

# Schizoid Personality: The Solitary Inner World

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Schizoid personality disorder (SPD) is a personality disorder characterized by a lack of interest in social relationships, a tendency towards a solitary lifestyle, secretiveness, emotional coldness and sometimes (sexual) apathy, with a simultaneous rich, elaborate and exclusively internal fantasy world. SPD is not the same as schizophrenia, although they share some similar characteristics such as detachment or blunted affect; there is increased prevalence of the disorder in families with schizophrenia.

## Signs and Symptoms

People with SPD are seen as aloof, cold and indifferent, which causes some social problems. Most individuals diagnosed with SPD have difficulty establishing personal relationships or expressing their feelings in a meaningful way, and may remain passive in the face of unfavourable situations. Their communication with other people at times may be indifferent and concise. Because of their lack of meaningful communication with other people, those who are diagnosed with SPD are not able to develop accurate reflections of themselves with respect to how well they are getting along with others. Such reflections are important for a person's self-awareness and their ability to assess the impact of their own actions in social situations. R. D. Laing suggests that without being enriched by injections of interpersonal reality there occurs an impoverishment in which one's self-image becomes more and more empty and volatilized, leading the individual himself to feel unreal.

According to Gunderson, people with SPD "feel lost" without the people they are normally around because they need a sense of security and stability. However, when the patient's personal space is violated, they feel suffocated and feel the need to free themselves and be independent. Those people who have SPD are happiest when they are in a relationship in which the partner places few emotional or intimate demands on them, as it is not people as such that they want to avoid, but both negative and positive emotions, emotional intimacy, and self disclosure.

This means that it is possible for schizoid individuals to form relationships with others based on intellectual, physical, familial, occupational, or recreational activities as long as these modes of relating do not require or force the need for emotional intimacy, which the individual will reject.

Donald Winnicott sums up the schizoid need to modulate emotional interaction with others with his comment that schizoid individuals "prefer to make relationships on their own terms and not in terms of the impulses of other people," and that if they cannot do so, they prefer isolation.

## 'Secret schizoid'

According to Ralph Klein there are many fundamentally schizoid individuals who present with an engaging, interactive personality style which contradicts the timidity, reluctance, or avoidance of the external world and interpersonal relationships as emphasized by the DSM-IV and ICD-10

definitions of the schizoid personality. Klein classifies these individuals as secret schizoids who present themselves as socially available, interested, engaged, and involved in interacting in the eyes of the observer, while at the same time, he or she is apart, emotionally withdrawn, and sequestered in a safe place in his or her own internal world. So, while withdrawal or detachment from the outer world is a characteristic feature of schizoid pathology, it is sometimes overt and sometimes covert. While it is overt it matches the usual description of the schizoid personality offered in the DSM-IV. According to Klein, though, it is "just as often" a covert, hidden internal state of the patient in which what meets the objective eye may not be what is present in the subjective, internal world of the patient. Klein therefore cautions that one should not miss identifying the schizoid patient because one cannot see the patient's withdrawal through the patient's defensive, compensatory, engaging interaction with external reality. Klein suggests that one need only ask the patient what his or her subjective experience is in order to detect the presence of the schizoid refusal of emotional intimacy.

Descriptions of the schizoid personality as hidden behind an outward appearance of emotional engagement have long been recognized, beginning with Fairbairn's (1940) description of 'schizoid exhibitionism' in which he remarked that the schizoid individual is able to express quite a lot of feeling and to make what appear to be impressive social contacts but in reality giving nothing and losing nothing, because since he is only playing a part his own personality is not involved. According to Fairbairn, the person "...disowns the part which he is playing and thus the schizoid individual seeks to preserve his own personality intact and immune from compromise." Further references to the secret schizoid come from Masud Khan, Jeffrey Seinfeld, and Philip Manfield, who gives a palpable description of an SPD individual who actually "enjoys" regular public speaking engagements, but experiences great difficulty in the breaks when audience members would attempt to engage him emotionally. These references expose the problems involved in relying singularly on outer observable behavior for assessing the presence of personality disorders in certain individuals.

