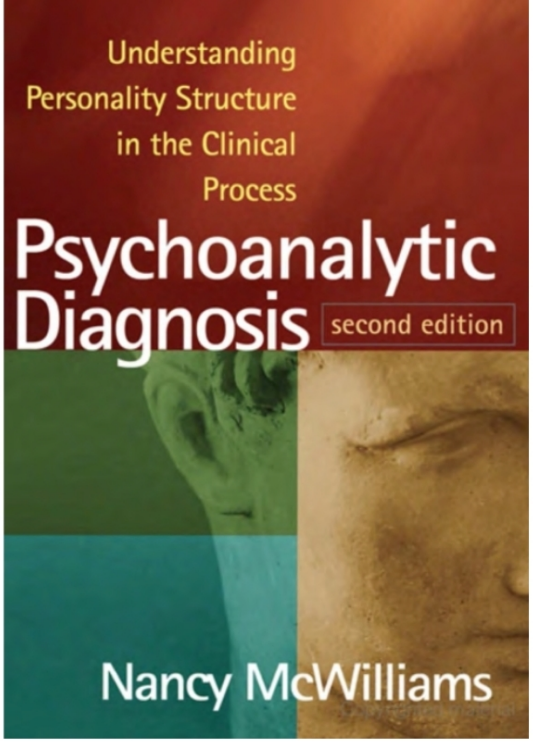

12

Masochistic (Self-Defeating) Personalities

People who seem to be their own worst enemies pose fascinating questions for students of human nature. When someone's history is filled with decisions and actions antithetical to that person's well-being, we find it hard to grasp. Freud saw self-defeating behavior as the most vexing problem addressed by his theory, since he had founded it (in conformance with the biological theory of his day) on the premise that organisms try to maximize pleasure and minimize pain. He emphasized how in normal development, infantile choices are determined by the pleasure principle, later modified by the reality principle (see Chapter 2). Because some choices seem at face value to observe neither the pleasure nor the reality principle, Freud did a lot of stretching and revising of his own metapsychology to account for self-defeating or "masochistic" behavior patterns (Freud, 1905, 1915a, 1916, 1919, 1920, 1923, 1924).

Early analytic theory needed to account for the erotic practices of those who, like the Austrian writer Leopold von Sacher-Masoch, sought orgasm via torment and humiliation. Sexual excitement in suffering pain had already been named after Sacher-Masoch, just as pleasure in inflicting it (sadism) had been named after the Marquis de Sade (Krafft-Ebing, 1900). To Freud, who emphasized the ultimate sexual origins of most behavior, it followed naturally to apply the term "masochism" to ostensibly nonsexual patterns of self-created pain (see LaPlanche & Pontalis, 1973; Panken, 1973).

To distinguish a general pattern of suffering in the service of some ultimate goal from the narrow sexual meaning of masochism, Freud (1924) coined the phrase "moral masochism." By 1933 the concept was accepted widely enough that Wilhelm Reich included the "masochistic character" in his compilation of personality types, stressing patterns of suffering, complaining, self-damaging and self-depreciating attitudes, and an inferred unconscious wish to torture others with one's pain. Moral masochism and masochistic personality dynamics have intrigued analysts for a long time (Asch, 1985; Berliner, 1958; Grossman, 1986; Kernberg, 1988; Laughlin, 1967; Menaker, 1953; Reik, 1941; Schafer, 1984) and have interested the larger community as well; for example, Millon (1995) describes an "aggrieved" self-defeating personality style, and the American Psychiatric Association (1994) considered including "self-defeating personality disorder" in DSM-IV.

The concept remains vital: In a 1990 paper that attained iconic status within contemporary relational psychoanalysis, Emmanuel Ghent argued that masochism is a perversion of the natural wish to surrender, a challenge to the Western assumption that surrender is synonymous with defeat. Comparably, a Jungian perspective on masochism frames it as the "shadow side" of our archetypal need to venerate and worship (Gordon, 1987). Gabriel and Beratis (1997) have related masochistic patterns to early trauma.

Like other phenomena covered in this book, masochistic behavior is not necessarily pathological, even though it is, in the narrowest sense, self-abnegating. Sometimes morality dictates that we suffer for the sake of something worthier than our short-term individual comfort (see C. Brenner, 1959; de Monchy, 1950; Kernberg, 1988). This is the spirit in which Helena Deutsch (1944) observed that motherhood is inherently masochistic; mammals put the welfare of their young ahead of their personal survival. This may be "self-defeating" for an individual animal but not for the offspring and the species. Even more praiseworthy instances of masochism occur when people risk their lives, health, and safety in the service of a greater social good, like the survival of their culture or values. Some people—Mahatma Gandhi and Mother Teresa come to mind—who may have had masochistic trends in their personalities, have demonstrated heroic, even saintly devotion to causes greater than their individual selves.

The term "masochistic" is sometimes used to refer to nonmoralized patterns of self-destructiveness, as with people who are accident prone, or with those who mutilate or otherwise harm themselves deliberately but without suicidal intent. Implied in this use of the word is that there is some method behind the self-destructive person's apparent madness, that some objective is being pursued that makes physical suffering pale,

in the mind of the self-injurer, when evaluated next to the emotional relief being sought through these improbable means. Self-cutters, for example, will typically explain that the sight of their own blood makes them feel alive and real, and that the anguish of feeling nonexistent or alienated from sensation is profoundly worse than any temporary physical discomfort. Masochism thus exists in varying degrees and tones. Self-destructiveness can characterize anyone from the psychotic self-mutilator to the workaholic. Moral masochists range from the Christian martyrs of legend to the Jewish mothers of lore.

