Masochism has become a contentious term. Although we believe that masochism and masochistic behavior are psychopathological realities and are pervasive in many patients, there has been a groundswell of social-political opposition to the diagnosis based on the premise that such labeling is a form of “blaming the victim.” However, this argument ignores everyday clinical reality and may subvert appropriate therapeutic interventions. Patients who present with a history of unnecessary suffering, self-defeating behaviors, and recurrent self-induced disappointments in life are ubiquitous in clinical practice. The clinician’s sophisticated understanding of conscious and unconscious masochism is the first stage in helping such a patient free himself from a destructive dynamic that is predicated on a seemingly paradoxical desire to seek pain.

The term masochism first appeared in Krafft-Ebing’s treatise Psychopathia Sexualis, published in 1886. It contained a detailed description of submissive sexual practices, largely in males, involving humiliation at the hands of a woman as a requirement for sexual arousal. Krafft-Ebing derived the term masochism from the name of the nineteenth-century author Leopold von Sacher-Masoch, whose novel Venus in Furs (1870) was widely read in Europe. That story began with the narrator having a dreamlike interaction with Venus, a marble goddess, who was wrapped in furs and tormented him with his desire to be sexually humiliated. The narrator talked with his friend, Severin, who then described his own experience with a young woman whom he persuaded to humiliate, beat, and scold him in order to arouse him sexually. Severin eventually signed a contract to become his lover’s slave, and they traveled together throughout Europe as slave and mistress. The utter ruin of his life that resulted was compensated for by the constant enactment of his masochistic perversion.
Krafft-Ebing saw masochism as "the association of passively endured cruelty and violence with lust." He further noted, "Masochism is the opposite of sadism. While the latter is the desire to cause pain and use force, the former is the wish to suffer pain and be subjected to force."

Today most clinicians view them as intertwined and speak of sadomasochism. Sadism is, like masochism, an eponymous term derived from the name of the eighteenth-century French aristocrat the Marquis de Sade, who, in such works as *The 120 Days of Sodom*, describes in horrifying pornographic detail the cruel and literally murderous abuse of other people for perverse pleasure. It is significant that de Sade proclaims in the above work that "most people are indeed an enigma. And perhaps that is why it is easier to fuck a man than try to understand him." As Bach has pointed out, the translation is: "it is easier to exploit a person than to relate to him," a keen insight into the pathology of some sadomasochistic patients and other related character disorders.

Krafft-Ebing emphasized the importance of fantasy for the masochistic patient. He described a desire on the part of the sexual masochistic patient to be "completely and unconditionally subject to the will of this person as by a master, humiliated and abused." Today, themes of humiliation, subjugation, and abuse continue to be important in understanding masochism.

The concept of sexual bondage, which he described as a form of dependence, was of primary importance for Krafft-Ebing. This notion continues to be important today, with masochism also understood as a pathological behavior pattern designed to maintain an attachment to another person. Krafft-Ebing wrote about the masochistic patient’s fear of "losing the companion and the desire to keep him always content, amiable, and present."

He also described a second component in masochism that he believed to be sexual ecstasy. He saw this as a physiological hyperdisposition to sexual arousal or stimulation, even if that stimulation was mistreatment or abuse. In other words, at both a mental and physiological level of organization, he saw a fundamental tendency toward pleasure in pain for the masochistic patient.

Krafft-Ebing’s work exerted a strong influence on Freud. Freud viewed sex as a fundamental biological function that was a powerful motivator of behavior. In understanding the puzzling phenomenon of masochism, which seemed to contradict his "pleasure principle," Freud followed Krafft-Ebing in postulating a primary sexual pleasure in pain and saw this as the basis for both masochistic paraphilias and masochistic character patterns.
The study of masochistic fantasies and behaviors has continued to influence the development of psychodynamic thinking and psychoanalytic theory. Clinicians and theoreticians have struggled with understanding motivations that lead people to pursue pain and to find pleasure in it. Freud defined moral masochism, separate from masochistic paraphilia, as the renunciation of pleasure in favor of self-sacrifice as a way of life, leading to emotional suffering coupled with a sense of moral superiority. Many psychoanalysts believe that masochistic sexual fantasies are invariably present in the sexual lives of people with masochistic characters, even if overt masochistic paraphilias are not present. Schaffer feels that a diagnosis of masochistic character should not be made without the presence of sexual masochism, because otherwise the diagnosis becomes too inclusive.

One hypothesis is that pain is not pursued for its own sake but rather because all other options seem even more painful. Thus in these situations the pleasure principle is actually preserved. However, this dynamic may be difficult to understand when the clinician is unable to imagine or empathize with the greater pain that the patient envisions (often unconsciously) if he were to pursue alternatives considered by others to be preferable. The pursuit of mental or even physical pain can also be understood as derived from the child’s struggle to maintain an emotional connection with an abusive parent. The term masochistic is sometimes misapplied to describe any self-defeating or maladaptive behavior, even though the self-defeating aspect is an unintended side effect, a “secondary loss,” rather than a primary motive of the behavior. The term is also misused when one fails to appreciate that the experience the interviewer views as painful may be one that the patient enjoys. In other words, spending Saturday at a professional meeting is only masochistic if one does not want to do so and finds it painful, yet consciously believes that it is the only possible choice. In order to be considered masochistic, a person must have a conscious subjective experience of displeasure while obtaining gratification at an unconscious level. In this example, the unconscious satisfaction might stem from viewing oneself as dedicated or scholarly.

The masochistic individual is relatively easily recognized. In his work, he typically accepts a job in which he is either overworked or underpaid, or both, and in which there is no prospect of future gain. Apprenticeships or internships do not qualify, because the future potential constitutes a reward. Jobs that offer great internal satisfaction do not qualify either. The person must be doing the job in spite of better choices and feel that he is being exploited. The gratification is at an unconscious level. His personal life is no different; he selects friends
and romantic attachments that are inappropriate for him. His relationships end in hurt feelings, disappointment, and resentment. He responds to personal success by feeling undeserving and guilty. This feeling may be acted out through some accident, such as leaving his briefcase in a taxicab. His portrayal of himself as a victim may evoke annoyance and displeasure from others, who may detect that his complaining is really bragging. His affect is usually somber. Even when he does not complain, others are aware that he suffers and perceive him as a "no fun" person. In his attempt to win acceptance from a friend, the masochistic patient will help with his friend's college paper and then be late in completing his own, a fact that he will tell the friend later, thus causing the friend to feel guilty. This is the sadistic component of masochistic behavior, an aspect of which the patient has no awareness.

