The Role of Shame in the Development of the Schizoid Process

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Abstract

The author considers the role of shame and the response to it, which she describes as self-protective avoidance of relationship, in the development of a schizoid process. She proposes that the intention and action of suicide may in some cases be the ultimate schizoid withdrawal. She describes her work over 10 years with a young woman who required a gentle, attuned, relational process to help her heal a relational split.

Keywords: Schizoid process, schizoid compromise, shame, suicidal ideation, suicide, somatic, psychogenic pain, script beliefs, attunement, relational needs

The Referral

Some years ago, I received a call from a woman who was desperate for me to work with her adult daughter, Carmen, who had just been discharged from a psychiatric unit. Normally I would expect an adult client to make their own contact and request for therapy, but the desperation in her mother's voice convinced me to make an exception. It was also clear that her daughter did not have the capacity to make the request herself because of her deeply depressed state and inability to connect with the world in any meaningful way.

Carmen's Medical and Psychological History

Carmen had made several attempts to take her own life and had a history of chronic abdominal pain dating back to adolescence, the cause of which could not be established despite seven exploratory laparoscopies. A small amount of endometriosis had been found but not nearly enough to justify the level of pain that Carmen experienced.

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Carmen had first engaged in counseling for 2 years at school when she was between 14 and 16 years old. She had more counseling during her university years followed by three blocks of cognitive-behavioral therapy (CBT) through her doctor's surgery in her twenties. None of the therapy so far had been useful.

Carmen was in her early thirties and on long-term sick leave from her work in the pharmaceutical industry when we began our work together. Her therapy continues as I write this article, and we have talked about the potential impact of my writing, including the possibility that her agreement to my using her material came from a compliant, transferential place. We have considered that we might use this article in her ongoing therapy, slowly exploring and dealing with the inevitable shame that is stimulated through our exploration of her therapeutic journey thus far.

The Etiology of Pain

At the beginning of our work, Carmen was taking 11 types of prescribed medication, including two antidepressants and an antipsychotic, high doses of opiate medication and other analgesia, hormone treatment, and a nerve block every few months. None of this appeared to have any impact on her level of physical pain or her depressed mood. Whether the physical pain was a manifestation of her psychological pain or vice versa was an important consideration for me. The word *pain* comes from the Latin *poena,* meaning punishment or penalty, so I wondered if Carmen's physical pain was a form of unconscious self-punishment or a kind of self-destructive behavior, although she described it to me during a session as "a big hug."

> We discover that in the course of the child's development, pain and relief of pain enter into the formation of interpersonal (object) relations and into the concepts of good and bad, reward and punishment, success and failure. Pain becomes par excellence a means of assuaging guilt and thereby influences object relationships. (Engel, 1959, p. 899)

Although the link between somatic and psychogenic pain has been well discussed in the psychiatric literature for many years (Bass, 1990; Blumer & Heilbronn, 1982; Engel, 1959; Tyrer, 2006), Carmen's physical pain and depressive symptoms had been treated individually and separately since their onset in adolescence, without success. Her pain and suicidal intent always increased when the status quo was threatened and especially if anyone suggested that she was getting better. When I suggested to her that taking

responsibility for the management of her medication represented a step forward, she described my comment as a “slap in the face.” This was an example of my misattunement to her relational needs (Erskine et al., 1999) in that moment. I believe that she needed to continue to define herself and for me to be accepting of her without judgment instead of validating her change in behavior, which meant that I was defining her.

The Beginning of Therapy

My first impression of Carmen was that she was overweight, unkempt, and older than her years. Much of the excess weight was a side effect of her medication. Through her heavy sedation, she found coherent thought difficult, and her ability to verbalize was initially exceedingly difficult, at times impossible. As an intelligent woman, this inability to articulate her thoughts and feelings stimulated her shame and reinforced her script beliefs of being “useless, worthless, and unable to do anything right.”

During this first phase of therapy my task was simply to be a stable, dependable other who had no agenda and no expectations of Carmen. I imposed no time scale for her to be well and return to work. My focus was on careful rhythmic attunement, not too fast so that she felt overwhelmed and not too slow so that she felt abandoned. It took many sessions of my sitting and waiting for her to feel safe enough in our relationship for her to begin to emerge.