Everyone behaves masochistically under certain circumstances (see Baumeister, 1989; Salzman, 1960), often to good effect. Children learn on their own that one way to get attention from caregivers is to get themselves in trouble. A colleague of mine described his initiation into the dynamics of normal masochism when his 7-year-old daughter, angry at him for not having spent any time with her, announced her intention to go upstairs and break all her toys. A modus operandi of moral triumph through self-imposed suffering may become so habitual in a person that he or she may be legitimately seen as having a masochistic character. Richard Nixon, for instance, has been regarded as a moral masochist by many observers (see Wills, 1970) on the basis of his aggrieved, self-righteous tone, his predilection to present himself as suffering nobly, and his questionable judgment in situations in which his welfare was at stake (e.g., his failure to destroy the Watergate tapes that eventually destroyed his presidency).

I want to stress that the term "masochism" as used by psychoanalysts does not connote a love of pain and suffering. The person who behaves masochistically endures pain and suffering in the hope, conscious or unconscious, of some greater good. When an analytic observer comments that a battered wife is behaving masochistically in staying with an abusive man, the commentator is not accusing her of liking to be beaten up. The implication is rather that her actions betray a belief that tolerating abuse either accomplishes some goal that justifies her suffering (such as keeping her family together), or averts some even more painful eventuality (such as complete abandonment), or both. The remark also suggests that her calculation is not working, that her staying with an abuser is objectively more destructive or dangerous than her leaving would be, yet she continues to behave as if her ultimate well-being were contingent on her enduring mistreatment. I emphasize this because in discussions about whether the DSM should include a self-defeating personality disorder, it became apparent that many people regard the attribution of masochism or self-destructiveness as equivalent to accusing someone of enjoying pain—of "blaming the victim" as if he or she consciously provoked abuse for the sake of some perverse form of enjoyment.

When anyone's character is problematic enough to be considered a personality disorder, there is by definition something masochistic about it. If one's core ways of thinking, feeling, relating, coping, and defending are repeatedly maladaptive, one's personality patterns have become self-defeating. People whose masochism is in the *foreground* of their repetitive patterns, rather than being a by-product of other dynamics, are the ones analysts may consider masochistic personalities. As with depressively organized people, their dynamics range from more anaclitic (self-in-relation) to more introjective (self-definition) (Blatt, 2008). Masochistic people with intense anaclitic needs are sometimes called relational masochists; that is, their self-defeating actions result from efforts to keep an attachment at any cost. The term "moral masochist" is more commonly applied to more introjectively organized people who have organized their self-esteem around their capacity to tolerate pain and sacrifice. In the latter category I would put the exhausted intensive-care nurse to whom I suggested working fewer than 80 hours a week. "Well, maybe *some* professionals have low standards," she announced, looking intently at me, "but I'm not one of them."

Masochistic and depressive character patterns overlap considerably, especially at the neurotic-to-healthy level; most people with one have aspects of the other. Kernberg (1984, 1988) regards the depressive–masochistic personality as one of the most common types of neurotic character. I am emphasizing the differences between the two psychologies because, especially at the borderline and psychotic levels, they require significantly contrasting therapeutic styles. Much damage can be done when, with the best intentions, a therapist misunderstands a predominantly masochistic person as basically depressive, and vice versa. I recently found that Richard Friedman (1991), coming from a different disciplinary tradition from mine, has made similar observations, distinguishing depression that is "integrally associated with characterological masochism" from depression that is not, and arguing that "masochistic depressed patients constitute one important, presently hidden, subgroup among those who are chronically depressed. They are particularly likely to be found among chronically depressed patients whose treatment response is suboptimal" (p. 11).

DRIVE, AFFECT, AND TEMPERAMENT IN MASOCHISM

In interesting contrast with depressive conditions, self-defeating patterns have not been subject to extensive empirical research, possibly because the concept of masochism has not been widely embraced beyond the psychoanalytic community. Consequently, little is known about consti-

tutional contributions to masochistic personality organization. Except for Krafft-Ebing's (1900) conclusion that sexual masochism is genetic and some speculations about the role of oral aggression (e.g., L. Stone, 1979), few hypotheses have been made about innate temperament. Clinical experience suggests that the person who becomes characterologically masochistic may be (as may also be true of those who develop a depressive character) more constitutionally sociable or object-seeking than, say, the withdrawing infant who inclines toward a schizoid style.

The question of constitutional vulnerability to masochism is thus still open. A topic that has claimed more professional attention concerns gender. Many scholarly observers (e.g., Galenson, 1988) have the impression that childhood trauma and maltreatment have different effects on children of different sexes: abused girls tend to develop a masochistic pattern, whereas abused boys are more likely to identify with the aggressor and to develop in a more sadistic direction. Like all generalizations, this one has many exceptions—masochistic men and sadistic women are not rare. But perhaps the greater physical strength of adult males, and the anticipation of that advantage by little boys, disposes them to master trauma by proactive means and leaves their sisters with a disposition toward stoicism, self-sacrifice, and moral victory through physical defeat—time-honored weapons of the weak. Differential secretions of hormones such as testosterone, dopamine, and oxytocin may also play a role in such sex differences.

The affective world of the masochistic person is similar to that of the depressive, with a critical addendum. Conscious sadness and deep unconscious guilt feelings are common, but in addition, most masochistic people can easily feel anger, resentment, and even indignation on their own behalf. In such states, self-defeating people have more in common with those disposed to paranoia than with their depressive counterparts. In other words, many masochistic people see themselves as suffering, but unfairly; as victimized or just ill-starred, cursed through no fault of their own (as in "bad karma"). Unlike those with simply depressive themes, who are at some level resigned to their unhappy fate because it is all they think they deserve, masochistic people may rail against it like Shakespeare's lover who troubled deaf Heaven with his bootless cries.

DEFENSIVE AND ADAPTIVE PROCESSES IN MASOCHISM

Like depressive people, masochistic ones may employ the defenses of introjection, turning against the self, and idealization. In addition, they rely heavily on acting out (by definition, since the essence of masochism lies in self-defeating actions). Moral masochists also use moralization

(again, definitionally) to cope with their inner experiences. For reasons that I will cover shortly, people with self-defeating personalities are more active in general than depressive individuals, and their behavior reflects their need to do something with their depressive feelings that counteracts states of demoralization, passivity, and isolation.