**PSYCHOPATHOLOGY AND PSYCHODYNAMICS**

**Criteria for Masochistic Personality Disorder**

We have identified the following criteria for masochistic personality disorder:

1. Self-sacrificing, accommodating of others, then complains about not being appreciated. Accepts exploitation and selects situations in which he is exploited but then attempts to make others feel sorry for him or feel guilty instead of expressing appropriate assertiveness.
2. In response to overt aggression from others, tries to turn the other cheek but is usually resentful; exploits the role of the injured party, making the other person feel guilty.
3. Somber affect, rarely happy or exuberant—a no-fun person to be with.
4. Self-effacing, politely refusing the genuine efforts by others to meet his needs: "Oh, no, thanks, I can manage it myself."
5. Reliable, overly conscientious, with little time for pleasurable activity; obligation and duty supersede.
6. Avoids opportunities for advancement but then feels resentful for not being chosen. Responds to a promotion with fear of failing or guilt about defeating a rival.
7. Sexual fantasies include themes of humiliation, rejection, abuse, dominance, and submission.

Masochistic traits are often found in association with other character disorders, and interview strategies that are effective for an obsessive
character with masochistic features might not apply to the patient with hysterical, phobic, paranoid, borderline, or narcissistic character structure. Masochism is closely related to narcissism and might be thought of as its first cousin. The martyr receives attention and adulation for his suffering, as hundreds of graphic Counter-Reformation paintings attest. The masochistic martyr becomes the center of attention, uniquely "special" and even a "saint," characteristics that overlap those of the narcissistic patient with his grandiose inner world and exaggerated sense of self-importance.

Feminist groups have opposed the inclusion of this diagnosis in the official nomenclature, claiming that it will be used against female victims of abuse by suggesting that they bring it on themselves. To address that problem adequately is beyond the scope of a book on psychiatric interviewing, but it should be noted that the diagnosis does not appear in DSM-IV-TR and that the list that appeared earlier reflects our criteria for the diagnosis and is not official nomenclature.

Masochistic Characteristics

Suffering and Self-Sacrifice

The masochistic character immediately impresses one with his investment in suffering and/or self-sacrifice, manifested in his constant readiness to subordinate his apparent interests to those of the other party. It is easy for him to accept exploitation from others, and he continually seeks out people who will exploit him. He has a job that does not pay him adequately either for his qualifications or for the amount of time he devotes to the work. He has the less attractive room in a shared apartment, goes to the restaurant or film preferred by his companion, and gets the less attractive girl on a blind date. Although he feels exploited, he prefers to suffer silently rather than complain to (and risk hurting) his exploiter. When others offer to do something for him, he politely refuses their efforts to respond to his needs. He is always afraid of becoming a burden, and he believes that he does not deserve their help. Typically, he states, "Oh, no, that's all right; I can manage it myself." His constant self-sacrifice leads to feelings of moral superiority, a trait that might be apparent to others but is not to him. His behavior causes those around him to feel guilty. If he becomes aware of this, he apologizes and offers further sacrifice. Sympathy from others is one of his principal means of feeling better, and therefore he always pursues the position of the most hurt party.

The clinician must also bear in mind that the masochistic individual
does not seek any random pain. In order for pain to provide conscious and unconscious gratification, it must be a specific pain applied in a specific way and at least to some extent be under the patient's control. For example, one patient said, "I want you to beat me, humiliate me, and yell at me; I never said I wanted to feel ignored or rejected."

The diagnosis should not be made in situations in which the patient is a captive with no apparent means of escape, when adaptation to unavoidable pain is healthy. Submission to abuse and humiliation may be the only means to adapt to the situation and thereby increase the chance of survival. If the person has the means to escape and does not exercise it, or if he successfully escapes and then voluntarily returns, the diagnosis of masochism is possible. The diagnosis should also not be made when the patient has a clinical depression or during the recovery period from depression, a state in which it is virtually impossible to discern the masochistic trait.

**Masochistic Sexual Fantasies as a Diagnostic Criterion**

The masochistic patient's sexual life is, in the opinion of some theorists, the underlying source of the character disorder. Sexual arousal occurs in response to fantasies, pictures, or stories depicting themes of humiliation, punishment, rejection, belittlement, or coercion in which the "victim" can deny all responsibility. In spite of Freud's term feminine masochism, males are commonly interested in masochistic sexual scenarios.

The centrality of sexual fantasies as a diagnostic criterion for masochism is unique in the diagnosis of character disorders. The capacity for excitement or sexual arousal in response to sadomasochistic themes is an integral component of this character type. The overt acting out of more severe versions of these fantasies occurs only in a sicker group of patients with borderline or overtly psychotic psychopathology. Healthier individuals may have excitement in response to masochistically titillating themes such as a burlesque of a leather-clad female dominatrix subjugating a passive man, but that experience is foreplay to more typical forms of gratification. Nevertheless, when a patient describes such arousal, it is useful to inquire whether it remains central to his fantasy as he is engaged in the culminating sexual experience.

If the diagnostic criterion of masochistic sexual arousal were required, the diagnosis would be made much less frequently, because many patients are too ashamed to admit to such interests, and others are too inhibited even to entertain such fantasies consciously. For example, a female patient typified all of the criteria for masochistic per-
sonality disorder except that she denied masochistic sexual interests. Upon the clinician's pursuing this subject, the patient asserted that she had no sexual feelings or interests or fantasies of any sort. In the course of treatment, she became less inhibited and allowed herself to develop sexual interests in which themes of humiliation, pain, rejection, and coercion became present.

