that is, when *the* religion, idea, mate, or drug state that answers all prayers is briefly found. The high always ends, of course, and the person always returns to the essential affective state that characterized him prior to the illusory high.

Behavior

The behavior of the unloved or insufficiently loved child will vary on several basic dimensions. He or she will be able to function in the world based on how well the underlying powerful affects are controlled or held in. While the holding in may have other detrimental effects, such as psychosomatic illness, to be discussed later, or the diminished capacity for any kind of close relationship, it does

allow the person to function. To the extent that this is unaccomplished, one is dealing with an individual who is extremely sensitive to any harshness in the environment, who has difficulty maintaining a sustained commitment to any work activity or relationship, and who will flee, often in a more or less dissociated state, from one thing to another. So, to the extent that the underlying affects are available, one may be faced with an individual who appears quite fragile and susceptible to breakdown into emotional states, confusion, and even loss of contact with reality. This tenuous reality relatedness may be expressed in fairly mild forms of being "spaced out" to more profound fugue states or periods of psychotic-like behaviors.

Where the individual's defenses allow her to be more effective in the external world, one is more apt to find an individual who withdraws into those activities that offer some worldly accomplishment while avoiding other areas of involvement. For instance, one might be a computer whiz, a renowned ballet dancer, or a workaholic attorney with a conspicuously absent, late, or damaged history of intimate relationships. In those less damaged, there may be a sustained relationship with a spouse or family but with little emotional contact or intimacy. There may even be the ability for the person to play the role of an assertive or dominant individual in a certain isolated context (e.g., in the classroom or courtroom), in striking contrast to shyness and ineptitude in other social settings.

The key to understanding the schizoid structure is the disconnection of the individual from life processes—from the body, from feelings, from intimate others, from community, and often even from inanimate objects such as food, nature, etc. Except in those areas where an individual may have attained exceptional achievement, there is a universal tendency to avoid meeting life head-on—to look away, to twist out of confrontation or closeness, to "space out" or migrate internally away from contact. The person himself may be unaware of that tendency, since it is often an automatic, unconscious response to threat. Even in areas of great accomplishment, there is almost always the existence of severe and often debilitating performance anxiety, in that the person's identity is so invested in that achievement that any hint of failure is tantamount to annihilation of the self. It is not uncommon for these tendencies to also be expressed in perfectionism and procrastination. As stated earlier, the schizoid person often discovers that the pursuit of mental processes and

achievement is a safe haven from life. Since the schizoid character cannot identify with life in the body and develop a solid sense from that biological core, he needs to find that somewhere else. The defensive attempt to earn external approval and self-acceptance through achievement, often involving mental abilities, is common in this structure. This is often the only way in which he contacts the world, expresses himself, gains acceptance or recognition, and senses who he is and where he belongs. Failure in this area of endeavor can precipitate serious depression and suicidal thinking and behavior.

In the service of denying the hatred or coldness that he experienced, the schizoid character typically offers to others what he did not receive himself. That is, his ideal self is characteristically very accepting and understanding of others—he believes in letting others be. If the hostility toward himself or others begins to emerge, it is experienced as very threatening and cannot usually be acted out unless there is dissociation or an ego-syntonic excuse for that expression.

Paradoxically, some schizoid individuals will be experienced as quite controlling in relationships, particularly close relationships. These people, often in the personality disorder range, are keeping the archaic feelings of terror and rage at bay by maintaining a close watch on any circumstance that might trigger these emotions. Thus, they may carefully evaluate each action that involves another and insist on retaining control of it. In psychotherapy or other close relationships, for example, they may be continually regulating the amount and depth of contact to maintain safety. This will typically leave the other feeling controlled. The resulting control battles can be intense because the schizoid literally feels she is fighting for her life.