The hallmark of masochistic personality is defensive acting out in ways that risk harm. Most unconsciously driven, self-defeating actions include the element of an effort to master an expected painful situation (R. M. Loewenstein, 1955). If one is convinced that, for example, all authority figures will sooner or later capriciously punish those who depend on them, and if one is in a chronic state of anxiety waiting for this to happen, then provoking the expected punishment will relieve the anxiety and provide reassurance about one's power: At least the time and place of one's suffering is self-chosen. Therapists with a control–mastery orientation (e.g., Silberschatz, 2005) refer to this behavior as "passive-into-active transformation."

Freud (1920) was initially impressed with the power of what he called the repetition compulsion in instances of this type. Life is unfair: Those who suffer most in childhood usually suffer most as adults, and in scenarios that uncannily mirror their childhood circumstances. To add insult to injury, the adult situations seem to observers to be of the sufferer's own making, though that is hardly the conscious experience of that person. As Sampson, Weiss, and their colleagues have pointed out (e.g., Weiss, Sampson, & the Mount Zion Psychotherapy Research Group, 1986), repetitive patterns characterize everyone's behavior; if one is lucky enough to have had a safe and affirming childhood, one's repetitive patterns are fairly invisible, since they fit comfortably with realistic opportunities in life and tend to reproduce emotionally positive situations. When one has had a frightening, negligent, or abusive background, the need to recreate those circumstances in order to try to master them psychologically can be both visible and tragic.

A self-cutting patient I treated for many years eventually located the sources of her masochism in early abuse by her mother, including once when this deeply disturbed woman had, in a blind rage, cut my patient with a knife. As memories came back, and as she grieved over her prior helplessness and began discriminating between present and past realities, her self-mutilation gradually ceased. But not before she had scarred her skin irreversibly and had created traumatic scenes for other people. Because she was at the psychotic level of personality organization, the work was slow and precarious, though ultimately successful.

A much healthier woman I worked with used to announce her latest financial extravagances to her frugal husband whenever their relationship began to feel warm and comfortable. This would reliably send him

into a fury. We figured out together that this provocative habit revealed the enduring power of a conclusion she had drawn as a child that whenever things are calm, a storm is about to break. When her marriage was going well, she would begin unconsciously to worry that like her explosive father, her husband was about to destroy their happiness with an outburst. She was thus behaving in a way that she viscerally knew would bring it on, in order to get it over with and restore a pleasurable connection. Unfortunately, from her husband's standpoint she was not reinstating pleasure, she was causing pain.

Reik (1941) explored several dimensions of masochistic acting out, including (1) provocation (as in the preceding vignette), (2) appeasement ("I'm already suffering, so please withhold any further punishment"), (3) exhibitionism ("Pay attention: I'm in pain"), and (4) deflection of guilt ("See what you made me do!"). Most of us use minor masochistic defenses frequently for one or more of these reasons. Therapists in training who approach supervision in a flood of self-criticism are often using a masochistic strategy to hedge their bets: If my supervisor thinks I made a major error with my client, I've already shown that I'm aware of it and have been punished enough; if not, I get reassured and exonerated.

Self-defeating behavior in relational masochism can be understood as a defense against separation anxiety (Bach, 1999). It has a way of engaging others and involving them in the masochistic process. Once in a therapy group I belonged to, a member kept bringing the group's criticism down upon himself in a relentlessly predictable way, of which he seemed naively unaware. When confronted with the evidence that his whining, self-abasing stance evoked exasperation and attack from others, he became uncharacteristically subdued and admitted, "I'd rather be hit than not touched at all." I say more about this dynamic in the object relations section.

With those whose masochism is more introjective, moralization can be an exasperating defense. Often they are much more interested in winning a moral victory than in solving a practical problem. It took me weeks of work to get one self-defeating patient to consider writing a letter to the Internal Revenue Service (IRS) that would get her the large refund to which she was legally entitled. She spent her therapy hours trying to convince me that the IRS had handled her tax return ineptly—which was emphatically true but completely beside the point if the point was to get her money back. She much preferred my sympathetic indignation to my attempts to help her get recompensed. Left to herself, she would have gone on collecting and bemoaning injustices rather than eliminating one.

Part of the dynamic here seems to be a special way of handling the introjective depressive conviction that one is bad. The need to get

listeners to validate that it is others who are guilty can be great enough to overwhelm the practical objectives to which most people give priority. One reason that children with a stepparent—even a kind and well-meaning one—tend to behave masochistically (acting resentful or defiant, and inciting punitive responses) may pertain to unconscious guilt. Youngsters who have lost a parent tend to worry that their badness drove that parent away. Preferring a sense of guilty power to helpless impotence, they try to convince themselves and others that *it* is the substitute parent who is bad, thus deflecting attention from their own felt wrongdoing. They may provoke until the stepparent's behavior supports their conviction.

These dynamics may explain why it is often hard to influence a stepfamily system in a purely behavioral way. The agenda of an angry and guilt-driven party may have much more to do with continuing to suffer (so that someone else is seen as culpable) than with improving the family atmosphere. This phenomenon is of course not exclusive to children or to reconstituted families. Any elementary school teacher has a reservoir of anecdotes about biological parents who presented themselves as long-suffering martyrs to their child's misbehavior yet could not implement any suggestions for improving it. One gets the feeling that their need to be confirmed in a perception of the child as bad, and in their own role as enduring stolidly, outranks other considerations.

Another frequent defense is denial. Masochistically organized people frequently demonstrate by their words and behavior that they are suffering, or that someone is abusing them, yet they may deny that they are feeling any particular discomfort and protest the good intentions of the perpetrator. "I'm sure she means well and has my best interests at heart," one of my clients once remarked about an employer who obviously disliked him and had humiliated him in front of all his colleagues. "How did you feel about her treatment of you?" I asked. "Oh, I figured she was trying to teach me something important," he responded, "so I thanked her for her efforts."

