Complexities in the Treatment
of Masochistic Character Dynamics
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Introduction

The purpose of this presentation is to discuss the concept of characterological masochism with an emphasis on its potential usefulness in the clinical setting. I begin by discussing the boundaries of the concept itself, then move to a brief overview of some theoretical background, and finally to a discussion of masochistic phenomena as they relate to presenting problems and subsequent developments in the relationship between patient and therapist. My intention is to travel wide rather than deep to provide an introduction to the main issues involved.

Let me state at the outset that my theoretical orientation is psychoanalytic, and my clinical work is organized around helping patients identify and come to grips with defenses, anxieties, and motivations which are for the most part unconscious. This theoretical orientation is important because the concept of masochism does not rest on a description of behaviors so much as it rests upon inferences about the unconscious motivations for such behaviors. The concept itself has undergone a complex evolution with developing in parallel with newer trends in psychoanalytic theory such as ego psychology, self-psychology, and object relations theories. Most importantly, the concept has broadened from a narrow reference to sexual behavior, to a more general reference to pervasive patterns of character functioning. It is not sexual masochism, but rather characterological masochism which I intend to discuss.

Masochistic Suffering

When a person suffers physical or emotional pain, punishment, humiliation, abuse, and other forms of unpleasantness, two responses are understandable: an effort to escape

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such situations, and a tendency to try to avoid similar outcomes in the future. The concept of masochism has arisen to account for behavior in which such ordinarily painful and unpleasant experiences do not result in these expected responses. The masochistic person appears to the observer to remain in or even seek out such situations of likely suffering in a way which we would not expect.

It is important here to differentiate masochistic suffering from other forms of suffering. Suffering is an intrinsic consequence of most psychopathology and the search for relief from such suffering is a primary motivation for patients seeking psychotherapy. However, for the term "masochism" to be meaningful and useful, we need to make a crucial distinction between the suffering which accompanies psychopathology in general, and that which is uniquely "masochistic". While the masochist may be said to unconsciously seek suffering, not all suffering is masochistic. The key to this is an appraisal of motivation.

To illustrate this point, we might picture a continuum of suffering which focuses on the motivation of the sufferer. On one end of this continuum is externally generated suffering in which motivation is irrelevant. An example might be the suffering that results from being fired from a job because of an economic recession. Here, motivation plays no role. In the middle of the continuum is what we have referred to as the emotional suffering which accompanies psychopathology in general. Here the suffering is secondary, it is a by-product and not an end in itself. An example might be someone fired from a job for constantly being oppositional, defiant, and angry with the boss. Let us say that this hypothetical person is prone to such attitudes and behavior perhaps as an attempt to regulate a fragile narcissistic equilibrium. The suffering from being fired would then not be a goal, but rather an undesirable side-effect of an attempt to cope with internal vulnerabilities surrounding issues of self-esteem. The sufferer's attempts to cope with these conscious and unconscious difficulties are maladaptive insofar as they result in secondary consequences which lead to emotional suffering. Finally, on the other end of our continuum would be the motivation to suffer because the suffering itself offers something (which we will leave unspecified for the moment). Here our sufferer acts out

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in order to be fired, in order to create a certain dynamic of suffering and victimization. While the interplay of internal and external reality is not so neatly separated in reality, this continuum is perhaps useful in helping us conceptualize three potential sources of suffering, only the last of which can be meaningfully considered "masochistic".

Masochistic Suffering

Why the masochist seeks suffering is the crucial clinical question and the psychoanalytic literature abounds with theoretical proposals. The clinical and theoretical search for an explanation for the function of masochism began with Freud, whose theories were constantly evolving of necessity. I will do Freud an injustice here in drastically summarizing and oversimplifying his writings on masochism.

Freud (1905) began by viewing masochism as a secondary phenomenon derived from a primary aggressive instinctual drive which had, for various reasons, turned inward. In this view, masochism was really a sort of sadism directed toward oneself. Later (*Instincts and Their Vicissitudes,* 1915), Freud pointed to the tendency of all instincts to alternate with their opposites and observed that in clinical practice sadism and masochism typically co-existed in the same individual, although either might predominate and even function as a defense against the other. In this paper, Freud also emphasized the idea that the masochist does not take pleasure in pain and suffering, but rather accepts suffering as a condition of pleasure. In a 1916 paper (*Some Character-types Met with in Psychoanalytical Work*) Freud described "those wrecked by success". He referred here to those who seem to react to an achievement with some sort of self-sabotage or depression. In a paper entitled *A Child is Being Beaten* (1919), Freud stressed the role of unconscious guilt in the development of masochism.

