

Engaging With the Schizoid Compromise: A Response to Erskine's "Relational Withdrawal, Attunement to Silence: Psychotherapy of the Schizoid Process"

Ray Little¹

Abstract

This article presents a response to the paper "Relational Withdrawal, Attunement to Silence: Psychotherapy of the Schizoid Process" by Richard Erskine in which he described his treatment of a client who made use of schizoid processes and defenses to manage her experience. The current author responds by focusing on the self-protective defenses of schizoid compromise and withdrawal that individuals with a schizoid presentation employ. Their struggle with attachments is also examined, and various theoretical perspectives on developmental processes and the structure of the mind are discussed. The spectrum of schizoid processes is examined from the more extreme introverted schizoid personalities who exhibit severe withdrawn presentations to those who seek some form of attachment. The nature of the internal world and the difficulty of managing relationships is explored. Therapeutic action in response to the schizoid compromise and withdrawn individual is considered. The article includes a number of clinical descriptions and concludes by exploring the processes involved when the therapist themselves occupies a schizoid compromise position.

Keywords: Schizoid personalities, schizoid dilemma, schizoid compromise, withdrawal, relationships, transference-countertransference, therapeutic action

Richard Erskine (2020) recently invited me to respond to an article he has written about his treatment of a schizoid client. We were both on a panel 20 years ago at a transactional analysis conference in San Francisco, the theme of which was schizoid processes. The conference papers were published as a theme issue of the *Transactional Analysis Journal* (Daellenbach, 2001). It seems timely now to

¹Enderby Psychotherapy & Counselling Associates, Edinburgh, Scotland, UK; e-mail: enderby@janeandray.ndo.co.uk

revisit some of those ideas, having worked extensively with them in the interim, and to share some current thoughts about schizoid processes.

In Erskine's (2020) paper, entitled "Relational Withdrawal, Attunement to Silence: Psychotherapy of the Schizoid Process," he presented the case of Violet and described how that work taught him the significance of relational withdrawal and the importance of attunement in psychotherapy. Erskine's article provoked me to focus particularly on the notions of the schizoid compromise, withdrawal, and treatment considerations. The schizoid's behavior is marked by withdrawal and inability to form close relationships: "There is a consuming need for object dependence but attachment threatens the schizoid with the loss of self" (Seinfeld, 1991, p. 3). The person protects themselves by withdrawing from social contact.

In my article "Schizoid Processes: Working with the Defenses of the Withdrawn Child Ego State" (Little, 2001), I examined several theoretical descriptions of schizoid processes. I pointed out how the term *schizoid* has been used to describe both a personality structure and psychological processes. Melanie Klein (1946/1975) employed the term both to refer to a splitting mechanism and to describe a developmental position. In discussing the splitting of the self, she highlighted how the other is experienced as a persecutor. Fairbairn (1952) described three prominent characteristics of schizoid personalities: an attitude of omnipotence, detachment, and a preoccupation with fantasy and inner reality. He later described an intrapsychic structure that consisted of the splitting of the ego and repression as a defense. He pointed out that schizoid personalities may appear to fulfill a social role with others with what seems to be appropriate emotion and contact while actually remaining detached.

Before continuing here, I want to let readers know that I, as a White British male, will be drawing on my clinical experience to highlight some of the theory. The clients and supervisees' clients described here are largely White European and North American. I acknowledge this because we need to ask ourselves whether the theory is applicable across all races, ethnicities, and cultures given that there is little research into these aspects of personality disorders. However, some papers relevant to these issues have been published in the last decade, including Hossain et al. (2018), McGilloway et al. (2010), and Newhill et al. (2009).

Developmental Theory

A variety of theoretical models can be drawn on to elucidate the developmental history involved in schizoid processes and personalities (Fairbairn, 1952; Guntrip, 1968; Kernberg, 1984; M. Klein, 1946/1975; R. Klein, 1995; McWilliams, 1994). Some of them refer to schizoid mechanisms, whereas others refer to schizoid personality disorders. One perspective on understanding the etiology of schizoid phenomena is to consider how the individual negotiated relationships as an infant/child and then internalized those experiences. Ego state relational units (Little, 2006) and object relations (Fairbairn, 1952; Guntrip, 1968) both describe how relational experiences, and the child's perception of them, become organized and internalized as relational schemas (Little, 2013; Žvelc, 2010).

On examining these schemas, we can distinguish between tolerable experiences that were integrated and intolerable ones that remain unintegrated. Tolerable nondefensive experiences are an aspect of the integrating Adult ego state and represent autonomous, here-and-now functioning from an open system (Little, 2006, 2011) with the capacity for assimilation and accommodation (Piaget, 1952; Žvelc, 2010). Intolerable experiences remain as a dissociated structure consisting of defensive or maladaptive schemas (Eagle, 2011; Žvelc, 2010). I describe these schemas as Child-Parent ego state relational units (Little, 2006), which are located in unconscious, implicit memory. These relational units make up the internal structure of the schizoid individual. (For a full discussion of the theory of relational schemas, see Eagle, 2011; Little, 2006, 2011; Piaget, 1952; Žvelc, 2010).

The basic need for attachment and object relatedness and the desire to “discover one's reflection in the look of the other” (Seinfeld, 1991, p. 33) exists in the schizoid personality, as it does in everyone. It is intrinsic to who we are as a species. When we think of the adult person who presents with a schizoid characterological structure, we may wonder what the nature of the person's early experiences were, particularly with their primary caregivers, that led them to feel such hopelessness and fear in relation to being with others. Those early experiences led them to feel a tension between attaching and not attaching (or nonattachment). For Ralph Klein (1995), the question revolved around “what kind of deal does the schizoid negotiate in order to gain the benefits of attachment while avoiding the anxieties and dangers of nonattachment?” (p. 45).

