REGULAR ARTICLE

Psychotherapeutic Approaches to Masochism

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Self-defeating personality disorder (SDPD) is quite well defined in the appendix of DSM-III-R, and preliminary research indicates that it is a robust entity with a high prevalence. The hallmark of the SDPD or masochistic character is the mechanism of "injustice collecting," a behavioral syndrome that can be readily identified. However, a number of special difficulties arise in the treatment of SDPD. These are identified, and techniques for handling them are described. A knowledge of the psychodynamics of this disorder is at least helpful and probably necessary to conduct successful psychotherapy.

Patients whose lives are characterized by behaviors that result in seemingly needless disappointment, defeat, and suffering form a significant portion of psychotherapeutic practice. These patterns of self-inflicted, self-defeating behaviors have been of interest to psychiatrists at least since the work of Krafft-Ebing in 1895.[1] He coined the term *masochism*, giving credit to Leopold von Sacher-Masoch, who in his novel *Venus in Furs*[2] described a man who ruined his life through his enthrallment to a woman. The 1931 movie *The Blue Angel*, directed by Josef von Sternberg and featuring Marlene Dietrich and Emil Jannings, adapted from the book of Heinrich Mann, similarly described the total enslavement and humiliation of a self-respecting schoolteacher when he becomes infatuated with a nightclub singer.

Freud adopted Krafft-Ebing's term *masochism* to describe two related, but different, psychic situations. In his early writings he was primarily concerned with perversion masochism,[3] in which there is a clear conscious sexual pleasure that accompanies painful experience, whether the pain is self-inflicted or not. He later took up the problem of moral or psychic masochism,[4] in which the individual relentlessly pursues psychologically pain-

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ful, humiliating, or self-defeating outcomes and seems to avoid opportunities for pleasure and success. In these instances, sexual satisfaction is usually not a component of the overt behavior patterns. Freud puzzled over these curious reversals of the pleasure principle and suggested in the course of his work a variety of possible explanations.

Although Krafft-Ebing and Sacher-Masoch before him had described this behavior in male patients, Freud and some of his followers, noting the passivity that seemed so much a part of the character structure of masochistic individuals, assumed that this passivity represented a feminine characteristic and, through this logic, regarded masochism as a feminine trait. Helene Deutsch, in particular,[5] emphasized masochism as innate to femininity and related to the sexual experience of being penetrated and the painful circumstances of giving birth. The error of equating passivity with femininity was pointed out quite early[6] in the psychoanalytic literature but persisted until the feminist critique of the past several decades put to rest that unfortunate culturally determined misunderstanding.

More recently, residues of this heritage linking masochism and femininity led to fierce debate over the inclusion of the category of "Masochistic Personality Disorder" in DSM-III-R. Feminist clinicians feared that such a category would be used prejudicially against women, would put the blame on women when they were the objects of abuse by men, and would lead the judicial system toward exoneration of men guilty of violence against women.

In an attempt to reach a compromise over these concerns, the framers of DSM-III-R agreed to drop the term *masochism* because of its earlier psychological linkage with femininity, and they substituted the term "Self-Defeating Personality Disorder" (SDPD). Furthermore, the description of this syndrome was placed among the "Proposed Diagnostic Categories Needing Further Study."[7]

DESCRIPTION OF THE SYNDROME OF SELF-DEFEATING PERSONALITY DISORDER

The DSM-III-R criteria follow:

A. A pervasive pattern of self-defeating behavior, beginning by early adulthood and present in a variety of contexts. The person may often avoid or undermine pleasurable experiences, be drawn to situations or relationships in which he or she will suffer, and prevent others from helping him or her, as indicated by at least five of the following:
   1. Chooses people and situations that lead to disappointment, failure, or mistreatment even when better options are clearly available.
   2. Rejects or renders ineffective the attempts of others to help him or her.
   3. Following positive personal events (e.g., new achievement), responds with depression, guilt, or a behavior that produces pain (e.g., an accident).
   4. Incites angry or rejecting responses from others and then feels hurt, defeated, or humiliated (e.g., makes fun of spouse in public, provoking an angry retort, then feels devastated).
   5. Rejects opportunities for pleasure, or is reluctant to acknowledge enjoying himself or herself (despite having adequate social skills and the capacity for pleasure).
   6. Fails to accomplish tasks crucial to his or her personal objectives despite demonstrated ability to do so, e.g., helps fellow students write papers, but is unable to write his or her own.
   7. Is uninterested in or rejects people who consistently treat him or her well, e.g., is unattracted to caring sexual partners.

