Silence, Withdrawal, and Contact in the Schizoid Process

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Abstract

Silence, withdrawal, and contact as related to the schizoid condition is considered. Winnicott's theory of impingement, an understanding of the encapsulated self, and withdrawal from contact are used as the basis for therapeutic interventions. Case vignettes demonstrate the impact of contact with the client who is silent and withdraws.

Keywords: Impingement, encapsulated self, silence, withdrawal, case examples

The Questions

One of the most important questions a psychotherapist must consider is how to listen to a client's silence or maintain contact when the person withdraws. That became relevant to me early in my career and has continued to be of interest and relevance ever since. In an article I wrote 20 years ago (O'Reilly-Knapp, 2001), I considered two questions: "What is required in a therapeutic relationship so that the uncommunicable, walled-off parts can be spoken, heard, and understood? At the same time, how can the integrity and stability of the client be maintained so that self-emergence is facilitated?" (p. 44). Two new questions are at the center of this current paper: How can the therapist provide the space for silence to be supported? What is needed for the therapist to maximize her or his presence when a client withdraws?

Case Vignette: Peggy

As a graduate student, I could select who I worked with in my clinical rotation. I noticed Peggy while talking with others on the unit. I would see her for a brief moment and then she would disappear. At the end of the morning, I decided that Peggy would be my first client. I remember being excited to meet with and get to

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know her and hopefully to be helpful. Little did I know that my relationship with Peggy would begin my lifetime search for understanding the therapeutic process and the interventions needed to work with the sequestered part of the psyche. In a journal I kept about our sessions together, I noted:

> The first time I spoke to Peggy I told her I would be on the unit 3 days a week and I would like to meet with her and talk. She did not say anything, so I hoped this was a yes rather than a no. The first session started the next day when I sat down in the dayroom and waited for Peggy to appear. I did this the same time each day I was on the unit. She did come. I greeted her and then we sat in silence for about 10 minutes. The second week she told me to leave her alone. However, she continued to come and sit beside me. I sat in silence with her with an occasional comment about my thinking about her, checking about her eating and sleeping and activities on her unit. Most of the time she did not respond.

Over the next couple of weeks, our time together increased from 10 to 30 minutes. Peggy tolerated sitting with me. In the 8 months I worked with her, Peggy went from confinement on a closed unit to permission to go off the unit and onto the hospital grounds. She stopped using the bathroom floor as her escape and joined in some of the unit's activities.

I believe one of the pivotal points of our work together was in our third month. When Peggy did not turn up at our appointed time, I went looking for her. I was told by one of the patients that she was in the bathroom. I found her there lying on the floor. I told her I had been looking for her. I was upset and with raised voice told her that I did not want to see her on the floor, that she was better than that. I left telling her I would be waiting outside. What worried me the most is that I could not think of any therapeutic approach that would validate my reaction. After all, I was a student, and I was concerned that my behavior might have been inappropriate and that there might be consequences. I was also concerned that Peggy might experience this as a rupture in our relationship. A few minutes later, she came out of the bathroom, looked at me, and then turned away. I told her I was glad to see her. I asked her if she heard me, and she nodded her head "Yes." I asked about her retreat to the bathroom, but she did not respond. For the rest of the time of our meetings, she never returned to the bathroom floor.

As I look back, I know my distress was appropriate and effective. As Bettelheim (1976) wrote, “The infant must first become important to a human being he can influence and who therefore becomes important to him” (p. 229). This quote resonated with me because Peggy certainly influenced me as she lay in the bathroom. I believe that with my response she saw me as genuinely caring about her. I became important to her. Over time she responded. Much of what I did with her was to be present and allow her to connect with me at her speed. We created a space relatively free of impingements, and I made contact by sitting with her in silence. Although I did not have the theoretical basis I have now, I began developing a strong foundation for a therapeutic framework through reading the works by Erikson (1963), Bowlby (1969), Perls (1969), Balint (1968), Piaget (1971), May (1953), and Bruch (1969). In working with Peggy, I believe my naiveté allowed me to be open with her and more accessible to new information. When I eventually said good-bye to her, I was sad and had tears in my eyes. I gave her a small cake with a card to celebrate her birthday. She insisted on putting the cake in the locker by her bed. I often wonder where Peggy is today.