The prevalence of masochistic fantasies is reflected in the successful market strategies of publishers of sexually oriented magazines in which masochistic acts are often graphically portrayed. However, most of the people who are titillated by this material never engage in an overtly perverse sexual act but, as described earlier, may think about it during their sexual experiences.

A masochistic male patient in his 30s denied being aroused by typical sadomasochistic scenes during his evaluation. However, a year into his psychotherapy he reported a fantasy: He assumed a dominating role, issuing orders and instructions to his partner, requiring that she respond to his every whim. Although his overall adaptation was that of a high-level masochistic character, in his sexual fantasy he placed himself in the sadistic role, not an unusual phenomenon in masochistic characters. In response to a question about how the fantasy usually began, he added, “It always starts with the woman being cold, aloof, and unresponsive—perhaps even rejecting.” When the clinician asked if he differentiated this from a woman who was in a neutral state of arousal vis-à-vis him, he replied, “Yes, and cold is better.” Then the woman was totally overcome by his charm and power to the point of becoming his slave.

This vignette illustrates several points. First, the phenomena of masochism and sadism are positive and negative images of the same theme. The scene involved some form of pain, rejection, or submission, with humiliation a prominent feature and a relative absence of feelings of tenderness, love, closeness, and equal sharing. Second, it is difficult to elicit accurate sexual material. There is no other area in clinical work in which the conscious feelings of the interviewer may so distort his capacity to elicit objective and accurate data. There are also the unconscious conflicts in the interviewer that may further add to the complexity of the challenge. Obtaining an accurate history of a patient's sexual behavior and fantasy is one of the most difficult areas facing the interviewer, partly because of feelings of embarrassment, voyeurism, and intrusion that may be aroused. Nonetheless, gleaning such information is critical. Third, it is of interest that this man acted out this same role in other situations in life. For example, he only played his best tennis when his opponent had taken a commanding lead. As he began to feel he was being humiliated, he experienced a sadistic desire to turn the
tables and to humiliate his opponent. In his work he felt humiliated when his boss criticized him. At that point he experienced narcissistic rage and performed at his best, hoping to shame the boss. The interviewer inquired, "Don't you want your boss to like you?" The patient appeared puzzled and said, "I want him to respect me, maybe even fear me." "Fear you?" the clinician responded. "Yes, that is the ultimate sign of respect," the patient said.

This exchange illustrates the delicate intertwining of sadomasochistic, narcissistic, and obsessional features. The masochistic component is in his entering into a feeling of humiliation by not playing tennis at his best; he then turns sadistic in his wish to humiliate his opponent. The narcissistic component is in his preoccupation with himself; he is putting on a show for the benefit of an invisible (unconscious) audience that exists only in his mind. The obsessional component is in his need to always feel in control.

**Superego Relief**

For some, pain becomes a necessary prerequisite for pleasure. The superego is assuaged and guilt is expiated either for past offenses or to pay in advance for future pleasure. In the masochistic patient's childhood experience, abuse, pain, or sacrifice was usually followed by love, just as in society fasts are followed by feasts. An example is that of the talented young attorney who had been abandoned by his father at the age of 4.

He had been brought up by his mother and an assortment of aunts and had no subsequent contact with his father, who became an "unmentionable" in the household. The patient unconsciously felt profoundly guilty about his father's disappearance, feeling, as children often do in cases of divorce or parental death, that he was responsible and that he had achieved an "oedipal triumph," but it was a Pyrrhic victory that distorted his character and gave it a masochistic bent. He proclaimed in the initial interview, "I hate my father. He was irresponsible, selfish, and cruel. How could he leave a little boy who loved him?" Behind this angry statement lay a deep longing and a profound sense of guilt.

Further discussion revealed that the patient regularly engaged in sadomasochistic interactions with senior partners in his law firm. He would be late preparing an urgent brief and would gratuitously and provocatively tease his superiors. The result was that he would be attacked and humiliated in firm meetings. His legal ability was such that he was not actually fired, but the drama that he created would continue in one form or another. As treatment progressed, he became aware of the pleasure he took in being attacked. "It doesn't bother me. Weirdly, I feel better when it happens." He acknowledged enjoying the negative attention, and far from feeling guilty, he took pleasure in these alter-
The Masochistic Patient

A number of unconscious dynamics were at work. He had the "sadistic" attention of the father-surrogate, was no longer abandoned, and felt less guilty for his unconscious crimes. His superego was appeased by the beating.

Maintaining Control

Other mechanisms of defense in the masochistic patient are the feeling of safety provided by the familiar and a desire to maintain omnipotent control of the universe. The person who does not try cannot fail. By not competing, one wards off frustration and retains the unconscious fantasy of control of one's universe. For example, if one does not seek a promotion, one does not feel passed over.

In a sadomasochistic dyad, the subtle control of the sadist by the masochist is often a major theme.

An accomplished graduate student recounted her passionate romantic involvement with a female colleague. Although the sexual excitement factor was intense, this patient's day-to-day experience with her lover was one of regular humiliation, verbal and physical abuse, and constant derigation. She recognized the pathological nature of her involvement with this woman who, alongside her sadistic behavior, was a binge drinker and recurrently unfaithful. "How could I fall head over heels in love with someone who takes such pleasure in treating me so horribly?" the patient lamented. Her history revealed that her mother had had recurrent psychotic breakdowns, usually precipitated by her father's absence on business trips. This left the patient alone with her disintegrating parent, who occasionally subjected the patient to life-threatening situations, such as crashing the family car when the patient was a passenger.

It became apparent to the interviewer that the patient's current lover was a direct stand-in for her mother, someone who was unpredictable, prone to explosive outbursts of rage, occasionally frightening, and, when drunk, dangerous. The patient's masochistic surrender and suffering provided an unconscious attachment to her mother whom, consciously, she pitied. Her moral superiority to her lover was apparent—she was never cruel or unfaithful; she suffered her lover's abuse out of love. She was the forgiving one who, no matter how badly she was treated, would never abandon her lover. Her all-accepting attitude tended to induce further paroxysms of rage and overt cruelty in her partner. Toward the middle of the first interview, the patient commented insightfully, "It's a pretty perverse love, isn't it?" She was correct. Regular beatings formed a central part of their love-play and were sexually exciting for her. In the second interview, it became clear that her flagrant masochism was a subtle means of control. Her lover often threatened to leave her but never could, stating: "You are so forgiving and understanding of my craziness. I need you because you make me feel human after I have behaved like a lunatic." This sadomasochistic interaction...
provided considerable gratification for both parties and bound them together. The sadistic partner thought she controlled the masochistic one and could abuse her at will, but in fact she was equally controlled by the masochistic partner’s submission, suffering, and forgiveness.