R. Klein (1995, p. 51) described two positions—nonattachment and attachment—that the schizoid individual may occupy. The first consists of the schizoid's self-sufficiency and self-reliance. The second consists of being close and involved with another but runs the risk of being let down, rejected, or

abandoned. As one client said to me, “Relying on people is seen as a bad idea as they will eventually let you down.”

Guntrip (1968) and R. Klein (1995) agreed on the nature of the schizoid condition. They disagreed, however, as to the point during development at which the condition originates. Guntrip, following Fairbairn (1952), suggested that in response to the traumas of postnatal life, we develop a split structure that he described as the *schizoid position*. This refers to the primary structuring of the personality. If the schizoid position develops to an extreme extent (Gomez, 1997, p. 66), it may become the schizoid personality. For R. Klein (1995, pp. 40–41), the condition occurs during the rapprochement phase of development. He stated that schizoid personalities are aware of the two sides of their dilemma, thus indicating a certain degree of psychological separateness. They are also aware of the difference between external reality and their internal world, which, as R. Klein stated, reflects difficulties emanating from the rapprochement stage (Mahler et al., 1971/1975). However, my experience is that more severely withdrawn and introverted schizoid personalities do not seem to experience the two sides of the dilemma as R. Klein described it. They seem to only occupy the nonattachment side. It is as though they have relinquished any desire for attachment. In this way, R. Klein’s notion that the schizoid develops at the rapprochement phase does not account for my clinical experience of working with schizoid personalities with whom there seems to be evidence of earlier trauma and relationship failings.

I agree with Kernberg and his colleagues, who suggested that schizoid personalities, like other personality disorders (Clarkin et al., 2006), rely on more primitive defense mechanisms (e.g., projective identification), which suggests an early developmental struggle/failure. In light of this, it may be that R. Klein was describing more integrated personalities.

Structure of the Mind

Many of my schizoid clients have felt safest when they are at home, with solid walls around them for protection. As children they would frequently withdraw to their bedrooms, or somewhere similar, to feel safe, often playing on their own. For example, Nicola worked as a doctor and was proud of her care for her patients. This care was something that she did not receive from her parents when she was a child. Her mother was cruel, violent, and unpredictable. As an adult, Nicola was phobic about socializing with people. She also located the cruel object of her childhood in animals and was fearful of them. She hated dogs and would not go near them, particularly if they were not on a leash. She viewed them

as unpredictable and vicious. As a result, she would not go into her local park unless she was accompanied by her husband. Nicola's withdrawn state of being in exile was linked to her experience of a cruel and unpredictable mother. My countertransference picture of Nicola's childhood was of her in a cot terrified of the world around her as represented by her mother.

Marye O'Reilly-Knapp (2001), who was also on the 2000 panel in San Francisco with me and Richard Erskine, described the schizoid individual as an encapsulated self "hidden from the world and even from himself or herself" (p. 44). She saw the schizoid's withdrawal as an "autistic encapsulation [that is] the psyche's most primitive form of organization and the earliest form of withdrawal" (p. 46).

If the person's experience as a child and the idea of closeness to others as an adult does not involve the internalization of a caring relationship, and instead is experienced as some kind of "master-slave" relationship (Klein, 1995), this often results in an internalization of a bad object relationship as described by Fairbairn (1952). He saw the good object internalized as memory, whereas the bad object relationship is internalized in a much more vital and fundamental sense than memory alone (as cited in Guntrip, 1968, pp. 21–22). Perhaps what Fairbairn was referring to was that a good object is experienced as benign, whereas a bad object is experienced more intensely and as profoundly charged with affect and frustrated needs.

R. Klein (1995) used the term schizoid from the perspective of Masterson (1988) to describe a further disorder of the self (in addition to borderline and narcissistic personality disorders). In taking an object relations view, Klein saw the schizoid as either in a self-object relational unit as a slave attached to a master or as a self-in-exile fearful of a sadistic object. This view of the person's internal world represents a split structure.

Some schizoid personalities may perceive the master/slave unit as more acceptable than being in exile and therefore attach to others at a cost to themselves; other schizoid personalities may prefer withdrawal and fantasies to that of being closer, which is felt as more threatening. For the withdrawn schizoid, fantasy serves to maintain some sort of link to the world of relationships when actual people and reality are intolerable. Fantasy can be fulfilled by novels, films, pornography, and gaming, all of which can stimulate fantasy relationships (Manfield, 1992).

As children, such individuals may live, through fantasy, in the world of the stories they read and may imagine themselves playing a part in the adventures of

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the characters. They come to inhabit their fantasies. This is a more extreme version of what most children do and serves the function, as previously mentioned, of maintaining some link to the world of relationships. The fear of being in exile, with its experience of isolation and nothingness, may be avoided by maintaining a “tie to the bad object” (Seinfeld, 1993, p. 65). Fairbairn (1952) described these ties as “the libidinal bonds whereby the patient is attached to these hitherto indispensable bad objects” (p. 74). Further, Grotstein (1994) depicted this as “the unwavering loyalty that schizoids maintain towards their objects” (p. 116). The schizoid personality’s connection to the external world is usually superficial. They have withdrawn from the outer world and are living in an internal world of fantasy. However, by maintaining a relationship with the bad object, schizoid individuals keep in touch with the world, protecting themselves against a flight from reality and decent into nothingness. Guntrip (1994) suggested that the individual preserves the ego by “taking refuge in internal bad-object phantasies of a persecutory or accusatory kind” (p. 164).

