PSYCHOTERAPIA 1 (216) 2026
PAGES: 19–30
DOI: 10.12740/PT/215650

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WORKING UNDER PRESSURE. PSYCHODYNAMIC PSYCHOTHERAPY OF SCHIZOID PERSONALITY

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psychodynamic psychotherapy
schizoid personality
neurodiversity

Summary

The article concerns patients in whom, at the initial stage of therapy, a diagnosis of narcissistic personality was considered, whereas during the course of the therapeutic process, a picture of schizoid personality co-occurring with neurodiversity traits (ADHD, autism spectrum) gradually emerged.
I present fragments of psychotherapeutic processes conducted in a psychodynamic approach with adolescents and young adults. Their common denominator is the experience of strong, often overwhelming feelings of pressure – both on the part of the patients and the therapist. The starting point for understanding the described issues is the search for the sources of this pressure, that is, the analysis of the configuration of defense mechanisms and transference-countertransference phenomena in connection with neurodiversity traits.
In the description, I rely on experiences from therapies I have conducted with adolescents and young adults. In defining the concepts, I use psychoanalytic and psychodynamic approaches to schizoid personality (McWilliams, Kernberg, Johnson), Tustin's concept of autistic defences, Mollon's notion of self-objects as the psychological substrate of ADHD traits, and Klein's concept of the schizoparanoid position.
The aim of the article is to demonstrate how neurodiversity co-constructs specific configurations of defense mechanisms and may facilitate the development of a schizoid personality configuration, and what implications this has for the course of psychotherapy under pressure.

Introduction

Nancy McWilliams, contrary to Otto Kernberg, who places schizoid personality on the lower levels of borderline organization, emphasizes the great variety in the level of functioning of this personality organization. In her opinion, the schizoid continuum ranges from hospitalized patients in catatonic states, through individuals with severe deficits in ego integration, to individuals who function above average and are often creatively gifted [1]. The one commonality is a special kind of susceptibility to emotional and cognitive overstimulation and a characteristic withdrawal into a fantasy world as a fundamental defense mechanism.

McWilliams points out that the psychoanalytical concept of schizoid personality has a lot in common with Jung's idea of introversion – especially the INFJ type in MBTI – and that the highly functional version of this pattern can be understood as being placed on the "healthier end" of the autistic spectrum [1]. This means that certain traits, which from the psychiatric perspective could be considered softer forms of autism spectrum disorder, are described as components of schizoid structure in the psychoanalytical view.

Otto Kernberg et al. characterize schizoid personality as falling within a wide spectrum – from a moderate, consolidated sense of identity to a serious setback in this regard. The clinical picture includes 1) flat affect, 2) lack of explicit expression of anger, 3) a ruminative and inward-directed cognitive style, 4) a restrained, distant, sometimes unsentimental interpersonal style, and 5) a tendency to isolation, apathy, and anhedonia. The main conflict is between the desire for affection and a simultaneous fear of being absorbed, which results in defensive withdrawal. The dominant object relations are those between the emotionally distant, grandiose self and an intrusive, omnipotent other [2].

Stephen M. Johnson describes individuals with schizoid personality structure as having a fundamental feeling of having no right to exist or of being a threat to others. He highlights the presence of chronic, oftentimes unconscious fear and terror, unconscious rage, a tendency to avoid engagement and withdrawal in the moments of closeness, and an intensified auto-aggression and difficulties in self-care. He points out the problems with identifying emotions and with separating the thinking from experiencing, and a propensity to fragment experiences [3].

From the aforementioned examples emerges a picture of a hypersensitive individual, susceptible to overstimulation, on the one hand in need of relationships to regulate emotions and, on the other, withdrawing into the world of fantasy, rumination, and internal constructs. Such an individual disassociates from overstimulating experiences of the outside world and treats reality as dangerous due to the potential aggression and invasiveness – including one's own and someone else's. He often relies on narcissistic defenses (grandiosity, omnipotent control, denial, depreciation, fragmentation) and autistic defense mechanisms (withdrawal into a fantasy world, avoidance, isolation, self-regulation through inanimate objects).

