Schizoid Phenomena and Relational Needs

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Abstract

This article describes schizoid phenomena and how the concept of relational needs is used in integrative psychotherapy. Drawing from client work, the author explores some of the unique qualities involved in offering a contact-oriented, relational form of therapy with an individual who uses the schizoid process of a *social façade* to protect the vital and vulnerable self. Relational needs are discussed in terms of transference, countertransference, and schizoid phenomena.

Keywords

Schizoid, schizoid process, social façade, relational needs, schizoid phenomena, transference, countertransference, relational psychotherapy, integrative psychotherapy

Was Fairbairn (1952) being provocative when he wrote that “according to my way of thinking, everybody without exception must be regarded as a schizoid”? (p. 7). There appears to be a sense of mischief in his words, but it remains a wonderful starting point for a discussion on the schizoid process: the idea that on some level we all share the psychological ability to split off experiences, compartmentalize the self, and use withdrawal into inner reality as a means of organizing our relating and how we regulate being in contact with others. It also serves as a beginning to a discussion about how, as therapists, we might use our own experiences of schizoid phenomena to help our work with clients who rely on relational withdrawal to stabilize and regulate their affect. It may help us to remain present and in contact with such individuals, appreciating the creative, adaptive ways a schizoid person will regulate and control relational contact.

When we are with a schizoid individual and there seems to be little emotional contact, as therapists we need to find ways to maintain contact within ourselves, that is, to remain solid and present and at the same time to facilitate the client's reestablishing contact with their affect and physical sensations. When someone is "talking at me, rather than to me" (Erskine, 2020, p. 15), therapy becomes a performance, an acted-out interaction rather than an experience of authentic contact. Exploring how relational needs (Erskine et al., 1999) are experienced moment to moment, and how they are expressed by the client, offers structure to the therapeutic work.

We cannot know what is happening in the inner world of a client. We are always reaching for understanding: assimilating, noticing, and developing ideas and clues to a person's internal experience. Our experience of this reaching for (or waiting for) can often hold crucial information about how to be in contact with certain clients. We have to indwell, to put ourselves into the internal experience of the client who uses a schizoid process. In fact, I find it necessary to go searching for the person in their schizoid withdrawal. I search for a connection with the fragmented, split off, or hidden parts of my client. When I sense that I do not know what my client may need from me, when I feel there is something lacking in our interpersonal contact, or when I do not know what we are doing, it is essential that I attend to these internal experiences and use them as guides. In attending to my countertransference, I am building a collection of impressionistic images, developmental and relational pictures, and a sense of what relational experiences were missing in my client's early life.

In this article, when discussing the schizoid process or a client who engages in schizoid phenomena, I am not referring to a person diagnosed with schizoid personality disorder. Johnson (1994) viewed character structure as existing on a continuum. At one end is the personality disorder and at the other is a higher level of functioning that he called a "character style" (p. 11). An individual with a schizoid personality is at the disorder end, and someone with an avoidant personality is at the style end (Little, 1999, p. 3). In defining an integrative psychotherapy perspective, Erskine (2011, p. 3) used a three-part continuum—schizoid style, schizoid pattern, and schizoid disorder—to distinguish the frequency, duration, and severity of the client's internal splitting and their use of archaic self-protective procedures.

Using the idea of a continuum, I experienced the client discussed here as having a unique way of relating that I describe as a schizoid pattern. We often speak of working with schizoid phenomena or with a schizoid process, but I think it is also helpful to talk about the psychotherapy we do as working within the schizoid

process. This involves being prepared to work within the therapeutic transference (Little, 2011) alongside the theoretical belief that “the sense of self and self-esteem emerge out of contact-in-relationship” (Erskine &Trautmann, 1996/1997, p. 317).

In making the concept of relational needs a cornerstone of the psychotherapy, I can remain within the client’s unique process:

> Relational-needs are the component parts of a universal human desire for intimate relationship and secure attachment. They include 1) the need for security, 2) validation, affirmation, and significance within a relationship, 3) acceptance by a stable, dependable, and protective other person, 4) the confirmation of personal experience, 5) self-definition, 6) having an impact on the other person, 7) having the other initiate, and 8) expressing love. (Erskine, 2011, para 17)

Working closely with relational needs provides a way to understand and track the client’s attachment style, relationship history of needs met and not met, and patterns of accommodation and coping while also providing a here-and-now guide to the client’s current needs in the therapeutic relationship. I am attentive to these various expressions of transference, including various ways of relating to me, expressed and unexpressed emotions, and the qualities of our intersubjective dialogue. Each of these provides me with a unique lens to view what is happening within the person. As Erskine (2001) described, “Transference is the active means whereby the client can communicate his or her past. This includes the neglects, traumas, and needs that were thwarted in the process of growing up, as well as the defenses that were created to compensate for the lack of need fulfillment” (p. 4).

In working with clients who exhibit a schizoid style or pattern, I find it crucial to find ways to anchor myself in the relating so I can remain fully present. Working closely with relational needs, I can better understand my clients’ histories, the story being enacted in their transference, my own countertransference, and what they require from me in order to have a healing relationship. The concept of relational needs creates an anchoring in the relating and a structure to my understanding of which needs are emerging in the foreground of the relating and which are in the background, either disavowed or waiting to emerge.

Many clients who have either a schizoid style or schizoid pattern will enter therapy with little or no appreciation of their current or historical relational needs.

A psychotherapy that is relationally focused involves creating an interpersonal environment in which the person's relational needs can freely emerge, be felt and known, and be responded to in active, contactful relating.

Case Study: Helen

I will use a case study of psychotherapy with "Helen" to illustrate the concept of relational needs. I will show how different relational needs moved in and out of the foreground of our relating, including which needs were out of the client's awareness, yet to emerge. I will highlight the quality and nature of how relational needs were expressed or not expressed and describe how I used my countertransference to discover and attune to the relational needs of this withdrawn, hard to reach client. It is possible to see a cluster of relational needs unique to clients who have either a schizoid style or pattern, and this awareness can guide our work. Relational needs are often out of the client's awareness and may be disavowed, inverted, or blended together. In my experience, working with relational needs within the schizoid process facilitates the emergence of the true self (Winnicott, 1965), that is, an intrinsic sense of self that is "vital and vulnerable" (Erskine, 2020, p. 18).