RELATIONAL PATTERNS IN MASOCHISTIC PSYCHOLOGY

Emmanuel Hammer was fond of saying that a masochistic person is a depressive who still has hope. What he meant is that in the etiology of masochistic as opposed to depressive conditions, the deprivation or traumatic loss that led to a depressive reaction was not so devastating that the child simply gave up on the idea of being loved (see Berliner, 1958; Bernstein, 1983; Lax, 1977; Salzman, 1962; Spitz, 1953). Many parents who are barely functional can nevertheless be jarred into action

if their child is hurt or endangered. Their children learn that although they generally feel abandoned and therefore worthless, if they are suffering enough, they may get some care (Thompson, 1959). To a child, any parental attention can feel safer than neglect, a reality that Wurmser captured in a book titled *Torment Me but Don't Abandon Me* (2007).

One woman I assessed had an extraordinary history of injury, illness, and misfortune. She had also had a psychotically depressed mother. When I asked for her earliest memory, she cited an incident from age 3 when she had knocked over an iron, burned herself, and received a rare infusion of maternal solace. Usually the history of a masochistic person sounds like the history of a depressive one, with unmourned losses, critical or guilt-inducing caregivers, role reversals where the child feels responsible for the parents, instances of trauma and abuse, and depressive models (Dorpat, 1982). Yet if one listens carefully, one also hears a theme of people having been responsive when the client was in deep enough trouble. Whereas depressive people feel that there is no one there for them, masochistic ones may feel that if only they can demonstrate sufficiently their need for sympathy or care, they may not have to endure complete emotional abandonment.

Esther Menaker (e.g., 1953) was one of the first analysts to describe how the origins of masochism lie in unresolved dependency issues and fears of being alone. "Please don't leave me; I'll hurt myself in your absence" is the essence of many masochistic communications, as it was in the example of my colleague's daughter who threatened to destroy all of her toys. In a fascinating research project on the psychologies of severely and repeatedly battered women, the ones who drive women's shelter personnel to tear their hair out because they keep returning to partners who barely stop short of killing them, Ann Rasmussen (1988) learned that these gravely endangered people fear abandonment much more than they fear pain or even death. She notes:

> When separated from their batterers, most of the subjects fell into an abyss of such acute despair that they succumbed to Major Depressions and could barely function.... Many described being incapable of feeding themselves, getting out of bed, and interacting with others. As one subject put it, "when we were apart I didn't know how to get up in the morning ... my body forgot how to eat, each bite was like a rock in my stomach." The depths to which they sank when alone were unrivaled by any states of distress they experienced when with their abusive mates. (p. 220)

It is not uncommon to learn from masochistic patients that the only time a parent was emotionally invested in them was when they were being punished. An association of attachment and pain is inevi-

table under these circumstances. Teasing, that peculiar combination of affection and cruelty, can also breed masochism (Brenman, 1952). Especially when punishment has been excessive, abusive, or sadistic, the child learns that suffering is the price of relationship. And children crave relationship even more than physical safety. Victims of childhood abuse usually internalize their parents' rationalization for the mistreatment, because it feels better to be beaten than to be neglected. Another subject in Rasmussen's (1988) study confided: "I have had the feeling I wished I was little again. I wish I was still up under my mother's care. I wish I could be whipped now, because whipping is a way of making people listen and to know in the future. If I had a mother to whip me more, I could keep myself in line" (p. 223).

One other aspect of the history of many people whose personalities become masochistically structured is that they have been powerfully rewarded for enduring tribulation gallantly. When she was 15, a woman I know lost her mother to cancer of the colon. The mother lived at home in the months she was dying, wasting away in an increasingly comatose and incontinent state. Her daughter took over the role of nurse, changing the dressings on her colostomy, washing the bloody sheets daily, and turning her mother's body to prevent bedsores. The mother's mother, deeply touched by such devotion, expounded fulsomely on how brave and unselfish her granddaughter was, how God must be smiling on her, how uncomplainingly she gave up normal adolescent pursuits to care for her dying mother. All this was true, but the long-term effect of her having received so much reinforcement for self-sacrifice, and so little encouragement to take some time off to meet her own needs, set her up for a lifetime of masochism: She handled every subsequent developmental challenge by trying to demonstrate her generosity and forbearance. Others reacted to her as tiresomely self-righteous, and they chafed at her repeated efforts to mother them.

In their everyday relationships, self-defeating people tend to attach to friends of the misery-loves-company variety, and if they are of the moral masochistic variety of sufferer, they gravitate toward those who will validate their sense of injustice. They also tend—battered partners being only the most extreme example—to recreate relationships in which they are treated with insensitivity or even sadism. Some sadomasochistic attachments seem to be a result of the self-defeating person's having chosen a mate with a preexisting tendency to abuse; in other instances it appears that the person enduring mistreatment has connected with an adequately kind partner and managed to bring out the worst in him or her.

Nydes (1963) argued (cf. Bak, 1946) that people with masochistic personalities have certain commonalities with paranoid people, and that some individuals swing cyclically from masochistic to paranoid orienta-

tions. The source of this affinity is their common orientation to threat. Both paranoid and self-defeating people feel in constant danger of attacks on their self-esteem, security, and physical well-being. The paranoid solution in the face of this anxiety is something like "I'll attack you before you attack me," whereas the masochistic response is "I'll attack myself first so you don't have to do it." Both masochistic and paranoid people are unconsciously preoccupied with the relationship between power and love. The paranoid person sacrifices love for the sake of a sense of power; the masochistic one does the reverse. Especially at the borderline level of personality organization, these different solutions may present as alternating self-states, leaving a therapist confused as to whether to understand the patient as a frightened victim or a menacing antagonist.