In this article, I will attempt to examine schizoid personality in terms of its underlying characteristics of neurodiversity. By neurodiversity, I am referring to the phenomenon of natural, inherent diversity in the structure and functioning of the nervous system, encompassing, among others, varied attention profiles, ways of processing stimuli, emotion regulation, executive functions, and communication styles. In this context, the differences associated with, for instance, ADHD or autism spectrum disorders are not intrinsically pathological but are placed within the broader continuum of the developmental norm.

I reserve the term n e u r o d e v e l o p m e n t a l d i s o r d e r s for situations in which these differences lead to significant psychological suffering or substantially restrict functioning in terms of society's expectations. From a clinical perspective, I am not merely interested in determining whether the patient has ADHD/ASD, but in how the characteristics of neurodiversity influence the development of a set of defense mechanisms and the structuring of personality organization – including schizoid personality.

Frances Tustin describes autism as a pseudo-independence phenomenon in which a child stubbornly treads his own eccentric path, trying to adjust to the way of functioning of others only in a minimal way [4]. She highlights that this demeanor serves as a protective measure against the fear and pain resulting from dependence. She also introduces the notion of a u t i s t i c o b j e c t s – inanimate objects that serve the purpose of regulating and alleviating tension, rather than relying on a relationship with another human being.

Phil Mollon defines ADHD on a biological level as a set of atypical attributes in networks affecting the frontal lobe, whereas on a psychological level – referencing Heinz Kohut's psychology of the self – as an increased need for "selfobjects" [5]. A person with ADHD requires constant responses and support from the environment, help in modulating arousal, mood, and impulses, as well as maintaining contact with the outside world. According to Mollon, fear in ADHD is a response to the feeling of disintegration of experience, and the fear of fragmentation is one of the most primal fears. The defense mechanism in these cases is a withdrawal into the autistic state, based on sensations, which can generate intense, narcissistic rage towards encountered obstacles.

Mollon draws attention to the fact that people with ADHD use others as "compelled self-objects," attempting to impose on them the task of filling the regulative gaps in the mind-body system. Individuals with ASD more often seek relief in the inanimate world, which is related to an "ineffective stimuli barrier" and difficulty filtering the surge of sensations [5]. In this context, neurodiversity may lead to the formation of specific defense configurations, which – under adverse environmental conditions – give rise to the image of a schizoid personality.

Research aim and methods

In recent years, especially during my work with teenagers and young adults, I have more often come to encounter patients who reported severe anxiety and depression, multiple somatizations, social withdrawal, and who described feelings of being under tremendous pressure – due to their environment, the educational system, their family, or themselves. In the therapeutic relationship, these experiences took the form of a kind of intensified pressure that could be felt by me as well as by my patients.

I subjectively experienced this pressure as a mixture of anxiety, feelings of inadequacy, shame, fear of making a mistake, as well as the need to act quickly and effectively. Throughout the course of therapy, I began to notice that these were the states that resembled the patients' personal experiences – their fear of being judged and accused of being worse, the exposure of their flaws, as well as the profound need for "repair" by the idealized object.

The aim of this research paper is to depict and conceptualize the selected psychotherapeutic processes carried out using a psychodynamic modality within the context of schizoid personality and neurodiversity, with particular emphasis on the phenomenon of pressure understood as a transference and countertransference reaction.

Pressure, in this case, is understood as the effect of projective identification: aspects that the patient rejects in themselves – their anxiety, shame, sense of deprivation, and fear of invasion – are embedded in the therapist, who initially experiences these feelings as his or her own. These include, among others:

- fear of not being competent and "therapeutic" enough;
- shame and fear of being judged (by the patient, psychotherapy supervisor, or one's own internal objects);
- fear of invasion, i.e., "digging into" the patient's painful deficits and simultaneous concern about experiencing them in one's own psyche;
- a tendency to avoid deeper relationships in the interest of maintaining a "safe" facade.