Concomitant with all of this, there is often the need, usually conscious, to be special. As a way of denying the reality of being unloved, even hated, rejected, and abused, there is the compensatory ideal of specialness, which is often realized one way or another. This may be through real achievement in science or art or through the delusional achievement of the kind so well portrayed in Robert De Niro's more narcissistic character (Rupert Pupkin) in the film *King of Comedy*. When the specialness, real or delusional, is threatened, there results a tightening of the defense and eventually a breakdown in the structure.

I am reminded of one of my clients, a successful 40-year-old doctor, who remarked poignantly, "I think I have worked so hard all my life in order to forget that I don't have the right to exist." The schizoid issue is literally existence and those who have to deal with this issue will try to find something that will justify their existence. Their right to exist is always on the line, and there is extraordinary anxiety in case the justification should fail.

Cognition

Any of the adaptive or cognitive functions that are developing during attachment-bonding may be seriously weakened or retarded by trauma. The extent and duration of the trauma, the genetic strengths of the organism, the availability of alternative resources such as extended family, and the nature of the available defenses or compensations will determine the extent to which adaptive functions or structures are over- or underdeveloped. For these reasons, it is probably more instructive to be aware of the cognitive abilities that one might assess than to describe any fixed way in which they may be represented in people with this character structure.

It is possible, however, to outline a number of internal belief structures, ego ideals, and "script decisions," which are usually operative in people with this kind of history. In this latter area, there will always, for example, be the underlying sense that "there is something wrong with me." And, there will always be the belief that the world is dangerous, hard, or cold. To the extent that the person has compensated or defended against this, these ideas will be denied and there will be a cognitive structure or belief system supporting that denial. The denial may well break down under stress, however, and this breakdown may be accompanied by suicidal ideation or behavior, depression, panic attacks, paranoid thought, and other symptoms. The more frequent and florid that breakdown, the more one is dealing with a person whose defenses are fragile and whose diagnosis would most likely be in the personality disorder range. The more a person is able to intellectualize or otherwise defend against these cognitions and their associated feelings, and the more intact the other adaptive functions, the more one is dealing with a more reliably functioning person who can tolerate more stress (character neurosis or style). The underlying dynamic, however, is similar in spite of

these very important differences, and it is this core issue that must sooner or later be addressed for the person to realize her potential.

Because the issue of existence is critical in this structure, there will likely be some expression of this in a person's day-to-day life. For instance, the issue of security may be particularly important or obviously denied. Having enough money, holding on to one's job—in short, "making it" in life—may be a persistent concern. Alternatively, in an attempt to escape the anxiety associated with survival, the person may simply look the other way regarding these adult responsibilities and be defensively oblivious to security issues. There will be the polar opposite defensive idea or belief that "I am special." Similarly, there will often be the associated belief of a philosophical or religious nature asserting that the universe is benevolent, a unity, and supremely meaningful. In both cases, these beliefs will not be particularly well integrated or digested within the person. The specialness may be grandiose, at least at times, and the philosophical or religious beliefs may be such a part of the self-concept that contrary beliefs are experienced as threatening. Because these ideas maintain the denial of the original position, they may be held very tenaciously.

Whatever the quality of the schizoid cognitive functioning, one common characteristic is the dissociation of thinking and feeling. It is with these people that one can most readily realize the limitations of pure intellectual, affectless insight. It is perhaps this ability to dissociate, however, which is responsible for the fact that many with this kind of problem have been able to develop cognitive abilities to a highly sophisticated level, though often within a narrow range. It is as if the dissociation of feeling and thinking protects these intellectual functions from contamination. It is as if the intellectual functions are walled off from upsetting affects and thoughts and therefore protected. Like so many other defensive and compensatory moves, this one has its cost, but it also has obvious survival value for the organism, not only in childhood but throughout life.