All of the psychological assessments and offers of therapy from the psychiatric services, none of which Carmen had found helpful, simply increased her shame and belief that everything was her fault. She told me that her husband had constantly shamed her for not being able to do anything right. If she vacuumed the carpet, he found pet hair that she had missed; if she chopped vegetables, he claimed they were the wrong size. He told her that it was her fault that their marriage had failed. At work, if she was summoned to her manager’s office, she always assumed that she had done something wrong.

Carmen’s final attempt to hang herself came after a failed attempt by hospital staff to perform a nerve block. She naturally believed that its failure was her fault, and coinciding with my absence at a conference, it overwhelmed her. Suicide seemed to be the only way she could withdraw far enough. As Yontef (2001) wrote:

> Suspended in the death-level conflict between total isolation and being swallowed up, these individuals often feel tired of life and the urge for temporary death. This is not active suicide, just exhaustion from living a life with insufficient nourishment. (p. 11)

For Carmen, after so many years of a battle to which she could see no end, it was another active attempt at ending her life.

Carmen's Early Life and Relationship With Her Parents

Fairbairn (1952) suggested that people who develop a schizoid process are bought up by parents who were unable to demonstrate tender, loving emotions, causing the child to experience rejection and to withdraw into an inner world that is safer but lonely. Carmen was the only child of professional parents whom she experienced as having no time for her. She had a clear script message that she was always in the way.

Both Masterson (1988) and Yontef (2001) described the cold, disconnected childhood experience of someone who develops a schizoid process, and on several occasions Carmen told me that her father's view of children was that they were a "sexually transmitted disease." When she first told me this, there was no feeling in her voice, as if she had just told me that it was raining. Over time, with each new telling of this story, the distress and shame that this view of herself caused her became more apparent. Eventually she was able to connect with an appropriate angry response to being defined in this way by her father. Each new appropriate expression of affect, especially anger, coincided with an improvement in her mood and a decrease in her physical pain.

Through careful attunement to Carmen's capacity to connect with her own outrage, my role during this time was to assess what would be an appropriate response from me. If I had expressed my own indignation too soon, I would have been at odds with Carmen's response, and offering my judgment on the parents whom she still relied on so heavily would have been counterproductive.

I attempted to obtain a picture of Carmen's childhood and early adult life through historical inquiry, which was difficult because of the heavy doses of medication that made her barely able to stay awake in our first year or so of therapy. I felt as though I was just holding a space where there were no demands, criticisms, or definitions.

The first real breakthrough came after nearly 2 years when she said, “I’m not worth anything.” Then, immediately, without being prompted by me, she changed her statement to, “I don’t believe I’m worth anything.” This showed that her self-definition was changing, and she was becoming more aware of the script decisions that she had made early in her life.

Supervision and Shame

Often during the first few years of therapy with Carmen, I would think to myself that we were just chatting. We chatted about birds, gardening, wildlife—anything provided it was a safe subject that did not require any deep self exploration or expression of affect. I took this to supervision regularly and always felt criticized by my supervisor’s response, which was to question my lack of working at depth with and challenging Carmen. This, of course, paralleled the criticism, both real and imagined, that Carmen experienced from her husband, parents, and managers at work and that left her feeling that she could never be good enough. This parallel process stimulated my own shame for not being a good enough therapist, which in turn caused me to distance myself from my supervisor. With hindsight, it might have been more helpful to explore with my supervisor my countertransference, which made me very protective of Carmen. Her transference invited me to be the idealized mother who had been missing all her life, which was vital during the years in therapy when she was actively suicidal. She needed a mother who would validate her internal experience and be stable and dependable (Erskine et al., 1999).

I always returned from my supervision sessions resolved to challenge Carmen to go deeper and to express more of what she was experiencing phenomenologically. I was aware that sometimes I felt irritated by her inability to work at greater depth. I was at risk of projecting my shame onto my client and blaming her for her lack of progress in the therapeutic work—a blame, of course, that was familiar to Carmen throughout her life and would have confirmed her script that it was all her fault. However, by continuing to work within the transference, I chose not to challenge but to support, validate, and nurture so that Carmen began to develop a sound sense of who she might be as an adult.

