Therapeutic Withdrawal and Painful Memories: Part 4 of a 5-Part Case Study of the Psychotherapy of the Schizoid Process

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Abstract

This article describes the relational qualities of the psychotherapist that are necessary to facilitate a supported therapeutic withdrawal for a middle-age man who relied on disengaging from relationships as a way to manage both internal criticism and involvement with people. The relational methods that supported therapeutic withdrawal provided the stimulus for the integration of early childhood memories.

Keywords: Withdrawal, supported withdrawal, therapeutic withdrawal, schizoid, schizoid process, relational therapy, integrative psychotherapy, memory retrieval, case study, self-criticism, internal criticism

The real voyage of discovery consists

not in seeing new landscapes,

but in having new eyes.

--- Marcel Proust, 1929, *Remembrance of Things Past*

After the Christmas holidays, Allan and I resumed our work. Allan usually talked about the events of his past week, his travel and hiking, and what he was doing with his photography. As soon as I had the opportunity, I shifted our conversation to discussing his self-criticism and how it served as a deflection from all the memories of his mother's criticisms. I encouraged Allan to speak his self-criticisms aloud, and we compared those to the degrading comments his mother and sister had actually said to and about him. Allan could see how he was criticizing himself

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just as his mother had criticized him, but he described his self-criticism as more frequent and harsher than what he remembered from his mother.

Allan was now aware that, since his mother's death about 7 years earlier, the self-criticisms had increased. We discussed how the self-criticism served two functions: to distract him from the emotional distress caused by her criticisms and, at the same time, to remain emotionally attached to her by imitating her caustic remarks. These discussions about Allan's self-criticism and how it served to deny the actual criticism from his mother reiterated what we had previously discussed: They strengthened Allan's understanding of his internal conflict, which was composed of wanting a deep emotional connection with his mother and the fear of her constant negation of him.

During some of these conversations, Allan would hold his breath for several seconds and then sigh. I worked with another client who used a schizoid process to manage her relational distress, and it finally dawned on me that, like her, Allan's breathing pattern was his subtle sign of relational withdrawal. Although I had noticed Allan's breathing pattern for a couple of years, I had not attended to its significance. I now realized that Allan was withdrawing right in front of me whenever his affect was aroused. I had planned to initiate supporting Allan in a therapeutic withdrawal the previous September, but I inadvertently made a comment that took us to another important issue. I now decided to attend to Allan's pattern of sighing and to perhaps use it as an opportunity to support him in an ameliorative retreat.

In the next session, when we were talking about Allan's reactions to his mother's stern behavior, I noticed that he was again holding his breath. It was clear that this was an emotion-filled moment. I asked him to close his eyes and go to the security of his private place. I assured him that I would remain present and, importantly, not invade that special space. In the past, I had facilitated some therapeutically supported withdrawal, usually for just a few minutes, to help Allan manage distress. Now I thought that it might be useful if I encouraged and supported his relational disengagement both more frequently and for longer periods of time. I wanted to create a safe place for Allan in which he could experience a caring relationship but on his own terms and at his own pace—a place, perhaps, where he could discover even more of himself.

In response to my suggestion, Allan closed his eyes and silently curled forward with his chest to his legs. Two minutes later, I noticed that he momentarily looked at me. I responded with "I'm right here. I'm relaxed and staying with you." He closed his eyes again. After another couple of minutes I said, "I'm right with you. It is so

important to have a quiet place." A few minutes later I added, "It's so necessary to have a safe and quiet place." Allan said nothing, his eyes were still closed, but his head nodded in agreement. He remained withdrawn for another 5 minutes. I softly reassured him that I was present. When he straightened up and opened his eyes, he looked more relaxed and said that it felt good to "just be quiet."

Halfway through the next session, when I could see Allan looking away, I again asked him to close his eyes and go to his private place. There were several minutes of silence except for my making a few reassuring comments such as, "I'm still here. I'm not going to move closer and I am not going away"; a minute later, "It's so necessary to feel safe"; 2 minutes later, "Being quiet and safe is so important." This pattern continued for 15 minutes. With each of these comments, Allan remained silent but slightly nodded his head. When he opened his eyes he said, "The only quiet place I had was when I was watching TV in my room. And even then my mother would shout commands at me. My sister would come in and torment me." He spontaneously closed his eyes and withdrew for another several minutes. When he opened his eyes, he stared at me for a few silent moments and then said, "I wish you could have been with me in my room. You would have made it quiet."