### **Avoidant attachment style**

The question of whether SPD qualifies as a full personality disorder or simply as an avoidant attachment style is a contentious one. If what has been known as schizoid personality disorder is no more than an attachment style requiring more distant emotional proximity, then many of the more problematic reactions these individuals show in interpersonal situations may be partly accounted for by the social judgments commonly imposed on those with this style. To date several sources have confirmed the synonymy of SPD and avoidant attachment style which leaves open the question of how researchers might approach this subject best in future diagnostic manuals, and in therapeutic practice. However, characteristically - and depending on the severity of the disorder - individuals do not seek social interactions merely due to lack of interest, as opposed to the avoidant personality type in which there is craving for interactions, but then fear of rejection.

## Schizoid sexuality

People with SPD are sometimes sexually apathetic, though they do not normally suffer from anorgasmia. Many schizoids have a normal sex drive but some prefer to masturbate rather than deal with the social aspects of finding a sexual partner. Therefore, their need for sex may appear to be less than those who do not have SPD, as individuals with SPD prefer to remain alone and detached. When having sex, individuals with SPD often feel that their personal space is being violated, and they commonly feel that masturbation or sexual abstinence is preferable to the emotional closeness they must tolerate when having sex. Significantly broadening this picture are notable exceptions of SPD individuals who engage in occasional or even frequent sexual activities with others.

Harry Guntrip describes the "secret sexual affair" entered into by some married schizoid individuals as an attempt to reduce the quantity of emotional intimacy focused within a single relationship, a sentiment echoed by Karen Horney's resigned personality who may exclude sex as being "too intimate for a permanent relationship, and instead satisfy his sexual needs with a stranger. Conversely he may more or less restrict a relationship to merely sexual contacts and not share other experiences with the partner." More recently, Jeffrey Seinfeld, professor of social work at New York University, has published a volume on SPD in which he details examples of "schizoid hunger" which may manifest as sexual promiscuity. Seinfeld provides an example of a schizoid woman who would covertly attend various bars to meet men for the purposes of gaining impersonal sexual gratification, an act, says Seinfeld, which alleviated her feelings of hunger and emptiness.

Salman Akhtar describes this dynamic interplay of overt versus covert sexuality and motivations of some SPD individuals with greater accuracy. Rather than following the narrow proposition that schizoid individuals are either sexual or asexual, Akhtar suggests that these forces may both be present in an individual despite their rather contradictory aims. For Akhtar, therefore, a clinically accurate picture of schizoid sexuality must include both the overt signs: "asexual, sometimes celibate; free of romantic interests; averse to sexual gossip and innuendo," along with possible covert manifestations of "secret voyeuristic and pornographic interests; vulnerable to erotomania; tendency towards compulsive masturbation and perversions," although none of these necessarily apply to all people with SPD.

## Causes

There is some evidence to suggest that there is an increased prevalence of schizoid personality disorder in relatives of people with schizophrenia or schizotypal personality disorder. Unloving or neglectful parenting is hypothesized to play a role.

## Diagnosis

### DSM

The Diagnostic and Statistical Manual of Mental Disorders fourth edition, a widely used manual for diagnosing mental disorders, defines schizoid personality disorder (in Axis II Cluster A) as:

A. A pervasive pattern of detachment from social relationships and a restricted range of expression of emotions in interpersonal settings, beginning by early adulthood (age eighteen or older) and present in a variety of contexts, as indicated by four (or more) of the following:

neither desires nor enjoys close relationships, including being part of a family

almost always chooses solitary activities

has little, if any, interest in having sexual experiences with another person

takes pleasure in few, if any, activities

lacks close friends or confidants other than first-degree relatives

appears indifferent to the praise or criticism of others

shows emotional coldness, detachment, or flattened affect

B. Does not occur exclusively during the course of schizophrenia, a mood disorder with psychotic features, another psychotic disorder, or a pervasive developmental disorder and is not due to the direct physiological effects of a general medical condition.

It is a requirement of DSM-IV that a diagnosis of any specific personality disorder also satisfies a set of general personality disorder criteria.

In the draft of the DSM-V it is proposed that schizoid personality disorder should be represented and diagnosed by a combination of core impairment in personality functioning and specific pathological personality traits, rather than as a specific type.