Considering all of this, R. Klein’s (1995) description of the withdrawn position as nonattachment may not be strictly true. Withdrawal from the world of potential real-life attachments to an internal world may be a retreat to a position where attachments of a sort are maintained. The internal world of bad object relations consists of attachments, albeit to a bad object. This internal world is a world of attachments in a similar way that external relations constitute attachments. To live in this internal world is to occupy a world of relationships rather than an objectless/relationshipless world.

I am suggesting that the nonattachment position R. Klein described can also be seen as consisting of no external relationships but instead a retreat to an internal phantasy world of attachments that, to some extent, can be controlled.

Case Study: *A Beautiful Mind*

This process of internal attachments was brought home to me dramatically by the film *A Beautiful Mind* (Howard, 2001), in which Russell Crowe plays the part of Nobel Prize winner and mathematician John Nash. I will use this film and the biography it is based on to illustrate the schizoid withdrawn state and the internal world with its relational schemas and its defenses against objectlessness and the black hole of nothingness.

In the film, Nash initially comes across as withdrawn and obsessed with patterns and numbers. He is seen as strange by his fellow doctoral students,

from whom he is socially isolated. They describe him as aloof, without affect, detached, and isolated. "He's not one of us," one of them was reported to have said (Nasar, 1998, p. 13). In the film, Nash has an exuberant roommate, Charles, who appears to be everything Nash is not. Charles is heard to suggest that they get a pizza: "You know, food!" Charles appears outgoing and interested in alcohol and women. At one point, Charles asks Nash about friends. Nash replies, "I don't much like people, and they don't much like me." Nash fights with Charles in his room, pushing a table to and fro, which Charles pushes out of the window. In another scene, Nash is sitting on the roof of the building chatting to Charles and shouting at students below. There is a point later in the film when Nash is helping the military solve a code-breaking problem and catches sight of someone watching him from the balcony. He calls that person "Big Brother." The person later identifies himself as William and behaves with authority, telling Nash he will arrange for Nash to have top secret clearance to continue the work. Later in the film, when Nash tells William he needs to resign because his wife is pregnant, William responds by saying, "I told you attachments are dangerous."

What eventually becomes apparent is that Charles and William are visual and auditory hallucinations and part of Nash's internal world of attachments. Some of them are punitive and some more amiable. One of the things the film demonstrates is that Nash's life appears as an illusion with occasional excursions into reality. There seems to be a tension for Nash between rational and irrational thinking. Later in life, he considered that his "dream-like delusional hypotheses" (Nash, 1994, para. 27) had been irrational. He went on to say that "one aspect of this is that rationality of thought imposes a limit on a person's concept of his relation to the cosmos" (para 29).

Nash, age 31 years, having worked for 10 years as a brilliant theoretical mathematician, is diagnosed as suffering from paranoid schizophrenia after having a breakdown. Charles turns up again in the film, greeting Nash with a hug. Charles is accompanied by his niece, who expresses feelings with Nash, something he does not seem to experience a great deal. She seems to be the repository of Nash's unexpressed affect. As Nash later moves into remission, he realizes that, although he continues to see her over many years, she does not age. These characters are externalizations of Nash's internal world, his world of attachments and containers for his disavowed affect, attachments that, I suggest, are preferable to the black hole of nothingness. Nash's internal world is also a world of patterns and numbers, which is where he seems to feel safe and at home.

When Nash was a child, his parents were worried about him. He had a lack of childish pursuits and friends (Nasar 1998, p. 32). According to his sister, he wanted to do things his own way. Other children thought him weird and bullied or just tolerated him (p. 36). It seems that he learned to “armor himself against rejection by adopting a hard shell of indifference and using his superior intelligence to strike back” (pp. 37–38). Nash used his superiority, standoffishness, and occasional cruelty to manage his loneliness, thus maintaining his self-esteem (p. 38).

Nasar, in her biography of Nash, described some of those schizoid personalities who are brilliant scientists and thinkers from whom society benefits but who are strange and solitary, such as Albert Einstein, Isaac Newton, Immanuel Kant, Ludwig Wittgenstein, and René Descartes. She draws on the writing of Anthony Storr, a British psychiatrist and psychoanalyst, who wrote that the schizoid state is characterized by a sense of meaninglessness and futility. Creative activity is a particularly apt way to express himself ... the activity is solitary ... (but) the ability to create and the productions which result from such ability are generally regarded as possessing value by our society. (Nasar, 1998, pp. 15–16).

The Schizoid's Experience

Schizoid personalities function at a borderline level of personality organization (Kernberg, 1984), a position between neurotic and psychotic. This level of functioning suggests that they have not managed to individuate and integrate sufficiently. These individuals often suffer as a result of poor interpersonal ego boundaries. Kernberg saw the schizoid personality disorder, with other personality disorders in this category, as having a poorly integrated sense of self and subsequent confusion about personal identity. These individuals have a predominance of and reliance on primary defenses (McWilliams, 1994), primitive object relations (Kernberg, 1984), and early persecutory anxieties associated with the paranoid-schizoid position (M. Klein, 1946/1975).

On entering therapy, an individual with a schizoid presentation will probably feel anxious as a result of projecting either a sadistic object or the master-object representation onto the therapist. Alternatively, through projective identification, the person may locate the self in the therapist and inhabit the object aspect of the relational units.

The various theories just discussed and my description of schizoid processes and personalities emerge from clinical experience. What is being discussed here are those individuals who present for therapy with these characteristics and who are struggling in some way. Usually, they are seeking more contact and closeness but are fearful at the same time. There are also many people who could be described as having a schizoid personality who do not experience any tension and are content with their lives.