8. Engages in excessive self-sacrifice that is unsolicited by the intended recipients of the sacrifice.

B. The behaviors in A do not occur exclusively in response to, or in anticipation of, being physically, sexually, or psychologically abused.

C. The behaviors in A do not occur only when the person is depressed.

There have been an increasing number of empiric studies of self-defeating personality disorder during the past several years. These studies are the subject of an exhaustive review by Fiester[8] in which she concludes:

> Data from existing studies show a relatively high prevalence, slightly higher female:male sex ratio, good internal consistency, significant overlap with several other personality disorders (particularly borderline, dependent, and avoidant personality disorders), some possible inherent sex bias in the criteria, an apparent lack of sex bias in the application of the criteria by clinicians, and lack of differentiation of patients with SDPD from patients with other disorders in terms of demographic factors other than gender. (p. 207)

Fiester concludes that the research is not yet adequate to decide upon its inclusion in DSM-IV.

In this article the terms *self-defeating* and *masochistic* will be used interchangeably. Masculine pronouns will be used in generalized references to therapists and patients.

Theories of Masochism

The psychodynamic and psychophysiologic understanding of the ways in which people can derive pleasure or satisfaction from painful circumstance, or are, at least, more comfortable with defeat than with success, has been a topic of major significance since the very beginnings of psychoanalysis. I have elsewhere[9] reviewed our clinical knowledge of and theoretical constructions for an understanding of masochistic behavior, and I will not detail them here. The chief explanations of such behavior, generally stated, are as follows:

1. Attitudes of passivity, harmlessness, and nonaggression are unconsciously adopted as a defense against dangerous competitive impulses and fear of retaliation.
2. Suffering, helplessness, and defeat represent a cry for love and are unconsciously intended to ensure loving care, which is otherwise perceived not to be available.
3. Early, severe, inescapable painful traumas lead to defensive efforts to cope with the trauma by learning to enjoy it, adopting it as one's own.
4. Early injuries to the infantile sense of omnipotent control are adapted to defensively by the fantasy of control over disappointing, powerful parents and by defensively claiming the disappointment as directed by oneself.
5. Experiences of pain result in endorphin release in the attempt to ease the pain, and one becomes self-addicted to endorphin release, pursuing painful events for this end.[10]
6. Children reared under abusive conditions nonetheless attach to their abusing caretakers. For these persons with damaged self-esteem and fears of abandonment, maintaining the safety of familiarity takes precedence over potential pleasure that entails the anxiety of the new.
7. The Lesch-Nyhan syndrome, in which, among other things, children are born with what seems to be a defective capacity for experiencing protective pain responses and engage in severe self-mutilating behaviors, has been suggested as a biologic analog for psychological self-inflicted pain.[11] There is, however, no evidence that would con-

nect the two quite different conditions.

These explanations are not mutually exclusive, and it is likely that in every masochistic individual there is an amalgam of several of these attempts at adaptation, with one or another group of defense mechanisms predominant in a particular patient. However, except for the suggestion about Lesch-Nyhan syndrome, all of these explanations share the view that individuals who develop SDPD were, at least in their own perception, the victims of unempathic or abusive childhood settings, and clinical experience would seem to confirm that abused children are prone to develop sadistic and masochistic relationships in later life. Again with the exception of the Lesch-Nyhan syndrome, all of the explanations posit early failure to support the child's budding self-esteem and to provide the atmosphere of safety required for adequate development of healthy narcissism and assertion.

As I shall attempt to demonstrate in this article, the understanding of masochism is enhanced by understanding the narcissistic roots of the masochistic defenses that lead to self-defeating behavior.

The Narcissistic-Masochistic Personality Disorder

Although the DSM-III-R description is generally in accord with clinical experience, it can be enhanced by providing a richer clinical texture and an attempt to understand the psychodynamics that are part of the behaviors. My description will be colored by my conviction that masochism is a variant of narcissistic personality disorder and that in every masochistic patient one finds prominent narcissistic traits. I have in a series of papers suggested that self-defeating or masochistic personality disorder is best understood as a constellation involving narcissistic and masochistic conflicts[9,12,13] and is more accurately classified as "Narcissistic-Masochistic Personality Disorder."