The description of the clinical material has a qualitative and illustrative character. I draw upon the content recalled from sessions, notes made after meetings, as well as reflections from supervision. This is neither a systematic study nor an attempt at statistical generalization, but rather a case study that serves the purpose of deepening the understanding of clinical phenomena.

In the next section, I will cover three brief descriptions of therapeutic processes (Mr. Z's, Ms. B's, and Patient P's) in which, to varying degrees, schizoid personality organization, neurodiversity traits, and a clear sense of pressure were present.

The case of Mr. Z

Mr. Z (25 years old) signed up for therapy due to increasing episodes of shortness of breath. He associated the onset of his symptoms with his first serious relationship, in which – as he related – "he felt that for the first time someone really depended on him." After the end of this relationship, the shortness of breath subsided, only to return twice as strong in the next relationship, gradually affecting more and more spheres of life: social interactions, work-related matters, and, with time, also everyday, regular activities.

It was another therapy in his life, but his first psychodynamic one. He came forward with great emotional tension, experiencing contact with me as "the last resort." From the very beginning, he radiated a strong energy, which consisted of anger, frustration, and anxiety. The situation made me feel uneasy, and at the same time, I felt the need to meet his expectations.

Due to the lack of available appointments, he attended the sessions at a time that was inconvenient for him from an occupational standpoint. He rationalized this by saying: "If you don't have any open slots, then I guess you're good – it's worth the sacrifice." During this period, the dominant feeling was that of idealization coupled with strong criticism of previous therapists who "did nothing" and "were just talking."

Relatively quickly, his need for control and to hold me accountable for "results" began to emerge. Mr. Z started converting the time I devoted to him into money, as he demanded "concrete" interpretations and tools that would help bring about swift symptom relief. He expected unambiguous answers, reassurance, and accurate guidance. Every attempt on my part to reflect together on the meaning of his symptoms was treated as too "theoretical" and "not very useful."

His irritation and hostility were gradually increasing. He began saying outright that "he did not have the time for philosophy" and that "that's not the reason why he's paying" to "understand himself better" but to "stop suffocating." He rejected interpretations linking his symptoms with relationships, reacting with anger. However, he experienced brief relief

associated with my more immediate ideas for dealing with the problem (e.g., breathing techniques), which he then quickly devaluated, deeming them "too trite."

In the countertransference, I felt increasing pressure to "finally do something about him." I began to intellectualize intensely: I presented him with detailed conceptualizations of his problems, referenced multiple theoretical models, and tried to find the appropriate language. On the one hand, it protected me from feeling helpless and small. On the other hand, it distanced me from his real pain.

In the course of time, Mr. Z began to complain about my "disorganization" and "digressiveness." He said that "he's lost" in our conversations, that "he doesn't know what's most important," and that "everything is getting mixed up." He asked for summaries after the end of sessions and demanded pointing out the "main conclusion." Simultaneously, he himself reported significant difficulties with concentration and memory: "everything is slipping out of my mind" and "when I leave, I don't remember what we were talking about."

I noticed that I myself had difficulties remembering the material that he brought to our sessions. I was under the impression that my thinking "fell apart" and that I was unable to create a coherent dialogue. I began to experience states which, from a theoretical perspective, could be described as a temporary loss of the ability to mentalize and of theory of mind – I was more focused on my own anxiety and pressure than on understanding the patient.

During supervision, we interpreted these occurrences mainly in terms of envy, devaluation, and the inability to attribute anything valuable to the object. Over time, however, other themes began to emerge more clearly. A more thorough developmental interview revealed that Mr. Z had experienced difficulties with concentration, hyperactivity, impulsivity, and planning since childhood, all of which he had hidden underneath a mask of excessive control and perfectionism. He also reported periods of hyperfocus in which he could be preoccupied with one activity for hours, completely losing track of time. He mentioned sensory hypersensitivity, difficulty with filtering stimuli, being easily overwhelmed by noise, light, and the presence of other people. Over time, it became evident that in his case, apart from the personality dimension, there was a crucial neurodevelopmental component – ADHD traits and elements of the autistic spectrum.