Helen entered therapy with no awareness of her relational needs and appeared unconscious of having any needs at all in relation to others. Therapy involved her gradually seeing herself as having unique relational needs, understanding how these were neglected by significant others, and discovering how she created ways of coping. Her primary way of coping and adapting involved being a hard-working student and disavowing her feelings and needs. This continued into higher education, where she achieved several degrees in mathematics and science.

In Helen's early childhood, her mother focused her attention on Helen's two brothers. Significant memories for Helen included her father dying when she was 17 and her leaving home for university. She took pride in being the "trailblazer" of the family and described how she went it alone as a "self-sufficient unit." When her mother moved the family to a new house, Helen no longer had a bedroom and so seldom returned home. She said, "I'm like a bad penny" to describe how she always seemed unwanted.

In our psychotherapy sessions, Helen behaved as a "good client," always arriving on time and rarely missing a session. She was the same way at work, a good

employee who worked hard and waited for praise. As a result, she performed at a consistently high level in her work but was always exhausted and lonely. Her husband worked in the same company, and they had two children. Helen described herself as having a "breakdown" in which she felt emotionally and physically incapacitated. Her doctor diagnosed a major depression. I understood her breakdown to mean that Helen's sense of self, her internal structure, became so emotionally overwhelmed that it no longer provided the psychological functions of stabilization and regulation.

As I pieced together a picture of Helen's script system (Erskine, 2015a, 2015b), it became clear how her early experiences, her relationships with others, and her ways of coping matched the isolated attachment style (Erskine, 2011) people like her use to organize their relating with others. Her core script beliefs had shaped her career and approach to life. These included: "I am alone in the world," "Other people are scary," and "I must work hard for others." These and other behavioral patterns reinforced the necessity of finding ways to fit into the world.

Eventually, Helen's script system exerted such overwhelming pressure on her work persona that she was unable to interact and perform in the workplace. Under the pressure of her script beliefs, she could no longer integrate her affect, physiology, and cognition. The result was a breakdown in her sense of self—the capacity to integrate physiological sensations, various affects, and thought processes—and a retreat to a less demanding internal world. Deciding to come to therapy was difficult for Helen because it was an admission to herself that she could not cope and needed the support of a psychotherapist to reestablish a secure sense of self and to be able to work again. Her initial struggle in therapy was about the polarity between her childhood patterns of self-reliance and self-containment and the therapeutic opportunity to be vulnerable and receive support from someone else.

Prior to her breakdown, Helen's role at work had changed. Previously her tasks had been solitary, and the isolation from other people had become her "comfort zone." However, she had been made a project manager, which required her to interact with numerous workers as well as to rely on others. Helen described herself in this breakdown as if she were in a "mixing bowl with no ingredients, with an emptiness and loss of purpose." She told me she felt like a "jigsaw puzzle broken up and swept off the table" and described how her depressive phase felt as if the world had been turned on its head. Her usual ability to rationalize and order things had been taken away, and she felt stripped of her normal self. Helen experienced a great deal of shame in going through the breakdown and being off

work. She talked about losing her role and purpose and being embarrassed about what others would think of her on her return.

In the beginning of our work together, I frequently asked Helen what she needed from her session that day in an attempt to give her a sense of choice and bring us into contact with what she needed. Over time, I discovered that my questions were misattuned to her patterns of being in relationship. The inquiry was too confusing and opaque for her; she was not in a place to communicate her needs or even to access what her needs were in the moment. I began to see her confusion as an important communication in itself. The "I don't know" to the question of "What do you need?" was an expression of her unmet relational needs, needs that were unknown to her. I wondered if her "I don't know" meant "I don't know who I am." In those early days, Helen was unable to define herself, particularly in relation to the "authority" of a psychotherapist. Instead, our work centered on Helen finding her own needs in relation to me rather than my explicitly inquiring about them. However, both Helen and I became increasingly aware of her relational needs as they emerged both in our person-to-person relating and through the transference.

Security

In the beginning, I did not yet know of Helen's rich, creative fantasies and ideas. I was preoccupied with the rigidness of how she presented herself, her routinized behaviors, and how she related to me. The more I tried to make contact, the more she pushed me away. I began to appreciate Helen's overwhelming need for safety in the therapy. This was not initially obvious because of the way she presented herself: She was not nervously quiet or shut down nor did she show a clear need for protection. As Moursund and Erskine (2003/2004) described, "The need for relational security is most likely to be foreground at the outset of treatment" (p. 109). Helen strove to uphold a narrowed perspective on her life that discounted and avoided other aspects of who she was, particularly her relationships with others. Her life had involved carefully structured, controlled relations with people; she remarked that she was experienced by others as a loner, superior at times, not easy to interact with.

My experience of her relational need for safety in the therapy emerged in my countertransference. I felt controlled; the space, interactions, and rhythm of our work felt stifling. Early on I felt fixed, positioned, and unable to feel involved. I experienced Helen as needing to direct the dialogue. She ignored my questions

and changed the subject so that our conversation remained superficial. She kept me at a distance, avoided interpersonal contact, and declined my invitations to explore her affect. She needed to feel safe: safe in herself, safe in relating with me, and safe in the parameters of what our psychotherapy was for her. Helen's relational need for security in relationship was masked by her various attempts to control the process of the therapy sessions. She was often highly descriptive in her language, using words or intellectualization to fill the space. It was as though she were saying: "If we stay over here talking about this stuff, we won't get near to the vulnerable me inside."