Very briefly, masochistic patients are those who as children were especially intolerant of the hurts to their self-esteem that regularly accompany frustration or who experienced an actual excess of such hurts. An excess of shame and experiences of humiliation are important components of the psychic experience of these patients as children.[14] Rather than admit to the defeat, or to the state of relative childhood helplessness, or to the need for the benign intervention of others to provide their satisfactions, these children resort to a special defense. In effect, they deny their childhood helplessness by claiming control over their frustrators, especially the mother of the pre-oedipal period, inwardly asserting that the frustrations were delivered because the child forced the parent to do so. What's more, the child claims to be so powerful that the parent cannot really hurt him because he enjoys the injury that has been suffered, and if he does feel hurt it proves the extraordinary power and malice of the parents who are mistreating him. All of this goes on out of awareness and arouses its own guilty responses, requiring the conscious denial of pleasure in pain through exaggerating the feelings of hurt, thereby proving the child's own innocence of self-defeating intentions.

Phenomenologically, behind a thin facade, these patients behave as if motivated by a need for defeat and victimization, and they pursue humiliation and defeat. Success seems to make them uncomfortable, whereas they experience a sense of act completion, the sense of an ending, when finally they feel hurt. With the feeling of victimization, the drama has come to what feels to the masochist like an appropriate and expected ending—as with the child who comes to the end of a favorite fairy tale whose ending he knows very well—and there is a sense of familiarity, relief, and closure. One can now go on to other things.

It is implicit in the definition of all personality disorders or neuroses that they handicap adaptation. What is specific to the masochist is a pursuit of failure in one or

several areas of psychological function that goes beyond the ordinary accompaniments of maladaptation. These are individuals who unfailingly succeed in snatching defeat from the jaws of victory and seem unable to recognize occasions for enjoyment or self-reward. Self-defeating personality disorder is distinguished from the accidental consequences of psychological maladaptation by an unconsciously determined desire for defeat, shame, self-pity, humiliation, and secondary righteous indignation. Masochists arrange their lives for unhappiness. A man who loves sex marries a frigid woman, setting the stage for decades of bitter complaint. A woman is told that Mr. A. is a womanizer; she meets him and falls in love, and he is a womanizer, and she suffers.

Masochists exaggerate their defeats and minimize their successes. A patient who had just won a significant prize in his field found himself far more concerned with the nastiness of the cab driver who took him to the award ceremony than he was with the award. Incidentally, this little vignette points up that masochistic patients may do very well in some sectors of their lives, but if they do, they will drain their success of much of its pleasurable quality. The pain-pursuit of these patients leads them to avoid usually pleasurable experiences or at least not acknowledge the pleasure that would seem to be in order.

The self- and object-representations of the masochist deserve note. These individuals assume that all objects close to them exist as a source of frustration and malice. In effect, they use their relationships in the external world to produce endless duplications of the refusing, cruel pre-oedipal mother that dominates their internal world. Some masochistic patients will acknowledge that there are good, giving persons in the world, but feel it is part of the special bad luck with which they are cursed that these people are not part of their world. Internally, the masochist simultaneously or alternately maintains a double fantasy; one of himself as controlling and extracting secret pleasure from the actions of malignant others who wish to harm him, and another of himself as innocent child victim of malicious parents who might love him if he is submissive. These internal representations of objects are matched by a self-representation that includes the disagreeable knowledge that the patient is incapable of the self-esteem that comes from the inner conviction that one is capable of giving oneself the pleasures that one craves. The masochist does not regard himself as a reliable provider of satisfaction. He lacks the capacity for adequate appropriate assertion in the world, and his aggression is generally confined to inner anger or self-defeating expressions of aggression in the wrong place, at the wrong time, against the wrong people.

Self-defeating individuals are also great blamers, and whereas they are capable of wallowing in self-pity and debasing themselves with an excess of self-blame, when you examine this more carefully, they are always blaming someone else. For example, an isolated man who believed he was unlovable because his body was so unattractive that he couldn't blame anyone for running from him, at a slightly deeper level blamed his mother for having cursed him with his unacceptable body. Incidentally, this was all part of an inner fantasy; his body was in no way abnormal.

As one would expect of a group of severely narcissistic patients, self-defeating patients may be extremely self-centered. Some masochistic patients who seem overtly self-sacrificing, unassertive, empathic, and nice will, on closer examination, prove to be interested primarily in their own special suffering and resentment and to have limited empathy. A man who was regarded by his friends as the most understanding and "nicest" person in their circle confessed to his utter boredom with his friends' troubles, but he was too passive and frightened to try to shut anyone up. He did, however, enjoy the reputation he had of being a special person in his group. Masochistic patients are convinced of the special quality of their suffering—no one else

endures as much as they do.

