Questions and Answers

WEBINAR ON THE SCHIZOID CHARACTER STRUCTURE

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Can't seem to find any training on this modality in the UK, do you have any suggestions whom to contact? (A.P.)

I suggest you get in touch with the IIBA through email. There is a new booklet published by the IIBA that gives you all kinds of useful information, among other things the website addresses of all the local bioenergetic societies in the world. This is a booklet you can get in a pdf format by writing to the IIBA office: info@bioenergeticanalysis.com or you can go to the IIBA website where you will find information about the various Societies that provide bioenergetic analysis training. You would need to check where the training is given in English in Europe, unless you can speak another language like French, Spanish, Italian or German.

If the energy of the schizoid flows upwards and into the head, and into intellectual activities, why doesn't Lowen's diagram show that energy flow? (D.C.)

What Lowen's diagram describing the energetic state of the schizoid shows, is that although a lot of energy goes to the head in the case of the schizoid, it has to do more with mental energy of a survival type. The kind of energy that does not flow to the points of contact (head, arms, legs, and genitals) is a feeling energy, an emotional energy. This is because there is an important head/body split in the schizoid. The schizoid is not really connected to his/her feeling states (sensations, emotions) because the "frozen body" does not allow much feeling. Hence, the energy in the head is more of a mental type without much connexion to sensations and feelings. The kind of energy that is related to sensations and emotions remains trapped at the core of the frozen body and does not flow freely to the periphery.

What is the difference between schizoid and schizotypical? (F.M.)

According to a description provided by the Mayo Clinic (USA) website:

"People with schizotypal personality disorder are often described as odd or eccentric and usually have few, if any, close relationships. They generally don't understand how relationships form or the impact of their behavior on others. They may also misinterpret others' motivations and behaviors and develop significant distrust of others.

These problems may lead to severe anxiety and a tendency to avoid social situations, as the person with schizotypal personality disorder tends to hold peculiar beliefs and may have difficulty with responding appropriately to social cues.

Schizotypal personality disorder typically is diagnosed in early adulthood and is likely to endure across the lifespan, though treatment, such as medications and therapy, can improve symptoms."

Several of the traits described above can equally be found in a person who develops a schizoid character structure. For example, the difficulty to form close relationships, the tendency to misinterpret other's motivations and behaviors, distrust of others, etc. However, I would say that the schizoid character structure encompasses a larger range of traits and behaviors and includes people with less severe dysfunctions compared to the people who are diagnosed with schizotypal personality disorders, as described above.

If the energy is frozen in the center, why don`t I work from the center to the periphery? Shouldn`t that be the same as trying to bring the energy downwards because its`s flowing upwards? (D.C.)

No, "working from the center towards the periphery" it is not at all equivalent to "bringing the energy downwards".

Bringing the energy downwards, or grounding, is a kind of work that helps the person develop a capacity for "containment": in other words, a capacity to tolerate intense emotions without "exploding", so to speak, or without being overwhelmed and losing oneself. Working from the periphery towards the center by softening the tensions in the joints in the arms and the legs as well as in the occipital region (among other things), is necessary in order to open up channels of expression, facilitating the flowing out of energy and expression. If this kind of work is not done, the mobilization of intense core emotions (terror/murderous rage) risk creating a situation where the person can either implode (because the emotional and energetic charge will hit blocks and will not be able to come out freely), or explode, creating a state of fragmentation and possible psychotic decompensation because the "container" is still fragile (frozen body, lack of integration in the sense of Self) and will not have been prepared to manage such an intense emotional/energetic charge.

Can the schizoid patient achieve bonds with greater intimacy? (L.M.R.)

Yes, most certainly when the schizoid patient can work through his/her core issues in therapy. The therapeutic setting offers schizoid patients the possibility of experiencing a "safe base", which is something they did not have during their early life. Through the therapeutic process, they also learn to form an attachment with a caring figure (the therapist), which will constitute a model for establishing further intimate relationships. They will also be able to connect with, express and process intense emotions that were repressed. As they open up to their own sensations and feelings and learn to tolerate them, they develop a capacity for intimacy with themselves, which will facilitate the forming of intimate relationships with others. Of course, the therapist must be a person who has a good understanding of the schizoid issues and who is able to relate to the schizoid patient on a deep level, so as to offer the kind of therapeutic environment conducive to a resolution of the schizoid's core issues, the capacity for intimacy being one of them.

When some birth disease occur, babies are separated from their mothers (and caregivers) at birth in baby incubators for many days, also weeks. Could be this condition a trigger for this personality trait? (M.P.)

I would say that, in general, the kind of situation you describe would probably be more conducive to an experience of abandonment instead of rejection. Now, it also depends on how the infant is treated during his/her stay in the incubator. If, for any reason, the personnel of the maternity ward are overworked, irritated and hostile, and if the mother or parents of the infant do not have many interactions with the infant during that period, or if they are uncaring parents, the infant may experience rejection and possibly develop a schizoid character structure. Rejection is the fundamental experience of the schizoid, whereas abandonment is the fundamental experience of the oral character structure.