### World Health Organization

The World Health Organization's ICD-10 lists schizoid personality disorder as (F60.1) Schizoid personality disorder.

It is characterized by at least four of the following criteria:

Emotional coldness, detachment or reduced affection.

Limited capacity to express either positive or negative emotions towards others.

Consistent preference for solitary activities.

Very few, if any, close friends or relationships, and a lack of desire for such.

Indifference to either praise or criticism.

Taking pleasure in few, if any, activities.  
Indifference to social norms and conventions.  
Preoccupation with fantasy and introspection.  
Lack of desire for sexual experiences with another person.

It is a requirement of ICD-10 that a diagnosis of any specific personality disorder also satisfies a set of general personality disorder criteria.

### **Millon's subtypes**

Theodore Millon identified four subtypes of schizoid. Any individual schizoid may exhibit none or one of the following:

languid schizoid  
including depressive features  
remote schizoid  
including avoidant, schizotypal features  
depersonalised schizoid  
including schizotypal features  
affectless schizoid  
including compulsive features

### **Dynamic diagnostic criteria**

Ralph Klein, 1995 brought new light into the commonly held beliefs about the schizoid which focus mainly on the schizoid's apparent disinterest in relationship. Clarifying the causes and conditions underlying the characteristics listed above, Klein describes a 'split' in the object relations of the schizoid. This split involves: on the one hand, the "slave/master" relationship, a relationship characterised by exploitation, appropriation, and dehumanisation, and on the other, the "self in exile". It is in aversion, or recoil from the exploitive relationship that the self goes into exile. It is this, the self in exile, that is the more commonly recognised aspect of the schizoid, as described in the DSM--the distanced or unresponsive person. As Klein puts it: the..."seeming detachment from feelings should never be accepted as the real state of affairs" p. 135. Of particular significance is the correlation between the Narcissistic disorder and the schizoid. For example the "over entitlement" of the narcissist in a family can result in the "under-entitlement" of the schizoid. It is also the disavowed shame of the narcissist that is often absorbed by, or projected into the schizoid, thus giving rise to the experience of psychic invasion, and the vulnerability to intrusiveness. Paradoxically, a schizoid may also be attracted to exploitive relationships, where they long to experience significance and recognition by serving a need of the other. Yet this same person may be highly aware of any forms of corruption or exploitation outside of this relationship. In this

approach diagnosis is based on the dynamic of this split, and all its consequences, as opposed to diagnosis on the basis of a list of external behaviours.

### **Guntrip criteria**

Ralph Klein, Clinical Director of the Masterson Institute delineates the following nine characteristics of the schizoid personality as described by Harry Guntrip: introversion, withdrawnness, narcissism, self-sufficiency, a sense of superiority, loss of affect, loneliness, depersonalization, and regression.

### **Introversion**

According to Guntrip, "By the very meaning of the term the schizoid is described as cut off from the world of outer reality in an emotional sense. All this libidinal desire and striving is directed inward toward internal objects and he lives an intense inner life often revealed in an astonishing wealth and richness of fantasy and imaginative life whenever that becomes accessible to observation. Though mostly his varied fantasy life is carried on in secret, hidden away." The schizoid person is cut off from outer reality to such a degree that he or she experiences outer reality as dangerous. It is a natural human response to turn away from sources of danger and toward sources of safety. The schizoid individual, therefore, is primarily concerned with avoiding danger and ensuring safety.

### **Withdrawnness**

According to Guntrip, withdrawnness means detachment from the outer world, the other side of introversion. While there are many schizoid individuals who will present with obvious withdrawnness (a clear and obvious timidity, reluctance, or avoidance of the external world and interpersonal relationships), this defines only a portion of such individuals. Many fundamentally schizoid people present with an engaging, interactive personality style. Such a person can appear to be available, interested, engaged, and involved in interacting with others; however, in reality, he or she is emotionally withdrawn and sequestered in a safe place in an internal world. While withdrawnness or detachment from the outer world is a characteristic feature of schizoid pathology, it is sometimes overt and sometimes covert. When it is overt it matches the usual description of the schizoid personality. Just as often, it is a covert, hidden internal state of the patient.