Their covert narcissism is often disguised behind their passive depressive stance, and Walter Mitty-type fantasies of greatness and specialness and revenge are revealed after one gets to know the person better. They frequently have fantasies of being specially victimized in ways that will bring them finally to the attention of the cold uncaring outside world. These patients may have fantasies of suicide, or of being prey to a deadly disease, but the major content of these fantasies is that finally others will know how much they have suffered. They are in general not suicidal risks.

Finally, a word about the operations of conscience in masochists. As with all narcissistic patients, their superegos are deformed—both excessively harsh and corrupt. They suffer severe pangs of shame and guilt for every shortcoming and failure to achieve perfection, as well as for the anger they feel against those they are close to, and this guilt leads them toward further self-punitive actions. Because these self-punishments are accompanied by some degree of secret satisfaction, they further incur the wrath of conscience for indulging in such forbidden pleasures. Whereas some self-defeating persons torture themselves with hyperscrupulosity, a technique that allows them to make hidden fun of their educators and prove that all rules are ridiculous and designed to prevent any pleasure, another group may flout the rules of society, but in ways that guarantee their being caught and punished, further adding to their burden of suffering. In both cases, it is as if inner conscience did not act to prevent the damaging action but appeared on the scene only for the sake of punishment. Self-reward and self-soothing seem not in the repertoire of the severe masochist.

Edmund Bergler[15,16] suggested some years ago that the clinical sequence that he labeled the "mechanism of injustice collecting" is paradigmatic for the masochistic character and that understanding the mechanism of injustice collecting is the key to recognizing the masochistic character. There are three steps to this sequence of injustice collecting.

1. Either through his own provocation or by his misuse of an available opportunity to personalize one of life's regularly expectable unfairnesses, the masochist arranges to experience disappointment, rejection, and humiliation. He is totally unaware of his role in engineering his misfortune and experiences great pain.
2. Having garnered the unconsciously sought-after injustice, the masochist responds with righteous indignation and defensive rage against the refusing or humiliating object. Close examination, however, reveals that the rage is not genuinely intended to right a wrong or to gain a victory; rather, its purpose is to demonstrate to his own accusing inner conscience that he was not guilty of the charge of having wished for and provoked the injury and the even worse accusation that he enjoyed the injury: "How can anyone believe that I enjoy defeat? Look how furious I am at my enemies." Because the motivation of this rage is the desire to quiet conscience, rather than to achieve positive goals in the external world, the expression of the anger is often inappropriate in timing and magnitude, thus leading to further actual defeats.
3. After the defensive aggression peters out, the person succumbs to depression and self-pitying feelings that "This only happens to me."

A trivial example of injustice collecting:

A man tells his wife that he is not sure what time he is coming home that evening. He arrives earlier than usual and feels disappointed that his wife is not home. When she arrives a half-hour later he berates her for not having been there. She feels unjustly accused and is angry in turn,

another evening is ruined, and he mopes through the evening obsessing about how he could have made such a bad marriage.

Masochists take personally what less neurotic individuals accept as ordinary, lending a certain paranoid quality to these patients. A more substantial example:

A lawyer who has been warned repeatedly because he is late with briefs and documents receives a smaller bonus at the end of the year than some of his colleagues. He is enraged and indignant and conveys this to the senior partner, who tells him that if he is not happy at the firm perhaps he should leave. He quits on the spot—in the middle of a recession—and lapses into a self-pitying depression over his bad luck, realizing the mess he now is in.

My clinical experience indicates that this three-step mechanism of injustice collecting that Bergler described is indeed paradigmatic for patients with SDPD. All of us engage in this technique at some time or other, to some degree, but the masochist makes it his life's work. The mechanism of injustice collecting serves not only as a marker for SDPD, but also as an indicator of the powerful narcissistic component that enters into self-defeating behaviors.