In his last paper on masochism (*The Economic Problem in Masochism,* 1924), Freud differentiated between three types of masochism. "Erotogenic Masochism" was a complex, highly theoretical metapsychological construct involving the death instinct, which provided a conceptual underpinning for the actual clinical manifestations of masochism, which Freud termed "feminine" and "moral" masochism.

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"Feminine masochism" was Freud's unfortunate term for the masochistic sexual perversion. The term itself has led to some confusion and unfortunately has often been misconstrued as meaning the "masochism of women". In fact, what Freud discusses under this heading is the essence of the masochistic sexual perversion in men, which he views as an unconscious fantasy of being placed in what the male fantasizes as a characteristically female position. Without being in any way an apologist for Freud's views on femininity, it should be remembered that in the context of his theory of fundamental bisexuality, Freud used the term "female" to indicate passive and "male" to indicate active with the understanding that both trends are found in men and women alike (Freud, 1905). Feminine masochism is possible for any human being regardless of gender.

The third, and according to Freud, most observed form of masochism, he termed "moral masochism". It was here that he extended the notion of masochism beyond the scope of overt sexual behavior and laid the theoretical foundation for subsequent discussions of the masochistic character.

Freud described moral masochism as a derivative form of masochism where the subject, because of an unconscious sense of guilt, seeks out a position of victimization or suffering, without any sexual pleasure being directly involved. I want to emphasize this latter point because it contrasts with the frequent misunderstanding that the masochistic personality receives some pleasure from pain. Moral masochism describes not a sexual perversion (which may or may not be associated), but rather a pervasive pattern of personality functioning in which the subject unconsciously seeks people and circumstances which bring emotional suffering, defeat, and injury.

A great deal has happened in psychoanalytic theory since Freud. "Freudians" themselves have picked and chosen which aspects of his theories to maintain and elaborate. In this country, for example, the concept of the "death instinct" has largely been abandoned and the role of unconscious guilt in masochism highlighted. Clinical case presentations and discussions in the mainstream psychoanalytic literature have continued to emphasize the role of masochistic suffering as an atonement for unconscious guilt, typically related to

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forbidden libidinal and aggressive drives surrounding the Oedipal conflict. However, perhaps the central legacy of Freud's work on masochism is the broadening of the concept from a sexual behavior to a personality formation.

Post Freudian Perspectives

Post-Freudian theoretical perspectives such as ego-psychology, object-relations theories, and self-psychology have sometimes included, sometimes offered counterpoint to, and sometimes run in opposition to Freud's drive/structural model. Nonetheless, there appears to be widespread agreement that "masochistic character" is a viable, common, and important syndrome which can be described in terms of a pervasive, explanations vary in focus and are often in disagreement. The disagreement has to do with why and in what way suffering offers something to the person.

The importance of unconscious guilt which has so much prominence in the classical psychoanalytic theory has become the center piece of the Control-Mastery Theory developed by Sampson and Weiss (1986). This theory focuses on the role of grim, irrational pathogenic beliefs which are formed early in life. Typically, these involve a conviction that it is disloyal, unloving, and even destructive to one's parent(s) to fully individuate from them and especially to have a better life than they might have had. In this account, masochism emerges as unconsciously motivated self-sabotage to avoid the possibility of having a such a life, or alternately as unconsciously motivated self-punishment to atone for the guilt in having achieved such a life.