Masochistic dynamics may permeate the sexual life of someone with a self-defeating personality (Kernberg, 1988), but many characterologically masochistic people are not sexual masochists (in fact, whereas their masturbation fantasies may contain masochistic elements in order to magnify excitement, they are often turned off sexually by any note of aggression in their partner). Conversely, many people whose particular sexual history gave them a masochistic erotic pattern are not self-defeating personalities. One unfortunate legacy of early drive theory, which connected sexuality so intimately with personality structure at the conceptual level, has been a glib assumption that sexual dynamics and personality dynamics are always isomorphic. Often, they are. But, perhaps luckily, people are frequently more complex.

THE MASOCHISTIC SELF

The self-representation of the masochistic person is also comparable, up to a point, with that of the depressive: unworthy, guilty, rejectable, deserving of punishment. In addition, there may be a pervasive and sometimes conscious sense of being needy and incomplete rather than simply bereft, and a belief that one is doomed to be misunderstood, unappreciated, and mistreated. People with a moral–masochistic personality structure often impress others as grandiose and scornful, exalted in their suffering and scornful of those lesser mortals who could not endure equivalent tribulation with so much grace. Although this attitude makes moral masochists look as if they are enjoying their suffering, a better formulation would be that they have found a compensatory basis in it for supporting their self-esteem (Cooper, 1988; Kohut, 1977; Schafer, 1984; Stolorow, 1975).

Sometimes when masochistic clients are recounting instances of mistreatment by others, one sees traces of a sly smile on their otherwise

aggrieved features. It is easy to infer that they are feeling some sadistic pleasure in defaming their tormenters so soundly. This may be another source of the common assumption that self-defeating people enjoy their misery. It is more accurate to say that they derive some secondary gain from their attachment-through-suffering solutions to their interpersonal dilemmas. For those who tilt toward moral masochism, they may be fighting back by not fighting back, exposing their abusers as morally inferior for showing their aggression, and savoring the moral victory that this stratagem achieves.

Those who lean more relationally may be smiling because their masochistic behavior is expected to elicit more connection with the person to whom they are relating. Psychiatrists are painfully familiar with the returning patient who comes in looking disappointed, but with a tiny smile at the corner of the mouth, while announcing, "That medication didn't work either, it seems." Most therapists are familiar with clients who complain piteously about mistreatment by a boss, relative, friend, or mate, yet when encouraged to do something to remedy their situation, look disappointed, change the subject, and switch their grievances to another arena. When self-esteem is enhanced, and/or a relationship is felt to be reinforced, by bearing misfortune courageously, and when these goals are seen as less achievable if one acts on one's own behalf ("selfishly"), it is difficult to reframe an unpleasant situation as requiring corrective measures.

Unlike most depressively organized people, who tend to retreat into loneliness, masochistic individuals may handle their felt badness by projecting it onto others and then behaving in a way that elicits evidence that the badness is outside rather than inside. This is another way in which self-defeating patterns and paranoid defenses are similar. Masochistic people usually have less primitive terror than paranoid ones, however, and do not require as many defensive transformations of affect in order to eject their unwanted aspects. And unlike paranoids, who may be reclusive, they need other people close at hand to be the repositories of their disowned sadistic inclinations. A paranoid person can resolve anxiety by attributing projected malevolence to vague forces or distant persecutors, but a masochistic one attaches it to someone nearby, whose observable behavior demonstrates the rightness of the projector's belief in the moral turpitude of the object.

TRANSFERENCE AND COUNTERTRANSFERENCE WITH MASOCHISTIC PATIENTS

Masochistic clients tend to reenact with a therapist the drama of the child who needs care but can only get it if he or she is demonstrably suffering.

The therapist may be seen as a parent who must be persuaded to save and comfort the patient, who is too weak, threatened, and unprotected to handle life's challenges without help. If the client has gotten into some truly disturbing, dangerous situations, and seems clueless as to how to get extricated, it is not uncommon for a therapist to feel that before treatment can begin, the person's safety must be secured. In less extreme examples of masochistic presentations, there is still some communication of helplessness in the face of life's insults, along with evidence that the only way the client knows how to cope with difficulty is by trying to be tolerant, stoic, or even cheerful in the face of misfortune.

Masochistic clients often try to persuade the therapist that they need to be, and deserve to be, rescued. Coexisting with these aims is the fear that the therapist is an uncaring, distracted, selfish, critical, or abusive authority who will expose the client's worthlessness, blame the victim for being victimized, and abandon the relationship. The rescue agendas and fears of maltreatment may be either conscious or unconscious, ego syntonic or ego alien, respectively, depending on the client's level of organization. In addition, self-defeating people live in a state of dread, almost always unconscious, that an observer will discern their shortcomings and reject them for their sins. To combat such fears, they try to make obvious both their helplessness and their efforts to be good.

There are two common countertransferences to masochistic dynamics: countermasochism and sadism. Usually both are present. The most frequent pattern of practitioner response, especially for newer therapists, is first to be excessively (and masochistically) generous, trying to persuade the patient that one appreciates his or her suffering and that one can be trusted not to attack. Then, when that approach only seems to make the patient more helpless and wretched, the therapist notices ego-alien feelings of irritation, followed by fantasies of sadistic retaliation toward the client for being so intractably resistant to help.

Because therapists often have depressive psychologies, and because it is easy—especially early in treatment—to misunderstand a predominantly masochistic person as a basically depressive one, clinicians often seek to do for the patient what would be helpful to themselves if they were in the patient role. They emphasize in their interpretations and their conduct that they are available, that they appreciate the extent of the person's unhappiness, and that they will take extra pains to be of help. Therapists have been known to reduce the fee, schedule extra sessions, take phone calls around the clock, and make other special accommodations in the hope of increasing a therapeutic alliance with a patient who is stuck in a dismal morass. Such actions, which might facilitate work with a depressive person, are counterproductive with a masochistic one in that they invite regression. The patient learns that self-defeating

practices pay off: The more pronounced the suffering, the more giving the response. The therapist learns that the harder he or she tries, the worse things get—a perfect mirror of the masochistic person's experience of the world.