Identifying these trends – initially in my mind and later during conversations with the patient – proved to be a groundbreaking development. For me, it meant the possibility of understanding my own "disintegration" and fragmentation of thought in his presence. I started identifying them as experiences of projective identification with his "ADHD-autistic" part, rather than just as the therapist's failure. For him, it meant the possibility of making sense of his past difficulties, which, up until then, he had mainly experienced as proof of his own "weakness" and "incompetence."

Gradually, we started addressing his coping mechanisms: obsessiveness, omnipotent control of himself and others, rigid thought patterns, and being too hard on himself. A hypersensitive, hyper-responsive to stimuli Self, scared of the possibility of invasion, rejection, and revealing deficiencies, began to emerge from the pressure to "own everything" – knowledge, control, and solutions.

The case of Ms. B

Ms. B was referred for therapy by a psychiatrist to whom she was admitted due to increased feelings of anxiety, manifesting themselves through multiple occurrences of derealization, episodes of depersonalization, and experiences of "melting away" in reality. This was accompanied by a deep sense of guilt related to the drive for autonomy and a sense of being profoundly different from other people.

This otherness had an ambivalent nature. On one hand, it created a fear in Ms. B that she was "seriously ill" and might be developing a severe mental illness; on the other hand, it reinforced her feelings of uniqueness and superiority. Ms. B had a hard time coming to terms with both of these perspectives; depending on the context, one dominated over the other.

When describing her way of functioning, the patient emphasized that her analytical mind works "in the background," unconsciously; it "processes data" and generates solutions without the involvement of emotions. In practice, it meant that many of her difficult experiences were subjected to quick "talks" and rationalizations, without being in touch with the emotions that accompanied them.

Even as early as the consultation stage, the patient emphasized that she needed a therapist who was "infallible" and had appropriate education and experience. She openly admitted that she would be fact-checking what I told her because she was scared that I might "convince her of something that contradicted her beliefs." In the transference emerged expectations of me as a perfect, omniscient figure, as well as strict monitoring of and distrust towards my authority.

From the beginning of the therapeutic process, I was accompanied by a paralyzing fear. I felt that I was constantly being evaluated, as if I could not make the smallest mistake. I had a feeling that every one of my statements needed to be "scientifically justified," supported by the literature – otherwise it would be questioned immediately. Simultaneously, I experienced difficulties with thinking clearly and asking questions; I felt that my attempts to conceptualize her experiences were insufficient.

As the therapy progressed, it became evident that behind these expectations was a severe, pathological feeling of guilt caused by separation from her immediate family, especially from her ill mother. Her every attempt to take care of herself – rest, pleasure, giving up some of her duties – was experienced by the patient as the equivalent of betrayal or abandonment.

In my relationship with her, the same pattern emerged: when I offered her a more realistic view of her options, the patient took it as an attempt to "weaken her," depriving her of her agency, or, on the contrary, as proof that "I do not understand the seriousness of the situation." On the other hand, my friendlier, more supportive interventions raised her suspicion that I would "lull her into a false sense of security" and prompt her to make decisions that she would later regret.

In the course of our work, she started introducing me to the world of her inanimate objects. Since childhood, she had had a favorite toy that served the purpose of an autistic object – regulating tension and providing a sense of steadiness and safety. In stressful situations, the patient fiddled with it, "indulging" in tactile sensations, which allowed her to put overwhelming emotions aside.

During sessions, I felt like such an object on more than one occasion: being used primarily as a regulating tool and not as a separate person. It was especially evident when the patient expected immediate, complete solutions from me – for instance, whether she should cut off contact with her family, change her job, or decide on a pharmacological treatment.

Other aspects of neurodiversity started to be uncovered with time: hyperactivity, difficulties with sitting still, increased motor tension, twitching, fidgeting in a chair, finger snapping, and problems with staying focused. These elements, which until then had been offset by the patient (e.g., through perfectionism and excessive control), began to be incorporated into the mutual understanding of how she functions.