In terms of an object relations view of the developmental arrest in early attachment-bonding, it is useful to note that a salient feature is the merged experience with the caretaker. There is the ability to imitate and the ability to engage in the primitive defensive functions of denial, introjection, and projection. There also is the ability to retreat to the more withdrawn state of the first few weeks of life. The development here is from (1) a relatively withdrawn state to (2) a state of merged experience or symbiosis to (3) a phase in which the self is consciously differentiated from others. While there will later develop other ways to defend against the schizoid's reality, in the early period all that appears to be available is direct denial of that reality and withdrawal as well as the mechanisms of projection and introjection. In other words, all the individual can do is to primitively block out the reality of his existence, while introjecting the bad object and then projecting aspects of it outward.

As the ultimate result of all the schizoid trauma and these early developmental limitations, the individual will freeze in his body in order to control the powerful negative feelings. He can then move on to develop, in relative isolation, the cognitive adaptive functions that will begin to emerge as a function of his natural growth. Because of the disruptions in this early period, there may be a continuing failure of the powers of discrimination, particularly in social contexts, and, at the deepest level, problems with differentiating between his own thoughts and feelings and those of others.

As opposed to those characterological problems to be discussed in later chapters, the hated child is really faced with a choice between involvement and withdrawal. Developmentally, he is not up to more sophisticated adjustments. Involvement hurts so withdrawal is chosen. The naturally desired attachment is foregone in the interest of survival. In reviewing the research of Harlow et al. (e.g., Harlow & Harlow, 1966), we may remember that while the monkeys raised by artificial mothers were generally not very happy, social, or well adjusted, they did, by and large, survive.

In every schizoid personality I have treated it has eventually been necessary to face the destructive, demonic force. This is typically experienced as completely alien and often completely beyond the control of the individual. Structurally, I believe it is useful to understand this as an unassimilated introject of the mothering figure, as well as the natural response of rage at this rejecting or cold figure. If this destructive force is experienced prematurely, before sufficient grounding, understanding, and the building of security in therapy, it can lead to a disintegration or decompensation. Where self-other discrimination is weak, as in the personality disorder, this disintegration can result in paranoid pathology. These signs of disintegration are most obvious not in the chronically mentally ill but in those persons who disintegrate in response to mind-altering drugs, encoun-

ter marathons, or psychotherapeutic techniques, which prematurely overwhelm the defenses.

Summary

The schizoid experience basically involves a failure in the attachment process at or near the beginning of this process. This failure occurs when the cognitive and structural resources of the organism are minimal. As a consequence, the defense mechanisms which the individual must use to deal with this fundamental assault are primitive—primarily denial, introjection, and projection. These mechanisms will be called upon again and again to deal with the persistent issue of existence and survival, as well as with any subsequent situation that in any way triggers these more basic issues. So, while the autonomous functions and other cognitive and ego abilities may very well develop, often to an extraordinary degree, there exists this basic structural vulnerability in the organism. In short, it is critical not to underestimate the degree of damage and consequent vulnerability in this character structure.

In spite of apparent strength, individuals with an essentially schizoid character structure must, at core, deal with the issue of survival and the terror and rage around the threat to existence. It is important that they not be overwhelmed by powerful therapeutic technique. It is essential to develop their tolerance for aliveness in the body, to solidify their trust in the therapeutic relationship, and to build a well-grounded ego strength before they are asked to face this ultimate issue that will emerge when they melt their defenses and touch the feelings that exist within them.

ENERGETIC EXPRESSION

Those who emphasize the physical dynamics of character structure simply assert that the organism will respond to environmental frustration not only with a change of attitude and behavior but also with responses in the voluntary and even involuntary musculature. When the young organism comes up against continual and seemingly immovable negativity and frustration, it will, in an attempt to survive, begin to inhibit or contract against the impulses that seem to produce that negativity. This inhibition is represented in the organism by contraction of those muscles that inhibit the impulses. The contractions become chronic and as a result can produce rather dramatic changes in posture and even in the functioning of bodily organs.