I think of the schizoid personality structure as having developed as a defense and as a means of managing early experiences of trauma or developmental deficit and rupture. I see their internal world as consisting of a split structure that has come about as a result of failures in bonding and attachment. The infant retreats inwardly, maintaining a more superficial relationship with attachment figures.

Seinfeld (1996, p. 78), citing R. D. Laing, wrote that in human development there is a polarity between separateness and relatedness, both of which represent profound human needs. The person with a schizoid personality experiences this process in a more extreme way. They are usually highly anxious, with the fear of closeness being experienced as a fear of dependency or a fear of merging with a subsequent loss of a sense of self. Separation may be experienced as isolation or being in exile. Both positions are experienced as frightening. Thus, nowhere feels safe for the schizoid individual. This is in contrast to the narcissist, who feels safe when merged with an idealized object, or the borderline, who feels safe when clinging and merging with a rewarding object.

Withdrawal: Home Base

Everything Starts and Ends at Home

Any description of a schizoid presentation will include the characteristics of withdrawal, self-sufficiency, detachment, aloofness, and lack of affect. Withdrawal is often the home position of the schizoid individual. R. Klein (1995) described this as a nonattachment position and McWilliams (1994, p. 100) as a primitive defense. It is where schizoid personalities seem to spend most of their time and also how people often think of them.

Withdrawal into a different state of consciousness is an automatic, self-protective behavior that can be observed in infants. The same can be seen in

adults who may retreat from others to their internal world of fantasy. Some infants' temperament may lead them be more inclined to withdraw, and there is some suggestion that they may be particularly sensitive (McWilliams, 1994, p. 100).

For example, I often see a certain man who lives in our locality walking around the streets. He wears the same clothes most of the year, and his unkempt beard gives him a medieval appearance. I have never seen him with anyone. We nod at each other as we pass, occasionally exchanging a polite greeting. I make a point of saying hello, but nothing more is said. He walks on, not really looking at people. He buys his lunch at a local shop and then eats it sitting on a park bench. He does not appear to work. My fantasy is this is the sum of his life, that this is how he spends his time. I cannot imagine that he has ever had a relationship in his adult life.

The appearance I am describing might be thought of as a more extreme withdrawn schizoid presentation. I doubt that he and others like him would seek out therapy. He may not even be uncomfortable with the way he is. His position may be a result of how he negotiated early-life experiences and his relationship with his caretakers (R. Klein, 1995). His is a severe, introverted schizoid presentation, functioning in isolation, living in the citadel of his mind, perhaps living in imagination rather than in the external world with its possibility of relationships. The dread of relationships with the possibility of being smothered, suffocated, possessed, imprisoned, or absorbed (Guntrip, 1994, p. 166) feels claustrophobic. This extreme schizoid withdrawal was described by Guntrip (1968) as follows:

Womb fantasies and/or the passive wish to die represent the extreme schizoid reaction, the ultimate regression, and it is the more common, mild characteristics which show the extraordinary prevalence of schizoid, i.e. detached or withdrawn, states of mind. (p. 58)

In considering these disorders, the description and behavioral elements need to be combined with a phenomenological and intrapsychic analysis in order to fully understand and possibly diagnose a schizoid personality disorder.

Returning to Erskine's (2020) work with Violet, he initially focused on her withdrawal behavior, commonly exhibited by schizoid personalities. She was, for him, confusing and, at times, difficult. He described how in his work with her, he learned about relational withdrawal and the significance of attunement, particularly to silence, in psychotherapy (p. 14). Violet's internal world emerged early in her meetings with Erskine when she described how "her husband

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alternated between ignoring her and controlling her” (p. 15). This also echoed her relationship with her mother. Her comments about her husband were probably a transference projection of that internal world as well as the reality of her experience with her husband. That was a point at which her internal and external worlds came together. Her experience of her husband became a hook on which she could hang her projections and probably represented the object from which Violet withdrew.

In my 2001 article, I wrote about Sebastian, who usually started a session by saying something placatory that we could talk about but that did not reveal his vulnerability. Sessions seemed to be isolated experiences for him, without continuity. He often seemed to have forgotten the previous session, having wiped it out:

Sebastian often withdraws and seems to be watching me. It is as if he is on the inside of his head looking out of his eyes watching my every move. He has described having retreated into a castle, staying in the dungeon where he feels safe. He leaves a guard on duty. The drawbridge is down but can be raised at any time. If I see an expression of emotion on his face and respond, he is moved at having been seen but feels he cannot call out. He feels it would be dangerous and frightening to do so. Sebastian has retreated from the world and is detached from interpersonal relations. He has numbed his emotional responses to people and events. (Little, 2001, p. 35)

More extreme introverted schizoid personalities occupy what R. Klein (1995) described as “the safe place or haven, the impenetrable fortress, and the point of no return” (p. 55). The citadel is a womb-like state free from demands or attacks, with no need to adapt (Little, 2001, p. 38). The person is unlikely to experience any ambivalence about relationships. On the other hand, those schizoids with milder characteristics are more likely to want relationships with others. Perhaps there is a continuum for those with schizoid personality: at one end, more integrated individuals and, at the other, more severe presentations.

When thinking about schizoid individuals’ ambivalence about attachment—craving closeness yet fearing engulfment, seeking distance but complaining of loneliness (McWilliams, 1994, p. 193)—I distinguish between these two aspects of ambivalence and the kind where withdrawal is more profound and individuals retreat into fantasy and their internal world. I refer to the latter as an “introverted regressed schizoid” (Guntrip, 1968, p. 42), someone who does without relationships.

