Depression or Isolated Attachment? Part 1 of a 5-Part Case Study of the Psychotherapy of the Schizoid Process

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Abstract

This case study explores depression as a presenting symptom that reflects an isolated attachment pattern, a core feature in the personality of psychotherapy clients who rely on a schizoid process as a form of emotional stabilization. The psychotherapist's various forms of countertransference—responsive, reactive, and identifying—were an essential part of uncovering the client's use of a relational withdrawal and in offering a reparative relationship

Keywords: Attachment, isolated, isolated attachment, schizoid, depression, integrative psychotherapy, relational psychotherapy, reactive countertransference, responsive countertransference, identifying countertransference, developmental image

> In wildness is the preservation of the world,
>
> When we walk, we naturally go to the fields and woods:
>
> From the forest and wilderness come the tonics
>
> and barks which brace mankind.
>
> — Henry David Thoreau, 1862/2002, *Walking*

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Allan's physician recommended that he call me for a series of psychotherapy sessions. In the initial phone contact, Allan said that he had been taking antidepressant medication for 3 years but without any noticeable results. He said that he always felt "low down" and did not have much energy, particularly when he was home. The doctor wanted Allan to try psychotherapy "to see if it will work." Allan and I agreed on three sessions to evaluate if psychotherapy was appropriate for him and whether we could work well together.

When Allan entered my office 2 days later, I saw a tall, thin man who was dressed like he was going hiking in the mountains. His attire and high boots were unusual for someone living in New York City. He spoke slowly and softly. When I inquired why he was seeking psychotherapy, all he could say was that he wanted his depression to stop. As I tried to establish a contract that would define the outcome of our work, Allan had difficulty stating any definable objective. I presumed that it was too soon to establish any goals; perhaps we needed to get to know each other first.

In the next two sessions, I learned that Allan was 50 years old, never married, and had lived in the same apartment since he was a young child. A bookkeeper in a large accounting firm, he was content with his job and liked the people at work, although he did not socialize with them because "I never go to bars." He said that he attended church almost every Sunday because he was in charge of the church's finances. Allan spent Saturdays and holidays hiking various portions of the Appalachian Trail and his 4 weeks of summer vacation camping in the wilderness where he could be "all alone with nature."

Allan's mother had died 4½ years earlier. As I inquired about Allan's possible grief, he was slow to respond. After shrugging his shoulders, he hesitantly told me about his mother's painful struggle with cancer. He claimed that he was not sad about her death but that he did miss her cooking. There was an absence of sensitivity in his response to my questions about his mother's death (Erskine, 2014a, 2014b, 2014c). I wondered if his flat affect indicated that he was not ready to talk about losing her or if it reflected a personality pattern. Allan had no memory of his father, who died when Allan was in kindergarten. Allan had a sister who was 5 years older whom he had not spoken with since his mother's funeral. He sarcastically said, "I can't be in the same room with her. She's a know-it-all." Then he added, "Life is better all alone."

In our third session, Allan was contemptuous of his medical doctor's abrupt manner of speaking. At two different moments I inquired about his feelings of

anger at his doctor's behavior, but Allan avoided my questions. The doctor had decided that Allan would slowly reduce and eventually stop the antidepressants. Allan said that he wanted to continue psychotherapy sessions with me "because it could help." He was not interested in forming an outcome-defining contract (Berne, 1966), but he volunteered that he would come for individual psychotherapy once a week for a year.

It was time for me to do some introflection, a sensorial search of my internal process: I found Allan pleasant, shy, and either withholding his responses or slow to respond to my questions. He was interesting when he talked eagerly about hiking and camping. At the end of this third session, I doubted whether I could help Allan resolve his depression. I still did not feel an affective connection with him. He was evasive whenever I asked him about his body sensations or other subjective experiences. Other clients had taught me that I need to maintain my own vitality and curiosity when I am working with someone who is depressed. With many such clients, I rely on phenomenological inquiry and carefully observe their style of answering my questions. That style is often more revealing of who they are than is the content of their answers. In the first three sessions with Allan, my phenomenological inquiry seemed to be more of a hindrance than a help. Unlike many other clients, Allan did not respond to phenomenological inquiry (Erskine et al., 1999).