The muscular inhibition of impulse is a concrete and visible manifestation of the parental or environmental prohibition. It is the physical manifestation of the process of introjection. This assumption of the prohibition or negativity initiates the loss of spontaneous movement, feeling, and behavior. It is chosen only because it is preferable to the pain involved in continuing the natural, spontaneous reactions to the chronic frustration. The decision to inhibit is experienced as a choice of survival over expression. The dependent infant cannot exist in a chronic state of war with the environment and the internal states of chronic rage, terror, and despair, which accompany the rejection of spontaneity. So, the organism turns against itself, restricts its impulses, and internalizes that battle between its innate needs and the prohibitions of the environment.

If we accept the proposition that adaptive self functions promote the survival of the organism in negotiating the demands of the environment and the organism itself, we can appreciate how the self becomes identified with the inhibiting process as a survival mechanism. The inhibiting pattern becomes a survival pattern, which in turn becomes a part of the individual's ideal self. The ideal self is, from that point on, threatened by an alive, spontaneous self-expression and maintained by control of those impulses. Thus, cognitive self-statements in the form of "script decisions" (e.g., "I am an understanding, giving, peaceful person," etc.) reinforce the muscular blocks.

There is the corresponding illusion that the release of the blocks will yield catastrophe, often both personal and environmental. In the case of schizoid character, the illusion of release is annihilation—often not only the annihilation of oneself but also the annihilation of others as the uncontrollable rage is let go on the environment. The essential schizoid experience is, "My life threatens my life." So, what is ultimately blocked is the life force itself. The organism freezes, stiffens, or clenches in tension, and twists away from the threatening environment. All of the bodily consequences that the body oriented therapists have noted in this character structure are a result of this process.

In listing the body characteristics of the schizoid, it must be kept in mind that they represent the observations of a number of somatically oriented therapists who have treated a variety of clients with, presumably, various mixtures of schizoid and other characteristics. The listing is more of what one may look for rather than an exhaustive or exclusive list of what will always be present. Furthermore, where these chronic muscular contractions have characteristic postural consequences, it must also be remembered that characteristics of posture, as well as other physical dimensions, can also be the result of genetic endowment. A well-trained body oriented therapist does not typically look at the body to classify the pathology; rather, he looks to see where and how the natural flow of the organism has been restricted by chronic contraction.

Perhaps the most salient thing to look for in a schizoid personality is the virtual cutting off of life in the body. Movements tend to be restricted, often mechanical, and lacking in natural spontaneity and flow. Cutting off the life flow is particularly accomplished through restricting the breathing and in this personality structure that is often done by a constriction of the diaphragm and shallow breathing in the chest. This may be accompanied by raised shoulders and a concomitant contraction of the chest. This breathing constriction obviously can affect the voice and accompanying constriction in the throat may yield a high-pitched and often young-sounding voice, due to the narrowing in the throat. Correlated with this, one often finds that the choke response is easily elicited if the person is asked to breathe deeply. It is thought that the schizoid's split in thinking and feeling is literally represented in this chronic tension in the neck—the area separating the head and the trunk. It is as if the natural instinctual impulses are blocked off there and not allowed to register in the head.

Together with this characteristic contraction in the upper chest and neck, there is typically severe tension at the base of the skull corresponding to the characteristic block in the ocular segment of the head. This ocular block may also be observed in the appearance of the eyes, which may, especially under circumstances of stress, appear disconnected or unresponsive. It has been hypothesized that this ocular block results from the attempt on the part of the organism not to see the painful truth of his state of existence. Under stress, the schizoid individual may literally go away from the current circumstances and that escape may be perceived in the eyes, which appear to be looking but not seeing, disconnected from the present reality. Occasionally, the experience of frozen terror may also be seen in the eyes of the schizoid individual, a terror that is not consistent with the rest of the facial expression and that does not systematically vary with the situation but is fixed or frozen.