The case of P

I met Patient P (15 years old) during her first psychiatric hospitalization. She was admitted to the hospital in a state of severe psychomotor agitation, with psychotic symptoms: mutism, delusions, and episodes resembling catatonia. The initial attempts to initiate contact were very challenging – the patient was silent, avoided eye contact, and seemed cut off from the surrounding environment.

After implementing pharmacotherapy and several attempts to talk, it was possible to establish a more coherent picture of her experiences. It was revealed that one of the reasons for her silence was the sense that when she spoke, others were "stealing her character." Words spoken out loud – according to her – were supposed to lose touch with her persona and, in a way, become the possession of the listener.

In the countertransference, I interchangeably experienced:

- intense fear when I actively tried to get through to her;
- a state of numbness, disintegration, and the inability to think, when I had a feeling that my every action could be experienced as invasive.

During talks with P's parents, I initially heard a description of an ordinary childhood: school, good grades, friends, dancing classes, a "smiling, helpful, likable" girl. In her everyday behavior, no one noticed anything that could have foretold the coming disaster.

It was only after a more thorough, step-by-step developmental interview that a series of signals that could point to neurodiversity was revealed:

- the usage of language that was mainly understandable to her and her parents during childhood,
- numerous motor stereotypies,
- a tendency to play alone,
- episodes of "freezing," during which it was hard to establish contact with her,
- a strong response to changes of routine or environment.

During conversations with P, the topic of "a second world," to which she moved with the help of specific body movements similar to tics, also emerged. In this world, the same people existed as in external reality, but it was she who decided what they were doing or saying. This world gave her the feeling of omnipotent control and immunity to being hurt, but at the same time, it distanced her from real relationships with people.

Ultimately, P was diagnosed with autism spectrum disorder. In therapy, the main goal was to acknowledge the existing deficits (including the susceptibility to psychosis) and, at the same time, to gradually build the ability to form relationships. In my view, P mainly treated me as a regulating object for a long time – someone who was supposed to "calm her down" and to "keep her intact" – before she could start perceiving me as a person who was also interested in her subjective world.

Sources of pressure in the therapeutic relationship

In the aforementioned cases, the central experience – alongside the patients' reported symptoms – was the pressure in the therapeutic relationship. From the transference-countertransference perspective, it can be understood as the effect of projective identification: disapproved aspects of the patients' experiences – a sense of deprivation, hypersensitivity, fear of invasion and disintegration, shame, and anger – were placed in me, and subsequently I experienced them as if they were my own.

In the subjective experience, it manifested itself as:

- the feeling that I needed to help promptly and effectively,
- fear that I was not going to do that and would let down my patients, myself, and my internal objects,
- fear of making a mistake that could have catastrophic consequences,
- a tendency to avoid closer contact and escape into theory (intellectualization),
- the feeling of "disintegration" of thought and losing the ability to mentalize.

Working through this pressure required me to gradually recognize that these states were, to a greater or lesser extent, reflections of the patients' inner world. Realizing that the fear, shame, and sense of deprivation that I experienced were not "only mine" but were also a part of their psyche allowed me to slowly regain the containing function and to think about these states instead of reacting to them in the process.

Next stages of therapy

In the case of Mr Z, the next important stage was breaking up with his long-term female partner, which, on one hand, he feared, but on the other hand, he anticipated and hoped would bring relief. After the breakup, the relationship paradoxically improved – they talked to each other more often, occasionally had sexual relations, and formally remained "single." The patient felt temporary relief as his shortness of breath subsided, after which he showed symptoms that I identified as signs of grief and longing after the loss of an important object.

At his request, we increased the number of sessions to two per week. The increase in my actual and emotional availability changed the dynamic of the relationship: it allowed him to experience the loss without immediate fear paralysis and the need to immediately activate his defenses. Over time, from being a stiff, controlling man who fantasized about "owning everything," he started showing that he was a delicate, creative, manually gifted, dance-loving man, who longed for closeness and equal relationships.

In the case of Ms. B, the decisive moment was coming to the decision to undergo pharmacotherapy after a period of significant personal losses (e.g., the deaths of loved ones and infertility problems) and after pushing herself beyond her limits for many years. Symbolically, it meant allowing herself not to be self-sufficient and to reach out for help.