The mixture of narcissistic and masochistic defenses complicates the treatment because the patient perceives even the need for help as a blow to his fragile self-esteem. Every interpretation of the patient's self-defeating behavior, no matter how carefully phrased, will arouse in the patient a feeling of shame and wounded pride and personal injury, either because the interpretation means that the therapist figured something out that the patient could not and the patient is being "one-upped," or because the interpretation, no matter how gently it is phrased, implies that the patient's behavior has been both irrational and infantile, and the patient is being humiliated. These narcissistic injuries in response to interpretation form one aspect of the negative therapeutic reaction discussed below. Whereas interpretation of masochistic behaviors elicits narcissistic defenses, interpretation of narcissistic defenses elicits masochistic defensive behavior. Helping the patient to understand the secret pride and pleasure in his suffering may lead the patient to create new defeats and new heights of suffering in his effort to prove that he cannot be accused of wanting to be the victim that he seems always to be. This alternation of masochistic and narcissistic defenses contributes greatly to the complexity and unavoidable lengthiness of these therapies.

As in all personality disorders, there is every gradation from mild to severe. In the severe cases, the patients give the impression of a relentless pursuit of self-destruction from which they cannot be deflected—even by psychotherapy or analysis. The milder cases are compatible with considerable success in life, with some sectors of the personality relatively immune to the effects of the disorder. However, even when aspects of life are outwardly successful, there is a damaged inner capacity for pleasure in the accomplishment. Like all narcissistic patients, these ostensibly successful people often have little capacity for self-reward and require the applause and admiration of others to make their achievements meaningful to themselves. But because other people are basically always the depriving enemy, these rewards are never large enough.

When treating masochistic patients, it is necessary to bear in mind that the suffering of the masochist is no less authentic for its being unconsciously pursued and enjoyed and used as a source of narcissistic inflation. The provocation and sometimes barely hidden relish of their self-pity may tempt one to forget the genuine misery of these patients.

TREATMENT

Self-defeating patients often present initially with an acute depression or anxiety related to a crisis they have created, such as provoking a spouse to threaten to leave or creating difficulties at work, and they seek help to quickly

resolve a real situation or get some relief from their symptoms. Crisis interventions can be extremely effective in relieving these patients of temporary peaks of illness, especially at the beginning of treatment. Reassurance and preliminary interpretation may bring very rapid relief. Usually, however, this relief is quite temporary. This positive response is in part a tribute to the better adapted health-seeking aspect of the patient, but it also represents a defense and later resistance in the therapy, as the patient demonstrates that there was never anything wrong with him that kindness couldn't cure. Therapists can be lured into believing that they have an "easy" case on their hands when they see how quickly the patient responds to therapeutic interventions. However, when there is a history of significant self-defeating behavior and injustice collecting, one can be reasonably certain that the "honeymoon" will not last and treatment will be prolonged and taxing.

These treatments may be especially painful for both patient and therapist. I will try to give examples of kinds of behavior that are common in the treatment of these patients.

The Negative Therapeutic Reaction

In 1923 Freud[17] said,

> There are certain people who behave in a quite peculiar fashion during the work of analysis. When one speaks hopefully to them or expresses satisfaction with the progress of the treatment they show signs of discontent and their condition invariably becomes worse. One begins by regarding this as defiance and as an attempt to prove their superiority to the physician. But later one comes to take a deeper and juster view. One becomes convinced, not only that such people cannot endure any praise or appreciation, but that they react inversely to the progress of the treatment. Every partial solution that ought to result, and in other people does result, in an improvement or a temporary suspension of symptoms, produces in them for the time being an exacerbation of their illness; they get worse during the treatment instead of getting better. They exhibit what is known as a "negative therapeutic reaction." (p. 49)

Freud ascribed this to an unconscious sense of guilt.[18] Example:

> A 29-year-old banker entered treatment because of his increasing realization that, although he is unusually able and competent, he manages to make a bad impression at critical moments, displaying himself as anxious and uncertain and spoiling his chances for promotion to a more responsible position within the firm. He complained bitterly that he worked harder than anyone else, was on the brink of exhaustion, and was unappreciated. As we explored these behaviors and feelings he became more aware of his angry competitiveness with peers, its relation to his feelings toward his siblings during his childhood, and the degree to which this anger frightened him and made him feel guilty. After a brief moment of relief and gratitude that he could now more comfortably face something that he had to some degree already known, he became depressed and angry at me, convinced that I had called him a bad person for being so full of anger and that I must now hate him. Furthermore, I had misunderstood the problem—he didn't work harder than anyone else; in fact, he didn't work hard at all. He was convinced that it was hopeless for us to continue to work together since I so totally failed to understand him. Episodes such as this were repeated innumerable times in the treatment, often having the intended effect of leaving me feeling confused and helpless.