Although his medical doctor described him as depressed, Allan did not manifest some of the symptoms of a depressive disorder. He had previously said that he lacked energy, yet he described himself as engaging in intense physical activities and being a "diligent worker" both on the job and in volunteering for his church. He said that he ate and slept well but was uninterested in social activities with people, even with the "nice people at church." In evenings after work, he was "plagued with miserable feelings." Allan defined himself at those times as "depressed" and added that in those moments he was compelled to "get out and walk … even if it is near midnight."

Was he depressed? Yes. But it did not appear appropriate to diagnose him as having a depressive disorder. It was clear to me that the various things he said about himself required careful attention. I did not understand his internal processes, but I listened for the covert meaning in his stories. I needed to be patient, attentive, and attune myself (the best I could) to his indistinct and subtle affects. I was reminded of Guntrip's writings in which he described several of his "schizoid" clients who entered psychotherapy because of depression (as described in Hazell, 1994).

I asked Allan if he had any thoughts of suicide. He described how he had always imagined escaping to “another world.” As I inquired further, he said that he first thought about killing himself when he was 13 years old and that throughout his life he had continued to think about dying and going to “a place of peace and quiet.” I asked if he had ever attempted suicide, to which he answered “no.” He lamented that he could not kill himself while his mother was alive because “I had to take care of her. I was all she had.” While telling me this story, he used the word “despair,” and the way he said it evoked concern in me. When I inquired further about what he was feeling, he dismissed my question with, “I’m fine.” Each time I inquired about his affect he changed the subject.

I asked Allan how he imagined killing himself. With hesitation he described shooting himself in the head but quickly added that he did not now, nor had he ever, owned a gun. He described dying as going into a “peaceful, everlasting quiet.” He was worried that suicide was a sin and that if he killed himself he would “not attain peace and quiet.” By the end of that session, I was not worried that he was in imminent danger of suicide, but I was concerned that a long-term risk remained. His ideas about the quietness of death, the absence of close friends, the lack of energy when at home, and the death of his mother were some markers that could indicate a major depression, but he did not have many of the other characteristics (American Psychiatric Association, 2013). He ate well, walked extensively, and was able to concentrate on his work. He said that his apartment was neat and clean and that he was making plans for next summer’s camping trip in northern Canada.

As I reflected on all that he had told me, I was certain that encoded in his self-descriptions and behaviors were unconscious relational patterns that were being lived out in his daily life (Erskine, 2010). If we were to continue with psychotherapy, I would have to explore several clues that he had given me: his sense of despair, his longing for peace and quiet, his excessive walking late at night, the family dynamics of his childhood, and various body sensations and tensions that indicated disavowed affect.

I only had a few minutes left in the third session. We had not formed a sufficiently close relationship such that a no-suicide contract would be effective. As we concluded the session, I felt that it was necessary for me to rely on his religious convictions and his statement that he did not possess a gun. And I had his word that he would come for psychotherapy each week for a year.

I sensed that something vital was missing in Allan’s life. I was not sure what it was, but I kept thinking about how his life was devoid of any intimacy. Internally I

made an emotional commitment. I wanted our psychotherapy to enhance the quality of his life and provide him with a desire to live. I walked home from the office that night questioning myself: “Was I wanting more for Allan than he wanted or was willing to do?” I knew what was possible in an in-depth psychotherapy, but I had no evidence that Allan knew the commitment, perseverance, and time that would be required to make some fundamental changes in his life.

The First Year

The evening before our fourth meeting, as I contemplated Allan’s agreeing to come to weekly psychotherapy, I was touched by how alone he seemed, how he preferred to be in nature and not with people, and how he had difficulty talking about feelings. I thought about his “depression” and wondered if he was describing the results of a prolonged schizoid withdrawal. One of the clues was that he did not respond well to my phenomenological inquiry. I was not sure if I could be effective in helping him achieve a satisfactory comfort in his life, but I was willing to invest myself in our therapeutic relationship. I was relying on my perception that Allan was serious about resolving his depression. He must have had some form of connection with me because he was willing to make a commitment for ongoing work.