For the next several weeks, in most of our sessions, I continued to suggest that Allan retreat to his safe inner place. He no longer leaned forward with his chest on his knees; now he curled up on the couch. He was able to remain in his internal private place for longer and longer, sometimes for 30 minutes. I continued to make descriptive comments every 2 to 3 minutes just to let him know that I was fully present and attentive. I was physically still but attentive to Allan's breathing and gestures.

I had learned from other clients who used a schizoid process to maintain emotional stabilization and regulation that inquiry or questions are disruptive. As one client said, "Questions are an invasive demand." Instead of any inquiry, I made resonating comments every few minutes that indicated my attunement with Allan's inner processes. Some examples were: "It feels so good to be quiet"; "No one is invading your safe place"; "I'm watching over you"; "It is so important to be at rest"; and eventually, "Sometimes it's so lonely inside." I always watched for the agreeing or disagreeing movements of his head. He never said a word when withdrawn, but I had the sense that we were establishing a growing connection between us.

Following 20 minutes of being in his private place, Allan said at one point, "I wanted to be alive but not in my family." Two other notable comments were:

• “In withdrawal I feel peace, a deep sense of quietness and relaxation in all my muscles until the loneliness sets in. It begins in my stomach and climbs up to my chest, and it may jump to the back of my neck; it gives me a dull headache.”

• “I have a big pain when I am depending on my mother, wanting her, and knowing that she could never be in touch with me. I needed her but she was only there in her cold body, always wanting me to be a perfect child. I feel so alone because I need her so much, so much that I don’t want her anymore. I just want to be alone so that my body is not tense all over.”

With each supported withdrawal, an important therapeutic action occurred. Allan was increasingly having vivid memories of specific childhood events. He was often surprised and made comments such as, “I haven’t remembered that for years,” “I remember how I was trying to hide even before I went to school,” “I forgot all about how miserable I felt each night when we were having dinner.” He was telling me specific memories that documented what he had previously expressed in general terms. I made sure that we had sufficient time after each supported withdrawal to talk about his emerging memories. The beginnings of our sessions were no longer consumed by a review of his activities; instead, he told me about the childhood memories that he was having during the week. Allan was sad, and, although he did not talk about it, his anger was evident in the tone of his voice and his use of foul language.

In a session that began with Allan describing how he was now “taking photos of urban life,” he became abruptly quiet, sighed, and looked away. I asked him to take a moment to go to his private place. After only a few minutes he recalled being about 8 years old and how he would make funny faces and dance to try to please his mother. He described how he acted like a clown to get her to play with him. He said, “I remember that I would do anything to amuse her, to make her happy with me. I repeated my little performances many times until she would just walk out of the room. One time stands out in my mind. I remember my stomach aching and running after her. I don’t remember her words, but the look on her face made me want to hide. I didn’t know the word then, but today I would say she was disgusted with me. I was full of confusion. Today, as I think back, I would say that she was always disgusted with me.”

In three different sessions, Allan told me a variation of that story. Each time I felt my stomach churning as I identified with the young boy’s desire to be accepted as well as the painful sense of being rejected for doing what seemed so right. My countertransference had two forms: identifying and responsive. Stimulated by my identifying countertransference, I validated the boy’s need to be accepted “just as

I am." And, stimulated by my responsive countertransference, I talked about a child's joy of playing with an interested and involved adult. Allan cried as I described to him what a child of that age needed in companionship from an adult.

One day Allan was disturbed by a vivid memory from when he was 7 years old. His teacher had been screaming at another boy and dragging him out of the classroom by his ear. Allan was terrified. While the teacher was busy he snuck out of the classroom and ran home. He could not get in the house, so the neighbors called his mother at work. When she arrived home, she was furious with Allan. She slapped him across the face and then marched him back to school. Allan had an intense body reaction, horror, and an overwhelming realization that he could never trust his mother or the teacher again. He remembered saying to himself over and over, "I'm all alone, no one will be there for me, I have to do what they say." He repeated those words to himself over the years, particularly when his mother made demands or when teachers gave assignments. Allan learned to anticipate what any adult might say to him and then circumvented their possible criticisms by criticizing himself.