Another patient, in response to every interpretation or clarification, would respond with initial interest ("I never thought of that before"), would begin to elaborate how that view helped him to understand some of his behavior, and then would appear the next day looking depressed and would say, "I was thinking about what you said. It doesn't help me. And it wasn't very nice to

hear that I have yet one more fault."

Negative therapeutic reactions tempt the therapist to angry retaliation, bullying, feelings of confusion, and a sense of being unskilled. It is of enormous help to recognize the use and the unconscious meanings of negative therapeutic reactions and to see that they can be brought within the patient's coping capacities as he begins to understand them. The therapist's sympathetic but dogged persistence is essential in helping the patient gradually to begin to side with the therapist and accept the aid that is offered.

It is important to make every effort to interpret the occurrence of negative therapeutic reactions, bringing them into the transference. This enables the patient to begin to see that the sense of hopelessness and depression is occurring in relation to positive events in the treatment, and especially in response to helpful interactions with the therapist. The mere fact that the therapist persistently regards the patient's negative reactions as something that can be understood helps to begin to modify the internal qualities of the harsh superego that previously demanded punishment whenever pleasurable possibilities arose. The patient can begin to grasp that it is possible to carry on an inner argument with that portion of his superego that flatly denies the patient his right to pleasure. The therapist's attitude also brings to the patient's attention the angry, hating components of the negative therapeutic reaction—the demands for reparation and vengeance before pleasurable capacities can be admitted.

Finally, a word of caution. Patients can respond with what seems like a negative therapeutic reaction to the therapist's faulty understanding of them. The simple fact that a patient has a regressive reaction to an interpretation does not, however, justify labeling it a negative therapeutic reaction. One must first be reasonably sure that the patient is not responding to countertransferential insensitivity, empathic failure, or unconscious attack on the part of the therapist. A therapeutic attitude of considerable self-scrutiny is highly desirable when treating masochistic patients because their provocative capacities tend to bring out the worst in their therapists.

Damaged Capacity for Positive Identification

It is a crucial component of all psychotherapy that the patient have some ability to form a positive attachment—a positive transference—to the therapist. All forms of psychotherapy, from behavioral to psychoanalytic, probably depend significantly upon the capacity to internalize some aspects of the therapist as a figure who is loving and who can be loved, or idealized, or emulated. One of Kohut's[19] major contributions was to recognize the hidden elements of positive transference in those severely narcissistic patients who seemed detached from the therapist and the therapeutic process. Many masochistic patients are equally detached because of their narcissistic pathology, and in addition they use almost all interpersonal transactions for the purpose of demonstrating that they are perpetually frustrated, refused, and unappreciated. This inner need to prove their victimization within the treatment situation can dominate the transference and is a significant deterrent to the formation of positive attachment to the therapist or to the treatment situation. Example:

A patient relates that she had been very bothered by my greeting her in the hallway and holding the office door open for her rather than waiting for her to come into my waiting room. She said, "We were fighting over who was going to get to the door first and who was going to get in first." My ordinary politeness, an opportunity for her to feel that I respected her and that we shared a mutual regard, was interpreted by her as a sign of competitive aggression against her. She could not permit herself to be the beneficiary of even trivial demonstrations of kindness or respect that would bring us closer together, and she therefore reinterpreted my motives as hostile and controlling.

Some patients with SDPD report that the impending vacation of the therapist is a financial relief and a convenience and nothing more; they do not remember favors done them, and any therapeutic progress is regarded as entirely their own achievement, made in spite of the obstructions of the therapist. One patient said to me, "It gives me a creepy feeling, it makes my skin crawl to think that you are involved in my life. I'm in this by myself." Furthermore,these patients can relentlessly denigrate and devalue the therapist, reflecting their narcissistic need to eradicate all traces of superior or enviable traits in the therapist as well as the masochistic need to deny that anyone can help them. This inability to identify with the strengths and benign intentions of the therapist deprives the patient of a source of ego support that forms an important part of any successful treatment. Some analyses are unusually painful for the patient because of inability to form a positive identification with the analyst.[12]

Masochistic patients fight against their budding positive identifications because such responses undercut their conviction that all interpersonal contacts result in victimization. The challenge to the therapist is to maintain his general benevolence, i.e., his therapeutic neutrality, neither going to excessive lengths to prove his good intentions and that he is a "nice guy" nor openly or covertly berating the patient for his one-sided inability to see the therapist in any positive way. In time, the patient's own conscience becomes a source of conflict as the patient stands inwardly accused of falsifying the relationship and insisting on feeling aggrieved. As inner conscience becomes an ally of the therapist, at least temporarily, the patient can begin to experience the therapist as helper and model for identification, thus beginning to soften some of his own harsh self-condemnation.