Developmental Psychodynamics

The future masochistic patient often grows up in a household where one parent is masochistic, depressed, or both. The following is an example of the enduring impact of this childhood experience:

A masochistic female patient, when upset at the psychological injuries she recurrently suffered in her professional life through lack of recognition, appropriate advancement, and so on, would become preoccupied with suicidal ideation. She consciously felt on such occasions that she was “worth nothing” and would be better off dead. She contended that her therapist had been of no help to her, and he too would be better off if she were not around to bother him. Her rage and fury at her colleagues and her therapist remained out of awareness as she adopted the role of a martyr, one who was unappreciated for her Herculean efforts on behalf of others.

When the patient was little, her mother had exhibited virtually the same behavior in response to what she saw as a “lack of appreciation.” The patient had clear recollections of her mother threatening, “I am going to kill myself.” Her mother’s behavior on these occasions had sufficiently alarmed the family that she was twice hospitalized. The patient remembered feeling profoundly guilty, abandoned, and agitated at these times. The patient prayed to God to save her mother and made a pact that she would suffer in her place. In this she had succeeded, and she now replicated her mother’s psychological maneuvers.

This was a primary identification with a masochistic parent, a common pathological mechanism in the developmental history of the future masochist. It served two unconscious purposes. First, it was adopted competitively to gain the love of the other parent, that is, her father. Second, it maintained a powerful psychological tie through identification with the emotionally unavailable mother.

As a child, the future masochistic patient overemphasizes passivity and submissiveness, expecting that this will lead to approval and affection from others as well as protection from their wrath. When his submissiveness fails to win the parents’ warmth and love, the child feels resentful and is given to sulking as an expression of dissatisfaction. Commonly the parents may offer some comfort or affection when the “poor child is unhappy,” thereby reinforcing the development of pain-dependent behavior. The child brings that paradigm to his contacts.
with the outside world and behaves submissively toward other children who seem to take advantage of him. The affection he seeks is not forthcoming, and resentment is experienced toward others. If he returns home having given away his allowance or some other possession, he is scolded by an angry parent, which further fans his mistrust and disappointment in others.

The future masochistic patient develops a model of personal suffering as a means of obtaining attention and affection. Actual abuse by a parent or parental surrogate is translated by the child into “This is how love and attention occur.” This becomes the template for future relationships. Illness and the attention and caring this brings from otherwise remote and unaffectionate parents may also reinforce the “pain is pleasure” paradigm.

Fairbairn, in his work with delinquent teenagers raised in abusive households, observed that they were reluctant to admit that their parents were “bad” even though they had regularly been abused by them. They were much more ready to confess that they were bad. He surmised that these children were taking on the “badness” that resided in their parents by internalization and making them “good.” This seemingly paradoxical mechanism had the effect of inducing “that sense of security which an environment of good objects so characteristically confers.” Fairbairn framed this in religious terms:

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 certain sense of security to be derived from the fact that the world around is good—“God’s in His heaven—All’s right with the world!” And in any case there is always hope of redemption. In a 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.

This subtle metaphorical analysis is relevant to the psychodynamics of the masochistic patient who has often been abused in childhood and sees himself as bad. Fairbairn observed that the child internalizes aspects of his bad parents “because they force themselves upon him and he seeks to control them, but also and above all because he needs them.” This unconscious dynamic continues to be played out in the adult relationships of masochistic patients who have been raised in unempathic or abusive childhood settings.

Masochism frequently has a secret agenda, namely the control of another person who is bound by suffering in a sadomasochistic drama. As a child, the future masochistic patient often experiences an excess of shame and humiliation from his parents. He responds with a special
unconscious defense: “My parent cannot hurt me because I will enjoy the injury. I am more powerful than they are. I will control them with my suffering.” This dynamic can come to dominate the clinical situation, and the masochistic patient enacts a negative therapeutic reaction by lamenting, “You are of no help to me,” a refrain that tempts the therapist to angry retaliation. This is a re-creation of the childhood situation in which suffering provided power to dominate the parent and expressed the masochistic aggression and vengeance.

Differential Diagnosis

One of the more difficult issues in the differential diagnosis of masochism is the distinction from altruism, an important value in our civilization. A person who risks his life for his country or the parent who sacrifices pleasure for the welfare of a child is not masochistic. The altruistic person experiences conscious and unconscious pride and an elevation of self-esteem from such sacrifices, whereas the masochistic person may experience moral superiority but needs pain as well as the positive effect on the world. The masochistic person derives no conscious elevation of self-esteem from his sacrifices because they are not motivated by love. The masochistic patient feels exploited and unappreciated by others. The gratification derived from his behavior largely stems from the unconscious alleviation of guilt. His sacrifices result from fear, fear that he is not lovable, fear that others will find him selfish and greedy, and so on. In this manner he attempts to buy love from others whom he unconsciously resents. The mechanism is self-defeating because his behavior causes others to feel guilty so that they resent him and respond with avoidance. If the masochistic patient becomes aware of this reaction he is quick to apologize and to offer further sacrifices.

Another major differential diagnosis is with the self-destructive patterns of the borderline patient who shows more aggressive paranoid trends as well as impaired impulse control. For example, the borderline person has a greater tendency to provoke others and then counterattack with a conviction that they deliberately mistreat him. Masochistic sexual fantasies are more likely to be acted out by the borderline patient.