It eventually became apparent that Helen was withdrawing from interpersonal contact in the midst of our sessions. I suspected that she used this form of withdrawal in all her relationships. She appeared to have developed a carefully constructed social self, a part of her that was able to interact with others but in a rigid and narrowly prescribed way. She had a well-rehearsed social façade. Guntrip (as cited in Hazell, 1994) described this social self: "This fundamental detachment is often masked and hidden under a façade of compulsive sociability, incessant talking and hectic activity. One gets the feeling that such people are acting a somewhat exhausting part" (p. 168).

The beginning phase of therapy with Helen could be seen almost entirely as a demonstration of the importance of the relational need for security in relationship. She observed me from the safety of emotional withdrawal and revealed little of her inner experience. I was unsettled and distracted by her repetitive, prepared, and superficial stories, which kept us in "safe" areas of discussion. I was perplexed: "Where am I going with this?"; "How come I can't seem to feel a relational connection with this person?"; and "How come I am left confused and cold, out of touch?"

As with many clients, Helen's relational need for safety in relationship was crucial for any psychotherapeutic work to take place. However, this need is often not conscious because the person, like Helen, may have prematurely, and without awareness, assumed the function of stabilizing and regulating themselves: a pseudo sense of security. Reliance on a social façade as a protective way of relating and maintaining control with others can mask the underlying need for a profound physical and emotional sense of security. O'Reilly-Knapp (2012) compassionately depicted this attempt at pseudosecurity, describing how "a social façade masks the pain and loneliness of an isolated existence" (p. 3).

Many individuals who rely on schizoid processes had early childhood caretakers who repeatedly overlooked and neglected the person's physical and relational needs while also being invasive and/or controlling. Such neglect or

invasion/controlling resulted in the person accumulating physical and affective memories that are often disavowed and unconscious. This can result in them placing their personal needs secondary to the needs or even demands of their caregivers. They learned to hide what they needed—to split off from their own awareness—and to attend instead to the needs of their caretaker. This relational pattern is often reenacted in the therapeutic relationship, which is what Helen was doing by reenacting with me an early childhood pattern she had learned in order to cope with emotional neglect.

The schizoid individual may be extremely attuned to the therapist's needs, often appearing to be kind, thoughtful, compliant, and/or passive. As clinicians, we need to keep in mind the early experiences of the accommodating child, the adapted self that is skilled at meeting the needs of others and disavowing, splitting off, and/or detaching from their own. Stewart (2010) highlighted this: "If a therapist brings his/her archaic needs for security into session, then there's a likelihood he/she will communicate in covert ways messages such as 'I need to be taken care of' or 'I am overwhelmed by your needs' " (p. 43). The client's accommodating to the therapist is a form of withdrawal: "I sense you need caring for so I will go away" or "I sense you can see my vulnerability and I am scared."

The behaviors that emerge from a person's *social self* are centered around conforming and accommodating to others. It is as though the client were saying, "I need you to accept me in my adaptation"; "Please accept this version of me"; or "I will be OK for you." They are displaying a social self that struggles to maintain a façade that provides an artificial sense of acceptance, validation, and security. With many schizoid individuals, there may be periods of therapy in which the person needs to maintain a sense of safety by repeating a familiar story. When Helen told me the same stories, I was initially frustrated. There was no real contact between us, no emotional connection, and I did not know how to be involved with her. My reactions reflected part of Helen's story. I was often emotionally distant and uninvolved. Eventually, I learned the importance of patience and staying present.

Initially, I became another person to whom Helen accommodated. I felt that she was not interested or, more importantly, did not want to see me as a relatable other. But she also needed me to be there every week, to be reliable and consistent, to be a mirror to her rigid and repetitive style of relating. It was a long time before she could allow herself to see me as a person separate from my professional status. It was a revelation for both of us when she began to allow herself to see that the psychotherapy offered much more than support for her job performance.

As our work shifted into a new phase, Helen needed to idealize me in order to create a new sense of safety, much like a child needs a stable adult who is predictable, consistent, dependable, and responsive to their emerging needs. With Helen's increased idealization of me, she perceived a new quality of safety in our therapeutic relationship. She described needing a safe space to speak her thoughts to a sensitive listener who would not criticize, overwhelm, or make demands of her. This new phase allowed Helen to become aware of needing safety in the relationship with me. She needed a therapist who was involved in her life, whom she could trust with her ideas, and who would foster her changing sense of herself.

Impact

In supervision I shared how I believed I was not making an impact on Helen's life and how uninvolved I felt I was in our work together. I was in deep countertransference, feeling I had so little influence and so little emotional connection with her. There was something happening between us that I needed to understand and resolve. I wondered if I was mirroring her experience of me. Did Helen sense that she had no impact on me or on anyone in her life? Was she living without any emotional connections? Her relational need to make an impact became apparent to me through my experience of how hard I was trying to relate to her.

Helen was skillful at making as little impact on others as possible. She painted a picture of herself as being on the outskirts of social groups all her life, fearful of others, wanting to fit in but not knowing how. She described "floating around cliques at school" and "nabbing people for chats." Her adolescent experience of being an outsider and finding social interaction scary had continued into her work life and was an ongoing source of anxiety. She described feeling "invisible" to others, "not having a place," and "not having an impact." I imagined how lonely she must have been, and yet the sadness I felt did not match the matter-of-fact way she spoke. Helen's interactions with others were mainly through maintaining a social façade characterized by passive accommodation and adherence to social rules and etiquette. Manfield (1992) suggested that there is often a "careful screening" going on with schizoid individuals that helps protect them from "anything that might expose them to attack or rejection or may be later used to pressure or coerce them" (p. 208). This seemed to be the case with Helen.

Clients who rely on a schizoid process to manage the affect inherent in relationships often experience an emptiness, a being "missed," and an unfulfilled "longing for something." At the same time, being in a contactful relationship is a huge risk for them, the risk of being known and therefore possibly invaded or controlled by the other. Some schizoid individuals express their internal confusion and hurt through script beliefs such as "No one is there for me," "I'm on my own," and "I'm not important." Moursund and Erskine (2003/2004) wrote, "Relationships in which one does not experience having an impact on the other person are one-sided … ; just as with a thwarted need for self-definition, they foster the belief that one is unimportant and that others don't care" (p. 112).