From a quite different perspective, we have the developmental theories of Kohut's Self Psychology. This theoretical model emphasizes the twists and turns in the development of healthy narcissism and the patient's attempts to use others as "self-objects" which function in generating and maintaining a stable and consistent sense of self. Drawing on this theory, Stolorow and others have emphasized the narcissistic function of masochism in maintaining self-cohesion and boundaries (e.g., Stolorow, 1975). In Kohut's theory, an individual who suffers from defects in internal structures that maintain and regulate the self-representation may mobilize one of two primitive narcissistic configurations to restore a stable and positive sense of self. The first involves

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a merger with an idealized, omnipotent self-object. Stolorow suggests that the masochist's hunger for such an idealized powerful person to serve as a source of sustenance and to substitute for missing segments of the psychic structure may be what binds the masochist to the powerful, dominant sadist, The second maneuver described by Kohut involves creating a fantasized identity between the individual's actual self and the primitive grandiose self. Stolorow suggests that the masochist may accomplish this through an unconscious identification with a sadistic, abusive partner, thereby vicariously sharing the latter's exhilaration in power.

Regarding object relations theories, as you know, this is an umbrella term for a collection of extremely diverse ideas and perspectives. One might say in general; these theories have depicted masochism as a particular means of relating to actual persons in the present in the service of maintaining attachments to internalized others from the past. Albeit at a very high cost, masochism preserves the past in the present.

Before going on, let me pause to say that I suppose I am like many of us in the field who are seeking or at least would prefer a unified psychoanalytic theory that would be consistent and have strong explanatory power for all of our work with all of our patients. However, we often feel that we operate in a world of blind clinicians describing different aspects of the clinical elephant. And sometimes a particular theory seems to fit a particular patient better or at least be more helpful in guiding effective therapeutic interventions. In that sense I find some value in each of these perspectives, and I am disinclined to pronounce any true or false. Nonetheless, I can say that themes that have emerged in my clinical work so far have often leant support to the object relations theories linking attachment and masochism. So, allow me to speak further about this perspective.

Perspective from Fairbairn and Berliner

The classical psychoanalytic position that "libido is pleasure seeking" leads to the view that the infant forms attachments only out of the necessity in order to gratify its libidinal strivings. In the 1940's Ronald Fairbairn (1943), a Scottish psychoanalyst, made a seminal contribution by turning this on its head and proposing that "libido is essentially

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object seeking" rather than pleasure seeking. This is in line with an ethological viewpoint, that the infant naturally seeks attachments, and this search is rooted in an instinct for the conditions that will insure survival. The human infant depends on attachments for longer than any other creature. The recent infant research reported by Daniel Stern in *The Interpersonal World of the Infan*t (1985) appears to support this view. Unlike Freud and Mahler's infant who emerges from "primary narcissism" or "normal autism" reluctantly and only as a necessary compromise, Stern's infant arrives on the scene with capacities and desires to engage, connect with and attach to the primary caretaker.

This becomes an important shift with regard to masochism. If libido is pleasure seeking, then it becomes rather a difficulty in identifying just where the pleasure might be in a masochistic relationship. Freud had ultimately handled this by viewing masochism not in terms of "pleasure in pain" as is sometimes misconstrued, but rather in terms of pain as a condition for pleasure. However, if libido is essentially object seeking, then whether the nature of the attachment is essentially pleasurable or essentially unpleasurable becomes a different matter and we should not be surprised that children and adults can be quite attached to mistreating others.

In a series of highly influential and frequently quoted papers written in the 40's and 50's, Bernard Berliner (1958) extended the theme of masochism as an adaptive defense functioning in the realm of object relations. He attributed the genesis of the masochistic character to a particular kind of parent-child relationship in which the child received cruelty and rejection rather than love and affection. He proposed that masochism is neither an instinctual phenomenon related to the death instinct, nor the expression of a component of the sexual drive. Nor is it the result of the subject’s own sadism turned round on the self for reasons of unconscious guilt. Rather, it is the sadism of another person, an early love object (usually a parent) that has been turned on the self by way of introjection and identification.

According to Berliner, masochism is "a disturbance of object relations, a pathologic way of loving. Masochism means loving a person who gives hate and ill treatment". Thus, Berliner underlined the pre-Oedipal function of masochism as a defense against

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object loss which would otherwise overwhelm the individual with anxiety. But let us stop a minute to think of what all these terms actually mean.