Maintaining Withdrawal: Attacks on the Link

Withdrawal is both a behavioral process and a psychological strategy of retreating into fantasy and imagination and detaching from external reality and relationships. This entails withdrawing into an internal closed system to escape the dangers of engaging with the external world. Over time, a schizoid client may establish a psychological and emotional link with a therapist, one that may be experienced as a threat or as dangerous. As a result, the person's internal bad object relationship may attack the links to the therapist because the clinician represents a threatening external reality. This defensive process reinforces the client's isolation. The closed psychic system, with its bad object, impedes the relational-seeking aspect of the personality. This is akin to Fairbairn's notion of the client remaining loyal to the bad object.

For his part, Bion (1967) described how the psychotic mind attacks the perceptual apparatus that links it to the object. I have experienced less severe attacks on the link between myself and a client as part of a schizoid defensive stance. For example, Justine, on leaving a session, would sometimes say things to herself such as, "Did you see how he took your money at the end of the session? He's so greedy. All he wants is your money. You're just a cash cow for him. You shouldn't trust him." This was an attack on her emerging link with me. This demonstrates how the desire to attach and connect may be prevented by the antirelational unit attacking the link between the client and the therapist as the needed object/other by devaluing and belittling the therapist. This kind of postsession attack usually occurred when Justine had shifted in her position, taken a risk, and revealed more of herself to me. The attack was typical of the nonattachment, antirelational side of her personality and her attitude of not relying on others. The internal attacks would often leave her isolated and alone between sessions. At such times, she had destroyed the cocreated new relational unit.

After such self-talk, when Justine arrived at her next session, she was often wary of and less likely to trust me. I watched for this behavior and experienced it as "one step forward, two steps back." The antirelational self will attack the relational-seeking self's links to its attachment objects/others. These rejecting behaviors often echo the original caregiver's response toward the person's infantile dependency needs (Seinfeld, 1991, p. 73).

Enforced Withdrawal During Lockdown

Writing this article in May 2020 during the lockdown resulting from the COVID-19 pandemic highlights and affects my experience and understanding of these processes. When I venture out to the supermarket, I experience an increase in anxiety. I walk down the road wary of an unseen threat. Another person becomes a threatening enemy who may be carrying a deadly disease. Going around the supermarket picking up groceries I notice how watchful and anxious I am as other shoppers come close to me. There is an induced paranoia. It is not until I return home that I begin to relax.

I can imagine that this is not dissimilar to what less anxious schizoid personalities experience much of the time when they are out among people, anticipating an attack and withdrawing to protect themselves from danger. For some, the experience is even more extreme, and it is appropriate to talk of terrors and horrors and fear of mutilation: a world occupied by monsters. The difference for me during the pandemic is that my withdrawal is not something I chose but something that was imposed on me and is not my preference. Yet the danger is real. Needing to withdraw and isolate from face-to-face contact with clients, colleagues, and friends when personal contact involves the risk of catching a life-threatening virus has given me a perverted sort of empathy for the schizoid personality!

Listening to clients and talking to supervisees these days, I realized that being in lockdown suits some people more than others, depending on their characterological structures. Another lockdown experience that spoke to the defense of withdrawal was something I noticed while working with clients remotely. Because of the isolation that I experienced, and the lack of contact with colleagues and friends, I had a growing desire to be friendlier with clients than I would be normally. I felt the impulse to reveal more personal circumstances and experiences that had nothing directly to do with the therapy. I would end the session by saying, "I'll see you next week," which is something I would not ordinarily say. What I understood was that my need for attachment, connection, and contact was emerging as a desire to self-disclose as a result of my disconnection from friends and colleagues. It was also triggered by the abrupt end to the session. The process highlighted for me that, in a nonattached state—in this case imposed by circumstances—the need to connect was emerging and fighting to be met. I was thereby running the risk of a boundary crossing (Little, 2020) and a loss of my therapeutic frame.

Countertransference Reactions

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Returning to Erskine (2020), he wondered whether he had been caught in a countertransference reaction with Violet through the methods he was using to treat her, which he appropriately discussed in supervision. The supervisor reiterated what Erskine had already been doing and did not address his lack of attunement to Violet, including during her long silences. Erskine began wondering what was missing in the therapeutic relationship (p. 16) and stated that he “felt inadequate” (p. 17).

One aspect of Erskine’s countertransference was that he wanted something to happen in the therapy, so he focused on expressive methods, cognitive understanding, and behavior change. In my own work, sometimes my countertransference reaction to a schizoid client who has withdrawn has been that I want to “shake them up” and have them engage more with me. I can find it difficult to stay involved with someone who lacks affect and is self-sufficient and self-reliant. As therapists, with such individuals we can often feel useless or superfluous. Other therapists have described the experience of frustration or even abandonment in the face of the client’s lack of lively emotional engagement in the work. On the other hand, I have clients for whom my aliveness can be threatening as if it were a prelude to danger, a sign that I will become an intrusive or dangerous other. One of the things that helps me stay engaged in such situations is understanding the nature of the client’s early trauma.

With my client Sean, I recall wanting to disclose something of my poor, working-class background, which was very similar to his. I was fond of him and felt a desire to verbalize my warm feelings. It was difficult to sit with him session after session with his affectless presentation. At times I had the fantasy that expressing my feelings with him would somehow bring him alive, breathe life into his lungs. However, in fact, my presence was threatening to him.

As described earlier, countertransference reactions may include feeling tender while also struggling with how to connect and form a therapeutic alliance as well as to understand the client’s inner world without evoking too much anxiety or becoming too detached. The danger is in treating the client as an object of interest instead of as someone wrestling with a dilemma with its dual anxieties and helping them make meaning of their experience.

Schizoid Dilemma

My clinical experience is that those schizoid personalities who present for therapy often experience a dilemma (Fairbairn, 1952; Guntrip, 1968) with which they are

struggling. On the one hand, the person wants connection and closeness but fears feeling unsafe, even entrapped; on the other, they want to withdraw and retreat into exile to feel safe with the accompanying experience of isolation and aloneness.