Case Vignette: Sue

In my first year in private practice, I had a referral from the university where I consulted. Sue had been a student and was just released from the hospital, where she had been treated for a severe schizoid state. In her first session, Sue talked about her hospitalization and her fear of losing touch with reality. She was afraid that she would go so far away from reality that she would not be able to get back and would go insane. In her latest hospitalization, she tried to escape from the chaos created by her anxiety by retreating back inside, a schizoid flight to find a safe place. However, in the process she lost touch with her selfhood as well as the external world. I told her I could not ensure her that this would not occur again, but I would be there for her, whatever happened.

To begin, Sue recounted her life before she went to college and how she had come from a highly dysfunctional family. To help her stay together as she talked, I “held” her by asking her to slow her speech, to take deep breaths, to be aware of sensations in her body. I tried to support her in her struggles and to signal that I was there with her, that she was not alone. These steps were important as she talked about the death of her mother when Sue was only 12 years old and the loss of two sisters and a brother when they departed the household. Being the youngest, she was left alone with her father, who was physically abusive. The main purpose of therapy at that point was to provide Sue with a reliable, secure

relationship in which contact with her essence as a full human being could be realized.

Sue spent the next year encountering her childhood memories of abuse and neglect. Diminishing some of the tension and conflict of her struggles helped lessen her anxiety. She began to integrate some of her thoughts and feelings and to develop a core of her personal self. After 2 years, Sue left the area to live by the sea. Periodically, I would receive a note from her until that stopped. Some time later she called to tell me she was back in town and asked if I would see her. When she arrived for the session, Sue said she had been hospitalized again and she wanted to work with me once more. I took this as her desire to have contact even though she was fearful. We made a contract to "discover more."

The next 3 years were the foundation for the work that we did. I listened to her, took her seriously, reassured her, comforted her. I was there for her in her silence and there when she returned from withdrawal. Little (1990) described this state as "consummate patience" (p. 19). I valued Sue's aliveness and her unique identity as a human being. I admired her strength as she opened herself to new possibilities. This period of her therapy prompted me to recall Guntrip's personal therapy and his comment about his hidden self: "He remained alive and you have let him out" (Guntrip as cited in Hazell, 1994, p. 25). Guntrip described that through his therapy with Winnicott, he was able to reclaim the part of him that had been concealed and to come out of hiding with his therapist's help. Now, a part of Sue that remained alive and hidden was beginning to come out in therapy. She continued working with me for 5 more years, and in that time she was hospitalized once. She left therapy, has been living in a retirement community, and is doing well with support from friends and her church.

The Encapsulated Self

In the schizoid position, an organizing system is constructed in an attempt to gain some control by avoiding overwhelming thoughts and feelings. Within the pattern of an isolated attachment, a withdrawn, regressed part of the individual lies encapsulated, locked away in enclosed, protective fragments that serve as an armor of detachment. The mechanism of withdrawal provides the individual a place to hide, although it also inhibits activity and has a profound effect on mastery and self-efficacy. Orange et al. (1977) described the experience of self-loss as an

"intersubjective catastrophe" (p. 55). In my article "Between Two Worlds" (O'Reilly-Knapp, 2001), I described part of the turmoil in the loss of self as follows:

> Basic needs and wants become lost in a massive, psychic withdrawal, and relationships are dismissed because what is most needed is also what is most feared. The person is left suspended between both internal and external encounters with no real relationship with either. The inner world consists of object relations filled with fantasies and dreams and a shell created by primitive isolation. (p. 47)

I also noted that

> there is not only a primitive withdrawal … there is also a dissociative defensive stance used to protect the continuity of existence. The ability to separate experiences from awareness allows the individual to escape from perceived danger. Withdrawal, as well as separation from internal and external experiences, becomes the shield against overpowering circumstances. (p. 45)

My premise here is that in the schizoid process the person: (1) lives in a world of isolation, (2) within the matrix of unintegrated life experiences, and (3) copes as best they can in the real world. Guntrip (1968/1995) wrote that there are attempts to connect that are thwarted and end up in perpetual isolation—as a "detached spectator" (p. 18). He described mental activity as disappearing into an inner world where there is absolute withdrawal from life, "into the living death of oblivion, an escape into passivity and inactivity" (p. 92).

Case Vignette: Bill

Bill called for an appointment out of concern that he was going into a backward spiral. He came for psychotherapy because he felt like he was going back to his "old" days, when he lived for 2 years in the woods after his return from Vietnam. It reminded me of how Guntrip described a part of the ego "which knows and accepts the fact that it is overwhelmed by fear and in a state of exhaustion, and that it will never be in any fit state to live unless it can, so to speak, escape into a mental convalescence where it can be quiet, protected, and given a chance to recuperate" (as cited in Hazell, 1994, p. 178). I viewed Bill's time spent in the war as an important source for his present concerns. In psychotherapy, he needed a chance to recuperate.