Working With the Schizoid Process

From what I now know about working with someone who has such a profound schizoid process, my intuitive way of working was exactly what Carmen needed, and it provided an attuned, holding environment (Bowlby, 1969). This was

something she had never experienced as an infant, which resulted in her never developing an emotional attachment to her mother or father. My aim was to encourage a healthy attachment to me that would act as a template for developing other healthy emotional attachments.

I believe that what appeared to be somewhat superficial conversation also had a protective function. It kept us away from any deep connection that might have allowed an exploration of affect that was deeply buried for fear of the impact it might have on her ability to manage relationships within which she experienced a considerable amount of ambivalence. These relationships included her parents, her husband, and possibly me. It also reflected Guntrip's (1962) *schizoid compromise*, whereby we could be in relationship as long as the level of intimacy was superficial.

Another profoundly harmful script belief for Carmen was that she was "in the way." As mentioned earlier, both her parents were successful career people, and toward the end of her primary schooling, they both were appointed to new posts in a different town. Carmen was left at the family home during the week and cared for by a neighbor while her parents worked away. They returned each weekend, but Carmen's memory is that they made no attempt to engage with her needs but expected her to fit into the activities in which they engaged.

It was only later in her therapy that Carmen connected with intense rage toward both her parents and her husband. However, as a child, she relied entirely on her parents. She rarely mentioned extended family, and as an only child they were all she had. At the beginning of her therapy, she continued to rely on them because they held her medication, delivering one day's supply at a time, so she was unconsciously replaying her childhood dependence.

As she began to get in touch with her anger toward her husband, she realized that he had never made her a priority. For example, he refused to take a day off work when Carmen needed to go into hospital for a surgical procedure. She would not be able to drive herself home again, and the anesthetic meant that she was advised not to be alone for 24 hours after the operation. He arranged for someone to pick Carmen up from the hospital and drop her at the door to their house.

Sometimes, as I reflected on our work, I noticed the changes that she was making and found it hard to understand how "chatting" could have possibly helped to facilitate those. Now I understand that the importance of our chatting was that it enabled our secure bond to form with no threat to Carmen's integrity. Just to sit in silence with Carmen would have been shaming to her because she

would have believed that she was bad for not being able to fill the silence. Instead, our therapy sessions became a place where there was no risk of her being shamed, and our interactions provided a relationship in which she felt accepted and respected, where nothing harmful was demanded of her.

Shame and the Schizoid Withdrawal

Nathanson (1994) described a number of defenses against shame, including withdrawal and attacks on the self. With Carmen, I had to learn the importance of both rhythmic and affective attunement in avoiding a schizoid withdrawal when making phenomenological inquiry. Her inability to express her phenomenological experience would lead to shame, the defense against that being the denial of the need for relationship and consequent withdrawal (Erskine, 1995). Erskine suggested that "shame is a complex process involving (1) a diminished self-concept, a lowering of one's self worth in confluence with the external humiliation and/or previously introjected criticism; (2) a defensive transposition of sadness and fear; and (3) a disavowal and retroflection of anger" (p. 109).

Disavowal of Anger

Carmen's disavowal of anger was absolute, and I realized that part of my role was to help her to reconnect with her retroflected anger at a pace that was tolerable and acceptable within her script beliefs. In the first few years of her therapy, any mention of anger would send Carmen into a defensive withdrawal because she experienced anger as shameful and leading to conflict. If I mentioned anger, she would always say, "I don't like conflict." With her parents, Carmen would go to any length to avoid expressing her anger toward them, sometimes cutting her legs with scissors as a way of retroflecting her anger, particularly toward her mother.

In the early years of her therapy, any attempt at phenomenological inquiry would result in Carmen looking frightened. Being unable to answer my questions about what she was experiencing internally led to her feeling shamed because she thought that she "ought" to know. So, in those days, when I noticed the tension in Carmen's body and the darkness of her frown, I would tentatively say, "As you say that you sound angry." Her response would be to twist her fingers, her feet would point inward and raise up to give the impression that she was so small that her feet could not reach the ground, and she would respond with "but I don't feel angry" in the high pitched voice of a young child. The obvious defensive position that she adopted at those times was a clear message that I had

overstepped the mark in noticing the anger that terrified her and that had been disavowed. It was a clear misattunement on my part that resulted in a schizoid withdrawal. However, without those gentle invitations to notice her anger, no progress would have been made. Over time, through my noticing when either her tone of voice or her body language suggested that she was experiencing anger, she slowly began to recognize her affect and gradually learned to express her feelings more authentically.