Provocation, Conscious and Unconscious

Provocation is the stock in trade of masochistic patients, and the therapist is often astonished by the extent and ingeniousness of their provocative capacities. These are the patients who regularly pay their bills late, forcing the therapist to ask for the money, which proves that the therapist is only a money-grubber. Or after the therapist, at considerable inconvenience, changes an appointment time because the patient explained that the change was essential, the patient casually says that the old time was just as good, but he is willing to accommodate his therapist if he wants this new time. A chronically late patient once comes on time and instantly pounds on the shut office door while the therapist is still with another patient, feeling indignant that the therapist is a minute late beginning the session. A patient makes his therapy the topic of cocktail-party conversation, wildly misquoting or fabricating his therapist's remarks.

These provocations are all preludes to injustice collecting, intended to elicit aggression from the therapist; once this is achieved, the patient will overlook his own provocation and perceive himself as victimized. Patience and a sense of humor are essential in dealing with such situations. It is an error to let these situations go unnoticed, because this usually leads the patient to up the ante in his desire to achieve his grievance. On the other hand, scolding or moralizing or pleas for understanding only convince the patient that the therapist has his own and not the patient's interests at heart. It is often helpful to use interpretations of situations outside the transference, where the self-damage of his endless provocation may be more apparent. Frequently, the patient becomes aware of his disappointment in having been unable fully to engage the therapist in punitive behaviors toward him and begins to realize the unconscious intent of the provocations. A chronically late patient who began each session with a set of somewhat hypocritical apologies for the lateness and sorrow for the distress that his lateness undoubtedly caused the therapist was taken aback—and helped—by the therapist's explanation that while he was

sorry that the patient was not getting the full benefit of the treatment, he, the therapist, enjoyed the extra free time, and thus no apology was required. Of course, the patient seized on this to say that he always knew that the therapist didn't really want to see him. Although it is essential to avoid retaliation in the face of provocation, reality-testing should not be sacrificed, and patients need to understand that provocations beyond a certain point will not be tolerated.

There is also a group of masochistic patients who are excessively compliant—seemingly the opposite of provocative. Every interpretation is savored, bills are paid instantly, the attitude is always friendly—but the patient gets no better. Such patients' good behavior turns out to be part of an inner demonstration that in spite of their doing everything that is asked of them, they get nothing in return. They are not specially loved and given special treatment. Eventually, if this is not interpreted, the patient becomes overtly hurt and angry and leaves treatment.

Unconscious Demand for Reparation and Vengeance

One of the greatest obstacles to change in self-defeating patients is their unwillingness to make peace with their perceived torturers until they are convinced that those unconsciously maintained malicious internal figures from the past have made amends for the suffering that the patient feels has been inflicted on him. For many of these patients, giving up the painful life that they lead means admitting that the harm done them by parents and educators was less massive than they claim; they are not damaged beyond repair as they have insisted and partly believed. They cannot bear the thought that no one will be punished for the terrible things that were done to a poor innocent child—the patient—and no one will now make up for the suffering they have endured. Someone should pay for the crimes that were committed. This demand usually falls upon the therapist in some form—often with the bitter complaint that the therapist is insufficiently sympathetic to how miserable the patient has been and does not share the patient's view that he has been innocently victimized by cruel parents. Of course, there is no reparation that would be large enough to soothe the patient's grievance. When the patient does receive some form of apology or a gesture of reconciliation from a parent, or more usually a parent surrogate such as a spouse, he responds with a bitter sense of too little and too late. In fact, the gesture of appeasement from parent or spouse often serves only to prove that the patient is right in feeling injured; if the other person were not guilty, he or she would not try to "buy off" the patient with conciliatory gestures. Example:

> A patient, late in an analysis, described a visit to his parents' home and said, "They were genuinely glad to see me, and they can tell that I am now a much happier person than I used to be. They take great pride in my successes. And it never occurs to them that they owe me an apology for what they put me through. I know this is stupid, but I can't bear the thought that they are getting away with it. They don't even feel guilty. It made me very depressed and I ended up moping around. I could tell it bothered them, and I was glad. But they didn't seem as unhappy as I was. Finally, I picked a fight over what my mother served for lunch—the same crap that she knows I don't like to eat. I knew I was behaving stupidly but I couldn't help it. It was worth it to me to ruin the visit if it hurt them. But they were feeling fine when we spoke on the phone the next day, and I still feel like shit. I guess that's a pretty good example of my masochism in action."