Manfield (1992) movingly described this process as “too distant from people, he believes he will disintegrate, dissolve into oblivion, vaporize, be lost. [But] ... too close to someone, he is afraid of being co-opted, used, swallowed up, devoured, totally appropriated” (p. 215).

This process also demonstrates a tension between the needed relationship—that is, the desire for closeness—and the repeated relationship (Little, 2011) with its fear of retraumatization. Working as I do in the here and now of the transference-countertransference relationship entails the therapist being both the longed for attachment object and the feared object. The more the therapist represents the longed for other, the more he or she will be feared as the process begins to trigger memories of early traumatic experience. As the client allows the need for contact to emerge, they may also experience the fear of retraumatization and the expectation that the therapist will let them down. Thus, the therapeutic paradox is that the more the needs emerge, the more the fear of retraumatization is stirred. In the initial stages of therapy, the client has no idea that the therapist is going to be any different from those who were previously retraumatizing for them. This represents a transference expectation.

The therapist’s stance when working with these presentations should include an understanding of this dilemma and the associated relational impasse (Little, 2011). This understanding may be offered to the client as an interpretation. For example, the therapist might say, “On the one hand (you have an anxiety about getting close), and on the other ... (you are anxious about being isolated).”

Being close means the schizoid has to face the fact that they cannot control the other and that being involved in relationships runs the risk of being rejected, attacked, and/or experiencing pain. Some people prefer isolation rather than engaging with this process.

For example, as a child, Marcia retreated to her room to avoid the demands of her parents, whom she described as misattuned and not interested in her, only in her older sister. As an adult, Marcia preferred being on her own, but her job required her to do certain things for people. This meant she had to leave the safety of her womb-like state, which echoed her childhood bedroom. In doing so, she had to encounter the world that she hated. In her therapy, her infant needs emerged, and she wanted her therapist to be perfectly attuned to her. She *International Journal of Integrative Psychotherapy, Vol. 11, 2020*

unconsciously wanted to incorporate him into her safe, womb-like space and have him be devoted to her, thus protecting her from disappointment, pain, and separation.

For the schizoid individual, every place and every experience is fraught with anxiety, whether that is being with people or being alone. Being self-reliant avoids the problem of having to rely on or be dependent on another, but it can leave the individual having to do everything themselves and having no significant social contact. The dilemma can be described as an experience between an antirelational self and a relational-seeking self (Little, 2001; Seinfeld, 1991). Attending to the behavioral manifestations of the dilemma often highlights the person's own split internal personality structure, and the manner in which they experience others represents a transference projection.

Erskine (2020) described Violet as “unconsciously looking for interpersonal connection and simultaneously fearing any human closeness” (p. 22). The relational-seeking self desires connection, whereas the antirelational self wants to prevent that from happening. He described how Violet's “social self” has achieved some relational security by accommodating to the requirements of significant others, whereas her “vital and vulnerable self” remains “protectively internal” (pp. 18–19). Erskine made a note to himself “to respect her silences, to support her withdrawal, and to create a safe place for the deeply repressed to express herself” (p. 20). He wondered if he “thought of Violet's silence and withdrawal as her attempt to protect a vital and vulnerable aspect of herself” (p. 20). He understood that her “polite, proper, and superficial presentation as a social façade had at least two important functions: protection and attachment” (p. 20).

Schizoid Compromise

In common with Erskine, I (Little, 2012) admire the writings of Guntrip and his descriptions of working with clients who have withdrawn from relationship into a “schizoid compromise” (Guntrip, 1968, p. 58). That phrase describes what the client is trying to deal with psychologically, and the compromise indicates how they are managing the dilemma, that is, finding a middle ground between the two anxieties.

Erskine (2020) described wondering how he might make sense of his client's “superficial stories, the lack of interpersonal contact, and the absence of any vitality, emotions, or vulnerability” (p. 18). He saw Violet as “someone who

learned to hide her vitality and vulnerability,” who had “created a social façade (i.e., a false self) in order to maintain some form of relational attachment” (p. 19).

Previously, I (Little, 2001, p. 39) discussed how retreating from contact leaves the individual isolated, lonely, and in pain. Some schizoid personalities may attempt to avoid the pain through “workaholism, intellectualization and other distancing defences” (Manfield, 1992, p. 205). In some cases, the longing for contact will reemerge, and the person may want to move toward others; however, such movement also brings with it the anxiety of being close with its sense of being entrapped. Guntrip (1968) described this as the “in and out program” (p. 36), an expression of the hunger for and terror of contact and closeness, caught between the need and fears of close personal connection. They are driven “in” by their needs and driven “out” by their fears. Some individuals manage this dilemma by establishing the schizoid “compromise in a half-way house position” (Guntrip, 1994, p. 166). This is a way of keeping others around but preventing them from getting too close or becoming endangered by them. This may, for example, be achieved by maintaining contact at an intellectual level or by being present physically but absent emotionally. More often than not, relationships are kept emotionally neutral, an approach that undermines the possibility of forming friendships and romantic relationships.

In the United Kingdom there is an attitude known as the “stiff upper lip,” a cultural endorsement of the expression of the compromise that enables people to stay socially connected while hiding their emotions. Many “polite” behaviors in certain cultures are also an expression of the same compromise, one that is, in essence, a defensive position between the two fears of isolation, on the one hand, and enslavement or merging/fusing, on the other. The question for the individual is, “How do I keep people around without getting too close or being alone?” The compromise is a remedy to the oscillation of the in-and-out program, but the individual does not give themselves to anyone or anything fully.