Working in Conjunction With Other Psychological Professionals

Because I was working in conjunction with local psychiatric services, I attended Carmen's case reviews at her request. I met with her psychiatrist and community psychiatric nurse, and her general practitioner and parents were initially also present. At these meetings, I received a good deal of criticism for not working in a more solution-focused and time-limited way. The written reports following those meeting continually reiterated that open-ended therapy was not effective and that "a planned and managed ending that is a focus from the onset is of most therapeutic value." Throughout our work, any suggestion that her therapy needed to be time-limited would stimulate a schizoid withdrawal and an increase in physical pain for Carmen. As Guntrip (1962) wrote, "There is certainly no quick and easy way of making a stable and mature adult personality out of the legacy of an undermined childhood" (p. 273).

Carmen's psychiatric diagnosis was avoidant and dependent personality disorder with recurrent depression. It reminded me of Johnson's (1994) view of the continuum from schizoid personality disorder at one end to avoidant style at the other. In his description of the early development of the schizoid process, Johnson suggested that

> the hatred of the caretaking parent will be introjected and will begin to suppress the life force of the organism, such that movement and breathing are inhibited and there develops an involuntary tightening of the musculature to restrain the life force. (p. 75)

The Dilemma of Challenge

Whenever Carmen felt any challenge from me, no matter how small or gentle, her breathing would become seriously restricted. And when she began to feel tears pricking behind her eyes, she became so overwhelmed that she would

completely stop breathing and tense her whole body as if she were trying to disappear. For a long time, I had to gently remind her to breathe whenever she began to cry. Initially, her crying was silent and clearly painful because it resulted in a tensing of every muscle in her body in an attempt to prevent the tears from flowing. Reminding her to breathe resulted in a huge intake of breath followed by a loud, body-wracking sob.

Throughout the first few years of therapy, Carmen would panic at any suggestion that she was getting better. It would send her into a spiral of increased physical pain and suicidal thoughts. Her pain and incapacity had become part of her identity, without which she said that she did not know who she was. She saw herself not as someone who was experiencing pain but that she was the pain. She also said that she was afraid that if she got better, no one would like her.

Working With Calculated Risk

During the first phase of therapy, when Carmen was still taking large doses of medication, she made collections of her tablets as insurance that if life became too unbearable, she could end it with certainty. Initially, I talked with her about giving me her medication collection to dispose of, which she agreed to do. The second time she created a collection, she agreed to take it to her doctor's surgery. Relinquishing this "insurance" increased her anxiety, and after she had surrendered her second collection, I was greatly concerned about her physical safety. As I reflected on our work, I realized that I was not attuning to Carmen's needs. In telling me about her medication collection, she was trying to paint a picture for me of the existential dilemma of someone who has developed a schizoid process. My focus had been much more on what I considered to be my ethical duty to keep my client safe and prevent her from killing herself. In fact, I recognized that my oversimplistic method of keeping Carmen safe by removing the lethal medication was similar to how her parents would respond rather than offering an empathetic consideration of what was really best for her by attuning and inquiring.

I realized that Carmen would probably be safer if she was allowed to keep her "insurance" because she was in control. Without the medication she would look for other ways to kill herself, and because she had already attempted strangulation several times, that was a real danger. I wrote to her psychiatrist explaining the situation and my thinking, and he agreed with me for Carmen to hold on to her collection until she was ready to give it up. This immediately

reduced her anxiety and gave us the opportunity to focus on strengthening her sense of self as potent in the world.

Carmen gradually learned to identify her angry response, almost as though she were learning a foreign language. Through my assurances that her anger is justifiable, she has learned how to express it appropriately, which enables her to maintain a relationship with whomever she is angry at.