In the remainder of that session and in the ensuing weeks, I allotted some time to attend to Allan's emotional pain and fear, betrayal and distrust. Although what he had told me was a specific story of an actual event, I often thought of it as a metaphor for many other memories that remained nondescript. They were similar but lacked pictures or language because they were implicit and procedural. We investigated how Allan disengaged from people by transferring his experience of mistrust and betrayal into every relationship. We explored his three script beliefs ("I'm all alone," "No one will be there for me," and "I have to do what they say"), how they manifested in his current life, and how he collected evidence to reinforce each belief. We talked about how each fantasy, when contrasted with reality, served to confirm his various script beliefs (See Chapter 7, Erskine, 2015, for a detailed explanation.)

In this same series of sessions, I allocated time to hear about Allan's life, provided time for supported withdrawal, attuned to his affects and rhythm, and took his memories seriously. As with most clients, there were many facets to our therapeutic work. As I studied my notes and reflected on the details of Allan's psychotherapy, I was challenged to write this case study in a logical and understandable sequence because psychotherapy is multidimensional, with many elements requiring deliberation. I often experience myself as working within a many-sided hologram in which every dimension is in some aspect interrelated with several others: body tensions, inchoate affect, self-soothing behaviors, unarticulated stories, and stylized procedures in relating. As I attend to one set of

facets, I overlook others. Often, I am attending to two, three, or more psychological issues in one session. Or, I many not attend to some facet for a few weeks and then give it intense attention for a couple more. So please bear with me as I report the story of Allan and the many dimensions of our psychotherapy.

Each week, as we continued the supported withdrawal, Allan's memories were increasingly of a younger age. Never previously talked about memories seemed to emerge in response to my careful listening and empathic acknowledgment and validation. I repeatedly brought his attention to his body sensations and previously nondescript affect. I talked about what a young child needs from an attuned parent while also creating enough silence for his internal process to gestate.

After Allan withdrew into several minutes of silence, he described his experience at a preschool age: "I always remained quiet when my mother said something because I knew that I must do what she said. It feels like I knew how to be quiet since I was a baby." As our weekly sessions continued, Allan's time in withdrawal was not always calm and secure. He was having body memories, painful physical sensations, and an "intense emptiness in my stomach." When he was withdrawn, I continued making resonating comments.

Allan told me about waking up one morning with a choking sensation in his throat. As we explored his body reaction, he had the impression that someone was forcing a spoon into his mouth. He was bothered because he had no visual image, "no real memory," only a choking reflex. Allan described his choking as a reaction to being force fed. As I asked about how he was fed as a toddler, Allan replied, "I can't remember that far back." I responded, "You know your mother's personality, how would she have fed you when you were first learning to eat solid food?" He immediately responded, "She would force me to eat. She certainly forced me when I was 9 or 10 and did not like the food." Allan had no explicit memory of being a toddler, but his body was revealing a story.

I watched for the nonverbal signs that I was resonating with his experience. I did not want to make suggestions about what he was feeling or remembering, but I did want to reflect what I thought he might be experiencing, to provide words for his silent, wordless experiences. Each time I made a resonating comment, I made sure that I said it in a tentative voice, almost like a question. I wanted to avoid sounding like I was making a defining statement. I said, "Perhaps, even as a toddler, you were forced to comply." He responded angrily with, "Comply, shut up, and be good. That was my childhood. There was no place to be me. Except I had my private place."

Whenever we had a session during which Allan went into his private place, I often saved the last 20 minutes to cognitively discuss with him what he experienced during his withdrawal. During that time, he talked about school-age memories, how strict his mother was about rules and school work, and the uncomfortable sensations in his body. On some days, it seemed like we had to mutually create a language that described his inner sensations, various affects, and the memories that he had never spoken about. I periodically used the last few minutes of our sessions to make a relational inquiry about how he experienced my transactions with him. These relational inquiries were a safety net in our therapeutic contact because they provided me with the information I needed to adjust the therapy according to what Allan could assimilate.

A few times, although there were no words, Allan cried from inside his hiding place. Whenever Allan withdrew into his lonely sensations, he talked afterward about envisioning himself as a baby, left alone to cry. We had several sessions in which Allan was both withdrawn and regressed to the age of an infant or toddler. He curled into a ball and whimpered like a baby. He had a visceral sense of neglect, but he was not sure if it was an actual memory or just his imagination. We talked about the significance of implicit and procedural memory and how such memories are experienced as body sensations and undefined affect. During our postwithdrawal reviews, he was not only “sad for the little boy” but also said, “I am furious at how she neglected me, how she demeaned me. I feel like I could rip her hair out … like she did to me once. I could just break her face. I’m so angry.”