Guntrip (as cited in Hazell, 1994) described this internal polarization of desire and fear as the *schizoid compromise*, that is, being half in a relationship while simultaneously being half out. This polarization then exacerbates an internal experience of loneliness. For instance, Helen described the tension she felt as a duality between "feeling alone and needing others." She noticed an uncertainty around depending on others and a "strange, uncomfortable" feeling when she felt others were dependent on her. Helen had not planned to have a family but had two children whom she described as "like accessories" and "little friends." Fairbairn (1952) reported how it becomes possible to recognize essentially schizoid phenomena in clients' experiences, such as

> full-fledged depersonalisation and derealisation, but also relatively minor or transient disturbances of the reality-sense, e.g. feelings of 'artificiality' (referred to the self or the environment), experiences such as 'the plate-glass feelings', feelings of unfamiliarity with familiar persons or environmental settings and feelings of familiarity with the unfamiliar. (p. 5)

It was heart-wrenching to hear about Helen's struggle to be in contact with her current family members. She reported feeling unfamiliar within her own family, a jarring confusion of "Who am I to these people? Who am I when I'm with these people?" These are the exhausting challenges faced by those living with schizoid processes who attempt to be parents and to be in intimate relationships.

This schizoid compromise results in the formation of a social self, a split-off part of the self that is adept at accommodating to different relational situations, including the relationship with a psychotherapist. This social self may dominate and distract from the person's attempts to express the vital aspects of themselves such as

various affects, unique interests, pleasures, desires, dislikes, or any aspect of vulnerability.

Helen's strong need to remain safe within herself and to regulate the impact she had on the world around her meant she would repeatedly experience misattunement and misunderstanding from others. Although her affect was often hidden and her stories were distracting, I committed to doing my best not to disregard Helen's relational needs for security and self-definition or to make an impact on me. Although her needs were not obvious, I finally realized that they were being expressed in her stories and metaphors, enacted in her behavior, and engendered in my confusion and lack of involvement. (See Erskine, 2015a, for a description of how unconscious early attachment patterns are expressed in psychotherapy.) This helped me to think about Helen's experience in her day-to-day life. I imagined what it would be like for her to go to work and her emotional struggles with the people in her life. I found myself willing to vicariously experience what life was like for her. After I started to work with this introspection, I found ways to attune to Helen's rhythms and affects. I allowed myself to drift in and out of contact with her and to notice where I went in my sensations, thoughts, and awareness. I began to allow myself to go with the experience of being in relation with her rather than asserting my image of how a psychotherapist ought to be.

Helen had become accustomed to the repetitive pattern of our sessions. She would arrive exactly on time. She would appear small and young-looking at the door. She would move into the room, making as little noise or impact on her surroundings as possible. She would present me with her payment in the same way a child might present a ticket for a fairground ride: nervously and deliberately. She would then find her position on the couch, careful not to intrude on the space around her. Clients similar to Helen may be in psychotherapy for a long time without making an impact on the therapist. They adapt to what they imagine are the therapist's requirements and continue to hide their own needs. They rarely cause disruptions or act out. For instance, Helen was shocked when I asked her to message me to let me know how an important medical appointment went. It was difficult for her to comprehend that she had made an impact on me, that her health mattered to me.

Many people who use a schizoid process to manage their emotional and relational life actively regulate both the impact they make on others and the degree and type of impact others make on them. They move through life without impacting others, and so they are often not aware of the effect they have. In the family stories, such clients reveal that their childhood was marked by the impossibility of defining themselves or of making any significant impact within the family. They report that

their need to make an impact was not enjoyed or welcomed. Growing up, they endured extensive disregard of their relational needs, so they stopped expressing their vital and vulnerable selves in favor of a version of themselves that worked for others. They were often without the experience of "making an impact" on others from an authentic part of them—the vital and vulnerable self, what Winnicott (1965) called the *true self*.

The relational need to make an impact becomes paradoxical for such individuals. The schizoid process often involves the individual working hard not to make an impact on the therapist, to control the space, to remain internally and relationally safe. With Helen, I felt the "impact" in my countertransference, my confusion, my sense of the lack of emotional vibrancy in the work, and the fatigue I often felt. Helen was making an impact on me; it was subtle but it was impactful. She was relating from her sequestered, vital, and vulnerable self.

If we are to be effective with such individuals, we must maintain a belief that we are gradually having an impact on them. This is where understanding the object relations theories of Fairbairn (1952), Guntrip (1969), and Winnicott (1965) can support practice so that we patiently trust what is going on behind the scenes, become aware of the phenomena emerging in the relating, and trust that the intrapsychic structure of the schizoid individual means that on some level we are becoming part of the person's internal landscape even though it may not appear so in our session-to-session relating. We must hold an appreciation of the level of stress and shame that these clients can have when a social façade is strong. Behind the scenes, the person may be observing words, responses, and expressions that can feed their fantasies about how they need to be in order to be acceptable to the therapist. Fairbairn (1952) described his schizoid clients' self-criticisms with the term "internal saboteur" (p. 101). The withdrawn self splits further to create the internal saboteur who turns against the vulnerable self. One of the functions of this saboteur is to anticipate criticism from others and regulate the person's behavior (Erskine as cited in Zaletel, 2010). The internal saboteur serves to keep the vulnerable self hidden and repressed. It is the antiwanting self that is contemptuous and despising of neediness and ensures the schizoid individual neither seeks nor obtains what they want (Klein as cited in Little, 1999, p. 6).

Self-Definition

In my work with Helen, I came to realize that her relational need to make an impact and for self-definition were simultaneous and interrelated, both part of her need for self-expression and validation. A person relying on a schizoid process struggles with a lack of self-definition and also to comprehend that they have an impact on others: "If I don't know me, how can I impact others?" Erskine et al. (1999) described how "children who grow up in an environment that demands conformity, unquestioning obedience to rules and norms, may never learn how to be themselves" (p. 137).