Several points are important to review at this time. First, what meets the objective eye may not be what is present in the subjective, internal world of the patient. Second, one should not mistake introversion for indifference. Third, one should not miss identifying the schizoid patient because one cannot see the forest of the patient's withdrawnness through the trees of the patient's defensive, compensatory, engaging interaction with external reality.

## **Narcissism**

Guntrip: "Narcissism is a characteristic that arises out of the predominately interior life the schizoid lives. His love objects are all inside him and moreover he is greatly identified with them so that his libidinal attachments appear to be in himself. The question, however, is whether the intense inner life of the schizoid is due to a desire for hungry incorporation of external objects or due to withdrawal from the outer to a presumed safer inner world." The need for attachment as a primary motivational force is as strong in the schizoid person as in any other human being. However, because the schizoid's love objects are internal, he or she finds safety without connecting and attaching to objects in the real world.

## **Self-sufficiency**

Guntrip writes, "This introverted narcissistic self-sufficiency, which does without real external relationships while all emotional relations are carried on in the internal world, is a safeguard against anxiety breaking out in dealing with actual people." The more that schizoids can rely on themselves, the less they have to rely on other people and expose themselves to the potential dangers and anxieties associated with that reliance or, even worse, dependence. The vast majority of schizoid individuals show an enormous capacity for self-sufficiency, for the ability to operate alone, independently and autonomously, in managing their worlds.

## **Sense of superiority**

Guntrip states, "a sense of superiority naturally goes with self-sufficiency. One has no need of other people, they can be dispensed with... There often goes with it a feeling of being different from other people." The sense of superiority of the schizoid has nothing to do with the grandiose self of the narcissistic disorder. It does not find expression in the schizoid through the need to devalue or annihilate others who are perceived as offending, criticizing, shaming, or humiliating. This type of superiority was described by a young schizoid man:

"If I am superior to others, if I am above others, then I do not need others. When I say that I am above others, it does not mean that I feel better than them, it means that I am at a distance from them, a safe distance."

It is a feeling of being horizontally, rather than vertically distant.

## **Loss of affect**

According to Guntrip, "Loss of affect in external situations is an inevitable part of the total picture." Because of the tremendous investment made in the self--the need to be self-contained, self-

sufficient, and self-reliant--there is inevitable interference in the desire and ability to feel another person's experience, to be empathic and sensitive. Often these things seem secondary, a luxury that has to await securing one's own defensive, safe position. The subjective experience is one of loss of affect. For some patients, the loss of affect is present to such a degree that the insensitivity becomes manifest in the extreme as cynicism, callousness, or even cruelty. The patient appears to have no awareness of how his or her comments or actions affect and hurt other people. More frequently, the loss of affect is manifest within the patient as genuine confusion, a sense of something missing in his or her emotional life.

### **Loneliness**

According to Guntrip, "Loneliness is an inescapable result of schizoid introversion and abolition of external relationships. It reveals itself in the intense longing for friendship and love which repeatedly break through. Loneliness in the midst of a crowd is the experience of the schizoid cut off from affective rapport." This is a central experience of the schizoid that is often lost to the observer. Contrary to the familiar caricature of the schizoid as uncaring and cold, the vast majority of schizoid persons who become patients express at some point in their treatment their longing for friendship and love. This is not the schizoid patient as described in the DSMs. Such longing, however, may not break through except in the schizoid's fantasy life, to which the therapist may not be allowed access for quite a long period in treatment. If longing is immediately present, however, it is more likely avoidant personality disorder.

There is a very narrow range of schizoid individuals--the classic DSM-defined schizoid--for whom the hope of relationship is so minimal as to be almost extinct; therefore, the longing for closeness and attachment is almost unidentifiable to the schizoid themselves. These individuals will not become patients. The schizoid individual who becomes a patient does so often because of the twin motivations of loneliness and longing. This schizoid patient still believes that some kind of connection and attachment is possible and is well suited to psychotherapy. Yet the irony of the DSMs is that they may lead the psychotherapist to approach the schizoid patient with a sense of therapeutic pessimism, if not nihilism, misreading the patient by believing that the patient's wariness is indifference and that caution is coldness.