There is a group of patients with dysthymia whose clinical presentation can mimic that of the masochistic patient. This group of depressed patients can be preoccupied with inadequacy, failure, and negative events to the point of morbid “enjoyment.” They can be passive; self-derogatory and worried; hypercritical–complaining, conscientious, and self-disciplining; preoccupied with inadequacy, failure, and negative events; pessimistic; and incapable of having fun. This
strong overlap has led some psychiatrists to feel that the masochistic patient has an affective spectrum disorder rather than a character disorder. The differentiation from the masochistic patient, however, can be made on the basis of the mood state, which in the dysthymic patient is that of mild depression. The masochistic patient is often gloomy and pessimistic about the future but usually not depressed. When present, masochistic sexual fantasies can also be particularly useful in distinguishing masochistic personality disorder from affective disorders. The sexual fantasies of the masochistic patient have generally crystallized by middle to late adolescence.

The dependent patient is lower functioning and more infantile, lacks the masochistic person's pathological conscience, and is gratified by other people making decisions for him. The passive-aggressive patient is more angry and defiant, thereby suffering greater work impairment than the masochistic patient. He is more likely to arrive late for the appointment, offer little apology, and elicit anger in the clinician.

The compulsive patient who speaks of how “hard he works” is really bragging rather than complaining. His self-esteem is elevated by his capacity to postpone pleasure. He is much more assertive and is able to accept recognition for his accomplishments. He is more directly controlling of others who should “do it his way” because he knows best and is unashamed of this unless it backfires. The avoidant patient, compared with the masochistic patient, is more phobic and more anxious and able to make demands on others that are related to helping him avoid his fears. In addition he tends to avoid situations that cause him anxiety, and thereby he rarely is exploited by others.

MANAGEMENT OF THE INTERVIEW

Inner and Outer Views of Masochism

There is a great discrepancy between how the masochistic patient perceives himself and how he is seen by others. He wishes to see himself as a modest, unassuming, altruistic, noncompetitive, accommodating, generous, shy, unintrusive person—one who is forgiving of others, places responsibility before pleasure, and puts the needs of others before his own. His ideal role model would be Job. However, each of these characteristics ceases to be adaptive when it no longer wins the love and admiration of others. Instead, others are driven away, either as the trait is carried to excess or because the unconscious coercive motivation to control and evoke guilt becomes apparent to the other person.
For example, a therapist receives an emergency telephone call during the masochistic patient’s appointment. The patient offers to leave the room. He says, “I feel so insignificant when you have so many people who really need you.” If the therapist tries to interpret the patient’s wish to court the therapist’s favor with that offer or suggests that it might be designed to cover up latent resentment, the patient responds by feeling misunderstood and hurt. It would be preferable to accept the offer at face value or perhaps interpret it as another example of the patient’s feeling of unworthiness.

**Excessive Modesty and Self-Righteousness**

The traits of excessive modesty and self-righteousness often provoke the therapist to attempt to show the patient that he is bringing his troubles on himself or sometimes to feel irritated, with resulting boredom and withdrawal. Interpretations of this dynamic make the patient feel totally misunderstood. The patient’s being not openly competitive leads to his losing through default, with resulting diminished self-esteem. The therapist is tempted to encourage the patient to assert himself or be more competitive. This makes the patient feel worse because he believes he will alienate people through such behavior and incur their wrath. His accommodating cooperative trait leads to his accepting abuse from others and then complaining about the unfair treatment he receives. The therapist again is tempted to push the patient to fight back and to stand up for his rights. This tactic usually has poor results. It is difficult for the therapist to understand that the patient believes that acquiescing to others is the way to be accepted.

The patient defers to the wishes of others. This constant self-sacrifice makes him feel others do not care about his wishes. The clinician may encourage the patient to make his wishes known but often subtly abuses him just like everyone else. This is the first patient one asks to shift the time of his appointment to accommodate someone else because he is most likely to acquiesce, suffering but stifling his complaints and submitting to avoid disappointing the therapist. A closer examination reveals the following: The patient has two standards of behavior, one of which is acceptable for others and provides a margin for error, and the other that is reserved for himself, to which he can never measure up adequately. However, in reserving a higher standard by which to judge himself, he develops a compensatory feeling of moral superiority to others. Other people, including the therapist, find this attitude offensive and may reject the patient because of it. However, if it is challenged, the patient feels that the therapist wants to destroy one of his few virtues.
The patient’s shy, unobtrusive nature is often perceived as aloofness with an unwillingness to participate in the real give-and-take of a relationship. As seen by others, he is a somber, self-righteous, guilt-provoking, self-effacing, aloof, morally superior martyr who cannot accept or give love and who complains about his misfortunes.

Treatment Behavior

The masochistic patient responds to interpretations by feeling worse. He complains about the treatment and how the therapist is not helping him. This occurs for a number of reasons. The patient is unconsciously highly competitive, resents what he considers the clinician’s superiority, and expresses his hostility by defeating the therapist. Interpretations are a blow to the patient’s self-esteem, confirming his subjective experience of imperfections and unworthiness.

The masochistic patient often develops a negative therapeutic reaction. This can be interpreted as, “You seem to search for evidence that you are bad, and you overlook or diminish evidence to the contrary.” The same is manifested with regard to the patient’s progress during the course of treatment. The patient counts only failures and not successes. Masochistic therapists tend to get caught up in this same pattern and share the patient’s belief that nothing constructive has happened.

Interpretations are experienced as personal rejections. The patient states, “You don’t like me” or “I must be a real pain to you.” Although craving love, the patient never misses an opportunity to feel rejected. When the patient experiences a brief feeling of relief signaling the possibility of change or improvement, this activates neurotic fears accompanying the threat presented by success, such as the anticipation of being crushed by rivals or fear of the envy of others. This is a largely unconscious process, in contrast to the dynamic in the narcissistic patient, which occurs in conscious thoughts.