Part of the schizoid dilemma is that the person lives within a world of isolation and unintegrated experiences and constructs a system of organizing events to avoid feelings and memories. In this position, splitting pushes out of awareness the need for contact and connection. For a client with a schizoid process, “a therapeutic relationship allows each Child ego state to emerge and be met with a safe, attuned response” (Erskine, 2001, p. 4).

In Bill’s therapy, we began with two areas that had not been dealt with in his previous therapies; only later did he examine his childhood experiences. The day before he and his friend were to leave Vietnam, a grenade was thrown into their encampment, and his friend was mortally wounded. In a session, I had Bill close his eyes and go back to that encampment where he held his friend in his arms as he lay dying. Bill was silent, tears coming down his cheeks. To help him give words to that traumatic event, I asked Bill to talk to his friend, tell him what he meant to Bill, and how he felt about him. Finally, I asked him to say good-bye and to tell his friend what he would remember about their friendship. We both then sat in silence. Later I told Bill how sad I was. I was also thankful that he was there and that his friend was not alone as he died. After the session I had a message from Bill thanking me for being there for him and that he recognized how important it was for him to be there with his friend.

A second area dealing with the war was raised in a weekend intensive workshop that I co-led. When Bill came home from the war, his plane was greeted at the airport by antiwar protestors. They spit at his troop and called them murderers and baby killers. In the group setting, through reenactment, group members listened as Bill described his return from Vietnam. He talked about his arrival home and the response of protestors as he left the plane. When he finished group members talked about their feelings. Then members welcomed Bill with respect and love. One member in the group had been an antiwar activist. Both cried as she went to him and asked for his forgiveness. This is an example of how an intensive therapy is necessary to affect difficult, unintegrated remnants of a person’s past. This group setting gave him a place to resolve a painful ordeal.

Most of Bill’s psychotherapy focused on reorganizing his internal sense of being and emerging from isolation and historical detachment. He described how he felt alone and isolated from the world, about living his whole life alone and afraid. In one session he started to talk about his time in the woods. I encouraged him to close his eyes and go to the woods. I told him I would go with him. Much of the time he was silent, and I sat with him and reminded him periodically that I was with him. In subsequent trips to the woods, he began to remember how as a young boy, around 5 or 6 years old, when his father would become violent and go after his

mother and any of the other children who were present, Bill would go into hiding, first under the kitchen table and then deep into his mind where he could not hear, see, or feel anything. According to Bill, he was invisible. Later, in school, he got into trouble for talking in class and fighting in the school yard. In high school he began to drink. When he joined the Army, he did better because the structure helped him. Over time in therapy, Bill described the story of his life, including the years of isolation and withdrawal and his feelings of hopelessness and helplessness. His fear was realized, his rage and despair were heard, his excitement and joy were celebrated. Bill lived for 15 years after he finished therapy. He saw his daughter graduate from college and his son finish high school. I heard from his wife that they had good times together before he became ill and died of kidney failure, which was attributed to a toxic herbicide used during the war.

The Between Space

Intensive psychotherapy is necessary to affect the core of an individual who manifests a schizoid defense structure. Effective therapy requires working with both the hidden, sequestered part of the psyche as well as historical events. With someone whose basic needs and desires become lost and relationships are dismissed, they are left suspended between both internal and external world encounters with no real relationship with either. The inner world consists of fantasies and dreams with a shell of primitive isolation. The external world is experienced as something with which the person is uninvolved, where they neither want nor have expectations of help from another. Due to “sustained relations broken down at their most basic level,” there is self-loss and no connection to either self or others (Orange, et al., 1977, p. 55)

An understanding of emotional conflicts, unmet needs, and the loss of relationship are all important in dealing with loss of self. Both here-and-now contact with the therapist and a return to states of fixation and dissociation provide the path for unfreezing early ego formation and unfolding of self. What was once constructed as protection and reinforced is now addressed in the therapeutic process. For both client and therapist, the process is unique to that particular relationship. Theory and technique are used as a guide with continual assessment by the therapist of the therapeutic process.