I have observed in myself and my students that we all learn the hard way how to work with masochistic clients, how to avoid acting out masochistically and suffering upsetting sadistic reactions to people for whom we would rather feel sympathy. Most therapists recall vividly the client with whom they learned to set limits on masochistic regression rather than to reinforce it. In my own case, I am embarrassed to report that in the flush of a rescue fantasy toward one of my first deeply disturbed patients, a paranoid–masochistic young man in the psychotic range, I was so eager to prove I was a good object that, on hearing his sad story about how there was no way for him to get to work anymore, I lent him my car. Not surprisingly, he drove it into a tree.

In addition to the common inclination to support rather than confront masochistic reactions, therapists usually find it hard to admit to sadistic urges. Because feelings that go unacknowledged are likely to be acted out, this inhibition can be dangerous. The sensitivity of consumers of mental health services to the possibility of therapists' blaming the victim is probably not accidental; it may derive from the sense of many former patients that they were subjected to unconscious sadism from therapists when they were in a vulnerable role. If one has extended oneself to the point of resentment with a client who only becomes more dysphoric and whiny, it gets easy to rationalize either a punitive interpretation or a rejection ("Perhaps this person needs a different therapist").

Masochistic clients can be infuriating. There is nothing more toxic to a therapist's self-esteem than a client who radiates the message, "Just try to help me—I'll only get worse." This negative therapeutic reaction (Freud, 1937) has long been related to unconscious masochism, but understanding that intellectually and going through it emotionally are two different things. It is hard to maintain an attitude of benign support in the face of someone's stubbornly self-abasing behavior (see Frank et al., 1952, on the "help-rejecting complainer"). Even in writing this chapter I am aware of slipping into a mildly affronted tone as I try to describe the masochistic process; some analysts (e.g., Bergler, 1949) writing about self-defeating patients have sounded outright contemptuous. The ubiquity of such feelings highlights the need for careful self-monitoring. Masochistic and sadistic countertransference reactions need not burden treatment unduly, though a therapist who denies feeling them will almost certainly run into trouble.

Finally, because masochistic patients tend to view their self-destructive behaviors with emotional denial of their implications, therapists are left

holding the anxiety that would normally accompany the danger of self-harm. I have often noticed, as I try to explore the possible consequences of a masochistic person's behavior, that as I am getting more anxious about what the client is risking, he or she is getting more casual, matter-of-fact, and minimizing. "Were you worried that you might contract HIV?" may elicit a vague "I don't think that's going to happen" or "That was just one time" or "Maybe a little, but that's not what I want to talk about right now."

THERAPEUTIC IMPLICATIONS OF THE DIAGNOSIS OF MASOCHISTIC PERSONALITY

Freud and many of his early followers wrote about masochistic dynamics, describing their origins and functions, their unconscious objectives, and their hidden meanings, but without comment on particular treatment implications. Esther Menaker (1942) was the first to observe that many aspects of classical treatment, such as the patient's lying supine and the analyst's interpreting in an authoritative manner, can be experienced by masochistic clients as replicating humiliating interactions of dominance and submission. She recommended technical modifications such as face-to-face treatment, emphasis on the real relationship as well as on the transference, and avoidance of all traces of omnipotence in the analyst's tone. Without the elimination of all potentially sadomasochistic features of the therapy situation, Menaker felt that patients would be at risk of feeling only a repetition of subservience, compliance, and the sacrifice of autonomy for closeness.

This argument still holds, though perhaps more in the spirit than the letter of Menaker's (1942) recommendations. Her remarks about the couch have become somewhat moot, since in current psychoanalytic practice, only high-functioning patients would be encouraged to lie down and free associate (and presumably the neurotic-level masochistic person would have a strong enough observing ego to appreciate that relaxing on a couch does not equate to accepting a humiliating defeat). But her stress on the centrality of the real relationship stands. Because the masochistic person urgently needs an exemplar of healthy self-assertion, the quality of the therapist as a human being, expressed in the way he or she structures the therapeutic collaboration, is critical to the prognosis of a self-defeating patient. The therapist's unwillingness to be exploited or to extend generosity to the point of inevitable resentment may open up whole new vistas to someone who was brought up to sacrifice all self-regarding concerns for the sake of others. Hence, the first "rule" for treating self-defeating clients is not to model masochism.

Years ago, one of my supervisors, knowing I had a commitment to serving people of limited means, told me that it was fine to let most patients run up a bill if they suffered financial reverses, but stressed that I should never be lenient in this way with a masochistic client. As I seem to be constitutionally incapable of taking good advice until I make the mistake that illuminates its wisdom, I disregarded his warning in the case of a diligent, earnest, and appealing man who convincingly described a money crisis that seemed outside his control. I offered to "carry" him until he got back on his feet financially. He proceeded to get more and more incompetent with money, I got more and more aggrieved, and eventually we had to rectify my mistake with a headache of a plan for repayment. I have not made this error since, but I notice that my students typically learn this piece of wisdom through bitter experience, just as I did. It would not be so upsetting if the therapist were the only one to pay the price of misguided generosity, but as the harm to the patient becomes obvious, one's confidence as a healer can suffer as much as one's pocketbook.

It is thus no service to self-defeating clients to demonstrate "therapeutic" self-sacrifice. It makes them feel guilty and undeserving of improvement. They can scarcely learn how to exert their prerogatives if the therapist exemplifies self-effacement. Rather than trying to give a masochistic person a break with the fee, one should charge an amount that is adequate recompense for the skill needed to work with a challenging dynamic, and then receive payment in the spirit of feeling entitled to it. Nydes (1963) would intentionally show masochistic patients his pleasure in being paid, fondling their bills happily or pocketing their checks with obvious relish.

The resistance of most therapists to showing appropriate amounts of self-concern and self-protectiveness, despite the clear need of masochistic patients to have a model of reasonable self-care, probably comes not only from possible internal inhibitions about self-interest—always a good bet with therapists—but also from accurate forebodings that self-defeating patients will react to their limits with anger and criticism. In other words, they will be punished for selfishness, in the same way many masochistic people were punished by their early objects. This is true. It is also to be hoped for. Self-destructive people do not need to learn that they are tolerated when they smile bravely; they need to find out that they are accepted even when they are losing their temper.

