Type	Schizoid
General **Core theme**	**Highly sensitive to interpersonal stimulation fear of closeness but also longing for closeness** Range from high-functioning to deeply disturbed: From the creative genius to the catatonic patient.
Drive, affect, Temperament	**Drive** - Oral-level issues fear of being engulfed, taken over **Temperament - h**yperreactive and easily overstimulated **Affect** - very much in touch with many emotional reactions- perceive what others disown effortlessly; General emotional pain when overstimulated; affect are so powerful that they feel they need to suppress them; are removed from the emotional contact with their own greed; **do not struggle with shame or guilt.** Withdrawal, seeking satisfaction in fantasy, rejection of corporeal world;
Defenses	To interpersonal stimulation respond with **defensive withdrawal and fantasies about intimacy.** Lack of defenses that blot out affective and sensory information repression, denial Or those that organize experience along good-bad lines compartmentalization, reaction formation, undoing, turning against the self
Object relations	The social world is dangerous and engulfing. Deep ambivalence about attachment **Come close for I am alone, but stay away for I fear intrusion!** Sexually apathetic often despite being functional and orgasmic. Crave unattainable sexual objects while feeling vague indifference towards available ones. Parenting: 1) Impinging, overinvested, overinvolved 2) Seductive or boundary-transgressing mother or impatient, critical father. 3) Double-binding, emotionally dishonest messages lead them to withdrawal and deep hopelessness
Self	**Split between self and the world, and between the <u>experienced self and desire.</u>** Their self stands at a safe distance from the rest of the humanity - disregard for conventional social expectations Detached, ironic, and faintly contemptuous Abandonment is a lesser evil than engulfment. **Self-esteem is often maintained by individual creativity -** have a high standard for creative endeavors The schizoid wants confirmation of his/her genuine originality, sensitivity, and uniqueness.
Transf/ Countertr	Most analysts enjoy treating people with schizoid character structures and they are grateful to have a place where the expression of their feelings will not arouse alarm, disdain or derision. **Transference** Approach therapy with sensitivity, honesty and fear of engulfment Commonly tongue-tied, empty, lost in the early phases. Long silences have to be endured while patient internalizes the safety of the setting. Patient test therapist s ability to tolerate their confusing messages and maintain empathy.

	Contertransference Because schizoids withdraw into detached and obscure styles of communication it is easy to fall into **counterdetachment** see them as interesting specimens. The subjective fragility of the schizoid is frequently mirrored in the therapist s frequent sense of weakness and helplessness. Images and fantasies of a destructive and devouring external world may also absorb both parties. Counterimages of omnipotence and shared superiority may also be present. Fond perceptions of the patient as a unique, exquisite, misunderstood genius or unappreciated sage may dominate the therapist s inner responses perhaps in parallel to the attitude of the overinvolved parent who imagined greatness for this special child.
Thera-peutic implications	**More responsive therapeutic style is required.** Working with schizoid patients requires a degree of authenticity and a level of awareness of emotions and imagery that would be possible only after years of work with patients of other character types. Since therapists are somewhat on the depressive side and fear abandonment more than engulfment they try to move closer. Empathy with schizoid s need for emotional space may consequently be hard to come by. **Early in therapy, interpretations should be avoided** on the basis of patient s fears of being treated intrusively. Phrase one s remarks in the words/images used by the patient in order to reinforce the sense of reality and internal solidity. **Normalizing** a way to communicate that the schizoid s internal world is comprehensible. Reframing of imaginal richness as talent rather than pathology is deeply relieving. Use of literary/artistic sources of imagery. It is important that therapists accept to act like and to be seen as a real person not just a transference object. The schizoid has an abundance of as if relations and needs the sense of the therapist s active participation as a human being: supporting risks in the direction of relationships, being playful or humorous in ways that were absent in the client s history. Transference reactions are not only not obscured by a more responsive style, they may even be more accessible to interpretation.
Differential diagnosis	**Degree of pathology** It is critical to evaluate how disturbed a person in the schizoid range is. DSM IV gives two alternative schizoid diagnoses. It is essential to distinguish psychotic processes. It is equally costly to misunderstand a psychotic as a nonpsychotic schizoid character or the other way around. One should not assume that a person is at risk for decompensation simply because he/she has a schizoid character. **Schizoid vs. Obsessive Compulsive** Schizoids isolate themselves and spend a great deal thinking even ruminating about the major issues in her fantasy life. Some have rituals or behaviors that appear compulsive. Obsessive individuals in contrast with schizoid people are usually quite social; they are apt to be moralistic while schizoid people are not particularly invested in questions of right or wrong. People with OC personalities deny or isolate feelings unlike schizoid individuals who identify them internally and pull back from relations that invite their expression.