For example, when Helen was in school, the teachers and other students defined her by her academic ability. In her adult life she was defined by her position and status at work. Her sense of self seemed strongly anchored to her performance on the job and how others perceived her. Helen was frustrated with repeatedly seeking validation through her role at work, particularly because it was "behind the scenes." She often despaired and was confused about how all her efforts to "be good" and perform well were not acknowledged. One of the few times I saw her express anger was in response to the pressure she felt to perform a certain way at work. That anger led us to explore how she could get a satisfying response to her need for self-definition and to have a sense of making an impact on others.

As the therapy progressed, my appreciation deepened for Helen's strong attachment to her work life and how meaningful it was for her to retell stories about her work experiences. I began to see these as essential to her sense of self and self-identity. Her work life made her feel real and connected to something. It created structure, attachment, and fulfilled her needs according to her script beliefs of having to work hard and do well for others. All her energy would go into managing and surviving her week, although she was often exhausted by the weekend. She did not have friends she saw regularly and found it difficult to initiate and keep in touch with people (she spoke of people seeming to drift away). The effort she put into work, particularly interactions with others, meant she needed to withdraw internally on weekends in order to recuperate. For a long time, she viewed her therapy as supporting this process, a chance to verbalize her grievances so she could survive the next week at work.

Guntrip (as cited in Hazell, 1994) described how the schizoid individual:

> Without a satisfactory relationship with another person he cannot become a developing ego, he cannot find himself. That is why patients are so often found complaining "I don't know who 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." Their early object-relationships were such that they were unable to "find themselves" in any definite way. (p. 129)

This reflects a core reason for the schizoid person to be in therapy: to find or reclaim their self-definition.

I wondered how I could help Helen with this when she needed such self-protection. How could I find her without losing her again? I needed to continue carefully, always holding in mind her fears around interpersonal contact and her need to protect herself.

Further into our work together, Helen arrived excited to tell me about a work-away day she had helped to coordinate around the theme of pirates. She had dressed up and organized games and activities. The excitement and change in her energy amazed me. I knew Helen was showing me something new and different, a spark of vibrancy that I had been waiting patiently to see for a long time. This marked a turning point in her therapy as we began exploring her creativity and her enjoyment in planning creatively for others. Helen was starting to allow herself to express a different, emergent energy, away from the structure of her daily life toward something creative, playful, and fun. These moments of vitality were polar opposites to the repetitive staidness of her social façade. I was excited to finally see them and at the same time careful not to overwhelm her with my responses. I did not want to scare her away by expressing too much excitement or suddenly changing how I was with her.

As we explored fantasies about what she would do outside of her long-term workplace, she shared her dreams about wanting to teach. I encouraged that through my inquiry and involvement, and she eventually decided to volunteer as a classroom support at a secondary school. This was a hugely significant decision: to move out of her comfort zone based around work and home life and to work alongside children who needed individual support. I was deeply moved when she reported the connections and relationships she was forming with the children and how she was appreciating their particular needs in learning. Helen began to reflect on her childhood through the experiences with the children, which led to richer exploration of her emotional memories. In Greenberg's (2016) words:

> I tend to find these particular clients difficult to connect with because their real self is so hidden, even from themselves. … All of their aliveness goes into their

> fantasy life. I have learned that if I am patient and those clients decide I am trustworthy, they will give me glimpses of the riches they have inside themselves. (p. 338)

Finding Helen's creativity came out of us exploring her inner world of metaphors and fantasies as well as from her experiencing me valuing and accepting the significance of those and letting her know about their impact on me. What had initially appeared as repetitive, superficial narratives around her work became a bridge to me appreciating how she made meaning within her world as well as glimpses of her vital and vulnerable self. Helen described herself at work as "a computer stuck and going round and round doing the same thing" and a "machine with grit in the machinery/cogs, grinding and missing connections." The more I attuned to and validated her wonderful metaphors and images, the more I heard faint expressions of unmet relational needs.

Such needs are often held within fantasy or "at a symbolic level" (Yontef, 2001, p. 8). They can be kept out of cognitive awareness or securely compartmentalized internally, away from contact with others. Within the safety of fantasy, an individual can imagine relational needs being satisfied but without genuine interpersonal contact with others. We can listen for and find these needs as our clients share subjects that feel safe to them. This interplay was described by Orcutt (2018) as follows:

> The therapist begins with showing interest in what is of interest to the patient. This may be as pertinent as the patient's intellectualized ideas about the presenting problem, or may diverge to topics of special interest to the patient such as books or computer games. This is to establish a mutual safe space with the patient, where verbal transaction can take place in an uncommitted way. This uses what Ralph Klein (1995) has called the schizoid patient's ability to form "relationships by proxy" and so defensively "act against the risks involved in connecting to, and sharing with the therapist" (p. 90). This ability can allow the patient to test out a harmless reciprocity in the sessions. Over time, the experience of this interplay may prove to feel safe enough so that the patient may begin to further test the possibility of a closer exchange. If all goes well, interchange becomes therapy as protective strategy transforms into relationship. (p. 44)

Instead of challenging or ignoring Helen's repetitive narratives around work, I moved into her work world with her. Through cognitive attunement, inquiry, and involvement in her retellings, I became deeply knowledgeable about her workplace: the people, the systems, how she worked, what she did. She was teaching me about her inner world, and the therapy began to deepen when I accepted what had initially appeared to be trivial. I began to understand through working with Helen to be involved in whatever is of interest to my client.

Work was safety for Helen. It gave her an identity and provided for some of her relational needs. Nevertheless, she was gradually able to verbalize how her work did not provide the valuing she needed. She realized how little impact she was having in her work life, regardless of how hard she worked to adapt to its requirements. Our sessions became more about her making contact with herself in a reflective way rather than controlling the space with retellings of what had happened to her. She was able to speak more emotionally and vulnerably about her experience as a mother and her struggles in connecting with her son.