### **Depersonalization**

Guntrip describes depersonalization as a loss of a sense of identity and individuality. Depersonalization is a dissociative defense. Depersonalization is often described by the schizoid patient as a tuning out or a turning off, or as the experience of a separation between the observing and the participating ego. It is experienced by those with schizoid personality disorder when anxieties seem overwhelming. It is a more extreme form of loss of affect than that described

earlier. Whereas the loss of affect is a more chronic state in schizoid personality disorder, depersonalization is an acute defense against more immediate experiences of overwhelming anxiety or danger.

## **Regression**

Guntrip defined regression as "Representing the fact that the schizoid person at bottom feels overwhelmed by their external world and is in flight from it both inwards and as it were backwards to the safety of the metaphorical womb." Such a process of regression encompasses two different mechanisms: inward and backwards. Regression inward speaks to the magnitude of the reliance on primitive forms of fantasy and self-containment, often of an autoerotic or even objectless nature. Regression backwards to the safety of the womb is a unique schizoid phenomenon and represents the most intense form of schizoid defensive withdrawal in an effort to find safety and to avoid destruction by external reality. The fantasy of regression to the womb is the fantasy of regression to a place of ultimate safety.

The description of the nine characteristics first articulated by Guntrip should bring more clearly into focus some of the major differences that exist between the traditional descriptive (track 1, DSM) portrait of the schizoid disorder and the traditional psychoanalytically informed (track 2, object relations) view. All nine characteristics are internally consistent. Most, if not all, should be present in order to diagnose a schizoid disorder.

## **Akhtar's phenomenological profile**

In an article in the American Journal of Psychotherapy, Salman Akhtar, M.D., provides a comprehensive phenomenological profile of Schizoid Personality Disorder in which classic and contemporary descriptive views are synthesized with psychoanalytic observations. This profile is summarized in a table (reproduced below) listing clinical features, involving six areas of psychosocial functioning and designated by "overt" and "covert" manifestations. Dr. Akhtar states that "these designations do not imply conscious or unconscious but denote seemingly contradictory aspects that are phenomenologically more or less easily discernible," and that "this manner of organizing symptomology emphasizes the centrality of splitting and identity confusion in schizoid personality."

One patient with SPD commented that he could not fully enjoy the life he has because he feels that he is living in a shell. Furthermore, he noted that his inability distressed his wife. According to Beck and Freeman, "Patients with schizoid personality disorders consider themselves to be observers, rather than participants, in the world around them."

## Differential diagnosis

Although SPD shares several aspects with other psychological conditions, there are some important differentiating features:

### Psychological condition and Features

#### Depression

While people who have SPD can also suffer from clinical depression, this is certainly not always the case. Unlike depressed people, persons with SPD generally do not consider themselves inferior to others, although they will probably recognise that they are different.

#### Avoidant personality disorder

Unlike avoidant personality disorder, those affected with SPD do not avoid social interactions due to anxiety or feelings of incompetence, but because they are genuinely indifferent to social relationships; however, in a 1989 study, "schizoid and avoidant personalities were found to display equivalent levels of anxiety, depression, and psychotic tendencies as compared to psychiatric control patients." One SPD patient remarked that previous knowledge, expectations, or assumptions may result in such elevated levels. Patients can mentally simulate damaging scenarios in order to flatten negative effects, should one occur.

#### Asperger syndrome

Asperger syndrome is an autism-spectrum disorder. Unlike AS, SPD does not involve an impairment in nonverbal communication (e.g., lack of eye-contact or unusual prosody) or a pattern of restricted interests or repetitive behaviors (e.g., a strict adherence to routines or rituals, or an unusually intense interest in a single topic). Compared to AS, SPD is characterized by prominent conduct disorder, better adult adjustment, and a slightly increased risk of schizophrenia.