The patient anxiously solicits advice from others, including the clinician: “I just can’t decide; I wish you could make the decision for me.” The stage is now set. If the interviewer replies, “Well, it sounds like a good opportunity,” the patient will state, “Oh, I’m so glad you think so because I’ll have to take a pay cut.” The interviewer is faced with unattractive alternatives of withdrawing the initial advice, inquiring why the patient withheld crucial information, or keeping quiet. The first may undermine the patient’s confidence both in himself and in the clinician. The second is experienced as a criticism. The third increases the danger of the patient acting out and then blaming the clinician. If the therapist does not answer questions like this, the patient states, “I’m
sorry I asked you. I know I'm supposed to work these things out for myself." If the therapist attempts to interpret the patient's feeling angry for not getting the advice, the patient will berate himself further, stating, "It's just another example of how infantile I am."

When the masochistic patient tries to free-associate, he typically states, "Nothing comes to mind" or "Nothing has happened since I saw you last" or "I'm trying to think of something to talk about." The patient has a constricted subjective life. His fantasies tend to be concrete and deal with reality problems and his own failures and guilt concerning his feeling of inadequacy. He likes to find nondynamic explanations for behavior and will bring in articles about biological or genetic explanations. At the same time, his ubiquitous response to interpretation is, "You are right; it's all my fault."

Empathy

Masochistic character traits have positive adaptive value that is usually the only aspect of the behavior consciously recognized by the patient. If the therapist does not relate to these positive adaptive aspects, the alliance is endangered and the interview will be unsuccessful. The patient views his martyred attitude as a function of altruism, an admirable trait. His self-effacing stance means that he is noncompetitive—a likeable trait. The patient confuses his acceptance of abuse with being cooperative and accommodating, and he does not see the unconsciously motivated pain-seeking aspect of this behavior. His pervasive moral superiority, which the therapist encounters early on, is experienced by the patient as his being forgiving of other people. He is unaware that this surface forgivingness conceals his unconscious pleasure in registering their deficiencies. The patient considers himself generous and does not realize that he uses giving in order to manipulate others and then deprives them of the opportunity to give to him in return. He cannot understand why others perceive him as aloof when he himself feels shy and nonintrusive.

A successful businessman complained in an initial interview, "My children are such ingrates. I have set them up, basically given them a comfortable annuity. But they don't even make an effort to celebrate or even acknowledge my birthday. I care about my birthday." Raised in Europe during World War II, he had experienced many deprivations as a child. He had devoted himself to his parents and rescued his father's business from insolvency. It had become the basis of his considerable fortune. His parents had never acknowledged either his achievement or his devotion but remained critical of him until their death. He replayed this scenario with his children. He was simultaneously generous to a fault and highly
critical of their attempts to achieve independence and financial autonomy. He regularly used money to manipulate them and then was hurt when they withdrew and did not “acknowledge my birthday.” He felt that he was “good,” and they were “bad.” His aggression was denied, and he was bewildered by their “insensitive” behavior. “I’m sick of suffering,” he complained. Gradually, with treatment, he began to understand his need to suffer and that his generosity had a hidden masochistic agenda—namely, to control and yet feel unappreciated and rebuffed.

The clinician should avoid premature interpretation of the patient’s enactment of the role of being a clinging, helpless, dependent child. It is necessary to answer the patient’s questions or requests for guidance and be interactive early in the treatment but not to make real-life decisions for the patient. If the patient asks, “Do you want to hear more about my mother?” or says “I hope I’m not boring you,” one should initially deal with those comments directly, concretely, and without interpretation. The clinician should avoid asking the patient, “Why do you want me to make the decision?” Instead, early in the contact the interviewer could interpret that the patient cannot decide because each choice appears fraught with potential disaster. When the patient agrees, the clinician can then review the negative consequences of each decision and ask the patient which pain he can live with better. Later, the clinician can point out, “Up to now, we have largely considered the negative factors involved in making decisions. Let’s try and consider the positive aspects as well.” It is only after the patient’s unconscious aggression has been somewhat neutralized by the development of loving and tender feelings that the masochistic character can tolerate exploration of his repressed rage.

Initially, the clinician should provide a concerned, holding, and supportive environment. Considerable transference gratification is necessary for this patient in the early phase of treatment. The clinician is advised to avoid silence, a deprivation poorly tolerated by the masochistic patient. The clinician should allow more time for history taking in the initial phase of treatment. This provides an opportunity to develop an appreciation of some of the patient’s strengths and areas of healthier functioning. Interventions that tend to alleviate the patient’s unconscious guilt are helpful, for example, “Haven’t you suffered enough?” or “Haven’t you punished yourself sufficiently?” It is often necessary for the clinician to strengthen the patient’s motivation for expressive psychotherapy. The masochistic patient is not interested in broadening his self-knowledge because he anticipates that each new discovery will confirm his inadequacy and unworthiness. This pattern may be explored in the early phase of therapy.
The clinician must listen carefully for evidence that the patient reacted to the interviewer's comments as criticism; this must be brought to the patient's attention empathically or the patient will simply transform it into another criticism, responding, "I'm sorry I took it as a criticism; I never can get anything right." The masochistic interviewer may be tempted to say, "Oh, no, it's my fault." Such a stance will only reinforce the patient's masochism.

It is essential to intercede when self-destructive acting out is anticipated and then later analyze the patient's reaction to the intervention. This is often accomplished with a question rather than by direct advice. A financial executive proclaimed, "I'm going to resign" because he felt that his commission was not commensurate with what he had achieved for his firm in the previous year. In reality, his performance had been mediocre, and he had still been handsomely recompensed. The interviewer inquired, "Do you have an offer for another position? You told me it hadn't been a great year." The patient then retreated from his threat of resignation, which would have been a masochistic acting-out, bringing considerable suffering upon himself. However, further discussion revealed that he had experienced the interviewer as suggesting that he had performed poorly, and he felt criticized. The interviewer pointed out that this was not the only possible meaning of his comments.

After the patient has developed some awareness of his angry feelings toward others, the clinician can point out how apparent self-punishment actually punishes others as well as the patient. If the patient accepts the interpretation without becoming depressed, the therapist can then interpret the patient's need to punish himself for having felt so angry at the other person. If the patient responds with depression, it is necessary to interpret the patient's disappointment in himself that he is not more tolerant as well as his fear of losing the other person's love. The patient can then be shown how in his depression he is expiating his guilt and seeking to regain the approval of the offended other by means of his suffering. The clinician then explains that the patient expects the other person to see how much the patient suffers and to feel sorry for him, a basic emotional paradigm that the patient confuses with love. In some instances, the patient has gone through all of these steps with no alteration of his behavior pattern. In those situations it may be necessary for the clinician to say, "All right, haven't you punished your mother enough?" This is not an early intervention. It is important to avoid the use of humor with the masochistic patient. The patient will invariably feel ridiculed and respond negatively.