Forming an identity from a place of schizoid withdrawal or protection comes from acknowledging and accepting a relational need for self-definition. As a result, the "organization of a once-hidden self can now begin to form an identity" (O'Reilly-Knapp, 2012, p. 8). Through our work, I learned to appreciate my active part in facilitating Helen's growing awareness of a relational need for self-definition and how to move into the schizoid individual's world by working within the client's metaphors and fantasies, to sometimes share in her experience of a lack of self-definition. In doing this, it was important to remain present and in contact with myself, which requires a careful balance. My own sense of self-definition is often impacted when I cannot sense the other person's vitality, when my client is withdrawn and I cannot reach them. I am left to wonder about my own capacity to make an impact. With Helen, I learned to remain present as well as noninvasive and attuned to the nonverbal, the repetitions, and the clues that might be there in the person's social façade. I came to appreciate the experience of the schizoid phenomena and to notice the spaces between our interactions, to pick up on and use all the sensations available to me, and to be able to sometimes drift with the process while staying defined at the same time.

In my experience, there are observable phenomena that may signal the client's absence of self-definition, for example, the phenomenon of someone seemingly not arriving in a room and appearing to drift in and out of transactions. I observed that Helen lacked definition in terms of how she arrived in the therapy room. I understood this as a lack of "aggress" in the space and in the relating, a passivity and an unclear definition in her physicality. Guntrip (as cited in Hazell, 1994)

described how “the regressive urge to remain identified for the sake of comfort and security conflicts with the developmental need to dissolve identification and differentiate oneself as a separate personality” (p. 50).

Interrelating Needs

Self-definition means an assertion of oneself, an expression of “me” in contrast to “you.” Developmentally this is a huge task under any conditions. For the schizoid individual, maintaining the security of the hidden self takes precedence over the risks of differentiating. This is an example of how relational needs interrelate and interplay and how one need can be compromised by or contrasted with another: “It’s not safe to define myself in contrast to others”; “I don’t know myself enough to make an impact on you”; “When you initiate with me it feels unsafe.”

I found that Helen’s relational needs often fused together in clusters and appeared “theoretically interrelated” (Žvelc et al., 2020). I came to understand how the triad of relational needs to make an impact, for self-definition, and to have others initiate were all in the background of our relating. These were needs Helen was not aware of and did not outwardly express. I believe it aided Helen’s therapy for me to hold the potential for them to emerge in our contact together, to be curious, and to watch for clues or expressions of them. These relational needs were thwarted at various points during Helen’s life. She had given up expressing or seeking satisfaction of them and had found creative ways to compensate or adapt. Her therapy involved a slow growth in her awareness of her previously unmet, unknown relational needs.

Need to Initiate

Helen’s need for me to initiate contact was in the background of our relating during our early work. Her dominant need was to remain safe and in control of the space. My attempts to initiate beyond the safe parameters of what she was prepared for were brushed away. I could see from her physiology and her responses to inquiry how wary she was of initiations into relational contact. However, the more I stopped trying to do and the more I allowed myself to work within the schizoid process—to involve myself in whatever Helen was prepared to involve me in—the more I began

to see the fragments of the need to initiate coming through, particularly in the form of developmental imagery.

As Helen trusted me enough to share more about her inner world, I was often reminded of how a young child might share ideas and thoughts. I imagined her not having the experience in childhood of a significant other alongside her at different ages, someone listening, involved, and impacted by her sharing ideas. It began to occur to me that Helen was, in her own way, initiating play in her therapy. She appeared to be enjoying my enjoyment of her sharing of ideas, concepts, and metaphors. If a child has not had others initiate with them, all their ideas for play stay internalized and in fantasy. In her workplace, I imagined Helen as a little girl trying to initiate and get on with the other kids, not understanding how they spoke and what they wanted from her. As Stewart (2010) suggested:

> It is important to be aware of the dynamics of initiating since sometimes it is clinically astute to wait until the client initiates reaching out to us. … The presence of the therapist's need to have the other initiate might be felt as a longing for the client to reach out to them, and a disappointment when they don't. … [Therapists should] be mindful of their own need in this regard and not make it an expectation of clients or withdraw when it's not met. (p. 48)

Again, the need to have others initiate may be bound up in the schizoid process and the unique style of relating that this involves: "I need you as a therapist to initiate contact but I need to regulate contact by withdrawing and presenting a social façade."

How do we as therapists hold on to the crucial need the client has when it is in the background of the relating? A schizoid person survives in relationships and interactions with others by relying on certain manners or creative personality adjustments, such as detachedness, robotic politeness, self-containment, or self-reliance. The underlying need for others to initiate is repeatedly missed as people relate to the social façade rather than the hidden self. This relational need remains out of awareness or hidden away, but it is there and will be within the field of relating in the psychotherapy. I imagined this confusion of unknown or hidden needs being expressed by Helen in statements such as "I need you as therapist to initiate contact with me but I am scared of what this is like" or "I need you to initiate but I can't tolerate this and need to regulate with withdrawal."

For such individuals, the idea of initiating with others, including the therapist, might be an unknown or frightening: “I didn’t think it was OK to ask for what I need.” Helen’s relational need for the other to initiate was there, but it was a long time before I could initiate contact and move into a more relational style of inquiry. As with the relational need for self-definition and impact, her need for the other to initiate emerged into the foreground of our relating. These needs were there in the relating but often expressed inversely. She appeared to lack self-definition and instead relied on a social façade, a compromised version of her that hid away the vital and vulnerable self. Her efforts to minimize having an impact within the therapy conversely made an impact on me. Her need to have another initiate was experienced by her as threatening and emerged through careful attunement to metaphor and her intellectual playfulness. Could the out-of-awareness relational needs in the client relate to the ones the therapist picks up in the countertransference? I found how important it was to identify and track where Helen’s relational needs were within our relating, that is, which needs were in the foreground, which could be noticed within my countertransference, and which were out of awareness or in the background.