About this time, Allan began his sessions by telling me “the internal criticism is increasing.” But the criticism was no longer in his own voice but in his mother’s voice. He could remember her bitter sound and chastising words. He described the difference: “When I criticize myself, the words come very fast, almost in a code, more like a pressure in my head: ‘I don’t belong’; ‘I’m worthless’; ‘There’s no use in talking.’ But now I clearly hear my mother’s voice. I can hear her awful sound when she says things like, ‘What’s wrong with you?’; ‘You are useless’; ‘No one wants to hear you’; “You’re a bother.’ Those are her real words. They are in my head but now I can remember exactly when and where she said some of those things. I am not making his up. She actually said those things.”

I was pleased with the flow of the therapy because Allan had been processing many memories. He seemed to be integrating body sensations and affect with clear cognitive understandings. Allan was currently involved with a group of avid hikers. He was amazed: “I even talk to a couple of them because we like the same things. They want to talk to me about the Arctic and places I discovered. Do you think I can show them my photos?” We often reviewed what we had previously

discussed, but each reiteration seemed like an important building block establishing inner security. Allan was changing. He seemed to be present much of the time, with far less self-criticism. He had clear memories of his emotional turmoil with his mother and sister, and he had stopped following women at night. When I carefully inquired, he talked about his continued loneliness.

But I was concerned about another recent change: Allan was periodically hearing his mother's voice criticizing him. When I inquired about the internal voice, he said, "It's my mother's voice. I don't always hear all her words, mostly I hear her despising tone. She is always an influence in me, particularly when I am around people. She interferes and says, 'People don't want to be with you' and 'You should be ashamed of yourself.' " I don't like what I hear but I can't stop her voice. When I hear her voice I can't talk to anyone."

I was uncertain once again about where to place the emphasis in our psychotherapy. We were accomplishing much, but Allan's description of his "mother's voice" added a new aspect to our work. I was stymied by the multiple dimensions of Allan's psychological processes and what was unfolding. Between our sessions, I mulled over the options. I pondered four possible therapeutic directions: We could continue with the supported therapeutic withdrawal that we had been doing for the past couple of months; we could stop the withdrawal work and celebrate the progress he had made; we could coalesce his emerging memories into a cohesive narrative; or I could redirect the psychotherapy and focus on the possible introjection of his mother's affect, attitudes, and behavior.

It was now well into spring. We would soon have to consolidate the work we had accomplished. Metaphorically, I did not want to open a new chapter, and I also did not want to close the book. At this point, it would be respectful and wise to involve Allan in any decisions about his psychotherapy. After all, at Christmas he considered terminating, but I encouraged him to remain in therapy. That seemed to have been a fruitful decision. I thought about how Allan's relationship with his mother left him with few opportunities for choice, so I wanted to provide him with a chance to influence how we proceeded.

I interwove a discussion of the various alternatives I had been considering into our therapeutic dialogue. We talked about how the supported withdrawal sometimes gave Allan the space to relax and feel protected and how at other times going into his private place stimulated intense emotion-filled memories. From these emerging memories he was forming a consistent and coherent personal story about his life. He no longer had the urge to walk the streets at night looking for someone to love him because he had an acute awareness that he had been

searching for the love he had been missing in his relationship with his mother. He realized, “My retreat to the wilderness was always an attempt to escape my mother’s control. It worked for a little while, but then her voice always snuck up on me.”

We discussed the advantages and disadvantages of Allan terminating at this point in the psychotherapy. He agreed to continue in September. If he returned, we would actively attend to his “mother’s voice,” how she had a profound influence on his life, his “empty” feelings, and any other obstacle that interfered with Allan being all that he could be. These couple of sessions were interspersed with Allan wanting to talk about his forthcoming camping trip, this time in a different part of the Arctic. He was keenly interested in the possibility of creating new wildlife photographs and curious about how he would interact with people on the 10-day excursion he would take with the hiking club. The next week I left for Europe, and he left for the north in time to catch the midnight sun.

References

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