On the other hand, if the personnel of the maternity ward are caring, if they have the time to take good care of the infant, and if loving parents have easy access to him/her, the negative impact of such a difficult early experience may be mitigated and may not result in the development of a schizoid structure. In that case, issues of abandonment may still be present due to the situation of early separation.

For the eyes, the gaze, is there any simple strategy derived from EMDR? (G.A.P.)

EMDR is a specific technique to work with trauma and this technique may be an interesting one to use when working with schizoid patients. However, I do not know of a "simple strategy derived from EMDR" to work with the eyes with a schizoid patient. Nevertheless, there is a type of work that a therapist can do using eye contact with a schizoid patient. But in my sense, that kind of work has to do more with "being" than with "doing" (which would be the case if we are talking about "using a strategy"). There are indeed simple exercises that the therapist can do with a schizoid patient. For example: inviting the patient to alternate between maintaining eye contact with the therapist, and then averting his/her gaze, and coming back to eye contact again, as the patient is invited to become aware of the impact of eye contact. But in this kind of exercise, the important part is the quality of presence of the therapist who is not trying to make something happen for the patient. The therapist simply tries to "be"

with the patient, curious of what is happening for him/her in this kind of intimate contact. In other words, in that kind of work, the emphasis is on "being" instead of "doing", as the experience may replicate that of a relationship between mother and baby.

More about Window of tolerance. How to define and find this? (D.B.)

The notion of "window of tolerance" refers to one's capacity to tolerate an experience that involves intense sensations and emotions, without having to disconnect because it is "too much". In the "window of tolerance" the person is able to remain "present", fully aware of his/her sensations and feelings, and able to own that experience without feeling overwhelmed or becoming dissociated. If we refer to Stephen Porges' model, it means that the person remains either in a sympathetic state, being able to mobilize a fight of flight response to deal with a stressful situation or is in a parasympathetic ventral vagal state, feeling safe, confident, and open. Exercises in grounding help maintain or come back to a state that is within the "window of tolerance".

Is there any correlation of the schizoid character with asd or adhd? (L.F.)

I am sorry to say that I am not sure what kind of disorder asd or adhd refers to. I suppose one of them has to do with a form of dissociative disorder, but I do not know which one. If you could tell me exactly what asd and adhd mean, I could perhaps answer the question.

How to differentiate the longing of schizoid from oral structure - and the murderous aggression from the rigid structure ? (T.W.)

To answer the first part of your question about the difference between the longing of the schizoid and that of the oral character structure: I would say that the longing itself is the same. It stems from the fundamental oral need we all experience as human beings as we come into life: to be loved and cared for unconditionally. It is the way in which that longing is met (or rather, not met) that differs for the schizoid and for the oral. In the case of the schizoid, that longing is met with rejection whereas in the case of the oral, is it met with insufficiency: there is a certain presence and caring from the caregivers, contrary to what the schizoid experiences, but it is not enough to respond to the need of the baby who then feels abandoned (caregivers may be too busy or may not have enough energy to be fully present to the baby).

Now for the second part of the question: the rigid structure usually does not experience murderous rage like the schizoid does. Rigid persons would tend to experience anger instead of murderous rage. As a matter of fact, they are usually relatively at ease with using their aggressive energy because most of the time, they were supported in their quest for autonomy and their self-affirmation during the intermediate period (anal phase). The difficulty of the rigid has more to do with accessing tender feelings. The rigid never felt threatened in his/her very existence like the schizoid did. Therefore, the rigid usually does not experience the kind of murderous rage the schizoid had to repress and dissociate from, due to an organism that was not mature enough to deal with the intensity of the feeling of terror and that of murderous rage, which emerges in response to the terror.

It seems that a schizoid patient comes from a schizoid mother (C.F.)

Not necessarily. For sure, a schizoid mother who has difficulty with intimacy and closeness, will provide a kind of cold, unfeeling, and even hostile caregiving that is conducive to developing a schizoid structure. However, a mother who is not necessarily schizoid, but who may not want the child she is carrying, may also display coldness, repressed anger and rejection in her relationship with that child, which could be equally conducive to the development of a schizoid character structure.

There are DREAMS typical of the schizoid structure? or typical images that recur in DREAMS? a thousand thanks (C.P.)

I must admit that I do not work much with dreams. Hence, I can't say that I have noticed anything particular regarding the dreams of schizoid patients. On the other hand, I can say that I have noticed that several of my schizoid patients have violent fantasies, like killing other people. But even if these kinds of images pop up, usually in moments of stress, they are not accompanied with feelings. Most of the time these fantasies, and the violent impulses that underlie these images, are scary for my schizoid patients. It is the work of the therapist to help these patients gradually approach the intensity of the emotions underlying these violent images, work through the repressed feelings of murderous rage and eventually transform them into constructive anger (self-assertion). This demanding work must be done while making sure the patient's experience remains within a "window of tolerance".