Need for Mutuality

Moursund and Erskine (2003/2004) wrote, “The need for self-definition is the complement of the need for mutuality” (p. 112). For her part, Helen’s relational need for mutuality was in the background of our relating until much later in our work together. Her predominant needs were to feel safe and to have her experiences and way of surviving validated and accepted. Any sense of mutuality between us would have been threatening and risky to her. Her loneliness and independence as a child did not include much companionship or many shared experiences with others. Her playfulness came through in her intellectual life and within fantasy. There was a gradual movement toward a more mutual relating as she grew in her self-definition and allowed me to be a more relatable presence. Zaletel (2010) described how with her client “[in] this therapy phase she expressed her needs of both mutuality and self-definition. Lara entered in contact with her real self and thus I, too, could become more of a ‘real’ person” (p. 23).

The more attuned I was with Helen, the more defended her vital and vulnerable self often became. I imagine the more we try to be in contact with the smoke and mirrors of the social façade, the more this increases a sense of unease or confusion for the client. However, as the person becomes more settled in the

relating, the therapist can be as well. As Helen's therapy progressed, we were able to relate together in an increasingly equal, mutual way.

Working within a schizoid process, we might meet the social façade of the person who seems easy in conversation and willing to engage in therapeutic interactions. There may appear to be a need for a mutual or shared relating when, in fact, the hidden, vital, and vulnerable self does not need mutuality with the therapist at all. That part of the self needs the emergent process of self-definition, to move out from a cut off, defended place to reclaim their voice and a sense of their uniqueness. There can be moments when it feels like the client is seeking some kind of mutuality or sharing of experience with the therapist when they are actually not ready to hear this and instead need the therapist to remain in an idealized position: bigger, protective, and an object onto whom they can project ideas from a younger, more vulnerable self. It might be like a scene in which a young child is sitting with adults at the dinner table attempting to join in grown-up conversation. This appears as a need for mutuality and shared experience when actually the stronger need is to have their own experiences responded to, validated, and accepted in an age-appropriate way (or even to get down from the table and go and play with the other kids!).

Need for Survival

Reflecting on the therapy with Helen, I suggest that the relational need for survival describes the internal struggle for self-survival happening inside the world of the schizoid person and within the therapeutic relationship. As O'Reilly-Knapp (2001) reported in describing her work with a client's schizoid process, "She used her withdrawal and dissociative states for protecting and sustaining her life" (p. 4). Defensive processes reflect the individual's need to survive in relationship. They are creative ways of maintaining safety in the maelstrom of relating with others. Beyond the need for safety is the need for the vital and vulnerable self to have survived as described in the "encapsulated self" (p. 12), a process that goes on internally, privately, and silently. A client will show their struggle for self-survival through the transference.

The philosophical principles of integrative psychotherapy include the idea that "all human behavior has meaning in some context" (Erskine, 2013, p. 4). Taking this into account, I think the person who uses silence, withdrawal, or a social façade to cope with extreme distress or trauma needed to create an internal closed

relational system in order to organize experience and keep the vital and vulnerable self alive. The therapist needs to appreciate and honor the function of this closed system and how the vital and vulnerable self has been in exile: deadened, put in a kind of deep freeze, the idea that to survive one must keep that part of the self "dead to the world." This becomes a need in itself. A client can show us in the therapeutic relating that "I need to be hidden," "I need to withdraw," or "To survive, I needed to seem dead in myself."

It is essential to acknowledge this need for solitary survival as part of a relational psychotherapy. Otherwise we may rush to offer the kind of contact and relating the individual may yearn for but also be highly fearful of. As Yontef (2001) outlined, from the perspective of the schizoid individual

> it is dangerous to move into intimate connection if you cannot separate when needed. If you think you are going to be caught up, devoured, or captured in the connection, it is terrifying to move into intimate contact. On the other hand, if you do not feel connected with other people, especially if you do not believe you can intimately connect again, the separation or isolation is both painful and terrifying. (p. 9)

A relational need to survive involves the individual's fears around intimate contact and threat to existence. The vital and vulnerable self is locked in a closed internal system of survival. Guntrip (as cited in Hazell, 1994) described the internal tension with a metaphor: "a closed picture frame, the inside edge of which was an unbroken array of sharp teeth all pointing in at the patient" (p. 142). This precarious, fragile, self-contained inner world has to be acknowledged by the therapist as part of an in-contact integrative relational psychotherapy. Helen showed me that she needed to create a rigid structure of relating to others. Her way of regulating interpersonal contact was a tolerable compromise born out of necessity in order to survive early experiences in which her relational needs were not met.

Conclusion

To borrow Woodman's (cited in Kullander, 2008) phrase about dreams, I like to think of the schizoid individual as "like a deer at the edge of the forest" (para. 13). At first you may catch only a glimpse of her, and then she is gone in the blink of an eye. But this is enough to know she is there. Reflecting on the many hours I worked with Helen, patiently listening and attuning to her repetitious narratives, hoping to catch something of the vital and vulnerable self that she guarded so well, I found in myself a unique love and care for her in our struggles to find authentic contact with each other. This was someone who found intimate relating frightening and risky. Helen entered therapy not knowing what she needed or what possibilities lay ahead, but she followed a yearning inside herself for something different.

Therapy within a schizoid process is a like a slow rescue mission. It is our patient caring and careful involvement with these clients that eventually allows someone to "unfold, like a flower" (Berne, 1961, p. 226) and emerge from the protected internal spaces in which they have hidden. Guntrip (as cited in Hazell, 1994) described therapy with these clients as being like "a steady recuperation from deep strain, diminishing of deep fears, revitalisation of the personality and rebirth of an active ego that is spontaneous and does not have to be forced and driven" (p. 186). The therapeutic relationship is a place of growth and healing, a symbolic space of potential in which someone can begin to emerge and express their vital and vulnerable self. Within this growth, we must validate and accept the person's unique ways of surviving.