The infant/child is absolutely dependent physically, emotionally, and psychically on the adult caretaker(s). Nowhere is the power imbalance between two persons greater than that between infant and caretaker. Usually the caretaking is "good enough" (as we say) and characterized by reasonably sensitive responses on the part of the caretaker. We even speak of "optimal failures" that give the infant/child a tolerable degree of frustration and thereby help fuel development.

But what happens if the infant/child is in a subtly negligent or overtly hostile caretaking environment? The infant has few options. One way of adapting is to develop a masochistic style of relating. This means to accept a position of pain, suffering, abuse, and victimization as the condition of proximity and attachment to the caretaker. Under these circumstances, the basic relational prototype of self/other internalized by the infant is one in which attachment and love become fused and/or confused with mistreatment and hate.

Such relational masochism is the best attempt by the infant to adapt to the sadism of the caretaker. It is motivated by the need for love and protection, needs which are basic for survival. Incidentally, such responses are well documented in studies on the "Stockholm Syndrome" in which adult hostages begin to attach and identify with the vision of their captors.

To come at this from a slightly different direction, we might ask what becomes of the infant/child's sense of goodness under circumstances of cruel parenting. Many clinicians have noticed that self-deprecation reflecting a sense of core inner badness is characteristic of the masochist. Fairbairn (1946) offers us something poetic here:

> ...it is better to be a sinner in a world ruled by God than to live in a world ruled by the Devil. A sinner in a world ruled by God may be bad; but there is always a sense of security to be derived from the fact that the world around is good. In a

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> world ruled by the Devil, the individual may escape the badness of being a sinner; but he is bad because the world around him is bad. Further he can have no sense of security and no hope of redemption. The only prospect is one of death and destruction. (The Repression and Return of Bad Objects).

For the infant to have any sense of security, safety, and protection, not to mention hope, it is necessary to sustain an illusion of the caretaker as "good", and therefore to account for received cruelty as an indicator of its own "badness". Thus, an important part of the masochistic enactment is an underlying sense that one is somehow deserving of poor treatment, and often reflected in self-deprecation.

Difficulties in Treatment

Masochism cannot be diagnosed on the basis of a descriptive list of presenting problems; one needs to be much more familiar with the patient's psychodynamics. Nevertheless, there are some common or typical elements of presentation. These patients most often present with a diffuse sense of depression and hopelessness. Very often it comes to center on some specific life circumstances involving love or work. Two of the most common presentations reflecting masochistic trends are: 1) the patient who presents pattern of self-sabotage or underachievement, 2) the patient who presents a pattern of abusive or cruel relationships. Their stories might be expressed with a sense of passive resignation or, by contrast, with an attitude of righteous indignation and anger regarding the unfairness and unjustness of life. The patient in either case expresses the impossibility of change and improvement and perhaps depicts a long history of failed attempts. Some patients have recognized the possibility that they play an active role in their suffering because the accumulation of evidence is inescapable. Nonetheless they feel powerless to understand or stop this. Others have no conscious sense of agency and proclaim their victimization at the hands of others. I have the impression thus far that men are more likely to present with stories of self-sabotaging inhibitions or anxieties around work, and women more likely to present embroilments with uncaring or hostile abusive men. No doubt cultural considerations both influence and support these dynamics and, of course, there are many exceptions.

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From the object relations viewpoint, we can predict some difficulties in treatment which follow from masochistic dynamics. Principally, we might consider that relational masochism is a survival strategy and as such will not be given up by the unconscious without significant anxiety being aroused and mastered. For the patient to progress in treatment and in life is to directly oppose a primitive unconscious survival strategy. This is not easy, nor does it follow simply from therapists' educational interventions, exhortation, encouragement, or even from insight. It requires a lengthy working-through which might be conceived of as a mourning process, which proceeds slowly, in incremental steps, and with feelings of loss which can seem unbearable.