Under stress, some people with schizoid personality features may occasionally experience instances of brief reactive psychosis. Schizoid individuals are also prone to developing pathological reliance on fantasizing activity as concomitant with their withdrawal from the world. Viewed in this fashion, fantasy constitutes a core component of the self-in-exile, though on closer examination fantasizing in schizoid individuals reveals as far more complicated than a means of facilitating withdrawal. Fantasy is also relationship with the world and with others by proxy. It is a substitute relationship, but a relationship nonetheless, characterized by idealized, defensive, and compensatory mechanisms. It is an expression of the self-in-exile because it is self-contained and free from the dangers and anxieties associated with emotional connection to real persons and situations. According to Klein it is "an expression of the self struggling to connect to objects, albeit internal objects. Fantasy permits schizoid patients to feel connected, and yet still free from the

imprisonment in relationships. In short, in fantasy one can be attached (to internal objects) and still be free." This aspect of schizoid pathology has been generously elaborated in works by Laing (1960); Winnicott; (1971); and Klein (1995).

According to Seinfeld, schizoid individuals frequently act out with substance and alcohol abuse and other addictions which serve as substitutes for human relationships. The substitute of a nonhuman for a human object serves as a schizoid defense. Providing examples of how the schizoid individual creates a personal relation with the drug, Seinfeld tells how "one addict called heroin his 'soothing white pet.' Another referred to crack as his 'bad mama.' I knew a female addict who termed crack her 'boyfriend.' Not all addicts name their drug, but there often is the trace of a personal feeling about the relationship." The object relations view emphasizes that the drug use and alcoholism reinforce the fantasy of union with an internal object, while enabling the addict to be indifferent to the external object world. Addiction is therefore viewed as a schizoid and symbiotic defense.

S. C. Ekleberry suggests that marijuana "may be the single most egosyntonic drug for individuals with SPD because it allows a detached state of fantasy and distance from others, provides a richer internal experience than these individuals can normally create, and reduces an internal sense of emptiness and failure to participate in life. Also, alcohol, readily available and safe to obtain, is another obvious drug of choice for these individuals. Some will use both marijuana and alcohol and see little point in giving up either. They are likely to use in isolation for the effect on internal processes."

According to Ralph Klein, suicide may also be a running theme for schizoid individuals, though they are not likely to actually attempt one. They might be down and depressed when all possible connections have been cut off, but as long as there is some relationship or even hope for one the risk will be low. The idea of suicide is a driving force against the person's schizoid defenses. As Klein says: "For some schizoid patients, its presence is like a faint, barely discernible background noise, and rarely reaches a level that breaks into consciousness. For others, it is an ominous presence, an emotional sword of Damocles. In any case, it is an underlying dread that they all experience."

## **Treatment**

Since schizoid traits are very similar to negative schizophrenic symptoms, atypical antipsychotics may have efficacy in alleviating them. Those who do seek treatment have the option of medication or therapy. For medication, the schizoid personality disorder seems to have similar negative symptoms of schizophrenia such as anhedonia, blunted affect, and low energy. The medication that is most recently used to treat the negative symptoms is risperidone. Before this, there was no psychotropic medication that made an impact on the negative symptoms. According to Joseph, low

doses of risperidone or olanzapine also work for the social deficits and blunted affect; Wellbutrin (bupropion) for anhedonia. Furthermore, the use of SSRIs, TCAs, MAOIs, low dose benzodiazepines, and beta-blockers may help social anxiety in the SPD. However, social anxiety may not be a main concern for the people who have SPD. Supportive psychotherapy is also used in an inpatient or outpatient setting by a trained personnel that focuses on areas such as: coping skills, improving social skills and social interactions, communication, and self esteem issues. Mark Zimmerman suggested the following questions for evaluation of patients with SPD:

Do you have close relationships with friends or family? If yes, with whom? If no, does this bother you?

Do you wish you had close relationships with others?

Some people prefer to spend time alone, others prefer to be with people. How would you describe yourself?

Do you frequently choose to do things by yourself?

Would it bother you to go a long time without a sexual relationship? Does your sex life seem important or could you get along as well without it?

What kind of activities do you enjoy?

Do you confide in anyone who is not in your immediate family?

How do you react when someone criticizes you?

How do you react when someone compliments you?

In the assessment process, note if these individuals make eye contact, smile or express affect nonverbally.