During therapy, she started becoming concerned about me, treating me as a real person. The patient started asking whether I took vacations or had the opportunity to relax. She wondered how I was experiencing her story. Our relationship was becoming more and more like a mutual exchange in which both her needs and my boundaries could coexist. From the expectations of "repair," the need to understand and to be understood increasingly began to emerge.

Patient P, after a period of alternating between "hiding" in the fantasy world and the gradual beginnings of interaction, made the decision to take the school-leaving exam. Taking into consideration her prior problems at school, the need for individual tuition, and her psychiatric hospitalization, it was a huge step for her.

In my countertransference, there appeared interchangeably: the fear of potential failure (and the resulting breakdown) and the desire to protect her from confronting reality – for example, by making her concentrate on less painful subjects, such as preparations for a family wedding. Ultimately, P passed her school-leaving exam. After a couple of months, she decided to undergo group therapy in the day care unit, which I interpreted as her next step into the social world and her attempt to confront the shame caused by her own limitations.

From the perspective of Melanie Klein's theory, these changes could be perceived as a progressive transition from the paranoid-schizoid position – dominated by disintegration, fear of invasion, and withdrawal – to the depressive position, in which it becomes more possible to integrate the good and bad aspects of the object, to acknowledge one's own aggression, and to cultivate a commitment to relationships.

The presentation of clinical reasoning results

The experience gained from working with the aforementioned patients leads me to the conclusion that the diagnosis of schizoid personality – especially in the neurodiversity context – is a complex process that requires multistage differentiation.

First of all, it is essential to distinguish schizoid personality from narcissistic and avoidant personalities. In schizoid personality, the ambivalent need for relationships takes center stage – the intense desire for closeness coexists with fear of invasion and of being consumed by the object, which results in withdrawal into fantasy and autistic forms of isolation. The devaluation of the object and attacks on relationships are often meant to protect from rejection and revealing deficits. In narcissistic personality, the devaluation primarily serves the purpose of protecting the fragile, idealized self-image, and the withdrawal from relationships aims to avoid the shame caused by confronting one's own limitations. In avoidant personality, the main concern is the fear of embarrassment and criticism, with relatively less involvement of fantasies and autistic defenses.

Second of all, it is necessary to distinguish between autistic defenses – which are understood as secondary, psychogenic strategies of isolation from relationships and emotional stimuli – and constitutional neurodevelopmental factors (ADHD, ASD). The latter

influence the way of processing stimuli, affect stimulation, and executive functions, but do not themselves constitute defense mechanisms. In the case of Mr. Z and Ms. B, I observed numerous ADHD traits (difficulties with concentration, hyperactivity, problems with planning, hyperfocus states) that were accompanied by autistic defenses (withdrawal into fantasy, self-regulation through inanimate objects, isolation). In P's case, severe traits of the autistic spectrum came to the fore, and the autistic defenses seemed to be largely intertwined with constitutional differences in the functioning of the nervous system.

Thirdly, it is worth noting that in all three cases, the therapeutic setting – time, place, and rules – was not attacked. On the contrary, the stability of the setting seemed to reduce the fear of invasion and the crossing of boundaries. This was particularly evident in light of the experience gained from working with patients with predominant borderline personality organization, where the setting is an area that more often creates greater conflict.

In the discussed therapies, it was also crucial to distinguish between what stems from neurodevelopmental deficits (e.g., difficulties with concentration and memory) and what is the result of defenses and resistance. It allowed for a more realistic assessment of the patients' capacities and for appropriately adjusting interventions – so that, on the one hand, they take into account the existing limitations, and on the other, they do not reinforce the avoidance of confronting difficult emotions and relationships.

Therapeutic recommendations

The combination of schizoid personality with neurodiversity traits poses particular challenges for the therapist. One of the greatest challenges is the ability to maintain an attitude of empathy and acceptance towards patients whose defenses – omnipotent control, projection, projective identification, disintegration, and devaluation – significantly disrupt the therapist's cognitive capabilities and, through the process of projective identification, cause the therapist to become the "bearer" of their fears, shame, and sense of deprivation.