Furthermore, if we consider Fairbairn's remarks regarding the benefits of being a sinner in a world ruled by God, we see another complication. If the infant/child, faced with the cruelty and rejection from the caretaker, has internalized a sense of badness to preserve the hopeful illusion of some parental goodness, then the aims of treatment must lie in reversing this. For the self to emerge as good, the badness must be "returned" to its original place in the internalized parent. This leads in several directions. To begin with, it means giving up an infantile sense of security and hope. If the self is bad and the other is good, "tomorrow is another day" holding the possibility that the self will become lovable with the right sort of effort. We see something of this in the dynamics of so-called co-dependent. They believe that if they could only somehow find and do the right thing, the partner would change from bad to good. This is a good deal easier to live with than to accept that you may never get what you want or need from the other and that this is simply very sad. I am often surprised at the power of this dynamic, the deep resistance to truly glimpsing the cruelty of the parent. How deep this goes is not at all obvious, can easily be obscured by the manifest activities of the patient who may spend much time describing how bad the parent is.

Case Illustration

A woman in her mid 20's is referred for treatment by after her boyfriend attempted to shoot her, firing and narrowly missing her before running off. At the beginning of therapy, she cannot believe how such a "good man could have been driven to such bad

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extremes”. What could she have done differently, she asks? Over the course of months of work, he emerges as not so good after all, and in fact she has managed to make excuses to herself for him all along rather than heed the warning signs present from the beginning. You won't be surprised to hear that both of her parents were quite hostile to her, and her father especially was openly abusive both verbally and physically. She presents as a tough woman with a stoic exterior. She is gradually able to express a great deal of anger toward her boyfriend and father for their mistreatment and one could easily believe this to be an indicator of progress or at least a sign that the badness is being returned to its rightful place. At the same time, her views on men slowly emerge. Men are all bad she convinces me with example after example; it's just a matter of time until you find out (my turn has not yet come but I imagine it will). I inquire about this belief, how she has come to it, what bears it out and what doesn't. At times I gently challenge it. After some time, we learn that now and then she has run across a few good men, but for one reason or another, she hasn't been too interested. She then mentions an exception, a man in her office who has recently offered her financial help and seems to have no ulterior motive. He has even invited her to dinner along with his wife. As she tells me this her tough, angry facade gives way for the first time in therapy and she is overcome with grief. Allowing herself to notice that there are good men highlights how much she missed from her own father. If she can maintain that all men are bad, and as long as she can link up with them, she in effect preserves an unconscious positive attachment to her father and avoids the tremendous grief of mourning the absence of a good father, in effect telling herself: "since they're all bad, he wasn't especially bad". I find it particularly important to emphasize that this unconscious positive attachment to her father persisted in a powerful manner despite her constant criticisms of him. However, the cost of maintaining this positive attachment is to live and love in a world populated by abusive men. To change this world, to discover a world in which there are at least some good men, her unconscious preservation of her father will need to be reversed, and this will entail a significant period of mourning as heralded by her sadness.

Countertransference Issues

These patients tend to mobilize very strong reactions in the therapist. There is frequently a pull to empathize with the patient in a way that colludes with their sense of

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being passive victims of unjust situations. On the other hand, this pull may be resisted by the therapist by going too far in the other direction with moralistic attitudes that "blame the victim". A middle ground must be found which empowers the patient by helping them discover their own active role in their predicament, but which also includes compassion and understanding of masochistic enactments as an attempt at adaptation. Blaming the victim is bad therapy; helping the patient understand their own role in victimization is good therapy.

If the patient has an investment in masochistic enactments, this will eventually play out in the transference relationship. This may involve subtle invitations for the therapist to become moralistic, domineering, critical, and sadistic. Some of these patients can become what Edmund Bergler (1982) termed "grievance collectors" in order to portray themselves as victims of the therapist's abusiveness**.** Perseverance and appreciation of the patient's full dynamics is called for.

An important related issue in the treatment of the masochistic patient is the Negative Therapeutic Reaction. This seemingly paradoxical phenomenon was originally noted by Freud (*The Ego and Id*, 1923) and refers to the patient who gets worse in therapy and suffers more, particularly following some actual advance in the treatment. One might regard it as fear or guilt over success in the context of the therapy itself. The patient makes some progress and then regresses, in attempt to manage the guilt or anxiety which accompanies breaking away from the internalized abusive parent. Freud observed that these patients "dreaded" recovery. This can be very trying for us as therapists. It is easy to be pulled into frustrated anger, clinical resignation, or greater attempts at rescue when what is needed is interpretation, working through, and a great deal of patience.

**References for this and all other presentations are listed on a separate PDF*

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