According to Beck and Freeman, people with SPD have "defective perceptual scanning which results in missing environmental cues. The defective perceptual scanning is characterized by a tendency to miss differences and to diffuse the varied elements of experience." The perception of varied events only increases their fear for intimacy and limits them in their interpersonal relationships. Also because of their aloofness, this barrier does not allow them to use their social skills and behavior to help them pursue relationships. Therefore, socialization groups may help these people with SPD. As said by Will, educational strategies also work with people who have SPD by having them identify their positive and negative emotions. They use the identification to learn about their own emotions; the emotions they draw out from others; and feeling the common emotions with other people whom they relate with. This can help people with SPD create empathy with the outside world.

### **Shorter-term treatment**

According to Ralph Klein, Clinical Director of the Masterson Institute, the concept of closer compromise means that the schizoid patient may be encouraged to experience intermediate

positions between the extremes of emotional closeness, and permanent exile.

As mentioned by Laing without being enriched by injections of interpersonal reality there occurs an impoverishment in which the schizoid individual's self-image becomes more and more empty and volatilized, leading the individual himself to feel unreal. Therefore to create a more adaptive and self-enriching interaction with others in which one "feels real" the patient is encouraged to take risks by creating less interpersonal distance through greater connection, communication, and the sharing of ideas, feelings, and actions. Closer compromise means that while the schizoid patient's vulnerability to the anxieties is not overcome, it is modified and managed more adaptively. Here the therapist repeatedly conveys to the patient that anxiety is inevitable, yet manageable, without any illusion that the schizoid vulnerability to such anxiety can be permanently dispensed with. The limiting factor is the point at which the dangers of intimacy become overwhelming and the patient must again retreat.

Klein suggests that closer compromise must be directly stated as the patient's responsibility; "It seems to me that in order to accomplish your goals, it is necessary to put yourself at risk," or "It seems to me that your willingness to come here (to treatment) and struggle with your anxieties must be mirrored by your willingness to challenge yourself outside of here," or "It seems to me that your efforts to connect with me are only half the battle; the other half must take place in the more dangerous arena of your life outside this office," i.e. therapist is always conveying that these are the therapists impressions. He or she is not reading the patient's mind or imposing an agenda, but is simply stating a position. Also, the therapist's position is an extension of the patient's therapeutic wish ("your goals," "your willingness," and "your efforts"). Finally, the therapist specifically directs attention to the need for employing these actions outside the therapeutic setting.

### **Longer-term therapy**

Klein suggests that working through is the second longer-term tier of psychotherapeutic work with schizoid patients. Its goals are to change fundamentally the old ways of feeling and thinking, and to rid oneself of the vulnerability to experiencing those emotions associated with old feelings and thoughts. A new therapeutic operation of 'remembering with feeling' is called for.

One must remember with feeling the coming into being of one's false self through childhood. (The concept of false self and true self comes from D. W. Winnicott, and is viewed as representative of schizoid phenomenology.) This means that one must remember the conditions and proscriptions that were imposed on the individual's freedom to experience the self in company with others. Ultimately, remembering with feeling leads the patient to the understanding that he or she had no choice in the process of developing a schizoid stance toward others. The patient did not have the opportunity to choose from a selection of possible ways of experiencing the self and of relating with others, rather, the patient had few if any options. The false self was simply the best way in which

the patient could experience repetitive predictable acknowledgment, affirmation, and approval (the emotional supplies necessary for emotional survival), while warding off the effects associated with the abandonment depression.

If the goal of shorter-term therapy is for patients to understand that they are not the way they appear to be and can act differently, then the longer-term goal of working through is for patients to understand who and what they are as human beings, what they truly are like and what they truly contain. The goal of working through is not achieved by the patient's sudden discovering of a hidden, fully formed talented and creative self living inside but is a process of slowly freeing oneself from the confinement of abandonment depression in order to have the opportunity to uncover a potential. It is a process of experimentation with the spontaneous, nonreactive elements that can be experienced in relationship with others.

Working through abandonment depression is a complicated, lengthy, and conflicted process which can be an enormously painful experience in terms of what is remembered and what must be felt. It involves a mourning, a grieving, for the loss of the illusion that the patient had adequate support for the emergence of the real self. Also, it is a mourning for the loss of an identity, the false self, which the person constructed and with which he or she has negotiated much of his or her life. The dismantling of the false self requires a relinquishing the only way of being that the patient has ever known of his interactions with others, an interaction which was better than no stable, organized experience of the self, no matter how false, defensive, or destructive that identity may be.