Recognizing that the masochistic patient has great difficulty in accepting or acknowledging feelings of anger, the clinician accepts the
patient's label of "disappointment" as the acceptable emotion closest to anger. The clinician must exercise caution in encouraging the patient to express anger toward significant others until he is able to cope with the counter-anger that this evokes, along with the patient's subsequent guilt. Masochistic patients in ongoing treatment often refer repeatedly to being a "disappointment" to their therapist. One patient stated, "I crave your admiration and affection, but I know you are disappointed in me as a patient. So I don't deserve it." This provides an opportunity for the clinician to show the patient that the "disappointment" goes two ways. If he believes the therapist is disappointed in him, he also secretly feels disappointed in the therapist for his "disappointment." The therapist responded, "You are actually disappointed in me because I have not conveyed my respect and appreciation for your efforts or my affection for you. Hence you don't feel you deserve it." This led the patient to recall that he felt he was a disappointment to his father while inwardly feeling disappointed in his father for not showing his love for the patient, a cycle that had come to dominate his relationships with other people. Masochistic patients tend to have a conviction that they are not loveable. They have great difficulty in telling another person "I love you," thereby avoiding a situation in which the possibility exists they will be told they are not loved in return, which is their secret conviction.

Later in treatment the clinician can address the patient's challenges to the psychological explanations of his behavior and interpret his questions and comments regarding genetic and hormonal theories of behavior as a fear of being to blame, something the patient cannot separate from the concept of responsibility for one's actions. The clinician should also recognize the patient's dissatisfaction with the slowness of psychotherapy and his fear that it will not work.

The masochistic patient acts out unconscious guilt and fear and feelings of inadequacy in the form of self-defeating behavior.

A middle-aged masochistic woman came for a session during a snowstorm wearing her boots but no shoes. After removing her boots, she hid her feet under her skirt instead of sitting in her usual position. The clinician remarked on this, and the patient confessed with some embarrassment that her feet had a mild deformity so that she refused to wear sandals or go to the beach. The flow of the material allowed the clinician to associate previous discussion concerning that patient's displaced feelings of castration. She seemed to understand the interpretation and was able to relate it to her inhibitions at work. However, on the way back to her office, she left her briefcase in the taxicab, and that night she bumped into her bedroom door in the dark, cutting her head. It was necessary first to interpret the patient's emotional reaction to the interpretation before connecting the behavior to the interpretation itself. The
feelings of shame and inadequacy were defensively displaced to the self-punitive behavior.

A sadomasochistic relationship is encapsulated in the story of one couple:

The wife asked her husband, “Should I take my raincoat and umbrella to the theater party tonight?” He replied, “No, I don’t think you’ll need them. I’m not taking mine.” When they left the theater that evening, there was a tropical downpour. Their friends had umbrellas, and cabs were scarce. By the time they arrived at their apartment, they were both thoroughly drenched, and she was in a rage. She berated him unmercifully, accusing him of not taking care of her, she did not know why she remained married to him, and so on. He told the interviewer how miserable she made him feel with her complaints about his total incompetence; picking up on her tirade he said, “I don’t know what’s wrong with me; I can’t seem to do anything right.”

The interviewer pointed out that this was a classic sadomasochistic story except that each considered him- or herself to be the suffering party and the other to be the sadist. The patient responded, “I guess that’s right.” The interviewer then asked if it would be possible to have answered her inquiry about the weather by making some joke about himself, such as “You know I’m not a very good weather forecaster. Let’s turn on the TV and find out what they predict. Besides, I don’t care that much about being wet, but I’ll carry the umbrella if they predict rain.” “Not in a million years would this have occurred to me,” the patient responded. At this point the patient appeared downcast and perplexed. It was time for an empathic recognition of his unconscious sadism. With a slight gleam in his eye, and a smile in his voice, the interviewer asked, “So how did she look dripping with rain? Like a drowned rat?” The patient burst into laughter and then reflected, “I guess I secretly enjoyed her misery, but I had not realized it until now!”

This vignette summarizes the story of their 25-year marriage. She wanted him to be her protector and to take care of her and was furious with herself for being so needy, dependent, and helpless. He found her neediness a burden. He was angry at himself that he had not done more with his business life and that they lived largely on his trust funds. He felt she loved him for his money, much of which he had put in her name. They had not had sex with each other in 15 years. In that way they each suffered deprivation while at the same time they punished each other.

The next example illustrates how the masochistic person’s unconscious narcissistic grandiose wishes and fantasies can reinforce his guilt.

An adult male patient arrived at his appointment overwhelmed with feelings of guilt intermixed with deep sadness concerning his elderly dog who was dying a slow, suffering death. The veterinarian had ad-
vised him there was nothing more that he could do. The patient believed that if he put the dog to sleep, he would feel guilty, and if he did not, he would still feel guilty, so he asked what he should do. To interpret the patient’s fear of assuming the responsibility, although correct, would make the patient feel worse and furthermore ignore the patient’s sorrow. The therapist began by empathizing with the sadness of the occasion and followed by stating, “It seems that the problem is not really what is in your dog’s best interest but rather how to manage your guilt, whatever you do. Does the guilt have to do with the expectation that there must be something else you could do?” “Yes, I feel that way,” the patient responded. The clinician replied, “Everyone wishes for the power to make such things right. Sad though it is, we have limitations.”

At the end of the session, the patient thanked the therapist, shaking his hand, and went straight home and took his dog to the veterinarian. He held the dog’s head in his lap while the doctor put her to sleep. He later reported that the experience was one of love, tenderness, and closeness rather than guilt and self-doubt. Later, when he told the story to his mother, she replied, “You should have put that dog to sleep 6 months ago.”