Case Vignette: Sandy

After consultation with an expert in the field of dissociative identity disorder, I agreed to work with Sandy, whom I had met at one of the weekend workshops I did. Over a year, she attended several more. She had been seeing another therapist in the state where she lived 400 miles away. Although she had asked me to work with her, I did not want to interfere with her current therapy. However, when she became suicidal she called me. I would talk with her and then call her therapist to discuss her treatment. He told me he was going to terminate his work with her. I was conflicted and went for supervision. It was then, having the consultant's opinion and support, that I made the decision to accept Sandy as a client. After she terminated with her therapist, she and I began telephone sessions.

Readers may be wondering why I included Sandy as a case example in this article. The reason is that I have found that several of my clients who had dissociative identity disorder also demonstrated a schizoid position. This was not evident at the beginning of therapy because the fragments that presented masked the withdrawn, regressed self. In this paper, most of the discussion will concern the schizoid condition.

In addition to weekly phone sessions, Sandy attended weekend workshops four times a year and a week-long residential treatment workshop in the summer. There were also occasional individual in-person sessions in my office when she was in the area. Because a strong therapeutic alliance had been established in our meetings over the first year and a half, her work moved rather quickly into the memories and feelings she had repressed.

During our telephone sessions, Sandy was often silent, and I would be with her, telling her I was there. She started sending me drawings in the mail after a session, and this helped her to find the words as we talked about the drawing in our subsequent session. She began to allow her hidden self to show in her drawings and to talk about her vulnerability. As she started to recall the reasons she had locked herself away, she began to work with the split-off and painful memories. She dealt with her fears by drawing pictures of anger with red and black circles, fear as balls of orange and yellow, and sadness as blue and white squares. She talked about being trapped in circles of anger, balls of fear, and squares of sadness. Each drawing had a feeling and a story, and I listened to them all. I sat with her as she went into the rage, terror, and despair. Slowly, the drawings facilitated the emergence of her self.

Later, Sandy began drawing pictures in which she was no longer trapped. There was a flow to the brush strokes and a lightness to the colors. The supportive, safe environment of the sessions allowed her to deal with the intense affect. Time was provided for her to reenter the here and now and talk about her work with me.

Because the work was exhausting, we allowed time for her to recuperate. Often a resting phase after the work helped her integrate new material. In the weekend workshops, she would go outside and sit under a tree after she had worked. She also used a journal to help her process additional information.

With Sandy, not only was a part of her withdrawn and hidden, she also held alter states of dissociated defensive structures. She had integrated several of her dissociated structures before coming to me, and for those that remained, I incorporated a method called “mapping” (Kluft & Fine, 1993). This type of recording represents a visual diagram in which dissociated parts are identified and given a voice. It was like putting the pieces of a puzzle together. In this process, Sandy had a visual representation of her narrative and the fragments that needed to be unified. As she filled in her “story lines,” she was able to identify past experiences, form meaning out of events, and eventually develop an understanding of the past. This method was particularly effective for Sandy because she was an artist and had a deep appreciation for graphics. Being able to give meaning was an important step for her in remembering and then appreciating the assets she possessed to help her survive.

The Impact of Impingements

Moving the body allows a person to shift in their surroundings as part of discovery and a “sense of real being” (Clancier & Kalmanovitch, 1984, p. 84). Spontaneous movement is essential for exploring the environment without the sense of self being lost. Winnicott described the importance of someone being present and not making demands, which allows for establishing an “internal environment” in which the self can be alone in the presence of another. When there is impingement or interruption of continuity in the body, there is “restlessness of the environment” (Winnicott, 1988, p. 127).

With the schizoid condition, movement is impeded. Winnicott’s theory (Newman, 1995) of impingements is useful in this regard, and his actual drawings illustrate the seclusion that occurs and how relationship patterns of isolation result. He used the analogy of a bubble wherein the baby is surrounded by the environment. When pressure on the outside is adapted to the pressure inside, there is a “continuity of existence” (Winnicott, 1988, pp. 127–128). In a state of being , before and after birth, movement is a way for the baby to discover the environment. This move out into the surroundings is a part of discovery and the sense of existence. When pressure outside is greater, there is impingement and disruption of continuity. When impingement or encroachment is repeated, the individual returns to

isolation. This isolation is different from loneliness in that it is a retreat from danger. In such cases, the person who withdraws from others "has experienced gross impingements from the beginning and has had to withdraw in order to preserve the core self from violation" (Abram, 1996, p. 35). The state of being for the baby and even later life experiences can trigger such withdrawal. A pattern of relationship develops whereby, even without restrictions or intrusion from the outside world, the feeling of being restrained may lead to seclusion of oneself from others. In the schizoid process, isolation into what Bettelheim (1976) called an "invisible fortress" severely restricts contact with others.