According to Klein the dismantling of the false self "leaves the impaired real self with the opportunity to convert its potential and its possibilities into actualities." The process of working through brings with it its own unique rewards, of which the most important element in new self-awareness is the growing realization by the individual that they have a fundamental, internal need for relatedness, which they may express in a variety of ways. "Only schizoid patients", suggests Klein, "who have worked through the abandonment depression ... ultimately will believe that the capacity for relatedness and the wish for relatedness are woven into the structure of their beings, that they are truly part of who the patients are and what they contain as human beings. It is this sense that finally allows the schizoid patient to feel the most intimate sense of being connected with humanity more generally, and with another person more personally. For the schizoid patient, this degree of certainty is the most gratifying revelation, and a profound new organizer of the self experience."

## **Epidemiology**

SPD is uncommon in clinical settings. It occurs slightly more commonly in males.

SPD is rare compared with other personality disorders. Its prevalence is estimated at less than 1%

of the general population.

As an interesting comment on the usual low-prevalence figures for this disorder, Philip Manfield in *Split Self, Split Object*, Arenson (1992) states that "I believe that the schizoid condition is far more common... comprising perhaps as many as 40 percent of all personality disorders. This huge discrepancy is probably largely because someone with a schizoid disorder is less likely to seek treatment than someone with other axis-II disorders." Manfield backs this claim with a study by Valliant & Drake (1985) who found that over 40% of a particular sample group of inner city males were schizoid.

## History

The term schizoid was coined in 1908 by Eugen Bleuler to designate a natural human tendency to direct attention toward one's inner life and away from the external world, a concept akin to introversion in that it was not viewed in terms of psychopathology. Bleuler also labeled the exaggeration of this tendency the "schizoid personality".

Since then, studies on the schizoid personality have developed along two separate paths; firstly, the descriptive psychiatry tradition which focuses on overtly observable, behavioral, and describable symptoms which finds its clearest exposition in the DSM-IV revised, and secondly, the dynamic psychiatry tradition which includes the exploration of covert or unconscious motivation and character structure as elaborated by classic psychoanalysis and object-relations theory.

The descriptive tradition began in Ernst Kretschmer's (1925) portrayal of observable schizoid behaviours which he organized into three groups of characteristics:

unsociability, quietness, reservedness, seriousness, and eccentricity

timidity, shyness with feelings, sensitivity, nervousness, excitability, and fondness of nature and books

pliability, kindness, honesty, indifference, silence, and cold emotional attitudes.

In these characteristics one can see the precursors of the DSM-IV division of schizoid character into three distinct personality disorders, though Kretschmer himself did not conceive of separating these behaviours to the point of radical isolation, considering them instead as simultaneously present as varying potentials in schizoid individuals. For Kretschmer the majority of schizoids are not either oversensitive or cold, but they are oversensitive and cold "at the same time" in quite different relative proportions, with a tendency to move along these dimensions from one behavior to the other.

The second path, that of dynamic psychiatry, began with observations by Eugen Bleuler (1924) who observed that the schizoid person and schizoid pathology were not things to be set apart. In

1940 W. R. D. Fairbairn presented his seminal work on the schizoid personality in which most of what is known today about schizoid phenomena can be found. Here Fairbairn delineated four central schizoid themes; firstly, the need to regulate interpersonal distance as a central focus of concern; secondly, the ability to mobilize self-preservative defenses and self-reliance; thirdly a pervasive tension between the anxiety-laden need for attachment, and the defensive need for distance, which manifests in observable behavior as indifference; and fourthly an overvaluation of the inner world at the expense of the outer world. Following Fairbairn, the dynamic psychiatry tradition has continued to produce rich explorations on the schizoid character, most notably from writers Nannarello (1953); Laing (1960); Winnicott (1965); Guntrip (1969); Khan (1974); Akhtar (1987); Seinfeld (1991); Manfield (1992); and Klein (1995).