In the first few weeks of sessions, I tried to inquire about the “low down feeling” and lack of energy that Allan had mentioned in our initial interview. He deflected my questions by talking about his work situation. He felt gratified by the “challenges of solving difficult tax problems” and “the freedom to do it on my own,” but he disapproved of his coworkers’ behavior because they were not as diligent as he was: “They waste a lot of time talking to each other.” He chose not to include himself in their lunch or after-work activities. I asked about other friends; Allan was vague and eventually admitted that he had none.

As I raised my concern about how much time he spent by himself, Allan said, “Some nights after dinner I prefer to walk the neighborhood for a couple of hours. I watch people a lot, I often see faces I recognize.” As I imagined myself in that situation, I felt an intense sadness. Yet Allan spoke of his situation matter of factly, with no emotion. He lapsed into long pauses, looking at the ceiling. In the next few sessions, Allan continued to describe his late night walks through New York City and how he distracted himself from feeling “low down” by watching

people. When I asked if he ever talked with anyone on his walks, he said, “I would never do that.”

These stories caused me to wonder what he was not telling me. Did he have some secret that he was keeping private? I was curious about Allan, but my inquiries were only partially effective. He answered my questions but often with reticence. I wanted to know him, to know the depth and extent of what he felt, what he had lived as a boy, and how he managed his life. It was necessary to continually remind myself to be patient, to just let his story unfold.

Two months later, Allan again told me that he was “irritated” by his coworkers and wanted some changes in the office. There was a condemning tone to his voice. I wondered if his unhappy work situation was contributing to his low energy when he came home at night. But when I implied that he could talk to his coworkers about his displeasure, Allan made it clear that he would never reveal his discomfort to anyone. His solution was to stay distant. Incidentally, from the moment I suggested that he could engage with his coworkers, he was distant with me. He averted his eyes and proceeded to talk about camping equipment that was currently on sale. It became evident that whenever I made a suggestion about changing his behavior, Allan would put an end to the discussion. Apparently he was closed to any therapeutic focus on his behavior just as he was closed to my inquiring about his affect.

In the next few sessions, rather than focusing on his behavior, I increased my use of phenomenological inquiry, particularly about his affect and body sensations. Although he was slow to answer, he usually identified tension in his neck and chest. Somehow that led us to talking about his difficulty in expressing emotion to people. He said, “I want to remain private. I don’t want anyone poking their nose into my business.” I asked if that included me. Allan answered, “Yeah, sometimes your questions are too damn invasive.” I responded, “What happens inside you when I ask such questions?” Allan shrugged his shoulders and remained silent for the remainder of the session. During the next couple of sessions, he struggled to describe how he became physically tense, expecting me to criticize whatever he said, and how he quickly searched “for the right answer.” I recognized that psychotherapy was not happening when he was giving me “the right answer.”

I asked him to look me in the eye and tell me about his irritation, first with me and then with his coworkers. I wanted him to see my face and how I was impacted by what he did not like. It was difficult for him to voice his discontent, but after several sessions he was able to articulate some anger. I was not sure if

these sessions were therapeutic or not. Allan's expression of anger may have been authentic or he may have been complying with my request or a bit of both. I was surprised when a few months later he said that he felt better after the sessions in which he expressed his anger.

I was curious about Allan's childhood, and over the next months I asked several questions about his early family life. Allan was physically tense whenever I did this and did not want to talk about his past. He often said, "I don't remember my childhood." I was curious about whether what I was observing with Allan pointed to his having an avoidant attachment style. That stimulated me to think about the formation of unconscious relational patterns in childhood—unconscious patterns that determine the quality of interpersonal relationships in later life (Erskine, 2008, 2010). It is evident from the child development literature that children who develop avoidant attachment patterns most likely had parents who were rejecting and punitive (Cozolino, 2006; Wallin, 2007) or at least predictably unresponsive to the child's needs and self-expressions (Erskine, 2009). Main's (1995) research indicated that mothers of infants with an avoidant attachment style were emotionally unavailable; they tended to be neglectful when the child was sad and were uncomfortable with physical touch.