Case Vignette: Jane

For the first month of her therapy, Jane directed me to "just listen." If I even nodded my head, she insisted that I was not listening. She told me my words got in the way. By attending to Jane with my presence, I joined her without intruding. At times I broke the silence to tell her I was listening, but I think this had to do more with my own comfort than hers. Most of the time I just listened. I questioned my effectiveness, even though I realized at the time my silence was vital to Jane's progress. I believe she needed what Little (1990) referred to as a "settled" state, undisturbed by impingements (p. 44), and what Erskine et al. (1999) described as "therapeutic presence," a way of being there (p. 98). This attention was the entry into work about Jane's mother, who was always telling Jane and her siblings what to do. Jane felt like she was being smothered. She could not tolerate any reaction from me, and she later talked about how important it was for me to hear her. She reported she could now breathe. Continually assessing my own responses to Jane and her process helped me to safeguard our therapeutic relationship.

The Trauma Existing in Silence and Withdrawal

Maintaining a connection with someone who is silent or who goes into hiding requires the therapist's full attention. Silences can occur when there are no words or if the words are too difficult to say, so help is needed to find the words or to say the words out loud. The client may also be silent when their experience is preverbal. It is also important to notice sounds as well as physical movement and for me to monitor my own thoughts and feelings as I sit with a client. What am I experiencing? Is the connection with the client maintained? If I lose contact, what does that mean? It is important to remain calm and to tolerate silences so that a stable, settled state is created in the therapeutic setting.

Case Vignette: Linda

When we began group sessions, Linda would come into the office, sit in the corner, and remain silent most of the time. She had been referred by a colleague who thought a group setting might help Linda to interact with others. After graduating from college, Linda worked as a receptionist in a law firm. She was single and lived alone. Her family constellation consisted of her parents, sister, brother, and aunt. She said she called periodically to talk to her parents and would learn about her siblings, and her aunt called to see how she was doing “once in a while.” It appeared most of her time was spent alone.

Linda seemed distant and uncomfortable when she was involved in conversations both before and during group, and she was the first to leave after the group was over. She reported she would “go away mentally” when others were talking so that she could steady herself. The problem was that she lost connection with what was going on. Because she needed more time than the group could give her, I suggested she come to individual sessions to do the regressive work she needed. Her individual sessions were lengthened from 50 minutes to 90 minutes to give her time to settle in and fully experience my presence.

In the first individual session, Linda sat on a pillow in the corner and was quiet. I listened to her silence and sensed tightness in her body. When she started to speak, she would stop midsentence and become frustrated, saying she wanted to stop and go away. When I asked her about going away, she talked about hiding herself far away where no one could see or hear her. I asked her to close her eyes and go into her quiet, and I focused on being a witness to her withdrawal. The first sessions she remained still and calm in the withdrawal for about 10 minutes. She talked later about how she frequently went to that place when she was afraid. It was a place where she felt safe.

As the sessions progressed, Linda began to remember being afraid and alone. She had been shivering and said that she was cold, so I covered her with a blanket. This was a source of comfort as she began to remember her mother screaming and “doing crazy things.” She started to remember the times her mother tied her to a chair because she was making too much noise or the time mother locked her out of the house for a whole night. Linda’s father traveled for work and was not home most of the time. From the time she could walk until she left home to go to college, her mother continued acting out while Linda took most of the abuse to protect her sisters.

In her sessions, Linda began to deal with her feelings of terror because no one was there to help her. I reminded her that I was with her now. She wept with despair as she recognized her experience of not having a caring mother. I sat beside her and held her hand as she cried and screamed for help. And when she raged, I took her anger seriously about her mother's brutality by saying I was also angry at that behavior. One of the many times she went back to being tied up, I asked her to allow me to untie her. As she went through this she cried out "never again." When Linda opened her eyes, she reached out to me and I took her in my arms.

Contact in Silence and Withdrawal

Interaction with another is central to the discovery of one's self. Fairbairn (1952) highlighted the hunger for contact and connection. From in utero throughout the life span, the individual is in continual interaction with others, and these exchanges become part of the sense of self. Mitchell (1988) considered the relational matrix as one in which

> the establishment and maintenance of relatedness is fundamental, and the mutual exchange of intense pleasure and emotional responsiveness is perhaps the most powerful medium in which emotional connection and intimacy is sought, established, lost, and regained. (p. 107)

The child learns a style of connection, and these learned modes are maintained throughout life. It is in the relationship with the therapist that connection that was lost or never provided can be established and retained so that a new relational pattern can develop. Guntrip (1968/1995) described the ultimate problem in psychotherapy with a schizoid process as "the rebirth and regrowth of the lost, living heart of the personality" (p. 12). As described earlier with Peggy, I spent a good deal of time in silence. I arrived at the same time and waited for her. My presence was an invitation to her: I am here for you, I am waiting for you. My presence also signaled: I want to be with you. As I sat anticipating Peggy's arrival for a session, I thought about our last time together. I looked forward to spending time with her. I believed she was able to sense my desire to be with her.