The early twisting away from the threatening environment may be chronically represented in a twisting of the body, which may be represented literally in a chronic spinal scoliosis. Again, there are many causes of spinal scoliosis but the schizoid experience is hypothesized to be one of them, a function of a chronically frozen twisting-away. The freezing or stiffening of the body is believed to typically result in difficulty in the joints. To understand this, one can imagine the chronic tension that would result in the joints from a response of chronic stiffening of the body. To illustrate this, I often ask my students to assume a posture of complete stiffening, locking the knees, elbows, and lower back while opening the eyes and mouth wide in an expression of terror. I then ask them to imagine themselves going through life in that position, bracing against the threat of life.

Many somatic therapists have also noted a number of characteristics in schizoid patients that could be summarized under the heading of "disproportional body." That is, the body does not present itself as a unitary whole, as certain parts do not fit with the whole. For example, the head may not seem to fit the body or the arms may not be proportional to the trunk. Bilateral asymmetry has also been noted, such that the left side of the body is larger or smaller than the right.

Finally, a general deadness of the schizoid body has often been observed and reflected in the lack of color in the body, particularly a lack of color or even coldness to the touch at the points of chronic constriction—the joints, diaphragm, and points where the body narrows (i.e., ankles, wrists, and neck). The lack of aliveness in the body is also often seen in a thin, narrow physique with limited bodily movement. Personally, I have seen a number of schizoid personalities where the body is more developed than in this classic type, though some of the energetic blocks are still present.

While I have sometimes found my students to scoff and dismiss the bodily implications of characterological theory, I have continued

to find the insights delivered by body observation extremely useful. Where the underlying characterological problems are well hidden and well defended, the individual may often be unable to report the reality of his etiological history. In this not uncommon situation, it will be the individual's characteristic behavior and the language of the body that will more reliably indicate the basic issues with which he is dealing. This is particularly true in the schizoid situation, wherein denial is the primary mechanism of defense and where the historical events may have occurred so early and been so traumatic that their remembrance is both less possible and more debilitating.

As is probably obvious, the combination of extreme bodily distortions and lack of physical and emotional awareness makes the schizoid a natural for the development of psychosomatic illness. The chronic tension in the upper body, neck, and ocular segment translates readily to the susceptibility to headache and difficulty with the eyes. The constriction in respiration results in a susceptibility to respiratory illness, just as the chronic tension in the joints produces a susceptibility to illness and injury there. The chronic but usually repressed anxiety and resulting twisting and holding in the body can render the normal organic processes, particularly digestion, susceptible to difficulty. Further, the generalized diminution of life's energetic properties can render the organisms generally susceptible to infection and injury. Indeed, it has been my experience that the better defended the character, the more likely the presence of illness.

THERAPEUTIC OBJECTIVES

In every case, the therapeutic objectives are to repair the deficiencies in structural functioning, to restore the flow of instinctual self-expression, and to integrate these behavioral and cognitive abilities into a life-supporting system, which is able to adapt to or modify the external environment. I see psychotherapy as beginning a process, which can last a lifetime. As life is a race between maturity and senility, effective psychotherapy is designed to aid the former and retard the latter.

The provision of a trusting and safe environment is, or course, necessary in all psychotherapy, but in the treatment of the schizoid patient its importance is enhanced. Essentially, the schizoid person was scared out of his body and cannot be frightened or confronted back into it. It is essential, therefore, that the therapeutic setting be safe, congruent, and human. Because of the history, the sensitivity, and extraordinary perceptiveness of the typical schizoid client, it is even more crucial that the therapist realize Carl Rogers' three prerequisites for an enhancing therapeutic relationship—accurate empathy, unconditional positive regard, and congruence. In short, the first objective with this patient is to restore trust—trust in the self, trust in the significant other, trust in the community at large, and trust in the life process itself. Once this therapeutic environment is achieved, the other objectives are possible.