Moreover, they need to understand that anger is natural when one does not get what one wants and can be simply understood as such by others. It does not have to be fortified with self-righteous moralism and exhibitions of suffering. Masochistic people may believe they are entitled to feel hostility only when they have been clearly wronged, a presump-

tion that costs them countless hours of unnecessary psychological exertion. When they feel some normal disappointment, anger, or frustration, they may either deny or moralize in order not to feel shamefully selfish. When therapists act self-concerned, and treat their masochistic patients' reactive outrage as natural and interesting, some of these patients' most cherished and damaging internal categories get reshuffled.

For this reason, experienced therapists may advise "No rachmones" (no expressions of sympathy) with masochistic patients (Hammer, 1990; Nydes, 1963). This does not mean that one blames them for their difficulties, or returns sadism for their masochism, but it does mean that instead of communications that translate into "You poor thing!" one tactfully asks, "How did you get yourself into that situation?" The emphasis should always be on the client's capacity to improve things. These ego-building, noninfantilizing responses tend to irritate self-defeating people, who may believe that the only way to elicit warmth is to demonstrate helplessness. Such interventions provide opportunities for the therapist to welcome the expression of normal anger, to show acceptance of the client's negative feelings, and to feel relief in an increase in authenticity.

Similarly, one should not rescue. One of my most disturbed masochistic patients, whose symptoms ranged from bulimia to multiple addictions to anxieties of psychotic proportions, used to go into a paralysis of panic whenever she feared that an expression of her anger had alienated me. On one such occasion, she became so frantic that she persuaded the staff of the local mental health center to hospitalize her and signed herself in for 72 hours. Within half a day, having calmed down and now wanting no part of an in-patient experience, she got a psychiatrist to agree that if she obtained my permission, she could be discharged early. "You knew you were signing yourself in for 3 days when you did this," I responded, "so I would expect you to keep your commitment." She was livid. But years later, she confided that that had been the turning point in her therapy, because I had treated her like a grown-up, a person capable of living with the consequences of her actions.

In the same vein, one should not buy into guilt and self-doubt. One can feel powerful pressure from masochistic clients to embrace their self-indicting psychology. Guilt-provoking messages are often strongest around separations. A person whose self-destructiveness escalates just when the therapist is about to take a vacation (a common scenario) is unconsciously insisting that the therapist is not allowed to enjoy something without agonizing over how it is hurting the patient. Behaviors that translate into "Look what you made me suffer!" or "Look what you made me do!", are best handled by empathic reflection of the client's pain, combined with a cheerful unwillingness to let it rain on one's parade.

Setting an example that one takes care of oneself without feeling guilt about the neurotic reactions of others may elicit moralistic horror from masochistic people, but it may inspire them to experiment with being a bit more self-respectful. I originally learned this while working with a group of young mothers whose shared masochism was formidable (McWilliams & Stein, 1987). My co-leader was the target of oppressive nonverbal broadcasts that her upcoming vacation was wounding the group members. These messages were delivered with disingenuous maternal reassurances that she should not feel too bad about forsaking them. In response, she announced that she did not feel the slightest bit guilty, that she was looking forward to having a good time and not having to think about the group at all. The women became incensed but were animated and honest again, as if pulled out of a quagmire of deadness, hypocrisy, and passive aggression.

It is often helpful to resist the anxiety one feels about a masochistic patient in a dangerous situation, and to address the upsetting material in a casual, dispassionate tone. My friend Kit Riley taught me that when one is trying to help a woman who keeps going back to a dangerous abuser, expressing anxiety only allows the patient to feel magically "rid" of worry—now it is in the therapist, not her. Instead, it can be valuable to say, in a serious but matter-of-fact tone:

> "I get that he doesn't want to kill you, and that he's contrite after he attacks you, and that that shows his love, and that you love him and want to go back. Fine. But of course we have to take seriously the possibility that without intending to, he'll get into a state in which he *does* kill you. So we should address this danger. Do you have a will? Have you talked to your kids about who would take care of them if you were murdered? Do you have life insurance? If your partner is the beneficiary, you might want to change that.... "

When the therapist refuses to take on anxiety and simply talks reality, such a client tends to feel in herself the anxiety she has failed to put into her therapist and to have to face the implications of her masochistic behavior.

Timing, of course, is critical. If one comes on too strong too fast, before a reliable working alliance is in place, the patient will feel criticized and blamed. The art of conveying a sympathetic appreciation that the suffering of masochistic people is truly beyond their conscious control (despite its appearing to be self-chosen) and at the same time adopting a confrontational stance, one that respects their ability to make their volition conscious and change their circumstances, cannot be taught in a textbook. But any reasonably caring practitioner develops an intu-

ition about how and when to confront. If one's efforts wound the client beyond a therapeutic level of discomfort, one should apologize (E. S. Wolf, 1988), but without excessive self-recrimination.

In addition to behaving in ways that counteract the pathological expectations of masochistic patients, the therapist should actively interpret evidence for irrational but prized unconscious beliefs such as "If I suffer enough, I'll get love," or "The best way to deal with my enemies is to demonstrate that they are abusers," or "The only reason something good happened to me was that I was sufficiently self-punitive." It is common for self-defeating people to have magical beliefs that connect assertiveness or confidence with punishment, and self-abasement with eventual triumph. One finds in most religious practices and folk traditions a connection between suffering and reward, and masochistic people often support their pathology uncritically with these ideas. Such beliefs may console us, softening our outrage about suffering that may be both capricious and unambiguously destructive. However, when these ideas get in the way of taking action that might be effective, they do more harm than good.