Part of Sue's therapy involved her struggle to maintain her saneness while at the same time deal with overwhelming feelings and memories. I arranged for her to hold my hand as she began regressive work. At times I would ask her to squeeze my hand to stabilize her and to be a link to me and hopefully to reality. Her clasp of my hand served as a reminder to her: You are here with me, you are not alone, I am not going away, and finally, I want you to stay with me.

With Jane, I was quieted by her, which allowed her to tell part of her story without interruption. Once she had a sense of me there with her, she then moved into interchanges with me. I envisioned her process as: I know you are here, I want you to know I am here, and then we can be here together.

In the work with Linda, I sat with her in silence, honoring her withdrawal. She needed me to be there for her to acknowledge the existence of her withdrawal, and later, to validate and normalize her withdrawal. Being present in the moment is one of the most powerful positions we have as a therapist. It takes desire and concentration to stay in contact and to provide a space in which the client's narrative can be recounted and understood. The position of witness provides an invitation to the client: I am here with you, I see you, I hear you, I am interested in you.

With Bill, I waited with him when he went into his hiding places. I sat with a little boy who desperately wanted to be out in the world and be safe. He needed a place where he could explore, which he did by taking me with him, in fantasy, under the kitchen table and to the woods. There he went further into his inner sanctuary, where I sat and waited for him to come back from the hiding place we shared under the table or in the woods. Along with dealing with his anguish, there were times when we played for that little boy's benefit. Sometimes there were songs, talks about baseball, laughter, and at times I even held him in my arms. My presence had the tone of "I encourage you to come out of hiding, I invite you to be in the world to explore and have fun. I know there are places in the world that are scary, and there are also wonderful places for you to be. Let's find ways for you to be safe."

In Sandy's drawings, unconscious material was brought into awareness. Giving words to her sketches helped her to construct her narrative. They provided a path by which to uncover and understand her withdrawal patterns. Appreciating how important graphics were to her, my remarks often included comments such as, "I see you, I picture you all alone in your hiding place, I see your struggle, I imagine you appreciating your strength."

With all the individuals described in this paper, I respected silence and withdrawal because of the importance both occupy in the schizoid process, even though it sometimes limited the exploration of other forces at work. For a more detailed account of therapeutic interventions, the reader is directed to my article "Between Two Worlds" (O'Reilly-Knapp, 2001).

In the therapeutic relationship, the therapist joins with the client in experiencing the affective connection needed for oneness and for the emergence of self-states.

Because of the extreme isolation and annihilation of self and others that characterize individuals with schizoid disorders, therapy needs to respectfully and consistently support the client's unique position, deal with the need for contact, and take into account intrapsychic processes. Providing a safe place for the emergence of the self and the establishment of a therapeutic bond is primary. The withdrawn space of encapsulation and the loss of relationship in the withdrawal need to be understood as attempts to survive. How the individual, with the therapist's support and encouragement, can move from a position of avoidance of contact becomes a major portion of the therapeutic work. Arieti (1974) wrote that the therapist needs perseverance in reaching such individuals. Tustin (1986) identified patience, tact, and skill as requisites for the therapist in working with a withdrawn person. Staying in contact takes effort for both the client and the therapist, but it is an effort well worth it in the end.

Conclusion

I hope this detailed discussion and the case vignettes will add to our knowledge about the importance of silence and withdrawal in working with schizoid processes. The ultimate purpose of therapy for clients with a schizoid condition is to provide a place for the reorganization of an internal sense of being and emergence from isolation. In this paper, I have attempted to answer two fundamental questions: How can the therapist provide the space for silence to be supported? And what is needed for the therapist to maximize her or his presence when a client withdraws? I have shown here how I used contact to maintain connection with each client during episodes of silence and withdrawal in the schizoid process. The stability and integrity of the therapeutic relationship allowed for the integration of a split self and ultimately an emergence from seclusion. Although the work was difficult, I never tired of it. In fact, I was honored by the trust given to me by these brave individuals.

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