Affective Objectives

Perhaps most basic to the schizoid problem is the need to reconnect the person with himself. Without this there can be no essential change in his relationship with the world. This may be begun by helping him regain a greater feeling sense of himself. An increase in the depth, range, and realness of one's feeling is an objective that can be accomplished by many therapeutic techniques, including movement, internal focusing, and physical expression. Along with this increased feeling and an enhanced identification with that feeling, we also wish to increase the individual's physical relationship to objects in the world. That is, the schizoid person needs an increased felt relatedness to reality—to food, work, nature, home, etc. Next, that reality relatedness needs to be expanded to the human world—to the therapist, loved ones, coworkers, and friends.

As a central part of increasing the client's sensory contact with the environment, it is particularly crucial to build the sense of stability or *grounding* in the world. This refers to the felt sense that one's feet are planted firmly on the ground and that one can stand one's ground in circumstances where it may be threatened. As a part and consequence of this work in increasing sensory awareness, the therapist must work in many ways to reduce all forms of chronic tension or spasticity in the affected areas of the body. Initially, this increased awareness and emerging letting go may be associated with physical pain, but eventually it will reduce experienced pain and affect any psychosomatic illness that has not already produced lasting physical damage.

As with all clients, it will be useful to increase the schizoid's aware-

ness of and identification with his own defenses. It is always useful for one to be aware of how one has and does defend himself, to respect the survival qualities of these defenses, and to understand how they were appropriate choices under the circumstances of one's development. In the schizoid case, for example, it will be useful to help the person identify his tendency to "go away," to ask him to do that deliberately, and to assist him in monitoring its effects.

As one works on the emotional level with the schizoid individual, one will confront deep-seated and profound hostility and terror. As the person begins to trust his body and feelings, more and more of these feelings will emerge to be owned, expressed, and eventually integrated into the self. Although getting to the terror is essential, it is in the retaliatory rage that the individual often experiences the surest road to finding his true self. When he experiences the power and realness of that rage, he begins to have the power base for self-expression. There is at last, in that rage, a self to experience and express. The alternating of experience and insight around that emotion, as well as around the terror, will initiate the emergence of self. In the expression of the rage particularly, the schizoid person restates his right to live and to be in this world.

As with the rage, the schizoid's ability to experience the terror and to tolerate it is an empowering experience. He can discover that the terror, like the rage, is within him, that it can be expressed, and that he will not disintegrate with its expression. Additionally, he can have someone to assist him and be in contact with during and after the emotional experience. The increase in feeling through the body and contact with the ground, the environment, and others allows him to experience the intensity of these feelings without needing to "go away."

A central objective throughout this process is to increase the schizoid's tolerance for feeling and expression. He can learn that neither rage nor terror results in annihilation or disintegration. He can be asked to reach out and maintain contact with the therapist, thereby reinforcing the notion that he can be expressive, identified with his negativity, and still not lose himself or the support of others.

In simple affirmation terms, we seek for the schizoid individual to experience the following on a physical, feeling level: "I am welcome here. I belong here. I can trust life. I can trust my own feelings. I am a member of the community. I am capable of love and lovable. I can

and will take care of and love myself. I can enjoy the movement in my body. I can run, jump, yell, express myself. I am safe. I am loved. I can relax."

Behavioral-Social Objectives

Since, in the schizoid problem, the main failure is in attachment, it will be the therapist's objective to establish that attachment. In some cases, the therapist may be the client's only meaningful human contact and it may be necessary to establish and then resolve a symbiotic attachment. In other cases, where there are relationship or attachment difficulties, the therapist will also work to assist in the development of those attachments and commitments. In general, growth in the schizoid character will involve an increase in commitments to love, friendship, and work relationships. Establishing or increasing involvement in some nonthreatening small group experience can often be very useful. In short, the individual needs to learn that he is a member of the group and equal to all other members, that he can take what he needs and give what he is able. Assistance in discovering that perfection or special performance is not required for acceptability will often be needed. Decreasing the perfectionism and need for specialness will usually result in decreasing procrastination and/or performance anxiety if these are problems.