Helen and I worked together early in my practice, when I was inexperienced and did not appreciate what I now know about the schizoid process. I wonder if this not knowing actually helped the initial phases of the therapy. I was not trying to impose myself too hard on the work or trying different strategies. I was prepared to work patiently and gently at the pace Helen needed in order for her to gain trust in the relating and to allow her true self and needs to emerge. When I first met Helen, I had no idea of the richness of her inner life or how creative she was in her fantasies, thoughts, and way of seeing the world. I was locked into relating with an adapted social façade that needed tight control over the therapy space in order to feel safe. The close consideration of how her relational needs shifted within the therapy offered anchoring in the often slow and repetitive early periods of our work. My attention to how her relational needs appeared out of awareness and yet longed to emerge gave me a guide to what could be happening in our relating.

Over the years we worked together, Helen taught me about what it means to be a therapist. Winnicott (1965) wrote of a "devotion" to the emergent self. This implies a commitment to cherishing the creative ways a person remains interpersonally

safe, their styles of withdrawal, and the internal unknowns that epitomize the schizoid struggle to find contact with the external world, themselves, and others.

References

Berne, E. (1961). *Transactional analysis in psychotherapy: A systematic individual and social psychiatry*. Grove Press.

Erskine, R. G. (2001). Psychological functions, relational needs, and transferential resolution: Psychotherapy of an obsession. *Transactional Analysis Journal, 31*(4), 220–226. https://doi.org/10.1177/036215370103100403

Erskine, R. G. (2011, 21 April). *Attachment, relational-needs, and psychotherapeutic presence* [Keynote address]. International Integrative Psychotherapy Association Conference, Vichy, France. https://www.integrativetherapy.com/en/articles.php?id=73

Erskine, R. G. (2013). Vulnerability, authenticity, and inter-subjective contact: Philosophical principles of integrative psychotherapy. *International Journal of Integrative Psychotherapy, 4*(2), 1–9.

Erskine, R. G. (2015a). Life scripts: Unconscious relational patterns and psychotherapeutic involvement. In R. G. Erskine, *Relational patterns, therapeutic presence: Concepts and practice of integrative psychotherapy* (pp. 91–112). Karnac.

Erskine, R. G. (2015b). Life scripts and attachment patterns: Theoretical integration and therapeutic involvement. In R. G. Erskine, *Relational patterns, therapeutic presence: Concepts and practice of integrative psychotherapy* (pp. 73–90). Karnac.

Erskine, R. G. (2020). Relational withdrawal, attunement to silence: Psychotherapy of the schizoid process. *International Journal of Integrative Psychotherapy, 11*, 14–28.

Erskine, R. G., Moursund, J. P., & Trautmann, R. L. (1999). *Beyond empathy: A therapy of contact-in-relationship*. Brunner/Mazel.

Erskine, R. G., & Trautmann, R. L. (1997). Methods of an integrative psychotherapy. In R. G. Erskine, *Theories and methods of an integrative*

transactional analysis: A volume of selected articles (pp. 20–36). TA Press. http://www.integrativetherapy.com/en/articles.php?id=63 (Original work published 1996)

Fairbairn, W. R. D. (1952). *Psychoanalytic studies of the personality*. Routledge.

Greenberg, E. (2016). *Borderline, narcissistic and schizoid adaptations: The pursuit of love, admiration and safety*. Greenbrooke Press.

Guntrip, H. (1969). *Schizoid phenomena, object-relations and the self*. International Universities Press.

Hazell, J. (Ed). (1994). *Personal relations therapy: The collected papers of H. J. S. Guntrip*. Jason Aronson.

Johnson, S. M. (1994). *Character styles*. Norton.

Kullander, J. (2008). Men are from earth and so are women—Marion Woodman. *Awaken*. https://awaken.com/2018/03/men-are-from-earth-and-so-are-women

Little, R. (1999). Schizoid processes: Working with the defenses of the withdrawn child ego state. *Transactional Analysis Journal, 31*(1), 33–43. https://doi.org/10.1177/036215370103100105

Little, R. (2011). Impasse clarification within the transference-countertransference matrix. *Transactional Analysis Journal, 41*(1), 23–28. https://doi.org/10.1177/036215370103100105

Manfield, P. (1992). *Split self, split object: Understanding and treating borderline, narcissistic and schizoid disorders*. Jason Aronson.

Moursund, J. P., & Erskine, R. G. (2004). *Integrative psychotherapy: The art and science of relationship*. Thompson–Brooks/Cole. (Original work published 2003)

Orcutt, C. (2018). Schizoid fantasy: Refuge or transitional location? *Clinical Social Work Journal, 46*(1), 42–47. https://doi.org/10.1007/s10615-017-0629-2

O'Reilly-Knapp, M. (2001). Between two worlds: The encapsulated self. *Transactional Analysis Journal, 31*(1), 44–54. https://doi.org/10.1177/036215370103100106

O'Reilly-Knapp, M. (2012). Organizing self-experiences. *International Journal of Integrative Psychotherapy, 3*(1), 1–14.

Stewart, A. L. (2010). Relational needs of the therapist: Countertransference, clinical work and supervision. Benefits and disruptions in psychotherapy. *International Journal of Integrative Psychotherapy, 1*(1), 41–50.

Winnicott, D. W. (1965). *The maturational processes and the facilitating environment: Studies in the theory of emotional development*. International Universities Press.

Yontef, G. (2001). Psychotherapy of schizoid process. *Transactional Analysis Journal, 31*(1), 7–23. https://doi.org/10.1177/036215370103100103

Zaletel, M. (2010). Journey towards integration: The case of Lara. *International Journal of Integrative Psychotherapy, 1*(1), 11–24.

Žvelc, G., Jovanoska, K., & Žvelc, M. (2020). Development and validation of the relational needs satisfaction scale. *Frontiers in Psychology*. www.frontiersin.org/articles/10.3389/fpsyg.2020.00901/full https://doi.org/10.3389/fpsyg.2020.00901