In time the clinician explores the maladaptive aspects of the patient’s character traits. While doing so, one must be careful to recognize the adaptive components as well.

A young female college student’s mother asked her, “You don’t mind if we don’t come to your college graduation, do you? It is a 3-hour trip each way!” The patient responded, “Oh, no, it’s quite all right!” She then expressed her hurt feelings to the therapist, who asked, “Have you considered calling your mother back and telling her, ‘I’ve been thinking it over and I really want you to come. It would mean a great deal to me?’” The patient said the thought had crossed her mind, but she did not want to cause her mother any inconvenience. The patient appeared perplexed. The clinician then suggested, “Your mother may have the same problem that you do and feel that her presence is unimportant to you. She may be looking for reassurance that you really care whether she attends. She may feel hurt if you do not insist.” The patient responded, “I would never have considered that in a million years. I’ll call her when I leave.” She discovered that her mother had the same problem and was delighted to be wanted, and it was a milestone for both of them.

This was an opportunity to help the patient, whose hurt feelings and repressed rage about her mother’s absence from her graduation would only further add to the years of accumulated anger for which she had yet to forgive either herself or her mother. The clinician can later analyze any resulting feelings the patient may have of obligation to the therapist or anger at herself that she had not come up with this idea on her own. Therapeutic instances such as this provide a cognitive/affec-
The masochistic patient's initial transference is clinging, dependent, and apparently cooperative, but later it alternates with anger and unreasonable demands. The patient wants the clinician to replace some frustrating object, usually the emotionally unavailable parent, and become a substitute. The patient fears this will not occur, and the actual frustration of the transference confirms this fear. If the patient's wish is gratified, then he feels dependent, obligated, and ashamed of his childishness, confirming his feelings of incompetence. He resents the feeling that he has become an extension of the clinician just as he had been with his family. Gratification makes him feel his anger is inappropriate, which makes him feel more guilty. If the clinician withholds advice and support, the patient feels frustrated, unloved, helpless, hopeless, and coerced. It is vital that this paradigm be played out in the transference and that the clinician become involved on both sides before attempting to interpret it. The therapist must do this with a feeling of empathy for the patient's no-win situation rather than irritation over his own no-win situation. Masochistic clinicians do not do well with these patients' failure to progress, experiencing it as a proof of their own inadequacy as therapists. The emergence of the patient's conscious envy in the transference signifies progress. This is indicated by statements such as "I wish I could be more like you" or "You have a much better time with life than I do."

Countertransference dangers abound with the masochistic patient. The frequent negative therapeutic reaction in these patients can have an undermining impact on the clinician, making him adopt the patient's feelings of hopelessness and fail to recognize the patient's aggressive sadistic desire to make him feel inadequate and inept. The self-pitying quality of the masochistic patient can easily lead to a feeling of contempt in the therapist and a failure to recognize the patient's genuine misery. The pathology of the masochistic patient is designed to arouse a sadistic response in others, and this is heightened in the clinical situation. Constant self-scrutiny by the clinician of his aggressive feelings toward the patient's subtle and overt provocations is crucial. A typical example of such a provocation is the failure by the patient to pay his bill on time, so that the clinician is forced into the role of a collection agency.
and is experienced by both as venal: “You only care about my check, not me,” declares the patient self-righteously. Such an occurrence provides a rich field for psychological exploration, provided the clinician does not succumb to his own indignation. Injustice-collecting is the stock-in-trade of the masochistic patient; the clinician must constantly monitor his own aggression toward the patient because when it is acted out, for example, by a sarcastic comment, the patient is confirmed in his self-view as a victim mistreated by all, including his therapist.

Other common countertransference responses include assuming the role of an omnipotent parent making decisions for the patient or excusing his guilt. This was dramatically illustrated when a psychiatric resident who was also a Jesuit priest was interviewing a masochistic patient in front of a class. He told the Catholic patient that he was a priest and, after hearing the patient’s painful and self-critical story, granted him absolution during the interview. The patient briefly felt better. The other residents were enraged at their colleague’s behavior. The class teacher empathically interpreted their envy of their colleague’s magic power and how his manipulation concealed his feeling of inadequacy in the role of fledgling psychiatrist.

Another manifestation of countertransference is the clinician suggesting medication when there is no clinical indication. This is an example of responding to the patient’s negativity with a feeling of helplessness and a desire to overcome it. Beginning clinicians must resist the temptation to respond to the patient by being nice. It makes the patient feel worse because he believes that he does not deserve it or that he is unable to reciprocate. Excessive support or encouragement can elicit such a response.

Encouraging the patient to assert himself or to compete more actively without interpreting the defensive pattern may also represent an overidentification with the patient’s unconscious rage and be harmful. The clinician’s overactivity with the patient represents an attempt to deal with the feelings of helplessness and passive inadequacy that the patient engenders. Using the feeling of inadequacy that the patient generates in the clinician is an opportunity to have a shared experience. It is an entrée into the psychology of the patient. Empathically commenting on what progress has been made in understanding the patient’s plight while not succumbing to the patient’s complaints of “So much remains to be done” can be highly therapeutic.
CONCLUSION

Regardless of the eventual evolution of the official classification of masochistic patients, their existence is apparent, and they frequently pose a considerable challenge to the interviewer. The interviewer must use his knowledge of masochistic character structure as well as his empathy and his self-analysis of the countertransference. The clinician’s awareness and understanding of the inner aspects of the patient’s character will allow him to establish rapport with the patient by recognizing the ego-syntonic aspects of the patient’s view of himself. Each time the clinician explores a negative aspect of a particular character trait, he also supports the patient’s need to maintain the positive component of that trait. With that protection of his self-esteem, the patient can best accept his inner anger that he so readily directs against himself.

The masochistic character is one of the most difficult patients to treat successfully because of his tendency to turn the treatment situation into another sadomasochistic relationship. Nonetheless, a consistent empathetic position that presents reality to the patient and uses the countertransference constructively and not sadistically carries with it the possibility of therapeutic change that will free the patient from an endless cycle of self-defeating behavior.