To facilitate and expedite increased social involvement, it may be necessary to give feedback on, teach, or arrange for the teaching of simple social skills. The behavioral programs in personal effectiveness or assertiveness training may be useful in this regard, since these individuals may need to learn both verbal and nonverbal social skills.

While the aggressive impulses are almost always denied in individuals with this basic character structure, the aggression or hostility always finds an outlet in one form or another. Thus, it is an objective to help the individual discover the ways in which she unwittingly aggresses against others. Commonly, individuals with this character structure engage in passive-aggressive patterns such as withdrawal, or they provoke aggression in others to justify retaliation or provoke rescuing from others. The essential objective here is to discover the "games" that these people play, which in a very general way tend to operate by the presentation of the schizoid individual as understanding, accepting, and even weak, but which culminate in withdrawal,

rejection, hatred, and the humiliation of others. The typical characterological pattern is expressed here with the individual offering what was not forthcoming to her but ultimately delivering to others what was earlier received. In other words, we offer what we didn't get and we ultimately give what we got.

As the aggressive impulses are integrated, the individual will begin to behave more aggressively and assertively in the social world. The therapist will serve to smooth out this transition so that aggressive and assertive expressions in the real world are relatively appropriate and effective. The direct expression of aggression and assertiveness in appropriate ways and contexts will be encouraged in therapy. Similarly, therapists can encourage and facilitate the smooth and appropriate expression of other affective experiences in the real social world—sadness, anxiety, laughter, joy, etc.

Cognitive Objectives

There are two basic areas of repair that need to be considered in addressing the cognitive problems. The first involves the client's attitudes, beliefs, and processes of self-identification. These structures are represented by the "script decisions," "ego ideals," "false self" identifications, etc. Here we are talking about beliefs, attitudes, points of view, etc. The second area involves cognitive abilities or, in psychoanalytic terms, structural functioning. Here we are discussing the individual's cognitive strategies in dealing with the external world, the defense mechanisms used internally, and the quality and robustness of cognitive abilities (e.g., assimilation and accommodation). In the first case, the therapeutic objectives center around the restructuring of internal beliefs, while in the second case they involve the literal repair of structure or cognitive abilities per se.

Just as it is useful to help the client identify how his compromise solutions have expressed themselves in his body and behavior, it is useful to do this in the area of cognition or belief. The first step, therefore, may be to help the individual to identify the usually simplistic and exaggerated precepts of the ego ideal. In this process, the individual may find that she is demanding absolutely, "I must be all-accepting. I must be special." Or believing dogmatically, "I am my ideas. I am my achievements." Once these notions are identified and experienced with their real intensity, it becomes relatively easy

to explain their origins and assist the client through interpretation to develop further insight into their operation. Identification and understanding will initiate change in the ego ideals and false self identifications and more direct methods can then be employed to further those changes.

As the defenses at all levels are systematically relaxed, the therapeutic objective of uncovering the various "script decisions" about self, life, and others in general will be facilitated. In this character structure, these tend to be of the following nature: "Something is wrong with me. The world is a threatening place. I have no right to exist." In general, the "script decisions" in this structure will reflect self-hate and paranoia.

With the identification of the ego ideals and script decisions, the very basis for the false self will begin to erode and there will begin to be greater opportunities to strengthen a real self-identification. The therapist can begin this with strategies that strengthen the identification of the self with the body and its life processes. In this structure, that would amount to replacing the identification, "I am my ideas and accomplishments" with "I am my body and the life therein."