The schizoid character can be developed during the pregnancy? (Q.C.)

Incidentally, when referring to the schizoid character structure, Alexander Lowen talks about a fetus that develops in a "cold womb". We can easily imagine that a woman who does not want the child and/or who does not have a positive relationship to her own body, will not be able to offer a warm and welcoming uterine environment into which a fetus can grow. Some of my colleagues, like Wera Fauser from Germany, who have developed an expertise in prenatal care could certainly elaborate better than I can on that topic.

Could be dangerous reduce freezing, too? It is a defence, too. How we could do in order to avoid this danger? (R.D.S.S.)

This is a good question. Yes, of course if we try to force the expression of repressed feelings before making sure we have established a good therapeutic alliance and before having worked on "opening up the channels" (working from the periphery towards the center, softening the tensions in the arms, legs, neck and helping the schizoid regain a good connection with his/her body), this can result in fragmentation and in a traumatic experience for the patient, rather than an integrating and healing one.

The best way to "avoid this danger" is to make sure that the experience of the patient (as he/she is reconnecting with bodily sensations or getting in touch with repressed feelings), remains within the "window of tolerance". This means that at all times, we want the patient to remain fully present and able to tolerate the intensity of the experience without being overwhelmed or having to dissociate. If

emotional flooding or dissociation happens unexpectedly, which can be the case, the therapist must then use grounding strategies to help the person come back to the "here and now" and regain a sense of self-possession.

Could the mindfulness be useful with schizoid patients? (D.C.)

I believe that mindfulness is certainly a precious practice that can be used in the work with a schizoid patient. But even without practicing mindfulness as such, when we do exercises with the schizoid patients in order to help them regain their capacity to feel their body, we invite them to not only do an exercise in a state of awareness, but more important even, we invite them to take time to feel the impact of the exercise, to notice the changes in their sensations, in their breathing, in their contact with the ground and with their environment. In that sense, I would say that an attitude of mindfulness (and not necessarily the typical practice of mindfulness per se) is an integral part of the work we do in bioenergetics. This is true not only in our work with schizoid patients, but in our work with all of our patients.

Have you heard about Amniotic Psychotherapy developed at the University of Perugia and what do you think about it? (S.M.)

No, unfortunately I haven't heard about Amniotic Psychotherapy. Hence, I cannot comment on it. I am sorry.

How to physically differentiate the schizoid and rigid character. (L.M.R.)

Apart from the external appearance of rigidity in both bodies, the somatic structure is very different, and it has to do with the degree of development of the organism of each structure when they were faced with adverse conditions.

In the case of the schizoid, a trauma happened right at the beginning of life. The infant had to brace against a hostile caregiver and experienced a threat to his/her very existence. Because that happened at a time when the organism is still immature and with few defense strategies (an infant cannot fight or flee, having not yet develop his/her motor abilities and being totally dependent on the caregiver), the only recourse is to tense and to freeze. Hence the tensions and the rigidities in the body are deep within all the tissues, from the periphery right through the core, and prevents the person from feeling (dissociation between thoughts and feelings, head and body).

In the case of the rigid, the challenge happens much later in the development. It happens around the oedipal period (3-5- years of age). At that age, the child has developed his/her mobility during the intermediate period and the whole organism is charged with energy. This child has usually been welcomed into the world when he/she was born and was supported in his/her development until the oedipal stage. The oedipal stage is when he/she experiences a repression of his/her nascent sexuality. It is important to notice that it is not the very existence of the child that is threatened here, as is the case for the schizoid, but an aspect of the child that is being repressed: his/her sexuality. And so, because the challenge happens later in the development, once the organism is better developed and already charged,

the rigidity in the body will be more of a superficial kind, in the long muscles. The tensions will be noticeable particularly in the back and in the neck, as well as in the diaphragm, dissociating sexuality (lower body) from tender feelings (upper body). But unlike the schizoid, the rigid retains a capacity to feel, although being in touch with tender feelings is harder for him/her than being in touch with feelings of anger, for example.

What are the main fears you identify in your schizoid patients? (H.B.P.)

The fundamental fear I see in my schizoid patients is the fear of intimacy. Because of the terrifying experience of having felt threatened in their very existence so early in life, intimacy is associated with the risk of being annihilated by the other if they dare form an attachment.

But there is also the fear of fragmentation (or becoming insane), because the schizoid senses his/her fragility in the lack of connection between the various parts of his/her body, which corresponds to the lack of integration in his/her psychic organization.

I would also add that, as much as the schizoid has a fear of intimacy, he/she also fears life will pass by and he/she won't have been able to live it in its fullness.