This vignette also reveals one aspect of the so-called sadistic component to many self-defeating behaviors. What is significant in this regard is that the aggression is not enjoyed for itself; rather, it is a part of the patient's continuing self-pity and secretly enjoyed suffering, and the harm done to the other is a by-product of the patient's continued pursuit of his own lack of pleasure. Fur-

thermore, the patient usually suffers far more than his victim. For example: A shy, lonely man meets an attractive woman who clearly likes him. He is about to ask for a date and has the thought, "I won't give my analyst the satisfaction."

The demand for reparation and vengeance, and the unwillingness to give up one's self-defeating behaviors until that impossibly unrealistic demand has been met, is often a particularly difficult impediment in the treatment. These patients' inability to take pleasure in what would ordinarily be gratifying achievements includes their unwillingness to admit their psychological intactness, as well as their unwillingness to let parents or spouses or therapists "cash in" on the pleasure of their success when they ought to be making up for what they did to the patient. Patients with SDPD often feel a moral fervor—simple justice, an eye for an eye, it's only fair, people should apologize when they have hurt someone, one should pay for damage that one did—that harks back to the moral teachings of the nursery and lends a tone of self-righteousness to what is at bottom one more defense against having to give up the secret pleasures of self-defeat. Persistence in a therapeutic attitude of helping the patient to see his motives for retaining his feelings of victimization, appropriate sympathy and empathy over the irremediable reality of past suffering, and helping the patient to begin to accept the fact of his current adult autonomous status help the patient to overcome the temptations to get stuck in vengeance and self-pity. As patients begin to improve and to experience increasing satisfaction in their lives, it becomes increasingly difficult for them to fall back into this more neurotic mode.

Denial of Pleasure

It is implicit in all that has been said above that self-defeating patients have a need to deny ordinary conscious sources of pleasure and to insist on their miserable lot in life. When this quality is prominent, it can lend a depressive air to the patient—and to the treatment situation—that may put the therapist in mind of antidepressant medication. Some of these patients may fit criteria for dysthymic disorder, and a trial of medication may be indicated. However, a large group of these patients are not medication responsive but do respond to psychotherapy or psychoanalysis. Successful treatment requires that the therapist retain appropriate neutrality—that is, while sympathetic to the real suffering of these patients and empathic to their enchainment by unconscious conflicts, the therapist also insists that the continued disorder of the now-adult patient is the patient's responsibility and that the remedy lies with the patient. It is easy to become angry, bored, and depressed in dealing with what is often a monotonous litany of childlike whinings and feelings of injury or a persistent stream of aggressive provocations. It is here that the therapist's professional education and experience, his theoretical understanding of the disorder, and his appreciation of the havoc it is causing in his patient's life help him to maintain his therapeutic stance and enjoy his work. Helping the masochist to reduce his pain, contrary to the joke about sadists treating masochists, is ultimately a source of great satisfaction for both the patient and therapist.

SUMMARY

The treatment of SDPD, although always difficult, is most likely to succeed when the therapist is prepared with an adequate theory of the disorder that enables him to weather the severe stresses that the treatment of these patients can elicit. Without an understanding of the unconscious roots of the disorder, the therapist is prone to respond to the provocation and negativity of these patients with aggressive attempts to convince the patient to change such obviously maladaptive behavior and will quickly find himself involved in power struggles that are doomed to failure. I

believe that a clear recognition of the narcissistic aspects of the masochistic behavior and the ability to interpret both the narcissism and the masochism greatly facilitate the treatment. The concept of the narcissistic-masochistic personality can be helpful. The experienced therapist of patients with SDPD is also aware that in spite of his best efforts, even patients who will eventually do well are liable to go through difficult periods in which the patient carries his self-damaging tendencies and overt suffering to lengths greater than those experienced before treatment. Nonetheless, persistent efforts, a consistent therapeutic stance, and benevolence combined with willingness to present reality to the patient will in most instances yield therapeutic results that are gratifying to both the patient and the therapist.

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