In the second area of cognitive or ego functioning, the therapeutic task, simply stated, is to assess and repair the areas of cognitive weakness. In relation to the perception of external reality, for example, the client may need direct instruction in the processes of assimilation, accommodation, discrimination, integration, and generalization. The therapist may serve not only the role of reality tester but also that of instructor in the strategies for accurately perceiving and testing reality. Just as the schizoid individual may need to be directly taught simple social skills, he may also need to be taught strategies for simple social perception. How does one know when one is liked, disliked, or responded to with objective neutrality? How does one know whether the negative behaviors of others is the result of their internal preoccupation or their specific response to us personally? Similarly, the schizoid individual may be helped to sharpen his cognitive strategies for discriminating internal affective states. How, for example, does one discriminate anxiety from excitement or sexual arousal from love? All of this becomes increasingly necessary as the person's structure is in the personality disorder range and is typically unnecessary at the higher end of the continuum.

The schizoid individual will usually also need to be taught better

or more evolved defense mechanisms than the ones she already has. The schizoid defenses are primitive and few in number and most of these individuals are capable of learning far more efficient and less costly internal defense mechanisms. Particularly where used consciously and deliberately, such methods of internal defense are extraordinarily useful. A number of strategies are available from the cognitive wing of psychotherapy (e.g., rational emotive therapy, neurolinguistic programming) to teach such defenses. A part of this teaching, of course, would be the identification and strengthening of existing defenses, increasing appreciation of their survival function and rendering them conscious and under voluntary control.

The schizoid individual can benefit greatly from direct instruction in dealing with the harsh and anxiety-provoking parts of the real world. Much of this will involve behavioral instruction; however, on a cognitive level the therapist can assist with cognitive maps concerning how to approach and think about the demands of adult reality. Thus, the therapy may at times deal with strategies for managing one's time, dealing with the demands of others, or simple strategies for living life: how to clean the house, pay the bills, study for exams, etc.

Finally, a great deal needs to be done in the schizoid case on the integration of the "good parent-bad parent" and "good self-bad self" representations into a healthy, ambivalently experienced self-concept and view of others. The "good parent" is usually deficient in its representation in this structure and is particularly deficient in the nurturing functions. As a result, the schizoid individual is usually poor at self-soothing or self-nurturing. She may be directly taught to strengthen those self-soothing abilities that she does possess and to learn anew those that she does not.

In the course of the treatment, a central theme must be the identification of the unintegrated introject—the "bad parent." It is often so split off from the rest of the self that the person feels literally possessed by an alien and destructive force, which is aimed primarily at himself. The therapist's task is to assist the individual in identifying and taking responsibility for this negative force, in understanding its origins, and in beginning the process of integrating it into the ambivalently experienced self and other representations. In any person so hated, there will be hatred. To erode the denial of that hatred, to admit its existence, to aim it at its appropriate target, to accept it

as part of one's reality, and to release its expression in a manner that will reduce tension without undue harm is perhaps the central therapeutic task with the schizoid character. As this is accomplished, an integrated representation of the self with all its real components will be established at a cognitive level. Such a representation may be facilitated by intervention directly at the cognitive level.

An appreciation of the need for strengthening the cognitive abilities yields a solid theoretical justification for methods of direct instruction or influence. The theory presented here does so, however, without the extreme oversimplification in theory characteristic of those who espouse an exclusively cognitive understanding of the complex human condition. With this knowledge, one can engage in very simple and direct cognitive restructuring with an understanding of how that fits into a broader perspective of what the human dilemma is all about. One can help another to think differently without having to believe that thought is all there is. For a listing of all therapeutic objectives for each character structure, see Appendix B.

It may be useful at this point to remember that there is no such thing as a schizoid character. This is merely an archetype in a model, which identifies basic human issues. Those who have been terrified early in life by the harshness or coldness of the environment they found then will usually still be operating with the adaptations to that reality formed by a weak and frightened child. Understanding this element of any person seeking psychological assistance can guide the therapist in a useful way. Imperfect and incomplete, this map of the invisible territory is worth having. For those wishing further guidelines on the treatment of the schizoid personality, I would particularly recommend the following: Guntrip, 1968; Johnson, 1985, and Manfield, 1992.