Laing (1960), in describing the schizoid person, said this:

> Such a person is not able to experience himself "together with" others or "at home in" the world, but, on the contrary, he experiences himself in despairing aloneness and isolation; moreover, he does not experience himself as a complete person but rather as "split" in various ways, perhaps as a mind more or less tenuously linked to a body, as two or more selves, and so on. (p. 1)

Carmen had spent her whole life isolated from others and had no idea how to be in an intimate relationship. Her husband fit her life script in that he had similar interpersonal difficulties. Although we did not explore their relationship in any depth, I believe they probably had interlocking scripts. This made their divorce inevitable as Carmen became more able to enjoy being in relationship with me and developed a healthy autonomy. She had few friends at school, and when she began to work, she also had found it difficult to relate to others. When she came to therapy, the only people she described as friends were friends of her parents.

Carmen was on sick leave from her job for a number of years and was eventually made redundant. This gave her the freedom to begin volunteering in various ways in her community. This led to part-time paid work in a primary school working with some of the more challenging children and later a more substantial role in another primary school, again supporting children who display challenging behavior. She still has a rather small friendship group, but one of the most exciting developments for me was when she began dating and found a new partner with whom she has a sound, loving, mature relationship.

In Summary

> The greatest need of a child is to obtain conclusive assurance (a) that he is genuinely loved as a person by his parents, and (b) that his parents genuinely accept his love. … Frustration of his desire to be loved as a person, and frustration of his desire to have his love accepted, is the greatest trauma that a child can experience. (Fairbairn, 1952, pp. 39–40)

Carmen never received assurance of being loved from her busy, professional parents. She felt in the way, not important, and that everything was her fault. She is now living fully independent of her parents and has a more robust adult-adult relationship with them within which she is able to express her needs as well as her feelings. She has no problem expressing healthy anger toward them and other people in a respectful, relational way.

As our work has progressed, Carmen has gradually ceased taking all medication and is now mostly as pain free as the general population. She has learned to associate an increase in physiological pain to unexpressed emotions, especially anger and disappointment.

Two years ago, Carmen joined a group in which she is using artistic expression. She has shared some of her creative work in the group, and it has helped her to connect with some deep anger and sadness. As she spoke about the images she created, I thought I detected an unspoken question in her voice. “Why did we not use these techniques earlier in my therapy?” I asked if my thinking was correct. She nodded, looked thoughtful for a while, then without me saying a word, she said, “I would have been completely overwhelmed!” I felt an element of relief because I had heard my supervisor’s voice for a moment criticizing me for years for not challenging Carmen more robustly as well as the numerous reports from psychological services stipulating the need for a more solution-focused approach.

I am deeply grateful for the opportunity working with Carmen has given me to learn about the role that shame plays in the development of a schizoid process. I feel privileged that she trusted me enough to stay with the process through my learning how to be with her in ways that enabled the healing of the split within her. Her courage to stay alive when she believed that there was no hope of anything changing has been inspirational for me. I have also learned that for some people, suicide might be the ultimate schizoid withdrawal.

References

Bass, C. (1990). *Somatization: Physical symptoms and psychological illness*. Blackwell Scientific.

Blumer, D., & Heilbronn, M. (1982). Chronic pain as a variant of depressive disease: The pain-prone disorder. *Journal of Nervous and Mental Disease, 170*(7), 381–406. https://doi.org/10.1097/00005053-198207000-00001

Bowlby, J. (1969). *Attachment. Vol. 1 of Attachment and loss*. Hogarth.

Engel, G. (1959). “Psychogenic” pain and the pain-prone patient. *American Journal of Medicine, 26*(6), 899–918. https://doi.org/10.1016/0002-9343(59)90212-8

Erskine, R. G. (1995). A gestalt therapy approach to shame and self-righteousness: Theory and methods. *British Gestalt Journal, 4*(2), 107–117.

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

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

Guntrip, H. (1962). The schizoid compromise and therapeutic stalemate. *The British Journal of Medical Psychology, 35*(4), 273–288. https://doi.org/10.1111/j.2044-8341

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

Laing, R D. (1960). *The divided self*. Penguin.

Masterson, J. F. (1988). *The search for the real self: Unmasking the personality disorders of our age*. Free Press.

Nathanson, D. J. (1994). *Shame and pride: Affect, sex and the birth of the self*. Norton.

Tyrer, S. (2006). Psychosomatic pain. *The British Journal of Psychiatry, 188*(1), 91–93. https://doi.org/10.1192/bjp.188.1.91

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