Therapy of the Compromise: The Therapist’s Stance

The initial therapeutic task with schizoid clients is to create sufficient safety (R. Klein, 1995; Little, 2001; O’Reilly-Knapp, 2001), including a containing, holding environment that is both nonwounding and unobtrusive and that creates an opportunity for the hidden, vulnerable, relational-seeking self to reemerge. The therapist needs to be curious regarding why the person went into hiding, what their terror is about, and the nature of the defenses involved. In addition, it is important to comprehend how attempts at contact by the therapist may be

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experienced by the client as intrusive and frightening. For example, in the work with Violet described by Erskine (2020), she was afraid to “go internal” in front of anyone because “what I have inside is private. No one can know it ... my quiet hiding place. It has been my private place, all my life” (p. 21). The therapist needs to demonstrate an understanding of the schizoid dilemma and compromise and offer an attuned interpretation. In the inevitable push and pull of therapy, the therapist should try, as much as possible, not to behave as either a master or a sadistic object/other. Ware (1983) encouraged us to go slowly: “It must be remembered that the cure of Schizoids is a slow, painstaking process, taking only small steps at a time” (p. 15). I believe that we need to wait outside the “cave” until the person appears or invites us in. What may help them emerge from their particular cave is maintaining the clinical frame and boundaries, which will enable them to begin to feel safe from engulfment or intrusion. Going in after them may repeat the experience of an intrusive caregiver/other.

To establish safety for the client, I occasionally agree to a schedule that begins with meeting every other week and then, after some time, moving to weekly. In my consulting room, I have three sofas, and the client can sit wherever they choose so they can feel safe enough. The therapist needs to attend to variations in the client’s capacity to be present in whatever way they can manage. When a client does withdraw after having been more in contact, I wonder what went on that they became more withdrawn, which is often beneficial to interpret and discuss with them.

Schizoid clients generally begin treatment feeling anxious. During the therapy, this anxiety may be further triggered by moves toward the therapist and/or vice versa. These clients are sensitive to and impacted by changes in the therapist’s mood, demeanor, and/or behavior. In fact, the client’s withdrawal may well be triggered by the therapist’s behavior.

For R. Klein (1995, p. 71), therapy is oriented toward reality, which thereby disrupts transference expectations. In my view, this disruption results from a cocreated relational experience. Erskine noted that both Guntrip and Winnicott encouraged a psychotherapy that focuses on the client’s internal processes and not specifically on cognitive insight or behavioral outcome, “a psychotherapy that provides a healing relationship to a traumatized and fragmented client (Winnicott, 1965)” (Erskine, 2020, p. 19).

From a relational transactional analysis perspective, therapeutic action needs to entail working in the here and now of the therapeutic relationship in which the therapist is experienced as both an old object and a cocreated new object working directly with both relational units in the transference-countertransference

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relationship. The client's experience of the transference expectations reinforces their withdrawal from relationships. This is the nature of unconsciously engaging in psychological games and enactments.

As the therapist and client begin to develop a therapeutic alliance, the new cocreated self-other relational unit develops. For the client, this is a new lens through which to view and experience the world in contrast to their internal structure, which is projected onto the world of relationships. If the client begins to feel safe enough in the therapeutic relationship, they are more likely to experiment with taking risks with the therapist, such as sharing thoughts and feelings more freely. The nature of the client's compromise changes through their experiments.

For example, Lizzie, a woman in her late thirties who has always been independent and self-assured, came to see me because she felt there was something vaguely wrong. She did not trust anyone and could not recall ever doing so. But some things she had read recently led her to wonder if there was something wrong with that. The only contact she had with people was as the manager of an education service. From what she said, it seemed she could be helpful to those for whom she was responsible but without really feeling for them because she had no real emotional relationships. She found it difficult sitting with me because the familiar roles of helper and helped had been reversed, and she was the one requiring help. Her compromise position had always consisted of being helpful.

Any time I showed more than a bland presentation, Lizzie would complain of being intruded on. Over many years, in which I felt I had to sit patiently waiting for her to emerge, she began to tell me her early story of deprivation from an uncontained and intrusive caregiver. She gradually moved from her isolation, withdrawal, and a compromise position of being helpful and responsible for others to one in which I as her therapist became the one person who knew her story with its accompanying feelings. I felt that we had begun to cocreate a precious new narrative.

With another client who began expressing more of her feelings, fantasies, and inner world, it seemed she was experimenting with expressing previously repressed feelings and in so doing shifting her compromise position. She could justify her new behavior on the grounds that as a therapist, I was a professional and therefore different from others. This enabled her to change while remaining the same, thus maintaining her compromise of not revealing her emotions to the world. However, we could also see that she was nullifying me to some degree.

As therapists working with these presentations, we need to be wary of being excessively devoted to having our clients establish closeness, intimacy, and attachment to us or others in their lives, as if intimacy is a defining feature of psychological health and well-being. We might wonder if attachment is being fetishized, to quote a colleague, while acknowledging that to connect is a human need.

Dissociation

Dissociation is, in essence, disconnection from unintegrated states. One type of dissociation is depersonalization (a feeling that one is not in one's own body and is disconnected from one's sense of self), which Guntrip (1968, pp. 41–44) listed as a characteristic of the schizoid. Being disconnected from aspects of the self is a major defense of schizoid personalities. Living in their heads, with apparently little relationship with their emotions, is a common mode of being, as if there is a cutoff or blockage between their hearts and their heads that prevents any communication between the two. Dissociation is commonly used to protect the self from aspects that are felt to endanger existence or that are too painful to engage with. Dissociation maintains the split internal structure, and the therapeutic goal in such cases could be described as moving from segregation and disconnection to association and integration. O'Reilly-Knapp (2001) highlighted how schizoids use dissociation to “protect the continuity of existence” (p. 45).