It is now well recognized that, as an accommodating survival reaction to the caretaker's predictable unresponsiveness to their affects and relational needs, children learn to inhibit communicating emotions, needs, and internal experiences. As a result, they create an unconscious relational schema by which they inhibit emotional expression and undervalue the importance of relationship. They create an imago of interpersonal relationship where intimacy does not exist. Such children may form interpersonal relatedness strategies in which they do not express, or may not even be conscious of, their attachment-related feelings and needs. They may be disdainful of vulnerability and tender expressions of affection and/or prone to anger (Hesse, 1999; Kobak & Sceery, 1988; Main, 1990).

These ideas about unconscious relational patterns served to heighten my curiosity about Allan's childhood. I wanted to inquire about both his current life and his childhood, but he was not ready. Allan wanted to talk about the people at work and his activities at church. Each week he insisted on telling me about his experience hiking the previous Saturday. I began to form a developmental image of Allan as a 6- to 8-year-old boy, a child without a father to take an interest in his adventures (Erskine, 2019).

This developmental image evoked feelings of compassion in me and increased my interest in his stories. I wanted to go hiking with him and see the woodland trail that he saw, to smell the same forest smells, to be a companion. I listened intently and asked factual questions about his hiking and work. Periodically, he allowed me to inquire about what he was feeling, imagining, or remembering. Then I was able to have a glimpse of his internal world, a private world he was reluctant to reveal. I felt an emptiness, like a vacuum, in my belly when I imagined that Allan's world was deprived of intimate contact with people.

When I listened quietly to his stories, I used my face and body gestures to indicate that I was present and attentive. I wanted to convey empathy even though he expressed little emotion. When I asked about his affect, he generally gave me vague answers and rapidly went into details about his current life. I stayed present and interested. We were developing an emotional connection but it was still fragile. I was perplexed and questioned myself: Was my wanting Allan to have contact and possible intimacy with people a countertransference reaction or was my desire responsive to his needs? (Loewald, 1986). Pondering this question allowed me to modulate making any comments, interpretations, or observations about his life. I knew that there was so much more to learn about Allan. Patience, observation, sensitivity, and curiosity were my therapeutic tools.

Our therapy proceeded in this way throughout the first year. I, in a countertransferential way, slipped into responding like a good father, curious and listening to his stories, which alternated between the events at work and what he did on his days off. Periodically, he talked about the people he saw on his evening walks. I still did not know much about what he was experiencing emotionally, such as when he was at home or when he walked the streets late at night "hoping for distraction from feeling empty." But I felt myself fully attentive and involved.

I was perplexed. I read some of the classic psychoanalytic literature about the transference-countertransference matrix (Brenner, 1979; Freud, 1923/1961; Greenson, 1967; Heinmann, 1950). Was I experiencing what Theodor Jacobs (1986) termed a "countertransference enactment"? Were my behaviors concordant or complementary (Racker, 1968)? Over several months, my psychoanalytic peer group helped me to delve into my feelings and motivations. I took these conversations into account, formed impressions from what I was reading, and thought about several clients and the different forms of countertransference they stimulated in me (Novellino, 1984). I categorized my various internal experiences in three ways: reactive, responsive, and identifying (Erskine, 2012, 2013a, 2013b).