Mentalizing these mechanisms – rather than succumbing to them and acting on them – is a strenuous process that oftentimes requires the support of supervision. Initially, the responsibility for this process mainly falls on the therapist, who needs to face his or her fears of disintegration and being disintegrated, as well as a sense of inadequacy and guilt.

The stability of the therapeutic setting – not only in a formal but also in an emotional sense – is of great importance. Stable boundaries of time, place, and session rules, while avoiding superiority or a triumphant attitude, create a space in which the patient can gradually experience the relationship as less threatening and more predictable.

Nancy McWilliams emphasizes that the fundamental challenge in working with a schizoid patient is finding a way into his or her subjective world without causing excessive fear of invasion [1]. The patient is afraid that the therapist will withdraw emotionally and deem them a "hopeless case" or an oddity. If the therapist does not give in to the temptation to rush the patient to open up prematurely or to dehumanize them by treating them only as a set of symptoms, then it is possible to slowly build a therapeutic partnership.

It is also crucial that the therapist behaves like a real person – with their sensibility, limitations, and capabilities – rather than merely as a transference object. This applies both

to the way of responding to the patient's suffering and to establishing boundaries (e.g., vacations, working hours).

When working with patients who exhibit autistic defenses, one is inspired by the work of Frances Tustin, who compares therapists of such patients to people who "tunnel through the rubble" to reach the child hidden within [4]. Once it is possible to reach the child, psychic "reanimation" and providing the patient with care and understanding become essential. Tustin points out that depriving the patient of the protection of autistic defenses without offering alternative ways of regulation may be incredibly dangerous and even psychotogenic for them.

Hence, during the middle stages of the described therapies, the work focused on:

- reducing social anxiety,
- developing mentalization and theory of mind,
- searching for more adaptive strategies of emotional regulation,
- gradually naming, accepting, and respecting one's own individuality,
- differentiating between what is the result of a neurodevelopmental deficit and what results from defense.

From the therapist's perspective, it was also crucial to continuously monitor the degree to which my attunement to the patients stemmed from the actual need to work on the deficits and the degree to which it was an answer to their resistance to change and to the acknowledgment of their own distinctiveness.

Conclusion

Following Nancy McWilliams, who references the work of Louis Sass, one might conclude that the schizoid personality type is, in a certain way, a sign of our times – the age of withdrawal, excessive introspection, rationalization, the weakening of social bonds, and the transference of a major part of our lives to virtual reality [1].

In clinical practice, especially when working with teenagers and young adults, I have observed a growing attitude of isolation and alienation from peer and social groups coexisting with neurodiversity (ADHD, ASD). They are related, among other things, to hypersensitivity, cognitive rigidity, fastidiousness, hyper-reflexivity, diffusion, as well as the fear of outside invasion. This is facilitated by e-attachment – relationships transferred to virtual reality, where one can control the distance and exposure while simultaneously reducing the risk of real harm.

In such cases, the development of a schizoid personality appears highly probable. This means that, in therapeutic processes, it is necessary to take into account and reassess the following:

- the intensity of social anxiety and fear of invasion,
- the influence of neurodiversity (ADHD, ASD) on the development of defense mechanisms and personality organization,
- the pressure that results from the disparity between the rigid expectations of the outside world (school, family, job market) and the realistic possibilities and resources of the individual.

The experience of working under pressure with patients with this set of characteristics is a humbling one in terms of the possibilities of therapy. The change generally does not take the form of a remarkable disappearance of symptoms but is instead achieved through subtle shifts: a greater ability to remain in a relationship despite anxiety, a slightly more realistic perception of oneself, a slightly less critical self-assessment, and a greater readiness to acknowledge one's own limitations without an immediate attack on the self.

It is precisely these small, often difficult to notice changes – if they are reinforced over time – that may result in real improvements in patients' quality of life. From the therapist's point of view, they are the outcome of efforts to maintain mental capacity, oftentimes under pressure and in situations that naturally undermine it.

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