Aloof From the Crowd

Under stress, schizoid personalities may withdraw either temporarily or permanently from their own affect as well as from external stimulation (McWilliams, 1994, p. 192). Internal dissociation from affect can manifest behaviorally as aloofness, with the individual seeming to look down on others. These individuals appear to hold others in contempt and disdain, on occasions patronizing them while fearing being patronized. This is an expression of the internal saboteur (Fairbairn, 1952) who rejects the need of others. They appear to be proud of being independent and self-reliant (R. Klein, 1995, p. 57).

In such cases, the therapist's countertransference reactions may include feelings of inferiority because of having an emotional response to the client. The tendency of the client to behave in an aloof manner may have its origins in the relationship with primary caregivers who were overcontrolling or overintrusive

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(McWilliams, 1994, p. 195), although usually the main fear driving their behavior is of engulfment rather than abandonment.

For example, many years ago I worked with a man who appeared quite aloof and superior. Initially I thought him quite engaging, but over time I began to feel a strong desire to attack him and penetrate his defenses, even to subjugate him in some way. I felt quite aggressive toward him and wanted to show him how he was making things worse for himself. I arrogantly felt I knew better than he did. After some time and reflection, I realized that he had disconnected from any intense feelings. He could talk politely with me about emotions, but he dissociated from his more intense feelings. In discussion with my supervisor, I came to see that, through projective identification, I was experiencing the intense feelings with which he could not allow himself to connect.

Therapist's Defensive Compromise

Lastly, I want to address a defensive position that therapists themselves may occupy: a schizoid compromise position, not a countertransference reaction. Schizoid individuals can be very sensitive to other people and often bury their aggression. As McWilliams (1994, p. 196) wrote, schizoid personalities are able to care about others while maintaining a protective stance (as was the case with Lizzie as described earlier), and some even pursue careers in psychotherapy. In citing Wheelis, McWilliams described how people with a “core conflict over closeness and distance” may take up the profession of psychotherapy because it “offers the opportunity to know others more intimately than anyone else ever will, while concealing the self” (p. 196).

For instance, therapy sessions are time limited. Therefore, at an emotional level, the therapist knows that whatever may go on and emerge in the session, it will end at a given time. Potentially, this time boundary permits the therapist to hide their own emotional response. In my experience as a supervisor, I have noticed that some therapists can avoid certain feelings or experiences by not commenting on them or by behaving in a particular manner that conveys the message that certain feelings do not have a place in therapy and therefore will not be addressed. An example would be the therapist who, every time sexual feelings enter the conversation, changes the subject. We all have our blind spots, but most of these are never examined. The therapist can “coast in the countertransference” (Hirsch, 2008) and thereby avoid disrupting the therapy, which would otherwise involve moving out of the safety zone of the “compromise” and disrupting the transference-countertransference relationship. It is as if the

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therapist's "[f]eelings can be identified and utilized interpersonally, although in a limited and circumscribed fashion" (R. Klein, 1995, p. 56).

Working as a psychotherapist can in itself be a compromise position for some. During the pandemic, working remotely has suited some therapists and clients. They feel more at ease. Hirsch (2008), citing Buechler, described how therapists with schizoid qualities may be inclined toward retreating emotionally, especially with clients who are also comfortable with emotional distance. The therapy may then become politely inactive. In my view, therapy should help the client enrich their lives and not be an alternative for life.

For some therapists, technique is often seen as the main method for facilitating the client's integration and growth. Thus, a further compromise for the therapist can be to use various techniques with the client while remaining affectively uninvolved. The therapist in a compromise position may not push themselves or the client beyond "states of comfortable equilibrium to states of disruption and surprise" (Hirsch, 2008, p. 65).

For some clinicians, the work of therapy provides some affective engagement in relationship while still maintaining emotional safety. In fact, schizoid personalities may "gravitate to careers in psychotherapy, where they put their exquisite sensitivity to use safely in the service of others" (McWilliams, 1994, p. 196).

Having said that, it is important to bear in mind that most therapists have a course of therapy during their training and will have engaged in reading, supervision, and self-analysis. As a result, they should have developed a narrative that explains what happened to them as a child. Managing to reconcile childhood experience in therapy and understanding the impact the past has on the present allows the possibility of developing an "earned secure" (Wallin, 2007, p. 87) attachment style.

If the therapist unconsciously retreats to a defensive withdrawal, or compromise position, this may be an indicator of them being under more extreme countertransference stress. Therefore, the concerns already expressed here regarding the therapist's compromise are a warning of the risks for the clinician.

Conclusion

It has been interesting to reread the literature from the past 25 years since I first read and engaged with it and particularly in light of the clinical experience I now

have. Back 25–30 years ago, I had only limited clinical experience with schizoid processes. My first encounter with the literature was with Guntrip (1994). As I reread him today, I continue to review my thinking and understanding and to examine my therapeutic approach. Guntrip still has a good deal to offer the practitioner who wishes to understand the inner world schizoid individuals occupy.

It is easy to overlook schizoid traits in clients, particularly when they are withdrawn, quiet, or enslaved and thus adapted to the other. They are not generally as disturbing to the therapist as borderline and narcissistic characterological presentations.

If I think of schizoid processes in contrast to schizoid personality disorder, I no longer see the dilemma as belonging only to the latter. In the 20 years since that conference in San Francisco where Erskine and I presented, I have come to believe, as some others do (Manfield, 1992, p. 204), that the schizoid presentation, with its flight from object relations and its subsequent compromise, is more prevalent and commonplace than we often recognize.

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