Sometimes my emotions and behaviors were reactive, a reliving of some unfinished emotionally charged experience in my own life. In these moments. I was self-centered and the client's therapy was disrupted. In many situations, I was responsive and attuned to the qualities of interpersonal contact that the client needed in order to heal from the wounds of neglect and trauma. In these instances, my affect, attitude, and behavior provided a "healing relationship" (Erskine, 2021). Often my affect, demeanor, and words reflected my identifying with the client's unspoken affect or visceral sensations. These various identifications guide me as to when to speak and when to be patiently quiet, in forming the phenomenological inquiry I might make, and in assessing the client's developmental level of functioning. I challenged myself with several questions:

• Were my various affects, urges, and caring behaviors a useful pathway to understanding Allan's inner experience? I was sensing the desire of a 6- to 8-year-old boy to have an adult as his companion (identifying).

• Was I attuned to possible relational neglect that he might have experienced as a child? And would my compassionate responses actually be therapeutic (responsive)?

• Was the work with Allan reactivating unrequited relational needs from my own past (reactive)?

• Was my caring for him an unconscious identification with how Allan had prematurely cared for his mother (identifying)?

• Was I reacting to Allan's possible desire to be rescued by a good father (reactive)?

• Were we cocreating what he needed (responsive)?

I never found definitive answers to most of these questions. I was continually left to think about my motivations and to decipher the unconscious story enacted in his behavior, entrenched in his unrevealed affect, and envisioned in his fantasies about camping in the wilderness (Erskine, 2009).

Isolated Attachment Patterns

I kept thinking about unconscious relational patterns: those that can be described as "avoidant attachment" and those that take the form of "isolated attachment"

(Erskine, 2009). Allan lived his day-to-day life in a more solitary way than individuals who manifest an avoidant attachment pattern. Although people with such a pattern often avoid expressing tenderness and empathy, they usually have a social life that includes group activities and superficial relationships. Perhaps Allan's unconscious relational pattern was more isolated; he was a loner. In this first year of psychotherapy, Allan did not talk about any interpersonal connection, and he avoided talking about his relationship with his mother. There was no indication of any emotionally close relationship in his current life and, I suspected, not in his childhood.

In drawing on my therapeutic work with other clients and discussions with members of an ongoing professional development seminar, it became apparent that a person may form an isolated attachment pattern as the result of a series of experiences in which caretakers were experienced as repeatedly unresponsive to the child's relational needs, untrustworthy, and/or criticizing and controlling of the child's emotional expressions (O'Reilly-Knapp, 2001). Because vulnerability was sensed by the child as dangerous, they succumbed to an implicit fear of control, criticism, and invasion. As a reaction to such noncontactful parenting, the child may develop patterns of withdrawal from interpersonal relationships, a social façade, intense internal criticism, and the absence of emotional expression (Erskine, 2001). On cursory observation, such people often appear to be emotionally reserved, quiet in the presence of others, and self-sufficient.

In looking back over the years of my psychotherapy practice, I often overlooked the significance of these subtle signs of the schizoid process. It has taken me a number of years to become sensitive to the unspoken story of such clients, a story replete with fear, shame, disavowed loneliness, self-criticism, and a compulsion to isolate. Allan was one of the clients who taught me to listen for the therapeutically significant story encoded in what such individuals do not say.

As Allan's first year of psychotherapy came to an end, I hypothesized that his pattern of attachment was isolated. He was a loner, had no meaningful relationships, and was reluctant to talk about feelings or his childhood experiences. In some sessions, he implied that he frequently criticized himself. Although I always inquired about his internal criticism, he would not reveal any content. During the second part of the year he had acknowledged and expressed some discontent with his coworkers, and on one occasion, with me. He still did not initiate conversations with anyone. When I encouraged him to reach out to people, he was annoyed with me, turned away, and quietly said, "You're bossing me." Yet he also said that he liked coming to our sessions, and he never missed one. I hoped he was forming some embryonic attachment to our relationship.

When we parted for summer vacation, I realized that Allan was teaching me how to relate to someone who was always suspicious of interpersonal contact, particularly if it was intimate in any way. I suspected that he was deeply afraid of what he called “invasion,” but why? I was also curious about both his self-criticism, which seemed to lurk below the surface of our conversations, and the little criticisms he directed toward others. I looked forward to September when we could work together again. He was teaching me about relational isolation while I hoped that I was helping him with interpersonal contact.

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