Among the contributions of control–mastery theory to psychoanalytic understanding is its emphasis on pathogenic beliefs and on the client's repeated efforts to test them. In addition to passing these tests by such means as refusing to act masochistically in the role of therapist, the clinician must help the client become aware of what the tests are, and what they reveal about the person's underlying ideas about the nature of life, human beings, the pursuit of happiness, and so on. This part of treatment, though not as emotionally challenging as controlling one's countertransferences, is the hardest to effect. Omnipotent fantasies behind masochistic behaviors die hard. One can always find evidence in random events that one's successes have been punished and one's sufferings rewarded.

The therapist's persistance in exposing irrational beliefs often makes the difference between a "transference cure"—the temporary reduction of masochistic behaviors based on idealization of and identification with the therapist's self-respecting attitude—and a deeper and lasting movement away from self-abnegation.

DIFFERENTIAL DIAGNOSIS

As I noted earlier, there is a masochistic component in all the personality configurations discussed in this book—at least when they approach a pathological level of defensive rigidity or developmental arrest sufficient to establish them as character *disorders* rather than simply character.

But the masochistic function of any type of pattern is not identical to masochism as an organizing personality theme. The types of individual psychology most easily confused with the kind of characterological masochism covered here are depressive and dissociative psychologies.

Masochistic versus Depressive Personality

Many people have a combination of depressive and masochistic dynamics, and are reasonably regarded as depressive–masochistic characters. In my experience, however, in most individuals the balance between these elements tilts in one direction or the other. Because the optimal therapeutic style for each differs, it is important to discriminate between these two depressively toned psychologies. The predominantly depressive person needs above all else to learn that the therapist will not judge, reject, or abandon, and will, unlike the internalized objects that maintain depression, be particularly available when the client is suffering. The more masochistic person needs to find out that self-assertion, not helpless suffering, can elicit warmth and acceptance, and that the therapist, unlike the parent who could be brought to reluctant attention if a disaster was in progress, is not particularly interested in the details of the patient's current misery.

If one treats a depressive person as masochistic, one may provoke increased depression and even suicide, as the client will feel both blamed and abandoned. If one treats a masochistic person as depressive, one may reinforce self-destructiveness. At the most concrete level, most experienced clinicians have found that when antidepressant medication is given to someone with a masochistic personality, even if that person has diagnosable Axis I depression, the medicine does very little other than to feed the patient's pathogenic belief that to feel better, one needs authorities and their magic. When seeing a person with both depressive and masochistic tendencies, the therapist must keep assessing whether a more depressive or more masochistic dynamic is currently active, so that the tone of one's interventions is appropriate to the primary defensive process in the patient.

Masochistic versus Dissociative Psychology

Over the past several decades there has been an explosion in our knowledge about dissociation. Acts that we used to understand exclusively according to theories of masochism have been reinterpreted in more specific ways for patients with a history of traumatic abuse and neglect (Gabriel & Beratis, 1997; Howell, 1996). Many people are subject to dissociated states in which they repeat, symbolically or concretely, prior

harm to themselves. The most dramatic exemplar of a vulnerability to dissociated self-injury is the client who switches self-states by self-hypnotic means and then engages in a reenactment of early tortures. Investigation may reveal the existence of an alter personality, identified with the original tormentor, for whom the main personality is amnesic.

The general dynamic in such cases is indeed masochistic, but if the therapist misses the fact that the self-injury was carried out in a dissociated state by a part of the person not always in consciousness, interpretations will be futile. Chapter 15 addresses treatment for dissociative people; for now, readers should note that especially in more bizarre cases of self-harm, the patient should be asked matter-of-factly if he or she remembers doing it. If the client does recall inflicting the injuries, one can inquire about the degree to which he or she felt depersonalized or disembodied. Until such a patient has access to the state of mind in which a self-destructive act was committed, interventions aimed at reducing dissociation take priority over interpretations of masochism.

SUMMARY

I have given a brief history of the concept of masochism and related self-defeating patterns, distinguishing them from lay conceptions of masochism as joy in pain. I differentiated moral from relational masochism and mentioned gender predispositions (to masochism in women and sadism in men) while stressing that masochistic personality organization is common in people of both sexes. I construed masochism as involving the main depressive affects plus anger and resentment, and noted that masochistic ego processes include the depressive defenses plus acting out, moralization, and denial. I argued that masochistic relationships may parallel early experiences with objects who attended to the growing child negligently or abusively, yet with occasional warmth when he or she was suffering. The masochistic self is similar to that of the depressive self, with the addition that self-esteem is regulated through enduring mistreatment bravely.

I characterized transferences of self-defeating patients as reflecting wishes to be valued and rescued, and I discussed countertransferences of masochism and sadism. In terms of treatment style, I recommended attention to the real relationship (specifically the therapist's modeling of healthy self-regard), respect for the patient's capability and responsibility for problem solving, and persistence in exposing, challenging, and modifying pathogenic beliefs. Finally, I distinguished masochism from depressive and dissociative psychologies.

SUGGESTIONS FOR FURTHER READING

Reik's (1941) study of moral masochism, though dated, is still worth reading and is not so mired in difficult metapsychology that a beginner would be put off. Stolorow's (1975) essay examines masochism from a self psychology perspective. Cooper's (1988) article on the narcissistic–masochistic character is a classic. Jack and Kerry Kelly Novick (e.g., 1991) have examined the concept developmentally in readable ways. An edited volume on masochism by Glick and Meyers (1988) includes several good essays, most of which concern characterological patterns; *Essential Papers on Masochism* (Hanley, 1995) is also a nice compilation. The books I cited in this chapter by Leon Wurmser (2007) and Sheldon Bach (1999) are both excellent. Finally, I strongly recommend the relational classic by Emmanuel Ghent (1990) for a subtle and wide-ranging exploration of how different the valuable experience of surrender is from masochistic submission.

I did a DVD in the *Master Clinicians* series for the American Psychological Association (McWilliams, 2007) that involved an interview with a patient I saw as having a predominantly masochistic personality. This is available at *www.apa.org/videos*.